

**FACTORS ENCOURAGING OR DISCOURAGING MEN IN THE INFORMAL
SECTOR TO ATTEND HIV COUNSELLING AND TESTING (HCT) IN SOUTH
AFRICA: A CASE STUDY OF PRETORIA**

by

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DECLARATION

I declare that the work I am submitting for assessment contains no section copied in whole or in part from any other source unless explicitly identified in quotation marks and with detailed, complete and accurate referencing.

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ABSTRACT

The purpose of this study was to establish factors affecting the participation of men working in the informal sector economy of South Africa in HIV counselling and testing (HCT) or voluntary counselling and testing (VCT). This includes the exploration of reasons for acceptance and non-acceptance of HIV testing, knowledge and perceptions about HIV testing and behaviours and attitudes towards HIV testing. Data was collected through a structured questionnaire and a sample of fifty (50) men was purposively selected. It was found that the reasons for acceptance of HIV testing are satisfactory and reasons for non-acceptance are still a concern, and that several issues such as education about HIV testing and HIV in general still need to be addressed. Most of the respondents had undergone testing for HIV, but there is still a stigma attached to HIV testing.

Keywords: Encourage, discourage, HIV counselling and testing, voluntary counselling and testing, men, informal sector, South Africa.

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LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
HCT	HIV Counselling and Testing
MAP	Men as Partners
MSM	Men who have sex with men
NSP	National Strategic Plan for HIV, STIs and TB
SA	South Africa
SANAC	South African National AIDS Council
STDs	Sexually transmitted diseases
STIs	Sexual transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNISA	University of South Africa
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

HIV counselling and testing (HCT) is essential because it enable people to know their HIV status. It is extremely important for people to attend HCT to find out their HIV statuses. This is because they would be more likely to start with treatment as early as possible when they test positive. HIV counselling and testing involves counselling and testing for HIV on people who visit a clinic not specifically for HIV testing but for other health reasons and while at the clinic, HCT is done. The purpose and importance of this study is to find out whether or not men working in the informal sector know their HIV status. This chapter deals with the following: introduction; background to the study; rationale for the study; problem statement; aim of the study; objectives of the study; research questions; significance of the study; definition of key terms; and the chapter layout.

1.2 BACKGROUND TO THE STUDY

According to UNAIDS (2012: 9), the latest data shows that a 50% reduction in the rate of new HIV infections (HIV incidence) was achieved in low and middle-income countries between 2001 and 2011. More than half of these countries are in Sub-Saharan Africa where the majority of new HIV infections occur (Mbatha 2014). In nine countries, the rate of new HIV infections fell steeply by at least one-third between 2001 and 2011 (UNAIDS, 2012: 9), but in South Africa (SA) equivalent progress is not visible.

However, South Africa is making a significant effort to reduce the rate of HIV infections by investing in HIV programmes and activities, as stated in the AIDS Day Report: "South Africa is the country that has made the highest domestic investment in AIDS among all low- and middle-income countries. SA alone invested US\$ 1.9 billion last year from public sources, resulting in a five-fold increase between 2006 and 2011" (UNAIDS 2012: 21). South Africa has indeed invested a lot of financial resources to mitigate HIV/AIDS, but there is still a high prevalence rate.

Furthermore, the risk of sexual transmission remains high even within marriage, because of the prevalence of extra marital affairs and the risks that are driving the HIV epidemic in Africa, despite prevention programmes (Mbatha 2010; Converse *et al*, 2012).

The South African government has introduced a number of strategies to mitigate HIV/AIDS by introducing programmes for women and youth. However, there are only a few programmes designed for men. This may be one of the reasons why men do not attend voluntary counselling and testing (VCT) services as much as women do. Data from the 2010–2011 National VCT campaign indicates that men represented only 30% of those tested. Efforts should be made to increase men's health-seeking behaviour, including participation in VCT (South African Government 2012).

According to the AIDS Day Report (UNAIDS 2012: 29), HIV infection rates among men have declined, with the greatest progress evident in South and South East Asia where HIV prevalence among young men and women has decreased by 50%. Sub-Saharan Africa and the Caribbean followed with a decline of more than 35% among young men and women. According to UNAIDS (2012: 29), in Latin America, HIV prevalence decreased among young people and the decline was much higher at 33% among young men, which is the group in which the majority of new HIV infections among young people occurs (UNAIDS, 2012: 29). The question is why HIV infection prevalence rates still remain high among this population group in South Africa?

The VCT uptake in Sub-Saharan Africa is disappointingly low with reports of 12 to 56% among couples or the general public (Bwambale *et al*, 2008: 2). There is scant information on the reasons for the low VCT uptake among men, and also for the factors that influence it, (Bwambale *et al*, 2008: 2). Converse *et al* (2012) also found that most men (64.5%) have not previously been tested and 75% are unaware of their partner's HIV status. As a result, men more often transmit the virus unknowingly than women. This clearly shows that men hardly visit clinics or VCT for HIV testing.

Male health-seeking behaviour is generally poorer compared to women. Research has shown that male health-seeking behaviour is low, and Smith *et al* (2006) state that men's health-seeking behaviour and use of health services merits more attention. Generally, if one considers the findings of research into health-seeking behaviours such as those of Smith *et al* (2006), it is assumed that men are less interested in or concerned about their health, and therefore may be less likely to seek help for health-related problems. In this regard it can be said that men and women are equally exposed to various diseases, but men are reluctant to visit health centres for diagnosis, and instead wait until the symptoms become more aggravated or until they are seriously ill.

Men are risk takers and as a consequence the prevalence of HIV remains high in this demographic group. Smith *et al* (2006) further explain the reasons why men in particular are risk takers. These involve biological factors such as hormonal influences, socio-cultural or economic factors. Smith *et al* (2006) argue that that these factors are mediated by cultural pressures to present a particular masculine identity to the world. The above authors explain further that men are influenced by cultural stereotypes which, when translated into health-seeking behaviour, ignore screening and preventive health care, and delay help-seeking until symptoms appear. These factors result in men under-utilising health services aimed at early intervention. Poor health-seeking behaviour results in poor health care use among men, which limits their access to information and restricts opportunities for health-promoting interactions and use of primary care (Mbatha 2009; Smith *et al*, 2006).

The researcher chose men working in the informal sector economy as the target population because it can be assumed that

- they have services they can access because they are members of associations in their communities
- they are a marginalised target group for health information programmes
- they are poor and depend on public health services for their health, since they cannot afford to pay for private healthcare or medical aid.
- they are exposed to various health hazards

- more people work in the informal sector than the formal sector in South Africa. For instance, the International Labour Organisation (ILO) states that in Sub-Saharan Africa, the proportion of informal economic activity is higher than anywhere else in the world. It has been estimated that in Sub-Saharan Africa, the informal economy makes up as much as 78% of economic activity, while 93% cent of all new jobs created are informal, and on an average, the share of the informal economy in GDP is 42%, (ILO, 2011).

1.3 RATIONALE OR MOTIVATION FOR THE STUDY

The researcher wanted to investigate whether men working in the informal sector have ever gone for any HIV testing. She also wanted to know the factors that encourage or discourage them from going for HIV testing.

1.4 PROBLEM STATEMENT

It can be deduced from available literature that HIV and AIDS is a global pandemic. Worldwide there is an estimated 32.5 million people living with the disease (UNAIDS 2013) with Africa having the largest number of infected people (UNAIDS, 2009; Mbatha 2014). As a result governments in Africa have put in place policies aimed at reducing the incidence of HIV and AIDS, and educating people about the prevention of the disease. South Africa which is the focus of the study has an estimated 5.7 million (UNAIDS, 2009) which is the highest in the region. It is worth noting that efforts at reducing the incidence of HIV and AIDS should be coupled with stigma reduction. The South African government with the aid of non-governmental agencies have initiated programmes like National strategic plans aimed at reducing the incidence of HIV and Aids in the country. Of particular importance are the free HIV and AIDS Counselling and testing services rendered in all health centres in the country. Even though this is a free service and as such should encourage people to voluntarily go for counselling and testing, there are still a large number of people who do not know about their HIV statuses. Men constitute a group that are reluctant to patronise health services including HIV and AIDS counselling and Testing. This view is shared by Smith *et al* (2006) who opines that men are often blamed for being poor consumers of health services, and are thus seen to be victims of their own

behaviour. Could this attitude be attributed to lack of education on health related issues with particular emphasis on HIV and AIDS testing or that they are afraid of the possible results. It is against this background that the study sought to answer the question: ***what factors cause men working in the informal sector in South Africa to be reluctant to undergo HIV testing?***

1.5 AIM OF THE STUDY

Against the backdrop of the discussion above, the aim of this study was to investigate the factors that discourage men working in the informal economic sector in South Africa to undergo HIV testing.

1.6 OBJECTIVES OF THE STUDY

The study addressed the following objectives:

- To explore the reasons for acceptance or non-acceptance of HIV testing among men.
- To determine men's knowledge and perceptions of HIV testing.
- To investigate men's behaviours and attitudes towards HIV testing.

1.7 RESEARCH QUESTIONS

The study sought to answer the following questions:

- Why are men reluctant to undergo HIV testing?
- What are the knowledge and perceptions of men towards HIV testing?
- What are the behaviours and attitudes of men towards HIV testing?

1.8 SIGNIFICANCE OF THE STUDY

The researcher maintains that it is imperative for men in the informal sector to test for HIV since this is the best way to reduce HIV infection. Because men are reluctant to undergo testing, by changing their behaviour, the community as a whole will benefit, and if people know their status, HIV can be prevented.

1.9 DEFINITIONS OF KEY TERMS

1.9.1 Factors are the circumstances or influences that contribute to certain results, and in this study the term refers to the things that encourage or discourage men from undergoing HIV testing.

1.9.2 Encouraging refers to giving support or hope to someone, and in this study refers to items that motivate them to undergo HIV testing.

1.9.3 Discouraging means losing confidence in something, and in this study, this term refers to things that prevent men from undergoing testing.

1.9.4 Men are adult males, and in this study they are referred as males that are self-employed and sell merchandise on the streets.

1.9.5 The informal sector is defined by Essop and Yu (2008) as the sector that is not registered for either income tax or value-added tax and operates in establishments that employ fewer than five employees. In this study, the informal sector refers to men who are self-employed and sell goods at taxi ranks and on the streets.

1.9.6 HIV counselling and testing (HCT) service involves conducting counselling and testing for HIV on people who come to clinics not specifically for testing but for other health reasons, and while at the clinic, receive counselling and testing.

1.10 CHAPTER LAYOUT

Chapter 1 consisted of the introduction and rationale for the dissertation. It also briefly outlined the problem statement, research questions, the aims and objectives of the research, the significance of the study and the definition of terms pertaining to the research.

Chapter 2 provides a review of the relevant literature. The aim is to find further information on various issues pertaining to this study and to elucidate the problem under investigation. Another aim is to determine if there were gaps in previous studies so that this study can address those matters where applicable.

Chapter 3 provides a description of the research methodology used by the researcher. The focus is on the research design, the research instruments used, sampling methods, data collection and data analysis.

Chapter 4 deals with the presentation and discussion of the findings derived from the data collected as well as a description of the statistical methods used to analyse the data.

Chapter 5 summarises the findings of the study and draws conclusions from the findings. It also gives recommendations based on the findings and conclusions. Lastly, it identifies areas for further research based on the recommendations.

1.11 SUMMARY

This chapter highlighted the following: the introduction; the aim of the study; the objectives; and factors that encourage and discourage men from using HCT services offered by health centres. It is necessary to come up with strategies to motivate men to make use of HCT/VCT services to mitigate HIV and AIDS, especially during their later years. In the next chapter, the researcher review related literature on the topic under investigation.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the researcher reviews literature on the factors that encourage or discourage men working in the informal sector from making use of HCT/VCT services in South Africa, the notions of HIV epidemiology and the theoretical framework. The review of literature is informed by the central research problem as well as the objectives of the study.

2.2 HIV EPIDEMIOLOGY

Research shows that the prevalence of HIV is still high in some countries in the world. According to UNAIDS (2004: 23), the number of people worldwide living with HIV increased in 2004 to reach its highest level ever, namely an estimated 37.8 million. This figure included the 4.8 million people who had acquired HIV in 2003. The same UNAIDS report asserts that more than 2.9 million people died globally because of AIDS-related diseases in 2003, (UNAIDS, 2004: 23). Again, in 2007, UNAIDS (2008: 5) supported by Mbatha (2009) stated that about 33 million people were living with HIV, while 2.7 million had become infected with the virus and two million people died of HIV-related causes in that year (UNAIDS, 2008:9). However, UNAIDS reported that there were more than 700 000 fewer new HIV infections globally in 2011 than in 2001. Africa has reduced the number of AIDS-related deaths by one-third in the past six years (UNAIDS, 2012: 2).

According to research, the part of the world most impacted by HIV, namely Sub-Saharan Africa, cut the number of people dying of AIDS-related causes by 32% between 2005 and 2011, (UNAIDS 2012). The largest decline in AIDS-related deaths was in some of the countries where HIV has the strongest grip. In South Africa, 100 000 fewer deaths occurred, followed by nearly 90 000 in Zimbabwe, 71 000 in Kenya, 59 000 in Ethiopia and 48 000 in the United Republic of Tanzania owing to use of medication by those living with AIDS (UNAIDS, 2012: 15).

Even after a concerted effort, the National Strategic Plan (NSP) of the South African Government (2012-2016) states that South Africa has a generalised HIV epidemic driven largely by sexual transmission. Using the spectrum model, in 2009, HIV prevalence in the adult population (aged 15–49) was estimated to be 17.8%. An estimated 5.63 million adults and children were living with HIV in 2009. Of these, 5.3 million were adults aged 15 years and older, 3.3 million were females and 334 000 were children, (South African Government, 2012).

The UNAIDS report (2009: 21) and Mbatha (2012) asserts that “Sub-Saharan Africa remains the region most heavily affected by HIV.” Furthermore, Southern Africa remains the area most heavily affected by the epidemic. The highest HIV prevalence worldwide occurs in the sub-region of Southern Africa, with all countries experiencing adult HIV prevalence greater than 10%. For instance, Swaziland has the most severe level of infection in the world with 26%, followed by Botswana with 24% and Lesotho with 23.2%. UNAIDS (2009: 27) stated that “South Africa is home to the world’s largest population of people living with HIV (5.7 million)” (UNAIDS, 2009:27). However UNAIDS (2012: 9), stated that South Africa which is the country with the largest number of HIV infections, reduced new infections by 41% and in Swaziland, which has the highest HIV prevalence in the world, new HIV infections dropped by 37%.

2.3 MEN’S KNOWLEDGE AND PERCEPTIONS OF HIV TESTING

2.3.1 Men and health

Research has shown that men do not look after their health compared to women. According to Courtenay (2000), men in the United States, on average, die nearly seven years younger than women and have higher death rates for all 15 leading causes of death. Courtenay (2000) further stated that men's age-adjusted death rate for heart disease, for example, is two times higher than that of women and their cancer death rate is 11 times higher. The incidence of seven out of ten of the most common infectious diseases is higher among men than women, (Courtenay, 2000). Meryn (2001) agree with Courtenay and stated that men are also more likely than women to suffer severe chronic conditions and fatal diseases and to suffer them at

an earlier age. Nearly three out of four people who die from heart attacks before the age of 65 are men.

