

**THE CLINIC AS A GENDERED SPACE:  
AN EXPLORATORY STUDY EXAMINING MEN'S ACCESS TO AND UPTAKE  
OF VOLUNTARY COUNSELLING AND TESTING SERVICES (VCT) IN THE  
CONTEXT OF A MALE-FRIENDLY HEALTH FACILITY.**

María Fauli FLLMAR007

A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Masters in HIV/AIDS and Society

Faculty of the Humanities

University of Cape Town

2008

**Declaration**

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

Signature:

Date: 31 March 2008

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## **ACKNOWLEDGEMENTS**

My program has been coordinated by Dr Judith Head, and I would like to acknowledge her contribution to this piece of work, as through the core course, Critical Issues in HIV/AIDS, I was able to partly develop critical thinking on this subject and my academic argument.

I would also like to thank the teaching staff on the Public Health course, Gender and Health, who were, in part, the stimulus for this project. I would like particularly to mention Jane Harries and Dr Di Cooper as supportive and helpful, particularly with the task of finding a supervisor.

Further, without the consent of the Khayelitsha, Site C, Men's Clinic Partners, this research project would not have been possible. I am grateful to them for letting me carry out the research. The Clinic Partners include Cape Town City Health, the Western Cape Provincial Department of Health, Hope Worldwide and Medicine Sans Frontiers.

The staff at the clinic were amazingly accommodating of my needs at the clinic. The counsellors and nurse were welcoming and contributed to the smooth running of the interviews. They also contributed to the research data. Their help is greatly appreciated.

I am also grateful to Ms Andiswa Gidana who assisted me with transcribing and translating the recorded Xhosa interviews into English.

Funding for the project was made available through the National Research Foundation (NRF) and a UCT Harry Crossley Award for which I am grateful.

I would also like to thank Rosalie Richfield at the Graduate School of Humanities who has provided critical administrative support throughout my Masters Degree.

I would also like to acknowledge the invaluable help that I received from Mr Phumzile Nywagi who assisted me with my fieldwork at the Clinic, translating questions and answers in both Xhosa and English. He also offered insights and key information to my research through discussions we shared.

Finally, and most critically, I would like to thank my supervisor, Dr Christopher Colvin, PHD, MPH for his guidance and support through the writing of my Masters thesis. He has been unwaveringly committed to my project and his encouragement and expertise have been irreplaceable. I am grateful to Dr Colvin for the role he has played in this research project.

## **ABSTRACT**

# **THE CLINIC AS A GENDERED SPACE: AN EXPLORATORY STUDY EXAMINING MEN'S ACCESS TO AND UPTAKE OF VOLUNTARY COUNSELLING AND TESTING SERVICES (VCT) IN THE CONTEXT OF A MALE-FRIENDLY HEALTH FACILITY.**

Men in South Africa test for HIV at lower rates than do women. Investigating ways to increase men's uptake of Voluntary Counselling and Testing (VCT) services is therefore of critical importance to public health. The Site C Men's Clinic in Khayelitsha, where this study took place, is an attempt at increasing men's use of VCT. Men's views about a male-friendly space and its influence on VCT uptake had not yet been investigated in South Africa. The Men's Clinic in Khayelitsha allowed me the opportunity to interview men attending the clinic to explore their perceptions and experiences of VCT within this environment. The central aim was to explore whether men perceive the facility to be enabling in their decision to use VCT now or in the future. Furthermore, the intention of this study was to explore whether male clients perceive male health workers any differently to women staff with specific attention to confidentiality. This is closely linked to the uptake of VCT, as trust in health-workers is central to the process. The study also sought to evaluate how this male-friendly environment may contribute to normalising testing in men, which is another encouraging factor in VCT uptake. Finally, although this is a critical issue for men's health, the study aimed to investigate whether VCT services targeted at men, may benefit women's health too.

The interviews were qualitative, semi-structured interviews. Being an exploratory study dealing with men's perceptions of the clinic and its services, the qualitative approach was valid. This interview approach allowed for variety in answers, but also revealed commonality, as themes emerged in response to questions. The project involved 33 qualitative interviews with men attending the clinic in Khayelitsha (including 15 men who tested at the clinic and 18 non-testers). The client interviews took place between 5 – 27th October 2007.

Getting men to test for HIV is an urgent task for public health in South Africa. This study explored whether men experienced the clinic to be male-friendly and whether this influenced their attitude to testing. Most men expressed an increase in comfort and personal safety at the facility, which are valued attributes of a VCT facility. Many clients expressed greater trust in male staff, and surprisingly, trust in male patients, which contributed to their comfort at the facility. There was evidence in the interview data to suggest that male clients would contribute to normalising VCT through talking to peers about the clinic and its services. This is also likely to contribute to the greater VCT uptake in men. Testing clients seemed open to talking to their partners, having tested at the clinic. Some clients wanted to return to the facility with their partner to test. This indicates a potentially positive influence on the health of the couple.

