Men, Masculinities and HIV Care Work

A small-scale, exploratory study of the role of community care workers in supporting HIV positive men's health-seeking behaviour

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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SUPERVISOR'S APPROVAL OF SUBMISSION OF DISSERTATION FOR EXAMINATION

I confirm that I have seen/have not seen the final version of Lesley Gittings' dissertation and that it is submitted for examination with/without my approval.

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Abstract

Caring is typically constructed as a feminized practice, resulting in women shouldering the burden of care-related work. Health-seeking behaviours are also constructed as feminine and men have poorer health outcomes globally. Employing men as carers may not only improve the health of the men they assist but also be transformative with regard to gendered constructions of caring. This dissertation adds to the small but growing literature on men in caring by focusing on men as community care workers (CCWs) and their male clients.

Using semi-structured interviews and observational home visits, this study explores whether male CCWs have a unique role to play in addressing harmful health-related gender norms and in supporting HIV positive men's health-affirming behaviour. The empirical analysis draws on the perspectives of eight CCWs and three of their male clients from the Cape Town area. Being problem-driven in nature and situated within a 'gender transformative' agenda, it explores male client preferences for gender concordant care workers and the techniques that CCWs (with a focus on male CCWs) employ to support HIV positive men's health-affirming behaviour.

CCWs navigate around hegemonic masculine norms that require men to act tough, suppress emotion and deny weakness and sickness by using techniques such as indirectly broaching sensitive subjects, acting friendly and being clear about the intention of their work. The interviews revealed that CCWs strove not to rupture hegemonic masculine norms while encouraging male clients to engage in health-affirming behaviour.

This dissertation also explores male client preferences for gender concordant CCWs and the potential that these pairings have to support health and to be 'gender transformative'. Here 'gender transformative' refers to the creation of more gender equitable environments. The variety of intertwined factors that contribute to male client preferences for male CCWs include gendered power dynamics, comfort in sharing intimate health information and a fear of women gossiping. Drawing on current literature on men, caring and gender transformation to inform the analysis of participant perspectives and experiences, this study explores the barriers to encouraging men to seek health and also considers the challenges in recruiting and retaining men as CCWs.

Employing more male CCWs is a strategy that could improve male client's health outcomes and also contribute to the development of more gender equitable norms. Shifting such norms requires much more than simply hiring men. To contribute to gender transformation, male CCWs should ideally resonate emotionally with their work, possess gender equitable beliefs and ground these beliefs in practice.

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Chapter 1: Introduction and Overview

Given that the world is structured by patriarchy, the system of male domination and power (Bradshaw 1994), the idea that men are also harmed by this system might on the face of it seem incongruous. Despite ensuring that men generally have more power, opportunities and privileges than women, patriarchy can also be understood as a system which is damaging to both men and women, albeit to varying degrees and in different ways (hooks 2004). This is evident with regard to health, where norms of masculinity make it harder for men than women to access necessary care because it is seen as a sign of weakness and femininity. In the case of the HIV/AIDS[1] epidemic, the problem is compounded by men regarding clinics as female spaces, and by their reluctance to confront and manage the sexually transmitted dimensions of the disease.

This qualitative study explores the challenges and strategies of community care workers (CCWs) in South Africa as they seek to assist men living with HIV. An estimated 5.7 million South Africans are living with HIV and 17.9% of the adult population is infected (UNAIDS 2012). In 2012, an estimated 240,000 people died of AIDS-related illnesses and it is also estimated that 2.5 million of South Africa's children are orphans as a result of AIDS (UNAIDS 2012).

Women are disproportionally infected with HIV in South Africa for biological and social reasons (Shisana et al. 2014). Yet men seek treatment less and at a later stage (N Nattrass 2008), have lower testing rates, and are more likely to be lost to follow-up or die on antiretroviral treatment (ART) than women (Johnson et al. 2013). Women make up 55% of people living with HIV but comprise two-thirds of patients receiving public sector ART (Cornell, Grimsrud et al. 2010).

Understandably, the focus of HIV/AIDS resources, programming and research has been placed on women and girls (Sonke Gender Justice 2013). Men's health-seeking behaviour is a related but distinct issue. Men's poorer health outcomes are damaging to men, families and communities at large and warrant greater attention. It is for this reason that it is also important to consider masculinities and health-seeking behaviour.

Community care is an important aspect of South Africa's health care system, playing an invaluable role in service delivery (Care Givers Action Network 2013). CCWs are envisaged as continuing to play a central role in delivering primary health care under the proposed National Health Insurance system (Matsoso and Fryatt 2013, Department of Health 2011), marking both an acknowledgement and formalization of this important work.

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[1] HIV is the human immunodeficiency virus. AIDS is the acquired immunodeficiency syndrome, i.e. the set of illnesses associated with longer term HIV infection.

The rationale for focusing on male CCWs in this study is two-fold. First, there is a scarcity of literature on men in care work (Morrell and Jewkes 2014). Second, interviewing men who care for other men is a lens for exploring male CCW perspectives, the male client-CCW relationship and providing insight into male client challenges and preferences.

CCWs can shine valuable light on the needs and challenges of their clients. First, they have more (and regularly sustained) contact with clients than is the case between health practitioners and their patients in day clinics and hospitals. CCWs typically live in the same communities as their clients and visit them at home, which provides for some contextual understanding of their clients' needs. Despite that such home visits pose challenges around confidentiality and HIV-related stigma (Vale 2012b), the richness of CCW experiences and their knowledge in relation to clients' needs should not be discounted. This study draws on this knowledge in effort to understand how CCWs work with and relate to male clients to support their health.

Recent evidence has shown that involving men in health promotion and service delivery is fundamental for achieving better health outcomes for everyone (Sonke Gender Justice 2012). The findings of this study concur with such evidence and demonstrate that gender plays an important role in how CCW-client relationships are negotiated. Many male clients prefer to work with gender concordant CCWs for a variety of intertwined reasons such as comfort, a fear that women gossip and gendered power dynamics.

The techniques that CCWs employ to support the health-seeking behaviour of male clients are demonstrative of how they navigate around hegemonic masculine norms that require men to act tough, suppress emotion and deny weakness and sickness. Such techniques include speaking indirectly about sensitive issues, friendliness and being clear about the intention of their work. The interviews revealed that CCWs encourage male clients to engage in health-affirming behaviour while striving not to rupture hegemonic masculine identities. Despite its challenges, the CCW-client relationship provides the potential for clients and care workers to promote more caring and health-affirming masculinities. The possibility for such transformation hinges not only on the presence of male CCWs with gender equitable beliefs, but also on the grounding of these beliefs in practice.

This research is located within an analytical tradition that sees men's health-seeking behaviour as socially constructed and acknowledges that men can and do change (Hearn 2001). It is also situated within a gender transformative agenda and aims to deepen understanding about how CCWs and male clients negotiate relationships that are supportive of men's health. Further, it considers what these understandings might lend to the broader context of men receiving and providing care.

Findings are based on interviews that took place in late 2013 with CCWs employed by Kheth'Impilo (KI). Meaning 'Choose Life' in isiXhosa, KI is a South African not-for-profit organization that aims to support the South African government in delivering

quality services for the management of HIV/AIDS in the primary health sector. KI is funded by international and local governmental and non-governmental organizations (Kheth'Impilo 2014). For the purposes of this dissertation, community care work is referred to in the context of activities carried out by KI CCWs. Such responsibilities include assisting with treatment readiness so that when clients are prescribed ART they have the necessary emotional and logistical support; conducting psychosocial assessments; identifying barriers to adherence and providing pre-treatment initiation education (Kheth'Impilo 2011). These CCWs also provide support services to suit individual client needs through planned home visits, clinic support and conducting follow-ups (Kheth'Impilo 2011).

The study was conducted in townships in the Cape Town area and data was collected using semi-structured interviews, observational home visits and field notes. Male CCWs were the prime focus of the study with six of eight CCW participants being male and two female. These interviews were complimented by observational home visits, three of which turned into client interviews. Additional interviews were held with community members in Fisantekraal, KI head office staff, an HIV researcher and an HIV and masculinities activist. All participants were interviewed in the communities in which they lived and worked (see additional details in chapter three).

This research draws on the current literature on men, caring and gender transformation to inform the analysis of participant perspectives and experiences. It responds to, and reiterates the call for research to examine the ways in which men are currently involved in care work (Morrell and Jewkes 2014). It also highlights the importance of further considering ways that men living with HIV can be supported in seeking better health.

Structure

Following this introductory chapter, **Chapter Two** begins with stories to demonstrate the deeply entrenched nature of constructions of masculinities in health behaviours in the Western Cape. Following this, an overview of hegemonic masculinites theory is provided. The chapter includes a partial literature review on men, care work and health to provide a foundation for the research findings. The review is only partial because much of the relevant empirical literature is included in the later chapters and discussed where relevant to specific findings.

Chapter Three provides a comprehensive overview of the research design and methodology used for this research, and also considers the study limitations..

Chapters Four and **Five** present and discuss research findings. **Chapter Four** considers the technqiues that CCWs use to support male clients and **Chapter Five** explores male clients' preferences for gender concordant CCWS and the potential of the CCW-client relationship to be gender transformative.

Chapter Six summarizes findings and concludes the dissertation.

Chapter 2: Literature and Stories - Hegemonic Masculinities and Men's Health-Seeking Behaviour

Story 1: William

I meet William for the first time on the street outside of a township hospital.

He smiles broadly and shakes my hand. I thank him for agreeing to be part of the research. He is the only male KI CCW in the area and one of five male CCWs in the whole Western Cape region. KI is not unique in the gendered contingent of their CCWs. Indeed, women tend to dominate care professions and are often seen as more 'natural' carers (Morrell and Jewkes 2011). This is despite research showing that some men feel uncomfortable '*being seen by female health workers about intimate concerns*' (Faull 2010, 22). It is for this reason that William is often assigned to work with male clients.

William and I talk about our weekends while we drive to the interview site. He tells me that he injured his shoulder and ankle when he tripped over a curb, which explains why he is wearing a sling and walking with a limp. The sling is composed of a piece of cloth tied around his neck and another around his wrist, with a third attaching the two together in order to support his arm. It is clear that his sling is home made. I ask him if he knows the nature of the injury. He replies that he is not sure because he hasn't gone to the clinic, which seems peculiar because he often works at a clinic and I've just picked him up from the day hospital.

We arrive at the site and sit down for the interview. William is open and expressive, sharing his personal experiences and perspectives on a variety of topics from politics to care work to masculinities and HIV.

I ask him if he notices a difference between how his male and female clients seek health. He responds that men (would) '*rather do their home remedies and all their stuff then go to the doctor or clinic for some help. Or they will never* (seek medical help) *unless it's that urgent.*'

He then explains that there is stigma around weakness that prevents men from going to the clinic. This explanation echoes some of the key claims in social science literature on masculine gender norms, in which illness is equated with weakness and weakness with emasculation (Medical Research Council 2007, Colvin 2010, Sonke Gender Justice 2013a).

William illustrates the serious nature of this issue through telling me about how his father died after not visiting the doctor until it was too late:

> '*... I spoke to him "Papa wouldn't you rather go to the doctor?" and he said to me "what?! I'm not going to the doctor... only sissies* (Cowards) *go to the*

doctor... I'd rather see that I get helped myself... because a clinic or a day hospital is only for the sissies. I'll take my herbs and all that stuff"... the Sunday he passed away... He would rather wake up, get ready and go to work while he's sick, but he would never go to the doctor...'

At the end of the interview the conversation comes back around to William's injuries. I say '*Can I ask you a personal question?... Your arm – you haven't gone to the doctor for your arm and/or your ankle?*'
William responds with a laugh and says '*It's the same thing.*'

The irony isn't lost on either of us.
He has seen first-hand how gendered norms and stigma affect men's health-seeking behaviour with sometimes devastating consequences.
He works with men daily to support them with these challenges.
He has demonstrated an acute awareness of the norms that inhibit men from seeking health and a commitment to supporting men in living more healthily.

Despite all this, he suffered through our interview with a makeshift sling. Indeed the very issues he spends his life supporting others to overcome afflict him as well.

Story 2: Work-shadowing Lusanda
Lusanda is a CCW with KI. I've met her and her colleague Sam on two previous occasions: once for an initial meeting and again for an in-depth joint interview.

Lusanda conducts adherence support home visits weekly with each of her clients and today she is headed to the field for these visits while I shadow her to observe. KI has requested that Sam, a male CCW, accompany us over safety concerns.

It is a summer morning and she and Sam are both wearing crisp blue and white uniforms. Lusanda has her clipboard in hand with a list of male clients in her catchment area that she is hoping to visit today.

We set out and find most doors padlocked shut. Lusanda makes a note to visit these later in the week.

The first person we find at home is a young man whose health is improving after starting to work with Lusanda three months ago. At the second home we find a client and his sister. They speak excitedly about how they support each other, and share their perspectives on the gendered dynamics of community care.

It is an energizing day meeting with clients who have benefitted from Lusanda's work. It dove-tails with an overview of research in the field of community health work by Lehmann and Sanders (2007) which asserts that despite challenges and with varying degrees of success, there is '*robust evidence that community health care*

workers can undertake actions that lead to improved health outcomes…' (Lehmann and Sanders 2007, v).

We decide to do one more home visit before calling it a day. Lusanda knocks and a woman opens the door, eyes downcast. She ushers us in and offers us a seat. Five young children play on the floor. The quiet sadness in the room deepens as Lusanda asks the whereabouts of her client – the woman's son. The mother's eyes fill with tears as she explains that her son passed away a few days before. We leave after offering condolences, all feeling subdued.

On our way back to the clinic, Lusanda tells me that she saw this client very recently. He was a young man, very ill and struggling to take his treatment.
She notes that consoling families is a regular part of her job. Her work is challenging, with many clients facing insurmountable barriers to ART adherence.

I ask her about the demographics of who is dying.

Without hesitation she replies '*men*'. Sam nods silently in agreement.

Literature on male health-seeking behaviour and masculinities
These short stories sadly agree with the local and international research on HIV and men's health-seeking behaviour.[2] As previously noted, despite being less likely to contract HIV, men seek treatment less and at a later stage (Nattrass 2008), have lower testing rates and are more likely to be lost to follow-up or die on ART than women (Johnson et al. 2013). The case for increased focus on men and HIV/AIDS is strengthened by the fact that men's poor health-seeking behaviour also puts men's partners at increased risk of becoming infected with HIV and contributes to an '*expensive and unnecessary burden on women and health systems*' (Sonke Gender Justice 2013a). Indeed, men's poor health outcomes can add to the psychological, emotional and economic burdens of women and children.

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[2] The concept of health-seeking behaviour has been criticised for not lending itself easily to an exploration of the relationship between health systems and populations as much as between health systems and individuals (Bedri, Lovel and Mackian 2004). Health-seeking behaviour is a reflection of a wider social process, but research often portrays it as something that resides in the individual (Bedri, Lovel and Mackian 2004). Some argue that the dominant ideology of neoliberalism has been a vehicle for this influence (Navarro 2009) and places the responsibility for success or failure (and in this case health) solely onto the individual (George and Wilding 1985, 8,9). All too often, the onus is put on how individuals interact with the environment, without adequately considering the environmental factors that themselves shape these interactions. Despite striving to avoid simplistic, individual-focused explanations on men and health-seeking, this limited construction of health-seeking behaviour has invariably permeated this dissertation.

The social construction of gender as a tangible binary separates certain behaviours and attitudes into those deemed 'feminine' and others 'masculine'. Here, gender is understood as a '*set of socially constructed relationships which are produced and reproduced through people's actions*' (Gerson 1985, 327). The concept of performative gender states that gender is a set of cultural and social practices that are performed by men and women (Butler 1999). It follows that individuals can assert their gender by engaging in certain types of behaviours.

