



SUPPORTING MEN
IN HIV PREVENTION,
TREATMENT AND CARE



Men who Care: men's motivations in taking up positions in community mobilisation organizations in Gugulethu to improve the public healthcare system



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Part 0: Preamble

DECLARATION

I, *Samantha Malunga DCKSAM004*, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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DEDICATION

To the Malunga Molecule, may we be the academics, the doctors, the engineers, and the loving people we strive to be.

Ad maiorem Dei gloriam inque hominum salute

THESIS ABSTRACT

Many men in South Africa (SA) want to participate in improving their community. Having lived in the community, they are more attuned to the immediate needs of the community - and male members of the community's needs in particular - compared to NGOs or external support systems that may try do social development work in SA. There is a great opportunity to include more men in community mobilisation (CM) work and health systems strengthening programs in SA and beyond. Historically, volunteer work, including CM has been seen as a job for women. There are fewer male volunteers in CM than there are female volunteers; hence, more research has been conducted around female volunteers' experiences and motivations. In order to support the greater inclusion of men in volunteer work, this mini-dissertation explores men's motivations to participate in CM work.

This mini-dissertation is divided in the following three parts. A research protocol (*Part A*) which focuses on understanding the motivations of male community mobilisers who are involved in activist community work in the Gugulethu Township. A literature review (*Part B*) which examines existing literature on volunteer work and how gender affects experiences of, and motivations to volunteer. Lastly, a manuscript for Social Dynamics (*Part C*) that focuses on the gendered experiences and motivations of men who participate in CM work in the Movement for Change and Social Justice (MCSJ), a community organisation in Gugulethu, Cape Town.

The knowledge gained from this mini-dissertation can feed into the larger debate present in SA surrounding the need for more male-centred interventions in the public healthcare system and aims to show how the visibility and representation of male volunteers in the health system can have a positive impact on men's health seeking behaviours in communities through increasing their linkage to and retention in care.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CHWs	Community Health Workers
CM	Community Mobilisation
GUSTO	Gugulethu Ibhongolethu Sports Organisation
HIV	Human Immunodeficiency Virus Infection
HREC	Human Research and Ethics Committee
iALARM	Using Information to Align Services and Link and Retain Men in the HIV Cascade
MCSJ	Movement for Change and Social Justice
MSF	Medécins Sans Frontières
MWC	Men's Wellness Centre
PEPFAR	The President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child Transmission
SA	South Africa
SCT	Social Cognitive Theory
StatsSA	Statistics South Africa
TAC	Treatment Action Campaign
UCT	University of Cape Town
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNICEF	The United Nations Children's Fund
WHO	World Health Organization

Part A: Protocol

1. Background

1.1 The gendered nature of voluntary health promotion work

The act of community mobilisation action around uptaking healthcare may be perceived as falling under the duties of the women in the community, because of gendered expectations associated with the socialisation linked to one's biological sex (Dworkin, Fleming & Colvin, 2015). Such expectations from people gendered as women has allowed for women to then transition into roles in NGO work, if they so wish, and in community mobilisation - albeit at lower ranks such as grassroots level activist roles.

It can be perplexing therefore, when men perform the role of community mobilisation around promoting the uptake of healthcare and when they advocate for the wellness of members of the community; questions around their motivations may arise. This is because such an action could also be seen as falling under the duties of the women in the community as non-paying reproductive labour (Akintola, 2006; Swartz & Colvin, 2015). Reproductive labour can occur both in the home and within the broader community. Although not always termed as 'reproductive labour', certain tasks can be associated with the term such as: taking care of sick people in the community, raising awareness about sicknesses, being the first point of call for many people when one falls ill in the home, mobilising around advocacy, general community mobilisation, and being a voluntary health care worker. These forms of reproductive labour tend to be seen as roles taken up by, and 'fit for', women.

Men's motivations for taking up community mobilisation and volunteer work have been, historically, an under-researched area, but could be beneficial to understanding their motivations within the South African context where positions of health care work in socio-economically disadvantaged peri-urban settlements tend to be voluntary. It may be confusing to see a man take up a position of caring in a community for little, or no pay in a world where hegemonic masculinity (Morrell, Jewkes & Lindegger, 2012) influences the way men are viewed and what roles they can occupy and embody. It follows then, that when men are seen in roles within community mobilisation at a grassroots level, it does not immediately fit with understanding of constructions of masculinity and maleness (Hrženjak, 2013) when in that space, men have the agency for upward mobility to take on roles at higher levels of activist organisations. However, since gender is not

static, nor is it linked to biological sex, and therefore attributes associated with a certain gender are not limited to appear in one biological sex (Bohan, 1993; Crawford, 1995) men can perform acts of ‘feminine’ labour too.

1.2 Voluntary health promotion work in Sub-Saharan Africa

Current major HIV/AIDS interventions running in Sub-Saharan Africa are often focused on women and children (PEPFAR, 2007; UNICEF, 2010; UNAIDS, 2014). The knowledge gained from this study will feed into the larger debate present in South Africa surrounding the need for more male-centred interventions (Cornell, McIntyre & Myer, 2011) in the public-sector healthcare system, when working with HIV/AIDS. Men in South Africa have been noted as being less likely to get tested for HIV, compared to women. There is a growing spirit of activism around HIV in Sub-Saharan Africa, that does not portray men as propagators of HIV infection, and gives men a space to take part positively, in combating HIV in communities, particularly when it comes to the translation of policy that calls for greater inclusion of men’s engagement in sexual and reproductive rights (Cornell, McIntyre & Myer, 2011; Ratele, 2014).

Patriarchy (Bradshaw, 1994) not only oppresses the women and children in a situation, but the men too. There have been numerous research reports painting men as perpetrators of sex and propagators of HIV within literature about sub-Saharan Africa (Bingenheimer, 2010; Jewkes et al., 2010). Men have often been portrayed as ‘bad’ patients in HIV care; as a large proportion of men in South Africa do not go for testing, drop out of care if they have accessed it, and are non-adherent once they start on ART, if they start at all (Siu, Wight & Seeley, 2014). Such reports reinforce negative assumptions that *all* men embody and support hegemonic masculinity, which is the ideology that men are meant to be in a position of dominance, compared to their female counterparts, resulting in the rightful subordination of women (Connell, 2005). This is incorrect. Masculinity is layered, complex and multi-faceted. It needs to be viewed through an intersectional lens.

Hegemonic masculinity ‘is a necessary and integral element of patriarchy’(Jewkes & Morrell, 2010). Viewing hegemonic masculinity as the ‘right’ form of masculinity means invisibilising men of colour, men with disabilities, men who do not conform to heterosexual leanings and other such marginalised forms of existence (Barker & Ricardo, 2005), and considering them inadequate and

therefore not a part of heteronormative masculinity (Jewkes & Morrell, 2010). That means that within hegemonic masculinity, such men are not viewed as being on the same level of power and domination, when they embody such marginal characteristics. Therefore, hegemonic masculinity is one of various forms of intersectional understanding of masculine performance (Crenshaw, 1991), such as the masculinity embodied by the men who I will be focusing my research on; men who perform acts of care within the community through activism and community mobilisation. See more in the methods – inclusion criteria section.

Within South Africa, Morrell and Jewkes (2014) touch on issues of embodying sickness while still navigating the complexities of hegemonic masculinity, in their article on health care workers and their male patients (Morrell & Jewkes, 2014). They noted that by taking on techniques specific for male patients, the health care workers could de-stigmatise home visits for their patients and increase openness and disclosure of issues that the patients might be facing. Recent studies by Sonke Gender Justice (2012) have reflected that the involvement of men in roles such as health promotion, as well as delivering health care services, is pertinent to the fulfilment of increased positive health care outcomes for both men and women, for instance, when including men in the Sexual and Reproductive Health and Rights (SRHR) promotion.

1.3 The importance of voluntary health promotion work for combating the HIV endemic in South Africa

South Africa is home to nearly six million people living with HIV at present; this adds up to eighteen percent of the adult population of the country being infected by the virus (UNAIDS, 2012). Most research reports on HIV in the Sub-Saharan Africa region are focused on women and girls, and funding towards HIV programming and, as a result, is mostly funnelled to this population group (Sonke Gender Justice, 2013). The incidence of men with HIV is high. Men have been recorded as testing for HIV less often than women (Johnson et al., 2013). There are more deaths among men as men often seek treatment at later stages of illness (Nattrass, 2008). Women receive sixty seven percent of ART's that are being administered through the public sector (Cornell et al., 2010), which is in line with global data that reflects that often, women access health care services more than men (Wilkins, Payne et al., 2008). If South Africa wants to see a positive change in HIV prevalence among both men and women, men need to be actively included in health promotion and in health interventions (Sonke Gender Justice, 2012).

From early 2000s, the South African government had a strong focus on prevention of mother-to-child transmission (PMTCT). Consequently, when HIV prevention is being conducted in public sector spaces, it is largely focused on pregnant women or women of childbearing age. Often women go to primary healthcare (PHC) facilities to get contraceptives, and to get pre-natal check-ups (Abrahams, 2001). In this way, the clinic space has taken on an almost feminized aura and tends to hinder men's access to the space, for fear of the de-masculinisation of the patient (Medical Research Council, 2007). The feminisation of the clinic space may influence men's health seeking behaviours in communities where they may feel that they cannot access the clinic without portraying a 'weak' masculinity, and therefore link illness or being sick with being 'weak' (Siu, Wight & Seeley, 2014a). Therefore, it is important to have men working as healthcare workers (Schneider, Hlophe & van Rensburg, 2008), community activists, community leaders and community mobilisers; to raise awareness about the importance of male patients' needs to access health care services regularly, and to de-stigmatise the health facility space, and to make healthcare a non-gendered service that is easily accessible.

1.4 Unpacking the gendered nature of voluntary health promotion work and community mobilisation, and seeing where masculinities fit into this area of work

Gender, by its very essence, is a social construct, and so expectations of gender are also therefore constructed socially - certain behaviours, actions (Gerson & Peiss, 1985) and attitudes are deemed to display 'femininity' or 'masculinity'. Gittings restated Butler's concept of performative gender as "a set of cultural and social practices that are performed by men and women" (Butler, 1999; Gittings, 2015). However, it must be noted that Butler is critical of the sex/gender distinction. Certain forms of labour tend to be performed by people of a particular gender as those labour practices are seen in the greater social construct of gender, to be actions that reinforce notions of who is ascribed that gender (Bohan, 1993; Crawford, 1995). It has been posited that caring is perceived as a women's role in some communities and is often viewed as part of a woman's reproductive labour, because of the community's conceptualisation of femininity being influenced by their culture (Pleck, Sonenstein & Ku, 1994); this is then reinforced through women performing their gender through reproductive work such as caring for the sick (Dworkin, Fleming & Colvin, 2015).

A lot of research that focuses on men portrays them as ‘difficult’ patients, ‘abusers’ and ‘problematic’ (Reid & Walker, 2005; Morrell, Jewkes & Lindegger, 2012). However, men can also be viewed as: complex beings embodying masculinities shaped by socio-economic standing, geographic location, and political history of the nation that they reside in, among other factors (Dworkin, Fleming & Colvin, 2015). Indeed, men are capable and willing to perform such tasks, counter to gendered expectations linked to their masculinity and/or biological sex (Hearn, 2004).

2. The significance of this study to health promotion work and community mobilisation in South Africa

2.1 i-ALARM

This research study is in partial fulfilment for my Master’s in Public Health and is part of a broader research project called Using Information to Align Services and Link and Retain Men in the HIV-cascade, also known as i-ALARM (HREC ref. no. 802/2014). i-ALARM is a five-year collaborative study between the University of Cape Town (UCT) and Brown University (United States of America), that aims to develop an intervention to improve the linking and retention of men in the HIV-cascade, in the Klipfontein Sub-district in Cape Town” (Unpublished i-ALARM protocol, 2015).

There have been programmes implemented in peri-urban spaces such as Gugulethu to support men, and to help them to engage positively with their HIV care, to their benefit and their partners too, such as the One Man Can campaign and MenEngage; the men’s clinic where male staff are hired to support, not only HIV care, but also to support groups and psycho-social counselling (Sonke Gender Justice, 2012). This study will focus on the in-depth interviews of men who help to co-ordinate programmes that engage men in uptaking HIV-care. It will take place in Gugulethu at the NY3 clinic where the i-ALARM study site is located.

Furthermore, this study is important to public health, as it will help policy makers to understand how to motivate more men to take up positions as health care workers - which in South Africa is a predominantly female loaded occupation (Van Pletzen & MacGregor, 2013). It will also inform the policy makers on how best to remunerate health care workers, beyond just money (Akintola, 2010, 2011); such as in offering capacity building opportunities to them and for increasing opportunities for networking and upward mobility in the health sector, since motivation is complex

and not as binary as it may initially seem. Overall, this study can contribute to a discussion around bridging the gap between community care and state service providers (Schneider & Lehmann, 2010), when dealing with male patients and eventually act as a vehicle for bringing the state and activists together, to work towards the one goal of increasing men's uptake of HIV services.

2.2 Movement for Change and Social Justice

My study will be focusing on men who are part of the leadership body of Movement for Change and Social Justice (MCSJ), which is “an alliance of organisations aiming to improve the health and lives of people in Gugulethu and surrounding areas” (MCSJ Constitution, 2017, p.2). MCSJ is based in Gugulethu but aims to work with and around the surrounding areas such as Nyanga. During MCSJ meetings, which currently take place on the last Wednesday of every month, members discuss what they have done over the last month, what pertinent conversations have taken place, and what needs to happen over the next month to ensure that the goals of the MCSJ come to fruition. Dates of marches are shared, and issues happening in the community that need immediate attention are discussed. The participants are part of the leadership structure of MCSJ and receive no form of remuneration for their time on this board.

By looking at MCSJ activist men's motivations, the knowledge gained from this study will feed into the larger i-ALARM project that is aiming to link men into care, as well as to retain them. If we understand men's motivations to work within the MCSJ and similar community mobilisation consortiums and organisations, we can make working for men's health in the community a worthwhile endeavour. If the MCSJ members are able to increase men's linkage and retention in the HIV cascade, there is potential to set up similar MCSJ consortiums in peri-urban community settings of a similar socio-economic background, within South Africa.

3. Aims of this Study

This study aims to investigate the motivations of male community mobilisers who are conducting their efforts in the Gugulethu area, for no remuneration. The men who I will be interviewing are performing gender non-conforming activities within the community, which may be viewed as stepping into the role traditionally filled by women. This is the academic gap that my research will fill; looking at men in positions that may - at first glance - not seem like the norm and unpacking their motivations and their experiences in fulfilling this role.