Although the clinic quantitative data indicates a slow and disappointing start for the clinic, based on the perceptions expressed by these clients, the facility is filling an important health service for men. It is likely to encourage more men to access VCT, because men feel confident in the service and staff. This is arguably in the interests of men and women's health.

## **LIST OF ACRONYMS**

**ACTS - Assess, Consent, Test and Support**  
**CT1 – Client tester one**  
**CT2 etc – Client tester two**  
**CNT12 – Client non-tester twelve**  
**CNT21 etc – Client non-tester twenty-one**  
**HAART – Highly Active Anti-retroviral treatment**  
**HSB – health-seeking behaviour**  
**HWW – Hope Worldwide**  
**MC - Men's Clinic**  
**MSF – Medicine Sans Frontiers**  
**P1 – Partner one**  
**P2 – Partner two**  
**P3 – Partner three**  
**P4 – Partner four**  
**PGWC - Western Cape Provincial Department of Health**  
**STD- sexually transmitted disease**  
**STI – sexually transmitted infection**  
**SRH – sexual and reproductive health**  
**UCT – University of Cape Town**  
**VCT – voluntary counselling and testing**  
**WoM – Word of Mouth**

## TABLE OF CONTENTS

Title Page .....	Error! Bookmark not defined.
Acknowledgements .....	2
Abstract .....	3
List of Acronyms .....	5
<b>Chapter One: Introduction .....</b>	<b>10</b>
HIV and Gender in South Africa	10
<i>HIV in South Africa</i>	10
<i>Gender and HIV/AIDS in South Africa</i>	11
HIV, Gender and Prevention	13
<i>Gender and VCT</i>	13
<i>Human Security</i>	14
Health and 'masculinities' in South Africa	15
<i>'Masculinities'</i>	15
<i>Men's Health-Seeking Behaviour</i>	16
Rationale and Overview of Study	16
<i>The Khayelitsha Clinic and its Strategy</i>	16
<i>Overview of Aims, Objectives, Methods</i>	17
<b>Chapter Two: Literature Review.....</b>	<b>18</b>
Gender and Health	18
Gender and Access to Care: Barriers to Seeking Health-care and VCT	18
<i>Possible Barriers</i>	18
<i>Adapting Health Services for Men</i>	20
<b>Chapter Three: Methodology.....</b>	<b>22</b>
Background	22
<i>Main Research Question</i>	22
<i>Subsidiary Research Questions</i>	22
Population, Sampling and Data Collection	22
<i>Research Site</i>	22
<i>Method: Qualitative Interviews</i>	23
<i>Population</i>	24
<i>Sampling</i>	25
<i>Ethics</i>	25
<i>Consent Procedure</i>	25
<i>Logistics</i>	25
<i>After the fieldwork</i>	26
<i>Analysis</i>	26
<i>Reliability and Validity</i>	27
<b>Chapter Four: Introduction to Findings: The Clinic as a Gendered Space .....</b>	<b>28</b>
Clinic Partner Perspectives	28
Client Perspectives	29

<i>Illness and 'masculinity'</i>	29
<i>Gender and accessing health services</i>	30
<i>Only accessing care at times of crisis</i>	32
Thesis Outline	33
<b>Chapter Five: Male-friendly Clinic Characteristics.....</b>	<b>34</b>
Defining a Male-friendly clinic	34
Male Staff	35
<i>Man to Man</i>	35
<i>Man to Woman</i>	36
<i>'Traditional Confidentiality'</i>	37
<i>Someone like me</i>	38
<i>An exception to the rule</i>	38
Male clients	39
<i>Greater trust in male patients</i>	39
A Culture of Respect and Independence: Unthreatening environment to 'masculinity'	40
<i>Emasculating experiences at Public Clinics</i>	40
<i>Men's Clinic accommodates 'masculine' traits: Respect and autonomy</i>	41
<i>Counselling: a threat to 'masculinity'?</i>	43
Promoting alternative views of 'masculinity'	45
Location	45
Opening Hours	46
Decentralised Service/Non-clinical Site	47
VCT and STI treatment	47
Fast and Efficient Service	48
Is the male-friendly aspect of the clinic an enabling factor in men's testing?	48
<b>Chapter Six: Trust in Male Health-workers.....</b>	<b>49</b>
Factors contributing to Trust in Health-workers	49
<i>'Men will keep it inside'</i>	50
<i>Anonymity between client and staff</i>	51
<b>Chapter Seven: VCT Normalisation amongst men .....</b>	<b>53</b>
Testing as unusual and silenced among men	53
Self-efficiency and Life Chances	55
<i>Self-care</i>	55
<i>Some men did demonstrate the initiative to look after their health before becoming very ill.</i>	55
<i>Life Chances</i>	56
Routine Testing contributing to VCT normalisation	56
Talking about testing with male peers	57
<i>Attempts to encourage other men to test are often ineffectual</i>	57
Less direct, 'Word of Mouth' Marketing	59
<b>Chapter Eight: Advantages for women's health.....</b>	<b>62</b>
Male-friendly as opposed to Male-only	62
Improving the SRH of both men and women	63
<i>Addressing proxy-testing for the benefit of men and women</i>	63
<i>'Bring in the males so they ...would be part of the couple'</i>	64
<i>Promoting Dialogue between partners</i>	65