Health-seeking behaviours, like other social practices, are used to socially structure gender and power, providing avenues to perform according to norms of masculinities and femininities (Courtenay 2000). Men can demonstrate conformity to hegemonic masculinities by their health behaviours, which can be used as signifiers of masculinity and instruments to negotiate social power and status (Courtenay 2000, 1389). Gendered constructions of masculinities can influence HIV risk behaviours, such as condom use (Templeton 2003).

Due to societal power imbalances between men and women, men have most of the social determinants of health in their favour (Hearn 2001), including access to economic and political resources. Despite this, men globally have shorter life expectancies (by approximately seven years) and higher mortality rates for all leading causes of death (Hearn 2001, 24). Health behaviour paradigms related to norms of masculinity contribute to men's poorer health outcomes (Baker et al. 2014). Hegemonic norms of masculinities equate illness to weakness and weakness to emasculation, making it less likely for men to access HIV testing, treatment and support services (Medical Research Council 2007, Colvin 2010, Sonke Gender Justice 2013a).

Recent studies in Southern and Eastern Africa demonstrate the harm caused by these constructions of masculinity. Regionally, the 2010 Global Burden of Disease study demonstrated longer life expectancies for women than men, with men in sub-Saharan Africa living on average 5.3 years less than women (Institute for Health Metrics and Evaluation 2010). Here, hegemonic masculine norms increase men's risk of HIV infection and inhibit health-enabling behaviours such as getting tested, accepting their HIV positive status, and taking instructions from nurses (Baker et al. 2014).

There is a small but growing body of research that advocates for the importance of interventions focusing on men, with Cornell et al. (2011) stating that *'most international and national ART-related policies and programmes in Africa are still blind to men.'*

An editorial in *The Lancet* entitled '*Expanding HIV Care in Africa: Making Men Matter*' articulated the need to better engage men in services for HIV/AIDS and the treatment of sexually transmitted infections:

'encouraging men to get tested and into treatment is a major challenge, but one that is poorly recognised... addressing these issues effectively means moving beyond laying blame, and starting to develop interventions to encourage uptake of prevention, testing, and treatment for men—for everyone's sake.' (Mills, Ford and Mugyenyi 2009)

Globally, gendered policy approaches often focus on women and girls (Baker et al. 2014). Recently, the importance of considering men in health policy has emerged in light of the post-2015 development agenda, with civil society calling for the inclusion of men's health on the institutional agendas of global health institutions as well as national governments (Ibid).

As a result of advocacy by civil society, the South African 2012-2016 National Strategic Plan on HIV, Tuberculosis and STIs (NSP) includes commitments to programming for boys and men, marking a shift towards greater consideration of men and HIV. The plan articulates that *'efforts must be made to increase men's health-seeking behaviour'* and acknowledges some challenges that male patients face with accessing health services and treatment (Department of Health 2012, 40). The Western Cape Provincial strategic plan of the same name includes notable activities such as '*focusing on attracting more men to available services'*, providing '*suitable platforms*' for men to access care and '*offering comprehensive male sexual health services and policy scans and development, capacity building and advocacy to ensure that issues of men and boys are integrated*' (Western Cape Province Department of Health 2012, 49).

Critiques of these plans have alleged that they do not plan for research to understand the causes of men's poor health-seeking behaviour, and that they don't consider the potential for men to act as advocates for change and role models to other men in promoting gender-equitable behaviours (Sonke Gender Justice 2013b).

As Ratele (2014) argues, gender equality in the abstract is often removed from gender equality in practice. Despite the importance of having policy language that calls for the engagement of men in sexual and reproductive health (SRH), more must be done for the policies to be practically implemented (Cornell, McIntyre and Myer 2011).

The need to improve men's health-seeking behaviour and health outcomes is clear. This would ideally be done through expanding resources for health and should not reduce resources for women and children (Hearn 2001). Indeed, despite the presence of a strong policy framework, SRH policy implementation and service delivery for women in South Africa have been inadequate (Cooper, et al. 2004). Hodes (2013, 234) argues that the programmatic and activist emphasis on providing ART has overshadowed other crucial dimensions of SRH services for women.

The social contexts and conditions in which men live are fundamental for understanding men's health at individual, national and collective levels. It is within these contexts that men construct their social identities and behaviours. One such behaviour is violence, described by Hearn (2001, 28) as a '*graphic form of non-caring*'. This violence can include health-behaviours that are risky or harmful to oneself or others. Hearn (2001, 28) argues that men's poorer health is linked to dominant and sometimes even oppressive ways of 'being a man', citing an '*unwillingness to take one's health problems seriously*' as a macho risk-taking behaviour.

Power, structure and the study participants
Men are dominant structurally and interpersonally in most realms of life in most societies (Hearn 2004, 51). This assertion does not mean that men are a homogenous group but rather allows for an understanding of differences between men and the complex ways that they relate with other men and women (Hearn 2004).

Let us consider the structural power dynamics innate in the context of this study. Patriarchy, the system of male domination and power (Bradshaw 1994) is present in South African societies as well as most, if not all, societies globally. It is within this context of male dominance that masculine norms negatively affect men's health. While giving attention to the asymmetrical power relations between men and women, it is important to note that masculine power dynamics are fluid and differ by class, ethnicity and age (Hearn 2001). The individuals and groups that experience the poorest health in the world generally come from the most disrupted social settings (Mechanic 1990). Class dominance reproduces the exploitation that is responsible for poor health and poverty (Navarro 2009, 429), with economic deprivation being strongly linked to morbidity and mortality (Krieger 2007). South Africa sees some of the most severe class inequality in the world, still strongly linked to race (Seekings and Nattrass 2005). It is within this context that HIV disproportionally affects Black South Africans. Infection rates are higher for women, especially young women with lower socio-economic status (Nattrass et al. 2012). Men in South Africa are vulnerable to HIV infection across the income spectrum.

Burden of disease and access to care in South Africa are linked largely to the power dynamics that shape determinants of health such as socioeconomic status, educational attainment and social protection (Ele-Ojo and Alaba 2012). Such determinants were racially codified during colonialism and apartheid in South Africa and remain at the root of today's inequality (Ele-Ojo and Alaba 2012). As stated by Abdool Karim (2009) '*historical conditions continue to define the nature of HIV and TB epidemics*' although other factors such as sexual risk taking behaviour are also present. During apartheid, the systemic underfunding of health services for Black and Coloured people caused an increase in a variety of poverty related diseases (Coovadia, et al. 2009). Notable health inequalities, including in the burden of HIV/AIDS on South Africa's Black majority highlights this history. Apartheid's

legacy of forcing the majority of economically active Black adult men away from home for work can be seen today in the commoness of homes headed solely by women. This has influenced the socialization of children with grave adult health consequences (Coovadia et al. 2009, 823). Through the lens of embodiment, a '*concept referring to how we literally incorporate, biologically, the material and social world in which we live*' (Krieger 2001, 672)*,* one could consider these aforementioned factors as likely pathways of embodiment for the marginalized South African majority. South Africa's lower income groups still receive less in terms of health services, with the richest receiving the greatest share of benefits (UCT, HEU (1)2010, 4). There are essentially two health care systems: a private one accessed largely by the wealthy minority (UCT HEU 2010) and a '*shambolic and overburdened*' public system accessed by everyone else (Marais 2011, 7).

Men typically occupy higher social status positions than women, but their experience of power and privilege is far from uniform (Morrell 2007). This can be seen through a power analysis of study participants. The clients and CCWs interviewed sit in various places of privilege and marginalization, with the power dynamics between the CCWs and clients being of particular relevance.

CCWs had more social and economic power than their clients given that they were all employed (despite the poorly paid nature of the work and a perception that it is 'women's work'), had completed, at a minimum Grade 10 and were in comparatively good health. By contrast, most clients were in poorer health, less educated and unemployed. CCWs, despite doing work that rendered them less powerful than, say, a man working in a higher paid or male dominated profession, were thus in a stronger social and economic location than their clients. In addition, CCWs possessed intimate health information about their clients and entered into client homes, a private domain, especially when clients live with family members who do not know their HIV status. This could create a feeling of vulnerability among some clients, especially those who are in a space of diminished power due to their HIV-positive status. It is within these complex dynamics of privilege and marginalization that CCWs and clients negotiate relationships.

When reviewing the interview transcripts, it became quickly apparent that female clients were often framed by CCWs as the norm against which male clients were compared. It is possible that this type of framing of male clients as 'the other' was a response to the focused questioning on male clients or because the majority of KI clients are female. However, a more plausible explanation is that the way that women seek health has been naturalized and normalized. Women are more often recipients of health services and have entry points into the health system around reproduction that have been naturalized, although this does not mean that women are better served by the health sector. As previously mentioned, caregiving (of self and others) has also been feminized with the main care givers in society being women (United Nations 2009, Reddy 2014, Barker 2012). In contrast, much less research and programming has focused on men and health. This is perhaps due to

gendered norms which tend to exempt men's bodies from scrutiny, given that '*a body defined is a body controlled*' (Coward 1984).

This is not to say that focus should be shifted away from women's health. Indeed, the emphasis on women's health, especially in the realm of HIV and SRH is critical. It is however important to note that the dominant focus of discourses on the health of women and children has perhaps created a situation where 'gender and health' is ofter taken to mean 'women and health' (Baker et al. 2014).

Masculinities studies and the theory hegemonic masculinity
The introduction of masculinities theories has been central to the broader inclusion of men in gender research (Morrell, Jewkes and Lindegger 2012). Perhaps most pertinent, the concept of 'hegemonic masculinity' is defined as:

> '*the configuration of gender practice which embodies the currently accepted answer to the problem of legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women.*' (R. Connell 1995, 77).

Hegemonic masculinity refers to the dominant form of masculinity within a society (Connell 1995) and plays a foundational role in the study of masculinities. Considered to be the ideal type of masculinity, it imposes meanings about the position and identity on all other forms of masculinity (and femininity) (Connell 1995, 47). It is a theoretical concept applied throughout this study's findings.

Within the South African context, the application of the theory of hegemonic masculinity was first applied by Morrell to '*explain the nature, form and dynamics of male power*' (Morrell, Jewkes and Lindegger 2012, 12) and broadened to include multiple 'hegemonic masculinities' in acknowledgment of multiple dominant masculine ideals. The application of this theory has been used to understand cultural ideas of male behaviour (Morrell, Jewkes and Lindegger 2012, 23) and to understand how male dominance is reproduced over women as well as in hierarchies among men (Jewkes and Morrell 2010). Gender activists working on HIV played an important role in inserting the theory of hegemonic masculinities into health discourses as a way to understand 'risky' male behaviours (Morrell, Jewkes and Lindegger 2012, 23). The theory has since been applied to understanding men's poorer health-seeking behavior. HIV-related research has drawn widely upon this theoretical framework in considering gendered behaviour and related norms (Stern 2013). Despite the presence of multiple dominant masculinities (sometimes structured along racial lines), all hegemonic South African masculinities applaud toughness, physical strength, courage and men's exercise of control over other men as well as women (Jewkes and Morrell 2010). Indeed, South Africa sees high levels of gender based sexual and intimate partner violence (Jewkes and Abrahams 2002, Leclerc-Madlala, Simbayi and Cloete 2009, Vincent 2008, Thorberry 2010, Artz 2009, Artz and Smythe 2005, Vetten 2007).

Hegemonic masculinities theory also recognizes that gender norms are not fixed. Being situated within social contexts, these norms vary between societies, are fluid and changeable over time. Developing more gender-equitable masculinities is thus a focal point in HIV/AIDS care and prevention (Barker and Ricardo 2005, Stern, Peacock and Alexander 2009, Reihling 2013).

Patriarchy, hegemonic masculinities and critiques

It is important to emphasize that hegemonic masculinity '*is a necessary and integral element of patriarchy*' (Jewkes and Morrell 2010). MacInnes (1998) argues that 'masculinity' as a concept was invented at the same time that modern understandings of gender equality (rather than naturalized male dominance) emerged. In response to the idea that masculinity is in crisis due to major societal changes that affect traditional male roles, MacInnes (1998) argues that masculinity as a concept serves to legitimize patriarchy and that '*the invention of masculinity was essentially a holding operation… it has been in crisis ever since'*.

Critiques of the concept of hegemonic masculinities and the idea of the 'crisis of masculinity' argue that from a power perspective, little has changed with women in South African continuing to earn less and experience high rates of rape and violence (Chadwick and Foster 2007). Indeed a critique of South African texts on masculinity includes '*the disappearance of the term patriarchy in favour of multiple, elusive and ever shifting 'masculinities' and affirming, rather than deconstructing the male/female binary'* (Macleod 2005). For this reason, Macleod (2007, 4) argues for '*a reinsertion of the notion of patriarchy into our study of gender*'. Hegemonic masculinity as a concept has also been critiqued for not providing space for consideration of the ways in which women reproduce male dominance (E. Stern 2013).

For these reasons, some scholars (such as hooks, 2004 and Macleod, 2007) choose to engage directly with the concept of patriarchy, rather than that of hegemonic masculinities, as a framework for understanding harmful male and female behaviours. hooks (2004) argues that it is cultural patriarchal propoganda that is difficult to change, and not culture or tradition itself. She posits that it is preferable to problematize patriarchy rather than traditional masculinites because it is '*patriarchal culture (that) requires that boys deny, suppress, and if all goes well, shut down their emotional awareness and their capacity to feel'* (hooks 2004, 41).

Hearn (2004, 49) argues that the '*hegemony of men'* is a way to understand that men are both '*a social category formed by the gender system and dominant collective and individual agents of social practices*'. He advocates for the deconstruction of '*men's taken-for granted domination*' and the social category of 'men' altogether (Hearn 2004, 59). Indeed, rigid gender and sexual binaries are in themselves problematic (Hearn 2004).

This dissertation employs the concept of hegemonic masculinities in a way that considers its' patriarchal and harmful aspects, as well as how men choose to resist and conform to such norms. It also considers the potential for more gender equitable masculinities in a context where men can (and do) change (Hearn 2004).

Community Care Work

CCWs are common in countries like South Africa with under-resourced health systems and high burdens of HIV/AIDS (Care Givers Action Network 2013). However, the use of a primary health care approach and CCWs are not unique to HIV, nor South Africa. Originating in 1920s, the primary health care approach has been employed in many countries to provide good health affordably (Taylor 2011). The Alma-Ata declaration identified primary health care as key to the attainment of health for all in 1978 (World Health Organization 2013) and the 1981 'Health for All' policy reiterated this assertion (World Health Organization 1981).

Community care work is a cost-effective way to improve population health. Clients receiving community-based adherence-support (as provided by CCWs) have considerably better ART outcomes such as lower mortality rates, decreased likelihood of being lost to follow-up and better virological suppression (Fatti, et al. 2012). Despite having well-documented benefits, the formalization of community care work in South Africa has seen the formation of an ambiguous occupation located in-between state and non-state service provision, volunteerism and formalized labour, and home and health-facility spaces (Vale 2012b). There has been inadequate exploration of carer experiences within this ambiguous context (Schneider and Lehmann 2010, Van Pletzen, Colvin and Schneider 2009, Vale 2012b).

Chapter 3: Research Design and Methodology

Participants

Participants in this research were current and former CCWs from Fisantekraal, Mfuleni, Kleinvlei and Wallacedene. A total of five CCWs, one former CCW and two supervisors (both who had been CCWs themselves) were interviewed. As noted earlier, of these eight participants, six were men and two were women. In addition to these interviews, home visits were conducted to observe the dynamics between CCWs and their clients. A total of six home visits were conducted, with three of these visits being followed by client interviews. One such visit was a group interview with the client and his sister, who is also the client's ART adherence supporter. In addition, an interview was held with an HIV and masculinities activist at the outset of the research. While triangulating findings, two additional interviews were conducted. One was a large group interview in Fisantekraal that included a community developer and 19 of her community program participants. She participated in the interview in dual roles – by answering questions and facilitating participation of the group members. The second was a discussion and interview with a researcher and Treatment Action Campaign activist at the University of Cape Town's Centre for Social Science Research during the final stage of triangulation.