Furthermore, there is a sustained increase in psychosocial disorders in men, including alcohol and substance abuse, mid-life crisis, depression and domestic violence. Men's increasing aggression and auto aggression remain an unsolved health and societal problem. Over 30 wars and conflicts raged around the world, mostly created, maintained and aggravated by men when Meryn's research was conducted (Meryn 2001).

According to Smith et al (2006), the health of men is poorer than that of women, mortality rates are higher and it was found that men use health services less often than women. This could be one of the reasons why men are so vulnerable to various diseases and Smith et al (2006) assume that men are less interested in or concerned about their health, and therefore less likely to seek help for health-related problems. Men are reluctant or less responsible with regard to their health, not only in Sub-Saharan Africa but also in the United States and it is not a matter of affordability or belonging to a certain group. According to Courtenay (2000), men are more likely than women to have had no recent physician contacts, regardless of income or ethnicity, while low-income men are twice as likely as low-income women to have had no recent contact, although high-income men are more likely to have had recent contact than low-income men.

As mentioned in the introduction, men use all services in the healthcare system to a lesser extent than women, and women exhibit a greater acceptance of, and use of healthcare services. Men are often blamed for being poor consumers of health services and are seen to be victims of their own behaviour (Smith *et al*, 2006).

Peacock and Levack (2004) explain that the purpose of the "Men as Partners (MAP) programme" is to challenge the attitudes, values and behaviours of men that compromise their own health and safety as well as the health and safety of women and children, and to encourage men to become actively involved in preventing gender-based violence as well as supporting HIV/AIDS-related prevention, care and support activities.

2.3.2 Vulnerability of men

Men, like women and youths, are vulnerable to HIV and AIDS. For instance, men are involved in various relationships such as marriage, commerce transactions, cross-generational and casual sex. These types of relationships make men vulnerable to HIV and sexually transmitted infections (STIs). For example, migrant workers move from rural areas to urban areas for work, but leave their wives at home and on returning, they do not use any protection because they trust their wives. According to Matshalaga (1999: 93) the use of condoms bring the notions of prostitution and again indicate that one is suspecting that the other party is of loose morals. The author continued by saying that “it is rude to use condom when having sex with a married woman and to do that I will be treating her like a commercial sex worker” (Matshalaga 1999:94). Again, when they come home for a month or a week, their girlfriends might have engaged in extra-marital relationships. Migration contributes greatly to men’s vulnerability to HIV and other STIs. A study conducted in Durban by Lurie *et al*, (2000) revealed that out of the 138 couples recruited in the study, 62% were couples in which the male was a migrant, and 38% were non-migrant couples. Migrant couples are nearly three times more likely to be HIV-discordant compared to non-migrant couples. Among the 23 discordant migrant couples, the male was HIV-positive in 61% of cases while the female was HIV-positive in 39% of the cases.

Gregson *et al* (2000) explain that the difference between the observed sex ratios of HIV prevalence and excess adult mortality is probably due to more male infections occurring in the early stages of the epidemic and at older ages. Gregson *et al* (2000) further argue that mathematical model simulations show that this can happen where many men have extra-marital relationships with sex workers and young girls, where married women are usually faithful to their husbands and men are generally older than their sexual partners.

There are many factors that contribute to men’s vulnerability to HIV and other STIs, and alcohol is one of them. The South African Government (2012) state in the National Strategic Plan that alcohol abuse is a major risk factor for HIV acquisition and transmission. Heavy drinking is associated with decreased condom use and an

increase in multiple and concurrent sexual partners. Data from several studies indicate that people who drink alcohol are more likely to be HIV-positive. This figure is higher among heavy drinkers. It is also a major impediment to treatment adherence. Strategies should address male gender norms that equate alcohol use with masculinity. Indiana Prevention Resource Centre (IPRC), (2012) also stated that being drunk makes one more vulnerable to unprotected sex because one may not be in the state of mind to make rational decisions or may even have passed-out. In one of the studies on high-risk heterosexual women it was found that 98% of those who had unprotected anal intercourse also had unprotected vaginal intercourse and were more likely to binge drink (Jenness *et al*, 2011 cited by IPRC 2012).

Meryn (2001) argues that men's reluctance to embrace preventive strategies has also contributed to the spread of AIDS, particularly in Africa, and to an alarming rise in infection among young men, including other sexually transmitted diseases.

2.3.3 The prevalence of VCT use among men

Voluntary counselling and testing (VCT) uptake among men is low and reinforces the widely reported observation that men are not fully involved in HIV prevention programmes. Bwambale *et al* (2008: 7) explains that in a study by Hutchinson in the Eastern Cape, South Africa older men (35 years or more) were less likely to use VCT than younger men. Furthermore, Bwambale *et al* (2008: 7) explains that AIDS-related stigmas create barriers to seeking VCT among men. More than half of the men feared testing for HIV because of associated stigmas. Men were worried about being labelled HIV-infected, because they could lose their social privileges. They expressed the fear of meeting familiar people in HIV testing clinics, and preferred to test in distant clinics where they were not known by patients and staff (Bwambale *et al* 2008). Research has shown that low rates of VCT participation among men in Tanzania is alarming and previous studies indicate that many men in Africa engage in risky sexual behaviour that places themselves and their partners at risk (Converse *et al*, 2012).

2.4 FACTORS THAT ENCOURAGE OR DISCOURAGE MEN FROM USING HCT/VCT SERVICES

More men than women do not know their status, so it can be assumed that men are the main drivers of the epidemic because knowledge lowers the rate of infection and male-specific factors (behaviour) are one of the assumed reasons why South Africa's epidemic curve is still not decreasing. Men are reluctant to visit HCT/VCT clinics and are therefore less responsible compared to their female counterparts. Thlakudi in the Sowetan newspaper (2011) explained how the Deputy President, Mr Motlanthe, was concerned about the low number of men who go for HIV testing. For instance, the newspaper stated that the SANAC campaign found that fewer men have tested compared with the number of women, and that SANAC will embark on a targeted campaign to encourage more men and people at a high risk of contracting HIV to present themselves for counselling and testing.

2.4.1 Factors encouraging HIV testing among men

Men have their own reasons for undergoing HIV testing. In the next two subsections, encouraging factors and variables, and factors that prevent men from seeking health advice are listed. According to Bwambale *et al* (2008), men's strongest motivation for HIV testing is the desire to know their HIV status.

- Emphasising the positive consequences of VCT encourages men to go for testing.
- Men go for testing when they are very sick with AIDS-related symptoms and this makes it difficult for them to live longer.
- Married men are worried that they are going to die and their spouses and children are going to suffer, since they are the bread winners in the family. They therefore feel there is a need to test for HIV and start taking medication.
- They are worried about their own sexual behaviour and thinking of testing for HIV and if the results are negative they will change their behaviour by sticking to one partner.

- The death or sickness of a partner makes men think that they are also going to be sick/die soon, and therefore it is vital to do HIV testing and start with treatment before it is too late.
- They think that taking anti-retroviral (ARVs) is the best option to become better if tested positive.
- Blood donation is another way to encourage men to know their status and to start with treatment as early as possible. Men can do HIV testing by donating blood at clinics without visiting VCT centres.
- Being tested gives men specific advantages for leading future planning and encourages preventive behaviour. HIV testing results whether positive or negative can help men to plan and change their sexual behaviour.

2.4.2 Factors discouraging HIV testing

HIV-positive men might experience rejection from their family members, especially their wives, and this could drive male suicide rates when their HIV status changes. They are scared of being stigmatised by their communities which discourages them from testing for HIV (Bwambale *et al* 2008).

- Poor male VCT attendance could be due to a lack of knowledge about HIV information, prevention and care (Bwambale *et al* 2008).
- Men, like any other people, are afraid of a positive test result. They might have multiple relationships, and think that if steady girlfriends test negative they are also negative which may not be true. According to Gage and Ali (2005), VCT plays a critical role in HIV prevention because it enables early diagnosis of HIV infection and timely therapeutic or prophylactic interventions. For individuals with unrecognised infection, VCT provides the opportunity for partner notification and modification of behaviours associated with viral transmission (Gage and Ali, 2005). It is therefore important for everyone to visit VCT center in order to be checked and diagnosed at an early stage.
- Most men fear being stigmatised and therefore do not visit VCT services in their communities. According to Bwambale *et al* (2008), most men expressed the feeling that they would go somewhere else other than in the HSD, and the

majority preferred VCT sites outside Bukonzo West where the VCT counsellors do not know them. They feared that they would be identified and labelled as HIV victims. Some men also said that VCT staffs were being bribed and giving negative results to HIV-positive clients.

- Men between the ages of 30 and 60 years are more vulnerable to HIV and AIDS because they are involved with younger women who are still sexually active. For instance, Gage and Ali (2005) state that targeting men with high-risk behaviours should continue to be an important component of the country's HIV prevention and care strategies. This should also include special efforts to reach men in their thirties and fifties, because older men of "reproductive age" are significantly less likely to have been tested for HIV or to be willing to be tested, despite their higher likelihood of having a greater number of lifetime sexual partners. Converse *et al*, (2012) explain that programmes should continue to improve knowledge about HIV transmission and where to obtain an HIV test, and promote partner communication about HIV prevention.
- According to Converse *et al* (2012), two out of three men have not tested previously and a quarter of them are unaware of their partner's HIV status.
- VCT among men is still extremely low, especially in Sub-Saharan Africa, and Converse *et al* (2012) supports this statement by saying, "VCT remains low among men in Sub-Saharan Africa and underscores the need for more intensive initiatives to target men and remove the barriers that prevent HIV disclosure." Furthermore, these authors explain the factors associated with previous HIV testing and knowledge of partner's HIV status as described for 9107 men who visited the Muhimbili University College of Health Sciences' VCT site in Dar-es-Salaam, Tanzania, between 1997 and 2008. According to Smith *et al* (2006), most discussions on men's help-seeking behaviour position them as reluctant consumers or "behaving badly" with respect to their health. Data are from intake forms administered to clients seeking VCT services.

2.5 KNOWLEDGE OF HIV AND AIDS

There are few programmes that target men to mitigate the pandemic and Cloete *et al* (2007) acknowledged that interventions are needed in South Africa that can assist HIV-positive MSM (men who have sex with men) to better adapt and adjust to their conditions and the social environment. In particular, coping efficacy training targeted at addressing and managing social stigma and reducing internalised stigma should be developed and tested among them. Bwambale *et al* (2008) states that older men tend to be more conservative and may not have accepted VCT readily because they are more likely to be rural subsistence farmers, less educated, and less informed about HIV and VCT.

SONKE Gender Justice Network (2010) explains how the NSP in South Africa has focused prevention strategies on how best to reach women and youth, while men often go unmentioned. The need to address men's health-seeking behaviour in terms of treatment is not addressed in the NSP - nor is the important need for men to support women's uptake of treatment. Similar to VCT, it is essential that spaces in which treatment is accessed are made more male-friendly, as well as placed appropriately for increased male access (SONKE Gender Justice Network, 2010).

Leclerc-Madlala (2000: 10) points out that African society is more at risk for both STDs and HIV/AIDS than societies in other parts of the world, because men believe that they need to have sex regularly with more than one woman and without the use of condoms. Furthermore, the author also states that men are in an economic and professional position to exchange sex for money, favours and goods. This might be one reason why men are vulnerable to HIV and AIDS and are the drivers of the epidemic (Leclerc-Madlala, 2000: 10).

Death and morbidity rates among men are generally high because men do not tend to visit health services as often as women, and they wait until the problem becomes worse. For instance, Robertson *et al*, (2008: 9) states that men had higher mortality rates than women for the 15 leading causes of death in the United States in 1999 and men tended to visit their doctor later in the course of a condition than women, which is associated with poorer health outcomes.

2.6 MEN'S BEHAVIOUR AND ATTITUDE TOWARDS HIV TESTING

2.6.1 Cultural influences on men's behaviour

In some African countries such as Zambia, after the husband passes on, the wife must have sex with a man from the family to cleanse her dead husband's spirit. This is called "sexual cleansing". In some communities it is believed that condoms should not be used during the cleansing process. This can put both the widow and the man (cleanser) at risk for HIV and other STIs (Hunter 2005).

In South Africa, especially in the Zulu culture, it is the norm for a man to marry more than one wife, which also puts both men and women at risk of HIV and AIDS, because no condoms are used since the man trusts his wives. For instance, Hunter (2005) explains how men generally present "isoka", which broadly means a man with multiple-sexual-partners as a part of a seamless Zulu custom. Hunter interviewed Zandi, a 22-year-old township woman, and she describes how men conflate polygamy with multiple partners, to justify the matter: "they say that it is their culture to have more than one girl" (Hunter, 2005).

Many socio-cultural factors are associated with and influence health-related behaviour. Gender is one of the most important of these factors. Women engage in far more health-promoting behaviours than men and have healthier lifestyle patterns. Smith *et al* (2006) explain how masculinity affects men's health: "The social construction of masculinity acts as an important influence on health and illness, and one that may both prescribe and limit men's lives. Sociologists have implied that specific behavior associated with traditional forms of masculinity is likely to be hazardous to men's health. Dominant masculine cultures and values may negatively affect patterns of illness and men's experiences and behavior".

According to some African cultures, if a man is sick he needs to suppress the illness and pretend to be strong and if not he is not man enough. According to Smith *et al* (2006), stoicism and suppression of emotion, for example, are values often associated with masculine gender role socialisation and adherence to patriarchal masculine characteristics, such as superiority, independence, self-reliance and

dominance, which may in turn act as a barrier to men appropriately accessing and using health services.

Culture tends to prevent men from doing certain things such as helping people in the family when they really need them. For instance a study conducted in 1998 by UNAIDS in Tanzania about men, shed light on their lack of involvement in care and support and revealed that on occasion “male heads of households would wish to do more when their partners fall ill but were curtailed by cultural definitions of maleness and the roles defined which determine masculinity” (Peacock & Levack, 2004).

Smith *et al* (2006) mention that men are influenced by cultural stereotypes to ignore screening and preventive health care, and to delay help-seeking for symptoms. This result in them under-utilising health services aimed at early intervention. For instance, Gregson *et al* (2000) stated that HIV prevalence levels in Zimbabwe were extremely high in both males and females, even in the most rural areas. Rates rise rapidly in the teens and early twenties in females and the late twenties and thirties for men. Men as part of African culture are the ones who have to provide for their wives and children. According to Leclerc-Madlala (2000) the notion of giving gifts or selling sex for money is popular in most parts of Africa, consequently this sustain the epidemic in Africa.

2.7 THEORITICAL FRAMEWORK

The study is based on the Feminist and Masculinity theories. Crossman (2013) states that the Feminist theory is one of the major contemporary sociological theories, capable of analysing the status of women and men in society for purposes of utilizing a particular knowledge in bettering women’s lives. The relevance of this theory to the current study relates to the fact that the study explores men’s reasons towards their reluctance to undergo HIV testing. This reluctance can impact negatively on women in that their husband’s health status can affect them. Crossman (2013) differentiates between four main types of feminists, namely: gender differences, gender inequality, gender oppression, and structural oppression. The first three are related to the study under investigation in the sense that men use their power to oppress or overpower women who then put these women on the

danger of contracting sexually transmitted infections. The last above mentioned type of feminist relates to issues of gender at workplace among people who do not have intimate relationship.

Connell (1995) defined masculinity as the position of men in a gender order and patterns of practice by which people are engaged in. Connell (1995) indicated that masculinity can be hegemonic which is an enacted form of masculinity (being the real man) in a particular time and place. The relation of this study to this framework is how men's behave and react towards HIV testing. Men believe that going to the clinic is not for them because they are strong enough to tolerate or ignore any health haphazard they are faced with. Skovdal *et al* (2011) stated that men perceived themselves as physically strong, tough, resilient, problem solvers and capable of withstanding 'little illnesses'.