4. Objectives of this Study

My objectives for this study are to understand the motivations of male community mobilisers who are involved in activist community work in the Gugulethu Township. To understand adequately, men's motivations to uptake health care roles, I will explore the following research questions:

4.1 Research questions

Why are the participants volunteering their time to be a part of MCSJ despite the structural barriers they face such as poverty given the work they did was voluntary and unpaid?

- What are the participants' motivations to be a part of MCSJ?
- In what ways do the participants challenge hegemonic masculine norms in the roles that they play in their community?

5. Conceptual Framework

This study will employ a combination of two existing conceptual frameworks: Dr Albert Bandura's Social Cognitive Theory, which is made up of five aspects (Bandura, 2004) and Dr Olagoke Akintola's ten categories of functions served by volunteering. The two conceptual frameworks in combination work to cover all aspects of my study's enquiry into the gap in knowledge I seek to fill. Bandura looks at both internal and external motivation, while Akintola looks specifically at internal motivation. Internal and external motivations help to ground understandings of how motivation is experienced by a person, and they differ from one individual to another (Ryan & Deci, 2000). How a person acts upon motivation is also informative on how to incentive positive actions in future, for that person (Bandura, 2004). The cognitive social theory postulates that the way one views and understands one's own success has an impact on the intrinsic motivation one has while the Akintola's categories name very succinctly, some functions that volunteering serves to the volunteer, and give very tangible insights into aspects of intrinsic motivation of the volunteer, and how these aspects interplay and form what I understand to be intrinsic motivation.

Internal motivators that emerged within the literature are focused around perceptions of HCWs and volunteers more generally in the community (Akintola, 2011), and understandings of 'African-ness' or Ubuntu (Manda, 2010; Akintola, 2011; Swartz & Colvin, 2015) which is "generally

described as a uniquely Southern African humanistic ethic of care” (Swartz and Colvin, 2015, p. 142). Religion (Akintola, 2011) is also a motivator, as “links between care, volunteerism and Christianity have been documented in South Africa and beyond” (Swartz and Colvin, 2015, p. 143), and be understood to be both an internal and external motivator, depending on the person experiencing the motivation, and how they position it within their understanding.

5.1 Social Cognitive Theory (SCT)

5.1.1 Origins of SCT

Social Cognitive Theory was conceptualised by Dr Albert Bandura in the 1960s and has developed into what it is today in the 1980s. SCT “posits that learning occurs in a social context, with a dynamic and reciprocal interaction of the person, environment, and behaviour” (LaMorte, 2016). What makes this theory unique is how it focuses on the manner in which social influence makes an impact on an individual, as well as SCT’s emphasis on “external and internal social reinforcement” (LaMorte, 2016). SCT takes into account the way in which people learn and maintain behaviour, while simultaneously bearing in mind “the social environment in which individuals perform the behaviour” (LaMorte, 2016). I particularly wanted to use SCT as part of my conceptual framework, because of the manner in which it also deliberates an individual’s “past experiences, which influences reinforcements, expectations, and expectancies, all of which shape whether a person will engage in a specific behaviour and the reasons why a person engages in that behaviour” (LaMorte, 2016). This will ensure that I have an in-depth look at what motivates the participants who I will interview, to do the work that they do.

5.2 Unpacking the SCT Framework

LaMorte (2016) states that: “the goal of SCT is to explain how people regulate their behaviour through control and reinforcement to achieve goal-directed behaviour that can be maintained over time”, which is what I want to understand in my study, since the men not only start this behaviour but maintain it over time. I want to know what motivates them to keep going, and to keep conducting themselves in this manner. There are six aspects of SCT, as shown below:

1. **Reciprocal Determinism** - This is the central concept of SCT. This refers to the dynamic and reciprocal interaction of a person (individual with a set of learned

experiences), an environment (external social context), and behaviour (responses to stimuli to achieve goals).

2. **Behavioural Capability** - This refers to a person's actual ability to perform a behaviour through essential knowledge and skills. In order to successfully perform a behaviour, a person must know what to do and how to do it. People learn from the consequences of their behaviour, which also affects the environment in which they live.
3. **Observational Learning** - This asserts that people can witness and observe a behaviour conducted by others, and then reproduce those actions. This is often exhibited through "modelling" of behaviours. If individuals see successful demonstration of a behaviour, they can also complete the behaviour successfully.
4. **Reinforcements** - This refers to the internal or external responses to a person's behaviour that affect the likelihood of continuing or discontinuing the behaviour. Reinforcements can be self-initiated or in the environment, and reinforcements can be positive or negative. This is the construct of SCT that most closely ties to the reciprocal relationship between behaviour and environment.
5. **Expectations** - This refers to the anticipated consequences of a person's behaviour. Outcome expectations can be health-related or not health-related. People anticipate the consequences of their actions before engaging in the behaviour, and these anticipated consequences can influence successful completion of the behaviour. Expectations derive largely from previous experience. While expectancies also derive from previous experience, expectancies focus on the value that is placed on the outcome, and are subjective to the individual.
6. **Self-efficacy** - This refers to the level of a person's confidence in his or her ability to perform a behaviour successfully. Self-efficacy is unique to SCT although other theories have added this construct at later dates, such as the Theory of Planned Behaviour. Self-efficacy is influenced by a person's specific capabilities and other individual factors, as well as by environmental factors (barriers and facilitators).

6. Relevance to the Study

A benchmark for intrinsic motivation in Georgellis, Iossayz and Tabvuma (2010)'s work was having a "higher predicted satisfaction with the nature of the work itself" (p.474). They posited that people who are involved in public sector work are seen as having intrinsic motivation (Georgellis, Iossa & Tabvuma, 2011). Furthermore, they stated that placing a higher salary for a job in the public sector could crowd out (Frey & Jegen, 2001) people with intrinsic motivation from having an opportunity to take up a job in that sector. This is important for this study, as health and health behaviour are not only individually determined but it is a social issue too (Bandura, 2004). With this in mind, men who take part in community mobilisation's intrinsic motivation can be seen to exist within the realm of social cognitive theory, since their motivation goes beyond them as an individual, and is seen to come alive within the community (Bandura, 2004).

This theory also touches on elements of extrinsic motivation which also play a part in this study, such as notions of gaining the approval or lack thereof, from people around them who they conduct relational interactions with (Bandura, 2004, p.144), that the men deem important to them. Since how a person envisions the weight their own personal efforts holds in influencing and shaping the outcome of any endeavour they pursue (Bandura, 2004). This theory fits in well with the needs of this study in exploring men's motivation. Men who choose to be community mobilisers, I propose, are men who have within themselves high efficacy levels, and therefore feel that their efforts are more likely to yield positive results and even if they do not, they are not discouraged to the point of giving up, but instead, would rethink their approach and try again (Bandura, 2004, p.145) which is what I hope to see in the data that emerges from this study.

6.1 Akintola's Categories of Functions Served by Volunteering

6.1.1 Origins of Akintola's categorisation

Dr. Akintola's background in researching informal, unpaid work and caregiving of people with HIV/AIDS and/or TB, has largely informed his creation of the ten categories of volunteering (The Levy Economics Institute of Bard College, 2005). Akintola's categorisation looks at both intrinsic and extrinsic factors of motivation for volunteering. The research which these categories were shaped from, is within Sub-Saharan Africa, which makes this relevant to my study since this is the

region where HIV/AIDS is still rampant, and where there is a high unemployment rate within the population.

6.1.2 Unpacking Akintola's categorisation

Akintola (2011, p.55) identified ten categories of functions served by volunteering, which I think may resonate with the men who are voluntarily a part of the leadership body of MCSJ for this study:

1. **Values:** satisfying humanitarian obligation to help others or showing empathy for others
2. **Community:** concern for and worry about the community
3. **Career:** seeking career-related benefits/connections, skills or experience
4. **Protective:** reducing negative feelings about oneself
5. **Understanding:** the desire to better understand how to help others in society or to it
6. **Enhancement:** a desire to feel better about oneself or to be needed by others
7. **Reciprocity:** attracting good things to oneself
8. **Recognition:** needing recognition of one's skills and contribution
9. **Reactivity:** addressing one's own current or past issues, and;
10. **Social:** meeting the expectations of or getting the approval of significant others.

7. Relevance to the Study

Swartz and Colvin (2015) wrote on health care workers' motivations in Khayelitsha, where they picked up that some HCWs felt at odds with performing their roles with "altruistic intentions as well as for the tangible external reward (Swartz & Colvin, 2015, p.139). In their work they applied information gained by work done by Akintola (2006; 2010; 2011), where Akintola noted that though community work may not have financial rewards, there are long-term opportunities that HCWs felt would emerge, such as having a connection formed with international NGOs and job opportunities in the future (Kironde & Klaasen, 2002; Akintola, 2011; Jack et al., 2012). It is a hard thing to do work that is internally fulfilling, when there are external socio-economic needs and very real and valid expectations from dependents (Akintola, 2006). Doing activist work within an organisation or participating in community mobilisation often allows a person to learn skills to better themselves for future opportunities of employment, and sometimes; if the person is unable

to access learning institutions because of a lack of financial security, or if they do not see themselves as being academically inclined, working within activist spaces becomes a way for capacitating oneself with a valuable skillset, which could be understood to be an external motivator for taking part in activist community mobilising (Bhattacharyya et al., 2001; Akintola, 2010; De Wet, 2011). Swartz and Colvin concluded that: “neither altruism nor financial incentives on their own are sufficient explanations of CHW motivations in resource-constrained settings like Khayelitsha” (Swartz & Colvin, 2015, p.140).

8. Field-site

Gugulethu is a township that emerged because of the Group Areas Act (1950), to house people who were forcefully removed during apartheid from the inner city, namely Black, Coloured and Indian people, as they were no longer allowed to possess land in the inner city (South African History Online, 2013). The township itself was established in 1958 and has existed ever since; the name ‘Gugulethu’ means ‘our pride’ (South African History Online, 2013).

Once the government of South Africa allowed for Nevirapine to be distributed and later on when they made ART available at public health facilities, community mobilisation work around raising awareness on the benefits of getting tested and being linked to care for HIV/AIDS became more commonplace in peri-urban settlements such as Khayelitsha and Gugulethu (Swartz & Colvin, 2015). There has also been an increased presence of NGOs in these areas, such as Médecins Sans Frontières (MSF) in Khayelitsha and Sonke Gender Justice in Gugulethu; as well as the Treatment Action Campaign (TAC), which is more generally spread out in the region. There are currently a number of organisations that are conducting various forms of community mobilisation (Colvin & Robins, 2009) around HIV/AIDS in the Gugulethu area. Some organisations are well-funded and known, such as Sonke Gender Justice. Others are less known but still have some form of funding such as Parent Centre; while others are still emerging, and have little funding, such as Gugulethu Ibhongoletu Sports Organisation (GUSTO) and Soup. Yet all these organisations have representatives who are within MCSJ as they all have one common goal: to improve the health and the lives of the people living in Gugulethu and the surrounding areas, and to improve their access to health and social services (MCSJ Constitution, 2017, p. 2).

9. Methodology

9.1 Study design

9.1.1 Data collection methods

This will be a qualitative study that will take place in the Gugulethu Township. The research will be conducted inductively, using a range of qualitative methods of data collection which will make this research discovery oriented; meaning that I have some ideas on what I think the results of the data may be, but since it is qualitative, I can never know for sure what the data will be until at the end of the data collection (Bryman, 2004). Data will be collected through field notes, participant observation during the monthly MCSJ meetings, a focus group (Hesse-Biber & Leavy, 2006) and in-depth semi structured interviews with fourteen participants, over the research period, to get a fuller picture of men's motivations for taking up positions in community mobilisation structures in the Gugulethu Township.

9.1.2 Participant observation

Alongside the interviews, I will be taking fieldnotes (Gibson and & Brown, 2009) each time that I go into the field and when I attend the monthly meetings which I will do for a year. I will be attending the monthly MCSJ meetings and have informal conversations with the possible participants, as part of my participant observation for the duration of this research. My choice in doing so is growing rapport between myself and the participants, as well as allowing for space to ask questions and to learn from one another. I want to create trust, and to learn more about the community and to get exposed to the context from which my participants are operating.

I also want to see the participants' interactions with one another, and the content of the conversations that may emerge in the meeting space that may not necessarily come up in a one-on-one interview. With the small number of participants, it is important to me that I bring a lot of rich data about the study to the fore, to give as honest and as deep an understanding of the men by adding to the rigour of the data collection.

9.1.3 Narrative interviews

I will conduct one-on-one in-depth narrative interviews which will be semi-structured and based on questions around motivation (see Appendix 1). The aim in using this form of interview with the participants is that it will keep the conversation open-ended and will allow the men to express themselves freely and will minimize my influence on the information that they wish to share with me. There will be space for probing questions to be asked, if there is a need, so as to allow for the participants to fully express themselves and to be understood by me. If particular body language is apparent, that may influence the manner in which words said by the participant will be understood, I will note that down too. I want the participants to feel free to unravel the layered reasons for their motivations and unpack meaningfully with me as an interviewer. McAdams states that “the self is storied” (McAdams, 2008, p. 244), i.e. the way one speaks about one’s life is in a series of stories and that therefore, narratives about one’s life always involve the act of reconstructing the past, as well as imagining the future (McAdams, 2008, p. 244). Research that is focused on the personal narratives of a smaller group of participants for a case study such as this one, lends itself to the use of in-depth interviews (Atkinson, 1998).

Individual motivations are created and formed through life, previous experience and other events that inform decision making processes (Bauer & Gaskell, 2000). To dig deep into these experiences, these in-depth interviews will allow me to understand the nuances of motivation that will come through from the data collected and will allow the participants to put to the fore what they believe is most important and portray their interpretations and meanings they associate with what has happened in their lives to motivate them.

9.1.4 Focus Groups

Lastly, there will be a focus group (Hesse-Biber & Leavy, 2006) that will be conducted with all the participants, once emerging themes (Gibson & Brown, 2009) become known that may need further discussion. I will conclude the data collection with a focus group once all the in-depth interviews have been conducted and the initial coding has been done. Once themes emerge between the participants, a focus group will be conducted to dig deeper into the specific shared themes in a manner that will add to the richness of the knowledge being created for this study. Before conducting the research, I think that some themes that may emerge are: gaining social

capital, feelings of a need to give back to the community where the person has grown up, social impact entrepreneurship - which may entail giving back to the community, but also creating a means of income generation for oneself.

9.1.5 Characteristics of the study population

The inclusion criteria (Maxwell, 1998) to be a participant in this study, is that the person has to be biologically male, at least eighteen, be a resident of the Gugulethu area and be a member of MCSJ.