In total, 15 interviews were conducted with a total of 38 participants. The number of participants is skewed by one large group interview of 20 participants, not all of whom participated actively.

Participant Details – Community Care Workers and Supervisors

Name	Gender	# of Interviews	Nature of Interviews(s)
Thabang	M	2	Group interview with MJ followed by home visits
			Group interview with Roberto
MJ	M	1	Group interview with Thabang followed by home visits
Thandeka	F	1	Individual interview
Roberto	M	1	Group interview with Thabang
Lusanda	F	4	Group interview with Sam
			Home visits and interviews with two clients (one of which was also attended by a client's adherence supporter)
Sam	M	1	Group interview with Lusanda
William	M	2	Individual interview
			Group interview with client
Lebo	M	1	Individual interview

Participant Details – Clients

| Name	Gender	Details of Interview
Siseko	M	In-home, attended by Lusanda (his CCW) and Sam
Ayanda	M	Group interview, in-home with his sister/adherence supporter, attended by Lusanda (his CCW) and Sam
Phumi (adherence supporter to her brother, Ayanda)	F	Group interview in-home with her Brother, Ayanda to whom she provides adherence support, Lusanda and Sam
Yap	M	Public location, attended by his CCW

Participant Details - Other

Name	Job	Location	Details of Interview
Sihle Tshabalala	HIV and masculinities activist	Langa	Individual interview
Bertha	Community Developer, facilitator	Fisantekraal	Interviewed for purpose of triangulating findings as part of group interview with a seniors group that she facilitates
Senior's Group Participants (19)	N/A	Fisantekraal	Group interview to gather more information about Fisantekraal to triangulate findings
Thobani Ncapai	HIV activist and researcher	UCT Campus	Individual interview for purpose of triangulating findings

Participant Recruitment

KI regional supervisors recruited the participants and the CCWs recruited male clients to conduct observational home visits and interviews. This method of recruitment ensured that KI participants were each requested to participate by an organizational employee and briefed on the research in advance. This was done for the sake of simplicity and with an aim to best communicate the nature and intent of the research to potential participants.

Map of CCW research Sites
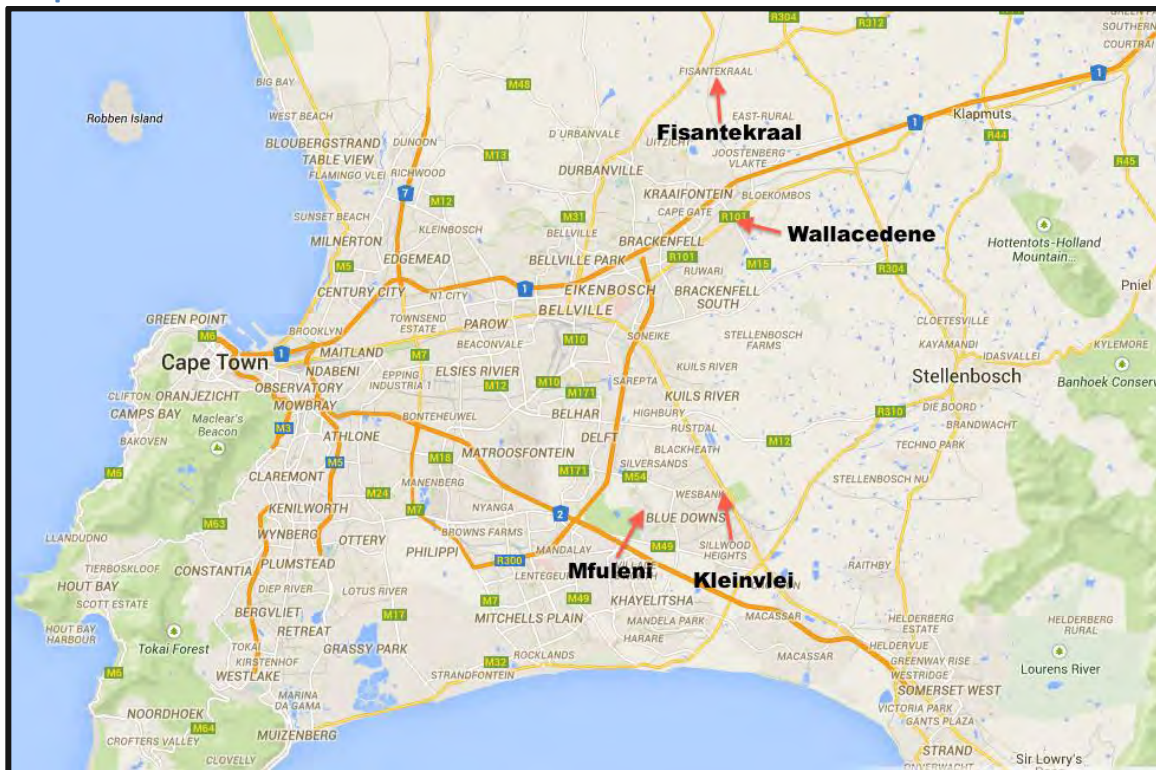
Community	Population	Racial Distribution	Unemploy-ment Rate	% of house holds living on <3200 ZAR per Month
Fisantekraal	12,369	'Black African' 51.5%	32.7%	82.3%
		'Coloured' 46.9%	21.6%	58.7%
		'Asian' .3%	14.3%	50.0%
		'White' .5%	10.0%	20.0%
		'Other' .8%	4.6%	60.0%
		Total:	**27.3%**	**72.5%**
Ward 17 (includes Kleinvlei)[3]	41,077	'Black African' 9.6%	20.0%	31.2%
		'Coloured' 87.6%	20.6%	32.6%
		'Asian' .7%	9.0%	44.3%
		'White' .4%	10.3%	12.4%
		Other' 1.7%	19.0%	51.0%
		Total:	**20.4%**	**32.7%**
Mfuleni	64,269	'Black African' 96.3%	39.7%	77.0%
		'Coloured' 2.7%	42.6%	71.9%
		'Asian' .1%	22.2%	85.8%
		'White' .2%	37.5%	80.0%
		Other' .7%	14.0%	73.9%
		Total:	**39.5%**	**77.0%**
Wallacedene (includes Wallacedene suburb)[4]	36,583	'Black African' 80.4%	36.6%	82.2%
		'Coloured'16%	34.0%	77.5%
		'Asian' .2%	20.0%	100.0%
		'White' .3%	22.2%	33.0%
		'Other' 3%	16.1%	72.7%
		Total:	**35.3%**	**81.1%**

As seen above, the employment, income and racial demographics vary between sites. Mfuleni and Wallacedene, both primarily 'Black African' areas, see the highest unemployment rates, at 39.5% and 35.3% unemployment respectively. These areas

[3] Kleinvlei is part of Ward 17, which includes the other areas of Eersteriver, Forest Heights, Greenfields, Hillcrest Heights, Kleinvlei Town, Malibu Village, Rosedale, the Conifers and Tuscany Glen.
[4] Wallacedene is part of Wallacedene suburb, which includes the other areas of: Klein Begin informal, Kraaifontein East 1, Kraaifontein East 2, Kraaifontein East Informal and Wallacedene.

are also the poorest, with 77% of Mfuleni residents and 81.1% of Wallacedene residents living on less than 3200 rand household income per month. Kleinvlei, a predominantly 'Coloured' area, has higher employment rates and income levels with 32.7% of residents living on less than 3200 rand household income per month. Fisantekraal is the most rural site with the smallest population. There, 72.5% of families live on less than 3200 rand monthly. It is also the most racially mixed site with about half its inhabitants being 'Black African' and the other half 'Coloured'.

The use of racial nomenclature has its history in South Africa's institutionalized discrimination and continues to be used in health and demographic statistics (Myer, Ehrlich and Susser 2004, 117). This nomenclature is problematic in that it may reinforce the concept of 'race' as a biologic or cultural category. It is however useful as a means of understanding demographic differences in health service access and provision (Ibid).

Data Collection

A qualitative approach was used in order to gather rich, context-specific information. All interviews were semi-structured based on a loose set of questions. This approach was used to allow for the subjective experiences of participants to be explored (Watts 2006). Participants were asked to elaborate on certain answers based on their content and meaning. Contextual details and non-verbal expressions were noted both for the purposes of data gathering and for determining how to proceed with the interview.

Interviews were conducted in a variety of places. Some at KI offices, others in community libraries, over meals, in homes, a community centre, a park and one was even in my car! All interviews occurred in the communities in which the participants worked and lived. This was for purposes of participant comfort, convenience and with an aim to '*attempt to make sense of and interpret phenomena in terms of the meaning people bring to them*' (Moen 2006, 5).

For each interview, I invited participants for a meal as a token of appreciation. Some participants accepted this offer and others declined.

With the exception of one CCW, I spent time with the participants on multiple occasions. In some cases, I met with CCWs to explain the research prior to the interview and other times the interview was held on the same day. Some CCWs had follow-up interviews. All of the client home visits occurred after meeting with the client's CCW at least once. This ensured that CCWs could explain the purpose of the research to their clients. The CCWs were also invaluable in setting up home visits and providing support during client interviews.

Interviews lasted between 20 and 65 minutes in length, with most taking slightly less than one hour. They were audio recorded with the consent of participants and later transcribed.

Language

All CCW interviews were conducted in English. Client interviews and home visits were in a mixture of English, isiXhosa and Afrikaans. The CCWs provided informal translation between the participants and myself, as I am unable to speak isiXhosa and Afrikaans.

Inevitably, rich information was lost in translation during these interviews. However this method did allow for me to capture summaries of the client's input and ensured that the participants were as comfortable as possible in the interview process. The CCWs adapted quickly to their client's linguistic preferences and abilities and were helpful in providing informal translation for my benefit.

Analysis Process

Braun and Clark define thematic analysis as '*a method for identifying, analyzing and reporting patterns (themes) within data*' (Braun and Clarke 2006, 79). This method was chosen primarily for its flexibility and ability to provide a '*rich and detailed, yet complex account of data*' (Braun and Clarke 2006, 78).

Interviews were first transcribed in as much detail as possible with an aim to capture the conversations accurately and so that I could become familiar with the data prior to analysis. Based on the transcriptions and interview notes, I colour-coded the transcripts, identifying themes and sub-themes. This helped me to have a visual in order to identify which themes had to be combined, reviewed and discarded. After reviewing and refining the themes, they were defined and named. Given the problem-driven nature of the research, and in keeping with the principles of grounded theory, I decided to focus on the themes that emerged most strongly from the data.

During the thematic analysis, it became clear that findings with regard to male clients' gender preference for CCWs were inconsistent in one community. These didn't seem to be easily attributed to age, language or race (the latter two being potential indications of culture). In an effort to understand this phenomenon, I returned to Fisantekraal and met with Bertha, a community facilitator. Bertha was an informal point person in the community and had resided there since soon after its inception in 1998. She was active in the community's development, having started a home-based care organization, a crèche, a senior's group and was also involved in animal rescue.

Bertha kindly agreed to be interviewed about Fisantekraal. She arranged for this interview to coincide with the weekly meeting of a senior citizen's group that she facilitates. The seniors were keen to share information about Fisantekraal and the interview ended up being a group interview, co-facilitated by Bertha and attended by 19 other participants. This interview provided valuable information about the community, its' history and the social dynamics within the space.

In an attempt to ensure accuracy of findings, a final triangulation interview was conducted with Thobani Ncapai, a TAC activist with experience working with university researchers. Being an HIV positive, Xhosa male living on the Cape Flats, he shared some demographic similarities with research participants. He was also familiar with the suburbs where the research was conducted and was invaluable in confirming and providing valuable depth to the study findings.

Positionality and Reflexivity

I first came to South Africa to conduct a month-long volunteer research project with KI. We had a two-week block set up for interviews. During these weeks I would go into the office in the morning and be informed by my supervisor where I would be going and who I would be interviewing that day.

One morning I was told I would go to Wallacedene to interview two male CCWs. This was a unique experience – all of the CCWs I'd interviewed thus far were women. In fact, it hadn't even occurred to me that there might be male CCWs.

It was then that I became interested in the field of masculinities in the context of care work and health-seeking behaviour. Almost three years later, KI and Lebo (one of the original male CCWs who I interviewed) agreed to be involved with the research for this dissertation.

Research is inherently motivated by ideological, political and/or social agendas (Tamale 2011). I have oftentimes critically reflected upon my agenda and place as a middle-class, white Canadian woman, to conduct such research given the long history of foreigners constructing Africans and African sexualities as the 'other', in oftentimes exotic terms which are always '*different from European/Western sexualities and self*' (Arnfred 2004, 7). Within this is also an implicit co-construction of the European/Westerner to be rational, civilized and modern (Arnfred 2004, 7). This 'dark continent discourse' continues to structure ways of seeing and understanding (Arnfred 2004, 60) and adds to the potential problematic 'gaze' of the researcher. Indeed, Morrell et al. (2012, 25) note the presence of a moralistic binary which links hegemonic masculinities to 'bad men' and stigmatizes certain behaviours and attitudes of African men in general, and young, Black and unemployed African men in particular.

The premise that '*knowledge can not be separated from the knower*' (Steedman 1991, 53) implies that the beliefs, values and lived experiences of the researcher will inevitably affect the process and outcomes of research. I strove to be introspectively reflexive throughout the research process as to how my personal beliefs and lens informed the way that I interacted with participants, analyzed the data and presented findings. This included considering the asymmetrical power relations between the participants and myself, in acknowledgement that power can shape the accuracy of the research outcomes (Roller 2012).

It is believed that participants are more likely to feel comfortable with researchers who are demographically similar to them. Despite this, the majority of participants seemed comfortable and willing to share their experiences and perspectives. It is possible that this could be attributed to them perceiving me as removed from the social complexities of South Africa by nature of my foreignness.

I understand that my attempts to make participants feel comfortable, break down barriers and make the research participatory do not shift the innate power dynamics in this study. I attempted to minimize these potentially harmful dynamics through shaping the research as problem-driven with an aim to contribute to transformative social change, and by conducting it through a local NGO that I have volunteered with in various capacities. I spent time with most participants on multiple occasions in hopes of building a degree of comfort and strove to be self aware and sensitive to social norms in these interactions. I also always invited participants to ask me questions about myself. This resulted in a variety of queries, such as '*How do you find South Africa*?', '*Are you married*?', '*Do you miss your family*?' and '*Tell me about HIV in Canada*?'.

Participants throughout the research were consistently kind, open and very generous with their time and the information they shared.

Ethics

The primary ethical concern with this research was to ensure that it did not make participants more vulnerable either by the research itself or any products coming out of it (Anthropology Southern Africa 2005). Indeed, the intimate nature of sexual health and gender research, coupled with the fact that participants included NGO CCWs and HIV positive clients required a very intentional, sensitive and participatory research design and execution.

The University of Cape Town's '*Code for Research Involving Human Subjects*' guided the ethical considerations for this research.

After an initial meeting, the proposal was presented to the KI management team for discussion before being finalized. After receiving organizational consent, I developed an interview plan in conjunction with the organization. They also reviewed and made suggestions to the interview questions and consent form.

Prior to conducting each interview, I explained the objectives, method and confidentiality of the interview to participants and received spoken and written consent. The CCWs arranged the client interviews and observational visits. Given that they already understood the objectives and nature of the research, they explained these to clients and ascertained their interest in participating. The same protocol with regard to written and verbal consent was followed during client interviews. Pseudonyms (selected in some cases by the participants themselves) were used for all CCWs and clients. In order to keep their identities confidential,

CCWs, former CCWs and CCW supervisors are all referred to as 'CCWs' throughout this dissertation and their ages and work locations are not specified. Transcripts and interview recordings were kept confidentially on my computer.