According to Gardiner (2002), the ancient Greek philosopher Aristotle portrayed women as naturally being men's inferiors in terms of reason. Feminist theories take a number of approaches to this slippery goal of gender equality that is intertwined with their varying perspectives on men and masculinity (Gardiner 2002). Furthermore, Gardiner (2002) explains how some aspects of traditional masculinity, critiques some, and ignores others, as they ask who will be equal to whom, in what respect, and with what results for male and female individuals and their societies.

Feminist and masculinity theories, according to Gardiner (2002), explain how cultural ideologies favour men, who as a group have benefited from the subordination of women as a group, despite the huge disparities that exist in the advantages accruing to individual men or subgroups of men in relation to other men and to women.

2.7.1 The relevance of masculinity theory to the study

In terms of feminist theories, men infect their wives because some women, especially in African countries, depend on their husbands to survive and so are unable to leave their partners even in the face of sexual infidelity. Traditionally, men have to provide for their families and culturally they give orders in the family. Men are

regarded as household providers and the ones to carry out responsibilities requiring physical strength in the family and such perceptions put pressure on men to believe that those who cannot fulfil their roles and responsibilities as bread winners and heads-of-house are not 'real' men, fathers or husbands (Skovdal 2011).

For instance "typical African men" do not understand why they should use condoms, when sleeping with their wives. Leclerc-Madlala (2000: 10) states that condom is not used or heard of in marriage. He explains further that sex in marriage is simply part of the marriage "deal" and whenever the husband demands sex, he must get it (Leclerc-Madlala 2000: 10). If the wife insists on condom use, this may lead to violence, rape and divorce, and this is where masculinity prevails. Leclerc-Madlala (2000: 10) states that often husbands insist on having sex without a condom and also tell their wives not to worry about falling pregnant or passing the virus on to their children, because they have a marital duty to produce children.

Men hesitate to visit clinics even if they are sick, and they will suppress the pain until they are extremely ill. This shows how men practise their masculinity incorrectly. Men also insist that women ask permission from them to visit VCT clinics, since they are the head of the family. The result is that VCT visits decline, especially in rural areas.

2.8 SUMMARY

This chapter highlighted the reviewed literature on the topic, factors that encourage and discourage men from attending HCT services and the theory that will guide the study. The next chapter is devoted for explaining the steps taken in conducting the empirical investigation.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research methodology for the study is described. The chapter gives a detailed discussion of the following: the research method; research design; area of study; study population; sample and sampling size; research instrument; pilot study; data collection procedures; the data analysis; ethical considerations; the pre-test of the questionnaire; and ethical considerations.

Research methodology refers to the methods used when data is collected to make valuable decisions and it includes information from articles, interviews and surveys.

3.2 RESEARCH METHOD

Research is defined by Leedy (1980) as a way of thinking and looking at accumulated facts so that a collection of data speaks to the mind of the researcher. There are two main research methods in social sciences, namely qualitative and quantitative methods (Leedy 1980).

Quantitative research utilises numbers and statistics from which interpretations are derived. The quantitative research method is defined by Dawson (2002) as a research method which generates statistics with “large-scale survey research, using methods such as questionnaires or structured interviews”. Creswell (2003) also stated that quantitative method employs strategies of inquiry such as experiments and surveys, and collects data on predetermined instruments that yield statistical data.

In this study, a quantitative research method was employed whereby a structured questionnaire was utilised in order to source the information from the target population.

The nature of this study was mostly descriptive and was directed towards finding answers to the questions posed in the objectives, which were what the respondents knew and perceived about HIV testing.

The researcher chose the quantitative research method because it is much easier and quicker for data collection. The quantitative method was cost effective for collecting data, and kept the project within budget (the researcher did have any financial aid).

3.3 LIMITATION TO THE STUDY

The data was collected in selected taxi ranks in Pretoria, in the Gauteng province, owing to the accessibility and time constraints, rather than in all provinces. Consequently, data could not be collected from other ranks in Pretoria and other provinces.

3.4 RESEARCH DESIGN

The researcher chose a descriptive survey research design to conduct the study. The descriptive survey research design entails sending interviewers to ask questions orally and record respondents' answers (Babbie, 1992). For this study, the researcher sent two interviewers to the area of study to collect data by asking questions orally and recording the answers in the questionnaire. The researcher selected two men to conduct the survey on her behalf because she is employed permanently. The reason she chose men, instead of women is that she believes that since the target group are men, they will be more open to answer questions about HIV and Aids freely. According to Skovdal *et al* (2011), men are generally afraid and shy to be known that they are HIV positive and they may only come out after they get seriously ill. Sometimes they will not even tell the truth to the nurses fearing that everyone might know that their statuses.. The respondents were given time to go through the questionnaire and to ask questions if not clear, before they can go to the field. To ensure understanding of the questionnaire the interviewers and the researcher went to the field to pre-test the questionnaire.

3.5 AREA OF STUDY

The area of study is the physical place where the research was conducted. The research was conducted in the Bloed Mall and at Marabastad taxi rank in Pretoria. The researcher chose the above-mentioned areas because they were convenient for her to conduct the research after work and even at weekends. The areas are in the same neighbourhood and within walking distance for the researcher. Another reason is that the researcher did not receive any financial help to conduct the research and depended on her salary hence the need to reduce costs.

3.6 STUDY POPULATION

The population refers to a larger collection of units from which a sample is taken (Neuman, 2009). For this study, the population included men between the age of 25 and 39, working in the informal sector. The informal sector is defined by Essop and Yu (2008: 8) as workers who are not registered for either income tax or value-added tax, who work in establishments that employ fewer than five employees.

The reason for choosing men between 25 and 39 years is that the researcher believes that men in this age group are more vulnerable to diseases such as HIV and AIDS. According to Gregson *et al.* (2000), older men are prone to HIV infection, and appear to be contracting and dying of AIDS.

3.7 SAMPLING

Neuman (2009) defines sampling as a small collection of units taken from a larger collection.

Non-probability, purposive sampling was used to select the respondents. According to Neuman (2009), purposive sampling occurs when judgement is used to select cases with a specific purpose in mind. The researcher chose purposive sampling because she knew her target group, namely men working in the informal sector aged between 25 and 39.

3.8 SAMPLE SIZE

Sample size is the actual number of respondents per study. In this study, fifty (50) men were selected to complete the questionnaire. The quantitative design enabled the researcher to measure the frequency of responses and to examine differences between key variables such as education level, age and knowledge regarding the issue of HIV testing. These biographical variables are used to give an overview of the profile of the respondents and to compare and contrast profiles among men.

Owing to time constraints for the researcher and the subjects (men working in the informal sector), only 50 were selected. The researcher believed that since these men do the same job, she would get the same response even if more men were selected hence a sample of 50 men was deemed appropriate.

3.9 RESEARCH INSTRUMENT

The research instrument is a tool used to collect data. A questionnaire was used to collect information from participants, because it is quicker and cheaper. The researcher used a structured questionnaire with closed-ended questions, since this enabled uniformity of responses and simplicity in coding, processing and comparison of responses. The questionnaire included an introductory statement, which briefly summarised the purpose of the study.

A structured questionnaire, with closed-ended questions meant that the researcher received standardised answers which were easy to code and analyse.

The questionnaire included a biographical section, intended to gather relevant biographical data on the respondents. A section that focused on the knowledge of HIV and HIV testing followed.

3.10 PILOT STUDY

A pilot study is used to test the research instrument so that it can be streamlined and amended if necessary. It was essential to pre-test the questionnaire to identify any

ambiguities in the questions. The purpose of a pilot study was to test the instrument used for data collection. To test the questionnaire, the researcher distributed five questionnaires to men between the ages of 25 and 39 years in Danville, which is location in Pretoria West.

The feedback received indicated that the questionnaire was too long. As such the researcher made changes by removing some of the questions from the instrument.

3.11 DATA ANALYSIS

Data analysis refers to the numerical representation and manipulation of observations for the purpose of describing the phenomena that those observations reflect (Babbie, 2008).

The data collected using questionnaires were coded and entered into the Microsoft Excel programme so that the researcher could identify and manage the information. The results are presented in tables and figures. . Afterwards, the researcher documented the findings, which formed the basis for conclusions and recommendations.

3.12 ETHICAL CONSIDERATIONS

It is vital to consider certain ethical aspects, such as confidentiality, informed consent, voluntary participation, no harm to subjects and no deception of respondents. In gathering data, the following was explained to the participants:

- The research was done mainly for study purposes;
- They are not compelled to participate in the study but if they choose to, they have to sign the consent form;
- If they participate, they may withdraw at any time during the study;
- The identity is protected and will not be disclosed at any time during and after their participation;
- Data will be kept in a safe place and only be accessible to the researcher to maintain confidentiality.

3.12.1 Permission to conduct the research

The University of South Africa (UNISA) granted formal permission to the researcher to conduct the research. Since the study was not about a company, no permission was needed to interview the subjects.

3.12.2 Anonymity and confidentiality

According to Babbie (1992), the clearest concern in the protection of subjects' interests and wellbeing is the protection of their identity. Researchers have to protect subjects' right to privacy by guaranteeing anonymity or confidentiality. In surveys using self-administered questionnaires where no names are attached, it is easy to maintain confidentiality. It is essential that confidentiality be maintained at all times.

To protect the identities of the participants, the researcher ensured that in terms of the informed consent form, no names were included or mentioned anywhere - nor were names of participants linked to any information in the study. For this research, ethical clearance was obtained from the Ethical Review Committee of the University of South Africa.

3.12.3 Informed consent

Informed consent is a written agreement that explains aspects of the study to participants and asks for their voluntary agreement to participate before the study begins (Neuman, 2006).

The informed consent form outlined the aims and objectives of the study. It also mentioned that participation was voluntary and that the respondents could stop participating at any time if they wanted.

3.12.4 Voluntary participation

According to Neuman (2009), voluntary participation means that no one is forced to participate in a research study and participants explicitly and voluntarily agree to

participate. In this study, men in the informal sector voluntarily participated in the study by signing the consent form. They were told that they could stop completing the questionnaire at any time if they wanted to.

3.12.5 Deception of respondents

The researcher informed the respondents of the purpose and benefits of the study in the consent form and also that participation was voluntary. According to Neuman (1991: 95), the social researcher follows the ethical principle of voluntary consent. Hence participants were not forced to participate in the study and information given was not misrepresented.

3.13 SUMMARY

In this chapter, the researcher described the research design, methodology and ethical considerations. The approach adopted in this research was a quantitative, survey-type approach. The next chapter presents the results of the study as obtained from the field.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

Babbie (2009) defines quantitative data analysis as the numerical representation and manipulation of observations to describe and explain the phenomena that they reflect.

This chapter presents the findings of the study. As mentioned in chapter 3, data were generated from fifty (50) respondents who were purposefully selected to participate in the study. The aim of the study was to investigate the factors that cause men working in the informal sector economy in South Africa to be reluctant to undergo HIV testing.

The questionnaire comprised the following three subsections:

- biographical data of the respondents
- question items intended to evaluate the perceptions of respondents regarding HIV testing
- question items intended to measure respondents' opinions about HIV testing

Data analysis was presented according to the research objectives, namely

- to explore the reasons for acceptance or non-acceptance of HIV testing among men
- to determine men's knowledge and perceptions of HIV testing
- to investigate men's behaviours and attitudes towards HIV testing

4.2 BIOGRAPHICAL CHARACTERISTICS OF THE RESPONDENTS

In this section, the biographical characteristics of the respondents are presented. In particular, the distribution of the respondents in terms of age groups, educational levels, relationship status, family and public facilities are discussed.

4.2.1 Respondents in terms of age

Respondents were asked to indicate their age. The reason for this question was to establish the age groups that dominate the informal sector. Respondents were given a list of ages to choose from. The results are presented in the figure below.

Figure 4.1: Respondents by age (N=50)

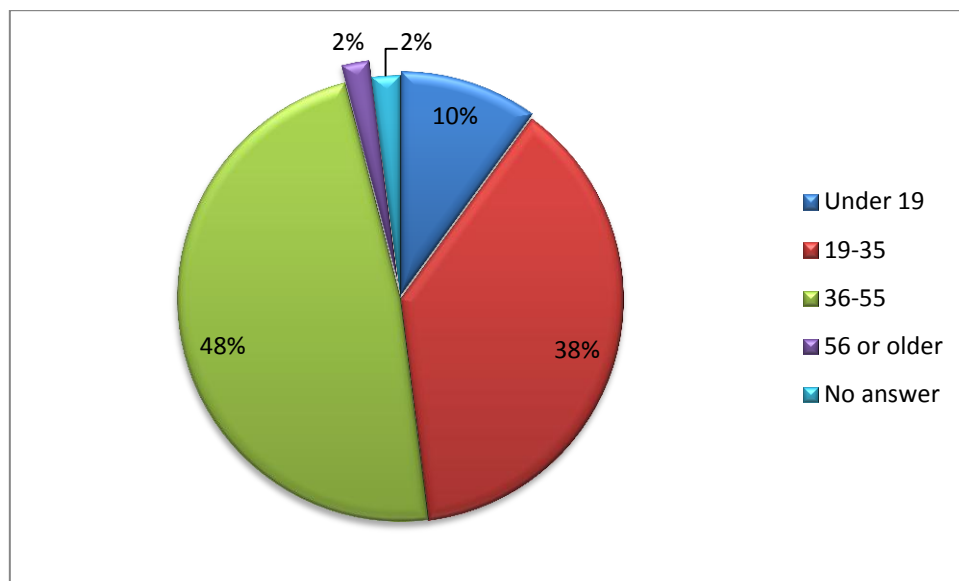


Figure 4.1 shows that 24 men (48%), that is, nearly half of the respondents were between the ages 36 and 55, and 19 (38%) were between the ages of 19 and 35, while five (10%) were under the age of 19. Only one (2%) was 56 or older and one respondent did not answer the question. The study revealed that most men in the informal sector are aged between 36 and 55 years. Men in this age group are more vulnerable than at any other age, because they have left their families and come to Gauteng province to look for jobs.. According to Courtenay (2000), men are less likely than women to engage in a variety of preventive and self-care techniques, which contribute to increased risks for them.

4.2.2 Respondents' educational level

Respondents were asked to indicate their educational level. The reason for this question was to establish whether the respondents' level of education had any influence on their decision not to visit VCT centres. Respondents were given a list of levels of education to choose from. The results are presented in the figure below.