9.1.6 Recruitment and enrolment

The sample will emerge from men who step forward voluntarily to be a part of the study when I make announcements at the MCSJ meetings to recruit participants. The rationale is that participants will be working alongside organisations working in the Gugulethu area, and so are already a diverse group of people as well as being key informants. In the final report on the project, once participants have been recruited, there will be a table describing the sample of participants while still upholding their anonymity. There will also be a closer description of the context from which the participants have come. Participants will be recruited from the MCSJ meetings and events that take place in and around the Gugulethu NY3 clinic where the Sonke Gender Justice Male Wellness Centre is based. I will take time during lunch breaks or tea breaks in meetings or events, to announce the reason why I am there, who I am, and I will enquire whether there are any men who would like to be interviewed for the purposes of my study. If the men do show interest, then I will get their details and have a follow up conversation, give them a copy of my consent form which has a short summary of my study, and then set up a suitable date for us to meet and to conduct an interview. Initial meetings between me and potential participants are negotiated through the gaining of trust and organic interaction that emerges from participant observation by the researcher during my time in the field. In a way it almost becomes participative research in that I help where I can, so as not to be completely invasive of the MCSJ space; but for the most part I must ensure that I do not conduct myself in a manner that may negatively impact on the space created by MCSJ or the men and women present in the space, in any way.

I am going to interview at least fourteen men, and if I have not reached data saturation at that point, I will interview more male members of MCSJ. Given the nature of this research, qualitative data collection methods lend themselves to a richer and a deeper knowledge creation for answering the

academic question being asked when compared to quantitative data. Hence data will be collected using an in-depth interview process which will be recorded for transcribing purposes (Lapadat, 2000).

The interviews will take place at the MCSJ offices that are based at the NY3 Clinic in Gugulethu. For the participants, the MCSJ offices will serve as the interview venue, which is easily accessible. After each interview I will provide the participant with a cooldrink and a sandwich as a show of appreciation for their participation in the interview process. It is anticipated that each interview will not last longer than an hour and a half at the most. If consent is given, the interview will be audio recorded and then transcribed later for analysis. The interviews will be conducted in English. If there is a need for a translator the MCSJ/ i-ALARM field, co-ordinator Phumzile Nywagi will conduct the translation for the duration of the interview, but this will be agreed upon prior to the setting up of the interview. It is noted that the use of a translator who is known to the participants as well as the researcher, may have an impact on the information that is gained during the interview process. Any impact that may emerge through the use of a translator will be recorded in the fieldnotes.

9.1.7 Data analysis

When I analyse the data that has been collected I will be using the realist approach to narrative analysis which will focus on the content of the stories, rather than on the manner in which the story is told. This is referred to as ‘Thematic’ narrative analysis (Riessman, 2008). The use of the in-depth interview process will allow the participants a space to speak freely and without restriction on their motivations for volunteering on a structure such as MCSJ, as well as the organisation or community structure that they represent on the board. It will help me present key elements of my participant’s narratives and provide an overview of the variations and similarities within the data.

I will analyse using a thematic analysis, which is “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). This will allow for a deeper dive into the intricacies that lie within the raw data and will help me to unpack and to construct a larger narrative on what motivates men who are a part of MCSJ to do the work that they do, once the data is fully analysed. I will look at both implicit and explicit themes that will emerge from the

data. As the data I that will have from the fifteen interviews will need to be analysed, I will also use NVivo 11 software, to ensure that I have greater ease when navigating between transcripts during the analysis phase of my study.

10. Ethical Considerations

As this study is part of the larger i-ALARM research project, HREC approval has been granted for the duration of the study (HREC reference number 776/2017), to ensure that informed consent (Hesse-Biber & Leavy, 2006) is attained ethically. I will attend MCSJ meetings monthly from February 2017 until February 2018. This is to build rapport, to be accessible to participants outside of the interview space, and to immerse myself into the field, and to better understand the relationships in MCSJ and to observe behavioural patterns of the men in the meeting space; and other such nuanced relational markers that may emerge through observation, that may not be communicated in the interviews. On all occasions, I will present myself as being part of the study and being present in the meetings as a means for adding to my data collection.

If the participant decides to participate in the research then before the interview takes place, I will send the consent form via email for the participant to look over, a week before the date of the actual interview and the participant will be given the option of having a hard copy printed for them if they so wish. If the participant would like the consent form in their home language, then this can be arranged. On the day of the interview, the interviewee will bring a hard copy of the consent form to the venue of the interview and I will go through it line by line with the participant, to ensure that everything has been understood. I will explain once I contact the participant to set a date for the interview, that they are under no obligation to give consent or to participate in the interview process and that their refusal will have no bearing on their ability to be a part of the MCSJ leadership structure. Furthermore, it will be made clear that if they do not want to participate in the research any longer, that they can withdraw with no further consequence. The description of the risks and benefits of the study and of participating in the study will be covered in the consent form.

If the participant signs the consent form and wants to partake in the interview process, it will mean that they are agreeing to allow the data from their interviews to be reproduced for the purposes of the study (Maxwell, 1998). The participant will be given the choice to pick a pseudonym (Gibson

& Brown, 2009). I am going to use interviews, participant observation and a focus group as the three ways of data collection that will help me as a researcher to ensure that my data is reliable, through data triangulation.

10.1 **Data storage**

Once a participant gives consent to partaking in the study, they will be given an opportunity to choose a pseudonym if they so wish, for the duration of the interviews that will take place. This is to protect their identity and to allow them to speak freely about what they may want to discuss. All identifying markers such as names, surnames, the names of organisations who the participant works with, and specific information that may be easily linked with the participant will be removed from the data that will be published, to ensure their privacy. Anonymity cannot be guaranteed in a focus group setting. This will be made clear prior to participants coming together for the conduction of the focus group. Access to raw data material will only be available to me, the researcher (Samantha Malunga); the co-supervisor of the thesis (Myrna van Pinxteren) and the Co-Principal Investigator of the i-ALARM project (Associate Professor Christopher Colvin). The unprocessed transcripts from interviews, as well as the recordings, will not be accessible to anyone beyond these three people. Once the study is completed, the raw transcripts and the recordings will be kept in an encrypted file on one computer for two years before being permanently destroyed.

10.2 **Reflexivity**

Reflexivity is the “ongoing questioning of one’s place and power relations within the research process” (Hesse-Biber & Leavy, 2006, p.38). Given South Africa’s economic climate, the socio-economic standing of the participants leaves them in a precarious position (Mason, 2002). Altruism in such a circumstance is not commonplace and so it would be interesting to interrogate their motivations, despite the lack of financial means. I will be using the fieldnotes to ensure that personal feelings are recorded to keep myself accountable. It will also be for transparency and to minimise bias (Willig, 2012), since research is neither value-neutral nor ideologically pure. After each interview, I will write down post interview notes to highlight some interesting comments, as well as my opinion on aspects of the interview.

I am aware that as a black female Zimbabwean middle-class researcher studying at UCT, that the way in which I will relate to the participants may influence the information they will share with

me (Shefar, 2009). I will be reflexive throughout my analysis and in writing up the process of my thesis.

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Part B: Structured Literature Review

1. Introduction

This literature review was conducted as part of a larger study on male volunteers at grassroots level in the health system in a South African peri-urban settlement, often referred to as a township. There is an abundance of literature on men and women who volunteer in the health system and community health workers (CHWs), but there is little literature on people who volunteer as community mobilisers in lower to middle income countries, particularly when the volunteers are members of the community in which they are volunteering.

1.1 Organisational pattern for the review of the literature

1. Introduction
2. Volunteering and community mobilisation
3. Male volunteers' experiences and motivations in CM work
4. The importance of the presence of male volunteers' in the health system on male patients' health seeking behaviours, and,
5. Conclusion.

1.2 The objective of the literature review

The objective of this review is to examine existing literature on volunteer work and to examine how gender affects experiences of, and motivations to volunteer. The review will explore male volunteers' experiences of, and motivations to volunteer in community mobilisation (CM) work. According to the various works of Cornish, one has conducted community mobilisation when active change is brought about in a community, by community members themselves, in order to improve a certain aspect of their collective lived experiences in the geographical space they occupy (Cornish and Ghosh 2007; Campbell and Cornish 2010; Cornish et al. 2014). This review aimed to collate current knowledge on experiences and motivations of male volunteers in community mobilisation and in doing so, to assess any key gaps in the literature.

1.3 The scope of the literature review

There are numerous studies on volunteering generally, but this qualitative thematic review focuses mostly on the gendered experiences and the motivation of male volunteer community mobilisers. This topic is important because of the gendered division of labour and the understanding of volunteer work to be women's work. When men do volunteer work at a grassroots level, they are challenging hegemonic masculine norms, which are often not accurately researched or understood

(Hearn 2004). There is a significant amount of literature on volunteer work and the motivations of female volunteers but there is very little literature that focuses on male volunteers and their motivations. Another reason that this topic is important is that having more men in volunteer positions in the health system could have a positive impact on male patients' health seeking behaviours, which could impact their partners and dependents' lives (Sonke Gender Justice, 2012), as well as relieve the health system's human resources crisis.

1.4 Literature search strategy

The literature search process started with looking for relevant peer-reviewed articles using the following key words: "Volunteer" or "Volunteering" or "volunteer work" and "men" or "masculine" or "male" and "South Africa" or "Sub-Saharan Africa" or "Africa" and inputting them into PubMed, Google Scholar, and MEDLINE. Reference lists of were examined, and relevant articles were drawn out and reviewed. Statistics SA was also relied on as a source for up to date statistics for the South African context. This literature review included studies conducted in Sub-Saharan Africa for the volunteering specifically in the health system. These studies were limited to articles written no earlier than 2001.

The studies on gender, and masculinity in particular, were researched, using the following key words "Men" and "Masculinity" and "Hegemony" or "Hegemonic". Most of the sources were from Europe and the United States for the early writings on the topic. There was no time limit for the general theoretical understanding of masculinity within the gender and health context. However, searching for empirical experiences of volunteering showed that there was a need for more contemporary articles, hence these searches drew on articles published from 2001 onwards.

Articles containing more specific explanations of interactions between masculinity, forms of employment and motivations for taking part in voluntary work in the SA health system came up. In particular, articles on community mobilisers since CM falls under the same sub-set as CHWs, health counsellors, community health promoters peer supporters, and adherence club leaders. The aforementioned positions in volunteer health care work are particular kinds of community-based volunteers.

2. Volunteering and Community Mobilisation

Volunteering can be defined using Akintola's (2011:54) definition, which states that: "volunteering involves committing time and energy to provide a service that benefits someone, society or the community without expecting financial or material rewards". This means that volunteers do the work that they do without expectation of monetary or non-monetary remuneration. It is unpaid, informal work, meaning there is no regulatory body for this form of work and the work done does not have financial compensation tied to it in any way (Grant-Smith & McDonald, 2018; Qvist & Munk, 2018).

Volunteering can occur in any field, for the purposes of this review, the focus will remain within the health system. Volunteering is not always informal, or unpaid. Within the South African health system, 'community health care worker' is a formalised volunteer position that receives a regular stipend, and so is paid work (Callaghan, Ford & Schneider, 2010). However, this literature review will be focusing on unpaid, informal community-based volunteers in South African peri-urban settlements.

CM is when participatory action is taken by members of a community to bring about change within their community (Campbell & Cornish, 2010). The action is strategized, implemented and evaluated by the community members, and they have complete ownership of the actions taking place within the CM action (Cornish & Ghosh, 2007). CM is usually implemented around issues such as health, education, housing and sanitation, as a means of improving the lives of members of the community (Cornish et al., 2014). CM allows members of the community to give their opinion on what activities should be conducted in their community and it gives them a place to speak about issues that should be addressed, and in what order of priority (Campbell, 2014).

Understanding of motivation for participating in volunteer work was drawn from some literature on CHWs, with the understanding that though CHWs are paid a stipend, it is very little compared with that of paid jobs. This review focused on understanding the motivations of unpaid volunteers.

Though Akintola's definition of volunteering states that people participate in volunteering with no hope for "financial or material reward" (2011, p. 53); his definition is a useful start but limited. Akintola's definition does not fully capture the experience of volunteers in the health sector in South Africa (SA). There have been articles written in SA stating that because of the socio-

economic circumstances of people who usually do volunteer work in communities, it is morally unfair to pay the volunteers an unreasonably low stipend (Hunter & Ross, 2013); especially when the volunteers come from the same community in which they are volunteering, as they share the same financial vulnerabilities as their community members. As a result, in SA, sometimes there are small material rewards and stipends awarded to CHWs.

SA has one of the highest income inequality rates in the world (Philip, 2012). The unemployment rate in SA is between 25.5% to 36.6% (Stats SA, 2014), depending on the use of the narrow or wide definition of unemployment. There is a close link between unemployment and poverty (Chibba & Luiz, 2011) in SA. These two factors are also closely tied to racial and geographical lines (Leibbrandt et al., 2012; Stats SA, 2014). Some people choose to take on volunteer roles during a period of unemployment, in order to access a stipend (Phillips, Greene & Jackson, 1999; Bhattacharyya et al., 2001; Hermann et al., 2009; Akintola, 2010, 2011), if the volunteer position has a stipend attached to it. The stipend is usually lower than a minimum wage job (Tschirhart et al., 2001). Most volunteer positions in SA do not have a stipend attached to them; if they do, it can be as low as seven hundred and fifty rand per month (DoH, 2009).

Despite this, volunteers may also want to use volunteering as an opportunity to seek career-related experience for their future (Akintola, 2011). Volunteers will participate so that they can access opportunities to better themselves, through skills-building opportunities (Bhattacharyya et al., 2001; Akintola, 2010; De Wet, 2011). Other volunteer positions may not be able to pay the volunteers, but they can remunerate them with learnership opportunities and that can act as a motivation (Bhattacharyya et al., 2001; Takasugi & Lee, 2012). Others spoke about the hope of accessing employment opportunities (Dageid, Akintola & Saeberg, 2016), through participating in volunteer work (Clary et al., 1998; Kironde & Klaasen, 2002; Akintola, 2011; Akintola & Hangulu, 2014).

It must be acknowledged that volunteering is a layered experience. One may want to volunteer but because of a lack of resources for sustaining themselves and dependents they may still feel the need to get an income (Swartz & Colvin, 2015). As a result, it is very possible to participate in volunteer work for both altruistic, religious and financial reasons (Akintola, 2006; 2010; 2011). People with intrinsic motivation are more likely to push through external stressors and keep doing

work that they find important, despite any potential hindrances that might try get in their way (Greenspan et al., 2013).