Beyond the University's Code for Research Involving Human Subjects, it is also important to consider the time and effort of KI employees and clients. Given that the objective of this research is to contribute to larger social transformation, a shorter and more accessible version of this study will be provided to KI management and the participants for their use. In addition, data from themes not included in this research (such as medical male circumcision which KI specifically requested) will be provided to the organization.

Limitations

The limitations of this research should also be acknowledged. Although the interviews provided for in-depth consideration on the question at hand, these findings are not broadly generalizable to male care givers and clients. Despite some overarching trends, men's needs are not homogenous and the complexity of this issue does not lend itself to a 'silver-bullet' solution. To generalize how all men work as and with CCWs would ignore both personal and structural differences amongst men. Although this study recognizes that men are not a homogenous group, other potentially important factors such as sexual orientation, gender identity, ability and class were not addressed in this study. Further research with CCWs that considers these and other factors that inform men's lived experiences of privilege and marginalization would deepen and contextualize this study. The male clients of CCWs are also not necessarily representative of a broader population of HIV positive men, given that they have entered into the health system and demonstrated, at the very least, a minimal degree of openness to receiving support.

Gender was not the only factor that emerged in this study as being relevant to the CCW-client relationship. Race, culture and age were also mentioned by some participants to be important factors. Despite simmering under the surface, race did not, however, inform the findings in any systematic way. While acknowledging the important relationship between history, race and health (which is discussed in chapter two), race was not the focus of this study. The complex racial dynamics in South Africa make it difficult to analyze hegemonic masculinities (Morrell 2001), which is potentially the reason that strong themes around race did not emerge. Gendered findings were much clearer, perhaps due to the research question or maybe because gender is an important organizing principle in the construction of social identities (Campbell 1995).

Chapter 4: *'When you visit a man you should prepare yourself'*
Community Care Worker Approaches to Working with Male Clients

Introduction

This chapter explores CCW perspectives on male clients as well as the techniques that they employ to support them. CCWs strive to develop supportive relationships with clients where they can speak openly about issues affecting their health. These relationships are complex and frequently challenging, as intricate power and gender dynamics are negotiated. Through employing techniques such as indirectness, friendliness and being clear about the intention of their work, CCWs try not to rupture hegemonic masculine norms while providing support. Male CCWs oscillate between hegemonic and alternative masculine norms as they navigate their own masculine identities while striving to perform their jobs as effectively as possible.

Working with male clients: CCW perspectives and approaches

The experiences and perspectives of the CCWs interviewed resonated strongly with the international literature discussed in chapter two. Both male and female CCWs pointed out that male clients have more trouble adhering to medication and are more likely to die than their female counterparts, with issues pertaining to hegemonic masculine identities complicating the management of client health. CCWs indicated that working with male and female clients require different approaches: *'Look, when it comes to males, it was… totally different dealing with them like the way you were dealing with females.'* (Lebo, Male, CCW)

Thandeka also said that she approaches working with male and female clients differently:

> Interviewer: '*Now say you go to visit a man and visit a woman. Would you talk the same?*'
> Thandeka: '*No I didn't talk the same… because they were different. It's a male and a female, so different.*' (Thandeka, Female, CCW)

The language that CCWs used to describe working with male clients (as opposed to women) was also notable. Most framed the behaviour of male clients in a negative light, using words to describe their male clients (and their behaviours) such as 'problematic', 'rude' and 'stubborn'. This viewpoint was evident amongst male and female CCWs across the age spectrum:

> '*You see, working with them* (male clients) *is another story because, if you see, men are very stubborn people, you know? They take things the other way rather than getting the straight, you know*?' (MJ, Male, CCW)

> Lusanda: '*It's easier to talk to women… sometimes a man you see that… men are grumpy.*' (Lusanda, Female, CCW)
> Sam: '*Men are very problematic.*'

...
Interviewer: '*So how do they act that's problematic? Like what do they do?*'
Sam: '*Get afraid to talk, they talk little...*' (Sam, Male, CCW)

'*The men is rude mos, the women is right.*' (Thandeka, Female, CCW)

These varied interpretations of male client's behaviours by CCWs can be understood through the lens of the theory of hegemonic masculinities, which (as discussed in more detail in chapter two) states that men must follow certain social norms such as being unemotional to conform to the dominant norm of masculinity (Connell 1995). Hegemonic masculinity(ies) may require that men have the appearance of independence, self-sufficiency and emotional and physical resilience and strength, which makes it difficult for them to acknowledge vulnerability (Erasmus 1998, Lindegger and Quayle 2009). These relate to male health behaviour norms where men should act robust, self-reliant and strong (Courtenay 2000, Williams and Best 1990, Golombok 1994, Martin 1995). Lindegger and Quayle (2009) argue that these norms are present in the South African context where men are under pressure to perform to physical and emotional strength and resilience. These masculine norms make it difficult for men to receive health care and other forms of help (Peacock, Khumalo and McNab 2006, Lindegger and Quayle 2009).

If male clients feel the need to perform to physical strength and act unemotional, independent and self sufficient, it is unsurprising that they may find dealing with CCWs to be difficult. Their discomfort is likely to find expression through the creation of barriers such as acting in a 'problematic' manner, being 'quiet', 'stubborn', 'grumpy' and 'rude'. In this way, they can resist behaviours that directly contrast hegemonic masculine norms such as speaking about issues of health and receiving support from care workers. 'Stubbornness' in HIV-positive men's health-seeking behaviour was also noted by Beck (2004) who argued that it was employed as a conscious, rather than unconscious defensive tactic. Regardless of whether this type of behaviour is conscious or not, it limits the development of a relationship where clients can receive adherence support from CCWs, and thus potentially undermines their health.

The norms associated with hegemonic masculinities limit men's ability to relate to others because emotions other than anger are considered to be a sign of weakness (Seidler 2006). In turn, relationships become spaces of performance rather than relating (Lindegger and Quayle 2009, 43). Although Lindeggar and Quayle (2009) render this argument in the context of intimate relationships, it has relevance here: through refusing to receive health care support from CCWs, clients are performing to masculine norms of toughness, strength and independence. They do this through putting forth the illusion of invulnerability, suppressing emotion and being unwilling to speak about the issues surrounding their health.

In contrast to the majority of participants who used negative language when describing male clients, Lebo understood men's challenges around health-seeking behaviour as stemming from their sense of vulnerability and need for privacy:

> *'The reality is, men are a little bit sensitive and when you talk to them, you need to understand that they, uh, they don't really talk to anyone about their private life and health to males is very private. And for you to know that they are HIV+, you need to understand that it is something very special because they are very secretive about their status, about whatever sicknesses they are having, diseases. So, ya it was, the approach was completely different... as I said, men, we are very sensitive.'* (Lebo, Male, CCW)

Lebo's description of men as 'sensitive' is also seen in a qualitative study by Chadwick and Foster (2007) of young white South African men. Some participants spoke of men being inherently sensitive, framing this sensitivity as a fixed, trans-historical truth that has not always had free expression (Chadwick and Foster 2007). In Lebo's interpretation, the sensitivity or vulnerability comes from having to share personal, and potentially stigmatizing information about one's health. If sickness is emasculating (and HIV especially so given that it can complicate sexual relationships), it is unsurprising that Lebo considers health information to be 'sensitive' and personal. To Lebo, knowing someone's HIV status is 'special' because of the vulnerability of sharing such personal information. Men's disclosure of HIV-positive status is a complex process influenced by multiple factors such as conventional views of male identity and a fear of negative consequences such as shame, isolation of loved ones and secondary stigma (i.e. stigma by associaton) (Iwelunmor, Sofolahan-Oladeinde and Airhihenbuwa 2014).

The far reaching effects of stigma and fear of stigmatization on HIV non-disclosure, prevention and treatment have been well documented in a local body of literature (such as Simbayi, Kalichman, et al. 2007a, Mills and Maughan-Brown 2009, Maughan-Brown 2007, Kahn 2004, Maughan-Brown 2004). Studies considering the impact of HIV stigma on men in a few African contexts (including Beck 2004, Wyrod 2011, Colvin 2010) indicate that HIV stigma affects men and women differently. Wyrod (2011) argues that an HIV positive status to be a barrier to conforming to hegemonic masculine norms because it is considered to be a barrier to having intimate relationships, having children and breadwinning for families (the same challenges that men face in living up to local ideals of masculinity, respect and status). Similarly, Steinberg (2013, 506) argues that for some South African men, being HIV positive '*is a mark of their diminishment, a biological manifestation of their social uselessness*'. Living in a context where many men do not have the material resources necessary to start families within the traditional institutions that legitimize them as men, HIV status represents men's failure to to procreate as partriarchs do (Ibid, Steinberg 2008).

Despite having different perspectives and value judgments around male client behaviour, CCWs held a common belief that male clients struggle with accepting and

sharing issues related to their health. As Hearn (2001) argues, the problems that some men create (collectively and individually within a context of male dominance) and the problems that some men experience, such as poor health outcomes, cannot be separated from one another. '*Men's accumulations and practice of power*' both benefit some men and also harm them, as seen with risk taking behaviour and illness (Hearn 2001). Thus it is possible for clients to be sensitive and problematic at the same time. Men are beneficiaries of a system that privileges men (albeit at varying levels) and at the same time, this system marginalizes men who do not reproduce it.

Some CCW accounts (by men and women) of male clients' resistance to support also spoke of anger and violence:

> '*This man I was visiting, this one want to hit me. He says he don't want to disclose to anyone in the house, even his sister…ya this man, I don't know what is wrong with this man. That's why this man is so angry. Because he didn't disclose his status…*' (Thandeka, Female, CCW)

Lindegger (2009) and Seidler (2006) assert that performing toughness hinders men's ability to acknowledge emotional vulnerability and deflects emotion into anger and violence. This behaviour both affirms male identities and leaves men more vulnerable. Campbell (1992) argues that violence is a compensatory mechanism for men with limited opportunities to assert their masculine power. It is perhaps for this reason that men who feel emasculated due to their illness may resort to physical violence, or threats of violence.

Four participants spoke about violence by male clients against female CCWs. In these areas, it was common practice for female CCWs to work in pairs.

> '*Like you know men, they like to take advantage, you know? So if it's a woman visiting you at the house regularly, then it is another story, you know. They will take that advantage of "yo, these ladies now visiting me, let me do that or let me approach her".*' (MJ, Male, CCW)

> '*The other men I don't trust. If I'm going to visit another man I don't want to go because the other man maybe they're going to rape you if you're going alone. That's why sometimes I'm working with Kholiswa… We're going with two in the house when the man is staying alone there because I don't trust some of the* (male) *clients…*' (Thandeka, Female, CCW)

Reading these quotes in the context of the gendered power dynamics between male clients and female CCWs creates quite a complex picture. Vale (2012a) investigated CCWs in Cape Town, finding that male clients challenge the authority of female CCWs through threats of violence. She argues that CCWs are constantly negotiating authority and are faced with the task of challenging traditional authority structures in the very spaces that reproduce them (Ibid).

Many CCWs, clients and KI head office staff purport that the clients who do not disclose their status and speak about their health have poorer health outcomes. Indeed, disclosure of status has been documented as a predictor of likelihood for adhering to ART (Cluver, et al. 2015, Agwu and Fairlie 2013, Hardon and Posel 2012), and despite the ethical implications discussed in Vale (2012a), is a prerequisite for determining that a client is ready to start treatment. Beyond disclosure, which is often used as proxy for a level of acceptance of status, participants spoke broadly about the importance of 'being open' and speaking 'freely' about issues affecting them in seeking better health. Participants believed that speaking openly was an important component of a supportive client-CCW relationship. Speaking openly was important in that it: 1) allowed CCWs to provide more relevant support through an understanding of their clients' needs; 2) demonstrated a client's receptivity to receiving support; and 3) provided a tool for clients to work through emotional challenges related to their health.

CCWs noted that speaking openly was a challenge for many male clients, making it difficult for them to develop an effective support relationship. This was put bluntly in a joint interview between a client and his care worker:

> William: '*Women are more open when it comes to, especially health issues. But when you speak to a man he will tell you just to shut up. And ya, men is not very open when it comes to health.*' (William, Male, CCW)
> Jaap: (agrees) '*Men don't usually talk.*' (Jaap, Male, Client)

That speaking about health is more difficult for male clients is not surprising given that the expression of emotion contradicts hegemonic or ideal norms of masculinity (Connell 1995, Lindegger and Quayle 2009, Seidler 2006). In addition, talking about issues of illness would contradict performances of masculinity in which sickness is denied or ignored.

Kaufman (1994) argues that the suppression of health needs and a refusal to admit or acknowledge pain is a way that men acquire power. In dismissing their need for help, men are denying weakness and vulnerability and putting forth the appearance of being strong and robust (Courtenay 2000). This may negatively impact client health and also reinforce cultural beliefs that men's bodies are superior to women's bodies, that men are more powerful and less vulnerable and that caring for one's health and asking for help is feminine (Courtenay 2000).

Lusanda spoke about the impact of men not accepting and talking about their health issues:

> '*And usually me, most of the time when I interview men, I will tell the men that "if you can see more women that are HIV-positive, that look bright. You can see them, they look healthy and vibrant. More men are dying because they don't*

want to accept or don't want to go out there. You see?'" (Lusanda, Female, CCW)

She also shared how she encourages clients to accept and speak about their HIV positive status:

> *'…you didn't buy the HIV. You never stood in a counter to buy it. And for you to be free in your spirit, you should talk. Because the heart pain, you see the wound in the heart, it's more painful. Like you get stressed under the circumstance of that denial, of that closet that you are sitting in. But if you start talking, you are getting free, you are getting even feel like healthy. You're not always sick because you are always worried about people around you but if you are, if you have spoken to yourself, you don't care about people. Not that you don't care but you aren't that worried about people who are whispering or what, you think they talk about you.'* (Lusanda, Female, CCW)

A male client said that speaking about his challenges improved his physical and emotional health: *'You can't be sane otherwise - you must talk, you must be open. If you keep it to yourself you're going to get sicker if you keep it to yourself.'* (Jaap, Male, Client)

Later he spoke of how talking helped him address his anger.

> Jaap: *'If you don't talk to other persons you got lot of anger.'*
> Interviewer: *'So talking to people helps with the anger?'*
> Jaap: *'Ja it takes the anger out of you, it takes the anger out of you. It makes the anger free. Ja it makes the anger free out of you.'* (Jaap, Male, Client)

Jaap's experience agrees with the literature (Lindegger and Quayle 2009, Seidler 2006) that posits that men deflect emotions into anger, an acceptable 'masculine' emotion. Jaap's anger receded when he moved away from performing toughness in conformation to masculine norms and began to speak about his physical health and the emotional implications.

Jaap's CCW also spoke of the importance of CCWs encouraging open communication with clients:

> *'I believe that in the health profession, if you don't speak to your client or patient on a regular basis, you'll never know what that client or patient is going through. And just to get rid of the anger and the frustration, you have to speak to them. And that makes it easier for them to open up to you. And that's what I experienced… if people do accept then they comply to the treatment, they're very open, they can speak about it and all that stuff.'*
> *(*William, Male, CCW)

Here William speaks not only of the importance of clients opening up but of the role that the care worker must play in supporting clients to do so. The type of communication that he highlights here provides an example of how the CCW-client relationship can challenge prevalent notions of masculinity. Similarly, Colvin (2010) saw male support group members contesting dominant understandings of masculinity in Gugulethu through therapeutic discourse.