Figure 4.2: Respondents by educational level (N=50)

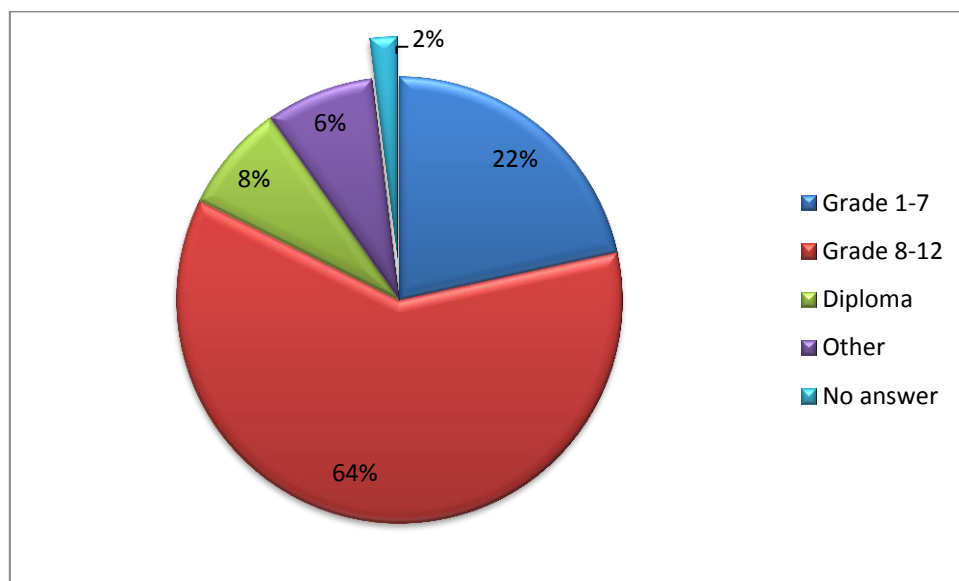


Figure 4.2 shows that the majority of the respondents (32 men or 64%), had passed Grades 8 to 12, while 11 (22%) had passed Grades 1 to 7. There were four respondents who had at least a diploma (8%) and only three (6%) indicated that they had another qualification (certificate, did not attend school or a degree). Only one respondent (2%) did not answer this question. This shows that the majority of the respondents had a basic education and could therefore read and write. This means that men who work in the informal sector can read printed material about HIV and AIDS and this gives them knowledge of the disease.

4.2.3 Respondents' sexual relationships (N=50)

Respondents were asked to indicate whether or not they were in a relationship. The researcher asked this question because the most common way of becoming infected with HIV is through sexual intercourse. It is also possible to become infected with HIV if one is in a relationship. A binary choice of "Yes" and "No" was used for the question. The figure below presents the results.

Figure 4.3: Respondents' sexual relationships (N=50)

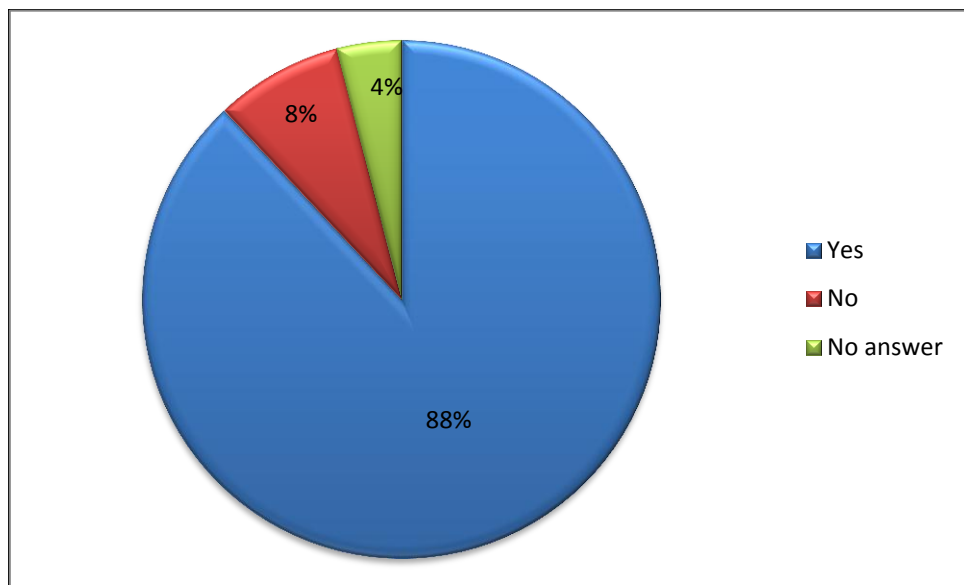


Figure 4.3 shows that 44 respondents (88%) were in relationships and only four were not (8%). Two respondents did no answer the question. Overall, this study established that almost all the respondents (44; 88%) were in relationships, which shows that they would be more at risk of contracting HIV, especially when prevention measures such as condoms are not used during intercourse. This also relates to the issue of masculinity where men might be in more than one relationship to prove their masculinity. Skovdal *et al* (2001) explain that for men, having multiple sexual partners is a sign of virility, but many also reported feeling embarrassed by failing to protect them. Many fear losing their dignity if found to be HIV positive, and many opt to ignore HIV services, or if they have been tested, hide their status from their wives and do not seek treatment.

4.2.4 Marital status

Respondents were asked to indicate their marital status. The reasoning behind this question was to check whether or not the respondents were married. Their marital status determines their vulnerability to diseases like HIV and AIDS. The choices offered were married, divorced, single or living with a partner. The results are presented below.

Figure 4.4: Marital status (N=50)

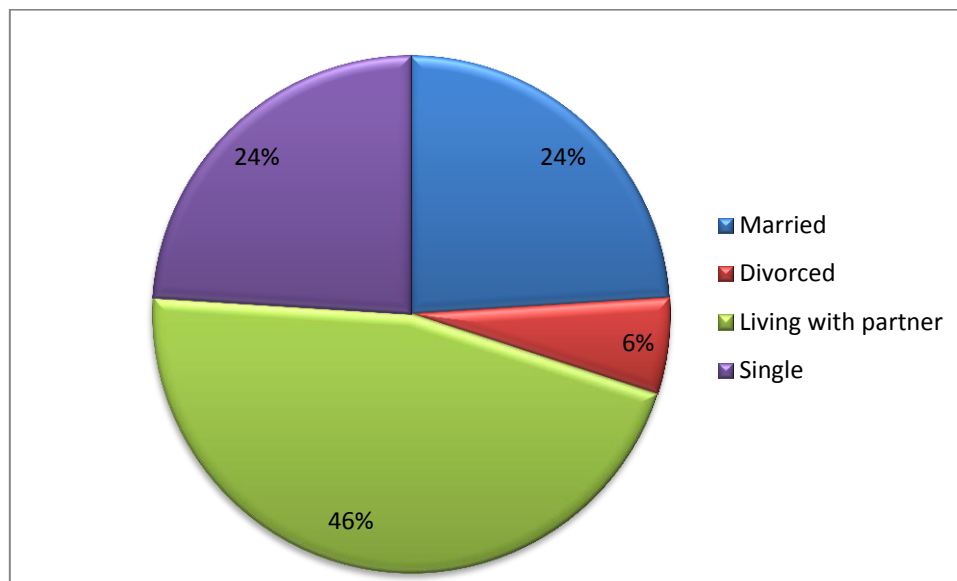


Figure 4.4 represents the respondents' relationship status and indicates that 23 respondents (46%) were living with partners, 12 were married (24%), 12 were single (24%) and three were divorced (6%). The study shows that nearly half of the respondents were living with their partners. This could make them more vulnerable to diseases such as HIV; because some of them have wives where they come from. EDK (1995) cited by Courtenay (2000) states that over 50% of all men have had six or more partners during their lifetimes, compared to 25% of women. Only one in four men always use a condom, and less than one-third of men at high risk for STDs always do so (EDK, 1995 cited by Courtenay, 2000). Furthermore, Skovdal *et al* (2001) state that the migration of men from one place to another places them at greater risk of HIV, because they spend their evenings away from home with different sexual partners.

4.3 PERCEPTIONS OF THE RESPONDENTS ABOUT HIV TESTING

4.3.1 Respondents' perceptions and understanding of HIV testing

Respondents were asked to indicate their perceptions and understanding of HIV testing. The reasoning behind this question was to check the level of understanding regarding HIV testing and how respondents viewed the HIV testing issue. It is believed that the reason some people do not get tested for HIV or any disease for that matter, is because they lack knowledge of that particular disease or they have a negative perception about the disease. Respondents were given a list of possible perceptions to choose from. The figure below presents the results.

Figure 4.5 Respondents' perceptions of HIV testing (N=50)

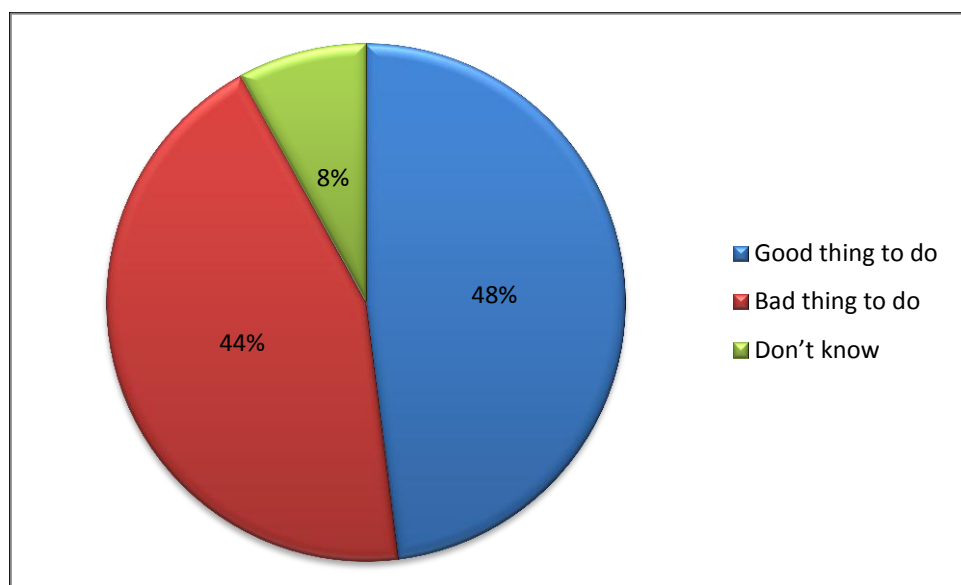


Figure 4.5 indicates that almost half of the respondents (24 men or 48%) answered that it is a good thing to do. The other half (22 or 44%) said that it is a bad thing to do. Four respondents (8%) indicated that they do not know if it is good or bad to have an HIV test. These results show that nearly half of the respondents viewed HIV testing as a good thing, but 44% viewed it as a bad thing. This is a good sign that at least the respondents understood that there is a need for HIV testing in order to order reduce the spread of the pandemic. Goldman and Hatch (2000:425) cited by Dube and Nkosi (2008:14) mentioned that knowledge and good perceptions of HIV

testing is a prerequisite for increasing the acceptability of HIV testing.

4.3.2 Source of HIV information

Respondents were asked to indicate how and where they first heard about HIV. The reason for the question was to check sources of information about HIV. Sometimes a source of information can mislead a person when it comes to education or imparting knowledge. Respondents were given a list of possible information sources to choose from. The figure below presents the results.

Figure 4.6: Source of HIV information (N=50)

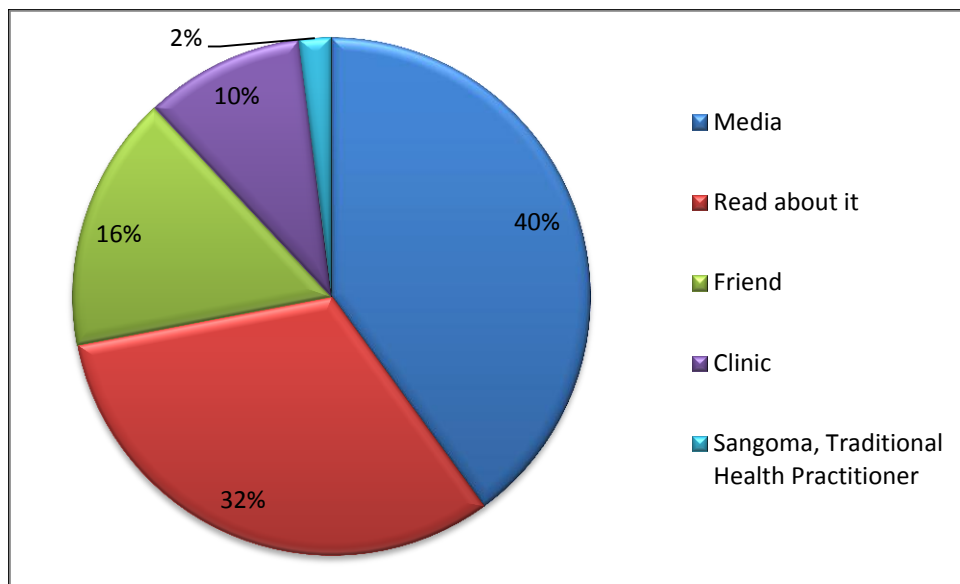


Figure 4.6 indicates that most of the respondents (20 men or 40%) knew about HIV through the media and 16 (32%) said that they knew about HIV/AIDS through reading. Eight (16%) indicated that they had heard about HIV/AIDS in the clinic, while five (10%) respondents indicated that their friends had told them about HIV/AIDS. Only one respondent (2%) said that he had heard about the disease from a Sangoma (traditional health practitioner). The findings of this study show that more people have access to media and clinics and know where to obtain information on HIV and AIDS.

4.3.3 Ways of contracting HIV

Respondents were asked to indicate their perceptions on how people become infected with HIV. The reason for this question was to check if they knew how one becomes infected with the disease. Some people believe that HIV is for certain people only and one can only contract it through sexual intercourse with an infected individual. Respondents were given a list of possible ways of contracting HIV to choose from. The figure below presents the results.

Figure 4.7: Ways of contracting HIV (N=50)

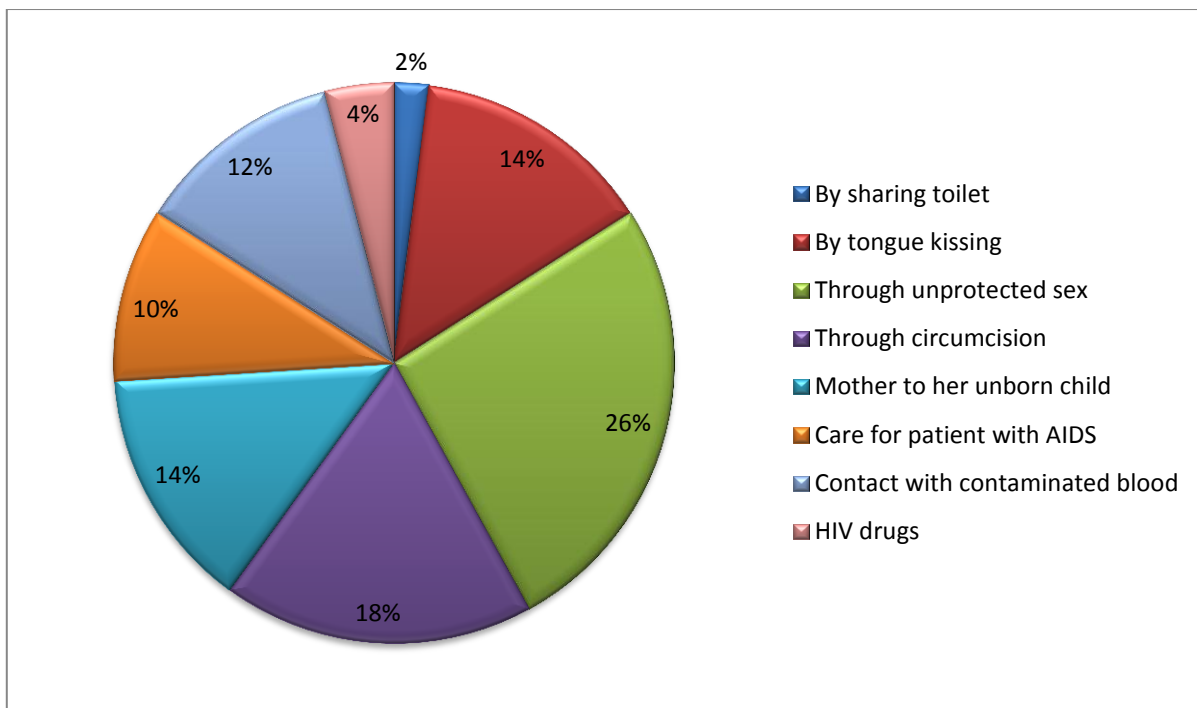


Figure 4.7 shows perceptions about different ways of contracting HIV. The figure indicates that 13 respondents (26%) said that people become infected through unprotected sex. Nine respondents (18%) indicated that people become infected by HIV through circumcision, while seven (14%) said that people become infected from mother to child during birth. Seven (14%) indicated that people become infected by tongue kissing. Five respondents (10%) said that people become infected when caring for patients with AIDS. Lastly, only two respondents (4%) indicated that people can be infected by taking HIV drugs, while one respondent indicated that people become infected by HIV when sharing a toilet. It was found in this study that

the majority of respondents were knowledgeable about how people become infected with HIV and only a few still believe the myths about how HIV infects people. This is an indication that HIV and AIDS infection will decrease in the informal sector.