3. Male Volunteers' Experiences and Motivations in CM Work

3.1 The gendered division of labour and its effects on volunteering

Gender is a socially constructed phenomenon (Gerson, 1985). When thinking about who 'should' and 'can' do certain forms of labour, gender influences that decision making process. The understanding of who can do certain forms of work is also influenced by the community that one works in, and the cultural and social norms upheld in that community (Butler, 1999).

Within SA, there is an apparent gendered division of labour, in community development work. When men engage in paid work within this, sphere they usually take on jobs at higher ranks within organisations or in communities. Their positions are usually paid, and more formal. More grassroots level positions which are often voluntary in capacity, and unpaid, tend to be held by women (Bohan, 1993; Crawford, 1995). These informal, volunteer, unpaid jobs tend to be viewed as 'feminine'.

Women are linked to these informal, volunteer, unpaid jobs because of the gendered division of labour (Meyer et al., 2014). More women than men volunteer within a health system as CHWs, lay counsellors, health promoters, and community mobilisers (Schneider et al., 2008).

In SA, there are more female than male volunteer workers in the health system, so most literature is based on female experiences and motivations to do volunteer work in a health context (Akintola, 2006; George, 2008; Gittings, 2018; Steinberg et al., 2002; Schneider et al., 2008; Swartz & Colvin, 2015; van Pletzen & MacGregor, 2013). Besides the fact that literature often suggests that volunteer work is largely altruistic (Blinkhoff et al., 2001; Dageid, Akintola & Sæberg, 2016; Steinitz, 2003), there are multiple motivations for participating in volunteer work, particularly in a community that one belongs to.

Because of gendered expectations of what men are meant to do in the home and within a relational sphere, more male volunteers feel the pressure of needing to have financial rewards for the time that they have committed to volunteering. They also use volunteering as a means through which to access future employment opportunities and they see volunteering as a short-term sacrifice of

not earning money in order to gain skills that will feed into the long-term gain of acquiring formal, paid employment. Being in a state of unemployment and wanting to access spaces that may potentially allow a person to get an employment opportunity could also be a reason for volunteering (Akintola, 2011; Jack et al., 2012; Kironde & Klaasen, 2002;).

3.2 Men's experiences as volunteers and community mobilisers

To better understand the motivations of men doing CM work, it is important to understand how this work affects ideas of masculinity, as volunteering is often viewed as women's work. Hegemonic masculinity is the dominant idealised form of masculinity, and thus informs the gendered division of labour, that associates volunteer work with being women's work (Morrell and Jewkes 2011; Hrženjak 2013; Gittings 2018).

Hegemonic masculinity is defined by Connell as follows: "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" (Connell, 1995, p.77).

Hegemonic masculinity is socially constructed and is exclusionary in nature (Barker & Ricardo, 2005; Jewkes & Morrell, 2010). In reality, very few men achieve this status of being the ideal man, but many see themselves in relation to that ideal and want to achieve it (Connell & Messerschmidt, 2005). This is why there are tensions surrounding men participating in volunteer work, as choosing to take part in volunteer work may be viewed as going against hegemonic masculine norms. An example of this would be men taking on positions as CHWs in communities (Gittings, 2015).

As mentioned above, gender is a social construct and not concrete, but rather, malleable. Masculinity then, cannot be viewed only in a one-dimensional way. Instead, there are multiple ways to view masculinity – from hegemonic masculinity to marginalized masculinity including other constructs in between. How someone embodies masculinity is influenced by various factors such as socio-economic circumstances, one's geographical location, one's state of able-bodiedness, among many other factors (Crenshaw, 1991; Dworkin, Fleming & Colvin, 2015), such as men being under pressure to provide for their families, since this influences what they feel that they need to do to provide for them. In addition to gender norms, there are also class issues that add to the resistance towards men participating in volunteer work. This is because of the precarious

social status and financial standing of community-based volunteers. There is a heightened need to provide for their families because of high unemployment rates in townships, which cause difficulty in providing financially, thereby adding pressure on volunteers to take on paying jobs. Combining these factors along with the understanding embodiment of masculine norms locates men's contested presence in volunteer positions in CM work in the eyes of their dependents.

There is only a small body of literature written about men that shows them going against hegemonic ideas of masculinity within the South African context, such as performing volunteer work in the health system (Gittings, 2015). There are men who want to, and do perform, against the hegemonic ideas of what is understood as 'a man' within their community, despite the fact that doing so goes against gendered expectations of men within their community (Hearn, 2004; Hrženjak, 2013). Men who perform work that has been socially constructed as 'feminine' are faced with social pressure to do other jobs.

In the South African context, men have participated in activist efforts in volunteer roles. Examples of this can be seen in literature written about the Treatment Action Campaign (TAC) (Robins, 2008). There has been much less male-only CM, but it is present through the work of organisations such as Sonke Gender Justice (Barker, 2010; Fleming et al., 2016), where there has been a focus on gender-transformative programming and its impact on men's testing and engagement with HIV care services. There has also been work done in the Western Cape townships in particular, where volunteers who were once community mobilisers came together to form the Khululeka Men's Support Group (Colvin, Robins & Leavens, 2010; Robins, 2007; 2008).

In a historically patriarchal society such as SA, the societal pressure for men to perform work that is viewed as 'masculine' is palpable (Hrženjak, 2013). This shows the power of patriarchy (Bradshaw, 1994) at play and the power it has over people's perceptions of what are 'traditionally' female and male jobs. Hegemonic masculinity cannot be used as the norm and the standard for what a 'real' man can do, without the power of patriarchy, also reinforcing that ideology (Jewkes & Morrell, 2010).

Societal pressure hinders men from usually participating in this form of work (Shefar, 2014). Some men may experience resistance from their social circle for engaging in what is perceived as women's work, and their masculinity and ideas linked to that masculinity by the community - such

as power dynamics in relationships with the female gender, and their social status in the community are put into question (Hrženjak, 2013; Gittings, 2018).

3.3 Men's motivations for participating in volunteer work

This raised the question about why men do volunteering. What are the motivations that drive them to work against these expectations? The Bhattacharyya et al., (2011) article showed that there is a high level of camaraderie between volunteers, and that between themselves they tend to create a supportive environment. There are sentiments also, that one may perform volunteering in the hopes of reciprocity for their actions or to be given recognition for their actions (Akintola, 2011). Recognition (Bhattacharyya et al., 2001) by the community can go a long way in terms of motivating CMs to continue doing the work that they do. When highly driven people work in environments that are supportive to their work, they can produce greater output (Bandura, 2004). It also strengthens (Bhattacharyya et al., 2001) the relationship between CMs and the community that they work in. Akintola (2011) stated that as a result of one's values, one may feel an obligation to serve in a voluntary capacity to give back to the community.

There is literature on the benefits of having community-based male volunteers in the health system in order to increase male patients' engagement with healthcare services and retention in care. Most of this literature was not based in Africa. There are numerous reasons why men take on volunteer positions. Some men may feel that they want to do some role modelling within their community (Bandura, 1977; Turner & Shepherd, 1999; Campbell & MacPhail, 2002; Gusdal et al., 2011). This can be through doing 'fathering' work, by mentoring and guiding younger men (Gavanas, 2002; White & Caldwell, 2006; Taliep, 2015). Being a role model can be a form of mentoring, as it can give the youth in the community someone to look up to. Men can take on these volunteer positions in order to be role models in their community when they feel that there is a lack of role models present (Bandura, 1977; 1986). Mentoring can take place through being a father figure for a younger person or through being a peer mentor for people within the same age range (Watson-Thompson, Fawcett & Schultz, 2008; Flood, 2011).

Male volunteers also seem to benefit from having support from fellow male volunteers (Callaghan, Ford & Schneider, 2010; Mwai et al., 2013). This is particularly important for male volunteers, as men do not actively seek out emotional support, and having a group of peers where one can seek support (Morrell & Jewkes, 2014). Reassurance is an important thing to have in ensuring emotional

resilience in male volunteers since the work is so emotionally taxing. The pressure to stay in 'emotional control' (Gibbs, Sikweyiya & Jewkes, 2014) through not expressing one's emotions as a man, has negative effects on one's wellbeing. Having safe spaces has positive impacts on men in townships particularly. It also impacts on their intimate relationships (Gibbs et al., 2015). There is strength in investing in safe spaces where men can work together to keep other men accountable for their health seeking behaviour. One example would be the establishment of male only adherence clubs (Cornell, McIntyre & Myer, 2011; Wilkinson, 2013; Ratele, 2014; Grimsrud et al., 2015; Khabala et al., 2015; Stern et al., 2017), or male friendly-clinics (Leichliter et al., 2011).

There are men willing to do volunteer work in the health system in order to get their fellow men to access health services within their community. There are also men who are willing to do the necessary work of getting other men to uptake health care services through peer to peer support (Bhattacharyya et al., 2001), within their community. The male volunteers doing CM work fit that criterion by performing mentoring; using the influence of their social capital within all male spaces in order to get other men within their community to seek care (Feldhaus et al., 2015; Gusdal et al., 2011; Merriam et al., 2001).

4. The importance of having male volunteers present in the health system for male patients' health seeking behaviours

Having reviewed literature on men who volunteer in the section above, the following section will review literature on the male patients who are being supported by male volunteers; in particular, their masculinity and health seeking behaviours.

There is a negative perception of men as patients in the SA health system. There is a large body of work written about men in the context of the health system, within a very particular narrative of being 'problematic', 'bad' patients with poor health seeking behaviours (Mansfield, Addis & Courtenay, 2005; Siu, Wight & Seeley, 2014), and tendencies towards sexual abuse and violence aimed at their female victims and their partners (Morrell, Jewkes & Lindegger, 2012; Reid & Walker, 2005; Jewkes et al., 2010; Bingenheimer, 2010).

Within Sub-Saharan Africa, one can see this narrative about men in literature on HIV. HIV has been the dominant public health problem in the region (UNAIDS, 2018) and it is a highly gendered disease (Gittings, 2018). In much of the literature on HIV, women and children have been framed

as victims. It is no surprise then that the funding for this region focuses on women and children (PEPFAR, 2007; UNICEF, 2010; UNAIDS, 2014), thereby leaving a very large population of men in the region not catered for (Cornell, McIntyre & Myer, 2011; Shand et al., 2014; Baker et al., 2014; Parpart & McFee, 2017).

It is true that men in SA do have poor health seeking behaviours. This is in line with literature on all men's health seeking behaviours (Courtenay, 2000; Kalichman & Simbayi, 2003; Galdas, Cheater & Marshall, 2005; Hutchinson & Mahlalela, 2006). However, there is little acknowledgement of the gendered expectations on men at play, when considering men's poor health seeking behaviours, as men in SA associate being sick with 'weakness' (Siu, Wight & Seeley, 2014). Long lasting change can only happen over time, and so, instead of trying to fully transform masculinity, there has been a move within interventions to subtly shift towards less harmful forms of masculinity changing, through male-focused interventions (Gibbs, Jewkes, Skweyiya & Williams, 2015).

Given the fact that men have worse health outcomes than women, including HIV care because of their poor health seeking behaviours, it is important to include more men in CM work in the health system. There are many volunteer roles in which men can effectively contribute to the South African health system. Morrell and Jewkes (2014) captured it well in their study of CHWs and their male patients. They showed, in this, as well as in other studies, that men have better health outcomes (in HIV care and beyond) when they feel safe and have male support - in the form of male CHWs (Mfecane, 2012; Vale, 2012; Morrell & Jewkes, 2014; Gittings, 2016; 2017; 2018) or when they are enrolled in men's only adherence clubs. Male patients are also receptive to learning about their health needs from other men, through peer to peer mentoring (Pearson, 2003; Levtov et al., 2014). It would be beneficial therefore, to have more men in volunteer positions to facilitate more male patients to use health care services (Schneider et al., 2008). This is particularly so, because it has been noted that having men in volunteer positions in the health system has shown a positive increase in the rates at which male patients enrol and stay; as men then feel that they are more represented in the health system (Morrell & Jewkes, 2011; Morrell & Jewkes, 2014; Gittings, 2018).

There have been studies written on how men doing 'women's' work does not change the gendered power dynamics between men and women (Cross & Bagilhole, 2002). Though the hope is to

increase gender equality by breaking down the gendered division of labour (Fisher, 2009; Connell, 2012); it is true that there are still power dynamics at play that may hinder this becoming a reality (Ratele, 2014). Nonetheless, there is still a need to get more men to participate in volunteering positions in the health system. Including men is not going to fix the problem, but it would still be useful to have more men present in the health system in a volunteer role.

5. Conclusion

Research on volunteering and CM has been conducted throughout sub-Saharan Africa, as well as in SA. There is tension around remuneration of volunteers, whether monetary based or not, and therefore there is a need for some form of remuneration.

There is a need for a more complex understanding of men who volunteer. There is no one form of masculinity, there are multiple forms, and they change over time. This understanding can be expanded upon by unpacking how some men express various forms of masculinity when participating in volunteering roles. They do this through working against hegemonic norms for the good of their community; rejecting gendered expectations; embodying alternative masculinities and performing counter to what is expected of them.

When men volunteer within the health system as CHWs, health promoters, adherence club leaders, or community mobilisers, they can positively impact other men's health seeking behaviours. More male representation and visibility in the health system, has been shown to increase the number of men who enrol into health services and remain in care. Men being linked to care, and remaining in care will benefit the men themselves, their partners and their dependents.

However, as seen in this review, there is a gap in literature on male volunteers in particular. Furthermore, there has not been enough literature on male volunteers who participate in CM work, their experiences and motivations, and their motivation to continue doing the work. If one is to effectively include men in volunteering roles, there is a need to better understand what their experiences and what their motivations are.

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Part C: Journal “Ready” Manuscript

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‘Fixing Home First Before Going Elsewhere’: Exploring the Gendered Experience of Movement for Change and Social Justice (MCSJ) Male Community Mobilisers in Gugulethu, Cape Town, South Africa.

Historically, volunteer work, including community mobilisation (CM) has been seen as a job for women. There are fewer male volunteers in CM than there are female volunteers. In order to support the greater inclusion of men in volunteer work there is a need to understand the gendered experiences and motivations of men who participate in CM work through Movement for Change and Social Justice (MCSJ), which is based in Gugulethu. Data was collected using in-depth semi-structured interviews with fourteen participants, one focus group with six participants drawn from the initial group of fourteen participants, field notes and participant observation at events held by the MCSJ including: monthly meetings, community-based campaigns and workshops. Data was analysed through thematic analysis. Three themes emerged from the findings of this study: 1) the familial pressure on male participants to not do CM work due to its gendered nature; 2) various ways to resolve tension between gendered norms of volunteering; 3) the importance of safe spaces within the MCSJ for male community mobilisers. The knowledge gained from this study can feed into the larger debate present in SA surrounding the need for more male-centred interventions in the public healthcare system.