In summary, participants believed that opening up (disclosing, discussing emotions) was important for clients' emotional and physical health and that this was more difficult for male clients than their female peers. In addition, some CCWs also said that the opening up process takes longer for men than for women:

> *'To be honest with you, they open up slowly. Once they know you, then they will open up.'*
> (William, Male, CCW)

> *'It's not like women..., it isn't rapid. It's slowly, you see?'*
> (Lusanda, Female, CCW)

Despite noting the reluctance and speed with which male clients open up, participants did not hold the belief that men have less to say. The stereotype that men are not emotionally expressive can be (re)considered in light of the argument that male babies cry longer and louder than female babies (hooks 2004, 35). Here she argues that boys '*enter into the world wanting to be heard'*.

Participants in the study also challenged the assumption that men are inherently less emotional, emphasizing the importance of verbal expression to men's health. One CCW spoke of his surprise over how much male clients actually want to share once they become comfortable with their CCW: *'I never knew that men offload so much. Especially when it comes to this illness and all that stuff.'* (William, Male, CCW)

In response to their observations that male clients have more trouble opening up and are less likely to be receptive to support, participants all said that they consciously employ specific techniques when working with male clients. Tentativeness and a 'feeling out' process characterized the beginning of their working relationship with male clients. At this point, CCWs seemed to be seeing how best to forge a support relationship that may contradict societal norms of what it means to be a man, in the knowledge that this might be foreign to some clients.

CCWs made it clear that negotiating a support relationship with clients (and male clients in particular) is fraught with vulnerabilities which if not handled gingerly could limit their ability to work effectively to support their health.

MJ, a CCW in Fisantekraal spoke of making sure not to 'cross the line' and broach sensitive topics too directly or too early: *'Visiting a man? You see when you visit a*

man you should prepare yourself. In other way that you might not cross the line or talk other things.' (MJ, Male, CCW)

Other participants also spoke indirectly of the presence of this invisible, yet highly important line. The picture that emerged was one of CCWs carefully searching for this invisible line, over which lies a highly fraught emotional ground. This line delineates private and intimate matters that are too uncomfortable to speak of, the crossing of which could upset clients and harm the support relationship they are trying to build. Restrictive masculine norms seemed to create a very small and tentative space in which CCWs could respectfully engage with their clients at first. It was the aforementioned masculine norms of physical and emotional toughness that constrained the negotiation of a support relationship.

In describing their techniques used to move clients into a place of openness and receptivity, a number of participants noted (either explicitly or implicitly) two phases in the client-CCW relationship. The first phase was characterized by tentativeness or resistance on behalf of the client and the accompanying need for the CCW to approach working with the client in a sensitive and cautious manner. After moving past this phase, a second phase (characterized by a degree of comfort between the CCW and client) was noted. It is during this second phase where the client and CCW can speak more openly about the challenges affecting the client.

> *'…there is a time like you start with the client. When your client is still new, you need to be sensitive in a way… but as the time goes by, you build that relationship with your clients and they become comfortable with you and once they are comfortable with you and they understand also the work that you are doing... So, from there, that's where you move another step. That's where you can try to talk about, like, anything, but you just mind the way you are saying it. So, that is it. It's not that you can't talk about some things, you can, but at the right time. And you find a way of like, talking about them, like in a very respectful manner.'* (Lebo, Male, CCW)

MJ speaks about moving into a more comfortable phase with his male clients where they feel free to open up and the relationship between the CCW and client deepens:

> '…t*hen the second step is its him that is going to speak. You know he's going to tell you "hey man, you see now what is happening, I have been there doing what what what what what, and doing the job because of this or that" then the friendliness start there, you are becoming connected.'* (MJ, Male, CCW)

In recognizing that there are many constructs of masculinity, it is also necessary to note '*the relations between the different kinds of masculinity: relations of alliance, dominance, subordination*' (Connell 1995, 37) in which the male body is often used as a vehicle of these negotiations (Courtenay 2000). As such, men often use their physical strength and abilities to demonstrate their power and dominance over each other, which explains why men who embrace hegemonic norms may not want to

admit illness. CCWs aim to connect with their male clients beyond these limited and fraught types of relating.

Despite indications that male CCWs embrace alternative masculine norms, they also sometimes conform to hegemonic norms of masculinity when working with their peers and clients. While receiving and providing health care is considered to be a 'feminine' practice, the provision of health care also constructs and reproduces gender hierarchies. Physicians, the most respected health providers are often men:

> '*maintaining power and control over the bodies of men who are not physicians, the bodies of women, as well as over male and female health professionals in lesser positions of power, such as nurses and orderlies*' (Courtenay 2000, 1395).

Beck (2004) argues that there is a certain necessity of authority required in compelling men to respond to their HIV status in a way that supports their health. The findings of this research challenge this assertion in some ways as participants spoke of approaches such as being friendly, open and gentle as strategies to reach their male clients. However, certain hegemonic masculine norms and attitudes did emerge in conversations with some participants.

MJ spoke about being persistent with his clients until they did what he wanted them to: '*If he desert[s] me today, then I have to come tomorrow. I have to keep going, yes, until I get them where I want him to be.*' (MJ, Male, CCW)

Sam spoke about how he has techniques for getting male clients to disclose: '*I've got my own way to make that guy to disclose but I'm giving him enough chance.*' (Sam, Male, CCW)

William spoke of how he uses male power in his job:

> William: '*It's only one* (male CCW) *and it's me. I'm the shepherd, they're the sheep. That's what I call them'.*
> …
> Interviewer: *How does it feel to be the only man?*
> William: '*It feels great because I can raise my voice when something's not going according to plan, especially when it comes to patients. Then I can raise my voice and then they can sense "oh wow, there's a man in the house, oh". It's really good.*'
> Interviewer: '*So the patients will listen more?*'
> William: '*Oh yes.*' (William, Male, CCW)

These quotes from MJ, Sam and William all demonstrate a certain sense of power and dominance that they sometimes bring into their work. Despite all demonstrating on many levels (including the fact that they are working in a female dominated field) that they embrace alternative masculinities, they still in some ways

perform to hegemonic masculine norms. These examples speak to the complex nature of performative gender and the ways in which men may conform to, and resist hegemonic norms of masculinity. Moreover, they speak to the way that male CCWs may simultaneously hold two seemingly contradictory positions: on one hand, they are asserting dominance over their clients and on the other hand, they are doing it in their role as men working in a 'female' profession. They are embracing an alternative masculinity through providing care, while providing care through performing to power and dominance. The participants' rationale for this power and dominance is clearly situated in their belief that these performances are part of the care that they are providing to male clients in support of their well-being.

As CCWs navigate the way they relate to clients, they employ different strategies and embody different masculine norms. This agrees with Vale (2012a) who demonstrates that CCWs use a range of techniques from lecturing and threatening clients to telling stories and speaking 'on their level'.

The delicate dance described by CCWs in working with male clients seemed to involve tip-toing to the edge of the aforementioned line which delineates intimate matters, and gently pushing it back when possible to bring issues to the fore for discussion. A variety of techniques were employed to avoid stepping into a space where client's hegemonic norms of masculine behaviour were threatened. These techniques were characterized largely by CCWs being clear with their intentions, friendly and indirect. These approaches were employed with an aim to move clients into the 'second phase' where they were more comfortable to open up and receive support.

A key approach that some participants employed in developing a supportive relationship with their male clients was to ensure that the client understands the purpose of their visits.

> *'What we want is just be polite. Try to make him see why you are here and why is it important of me being there.'* (MJ, Male, CCW)

> *'They need to understand the work that you are doing. They need to understand your stance.'* (Lebo, Male, CCW)

> *'I will do my utmost best to make sure that client understands and when I leave that client is at rest. So when I come back the next time then he must feel more free to open up because for the past month, I experience, most men, I never knew that men offload so much. Especially when it comes to this illness and all that stuff.'* (William, Male, CCW)

It is certainly understandable that clients want to understand why someone is coming to visit them in their home and speaking with them about highly personal subjects such as their lifestyle and adherence to medication. Being clear and informative about the purpose of their visits was a way to make clients feel

comfortable. Providing information to clients allows them an increased sense of control and sets the ground for a space where they may feel safer receiving support.

The importance of being friendly and open with clients is perhaps unsurprising but nonetheless notable. CCWs spoke about approaching clients 'as friends' with an aim to put them at ease. This approach serves to minimize perceptions of power dynamics between the CCW and client, which might impede on the client's ability to receive support.

That health care facilities in South Africa are not 'male friendly' has been widely documented[5]. Deterrents for men accessing health services include lack of service provider training/skills for men's health issues, unwelcoming, poorly equipped clinics, bad attitudes from health providers (Sonke Gender Justice 2013a), inaccessible hours and the perception of public clinics and hospitals as 'women's spaces' (Faull 2010). Another common complaint by men as to why they don't access health services is that clinic staff treat them in an unfriendly or disrespectful manner (Colvin 2010). As a result, CCWs try to demonstrate that contact with health care can be a pleasant experience:

> *'To be honest I'm a very polite and friendly person. I don't act like I'm from the clinic. Especially when there's other people around and I come to visit that person, I will act like we know each other and we're friends and all this stuff. And that is when they start to open up.'* (William, Male, CCW)

> *'You see for them to accept me it's to talk with them. To sit down, you see, make friends.'* (MJ, Male, CCW)

> *'It is just to educate first and to feel free to talk. Then it will convince him that he must also feel free to talk to me.'* (Sam, Male, CCW)

These quotes show that the gesture of friendliness and warmth by the CCW towards the client are not just functions of goodwill. They also help develop a relationship with the client where they are more likely to open up, and in turn become receptive to a relationship that supports their wellbeing. Vale (2012a) also found that some CCWs aim to speak to clients 'on their level' so that clients don't feel infantilized. Male peers sometimes struggle supporting each other because men have been socialized to be independent, with male relationships being defined by hierarchy and deference rather than cooperation and support (Wyrod 2011). Being friendly allowed for some CCWs to negotiate within a space to build a supportive relationship.

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[5] This is not to say that clinics are 'women friendly' either. Indeed, women are also commonly subject to unfriendly and oppressive treatment in clinics. This has been documented by researchers such as Wood and Jewkes (2006).

Jaap, one of William's clients, spoke of the difference it made to him to feel cared about by his CCW:

> *'For me it's nice because somebody came out to me and showed me that somebody cares about other people. It's his work that he do but this just one thing that I know, he cares for other persons. And somebody cares for me, I also cares for him. That's why. If he comes, I can sleep, I can do anything, I will stand up I will go to him because he's doing his work. I respect his work and I respect himself because he cares about other persons.'* (Jaap, Client, Male)

In observing Jaap and William's interactions, it was obvious that there was mutual respect and a level of warmth and friendship in addition to an acknowledgment of the practicality of William's role as a supporter.

In taking a warm, open and friendly approach, male CCWs are also demonstrating an alternative, more caring masculinity. This might enable male clients to also embrace alternative masculinities themselves and to speak openly, share feelings and acknowledge issues around physical and emotional wellbeing.

Taking an indirect approach to speaking with male clients was the most commonly citied technique in this study. By speaking indirectly about issues, CCWs could create a degree of distance from the sensitivity of health issues and the discomfort of accepting support. CCWs tried to avoid 'crossing the line' by depersonalizing the conversation while still indirectly providing support or advice. Hardon and Posel (2012, S3) challenge the dominant discourse '*in which silence and secrets are seen to undermine well-being and perpetuate* (HIV-related) *stigma'* arguing instead that a more subtle and cautious approach may be waranted because of the potentially adverse effects of pre-mature disclosure and openness. Such a subtle and cautious approach can be seen in the way CCWs were careful not to push clients to acknowledge illness or to directly share feelings. This approach allowed them not to directly challenge hegemonic male norms or undermine clients' façade of toughness.

> '*Some of the things you can't really say them directly in a way, you need to consider that some of the things that you might say, they might be offensive to that person.'* (Lebo, Male, CCW)

Lebo would speak indirectly so as not to offend (male) clients. He was also careful not to force conversation on sensitive issues. If he sensed a topic was sensitive, he would change the subject and then revisit it later.

> *'Like, ja, "what do you think of this?" And then someone will give you an answer and you say 'ok cool' then when you get back then you say "ok, this is the question that I wanted to ask".'* (Lebo, Male, CCW)

In not wanting to cross the invisible line and ask too personal a question, Lebo would near the line, retreat and then inch forward again in hopes of addressing certain issues without offending clients.

MJ also spoke of the indirect approach that he uses when he starts working with a male client:

> *'Put all these things that you know that they are main problem of us men not wanting to accept. Put them, put them… don't say "you know, you do this, you don't want to do that, you don't want to go to the clinic, what what", no just tell the guy that "if it happens that if you are not going to the clinic, you will die you see? You will become sick, you see?" and tell them that many men are dying because they don't want to do that. Not trying to tell them that "you aren't going to the clinic".'* (MJ, Male, CCW)

In taking such an approach, MJ was also trying to negotiate doing his job and not entering into potentially volatile territory with clients. In addition to speaking indirectly, he also spoke of giving options rather than outright advising male clients:

> MJ: *'You must try to be friendly first, then make points instead of telling what to do.'*
> Interviewer: *'So what would you say for example?'*
> MJ: *'So for example I'm trying to tell you if you are a man visiting you, the man then I will talk the views so that you will choose from. I will state all the facts that "this is what is happening outside here. Many men are dying of HIV because of what what what what"… (speak) around (the issue) so that they could choose… so that they could make the decision.*
> *After all, then it will get into him "oh, you are right" you see "you are right - I know that that is that, that is that[6]" you see, then you will start following you see. You will see him come into the clinic, you see?'*
> Interviewer: *'And after that when you visit him?'*
> MJ: *'After that when I'm going to the regular visits, then the normal thing, we are friendly now. All the stuff, now we are friends. No more argument or stubbornness.'* (MJ, Male, CCW)

Such an approach empowers male clients with information while allowing them to maintain a sense of control. Essentially, they are provided with information that they can use to make their own choices without being told what to do. In depersonalizing issues by making them hypothetical, CCWs can avoid situations of confrontation. Beyond avoiding confrontation, telling clients what to do is unlikely to result in behaviour change. In her study on condom use in mines, Campbell (1997) argues that the broader social context of 'masculine' and 'feminine' identities creates a complex environment for behaviour change, where telling someone what

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[6] In context, MJ was conveying 'this is that, this is that' to express that the client was making sense of things on his own.

to do is ineffective. The lesson she drew is relevant here. Indeed, approaches that provide information about health risks and how to avoid them are often ineffective, especially in low health communities (Campbell 2001). There is a body of literature that suggests that positive health outcomes may be associated with social capital, and which suggest that enhancing social capital in low health communities via targeted policy and programming may yield better health outcomes (Ibid).

Some participants noted that confrontation is not conducive to the development of an effective support relationship. One CCW spoke of how he responds to such situations where male clients become confrontational.

> MJ: '*No, (*I am*) not raising my voice. Because if you are also raising your voice then it's a fight. That's what we don't want. What we want is just be polite. Try to make him see why you are here and why is it important of me being there.'*
> Interviewer: 'S*o if he's raising his voice, you keep just talking around?'*
> MJ: '*Talking around, he try to run away from that thing, you see.*
> Interviewer: *So he's trying to run away from it if he's raising his voice?'*
> MJ: '*Yes if he is raising his voice he is trying to run away from your point, from what you are trying to tell him, you see? But if you keep trying and making other things...'* (MJ, Male, CCW)

As evidenced by this quote, MJ believes that if a client is being confrontational, he is avoiding the topic at hand. This agrees with the aforementioned literature saying that men seeking conformity to hegemonic norms of masculinities deflect vulnerability and emotions into anger, which is an acceptable feeling because it does not denote weakness (Lindegger and Quayle 2009, Seidler 2006).

In her work on authority and CCWs, Vale (2012a) speaks of different techniques that CCWs employ to assert authority over clients. One such technique is the use of stories to illustrate consequences. This is consistent with the indirect approach noted here where CCWs speak hypothetically rather than directly. One way of doing this is through sharing their own stories.