4.3.4 HIV prevention

Respondents were asked to indicate their perceptions about how one can prevent HIV. The reasoning behind this question was to ascertain whether they know how HIV can be prevented. This question is important because many people who are HIV positive claim that they were infected with HIV because they lacked knowledge on how it is transmitted and how transmission can be prevented. Respondents were given a list of HIV-preventive measures to choose from. The figure below presents the results.

Figure 4.8: HIV prevention (N=50)

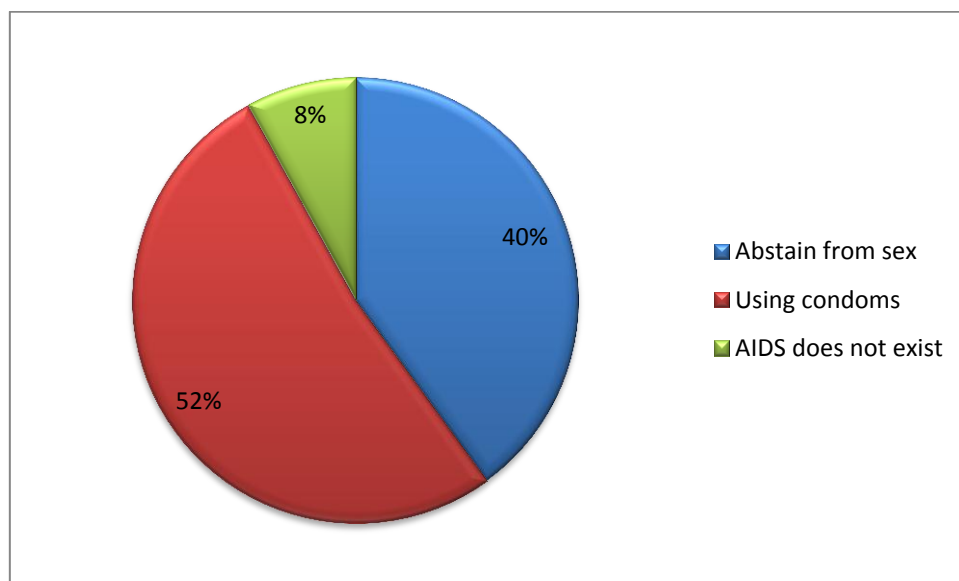


Figure 4.8 shows that more than half of the respondents indicated that HIV can be prevented by using a condom and 20 (40%) indicated that HIV can be prevented by abstaining from sex. Only four respondents (8%) indicated that AIDS does not exist. According to this study, most respondents knew how HIV can be prevented and only a few still believed that HIV/AIDS does not exist. Therefore it can be argued that about HIV should be held in the informal sector in order to mitigate the pandemic.

4.3.5 Cure for HIV/AIDS

Respondents were asked if there was any cure for HIV. A binary choice of “Yes” and “No” was used to measure their responses. The researcher wanted to establish whether the respondents knew that there is no cure for AIDS. The results are presented below.

Figure 4.9: Cure for HIV/AIDS (N=50)

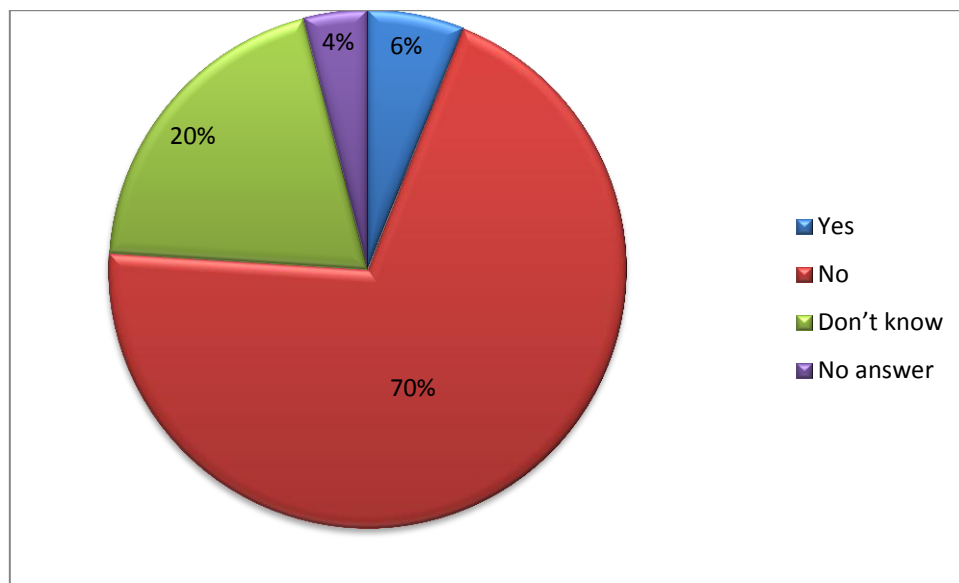


Figure 4.9 shows that 70% of respondents (35 men) said that there is no cure for HIV, whereas only six% (3 men) said that there is a cure. Ten respondents (20%) indicated that they had no idea whether HIV can be cured or not. Only two respondents (4%) did not answer the question. This study shows that most respondents knew that HIV cannot be cured and this is also a good sign that they will start to take prevention measures not to be infected by HIV.

4.3.6 Views on HIV and AIDS

Respondents were asked to indicate their views about HIV and AIDS. The reasoning behind this question was to check how respondents viewed HIV and AIDS. Respondents were given a list of views to choose from. The figure below presents the results.

Figure 4.10: Views on HIV and AIDS (N=50)

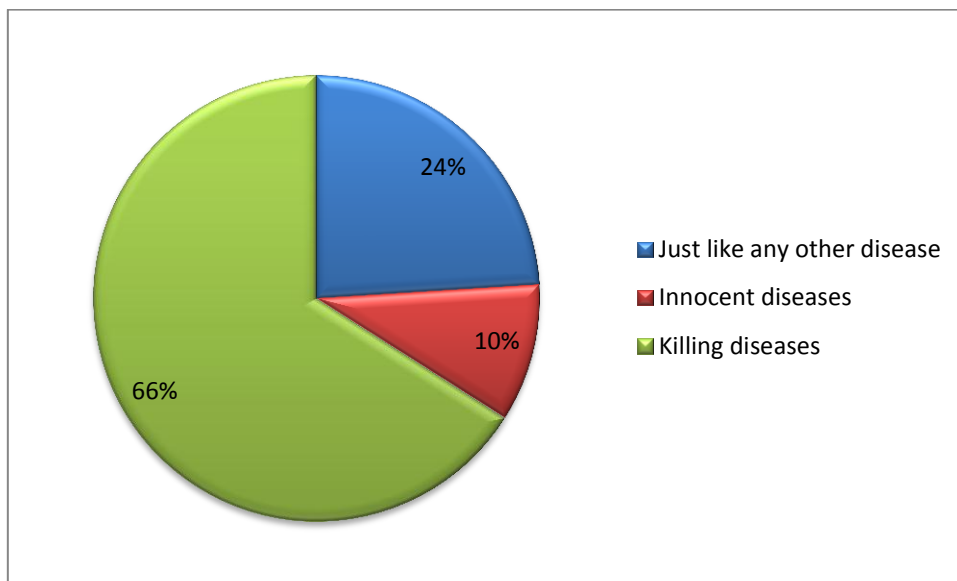


Figure 4.10 shows that 33 respondents (66%) answered that HIV and AIDS is a fatal disease, while 12 (24%) said that HIV is just like any other disease. Only five respondents (10%) indicated that HIV and AIDS is a non-fatal disease. The study shows that more than half of the respondents viewed HIV and AIDS as a fatal disease, indicating that there is still a stigma around the disease. Although the majority of men are at medium to high risk of contracting a sexually transmitted disease (STD), including AIDS, most never look for signs and symptoms (EDK, 1995 cited by Courtenay 2000).

4.4 HIV TESTING

4.4.1 Clinic visit in last six months

Respondents were asked to indicate how often they had visited a clinic in the previous six months. This question was posed in order to know whether or not the respondents visited clinics. They were given a list of possible answers to choose from. The results are presented below.

Figure 4.11: Clinic visit (N=50)

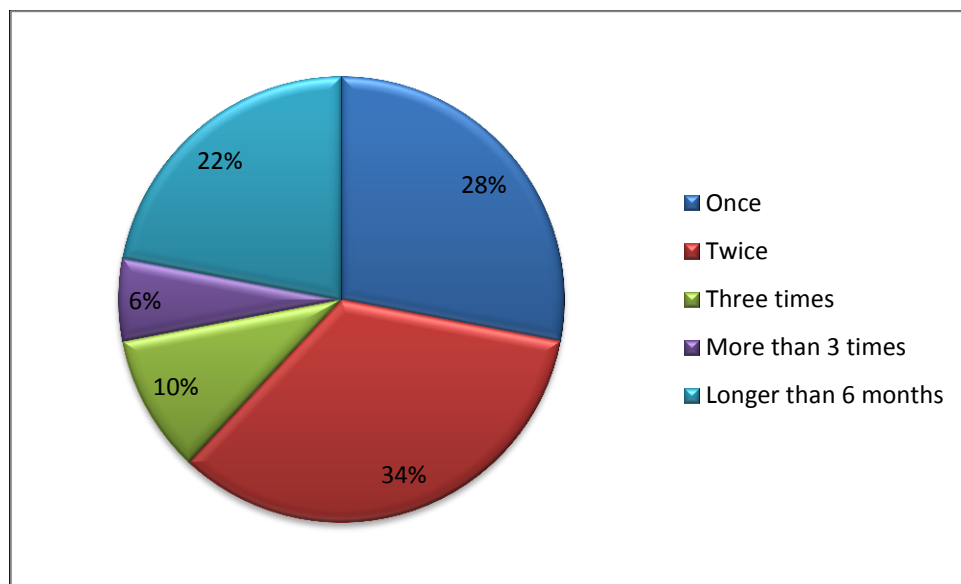


Figure 4.11 shows that 17 respondents (34%) had visited a clinic twice in six months, while 14 (28%) indicated that they had visited one only once in six months. Eleven respondents (22%) indicated that they had visited a clinic in longer than six months. Five (10%) stated that they had visited a clinic more than three times in six months, whereas only three (6 %) indicated that they had visited one more than three times in six months. The results established that the greatest number of respondents had visited a clinic at least twice in six months. However, the researcher believes that clinic visits are too low and that men should be encouraged to visit clinics more often. According to Sandman et al 2000, cited by Courtenay, (2000), men are less likely to have a regular physician and one in four men (24%) aged 45 and 64 years

do not have a regular doctor. Skovdal *et al* (2011) state that in South Africa, for example, only one out of five people tested for HIV were men and an investigation into HIV testing in a multi-country HIV workplace programme in Sub-Saharan Africa found that male workers (22%) compared to female workers (28%) and male spouses (6%) compared to female spouses (18%), were less likely to take advantage of the programme and undergo testing for HIV. To add to what was said earlier, Skovdal *et al* (2011) state the following: “Men view health issues as female issues. Women always go to the hospital from pregnancy until the children are grown up.”

4.4.2 Reasons for visiting the clinic

Respondents were asked to indicate their reasons for visiting a clinic. The reasoning behind this question was to ascertain why respondents visit clinics. Respondents were given a list of possible reasons to choose from. The results are presented below.

Figure 4.12: Reasons for visiting a clinic (N=50)

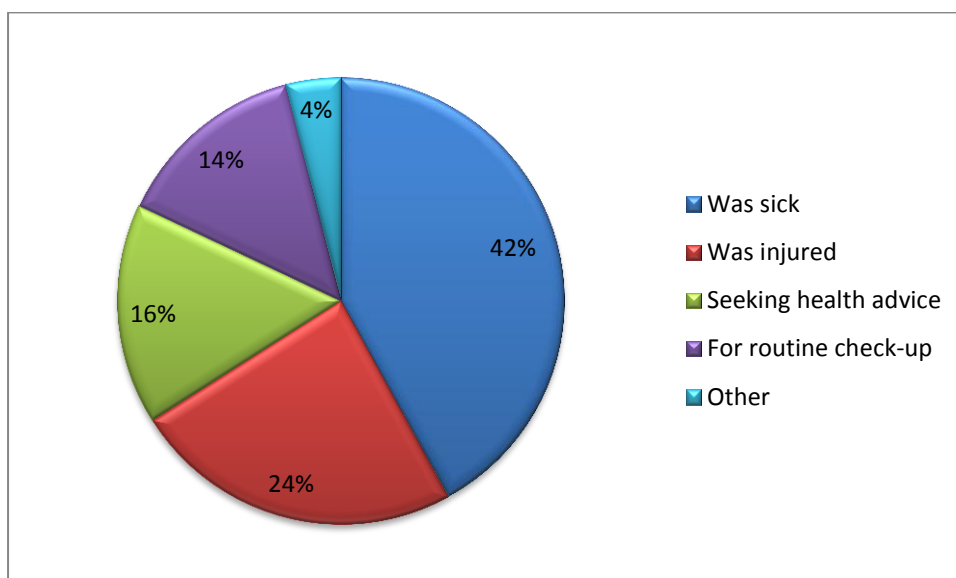


Figure 4.12 indicates that nearly half of the respondents (21 men or 42%) stated that they had visited a clinic because they were sick, while 12 (24%) said that they visited

a clinic because of an injury. A small number of respondents (8 or 16%) indicated that they had visited to seek health advice, while seven (14 %) visited for routine check-ups. Lastly, only two (4%) indicated that they were attending family planning workshops with their wives. The results show that more respondents visited a clinic when they were sick or injured. This highlights that more even though some men visited health centres when they were sick or injured, more needs to be done to encourage men to visit clinics for other health-related matters such as testing for various acute diseases such as HIV and sugar diabetes.

4.4.3 Source of help during clinic visit

Respondents were asked to indicate who helped them during their visit to the clinic. The reasoning behind this question was to find out who are the people working in clinic on a daily basis. It is believed that some men do not want to go to VCT centres because of the fear of being assisted by women. Respondents were given a list of answers to choose from and the results are presented below.