Volunteering - Community Mobilisation – Masculinity - Health Systems Strengthening - HIV

1. Background

This study looked at men volunteering in a community mobilising group called Movement for Change and Social Justice (MCSJ) which is based in Gugulethu, a township in Cape Town, South Africa (SA). This study sought to understand how gender impacted on the experiences and the motivations of the MCSJ male volunteer community mobilisers, as they conducted their work in Gugulethu. Men's experiences and motivations for taking up community mobilisation (CM) have been historically, an under-researched area in the South African health system, but it would be beneficial to understand this information. If this can be understood, it could help increase men's representation and visibility in community and health work nationally. It would also help to increase male patients' engagement with the health system, by positively influencing their health seeking behaviours.

When considering the gendered division of labour (Meyer, Reddy & Meyiwa 2014), CM and volunteering have traditionally been viewed as women's work. Volunteering has traditionally been conducted by women within the South African context due to gendered expectations in communities (Schneider et al., 2008; Meyer, Reddy & Meyiwa 2014); particularly when those positions are held in peri-urban informal settlements – often referred to as townships - and when they are done in a voluntary capacity (Steinberg et al., 2002; George, 2008; van Pletzen & MacGregor, 2013).

Furthermore, most research on CM work and volunteering is derived from women's experiences. The literature shows that women are more likely than men to volunteer (Akintola, 2006; Schneider et al., 2008). It can be perplexing when men volunteer and do CM work around promoting the uptake of healthcare services (Morrell, Jewkes, & Lindegger, 2012) and they tend not to do this form of salaried work as these positions are often viewed as women's work (Akintola, 2006;

Swartz & Colvin, 2015). Hegemonic masculinity (Connell, 1995; Connell & Messerschmidt, 2005), and the ways it informs the gendered division of labour (Fisher, 2009; Connell, 2012) influences the way that men are viewed when they take on positions that are not in line with perceived ideas on what roles they can occupy and embody when performing labour. The hegemonic masculinity present in many South African communities is perceived as exhibiting strength and hiding vulnerability (Mfecane et al., 2005; Thomson, 2009) - where vulnerability or caring are linked to femininity and are therefore avoided - and so, men are not immediately linked to this form of work. When men take on volunteer positions in communities, it does not immediately fit with the understanding of constructions of masculinity and maleness (Hrženjak, 2013).

There have been numerous articles that portray men as ‘difficult’ patients, ‘abusers’ and ‘problematic’ (Morrell, Jewkes, & Lindegger, 2012; Reid & Walker, 2005) in the frame of the health system, without interrogating how hegemonic norms shape how male patients seek health care. Indeed, hegemonic norms put pressure on them not to go to a clinic, and not to show ‘weakness’.

This study explored the experiences and the motivations of male volunteer community mobilisers working with the MCSJ and why they chose to do CM work within the health system. Men’s motivation for taking up CM and volunteering has been historically under-researched. Men have not been portrayed as being potentially helpful in aiding male patients to engage with the health system. Having more men in the health system will better enable men who are reluctant to go to a clinic to be better supported.

2. Methodology

2.1 *Study design*

The study was a combination of inductive and deductive research (Bryman, 2004). The choice to use qualitative methods of data collection was to allow for a deeper insight into men's experiences and motivations in doing CM work. While a quantitative approach may have explained how many volunteers were present in the MCSJ, it would not have allowed for the exploration of the reasons why the participants of this study took part in CM work, and what they experienced doing CM work.

2.2 *Data collection*

A range of qualitative methods were used to collect the data for this study. Firstly, field notes were taken during and after each visit to the field site. Secondly, participant observation occurred during eight monthly MCSJ meetings and two workshops. Thirdly, in-depth semi-structured interviews were completed with fourteen participants. Lastly, one focus group (Hesse-Biber & Leavy, 2006) was conducted, consisting of six participants drawn from the initial group of fourteen participants. The in-depth semi-structured interviews and focus group transcripts were audio-recorded and then transcribed for analysis.

2.2.1 *Participant observation*

Participant observation involved attending MCSJ community events, meetings, workshops and campaigns in Gugulethu. The choice in conducting participant observation was to grow a rapport between the researcher and the participants, as well as to allow for space to ask questions and to learn from one another. This was to create trust and to learn more about the community and to get

exposed to the context from which the participants are operating. It was also to allow the researcher to see the participants' interactions with one another, and the content of the conversations that may emerge in the meeting space that might not necessarily come up in a one-on-one interview. Fieldnotes were taken during the participant observation and were used to document the researcher's interpretation of experiences and observations in the field. Fieldnotes were written out after each visit to the field to ensure that they were as accurate and data rich as possible.

2.2.2 *In-depth semi-structured interviews*

The in-depth semi-structured interviews were conducted in English. The in-depth semi structured interviews were focused on four broad topics which were:

- i) background information
- ii) home life and what is expected of them
- iii) participant's involvement in CM broadly and within the MCSJ, and
- iv) how the participant perceived the CM work.

These interviews averaged forty-five minutes in length (shortest being twenty-four minutes, and the longest being an hour and fifteen minutes).

The one on one interviews allowed for the interviewer to get an initial understanding on issues faced by the men in their day to day lives. It also became evident that the interviewer's outsider status made the men at ease to be honest and blunt about some of their vulnerabilities in participating in CM work. At the end of the one on one interviews, the researcher realised that using English as the language of the interview process limited the participants' abilities to articulate themselves as fully as they could have in their home language. Though they had been given the option of being interviewed in Xhosa, all had opted for English. Once they were

comfortable with the idea of being interviewed for the research project, and a community member who also worked for UCT and MCSJ Mr Phumzile Nywagi stepped in and conducted the focus groups in Xhosa. Xhosa was the shared language of all the men present and the researcher did not want the participants to speak in English just to accommodate her, when the participants could best articulate their sentiments in Xhosa. To make the focus group a safe space, actively deciding to be excluded in the conversation to allow the men to speak freely led to very rich data emerging from the focus group.

2.2.3 *Focus group*

The focus group was conducted in isiXhosa and MCSJ/i-ALARM. Field co-ordinator Phumzile Nywagi conducted the translation for the duration of the focus group. The focus group lasted for an hour and twenty minutes. The questions asked in the focus group were meant to explore in depth some ideas that were raised in the first round of questions posed in the individual interviews. There were questions raised on the importance of CM to the participants, what role MCSJ has played in the participants' lives, and what role their gender played in their participation in CM.

2.3 *Study setting*

Gugulethu is predominantly isiXhosa speaking and is a politically and economically disadvantaged area which emerged after the Group Areas Act of 1950 saw Black, Coloured and Indian people forcefully displaced from their land within the inner city, and relocated to designated areas based on their race (SA History online, 2013). The township itself was established in 1958 and has existed ever since. The name 'Gugulethu' means 'our pride' (SA History online, 2013).

This study focuses on gendered experience of the MCSJ's male volunteer community mobilisers in Gugulethu. This study focused on men who are part of the Movement for Change and Social

Justice (MCSJ), which is “an alliance of organisations aiming to improve the health and lives of people in Gugulethu and the surrounding areas” (MCSJ Constitution, 2017, 2). The MCSJ is made up of men and women from Gugulethu. This study focused on the men in the MCSJ in particular, as the MCSJ itself emerged out of a broader research project called ‘Using Information to Align Services and Link and Retain Men in the HIV-cascade’, also known as ‘i-ALARM’. i-ALARM is a five-year collaborative study between the University of Cape Town and Brown University, that aims to develop an intervention to improve the linking and the retention of men in the HIV-cascade in the Klipfontein sub-district in Cape Town” (Unpublished i-ALARM protocol, 2015).

The MCSJ operates from an office based next to the NY3 Clinic in Gugulethu. Gugulethu is a neighbourhood in the Klipfontein sub-district within the City of Cape Town that aims to work with and around the surrounding areas such as Nyanga, Manenburg, Crossroads, KTC and Barcelona. During the MCSJ meetings, which occur once a month, members discuss what they have done over the last month, what pertinent conversations have taken place, and what needs to happen over the next month to ensure that the goals of the MCSJ come to fruition. Dates of awareness events are shared, and issues happening in the community that need immediate attention are discussed. The participants are members of the MCSJ and they receive no form of remuneration for their time.

2.4 *Recruitment and sampling*

2.4.1 *Characteristics of the study population*

The participants of the study did not get paid to do the CM work. The MCSJ members came together to establish this community-based initiative in 2016. The MCSJ works alongside NGOs and CBOs in Gugulethu, including Parent Centre, Sonke Gender Justice, and the Gugulethu Ibhongolethu Sports Organisation (GUSTO), among many others. All these organisations have

representatives who are within the MCSJ, as they all have one common goal: to improve the health and lives of the people living in Gugulethu and the surrounding areas, and to improve their access to health and social services through CM (MCSJ Constitution, 2017, 2).

The MCSJ members are seeking to address health systems issues within the community such as lack of health care practitioners in the clinics, long waiting times in the facilities, and the aspect of safety for patients attending public sector health facilities in Gugulethu. Alongside these primary initiatives, the MCSJ members have also begun to tackle issues of unemployment in the community, as well as working with the youth to help them to conceptualise an alternative means of embodying masculinity through helping out in the community.

2.4.2 *Recruitment and enrolment*

The inclusion criteria (Maxwell, 1998) to participate in the study were: to be male, to be at least eighteen years old, a resident of Gugulethu and a member of the MCSJ. Participants were recruited through several MCSJ meetings and events that took place in and around the Gugulethu NY3 Clinic where the Sonke Gender Justice Men's Wellness Centre is based, as well as at JL Zwane, a local church. The sample emerged from men who stepped forward voluntarily to be a part of the study when announcements were made, and the study was introduced. Three of the study participants are part of the leadership structure of the MCSJ, and the rest are members of the MCSJ.

2.5 *Data analysis*

The fourteen interviews and one focus group were transcribed. NVivo 10 software was then used to select codes and to create themes and sub-themes. The software was used to navigate between transcripts during the analysis phase of the study. The data was analysed using thematic analysis.

This allowed for a deeper understanding into the intricacies that lie within the raw data and allowed for the construction of a larger narrative on what motivated the participants to do the volunteer CM work.

To ensure that the data was reliable for purposes of data triangulation, participant observation, in-depth semi-structured interviews and a focus group were used for data collection. Once a participant gave their consent to partaking in the study, all identifying markers such as names, surnames, names of organisations that the participant works with and specific information that may be easily linked with the participant was removed from the data that will be published, to ensure their privacy.

2.6 *Ethical considerations*

The study was granted ethics approval for its duration of the study from the Human Research Ethics Committee, housed in the University of Cape Town's Faculty of Health Sciences (HREC reference number 776/2017). Informed consent was obtained. All participants received a physical copy of the consent form and were interviewed voluntarily. By signing the consent form and taking part in the interview process, the participants agreed to the use of the data that emerged from their interviews for several research outputs (Maxwell, 1998).

Potential harm that could have occurred from participating in a focus group was that anonymity could not always be guaranteed in a group setting. This was made clear to all participants prior to them coming together for the conduction of the focus group. Potential harm could have come in the form of sensitive information that was disclosed during the focus group being shared outside of the group. This was mitigated by having a senior member of the MCSJ leadership present during the focus group to reassert the rules of confidentiality, anonymity and upholding respectful

engagement as comrades within the MCSJ. This was done by Phumzile who also acted as the translator for the duration of the focus group.

3. Findings

There were fourteen participants who took part in this study. Their ages ranged from twenty-two to fifty-two. The participants in the study had previous experience in CM work. The participants' skills targeted a range of social issues including improving parenting skills; empowering youth through sports; increasing safety through patrolling the neighbourhood; a health promotion campaigning targeting HIV/AIDS awareness-raising, teenage pregnancy, alcohol abuse, gender equality, reduction of gender-based violence; and upskilling people in the community with disabilities, through workshops on income-generating skills such as making crafts and soap. The participants brought their expanse of knowledge on these social issues to the MCSJ.

Based on the data collected from the fourteen participants, three broad themes emerged from the findings: pressure on men to avoid informal, unpaid work, reimagining what is perceived as being the 'ideal man' in Gugulethu through CM efforts, and the importance of safe spaces within the MCSJ for male community mobilisers in Gugulethu.

3.1 *Pressure on men to avoid informal, unpaid work*

There is a gendered resistance to the work that the participants are doing. The participants' motivation to do CM work in some voluntary capacity violated expectations as they were expected to provide for their families. Many of the participants were met with resistance from their families. The participants' families were constantly placing them in positions where they had to validate their reason for participating in the CM work that they did, and this was difficult for them to do. The resistance against the participants being involved in CM work came from families in three

forms: generational expectations, gendered expectations and social expectations about forms of work.

3.1.1 *Generational expectations for participants*

Among participants, there was often a sense that Gugulethu as a community that has not developed as quickly as others, when compared to neighbouring townships. The community is known for lower health literacy, little advocacy and a lack of basic and health services. These issues were experienced by and intersected with different generations in Gugulethu in various ways.

There were three main generations at stake. Two generations were included in the study as participants; older participants and younger participants. Also important in their lives were the participants' parents.

Gugulethu has been experiencing a dynamic where the oldest generation living in the household had expected their children, who are now middle aged to become successful and to move out - both out of the house and out of the township - and that the children of the middle-aged cohort would also grow up and leave, which often does not happen. This has resulted in several generations of one family living together in the same home. This changes expectations and relationships between individual family members as well as expectations between themselves.

There are expectations for the older participants to provide for their partners and children, as well as for the oldest generation, that may be staying on the same property. Because of their unemployed status, most of the older participants were still living in the homes that they grew up in, and their parents were living there too, though they no longer earned a salary. There is a sense that it is the participants' turn to take care of the oldest generation who took care of them, and until they move into their own home, they need to take care of everyone who lives within the family home. Many

families struggled to grow and to develop in ways that they had expected and there is increasing pressure to contribute to the family finances if one stayed in the family home. There is also a sense that staying in Gugulethu equates to a lack of success.

3.1.2 *Gendered expectations for participants*

There were different gendered expectations placed on the participants, depending on their age and what role they held in their family. Younger participants had just finished secondary education. Older participants had several years of experience in volunteer work. Formal work was understood as being more masculine. The older participants expressed that their dependents had raised concerns about the participants' responsibility and need to provide for them. The younger participants felt pressure from needing to transition from being a dependent to providing for the family.

3.1.2.1 *Older participants' experiences:* Many of the participants wanted to give something to the community, and did so through giving their time, their energy and their labour - while others if they were able to, gave financially. Many of the older participants held multiple volunteer roles in the community. Some of these roles had a stipend attached to them while others did not. Older participants who earned stipends through long-term engagement in CM still had to find a means to supplement that stipend with other income-generating activities. This was either through selling merchandise or through part-time employment.