William uses his own story as a way to address sensitive topics with his clients. In this way he demonstrate openness and provides advice without seeming patronizing. Not only does this avoid challenging his male client's performance of masculinity by not drawing attention to their behaviour, but through sharing his story, he is also able to model a more vulnerable alternative masculinity.

> '*I'll be honest with you. When I talk to them about sex, when I open the HIV story, I've been HIV-positive for more than 16 years now... And for me it's very easy to talk to them about it. When I see the signs and symptoms that there's a risk...I'll speak to them about that and bring the sex topic in. and then it makes it easier for me... then that helps them open up.'* (William, Male, CCW)

The use of personal examples may also serve a purpose in relation to behaviour change. Lewin (1958) argues that people are more likely to change their behaviour if they see that those in their peer group are also committed to behaviour change. Thus male community care workers may provide an opportunity to demonstrate alternative masculine norms, which can support more positive health-seeking behaviour.

Conclusion

The techniques explored above are employed by CCWs as a way to develop open and supportive relationships with male clients within the context of constraining hegemonic masculine norms. As such, they serve to minimize or avoid destructive masculine power dynamics, reduce perceptions of hierarchy and put clients at ease. Some techniques provide male clients with empowering information so that they can make decisions about their health. Other techniques are employed to avoid situations where male clients feel that their masculinity is being challenged by being told what to do or being forced to address sensitive issues before they are ready.

While these techniques were used specifically in the context of male clients, it is not to say that CCWs do not employ them with other clients as well. Indeed, a critique that has been rendered against some male-friendly interventions is that the needs of women risk being side-lined. While acknowledging the importance of employing techniques to support men in seeking health, I am also operating on the assumption that women also appreciate being addressed in a friendly manner and like to be provided with full information about the purpose of their CCWs visits. Further research could interrogate these assumptions and address the question of whether women tolerate a more direct communication style. Given that this was not a subject of enquiry, it is unclear what kind of specific approaches CCWs use in working with women. It is important to acknowledge that everyone is deserving of respectful and informative health services. While striving to shift gender norms, it is important to consciously reject the reproduction of patriarchal values that prioritize men over women.

Some might argue that these aforementioned techniques are ways that CCWs pander to male dominance and power so that they can do their jobs. Such analysis does not seem relevant in the context of the broader gender transformative agenda in which this research is situated. If the goal is indeed gender transformation and healthier individuals and societies, tiptoeing around client's identities of masculinity is not an end in itself. Rather, the objective is to develop supportive relationships in which clients can improve their health behaviours for the benefit of themselves and their societies.

Chapter 5: 'We need more men to come forward'

An exploration of the role of male community care workers in supporting male clients

Introduction

This chapter explores male client preferences for, and responses to, the gender of their CCWs. The majority of participants indicated that clients prefer gender concordant CCWs and that more male CCWs are needed. While the sample size for this study was small, this was a strong thematic message. Factors affecting male clients' preferences to work with male CCWs include comfort in sharing intimate health information with someone of the same gender, as well as, in some cases, negative associations of women as untrustworthy gossips.

This chapter draws on the current literature on men, caring and gender transformation to inform the analysis of participant perspectives and experiences and considers barriers to recruiting and retaining men in this traditionally female profession. Last, the complex dynamics that inform and structure the CCW-client relationship are explored and the potential for such pairings to be gender transformative is considered.

'Male friendly' services

If men are to be encouraged to access SRH services and treatment, it is important that health services are reflective and responsive to men's needs (Pearson 2003). As such, the World Health Organization's (2007) *Global strategy for STI control and prevention* recommends '*male involvement, male motivation, and services for men*'. The International Men and Gender Equality Survey (IMAGES) (Levtov et al. 2014) assessed men's gender equality related attitudes and practices in eight low and middle-income countries. It demonstrated that health-sector approaches making SRH services more agreeable, attractive and convenient have shown evidence of impact in engaging men in health services (Ibid).

In recent years, local interventions have been developed to provide health and wellness services specifically for men. These have included the Sonke Gender Justice One-Man-Can Wellness Centre in Gugulethu, and the Siseko and Kuyasa Men's Clinics in Khayelitsha. These spaces aim to provide 'male-friendly' services, including providing male nurses and counsellors based on male client preferences to receive SRH services from men. These interventions were developed in response to the commonly held belief that South African health services are not amenable to men. They aim to address men's poor health outcomes and their impacts on men, families and communities.

Studies have documented a strong preference on the part of South African men to go to men's only, or male-friendly clinics where they can be seen by male nurses and counsellors (e.g. Leichliter et al. 2011 and Faull 2010). The rationale for male-

friendly spaces includes the commonly held perception that public clinics are for women, long wait times, inconvenient hours and lack of confidentiality, which deter men from visiting (Leichliter et al. 2011, Faull 2010, Orner et al. 2008). In addition, male clients have complained of poor treatment by clinic staff including rude and judgmental female nurses (Faull 2010, Colvin 2010, Levack 2005, Leichliter et al. 2011). The dynamics between nurses and CCWs are also important to note. Nurses possess a professional status that provides them with more privilege and authority than CCWs, which Vale (2012b) found to be exerted by nurses unfairly over CCWs at times.

Barriers to men in care work: money and manliness

There are significant barriers to attracting and retaining men as CCWs. Indeed, the reason why the particular sites for this research were selected was because they were the only ones in the region that employed any male CCWs.

These demographics are reflective of women's dominance in care work. Women shoulder the burden of care, with 70% of AIDs-related care in South Africa being done by women (Steinberg et al. 2002). Hegemonic norms of masculinity serve to construct certain jobs as 'feminine' and therefore subservient to 'masculine' occupations. These jobs are typically relatively poorly paid, as can be seen with care work. The 'unmanly' nature of care work, aggravated by poverty can deter men from being involved in caring (Morrell and Jewkes 2014). This probably explains the paucity of male care workers.

Social relations of work represent much of how gender is performed, including how masculinity is constructed (Collinson 2005) and how identities are formed. Paid work is a source of men's identity and can signify power and status. In occupying feminized spaces like care work, men may find themselves in conflict with their social space and devalued in their masculine identities (Hzenjak 2013, 347). Care work has been constructed as unskilled work that women are naturally predisposed to (Hzenjak 2013, 347). Thus men working in care are choosing de-professionalized, downgraded and feminized work (Ibid). Local research on male care workers such as Shefer (2014), Davies and Eagle (2010) and Morrell and Jewkes (2014) highlights stigma and the social questioning of masculine identities as barriers to involving men in care. Findings in this study agreed with these factors.

The importance of a man's ability to be an independent provider is linked closely to what it means to be a man in South Africa (Richter and Morrell 2006).

> Lusanda*: 'They're (*men*) not applying. I think because the community work doesn't pay much. When you're a man, you don't have power when you work in the community*.' (Lusanda, Female, CCW)
> Sam: '*But that doesn't make sense because most of them they are there, now at home, they do nothing.'* (Sam, Male, CCW)

This quote supports Colvin's (2010) argument that expectations for men to be providers can be so high that they do nothing rather than only bring in small amounts of money or food. In addition, it demonstrates the social expectation for men to be breadwinners and the tension this creates between being a provider and a care worker.

A male CCW from Fisantekraal indicated that he is embarrassed to still be a CCW, citing the lack of status associated with poor pay as the reason:

> MJ: '*It's embarrassing because I see my friends out there, they are doing high things than me... but I'm still standing on the same level, I'm not moving.*'
> Interviewer: '*And why do you see CCW as being a low level?*'
> MJ: '*...it's not at the low level because we are the more important people in the community you see? But other way financially, we are not doing anything.*'
> (MJ, Male, CCW)

This resonates with a study by Morrell and Jewkes which found that '*men working in NGOs were not materially secure, and regarded their work as a substitute for the real thing, a proper job*' (Morrell and Jewkes 2014, 337). As put bluntly by one participant in this study: '*I don't have a proper job you know*.' (MJ, Male, CCW)

Despite the poor pay, he still viewed his work as important. This was seen in other participants who also believed their jobs to be important and valued in their neighbourhoods.

> '*...they (CCWs) are appreciated for what they are doing in the communities but not as role models because a lot of people feel like they are doing a lot of work, but they are doing it for other people.*'
> (Lebo, Male, CCW)

Thus we see a tension between male CCW perspectives on the importance of the work, social status and poor pay. As per Morrell and Jewkes (2014, 340), to encourage men's entry into care work, changes are required to the constructions of male identity and what is accepted as 'men's work'. Men must be able to feel 'manly' or at least uncompromised by working in care (Ibid). Despite these barriers, there may be a unique and important role that male CCWs can play in the lives of HIV positive men in their communities.

There is a complex relationship between societal dynamics and how members embody health. The harmful hegemonic gender norms related to poor health outcomes in societies also inhibit men's involvement in paid and unpaid care work. Involving more men in care work is not an easy or 'silver-bullet' solution as the challenges for involving men as carers are tangled up in a web of related social challenges. As Hearn (2001) so aptly argues, the problems some men create and the problems that some men experience cannot be separated from one another.

Do male clients in the Western Cape have a preference for the gender of their CCW?
This study similarly found that clients in the Western Cape generally preferred gender concordant CCWs. This attitude was expressed by the majority of study participants (all CCWs at Mfuleni, Kleinvlei and Wallacedene, district management at KI, and two HIV and masculinities activists). A few participants (some CCWs at Fisantekraal and two clients) held differing views.

Comfort
Most participants believed that male clients are more comfortable speaking with men about issues of sexual health, due to the personal nature of the topic:

> *'He doesn't want to speak to a woman then he'd rather speak to me. He doesn't even speak to his wife... they feel more at ease when they speak to a male rather than a female.'* (William, Male, CCW)

By emphasizing that clients prefer to speak about issues of sexual health with a male CCW over their wives (assumedly women who they share a degree of intimacy and comfort with), William illustrates male clients' strong preferences to work with men. Lebo shared a similar sentiment:

> *'... there were guys who never wanted home visits (from female CCWs) ... they feel so uncomfortable with that... they can't talk to a female about your, what can I say, about your personal life because anything to do with sex is very personal.'* (Lebo, Male, CCW)

Similarly, in her study at a men's clinic in Khayelitsha, Faull (2010, 2) posits that men '*feel uncomfortable being seen by female health workers about intimate concerns*' and that '*discussing sexual health with female health workers makes most men very uncomfortable, if they are able to do so at all.*'

There have been many studies on client preferences on the gender of health service providers in a variety of contexts (such as Chur-Hansen 2002 in Australia; Ackerman-Ross and Sochat 1980; Fang et al. 2004 and Bertakis et al. 2009 in America, and Kerssens et al. 1997 in the Netherlands). A commonality in these studies' findings was that same-gender provider preferences increased based on the intimacy of the situation, such as examinations of genitalia or the evaluation of mental health status. This is relevant to the case of CCWs because HIV-support services are intimate (given that they often entail discussions of sexual behavior and other personal matters such as breast-feeding), especially when fellow community members provide them.

In line with the aforementioned studies on client preferences, participants who believed that male clients are best supported by male CCWs also believed that gender concordant client-CCW pairings are more comfortable and effective for women as well.

'…(when speaking to a male CCW) *he (a male client) can talk freely. I think maybe he's scared to talk to me about this status…* (instead he) *is rude to me.… its most easily women to talk to women…'*
(Thandeka, Female, CCW)

These gender dynamics were teased out in a group interview with Andile (1), a male client, and Phumi (2), his sister and adherence supporter.

Phumi (2): '*He can't say a man's stuff with a woman… he's gonna tell him (*a male CCW*) what is the problem… you know what, the woman's got her own stuff. Men got their own stuff… We can't talk about to the men, we are the women. The men, they can't talk about to the woman, it's the man. Man to man.'*
Andile: (1): *'Ya, ya of course.'* (Andile, Male, Client)
Phumi (2): '*… If I got the problem, I go to the woman. "Here Sisi, I got that and that and that". Even my boyfriend, I even won't tell him "I've got something wrong".… you can't share our stuff with a man. And the men, they can't share the male stuff with a woman. They must go to the other men to share, you see? (otherwise) You feel shame of yourself, shame that the other person is not like you…* after you tell (someone of the other gender), you feel shame.'
(Phumi)

This conversation highlighted feelings of shame and embarrassment in sharing intimate sexual health information with someone of a different gender. This dovetails with Faull's (2010, 16) finding that clients of a men's clinic in Khayelitsha believed that people of the same gender have shared experiences and knowledge and can therefore understand each other better and be more open with each other.

At the end of the study, I interviewed an HIV activist and researcher to triangulate findings. He argued that advice is more credible when it comes from someone of the same gender because of commonality of experience and understanding:

Interviewer: '*I'm curious because in most of my findings they said that men feel free to talk to other men. Is that true?'*
Thobani: '*Ya its true because men are always advising each other… because if you are a man, you have been into that situation, you manage to advise this person how to prevent it for the next time.'*
(Thobani Ncapai, Male, HIV activist and researcher)

Participants also shared their beliefs that working with male CCWs positively impacted male clients. They highlighted the importance of speaking openly about the issues affecting them (as discussed in-depth in chapter four) and indicated that male clients found this easier to do with other men.

'It made a huge difference to have male community workers… maybe, they had the female PA (CCW) *before. And then you (a* male CCW*) come, and when you talk to them you find that when you come with the information, the information is no longer the same, it has changed a lot. And that is a proof that they, now they have opened up to you and they've got some things that they manage to say… some of the guys they would say "you know what? Thanks guys… you know it was so difficult for us to talk to women all the time."'* (Lebo, Male, CCW)

Lebo also told a story of a specific client to illustrate his observations:

'There is one guy that, I can still picture him now. Because he used to default at treatment a lot … I started working with him ….. he took treatment quite well and that's the difference that I notice… a guy will tell you, maybe how the way he thinks he got the HIV sometimes when you are a guy. He will tell you that "you know, that woman, I dated that one, I dated that one, and I assume that's how I got this HIV thing" and whatever. But when he's having a conversation with a woman, it wouldn't be easy for him to talk about that, you understand. Some of them will tell you that, "no I was messing around with a lot of women, look I was like this" he's comfortable saying that to another man but to a woman, it's not going to be easy for him. So there was a difference there when you have a patient has been transferred from a female CCW then to you, you'll see there is difference there.' (Lebo, Male, CCW)

Thobani echoed Lebo's sentiments, articulating how men share more easily with other men about issues of sex and lifestyle.

'You are not afraid to say something that you feel. Let's say you have got an STI, you got it from someone else, you can explain to other guys "I've got this by doing this and this and this". Other guys they can explain you, how to prevent it for the next time. If there are women, we feel afraid.' (Thobani Ncapai, Male, HIV activist and researcher)

Sam, spoke of the unique support that male CCWs can provide to male clients because of this ease of sharing personal information:

*'There are sometimes they don't feel free to talk everything to the women, even if one of (the female CCWs is available)… I better go to do the home visit. When I'm there he will be free to talk….*Yes, *because if I'm talking to another man, they feel free to talk to me. Maybe that one has got some STIs, so that one will not feel free to talk about everything… especially STIs. That's why we need more men to come forward*.' (Sam, Male, CCW)

There is a body of literature that suggests that the way that men relate to one another is constrained by hegemonic norms of what it means to be a man. Socialization into traditional masculine attributes such as avoidance of openness,

displays of personal vulnerability and other 'feminine traits' hinders emotional intimacy between men (Lewis 1978). Similarly, a factor within gender role conflict for men is 'restrictive affectionate behaviour' in which men are uncomfortable with expressions of caring and being very personal with other men (Wisch et al. 1995). In addition, Kerssens et al. (1997) found that both men and women preferred female health care providers in the fields of 'humane-oriented' professions such as social workers and nurses. The '*Men who Care*' study (Barker 2012) also revealed that the presence of men in spaces perceived as female were met with mistrust by some clients and fellow workers.