Figure 4.13: Source of help during clinic visit (N=50)

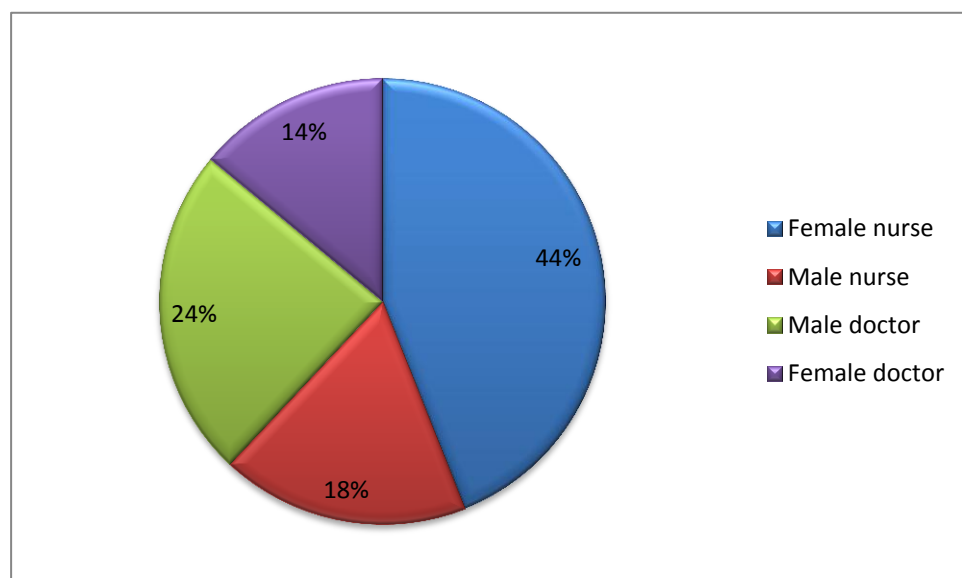


Figure 4.13 shows that 22 respondents (44%) indicated that a female nurse helped them during their visits to the clinic, while 12 (24 %) were helped by a male doctor. Male nurses were indicated by nine respondents (18%), while seven (14%) respondents indicated that a female doctor had helped during their visits. This study shows that more men were helped by female nurses and male doctors, while fewer mentioned female doctors and male nurses. This might be one of the factors that discourage men from being tested for HIV at clinics, since the clinics are female dominated. Myburgh (2011) support the statement by stating that men view the clinic as women’s space, since in many clinics women are holding positions as nurses and counsellors, as the result men may find visiting the clinic cumbersome, embarrassing, and challenging traditional and hegemonic notions of masculinity.

4.4.4 Preferred person to offer assistance at the clinic

Respondents were asked to indicate who they prefer to help them during clinic visits. They were given a list of possible health personnel to choose from, and the results are presented below.

Figure 4.14: Preferred person to offer assistance during clinic visit (N=50)

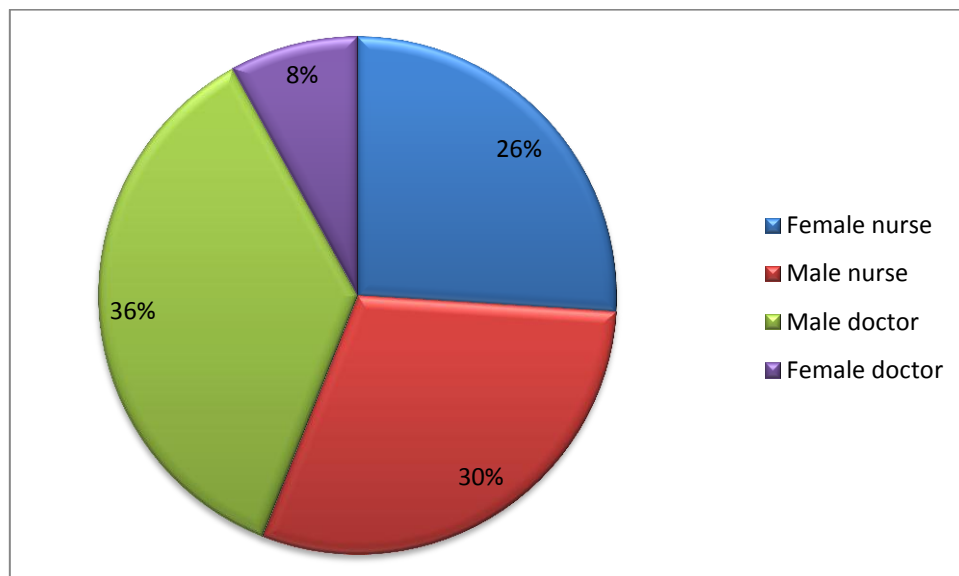


Figure 4.14 shows that 18 respondents (36%) stated that they preferred a male doctor to help them, while 15 (30%) preferred a male nurse. Thirteen (26%)

respondents said that they preferred a female nurse, while only four (8 %) preferred a female doctor. This study shows that since the respondents are men, they prefer to be helped by male health personnel and therefore more male personnel should be recruited in the Health Department.

4.4.5 Source of health advice

Respondents were asked to indicate where they sought health advice. The reasoning behind this question was to ascertain where they seek help when they are sick or have health-related problems. Respondents were given a list of possible sources to choose from and results are presented below.

Figure 4.15: Source of health advice (N=50)

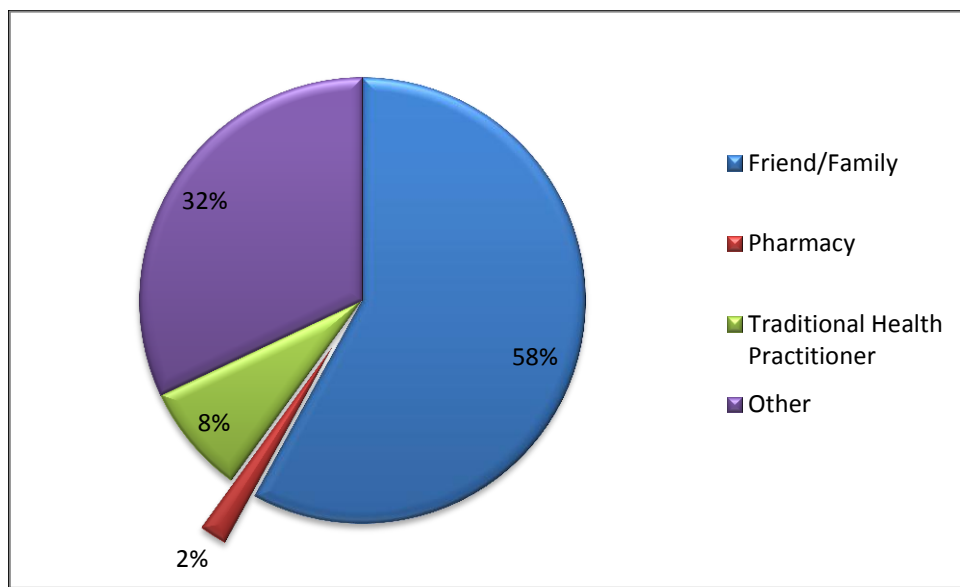


Figure 4.15 shows that more than half of the respondents (29 men or 58%) indicated that they sought health advice from friends/family, while 16 (32 %) respondents said they sought advice from a clinic. Traditional health practitioners were indicated in 8% of the respondents, while only one respondent (2%) used the pharmacy to seek health advice. This study shows that most respondents sought health advice from family and friends, fewer visited the clinic and only a few used a pharmacy or traditional health practitioner. This shows that men do not feel comfortable discussing their health problems with women.

4.4.6 HIV test

Respondents were asked if they had ever had an HIV and AIDS test and the binary choice of “Yes” and “No” was used to measure their responses. The researcher wanted to know whether or not they knew their HIV status. It is vital for people to know their HIV status so that when they are positive they can start living a healthy life style and obtain treatment if necessary before it is too late. The results are presented below.

Figure 4.16: HIV testing (N=50)

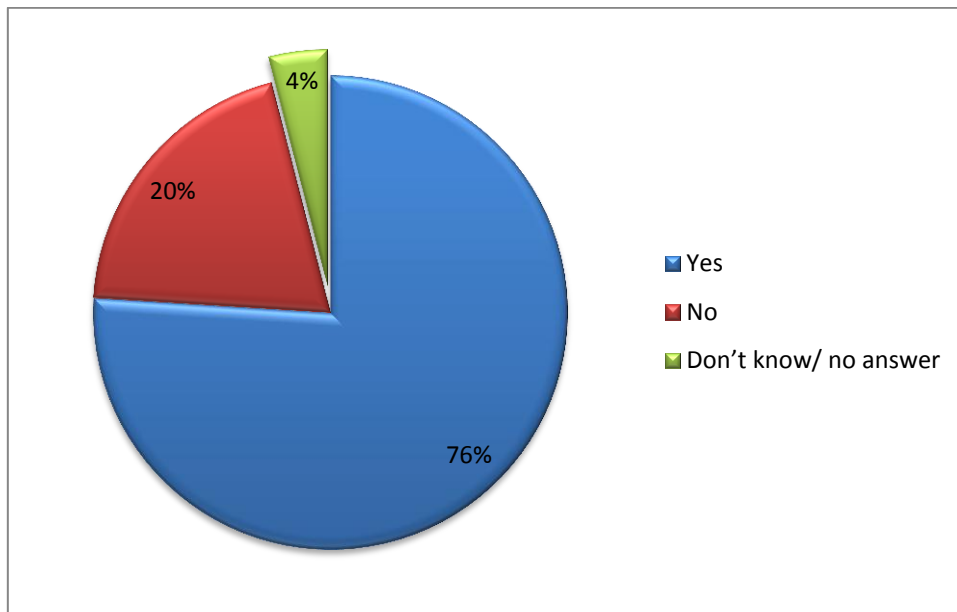


Figure 4.16 shows that the majority (38 men or 76%) of the respondents indicated that they had undergone an HIV test, while ten (20%) had not had an HIV test. Only two respondents (4 %) did not answer the question. Overall, this study shows that most respondents have tested for HIV, which is a good indication that they know their HIV status. It is vital that people know their status so they can start with treatment as soon as possible if the test positive, and if they are negative they are motivated to remain negative. According to research, currently 80% of those infected with HIV, and 80% of those who die of AIDS, are men. As noted above, HIV is the leading cause of death among 25- to 44-year-old men (DHHS, 1996a and Ward and Duchin, 1998, cited by Courtenay 2000).

4.4.7 Reasons for undergoing HIV testing

Respondents were asked to indicate reasons for HIV testing. The reasoning behind this question was to understand why the respondents who went for HIV testing did so. Respondents were given a list of possible reasons for undergoing HIV testing. The results are presented below.

Figure 4.17: Reasons for undergoing HIV testing (N=50)

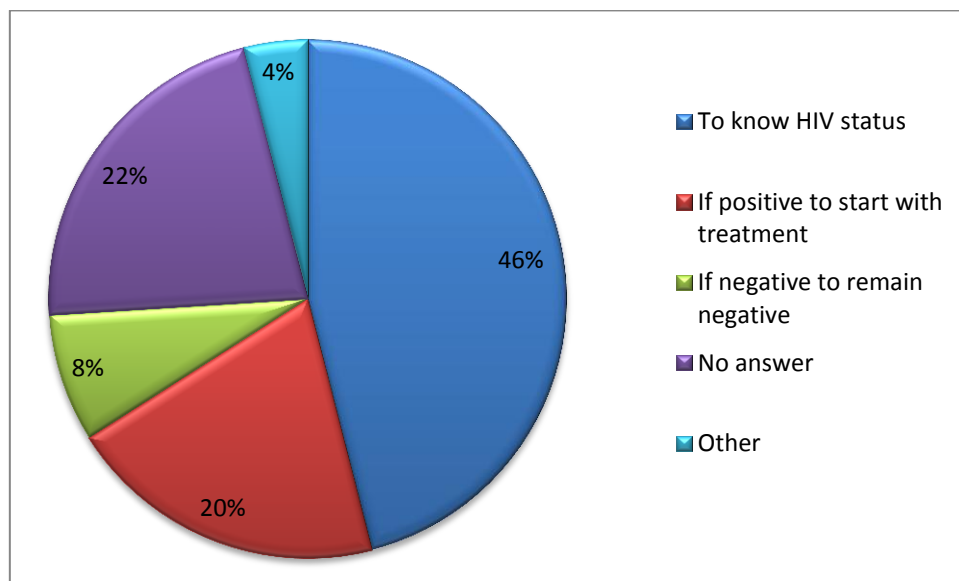


Figure 4.17 shows that the majority of respondents (23 men or 46%) indicated that they had undergone testing for HIV in order to know their HIV status, while (11 or 22%) did not answer the question asked. A total number of ten (20 %) said that they chose to test for HIV so that if they found that they were positive they could start with treatment. Four men (8%) said that they had been tested so that if they were negative, they could ensure that they remained negative. One (2%) said they had a test because they had had an extra-marital relationship, and another (2%) said that he had been tested because he was ill and the nurse had asked him to do a test while visiting a clinic. This study shows that nearly 70% of the respondents had been tested for HIV and knew their HIV statuses and this is good because they will either start with treatment if tested positive, or be motivated to remain negative if tested negative.

4.4.8 HIV test sites

Respondents were asked to indicate the place where they were tested for HIV. The reason for this question was to find out if respondents knew where to go for HIV testing. They were given a list of possible places to choose from and the results are presented below.

Figure 4.18: HIV test sites (N=50)

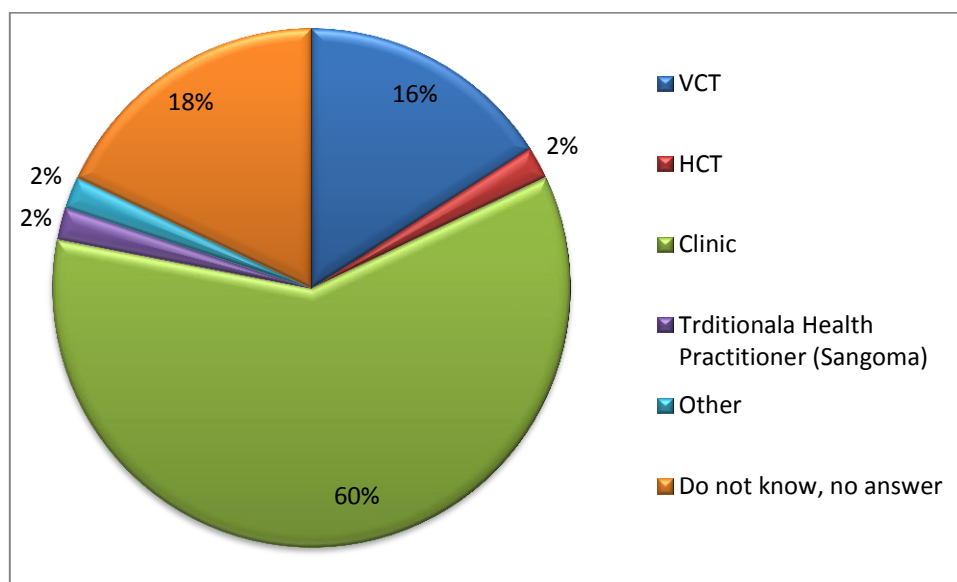


Figure 4.18 above shows that the majority of respondents (30 men or 60%) said they had been tested for HIV at a clinic. Nine respondents (18%) did not answer the question. Eight of the respondents (16%) said that they used VCT services to do their test. Two respondents (4%) indicated other that is, one respondent (2%) had his HIV test at a HCT centre, while another (2%) indicated that he had been tested at a traditional health practitioner (Sangoma). One respondent (2%) indicated that a doctor had done his HIV test. This study indicates that the majority of respondents had made use of the clinic for HIV testing followed by HCT, VCT, traditional health practitioners (Sangoma) and then medical doctors. The reasons for not using other sites could be the factors that had discouraged them from undergoing HIV testing. For instance, they are scared to be stigmatised and have no money to pay for tests

at doctors. Nuwaha *et al* (2002:631) support this view and state that at times the services are expensive and out of reach of many people. Another contributing factor as Nuwaha *et al* (2002:631) state is that testing centres are too far especially where there is poor means of communication/transport as in rural areas.