Though I do not have formal employment, but what I do is I sell ... sprays ... I had to identify how to make my money while I am not employed formally just to put a plate of food on the table, electricity and for life to go on for now.- Participant No. 7, Interview.

Many older participants experienced pressure from their families and loved ones to get a job that paid them a stable, and a higher income. The older participants expressed that they felt a tension between doing work that is fulfilling, as they fulfilled socio-economic needs and work to fulfil financial expectations from dependents. This was not the case for all the older participants however, as one man's family felt that his involvement would benefit the family.

My family is excited about [me] being involved in community work as they know that if something comes to me they know that it will be shared. They say if you work hard we hope that you are the one who will save us from this mess ... and I tell them whatever I get I will share with you. Participant No. 1, Interview.

3.1.2.2 *Younger participants' experiences:* For younger participants, the pressure that they faced from their families was the need for them to start earning to contribute to the family expenses, since they were no longer considered as children in their homes. One participant said that his parents expressed that as a man, he must hold a formal job with a regular income and that his participation in CM was not a desirable occupation in their eyes. This may have come from the engrained expectations of the participants by their families. Some of the younger participants did not get respect from their families for the roles that they the men played in CM, and instead they received a lot of resistance. The younger participants felt pressured to find a job to contribute to their family's expenses.

My family is not supportive. They don't see it the way I see it, that I'm living in a world, where our parents are used to working and have normal jobs ... they feel like I'm uncaring in the home and only caring out there- Participant No. 3, Interview.

Besides contributing to the family income, many participants felt that their involvement in CM work increased their employability and it would link them to future employment opportunities. They also felt that being a part of the CM was a way to prove to their family that they were trying to seek employment. Attempting to navigate through the resistance they faced, some participants

volunteered and did some informal work on the side to raise money. Several men chose to volunteer in their community while they were actively seeking jobs, because of the pressure that they felt around the expectations from their dependents for the participants to be ‘effective’ men who hold formal, paid jobs. Some of the young participants had already started doing activities to supplement their living costs, such as hosting dance competitions.

Yeah, I feel pressure that I should contribute financially. I do contribute though. The activist work is not how I make my money. I was working as a drama practitioner and that’s how I was making my money. Participant No. 13, Interview.

3.1.3 *Social expectations about forms of work*

Common grievances from participants were the generational expectations of what was deemed an ‘acceptable’ job for a man, as well as familial expectations that as men, the participants were meant to provide financially for their families. The participants were also expected to get formal work which was viewed as work outside the community. In comparison, CM work which is based in the community, was viewed as informal work. Within the community, unpaid work, and informal work was perceived as women’s work. The lack of pay for labour further cements the perception of CM work not being as ‘valuable’ as paid work. Work that is close to home is not valued in the eyes of the participants’ dependents. The participants’ roles in the MCSJ were not taken seriously by their dependents as a result.

During apartheid, homelands were set up in such a way that there was no other option but to go outside of one’s community to seek employment opportunities. Now, in post-apartheid SA, the perception that one has to leave to find ‘valuable’ work is still an idea held by older generations who lived through apartheid. As a result, the older generation who are now relying on some of the participants of the study are of the opinion that working within the community one lives in does

not give one an opportunity for growth, and they still prioritise work acquired further away from one's community, as superior.

Therefore, theme one showed that when the participants performed CM work, within their community, for no pay, that they were pushing up against the traditional understanding of employment. There were several reasons for this belief. Firstly, because the work is unpaid, so they are not fulfilling a perceived financial obligation to their family; and secondly, because the work is not viewed as formal, as a result of its proximity to home and the community.

3.2 *Various ways to resolve tension between gendered norms of volunteering*

Theme two was about the pressure that the participants faced because of doing CM work. Despite this pressure, they tried to resolve the tension between masculine norms and CM work. They also felt an urge to improve their community and to act as an alternative role model to the youth.

3.2.1 *Using CM to perform conventional masculine roles*

In some ways, the participants' involvement in CM could be seen as a conventional expression of masculinity: a desire to be role models, embodying fatherhood, wanting to perform protecting roles in their family and within the community. The participants seemed to also want to develop a valued social role in their community, by being protectors and role models to the youth. Such attributes fall under the conventional understanding of masculinity (White & Caldwell, 2006; Madhavan & Roy, 2012; Ratele, Shefer & Clowes, 2012).

Some of the older participants spoke about how they wanted to be respected in their homes and to have the ability to provide for their families and the communities through their CM work. Some participants have been able to provide through being a member of their local neighbourhood watch. According to participants of this study, a neighbourhood watch is a committee of men who take

turns to patrol streets in their area - on allocated nights of the week and on a shift basis - in order to ensure that there is community-implemented security in their area. Though a neighbourhood watch is not part of what the MCSJ does, there are members of the MCSJ who are involved in neighbourhood watch duties, including some of the participants of this study. This role was more acceptable to the participants' families and seemed to be a respected and a dignified role. One of the benefits of being part of a neighbourhood watch was the regular stipend, which makes the position more acceptable in the eyes of the participant's dependents because of the monetary remuneration, though it is not 'as good' as a 'formal' job located outside the township. 'My family is happy because they feel safe, and they feel respected because no one will just come into the house and do something.' - Participant No. 5, Interview.

One participant felt that his role as a father in his household could be extended to his community.

You know, I have this role as a father. I may not be anything out there but within my household I am a father, and that was when I realised that I could extend my father role to the community out there. I became part of the neighbourhood watch, I saw that I could guard and protect the people in the community." – Participant No. 1, Focus Group.

An older participant spoke about his gratitude for being seen as a role model in the community through his involvement with the MCSJ, and the importance of being visible in this position. This performance of caring through being a part of the CM resonated with many of the older participants in how they viewed their masculinity and what they felt was 'expected' of them as men in the community.

When some of us grew up there were no role models ... without having fathers around. I think now that the role that we are playing, by being here, we are closing that gap of fatherless households, and fatherless children. We are now being seen as people playing a big role in steering our children in the right direction - Participant No. 2, Focus Group.

We have a responsibility as fathers, in our community – Participant No. 7, Focus Group.

3.2.2 *Community pride and the urge to 'Fix Home First'*

Many of the participants spoke about their urge to contribute to their community and to restore a sense of pride in Gugulethu. The participants seemed to have resolved that, since they were not able to leave Gugulethu then or in the near future, that the next step to take was to fix their home and to make Gugulethu a place worth staying in. To do this, the participants had taken up unpaid, informal voluntary positions as community mobilisers and were actively working towards making Gugulethu a safer, better community for all who resided there.

The urge to rebuild Gugulethu as a safe and sustainable neighbourhood that one can live and raise a family in was expressed in several interviews. As many of the men are aware that they might not be able to move out of Gugulethu, they are striving to cultivate it into a safer place. Some participants felt strongly that they needed to improve their own community first before working on improving other communities, which they felt fell into their role as protectors and providers for their families and their community.

Before I go do work elsewhere, I need to work here in Gugulethu. There is no point in me waking up every day and going ... and yet I have not fixed home. I know my area, I feel that there is still work that needs to be done here first - Participant No. 12, Interview.

This contrasts with the idea that 'better' work can only be found outside of Gugulethu and this reinforces the idea that informal work is valuable work. It also asserts that the solutions can be found within the community and that Gugulethu residents do not need to leave home in order to find meaningful work. The participants are invested in making their community a better place as they are aware that opportunities to leave are scarce, and so it makes sense to invest in the improvement of a community space that one will inhabit for the foreseeable future.

Concerns around the improvement of the community came through clearly in the interviews with the participants. Many of them raised concerns about high crime rates, gangsterism, drug and alcohol abuse and high unemployment rates. They often felt unsupported by law enforcement, police and other official organisations and they realised that many of Gugulethu residents lacked a sense of pride.

Participants expressed the need to combat these issues through community mobilising endeavours that they had been pursuing prior to joining the MCSJ. One participant expressed that was is fulfilling a social need that was not being met. ‘Somehow, I feel like I’m contributing in the community - Participant No. 9, Interview.

Although the MCSJ has only recently been established, it has rapidly become an organisation in which members feel safe to express their vulnerabilities and their hopes for the future. It creates both a sense of obligation and a sense of pride to be part of a structure that keeps its promises.

You see its different organisations, different expertise, by coming together we are able to make working together in the community easier. If there is an issue we are now able to refer people to where to find help since we have different organisations working together - Participant No. 4, Focus Group.

3.2.3 *Reimagining the ‘ideal’ man in Gugulethu*

Another way that the participants seemed to manage this sense of crisis in masculinity was by naming the particular destructive notions of masculinity that are present in their community, and to criticize what is essentially the hegemonic masculinity embodied by the typical ‘Gugulethu man’ who is defined by one of the participants below:

The ideal man seems to be the guy with the stack of money, whether he is selling drugs or alcohol. But we are trying to change the perspective ... there is a need to put in hard work in order to get something – Participant No. 1, Focus Group.

There was a shared sense among the participants of wanting to revisit this notion of ‘the ideal man’ in Gugulethu and to work towards actively demolishing these stereotypes. Some participants expressed their desire to embody a responsible nature, and to lead by example, in order to give the youth of Gugulethu alternative role models to look up to.

You cannot sit with a child and say, ‘what is this tik that you are smoking?’ but you are also busy smoking this tik. It does not make sense. You now find that our icons ... are people who sell drugs. Kids no longer have icons such as Mandela, and people who have achieved big things. They see people flaunting drug money ... what is that teaching that child? – Participant No. 5, Focus Group.

The participants’ motivation to be involved in CM work was also perceived as a moral and social crisis amongst the Gugulethu youth. They wanted to be alternative role models to the youth. In particular, the male youths who faced a crisis in masculinity as they wanted to be able to portray an ‘effective’ masculinity that commanded respect and acknowledgment in the community; and in their families through acts of providing. The role models currently present in the community left the youth in a moral crisis because of the means through which they attained their wealth. Participants felt that the youths were comparing gangsters to the men who they knew in their lives who were currently unemployed and were unable to provide financially for their families, and then they chose to have the gangsters as role models.

There was an acknowledgement however, that participants themselves sometimes needed to change first before attempting to transform others. ‘We are here, we want to change the community, first we need to change ourselves because what you preach you need to do’ – Participant No. 1, Focus Group.

Other participants stated that their role models were people who held current community mobiliser positions in their community. Participant five felt that his peers in the MCSJ were his role model. He found that sharing community work spaces allowed him to respect and to learn from his peers.

Some men spoke about the MCSJ as a space to improve themselves, and a space where they had the opportunity to perform a positive and a valued role. In this way, they could act as role models to other men in their community. Through feedback from community members, the participants felt encouraged to continue doing CM work, and younger participants also aspired to one day perform praiseworthy work in their community.

I feel that this MCSJ is important. I hope that one day someone can stand up in a crowd and say the MCSJ helped me through Lwando*¹, because he approached me and he listened to a problem that I had, and he has helped me and I want to say thank you – Participant No. 3, Interview.

Therefore, Theme two showed that some participants fulfilled typically conventional masculine roles in being protectors through the neighbourhood watch, but they also worked to reinstate a sense of community pride by improving Gugulethu. Their work in the community allowed them to be role models for the youth and opened a pathway for a reimagining of what the ideal man in Gugulethu could be like.

3.3 The importance of safe spaces within the MCSJ for male community mobilisers in Gugulethu

Theme three was about how the participants felt isolated from their social circles because of being involved in CM work, and how the MCSJ then became a supportive space, where they found like-minded peers. They also chose to use the MCSJ as a platform through which to share self-care strategies to deal with burnout.

3.3.1 Lack of social support from male friends as a male community mobiliser

Often, participants felt a lack of support from friends when doing CM. Their friends did not value the importance of the work that the participants were doing. Many participants alluded to the lack

¹ Name changed to maintain anonymity.

of support for their CM participation from their peer networks, and some were ridiculed for believing so strongly that through participating in CM efforts that the Gugulethu community could be improved. The lack of a strong peer network (especially one that valued this work) wore down men's resilience in doing CM work. The participants alluded to not being able to tell their friends about the stress that came with doing CM work. This left the participants with few spaces to share their frustrations with the work and few spaces to seek solace. Often the participants would rely on their partners, their fellow CMs or themselves.

There are mixed feelings. It is difficult, but I know my identity and I know what me is. I think my purpose is to do community work. So, no one can convince me that I am wasting my time. I know my identity so if I know who I am no one can change who I am. I have come to the realisation a few years ago that I am a community worker. That is who I am - Participant No. 6, Interview.

3.3.2 *The MCSJ as a supportive space for community mobilisers*

The participants spoke about the different ways in which the MCSJ had created a space where they could voice their frustrations and their fears while still feeling safe enough to know that their work is valued, despite the difficulties that they were facing while conducting it. Many participants raised the importance of the MCSJ providing a safe space, where personal stories could be shared. It is a space where they felt supported and heard. Several participants expressed that they felt more connected to others after hearing their personal stories.

At first, I just came to listen and then finding out and listening to different stories. I also had a story to tell. I am also experiencing certain problems at home ... and they can share how they can cope with a similar issue ... the last training that we had, the lady was talking about 'have you ever been abused in any kind of way'. We are all from different areas, but after that workshop it was helpful because we were like a family. If I thought that I had problems after that training I felt like my problems are small - Participant No. 3, Interview.

Before the MCSJ was established, many participants felt that there wasn't a safe space for men to come together and to speak about their difficulties regarding CM work in Gugulethu. After

fieldwork was completed, the members of the MCSJ created a Men's Forum whose purpose was to be a male-only safe space. The safe space and Men's Forum that has emerged within the MCSJ has become a further motivation for the participants to continue with the CM work. The participants found that being a part of the MCSJ showed them that there is a lack of safe spaces where community mobilisers could come together and speak freely about the difficulties of the work that they did. The participants also found that in the MCSJ their contribution to the community felt valued.

There are days you feel like quitting but because of the work you have already done, and you have come so far you can't quit, what we have already achieved keeps us motivated because what we have done has come from our own pockets – Participant No. 2, Interview.

3.3.3 *Community mobilisers experiences of burnout and how they dealt with it*

The participants found that CM could be tiring at times. The lack of support, alongside the highly demanding work often led to a sense of burning out and being fatigued. The problem of burnout among volunteers isn't gendered, but the ways that men handle that stress and hardship is gendered. The participants often felt alone and could not speak to friends about their emotional stress, which is different from a woman's ability to open up and to rely on friends for emotional support. They had few resources for coping with the emotional and physical fatigue resulting from their volunteering efforts.