Testing together or testing alone?	66
<i>Testing alone</i>	66
<i>Testing together</i>	68
Do VCT services targeted at men in turn encourage these men to promote testing in their partners?	68
<b>Chapter Nine: Discussion and Recommendations.....</b>	<b>70</b>
Male-friendly clinic characteristics	70
<i>An Apparent Contradiction: Qualitative vs. Quantitative data</i>	70
<i>A Slow Start</i>	71
<i>Community</i>	72
<i>New Concept</i>	72
<i>Marketing Campaigns</i>	72
<i>Word of Mouth promotion</i>	73
<i>Staff</i>	74
<i>Location</i>	79
<i>Opening Hours</i>	80
Trust in Male Health-workers	80
Men's Clinic contributing to the Normalisation of VCT amongst men	82
<i>Testing is unusual for men: Feminisation of the Clinic, HIV and AIDS and VCT</i>	82
<i>Routine testing: an opt-out approach</i>	83
<i>Role Models</i>	84
<i>Testing in times of crisis</i>	85
Advantages for women's health	86
<b>Chapter Ten: Conclusion.....</b>	<b>88</b>
<b>References .....</b>	<b>91</b>
<b>Appendix 1: VCT Model.....</b>	<b>i</b>
<b>Appendix 2: Questions .....</b>	<b>ii</b>
<b>Appendix 3: Table of testers and non-testers.....</b>	<b>iii</b>
<b>Appendix 4: Additional Interview Quotations .....</b>	<b>iv</b>
Chapter Four: Introduction to Findings: The Clinic as a Gendered Space	iv
<i>Illness and Masculinity</i>	iv
Chapter Five: Male-friendly Clinic Characteristics	v
<i>Male staff</i>	v
<i>A Culture of Respect and Independence: Unthreatening environment to 'masculinity'</i>	vi
<i>Promoting alternative views of 'masculinity'</i>	viii
<i>Location</i>	viii
<i>Opening Hours</i>	viii
Chapter Six: Trust in Male Health-workers	viii
<i>Factors contributing to Trust in Health-workers</i>	ix
Chapter Seven: VCT Normalisation amongst men	x
<i>Testing as unusual and silenced among men</i>	x
<i>Self-efficiency and Life Chances</i>	x
<i>Talking about testing with male peers</i>	x
<i>Less Direct, Word of Mouth Marketing</i>	x
Chapter Eight: Advantages for women's health	x
<i>Improving the SRH of both men and women</i>	xi

*Testing together or testing alone?*

*xi*

**Appendix 5: Recommendations Table .....xi**

**Appendix 6: The Researcher: My Positionality .....xiii**

# **CHAPTER ONE: THE CLINIC AS A GENDERED SPACE: AN EXPLORATORY STUDY EXAMINING MEN'S ACCESS TO AND UPTAKE OF VOLUNTARY COUNSELLING AND TESTING SERVICES (VCT) IN THE CONTEXT OF A MALE-FRIENDLY HEALTH FACILITY.**

## **MAIN RESEARCH QUESTION**

Do men perceive the male-friendly clinic to be enabling in their use of voluntary counselling and testing services?