4.4.9 Source of encouragement to undergo HIV testing

Respondents were asked to indicate who had encouraged them to undergo HIV testing. The reason behind this question was to find out what had pushed respondents to undergo HIV testing. They were given a list of answers to choose from and results are presented below.

Figure 4.19: Source of encouragement to undergo HIV testing (N=50)

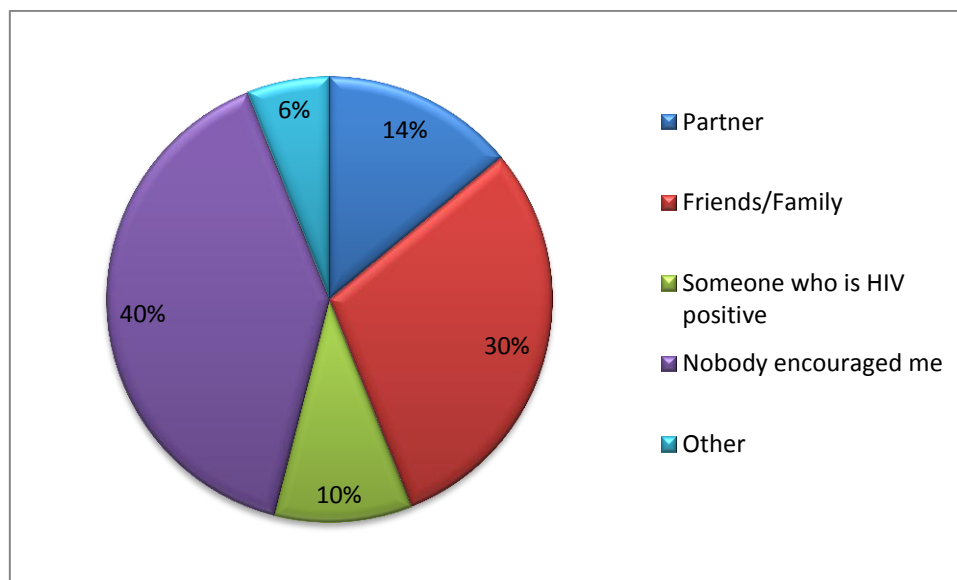


Figure 4.19 shows that the majority of respondents (20 men 40%) said that nobody had encouraged them to undergo HIV testing, while 15 (30%) indicated that friends/family had encouraged them. Seven respondents (14%) respondents indicated that their partners had encouraged them, while three (6%) indicated that nurses at clinics had encouraged them. Only one said that he had been sick for a long time and had decided to go for a test. Only five respondents (10%) stated that someone who was HIV-positive had encouraged them to go for testing. This study shows that almost 40% of the respondents had decided to go for HIV testing without anybody encouraging them to do so, which is a good sign that they are trying to help

fight against the spread of this epidemic that has claimed millions of lives. Nuhawa *et al* (2002:630) concur and state that voluntary counselling and testing is the only sure way of “proving” that one is actually infected with HIV. The researcher feels that men, especially in the informal sector, should be encouraged to have HIV tests since they are vulnerable to diseases like HIV because most of them stay with partners.

4.4.10 Sources of discouragement to undergo an HIV test

Respondents were asked to indicate who had discouraged them from undergoing HIV testing. The reason for this question was to find out what had made respondents undergo HIV testing. They were given a list of possible answers to choose from and the results are presented below.

Figure 4.20: Source of discouragement to undergo HIV testing (N=50)

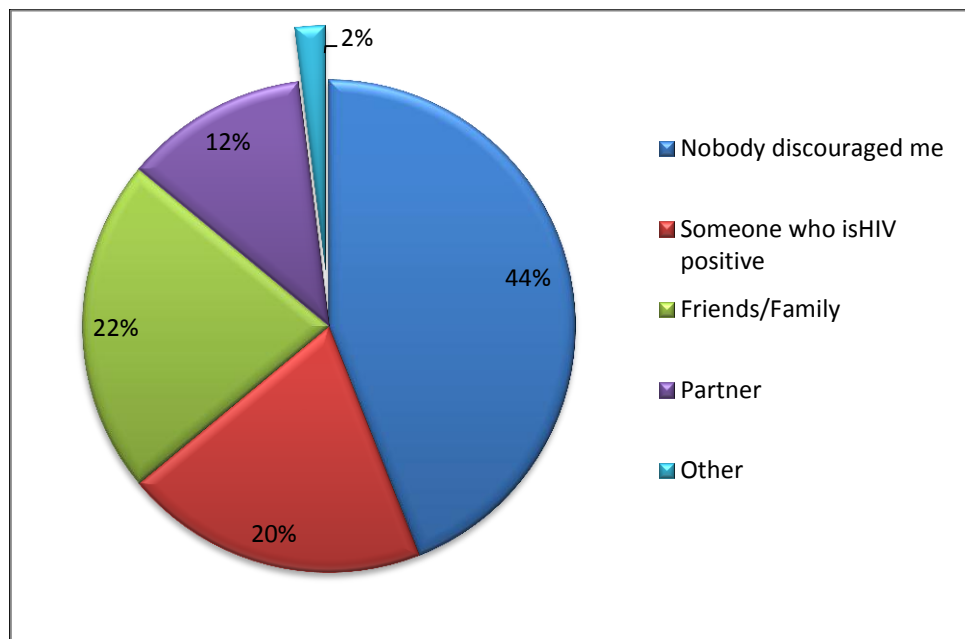


Figure 4.20 shows that the majority of respondents (22 men or 44%) indicated that nobody had discouraged them from undergoing HIV testing. Eleven (22%) said that their friends/family had discouraged them. Ten (20%) said that after seeing someone who was HIV positive they had become discouraged, while six (12%) indicated that their partners had discouraged them. Only one (2%) indicated that lack of confidentiality at the clinic and stigma had discouraged him from going to the clinic

to test for HIV. This study shows that more respondents has not been discouraged by anyone to test for HIV but it was their choice whether to test or not. Friends/family, partners as well as people who are infected with HIV had the greatest effect in discouraging respondents from testing. Men were discouraged from testing because of the stigma attached to HIV and AIDS. According to Skovdal *et al* (2011), men are generally afraid of being known to be HIV positive. They are shy and may only disclose their status when they become seriously ill. Some men are afraid that people in the community will laugh at them or look down on them for being HIV positive.

4.4.11 Factors encouraging HIV testing

Respondents were asked to indicate what had encouraged them to have HIV tests. The reason behind this question was to find out what had pushed respondents to have tests. Respondents were given a list of possible factors to choose from. The results are presented below .

Figure 4.21: Factors encouraging HIV testing (N=50)

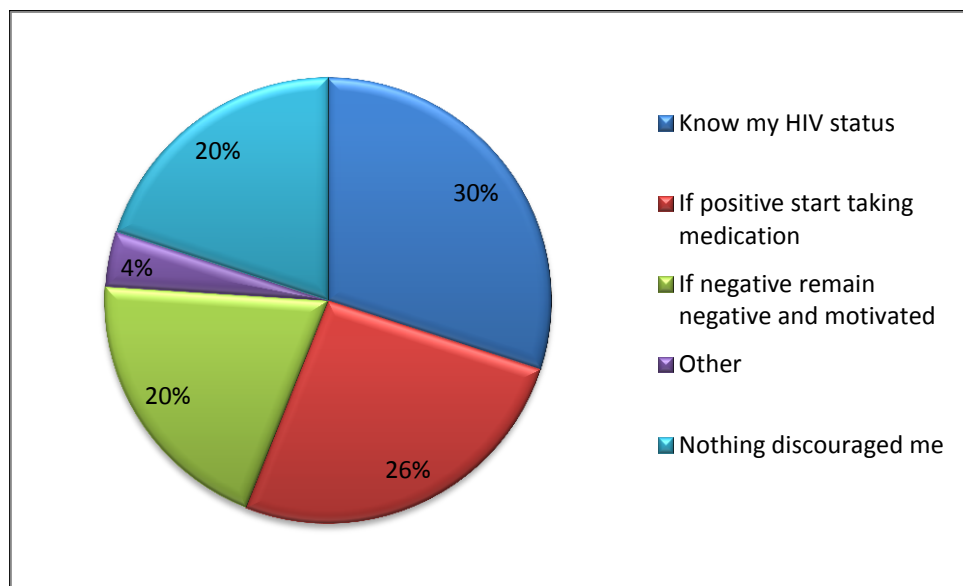


Figure 4.21 above indicates that most respondents (15 men or 30%) had been tested because they wanted to know their HIV status. Thirteen respondents (26%) respondents said that they wanted to start with treatment if they tested positive, while

ten (20%) said that they wanted to remain negative, if they tested negative. Another 10 respondents (20%) said that nothing had encouraged them to undergo HIV testing and only two (4%) indicated that they had been encouraged by nurses. This study shows that many respondents had been encouraged to do HIV testing, because they had wanted to know their HIV status and start with the treatment as early as possible (if positive) and if they tested negative remain negative and motivated. This will help reduce the number of new HIV infections, for those who tested negative because they will start using preventive measures when having sexual intercourse.

4.4.12 Discouraging factors in HIV testing

Respondents were asked to indicate what had discouraged them from undergoing HIV testing. The reason for this question was to find out what pushes respondents to undergo HIV testing. They were given a list of answers to choose from and the results are presented below.

Figure 4.22: Factors discouraging HIV testing (N=50)

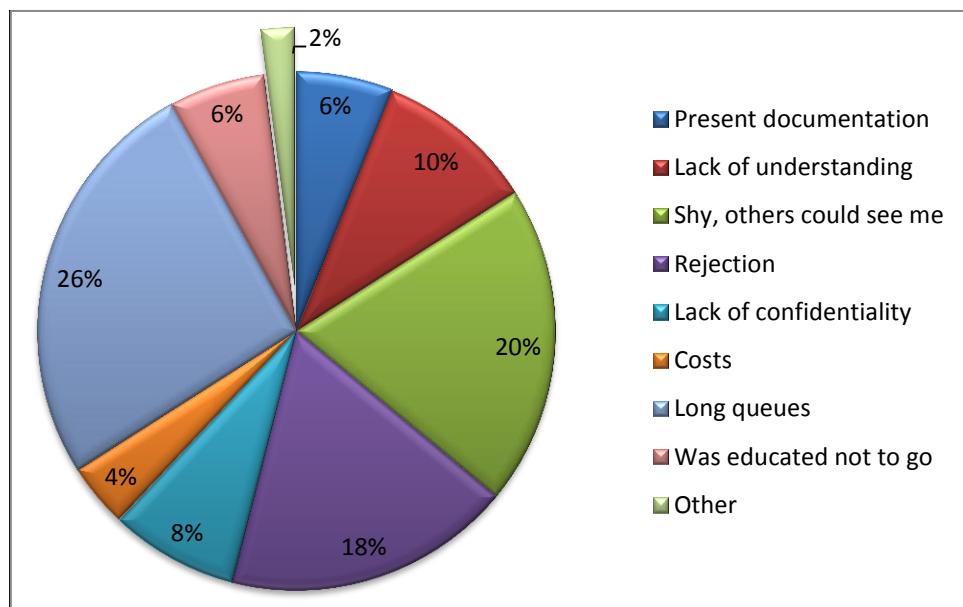


Figure 4.22 shows that the majority of respondents (13 men or 26%) indicated that the long queues at the clinic had discouraged them from undergoing HIV testing. Ten

respondents (20%) indicated that they were shy and scared that other people would see them while testing. Nine (18%) said that they had been discouraged from testing for HIV, because they had feared being rejected by their families/friends. Lack of understanding is one of the reasons why respondents were discouraged from testing for HIV (5 men or 10%). Four respondents (8%) indicated that they had been discouraged because of the lack of confidentiality at the testing station. Three (6%) respondents indicated that they had been educated not to undergo HIV testing and three (6%) said that the present documentation had discouraged them from undergoing an HIV test. Lastly, two (4%) said that the costs involved in HIV testing had discouraged them. One respondent (2 %) stated that because most people who contract HIV eventually die, he had been discouraged. More respondents had been discouraged from testing for HIV owing to long queues at clinics, and being scared that other people would see them. The issue of stigma and rejection were also a problem. The researcher thought that other sites could be used rather than the local clinic or VCT/HCT to test for HIV. Skovdal *et al* (2011) explain that men find it hard to go to the clinic. They do not have a lot of patience waiting in queues, whereas women are used to queues at clinics. Men might feel belittled waiting in queues shoving and jostling with women.

4.4.13 HIV test request

Respondents were asked whether anyone requested that they have an HIV test when they visited the clinic. A binary choice of “Yes” and “No” was used to measure their responses. The researcher wants to check if the respondents had undergone the HIV test while visiting the clinic for something else other than HIV testing. The results are presented below.

Figure 4.23: HIV test request (N=50)

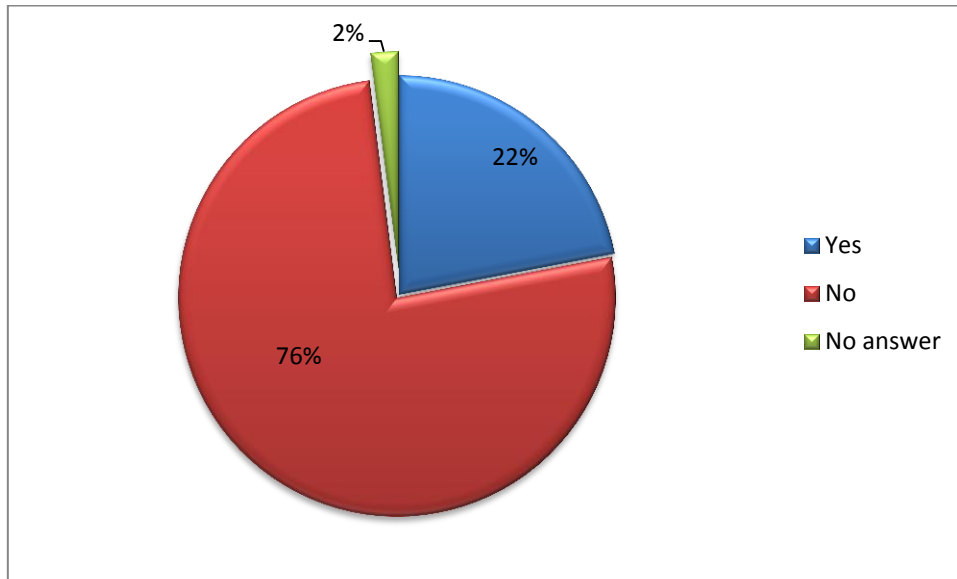


Figure 4.23 shows that 76% of respondents (38 men) stated that no one had asked them to test for HIV while they were visiting the clinic for other reasons such as injury or sickness. Eleven (22%) indicated that someone had asked them to do HIV testing while visiting the clinic for other reasons. Only one respondent (2%) did not answer the question. This study indicates that the majority of respondents had not been asked to do the HIV test while visiting a clinic. This could result in many people not returning to the clinic later to be tested due to long queues. Consequently to attract more people to test for HIV, they should be requested while visiting clinics to have an HIV test and as a result would increase the number of people being tested for HIV.