Despite the feelings of volunteer fatigue, some of the participants still persevered. The participants who mentioned feeling drained or tired of the work shared ways of self-care within the stressful environment. Some participants listened to motivational speeches or took time out.

I do feel tired of the work that I do sometimes, but I listen to Wilson B Nkosi, there is a speech where they say, ‘rest if you must rest’. I rest if I must rest, and when it is time to hustle I hustle. If there is time I say, ‘okay just give yourself time to rest for like twenty minutes and just look at your book and then go’. I never sit down. I am always busy. I maybe just read a few sentences at night – Participant No. 1, Interview.

Theme three showed that the participants felt that the MCSJ provided a safe space for them to speak about their challenges. They shared how they found solace in the MCSJ space, as their experiences were valued and acknowledged. They also shared the ways that they practised self-care to deal with the fatigue.

4. Discussion

Three themes emerged from the findings of this study. The first theme was the familial pressure on male participants not to do CM work, due to its gendered nature. The second theme was various ways to resolve tension between gendered norms of volunteering. The third theme was the importance of safe spaces within the MCSJ for male community mobilisers in Gugulethu.

The participants experienced a lot of pressure from their families and dependents to attain more formal, paid work outside of the community space. Paid work was viewed as more fitting than the informal, unpaid, voluntary work that the participants have been conducting within the Gugulethu community. The reason for the rejection of CM work by the participants’ families and dependents was that they did not view it as being the type of work that men were ‘meant’ to hold, and they felt that it was more in line with work that women have traditionally conducted.

Participants chose to do CM work in the community, which amongst many positive things, allowed them to be alternative role models to the male youth, by giving them an opportunity to reimagine how the ‘ideal’ Gugulethu man conducts himself.

There were sentiments held by the participants that doing CM work came with its own social pressures: not having support from family and friends and feeling exhausted by the work. The participants pushed through that discouragement however and showed resilience in their actions. The MCSJ unintentionally became a safe space where men could express their thoughts on CM work and could feel heard and encouraged to continue the work that they were doing. The participants chose to do this work because they saw a need for it in their community, and a gap in services that needed to be addressed (Cornish & Ghosh, 2007; Campbell & Cornish, 2010). By doing CM, they ensured that the community became safer, and that community members were more informed about health care, e.g. about the need to uptake HIV testing services, the provision of condoms in schools and affordable sanitary wear for girls.

CM work has also allowed the participants of this study to be alternative role models to the youth, by giving the youth an opportunity to reimagine how the 'ideal' Gugulethu man conducted himself. Some of the role models in Gugulethu embodied 'destructive' notions of masculinity; men who were gangsters and who sold drugs within the community. The men embodying the 'destructive' notions of masculinity may have been incorrectly revered by the youth because of their ability to access cash easily. In a community where there are high rates of crime and poverty, quick access to cash and the ability to provide for immediate needs, regardless of how the money has been attained can unfortunately be idolised. This left the youth in a moral fix, as they saw gangsters with a lot of money, made through selling drugs or stealing.

The findings of this study suggest that most participants took up CM positions after being inspired by somebody or by having a role model (Bandura, 1977; 1986). Many of the participants held multiple leadership positions in the community and were viewed as role models. For younger participants, there was an overwhelming sense of responsibility in the form of being role models

for peers (Watson-Thompson, Fawcett & Schultz, 2008; Flood, 2011); while older participants felt the need to act as father figures in the community (Gavanas, 2002; White & Caldwell, 2006). The fathering aspect of older participants' motivation is in line with the literature on mentoring and on masculinity. The participants are embodying a masculinity that is conflicting to narratives around absent fatherhood in the South African context, in that they are stepping in and filling the gap through their will to father and to mentor male youth in the community, in their positions within the MCSJ. This is where this current study fits in; it shows the idea of fathering in communities and alternative forms of fathering through mentoring, and being role models for the male youth. Participants felt that they had the opportunity to give the youth in their community a chance to look up to men who were performing positive behaviour such as protecting (Taliep, 2015) the community through the neighbourhood watch and marching for health rights rather than resorting to illegal activities such as selling drugs.

There is a potential for CM volunteers to feel a sense of fatigue when doing CM work. Doing CM work can be financially and emotionally taxing. This is because for some CM activities the participants had to use their own funds. Additionally, members of the community relied on the participants beyond their role in the MCSJ. Therefore, having peer support (Bhattacharyya et al., 2001), particularly for men in this form of work, is beneficial. Having monthly MCSJ meetings inadvertently became a form of peer support (Callaghan, Ford & Schneider, 2010; Mwai et al., 2013). Many participants felt less alone.

The participants in the study found comfort in sharing their stories with one another in the monthly MCSJ meetings. After seeing the growing need for a space purely for sharing purposes, the MCSJ has begun holding monthly Men's Forums in Gugulethu, apart from the monthly MCSJ meetings. In this way, they have created another safe space where they can educate one another, while also

sharing their stories with one another, in a male-only space (Morrell & Jewkes 2014). These Men's Forums show how much they needed their own space, where they could consult with one another.

As mentioned above, the participants acted as role models for members of the community. The participants felt the need to improve access to health care and health awareness in the community. Since it has been noted that men have poor health seeking behaviours, having male volunteers in the community doing CM work helps to increase awareness of the positive impact of accessing health facilities, on community members' lives, especially men. Getting men from the same community to do the advocacy work that is needed at grassroots level, to tap into male-only spaces, is useful (Feldhaus et al., 2015). Local knowledge and expertise is key when trying to target men to uptake health care services. Men who have been born and bred in Gugulethu have an insider perspective, as they know about the history of the community, the socio-economic challenges and the cultural context (Merriam et al., 2001). This local knowledge is key to improving health outcomes for men in Gugulethu.

There are three big public health debates relevant to this study:

- 1) the potential value of task-shifting within the health system
- 2) the importance of having more men volunteering in CM work, and
- 3) the need to explore the gendered nature of volunteer work and its impact on men's health seeking behaviours.

The South African health system is overburdened, historically and presently (Benatar, 2004; Natrass, 2004; Sanders & Chopra, 2006; Kautzky & Tollman, 2008; Coovadia et al., 2009). One of the burdens on the health system is the shortage of staff, which affects the quality of health care, including HIV care.

There are volunteers present in the South African health system who have helped to alleviate the pressure from doctors and nurses (Schneider & Lehmann, 2010; Alamo et al., 2012). The move to increase a community-based approach to health systems in SA is not without difficulties. Currently, in SA, volunteer work in the health system is a predominantly female-centred occupation (George, 2008; Van Pletzen & MacGregor, 2013). It has been posited that volunteering is often seen as a job for women (Pleck, Sonenstein & Ku, 1994; Dworkin, Fleming & Colvin, 2015). There is a need for gender equality when looking at CM work. For this to happen there is a need to break down taboos around men performing in volunteer roles in communities.

Increasing the number of men who perform volunteer roles would bring more gender equality to CM work. In doing this, the gendered understanding of who should hold volunteer positions in the health system will be challenged and changed. Having more men volunteering in various aspects of the health system should also positively influence men's health seeking behaviours. This is because men's health seeking behaviours show that they are less likely than women to seek health services (Mansfield, Addis & Courtenay, 2005). This behaviour is for several reasons including men's fear of portraying 'weak' masculinity, where understandings of weakness are linked to illness (Siu, Wight & Seeley, 2014).

The participants of this study are currently doing volunteer work in their community. By coming to understand their motivation for doing this, the results of this study can feed into knowledge on how best to get men to take up volunteer positions more widely in SA. This will help with the current deficit of volunteers in the health system.

Task-shifting has also allowed for more people to be involved in health care and promotion, as well as increased access to healthcare (Callaghan, Ford & Schneider, 2010). This is because the

task of health promotion is being shifted from only being done in the clinic space, to volunteers in communities; and they can access people who may otherwise have been hard to reach, such as the male population. It also has the potential to increase the number of people who will access care. One of the reasons for this is the exposure to health promotion, which may result in community members accessing the health system more frequently as misconceptions would have been addressed and fears dispelled through the health promotion work done by the volunteers within the community.

It has been stated in the literature that men prefer getting peer education and support (Schneider et al., 2008), health care (Pearson, 2003; Levtoev et al., 2014) and advice from other men (Mfecane, 2012; Vale, 2012; Morrell & Jewkes, 2014). Consequently, by getting more men to take up these positions, it may encourage more male patients to uptake health care services in SA. Recent studies by Sonke Gender Justice (2012) have argued that the involvement of men in roles such as health promotion as well as health care services is linked to increased positive health care outcomes for both men and women (Mills, Ford & Mugenyi, 2009).

Volunteer positions in the health system have traditionally been held by women. It follows then, that most research on CM work and volunteer work, including motivation for volunteering - especially health care work - has been done on women (Schneider, Hlophe & van Rensburg, 2008; Glenton et al., 2010; Alamo, Tasneem & Oliveras, 2011).

It is important, therefore, to get to understand men's motivations for participating in CM work in a voluntary capacity. Although CM work has been traditionally understood to be women's work, this study shows that there are men who are passionate about CM and increasing access to the

health system. In this way, the men who volunteer in CM work can disrupt understandings of masculinity and the 'kind' of work that men can do in the community.

Currently, there is little literature on the experiences and the motivation of men who participate in volunteer CM work. If one wants to encourage men to take on volunteer positions in the health system nationally, one must identify and work with the drivers of motivation, encouraging men to participate in the first place. This study has sought to contribute some understanding of what motivates members of the MCSJ in Gugulethu to participate in CM work.

Limitations of the research are that one on one interviews were conducted in English by a female foreign researcher. This may have limited the participants' abilities to express themselves fully. However, there is also a sense that this gave the participants a sense of freedom to disclose feelings of insecurity or frustration with the CM work which the researcher believes may not have been disclosed to a male researcher.

The results of this work emerged out of work done in one community. Nonetheless, in SA there are numerous townships that fit into the same socio-economic bracket as Gugulethu. Hence, there are shared sentiments within the oldest generation who are hoping for the next generation to leave home; as well as similar financial frustrations; and levels of unemployment; as were seen in Gugulethu. In this way, Gugulethu could be viewed as representative of experiences and sentiments held within other South African townships.

Future research could delve further into assessing the potential impact of male-only spaces in Gugulethu and how they could benefit health care advocacy efforts, as well as the value of peer to peer support amongst male volunteers. There could also be an exploration of the advantages of

having more male volunteers involved in CM work, to get men to uptake health care services in their community.

5. Conclusion

This study has shown that men in Gugulethu want to take part in improving their community through CM work. However, it is difficult to do work that is internally fulfilling, when there are external socio-economic needs, and valid expectations from dependents (Akintola, 2006). However, doing activist work within an organisation or participating in CM often does allow a person to learn skills to better themselves for future opportunities of employment. In this study, CM work also gave the participants a chance to be role models in their community, to gain peer to peer support and to have a safe space. These were all motivating factors for the participants to engage in CM work.

The creation of a safe space holds a lot of potential. Participants have expressed their preference for the space that the MCSJ has created; one where NGO members, community members and representatives from key community organisations can come together and have conscious conversations on an equal playing field. Joining the MCSJ was a method of self-care for the participants, as it created a safe space. It reinforced their drive and their will to be a part of CM efforts. For many of the participants, the MCSJ felt like ‘coming home’. It is a space that has been needed in the community of Gugulethu and they expressed excitement and hope for the future of their community because of the combined effort that they are all pouring into the MCSJ’s activities.

The knowledge gained from this study will feed into the larger debate present in SA surrounding the need for more male-centred interventions (Cornell, McIntyre & Myer, 2011) in the public-

sector healthcare system. Men in Gugulethu want to participate in improving their community. They have a passion for the upliftment of their community and are willing to be the drivers of the needed change, under the right conditions. Having lived in the community they are more attuned to the immediate needs of the community, as compared to NGOs or external support systems who may try to do social upliftment work in Gugulethu. Men in Gugulethu are willing to do this CM work. There is a need for the government to take into consideration the non-monetary motivations that volunteers have expressed and use those as inspiration for non-monetary forms of remuneration for future volunteer-based lay worker positions in the health sector. There is a great opportunity to include more men in CM work, and in health systems, strengthening programs based on these findings.

(9116 words)

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Declaration of Interest Statement

The authors declare that there is no conflict of interest.

Biographical note

Samantha Malunga is studying towards a Masters' in Public Health in the Division of Social and Behavioural Sciences at the University of Cape Town. She is currently a teaching assistant in the Gender and Development course housed in the African Gender Institute at UCT.

Myrna van Pinxteren is a PhD Candidate in the Division of Social and Behavioral Sciences, Department of Public Health, UCT. Myrna is currently conducting research in the iALARM project, focusing on improving the use of health care information among health workers and community actors in the Klipfontein sub-district in Cape Town.

Christopher J. Colvin is an Associate Professor and Head of the DSBS. He has a PhD in socio-cultural anthropology from the University of Virginia and a Masters in Public Health from UCT in epidemiology. He has lectured in anthropology, public health, epidemiology, African studies, and comparative literature at South African Universities, as well as Columbia, John Hopkins and the University of Virginia.

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Part D: Appendices

APPENDIX 1: QUESTIONNAIRE/DATA CAPTURE INSTRUMENT(S)

Introductory Questions

What is your name?

How old are you?

Where do you live?

What is your educational background?

Home Life

Where do you live?

Who do you live with?

Do you have to contribute to the finances in the home? (Prompt: In which ways?)

How do you contribute to the finances at home?

How do you balance this with the NGO work that you do?

Does this impact your involvement in NGO work in any way? (Prompt: How so? Give me an example)

Involvement in Community Mobilization

What organization are you involved with?

How did you get involved with it?

What drew you to this kind of work?

What is your role in that NGO/community mobilization group?

How did you come to work in the Gugulethu community? / What drew you to community mobilization work?

What is your main focus in community mobilization? (HIV, gender, education?)

What do you hope to do as result of being involved in NGO/community mobilization work?

Do you think the work that you do is important? Why?

What work experience have you gained from being involved in community mobilization work?

Has being involved in community mobilization work been helpful in terms of getting other jobs?

Involvement in MCSJ

How did you get involved with MCSJ?

What is your role in MCSJ?

What made you want to work within MCSJ?

Perceptions of the Work they do

Intrinsic/Internal factors

Do you feel the work that you do important to you?

What makes the work you do important to you?

Do you feel the work that you do has shaped how you see yourself in any way? (prompt: How?)

Do you think that being involved in this work changed you in any way? (Prompt: give me an example)

Do you ever feel tired of the work that you do? (Prompt: Why?; How do you deal with these feelings?)