One participant also held this belief, speaking to male client preferences for female CCWs:

> 'T*here's a client that is not accept the men. They want to visit with a CCW of a woman... (men) they really prefer a woman because they can easily speak to the women, but with men they don't think they can speak*.'
> (Thabang, Male, CCW)

Thabang's perspective and the aforementioned literature are seemingly contrary to the overall study findings that many men prefer to work with male CCWs. There are certainly a variety of factors that play into client comfort and gender preferences. Despite the presence of many factors that hinder supportive connections between men, the unique and highly intimate nature of HIV care work may explain why many men prefer gender concordant CCWs.

As Vale (2012a) argues, the naturalization of women in care giving makes female CCWs more acceptable than their male counterparts. However, this is mitigated by '*care that involves instruction, reprimanding, and constant probing into intimate bodily and behavioural functions*' which is not '*easily ingested when delivered by young women*', especially when clients are older and male (Ibid, 9). These very power dynamics, coupled with the level of intimacy of health services, plays a substantial role in gender concordant client preferences and will be explored later.

Gossip
A belief that female CCWs gossip with other women was often given as a secondary reason for male client's gender concordant CCW preferences. Gossip and the fear of gossip have been well documented as a reason for South African patients not wanting to seek services or disclose their HIV status (examples include Maughan-Brown et al. 2006 and Lane et al. 2008). Studies specific to men and gossip have documented HIV positive men's fear gossip (Mills, de Paoli and Grønningsæter 2009) and their non-disclosure for fear of gossip (Dageida, Govender and Gordon 2012). Vale (2012a) found that clients in general are distrustful of CCWs because many believe that they gossip.

Most relevant to these findings is Faull's (2010) study of men attending a men's clinic in Khayelitsha. This research revealed that some men do not trust female health workers for fear that they will gossip and disclose their HIV status. The implicit belief is that men are more trustworthy in this regard. *'So they feel like women will walk around and talking about them to their friends or whatever.'* (Lebo, Male, CCW)

William paraphrased one of his client's responses to his query about why he didn't ask certain questions to women*: '"we all know women. They speak to you now and the next morning the topic is on the street."'* (William, Male, CCW)

Gossip is linked to HIV stigma and fear of stigmatization, which are barriers to the success of HIV interventions. The way that stigma affects men is different to how it affects women (Beck 2004, Wyrod 2011, Colvin 2010). An HIV-positive status is often seen as an obstacle to conforming to hegemonic masculine norms of respect, status and strength because it is considered to be a barrier to breadwinning, having intimate relationships and children (Wyrod 2011). HIV status, compounded by conventional views of male identity, fear of shame, isolation of loved ones and secondary stigma (stigma by association) makes acceptance and disclosure difficult (Iwelunmor, Sofolahan-Oladeinde and Airhihenbuwa 2014). Simbayi et al. (2007b) found that HIV positive men reported more internalized AIDS stigma than women, were less likely than their female counterparts to discuss their HIV-status with friends, more likely to have lost a job or place to stay and more likely to report being treated differently since they tested HIV positive. Their findings also correlated with research that shows that men report less social support than women and are more likely to use alcohol and drugs to cope with depression rather than seek support (Ibid).

In addition, clients may see their HIV positive status as diminishing their sexual desirability (because it can be sexually transmitted), and therefore their conformity to hegemonic masculine norms. Lebo spoke of this:

> *'Say you are a CCW and I'm in the community. Now I'm HIV-positive and before I go to the clinic, I used to see you in the community right? And perhaps I had a crush on you or something like that, and now... you become my PA (CCW). You can imagine how uncomfortable am I going to feel about that. Perhaps, I even called you the other day and asked for your number, and asked for a date, and now here I am in the clinic. You are my supporter. It's totally awkward... now I would never even try to date this woman any more because she understand my status. She knows what's going on with me, she knows I'm sick.'* (Lebo, Male, CCW)

This 'awkwardness' that Lebo speaks of is also addressed by Vale (2012a) in her critique of the CCW model in which CCWs and clients live in the same communities. She argues that the proximity between care workers and clients '*militates against social distance, demystifying the ascribed authority of appointed CCWs*' (Ibid, 2).

The construction of 'feminine' and 'masculine' is essential in a gender-dichotomous sexist society (Courtenay 2000). The feminine is all too-often considered to be of lesser value than, or subservient to the masculine. Health-seeking behaviour is one way in which men can perform to hegemonic masculinities (Ibid) because suppressing health needs and refusing to admit or acknowledge pain is a way that men can acquire power (Kaufman 1994). Indeed, the denial and disregard of health care needs and physical discomfort are a way that men can differentiate themselves from women, prove their superiority and rank themselves among men as 'real' men (Courtenay 2000).

The patriarchal dividend is the advantage that men, as a group, receive for maintaining an unequal gender order (R. Connell 2009), which is accomplished, in part, through subscribing to hegemonic masculinities. This is seen in the way that male clients maintain power and authority over women by refusing to accept female CCWs.

Many participants spoke of male client's unwillingness, or sometimes flat-out refusal to work with female CCWs. William narrated one such story from his personal experience:

> *'…one of my colleagues… she asked me "William please come and speak to this gentleman about STIS, safer sex, and HIV… the man refuses to listen". He asked her to call a male because he's uncomfortable with her asking the questions so I had to do it, just to put the man at ease… When it comes to sexual questions, or STIs or HIV if there's no male then the male will back off … (*he will say*) "if you can't get a male then I'm not going to answer you". And we have to respect that because it's their choice. You can't go over their head and just make them listen, you have to respect them.'* (William, Male, CCW)

Similarly, Sam also spoke of how he steps in to visit male clients who don't want to work with female CCWs: *'In some cases, they* (female CCWs) *come to me and reports that there is a problem there* (with a male client)… *So I stand up and visit that person.'* (Sam, Male, CCW)

Mansfield, Addis and Courtenay's (2005) study on men's help-seeking found that the traditionally masculine factors of autonomy and self-reliance inhibit men in seeking help. They noted reactance, the process of seeking '*to preserve and reestablish autonomy when they sense autonomy is threatened*' (Brehm 1966) as a way of re-conforming to hegemonic norms of masculinity (Mansfield, Addis and Courtenay 2005). In the case of male clients giving female CCWs a hard time or rejecting them outright, it is possible that they are re-establishing their sense of autonomy by undermining their CCWs. In Vale's (2012a) study on authority and CCWs, she posits that gender is an important factor in the complex dynamics of authority between the

CCW and client. She points out that women account for a substantial portion of CCWs and that the poorly valued nature of women's labour serves to undermine their work (Ibid). Adding to these challenges, the home is one place where such power dynamics are reproduced and is the primary site where CCWs and clients negotiate their relationships (Vale 2012a). Women giving instructions and monitoring older, male patients on an intimate personal topic transgresses gender hierarchy where men hold the balance of power. The findings of this study agree with those of Vale:

> '*One of my colleagues told me that some men don't like a female to come and visit and check on them… Most of the men would prefer a man. They will ask for a male. Especially the eldest, the elderly men, they will ask for a male.*'
> (William, Male, CCW)

Similarly, in his 2012 study of disclosure and masculinity, Mfecane (2012) found that men are reluctant to test and disclose their status for fear of being seeing as weak and dependent for their health-seeking. He posits that part of this fear is that their health-seeking would '*subject them to control by 'young' women*' (health providers) (Mfecane 2012, S111).

The findings of these two local studies (Vale 2012 and Mfecane 2012) clearly show that some male clients do not want to work with female CCWs because this subverts the command of hierarchy. Similarly, Beck (2004) argues that authority is required in compelling HIV positive men to health-affirming behaviour. Despite other findings in this research showing that male CCWs often work in a non-authoritative manner, the very presence of a male body is likely to be read by clients as carrying some authority which the female body does not.

The rejection of female CCWs follows the same argument used in chapter four to explain why some male clients create barriers to working with CCWs. If hegemonic masculinities require male clients to perform to physical toughness and act unemotional, independent and self-sufficient, they are likely to feel highly uncomfortable working with a CCW whether male or female. Their discomfort may find expression in the ways they resist behaviours contradictory to hegemonic masculine norms such as speaking about issues of health and receiving support from CCWs. In extreme cases, this resistance was also expressed in rejecting, or threatening violence against female CCWs.

Just as rejecting health-affirming behaviour is a rejection of that which is feminine, undermining the abilities and authority of female CCW may also serve the same purpose. This push-back can reinforce cultural beliefs that men are more powerful and less vulnerable, that men's bodies are superior to women's bodies, that asking for help is feminine (Courtenay 2000) and that men's work is more valuable.

Thus a very complex picture of male client preferences for male CCWs emerges.

This paper has explored three deeply intertwined explanations as to why many male clients may prefer working with male CCWs:

1) A degree of comfort and understanding in working with a gender concordant CCW due to the intimate nature of HIV: This is consistent with international literature stating that gender concordant preferences for health providers increases with the level of intimacy of the issue being addressed.

2) A fear of female CCWs gossiping: This supports local literature on health service provision.

3) Being subject to the authority of a woman may be uncomfortable to some men: Indeed, men tend to be placed in positions of power and authority over women. This subversion of hierarchal power dynamics may be deeply uncomfortable to some men, especially if they are already feeling emasculated due to their illness. This is consistent with literature on local literature on men receiving SRH services.

Alternate Perspectives

It is important to also consider the alternate perspectives put forth by some participants in relation to CCW gender preferences. Two male clients indicated that the gender of the CCW did not make a difference to them:

> *'If there was a woman, I'd feel the same because she's just doing her work.'*
> (Jaap, Male, Client)

> Interviewer: *'Can you talk to women in the same way you can talk to a man?'*
> Siseko: *'Ya I can talk to her, it will not be like that'.* (Meaning here that he will not have a problem with speaking with her about his SRH needs) (Siseko, Male, Client)

These interviews were each conducted in the presence of the client's CCW, in one case a man and the other, a woman. Following both interviews, the CCWs pulled me aside. They explained that they believed that their clients were providing 'gender neutral' answers because they thought them to be appropriate. In other words, the suggestion here is that the presence of the researcher was generating social desirability bias in interviews with some clients in the presence of their CCWs. Without other indicators, there is no way of verifying if this is true. Social desirability is the '*tendency to respond to questions in a socially acceptable direction*' and it '*occurs mainly for items or questions that deal with personally or socially sensitive content*' (Lewis-Beck, Bryman and Liao 2004).

In reflecting on the International Men and Gender Equality Survey (IMAGES), Ratele (2014) posits that findings point to '*men's positive, but ambivalent and resistant gender attitudes*' (p. 510). He argues that gender equality discourses may influence men's support of gender equality '*in the abstract*' but that gender inequitable attitudes still prevail. He cites social desirability as a reason why men may not practice gender equality in their own lives, but still answer questions in acceptable

ways. It is possible that Siseko and Jaap's responses reflected their desire to perform to social desirability in the presence of myself and their CCW.

It wasn't just the aforementioned clients who differed from the commonly held belief that male clients prefer male CCWs. Despite all Fisantekraal participants' indications that male clients should be allocated gender concordant CCWs so as to avoid female CCWs being harassed, three of four did not believe that male clients prefer working with male CCWs. As previously mentioned, one believed that male clients prefer to work with women. The other two believed that the gender does not matter to the client: *'On my side, women and men with me, I see them, they are open. I see no problems.'* (MJ, Male, CCW)

Findings of a 2009 study by Bertakis et al. demonstrated that although gender can affect interactions in patient-physician relations, other unmeasured elements such as personality and social expectations are important (Bertakis, Franks and Epstein 2009, 545). Despite being an American study focusing on physicians rather than CCWs, these findings are relevant here. There was not uniformity in participant's preferences and experiences, although gender concordance was oftentimes noted as preferable. This speaks to the presence of other beliefs, personal preferences and perhaps other unexplored factors that did not emerge clearly such as cultural norms and varied levels of stigma and discrimination between communities. For example, CCWs in Fisantekraal were the only ones holding different views on client's CCW gender preferences. In addition to being a newer, more rural and culturally mixed community, stigma appeared to be rife here. CCWs from this community did not wear uniforms due to high levels of stigma, and some mentioned that they believe that gossip, stigma and discrimination are more pronounced in Fisantekraal than in other communities. Observations of home visits conformed to this, which were much shorter and more formal in nature. Fisantekraal was the only place where participants mentioned violence against female CCWs and the only place where they spoke of referring clients to social workers rather than discussing social problems themselves.

The reasons for many men preferring male CCWs are also complex and may include a variety of factors not explored in this study. How clients and CCWs identify with hegemonic or alternative masculine identities may also play a role. Indeed, gendered allocations of roles and responsibilities can be contested and are interwoven with '*a range of complex and shifting sentiments'* about gender and relating (Ratele, Shefer, et al. 2010). As such, there are complex and differing factors which influence the importance (and experience) of gender and gender preferences for clients. However, the strong positions, experiences and stories from the majority of participants and their call for more male CCWs deserve additional attention.

Responding to the call for more men to come forward

The majority of participants believed that male clients are best supported by male CCWs and hence that the community and KI would benefit if they employed more men. This section situates findings within a gender transformative agenda, and explores the potential challenges and benefits of involving more men as CCWs. In doing so, there are three main considerations to highlight: 1) the practical matter of supporting male clients for improved health outcomes; 2) the complex power dynamics in which male clients negotiate power with CCWs; and 3) the potential for gender transformation through the non-traditional brokering of relationships between men and the demonstration of more caring masculinities.

To illustrate these considerations, let us use an example cited often by participants: that of a male client refusing to work with a female CCW.

If we were to consider only the care worker's primary function of adherence support, it would follow that the care work organization should make efforts to provide the client with a male CCW. This logic could be applied to other client requests such as afternoon visits - if possible, the organization would meet the client's needs in order to provide the most amenable care services.

In considering the issue in light of the complex power dynamics of male dominance and the related undermining of women's work, a different picture emerges. Looking at the situation from a solely structural perspective, having a male CCW step in to work with the client may reinforce beliefs around male power, authority and superiority. By doing this, the male CCW's work may be valued over his female counterparts, in congruence with patriarchal power structures. Indeed, male power and privilege can be present even in female-dominant occupations (Williams 1995).

Both of the above readings of the situation are plausible, but overly simplistic. As articulated above, many male clients prefer male CCWs for a variety of reasons, and their motivations for doing so range from embarrassment to feelings more closely related to expressions of male power. A pertinent question, then, is whether it is possible for male CCWs to support male clients' health-affirming behaviour while promoting more gender equitable masculinities.

## The case for male care workers and gender transformation

Gender transformative approaches aim to alter discriminatory and biased gender practices, policies, beliefs and ideas (Betron et al. 2012) and have the ability to create more gender equitable environments and change men's behaviours (Sen, Östlin and George 2007 in Stern 2013). Barker (2005) argues that shifting harmful gender norms and creating more gender equitable relationships could be effective in preventing HIV transmission. Engaging men in such approaches in HIV prevention efforts creates an environment in which men can consider how gender inequalities can also be harmful to men (Clowes 2013 in Stern 2013).

A growing body of research has shown that efforts to engage men via well-designed health and social services have proven that men and boys can and do change (Levtov et al. 2014). Indeed, the very notion of male implacability is in itself condescending, narrow and dismissive of agency. Specific to caregiving, Shefer (2014) argues that men's engagement in care might be a 'key strategy' for challenging the social devaluation of care practice. This engagement can also contribute to the larger gender change project by challenging gender inequality and problematic hegemonic masculine norms (Ibid). Similarly, Hzenjak (2013, 358) suggests that including men in care work can foster more caring, gender equitable masculinities, desegregate the labour market, relax gender-binary stereotypes and transform traditional masculinities. Morrell and Jewkes (2014) also promote encouraging and supporting men to undertake care work because of its ability to change gender norms and constructions of masculinity. They argue that this is specifically relevant in South Africa for two reasons: (1) there is a need for more carers due to large numbers of sick and disabled people because of high rates of HIV infection, violence and injury and; (2) that South Africa has a policy environment conducive to gender equality but still has high levels of gender inequality and violence (Morrell and Jewkes 2014, 326). This provides space for '*kinder, gentler, masculinities'* to be constructed through the entrance of men into care work (Morrell and Jewkes 2014, 326). Hzenjak (2013, 359) found participant experiences of caring to '*loosen men's identity formations within the limits of hegemonic masculinity and leave them greater opportunity for alternative ways of being male*.'