4.5 SUMMARY

In this chapter, the researcher presented the findings of the study by means of figures. Furthermore, the researcher showed the relevance of the theory to this study. The next chapter presents the summary, conclusion and recommendations.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter summarises, concludes and makes recommendations based on the results of the study and is guided by the objectives of the study, namely to

- explore the reasons for acceptance or non-acceptance of HIV testing among men
- determine men's knowledge and perceptions of HIV testing
- investigate men's behaviours and attitudes towards HIV testing

5.2 SUMMARY

The summary is based on the objectives of the study as indicated above.

5.2.1 Reasons for acceptance or non-acceptance of HIV testing among men

Respondents mentioned various reasons that discourage them from being tested for HIV such as being helped by female nurses, long queues at clinics, being scared that other people will see them at clinics and the issue of stigma and rejection.

Respondents preferred to be helped by male personnel, since they are men. One of the reasons why men do not accept being tested for HIV, might be because they know that there are more women health personnel than men to help them at clinics. According to Myburgh (2011), by upholding and conforming to masculine ideals, men are able to assert their differences from women, and reinforce strongly held cultural beliefs that they are more powerful and less vulnerable than women; that men's bodies are structurally more efficient than and superior to women's bodies; and that asking for help and caring for one's health are feminine traits. According to Myburgh (2011), men are more likely to delay seeking help for medical problems as health-seeking behaviour has become "feminised" and admitting illness or weakness challenges their position as "men". Because of their masculinity, men do not feel comfortable with women knowing their HIV status. This is a disturbing trend because

men do not want to be tested at clinics where there are female staff. The fact is that in most clinics, there are few male nurses if any at all, meaning that men will not be tested there, because they feel that they will be deprived of their manhood by being tested by female nurses. This being the case, the country is going nowhere with regard to the fight against HIV, because people will keep infecting each other and South Africa will remain the country in the world with the highest absolute population of people infected with HIV and AIDS. According to SONKE Gender Justice (2008), HIV testing serves as the gateway to a range of HIV services, including treatment.

Also of note is that the long queues at clinics discouraged respondents from testing for HIV. Even if they want to be tested they are discouraged by waiting for long stretches to be tested and they are also scared that while queuing, other people could see them. They also fear being stigmatised and rejected by the community at large.

5.2.2 Men's knowledge and perceptions of HIV testing

The respondents perceived HIV testing differently. The results showed that the majority of respondents felt that HIV testing is a good thing to do, given the fact that it can contribute to the fight against the spread of HIV and AIDS. Testing for HIV also helps to diagnose other sexually-transmitted diseases such as syphilis and gonorrhoea. Once people know their status they can react accordingly by starting with treatment as early as possible and if negative they are motivated and can encourage others to undergo HIV testing.

The respondents viewed HIV and AIDS as a fatal disease, showing that there is still a stigma around HIV and AIDS. HIV and AIDS are just like any other diseases. Even though it cannot be cured, it can be treated so that a person living with the disease can live a normal life like any other person.

According to this study most respondents knew how HIV can be prevented and only a minimum still believed that HIV/AIDS does not exist.

This study showed that nearly 70% of respondents had an HIV test and knew their status. It also indicated that almost 40% of respondents had decided to undergo HIV testing without anybody encouraging them to do so, which is a good sign that they are trying to help fight the spread of this epidemic that has claimed the lives of millions of people.

This study also indicates that the majority of respondents were not discouraged by anyone to undergo testing but it was their choice whether to test or not. Friends/family and partners as well as HIV-positive people had the greatest effect in discouraging the respondents to go for tests.

This showed that many respondents had been encouraged to go for testing because they wanted to know their HIV status and if they tested HIV positive they could start with the treatment as early as possible, and if negative, they could remain negative and motivated.

The findings indicate that the majority of respondents had not been asked to undergo HIV testing while visiting clinics, which could result in many people not returning later to have tests.

5.2.3 Men's behaviours and attitude towards HIV testing

HIV is incurable and respondents had a positive attitude to testing for HIV, the reason being that they wanted to know their HIV status. This is a good sign that HIV will be reduced even though it was mentioned earlier that one of the reasons for not testing for HIV is the issue of lack of male nurses in clinics. Not all respondents had tested for HIV, which is also a concern because the few could still infect other people if they do not use other preventive measures when having intercourse. It is imperative for people to be tested and know their HIV statuses, to reduce the spread of HIV.

Clinic visits is still a challenge and according to this study, most respondents had visited clinic at least twice in six months, but the reasons for their visits were illness or injury. The researcher feels that there is a stigma around clinic visits. People

should be encouraged to visit clinics more regularly to obtain advice on health-related matters and chronic diseases such as prostate cancer and sugar diabetes.

5.3 CONCLUSION

Masculinity is still prevalent among the respondents, since one of the reasons for men not accepting HIV testing is that most clinic personnel are female nurses and they do not want women to know their HIV status. Based on the results of this study, it is evident that some men will not go for HIV testing and HIV prevalence will not decrease in South Africa since the Health Department is still dominated by female personnel.

Little has been done to encourage men to use HCT/VCT services. For instance, SONKE Justice Network (2010) stated that very few NSPs discussed the need to encourage men to increase their uptake of VCT services. There is no NSP acknowledgment of the need to transform men's attitudes towards HIV testing, to outline plans to address men's attitudes, or take specific measures to make VCT sites more male-friendly.

To avoid waiting for two to three hours to see a doctor at a clinic, people can use other facilities such as VCTs, HCTs and doctors' practices to test for HIV since it is absolutely essential for everyone to be tested. People should be encouraged to use other facilities available to their communities to test for HIV by emphasising the importance of HIV testing and knowing their status.

Even though many respondents have knowledge of how HIV infects people, there were a few people who still believed the myth that HIV does not exist. This is extremely disturbing because those few will continue to infect other people with HIV since they do not believe it exists. Undergoing HIV testing will help men to know their HIV status and also to check if they do not have other STDs that may also lead to HIV if not treated. It is paramount that everyone be tested for HIV and be aware of their status to encourage treatment if necessary.

Most people know that there is no cure for HIV and AIDS and it is thus essential for everyone to be educated so that they know that the infected will live with HIV for the

rest of their lives. People should be encouraged to change their negative attitude towards HIV testing and start testing for HIV so that they know their status. Knowing their HIV status is another way of combating HIV. For instance, if a person tests negative he/she will go on using preventive measures such as condoms when having intercourse with the aim to remaining HIV negative. Also, if a person tests HIV positive, he/she will seek help and start with treatment as early as possible, if necessary.

People should be encouraged to visit any of the homes where people with HIV are kept so that they can be persuaded to test for HIV as early as possible to enable them to take action and live a normal life just like any other person. Education is essential in this regard to show that HIV is not as bad as people think, and it is just like flu, but if not treated, it can escalate to another level. If HIV is not treated it will escalate to AIDS and later a person may die. At hospice centres, there are people living with HIV who are healthy and strong, and no one should give up if they test HIV-positive, because there is life after becoming infected by HIV.

Polygamy is one of the socio-cultural issues highlighted in the study as contributing to the spread of HIV, and it is empirical for men to have one partner in order to reduce the spread of HIV, especially in Africa. Again, the use of sex workers also should be avoided by men. Men should be encouraged to move along with their partners where ever they go, especially if it is work purposes whereby they have to be away for more than a month.

Men's negative attitudes toward condoms, as well as difficulties in using them during intercourse either with their wives or sex workers should be addressed. Advantages of condom use among married couples or extra marital relationships should be highlighted as one of the methods to decrease the HIV Infections.

5.4 RECOMMENDATIONS

The researcher recommends that the Department of Health starts to recruit and attract more male staff so that men can be motivated to use clinic services such as HIV testing with confidence. This would increase the number of men testing for HIV.

Another recommendation is to teach men about masculinity, especially if it prevents them from doing the right thing and affects their lives. Correct behaviour is testing for HIV and visiting clinics for any health-related matters. Respondents should know that HIV can infect anyone and therefore testing is a necessity.

Since there are still people who believe that HIV does not exist, it is vital that education on HIV and how people become infected be increased in order to mitigate the pandemic. It is also critical that HIV education reach everyone to prevent new infections so that South Africa can become a zero-infection country.

The researcher recommends that men's negative attitudes toward clinic visits and HIV testing be changed. Education on clinic visits is necessary because visiting the clinic can also encourage people to know other services the clinic provides to the community at large, including services for men. A clinic is a place for everyone; men, women, children and elders, and therefore all people should make use of the facilities available to them.

As mentioned in the study, only few respondents were asked to test for HIV while visiting the clinic for other health related matters, therefore it important that while people are visiting the clinic, nurses should request them to do HIV test. This exercise will help to increase the number of people who test for HIV and again reduce the new HIV infection in the country.

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APPENDIX A: INFORMED CONSENT FORM

Department of Sociology: University of South Africa

Date:.....

Name of researcher: Tiny Mashiane Radingwana

Informed consent

Title of study: Factors encouraging or discouraging men working in the informal sector to attend HIV Counselling and Testing (HCT) services in South Africa: A case study of Pretoria.

Purpose of the study: The aim of the study is to investigate the factors that make men working in the informal sector in South Africa reluctant to undergo HIV testing.

You have been selected to participate in this study. Your participation is voluntary and you are not obliged to take part in the study. You may withdraw from the study at any time without prejudice. The interview will last 15 to 20 minutes.

I will not record your name anywhere on the questionnaire and no one will link you to the answers you give. Note that all information will remain confidential and no information will be made available to anyone who is not directly involved in the study and there will be no repercussions from the answers you give.

Declaration by participant:

I hereby agree to participate in this study. I understand that participation is voluntary and that I can withdraw from the study at any time without prejudice.

I have read the procedures for this study described above and I understand what the study is all about and how it is being conducted.

Signature.....

Date.....

APPENDIX B: QUESTIONNAIRE

Questionnaire Code: _____ (e.g. 001, 002....)

Date:

Site:

Interviewer:

SECTION A: BIOGRAPHICAL DETAILS

01. What is your age?

- 011. Under 19 ()
- 012. 19-35 ()
- 013. 36-55 ()
- 014. 56 or older ()
- 015. No answer ()

02. What is your highest educational qualification?

- 021. Grade 1-7 ()
- 022. Grade 8-12 ()
- 023. Diploma ()
- 024. Other ()
- 025. If "other", please state.....
- 026. No answer ()

03. Are you in a relationship?

- 031. Yes ()
- 032. No ()
- 033. No answer ()

04. What is your relationship status?

- 041. Married ()
- 042. Divorced ()
- 043. Living with a partner ()
- 044. Single ()
- 045. No answer ()

SECTION B: PERCEPTIONS ABOUT HIV TESTING

05. What are your perceptions and understanding of HIV testing?

- 051. Good thing to do ()
- 052. Bad thing to do ()
- 053. Don't know ()

6. Where did you hear about HIV? More than one answer is possible.

- 061. Media ()
- 062. Read about it ()
- 063. Friend ()
- 064. Clinic ()
- 065. Sangoma, traditional health practitioner ()
- 066. Other () please state.....

7.How does a person become infected by HIV?

- 071. By sharing a toilet ()
- 072. By “tongue” kissing ()
- 073. Through unprotected sex ()
- 074. Mother to her unborn ()
- 075. Through circumcision ()
- 076. Hugging ()
- 077. Care of a patient with AIDS ()
- 078. HIV drugs ()
- 079. Contact with contaminated blood ()

8.How can we prevent HIV/AIDS?

- 081. Abstain from sex ()
- 082. Using condoms ()
- 083. AIDS does not exist ()

9.Is there any cure for HIV/AIDS?

- 091. Yes ()
- 092. No ()
- 093. Does not know ()
- 124. No answer ()

10. What are your perceptions about HIV and AIDS?

- 101. Just like any other disease ()
- 102. Innocent disease ()
- 103. Killing disease ()
- 104. Other ().If other, please specify.....

SECTION C: HIV TESTING

11.How often did you visit a clinic in the last six months?

- 111. Once ()
- 142. Twice ()
- 113. Three times ()
- 114. More than 3 times ()
- 115. Longer than 6 months ago ()
- 116. No answer ()

12.Why did you visit the clinic?

- 121. Was sick ()
- 122. Was injured ()
- 123. For routine a check-up ()
- 124. Seeking health advice ()
- 125. Other reason(s).Please explains ().....
- 126. No answer/don't know ()

13.Who helped you during your visits to the clinic?

- 131. Female nurse ()
- 132. Male nurse ()

- 133. Male doctor ()
- 134. Female doctor ()
- 135. Traditional health practitioner (Sangoma) ()
- 136. Other ().If other, who?

14. Where do you seek health advice?

- 141. Friends/family ()
- 142. Pharmacy ()
- 143. Traditional health practitioner ()
- 143. Other (), if other, please name.....

15. Whom would you rather choose to help you at a clinic?

- 151. Female nurse ()
- 152. Male nurse ()
- 153. Male doctor ()
- 154. Female doctor ()
- 155. Traditional health practitioner (Sangoma) ()
- 156. Other ().If other, who?

16. Have you ever had an HIV/AIDS test?

- 161. Yes ()
- 162. No ()
- 163. Don't know/no answer ()

17. If "yes" above, why did you go for the test?

- 171. To know my HIV status ()
- 172. If HIV positive, to start treatment ()
- 173. If HIV negative, to remain negative ()
- 174. No answer ()
- 175. Other reason. Please state.....

18. Did you get the results? I do not want you to tell me the results!

- 181. Yes ()
- 182. No ()
- 183. No answer ()

19. Where did you do your HIV testing?

- 191. VCT ()
- 192. HCT ()
- 193. Clinic ()
- 194. Traditional health practitioner (Sangoma) ()
- 195. Other ().If other, please state.....
- 196. Don't know, no answer ()

20. Who encouraged you to undergo the HIV test?

- 201. Partner ()
- 202. Friends/family ()
- 203. Someone who is HIV positive ()
- 204. Sangoma ()
- 205. Nobody encouraged me ()

206. Other ().Please state.....

21. Who discouraged you from undergoing the HIV test?

- 211. Partner ()
- 212. Friends/family ()
- 213. Someone who is HIV positive ()
- 214. Sangoma ()
- 215. Nobody discouraged me ()
- 216. Other ().Please state.

22. What encouraged you to undergo the HIV test?

- 221. Know my status ()
- 222. If positive start taking medication ()
- 223. If negative remain negative and motivated ()
- 224. Other ().Please state:
- 225. Nothing encouraged me ()

23. What discouraged you from undergoing an HIV test?

- 231. Present documentation ()
- 232. Lack of understanding ()
- 233. Shy, others could see me ()
- 234. Rejection ()
- 235. Lack of confidentiality ()
- 236. Costs ()
- 237. Long queues ()
- 238. Can treat myself ()
- 239. Was educated not to go ()
- 2310. Other ().Please state:

24. When you were at the clinic did someone ask you to undergo an HIV test?

- 241. Yes ()
- 242. No ()
- 243. Did not visit a clinic ()
- 244. No answer ()

25. Is there is anything else you want to mention relating to the topic that was not covered by the questionnaire?

.....

Thank you for taking part in this study