Extrinsic/external factors

How do you think the work you do impacts Gugulethu and the people who live here?

How do the people in your life feel about you being involved in community work?

Has being involved in NGO work affected how you are treated in your family, friend group, and community?

How does that impact your involvement in the work?

Have you had any mentors or role models who have influenced your involvement in this kind of work?

If yes, how did they influence you?

APPENDIX 2: CONSENT FORM AND PARTICIPANT INFORMATION FORM

Consent to Participate in Research

**Using Information to Align Services and Link and Retain Men in the HIV Cascade
University of Cape Town**

Qualitative Formative Research Study

1. WHO IS DOING THIS STUDY AND WHY?

My name is Samantha Malunga, a 2nd year Master of Public Health (MPH) student from the University of Cape Town. My study is part of a larger project called i-ALARM (Using Information to Align Services and Link and Retain Men in HIV Cascade) and the study will be a case study particularly looking at **men's motivations in taking up positions in community mobilisation in the Gugulethu** township which falls under the Klipfontein District.

This case study will explore the motivations of men in community mobilization structures and why they choose to play the roles that they do in their communities - as advocates for change and social justice. The study aims to understand the motivations of male community mobilizers who are working in the Gugulethu township. By looking at men's motivations, the knowledge gained from this study will feed into the larger i-ALARM project on trying to link men into HIV care as well as retain them in the treatment cascade. This is because if we understand men's motivations to work alongside such a project, we can make working for the good of the men in the community's health more worthwhile and if the MCSJ members are able to increase men's linkage and retaining in the HIV cascade it could potentially be a pilot study for an intervention that could be rolled out in similar community spaces.

2. WHAT WILL YOU DO IN THIS STUDY?

There will be three interviews that I would like you to participate in and a focus group with other participants if you consent to that too. In all interviews and the focus group there will be a voice recorder present that will be used to keep track of the conversation that takes place. I will then

transcribe the conversations and after analysing them will write a thesis and a journal article on the findings. I will ensure that at no point will any of the information disclosed in the interviews be linked to the research participants. Once the data analysis and write up has been completed, there will be a feedback process where the researcher will present the findings in the MCSJ meeting. Anonymity cannot be guaranteed in a focus group setting. This will be made clear prior to participants coming together for the conduction of the focus group.

Please feel free to ask for clarification on questions if you are unsure what they mean; you may also ask for the question to be posed to you in a language of your choice. If you would like to be interviewed in a language other than English please let the researcher know in advance so that adequate plans can be put in place. If there is a need Phumzile Nywagi, the i-ALARM field coordinator, will be present to interpret but that will be discussed prior to the interview.

The interviews will take place in a venue that is agreed upon by all parties. The interview has no time limit, it will go on for as long as the participant would like to speak. If there are time constraints and the interview can only take place for a certain amount of time please let the researcher know at the beginning of the interview.

3. ARE THERE ANY RISKS IN THIS RESEARCH?

There may be a risk of reliving traumatic instances of your past through talking through them but if such a thing was to occur the researcher will have pamphlets available to direct you to counsellors who will be able to aid you.

4. ARE THERE ANY BENEFITS OF PARTICIPATING FOR ME?

There are no direct benefits to you for participating in this study. There may be long-term benefits for the Gugulethu area since data collected here will feed into the larger i-ALARM project on linking men to care and retaining them there.

5. WILL I BE PAID TO PARTICIPATE?

There will be no financial incentive or remuneration in any form for taking part in the study. There will however be snacks made available for the duration of the interview so that the participant is comfortable as they relay their narrative.

6. WILL MY NAME BE SHARED WITH ANYONE?

If you consent to taking part of this study, you will be requested to choose a pseudonym for the duration of the interviews that will take place. This is to protect your identity and to allow you to speak freely about what you want to discuss. All identifying markers such as names, surnames, names of organizations that you work with and specific information that may be easily linked with you will be removed from the data that will be published to ensure your privacy. Anonymity cannot be guaranteed in a focus group setting. This will be made clear prior to participants coming together for the conduction of the focus group. Access to raw data material will only be available to the researcher (Samantha Malunga); the co-supervisor of the thesis (Myrna van Pinxteren) and the Co- Principal Investigator of the i-ALARM project (Chris Colvin). The unprocessed transcripts from interviews as well as the recordings will not be accessible to anyone beyond these three people. Once the study is done, the raw transcripts and the recordings will be kept in an encrypted file on one computer for 2 years before being permanently destroyed.

7. WHO ARE THE RESEARCHERS?

The Principal Investigators are Dr. Christopher J. Colvin from the School of Public Health and Family Medicine at the University of Cape Town and Prof. Mark Lurie from Brown University in the United States. The researcher conducting this interview is Samantha Malunga. The researcher's co-supervisor is Myrna van Pinxteren.

8. WHAT ARE MY RIGHTS AS A RESEARCH PARTICIPANT?

When saying yes to taking part in the study, you are under no obligation to stay as a participant in the study. If at any point you feel you may want to pull out of the study or no longer feel comfortable being interviewed just let the researcher know and you will be free to do so. There are no negative consequences to pulling out of the study. **If you have questions about your rights as a research participant, contact the Human Research Ethics Committee (HREC) at the Faculty of Health Sciences at the University of Cape Town at 021 406 6338.**

If you have any questions or concerns about the research, please feel free to contact:

Samantha Malunga

Cell: 0747470327

E-mail: samanthamalunga@gmail.com

or

Myrna van Pintexeren

Cell:

Email:

or

Dr. Christopher J. Colvin

Tel: 021 406-6706 (during office hours) or 084-684-7202 (anytime)

E-mail: cj.colvin@uct.ac.za

I have read the consent form and the research study has been adequately explained to me within the consent form. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact and have been provided their contact information. I agree to voluntarily participate in the research study as described above and understand that during any point I am free to withdraw. I will receive a copy of a consent form, which has been signed by me and the researcher, after I sign this consent form.

Having understood the above information and after the opportunity to have my questions answered, I agree to participate in this study.

SIGNATURE OF RESEARCH PARTICIPANT

The information above was described to me by _____. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

NAME OF PARTICIPANT

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant*]. [*He/she*] was encouraged and given ample time to ask me any questions.

SIGNATURE OF INVESTIGATOR

DATE

APPENDIX 3: LETTER OF APPROVAL FROM RESEARCH ETHICS COMMITTEE



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/ths/research/humanethics/forms

11 December 2017

HREC REF: 776/2017

A/Prof C Colvin
Division of Social and Behavioural Sciences
Room 3.46
Falmouth Building-FHS

Dear A/Prof Colvin

PROJECT TITLE: MEN WHO CARE: MEN'S MOTIVATIONS IN TAKING UP POSITIONS IN COMMUNITY MOBILISATION ORGANIZATIONS IN GUGULETHU TO IMPROVE THE PUBLIC HEALTHCARE SYSTEM (Masters-candidate-S Malunga)-sub-study linked to 802/2014

Thank you for your response letter dated 30 November 2017, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 December 2018.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: Samantha Malunga will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

APPENDIX 4: PAMPHLET INTRODUCING MCSJ (2016)



Movement for Change and Social Justice

The Movement for Change and Social Justice (MCSJ) is an alliance of organizations aiming to improve the health and lives of people living in Gugulethu and surrounding areas. MCSJ originated out of a need to address several health and social issues that have emerged in the various neighbourhoods of Klipfontein, including the lack of ARV's in clinics, long waiting times at community health facilities, and limited access to sanitary pads and condoms in schools. MCSJ is working to strengthen the relationship between various NGOs and community organizations in the area to address these issues and improve access to health and social services in Klipfontein. To achieve these goals, MCSJ will host open dialogues about sensitive issues in the community, organize short-term campaigns to address specific challenges, and promote gender equality and the improvement of men's and women's health through health education and health promotion. MCSJ is a joint initiative between the University of Cape Town (UCT), Brown University in USA, Sonke Gender Justice (SGJ), Treatment Action Campaign (TAC) and several other partners who share the same values and would like to collaborate to bring about change in our community. MCSJ is a not-for-profit, non-political, and non-religious initiative and is based Men's Wellness Centre (MWC) on the premises of the NY3 clinic in Gugulethu. Our working area is the Klipfontein Sub-district which includes the neighbourhoods of Gugulethu, New Crossroads, Nyanga, Manenberg, KTC, Phillipi and Heideveld.

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APPENDIX 5: EXAMPLE OF ONE OF THE CAMPAIGN DOCUMENTS THAT EMERGED FROM MCSJ ACTIVIST WORK



Donate sanitary pads to keep girls in school

Girls and young women in Klipfontein are at high risk of missing school or dropping-out due to lack of access to sanitary pads. The Movement for Change and Social Justice (MCSJ) urges the Western Cape Department of Health to put this issue on the health agenda and to provide schoolgirls in need with free access the shortage of sanitary pads and alternatives. Additionally, we ask individuals and NGOs to donate money or sanitary pads for distribution in the community of Klipfontein.

Lack of access to sanitary products contributes to absenteeism and school drop-out, exposes girls and young women to health risks, and undermines their dignity. South Africa has shockingly high school drop-out rates. Most learners drop out after grade 9, and the highest under-enrolment is in grade 12, where only 54.5% of the appropriate school-age population is in school.¹ This is problematic from an educational perspective, but also has significant public health consequences.

Children who drop-out of school are more vulnerable to economic and social difficulties, face a greater risk of behavioural, mental and family disorders, and are more likely to be victims of sexual and physical abuse.² For girls, dropping out of school puts them at a higher risk of HIV infection, other sexually transmitted diseases, rape, and unsafe abortion.

The main reasons for girls drop-out are teenage pregnancy, and poverty-related causes – such as the need to start working to support the family, or to care for a family member.

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Lack of access to sanitary pads is another poverty-related cause of girls' high school drop-out. It is impossible to know exactly how many girls and young women miss school or drop-out due to lack of access to sanitary pads. However, in 2011, the Department of Basic Education estimated that more than 25% of girls had difficulty accessing sanitary products.⁴ A month's supply of sanitary pads costs between R30-R55 – making them unaffordable for

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MCSJ is working to address these issues and improve access to health and social services in Klipfontein.

¹ Govender, Prega, 2016. *School dropout numbers blamed on poor learning in early grades*. Mail & Guardian, 07 June

² Wegner, L., A. J. Flisher, P. Chikobvu, C. Lombard and G. King. 2008. "Leisure boredom and high school dropout in Cape Town, South Africa." *Journal of Adolescence* 31(3): 421-431.

³ Wegner, L., A. J. Flisher, P. Chikobvu, C. Lombard and G. King. 2008. "Leisure boredom and high school dropout in Cape Town, South Africa." *Journal of Adolescence* 31(3): 421-431.

⁴ Bianca Ackroyd, 2016. *INFOGRAPHIC: Schoolgirl sanitary towels by numbers*. eNCA, 19 September

APPENDIX 6: RESEARCH INFORMANTS TABLE

Participant Number	Age	Community Focus
Participant 1	33	Disabilities
Participant 2	39	Sports
Participant 3	25	Domestic Violence
Participant 4	22	Community Development
Participant 5	52	Theft
Participant 6	37	Teen Alcohol Abuse
Participant 7	45	Education
Participant 8	43	HIV
Participant 9	33	access to education
Participant 10	27	Police visibility
Participant 11	49	Sports
Participant 12	45	Parenting
Participant 13	24	Youth
Participant 14	22	Youth

APPENDIX 7: THE THREE STAGES OF DATA ANALYSIS

Stage 1:

The data were read over several times using the research questions as a guide. The research questions were:

- Why are the participants volunteering their time to be a part of MCSJ?
- What are the participants' motivations to be a part of MCSJ?
- In what ways do the participants challenge hegemonic masculine norms in the roles that they play in their community?

The transcripts were coded. Having looked at the codes after this process, themes began to emerge after several readings of the transcripts.

Below is an example of how the transcripts were coded:

The last training, we had...was talking about have you ever been abused in any kind of way. We are all from different areas, but after that workshop it was helpful because we were like a family. If I thought I had problems after that training I felt like my problems are small.

It is a challenge man, for us to be a unit and for us to help ourselves and for us to help the community, to elevate us all.

7.1 EXAMPLE OF THE KEY TO COLOUR CODES USED DURING ANALYSIS

Colour	Codes
XXX	Skills development
XXX	Vulnerability/ ability to share
XXX	feeling connected like family
XXX	Community upliftment

Stage 2:

Once the themes emerged, they were clustered into groups with similar links.

Stage 3:

A long list of 20 themes, was reduced to nine sub-themes and 3 main themes

7.2 CODING FRAME AND DATA ANALYSIS

Final Themes	Definition of Theme	Sub-Themes	Examples of codes
1. Pressure on men to avoid informal, unpaid work	Familial pressure on male participants to not do CM work due to its gendered nature.	<ul style="list-style-type: none"> a. Generational expectations for participants b. Gendered expectations for participants c. Social expectations about forms of work 	caring labour; financing community mobilisation activities; financial insecurity;
2. Various ways to resolve tension between gendered norms of volunteering	Ways in which the participants to resolve the tension between masculine norms and CM work	<ul style="list-style-type: none"> a. Using CM to perform conventional masculine roles b. Community pride and the urge to 'Fix Home First' c. Reimagining the 'ideal' man in Gugulethu 	community collaboration; community pride; trust; rapport; volunteer fatigue; self-care; responsibilities; fatherhood;
3. The importance of safe spaces within the MCSJ for male community mobilisers in Gugulethu	Caring for the men who care: Self-care as a community mobiliser through the creation and maintenance of safe spaces	<ul style="list-style-type: none"> a. Lack of social support from male friends as a male community mobiliser b. The MCSJ as a supportive space for community mobilisers c. Community mobilisers experiences of burnout and how they dealt with it 	Support; camaraderie; friendship; feeling heard; isolation; lack of peer support

APPENDIX 8: INSTRUCTIONS FOR AUTHOR OF JOURNAL WHOSE FORMAT HAS BEEN USED

About the Journal

Social Dynamics is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy. Please note that this journal only publishes manuscripts in English. *Social Dynamics* accepts the following types of article: original articles, book reviews.

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Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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A typical paper for this journal should be between 5000 and 8000 words, inclusive of all notes and references. Reviews should be between 1,000 and 1,500 words, and review essays 1,500-3,000 words, unless otherwise agreed upon with the editors. Section headings and sub-headings should be clearly indicated by the use of bold typeface (section headings) and italics (section subheadings) respectively.

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Please refer to these [quick style guidelines](#) when preparing your paper, rather than any published articles or a sample copy:

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Title: Use bold for your article title, with an initial capital letter for any proper nouns.

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Fourth-level headings should be in bold italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

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