In her study on how 'tradition' is re-invited, Sideris (2004) posits that it is through practice that new ways of relating are produced. In concordance with the above studies, she finds that social support is fundamental to developing alternative masculine practices and shifting power dynamics. Similarly, the IMAGES study findings suggest that it is necessary to create lived experiences of gender equality through structural and policy approaches as well as to take programmatic approaches that change attitudes (Levtov et al. 2014). Engaging male clients with male care workers who demonstrate alternative, more caring masculinities provides an entry point for the modeling of more gender equitable practice and better health-seeking behaviour. Likewise, involving and supporting men as CCWs within a gender transformative agenda can provide for entry points to create lived gender transformative experiences in both health-seeking behaviour and through caring.

A model entitled *Building Male Involvement in Sexual and Reproductive Health Rights* was developed by Sonke Gender Justice with an aim to achieve gender equality through including men in SRH. It puts forth that 'the ideal' for gender transformation is for men to be involved as clients, as equal partners and as agents of change (Sonke Gender Justice 2012). In this model, the involvement of men in health promotion and service delivery is considered to be fundamental to achieving better health outcomes. Thus, engaging men as CCWs could be interpreted as men's involvement as agents of change. However, without such involvement in other areas of their lives, this might not create an ideal environment for gender transformation.

As stated by Williams (1995), men's working in feminized jobs 'does *not by itself necessarily mean actual transformation of the existing gender regime*'. As per Ratele (2014), gender equality may exist in the abstract and not result in changes in practice.
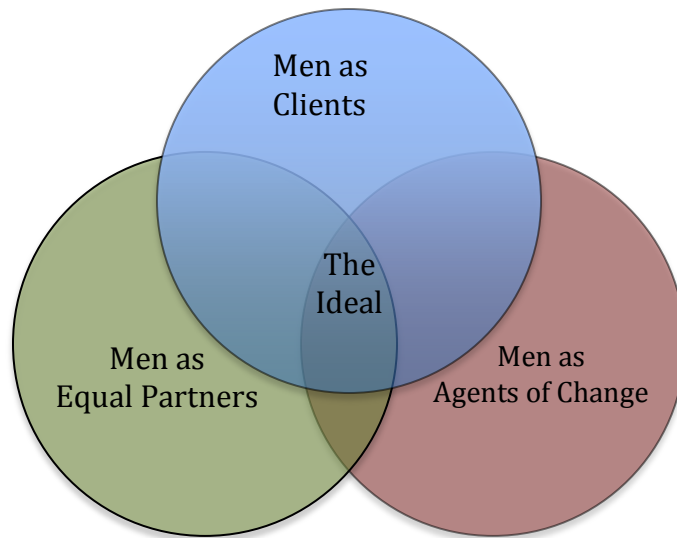
Building Male Involvement in Sexual and Reproductive Health Rights Model (Sonke Gender Justice 2012)

Grounding care work in gender equitable practice

Highlighting men who care

It is not enough just to call for more male CCWs. As outlined above, paying lip service to men in caring and actually creating gender transformative experiences via men in caring are two very different things. Men's commitment to gender equality requires that carers resonate emotionally with their work, demonstrating an emotional and/or political commitment, rather than interpreting care solely as a functional activity (Morrell and Jewkes 2011). Such resonance signals that this care moves beyond an abstract support for gender transformation into practice.

The different interpretations of care by the study participants could be observed beyond just the interviews. Indeed, their level of engagement with clients in and outside of home visits spoke to their interpretations of care. For example, some spent a significant amount of time engaging with clients' emotional and material needs such as helping with grant applications or listening and providing advice, while others counted pills quickly and left. Some participants displayed a high level of resonance with their engagement in care work both within and beyond their jobs. For example, when Lebo and I saw each other for the first time in three years, he updated me on the important developments in his life by showing me pictures of his two-year old daughter and the youth club he started in his community. Before and

after interviews, William spoke effusively about his volunteerism, which includes public speaking about HIV and participating in local politics.

Building cases of men already promoting gender norm changes provides vast scope for promoting gender equity (Levtov et al. 2014). Peacock (2009) argues that it is counter-productive to promote the view that men will not be involved in care work. He posits that highlighting negative masculine norms serves to reinforce gender role stereotypes that leave women with the burden of care (Ibid). Contrarily, making men's care giving visible has the potential to shift social norms and increase men's involvement in caring (Ibid).

In her reflections on the findings of the IMAGES survey, Shefer (2014) questions how successful work on engaging men and boys for gender equality in South Africa has been. Similar to Peacock, she recommends a refocus away from the negative aspects of hegemonic masculinity. Instead she recommends a focus on ways in which men are already practicing more gender-equitable masculinities, resisting harmful gender norms and strategically engaging with and acknowledging equitable, and constructive practices such as taking part in feminized labour. Lebo shared a similar sentiment. He believes in the importance of showcasing gender equitable men who are positively involved in their communities:

> *'In the communities, there is the role models, there is the guys that are doing good, but nobody's talking about them. Which is the other problem I have… with the media and whatever. Because sometimes they focus on the negative and they don't focus on the positive. Most of young boys… the people that they talk about and they look up to are those people that are doing wrong things. And they end up following them because they are the only people that they have been exposed in the communities… it's like when they talk about a guy who's selling drugs, that guy will be having a nice car, having a nice house and stuff. But they will never talk about the guy who doesn't have all that stuff but who is living a very good life in the community, who's doing good perhaps in trying to help other people… Because you can't just get a youngster to change to good if there is nothing that inspires him or motivates him to go into good. You need to show him good so he can go into good and if you show him bad, he will look for good in bad.'* (Lebo, Male, CCW)

Some of the men in this study are positive role models and are involved in gender transformative work in their communities. Let us now look at them.

Participant experiences: Conviction, transformation and (re)constructing care as masculine

The findings from this aspect of the study are consistent with the body of literature that shows that involving men as care givers has gender transformative potential. That some men chose to enter into caring out of a spiritual, religious or political conviction (Morrell and Jewkes 2014) was evident in this study. Quotes by William,

MJ and Sihle are demonstrative of such conviction, which focused on supporting the wellbeing of individuals and the communities in which they live:

> '…making a difference in somebody else's life, it means a lot to me. Even the person can't take the first step, and I'm there to help the person take the first step… I did find my calling because I love working with people and especially those who can't help themselves.'
> (William, Male, CCW)

> 'So I uplift in my job that I am doing and I am glad that I'm helping my community… I'm glad that the people also they are overcoming together to help each other.'
> (MJ, Male, CCW)

> 'We need what I call 'sacred activism'. Sacred activism is an activism that is free from any material possession and puts the wellbeing of people first. And its what I am practicing because I see myself as a resource to improve the lives of other people. So I'm like this open channel of the universe, for each now to showcase the goodness. The goodness it has to the broader society.'
> (Sihle, Male, Masculinities NGO founder and activist)

In addition to demonstrating these men's conviction and emotional resonance with their work, these quotes also demonstrate certain masculine traits that they ascribe to. Participant's emphasis on the value of their work in other's lives is in line with the '*the masculine imperative 'to do'*' (Davies and Eagle 2010). They see their work as valuable because they are '*helping their communities'* (MJ), acting as '*resources to improve the lives of other people*' (Sihle) and '*making a difference in people's lives*' (with an emphasis on those who cannot help themselves) (William).

Taking responsibility for the welfare of others is a highly valued characteristic in certain hegemonic masculinities (Davies and Eagle 2010). Khuleka, a men's Gugulethu-based support group interpreted 'responsibilised citizen' messaging as caring for themselves and the social through active membership in their families, communities and social movements (Colvin 2010). The concept of 'therapeutic citizenship' was first coined by Nguyen (2005) and Robins (2008) introduced the term 'health citizenship' into the South African context.

Men in occupations that have been constructed as female tend to maintain their hegemonic identity and values (Williams 1995), with men in paid care work tending to distance themselves from the nurturing and feminine aspects of care, emphasizing instead the '*masculine qualities of caring*' (Hanlon 2012). Hzenjak's (2013) findings on male care workers in Slovenia agreed with this - participants did not define themselves differently from hegemonic masculine norms although they did develop and negotiate ways to perform their caring through a masculine lens. Likewise, in Davies and Eagle's (2010) study of young South African male volunteer counsellors, participants construed their identities as CCWs as proactive and

dynamic in relation to their work. These findings were similar to this study, where participants emphasized the importance of their work and the impact that it makes in their communities. Not one participant mentioned feeling that his gendered identity was challenged by the nature of his work, although some did speak about the importance of demonstrating different ways of 'being men'.

Participants in the study demonstrated varying levels of emotional resonance with their work. Lebo resonated strongly emotionally with his work and demonstrated a commitment to modeling alternative ways of being a man:

> *'I think I was a role model (to clients) in a way because healthy lifestyle is what I'm living. I know that most of the times when I was doing the interviews, when I was there with the client, talking to them, I would make an example about myself like um, when you talk about drinking and all that stuff, I'm not drinking and I would talk about myself and say… 'I'm not drinking and I think you could also live the way I'm living. I'm not smoking and you could live in that way'. And obviously the matter of having a lot of partners, it was something that you need to talk about and you need to practice it. If they see me having a lot of partners and I still tell them that 'you can't have' but I'm doing it, it wouldn't make sense … that's the life I was already living and I saw my life as an example that can help them.'* (Lebo, Male, CCW)

In contrast, Roberto takes a more duty-based approach, clearly delineating his work from his personal lifestyle:

> *'I'm working from Monday to Friday from 8 til 4. My clients during the week, what I'm telling them must not reflect on my weekend, my personal lifestyle. So what I tell them, what we talk in the clinic stays in the clinic. But you see me outside the clinic, it's my life'.* (Roberto, Male, CCW)

These cases speak to the different understandings of duty associated with being a CCW. As previously discussed, it is the emotional resonance with work, combined with practice that has the most gender transformative potential.

Some participants told stories of the impact that working with male CCWs had on their lives. Jaap, a client of William, contracted TB for the first time in prison and became re-infected twice after. He spoke of how William inspired him because he also had TB many times and was presently in good health. He also spoke of how William's care had affected his life beyond his health:

> *'Ja, for me it's nice because somebody came out to me and showed me that somebody cares about other people… and (when) somebody cares for me, I also cares for him… If he comes, I can sleep, I can do anything. I will stand up, I will go to him because he's doing his work. I respect his work and I respect himself because he cares about other persons.'* (Jaap, Male, Client)

Sihle, a former gangster founded the organization 'Brothers for All' after being released from prison after 11 years. His work now rests on his commitment to modeling alternative, healthier and more gender equitable masculinities. He believes in the importance of men working in non-traditional masculine fields and role modeling for each other:

> *'I'm one beneficiary of a peer education model. As peers, and as men, we are able now to talk to our peers, change their perceptions, change their beliefs. you understand? But we need other men to stand up and start the journey. You understand? Then other men will draw from and be inspired by that.'*
> (Sihle, Male, Masculinities NGO founder and activist)

These two quotes serve as examples of the transformative potential of men's caring. Through receiving care from men in their lives who modeled different masculine ideals, Sihle and Jaap embraced alternative, gentler and more caring ways of being men. Through working with William, Jaap embraced more health-affirming behaviours and learned the importance of speaking about his feelings (as discussed in chapter four). Sihle changed his career and now runs an NGO called 'Brother's for All' which models more gender equitable and health-affirming masculinities in Langa where he lives.

However, as Reihling (2013, 104) points out, the '*work does not stop with becoming a health and human rights activist or a sudden transformation into a "gender equitable" individual*'. Indeed, a person can always choose from a number of options based on the situation. Gender equality efforts must address the factors and circumstances that contribute to rigid and harmful gender norms as well as the role that men play in challenging and perpetuating them (Levtov et al. 2014, 495).

Conclusion
'...the manifold axes of age, identity, economic and social class, education and health status (to name a few) feed into inertias and movements around care, welfare and social cohesion' (Meyer et al. 2014, 395)

This chapter explored male clients' preferences for the gender of their CCWs and the underlying reasons for such preferences. The current literature on men and care work suggests that care work may create lived experiences of alternative, more caring masculinities. The findings outlined above agree with this literature - male CCWs have the potential to go beyond supporting individual male clients to contributing to gender transformation. This chapter has described participant perspectives on their work, including cases where CCWs have strong personal conviction and emotional resonance with being a care worker.

However, meaningfully involving men as CCWs is complex as their work is informed by a variety of factors, including the very gendered power dynamics that are being

challenged. Thus, involving more men as CCWs is not an end in itself, but providing men with lived experiences that enable them to challenge harmful hegemonic masculine practices in themselves and others could be. In order to do so, significant barriers such as pay and gendered constructions of care work must be overcome.

Chapter 6: Conclusion

'Care matters, even as its meanings, effects and reach often go unacknowledged, or recognition for its significance is withheld.'
(Meyer, et al. 2014, 395)

The stories and perspectives of the participants are rich, complex and point to the need for a greater recognition of the potential of men in care work.

The findings suggest that CCWs work with male and female clients differently. With male clients, they aim to interact in ways that do not challenge hegemonic masculine norms by using techniques such as speaking indirectly about sensitive issues, acting friendly and being clear with the purpose of their visits. In this way, they navigate around hegemonic masculine norms that require men to act tough and suppress emotion. Through using these tactics, CCWs may avoid making male clients feel like they need to compensate for their reduced 'masculine power' or non-conformity to hegemonic masculine norms stemming from their illness. As a result, CCWs may avoid situations where clients assert their hegemonic masculine identities through expressions of anger, 'stubbornness', silence or by undermining their CCW's authority.

Male client preferences for male CCWs demonstrate that gender concordant CCWs may play an important role is supporting HIV-positive men. The reasons for some male clients' preferences for male CCWs include comfort in sharing intimate health information with someone of the same gender, a fear of women gossiping and gendered power dynamics that make receiving direction from women uncomfortable.

As the literature suggests, involving more men in caring has the potential to transform gender norms if male carers possess conviction for their work and ground their gender equitable beliefs in practice. Examples of this were seen in cases of participants who had been deeply affected by their experiences of caring for, and receiving care from other men.

This research combines conceptual frameworks by integrating literature on gender, masculinities and HIV with that of community care work and men in caring. Through doing so, it aims to contribute to expanding this critical but small body of literature. The context of this study is multifaceted. Complex gender dynamics are interwoven with other complicated factors such as high HIV prevalence, restrictive socio-economic conditions that preclude comprehensive access to care, and the decentralization of the ART program. At the same time, the issues of patriarchal hegemonic masculine norms, health and caring are issues of global importance. Men worldwide have poorer health behaviours and participate unequally in caring which is damaging to men, women and societies at large.

This study speaks to the potential of involving more men as CCWs to improve HIV positive men's health outcomes and to ground men's caring in practice. It considers the ways that men conform to and reject hegemonic masculine norms and provides an overview of the challenges and benefits of involving more men in paid care work. Despite the challenges that men face while navigating care relationships, such relationships have the potential to support clients' health-affirming behaviour and to contribute to more gender equitable masculinities. It is not just the presence of more male CCWs, but also the practice of male carers expressing gender equitable beliefs through action that will contribute to gender transformation. Such practice has the possibility to shift dominant beliefs and practices around men, health-seeking and caring.

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