## **Introduction**

### **HIV and Gender in South Africa**

#### *HIV in South Africa*

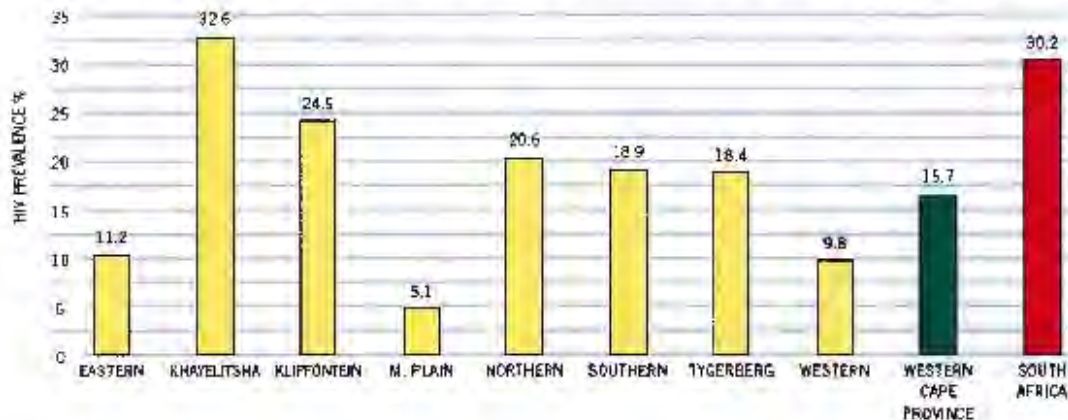
South Africa has more people living with HIV than any other country in the world (UNAIDS, 2007: 16). It is estimated that 5.54 million people are currently living with HIV in South Africa (National Department of Health, 2007c:9). The HIV adult prevalence rate varies within South Africa, with 15% in the Western Cape, and 39% in KwaZulu-Natal (UNAIDS, 2007:16).

Within the Western Cape there is also variance; Khayelitsha has 33.0% prevalence rate<sup>1</sup> (National Department of Health, 2007c:9). The table below shows the prevalence rates in the Western Cape in 2005. Khayelitsha is the highest in the province.

---

<sup>1</sup> Khayelitsha is a low-income area of the Western Cape. There is clear correlation between poverty and high HIV prevalence, with communities in informal settlements...often the most vulnerable. These communities are often also the most underdeveloped, with poor access to social services including HIV and AIDS prevention, treatment, nutrition and care programmes' (National Department of Health 2007c: 29 – 30). Moreover, poor people are less likely to have health schemes allowing them to access private care more easily. In the context of STIs and HIV/AIDS, where stigma is attached, many people would prefer to access these services privately, but for the poor, this is not usually possible. Economic status is therefore another aspect affecting men's low utilization of VCT in public clinics in Khayelitsha, because most of these men are unable to access these services privately.

Figure 13. HIV Prevalence by Area in the Cape Metropole District versus the Western Cape and South Africa: 2005



Graph from the HIV and AIDS and STI National Strategic Plan 2007 – 2011 (National Department of Health, 2007c: 29).

There is evidence<sup>2</sup> suggesting the South African epidemic is possibly stabilising; nevertheless, it remains a human security concern, threatening South Africans, physically, emotionally, socially, economically, and politically (Department of Health South Africa, 2007b:6).

### *Gender and HIV/AIDS in South Africa*

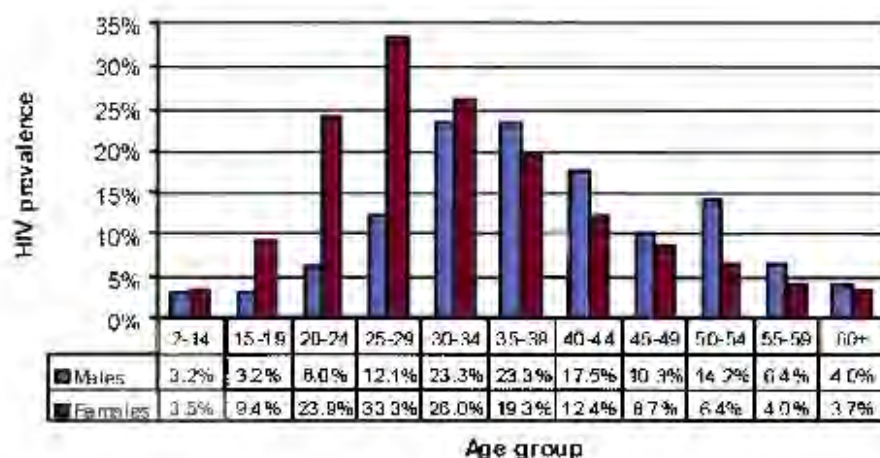
Health is 'a product of a complex interaction of human beings, social systems, and environments over time' and it is therefore important to examine how these 'determinants sort people for health' (Burriss, 2004:336). Gender is one such determinant, central in shaping the South African HIV epidemic.

UNAIDS data reflects that 61% of those infected with HIV/AIDS in Sub-Saharan Africa are women (UNAIDS, 2007:1). In the South African adult population reports differ about the infection rates of men and women. A University of Witwatersrand study (2004) indicates that 77 % of infected youth<sup>3</sup> are women (Pettifor, et al., 2004:1). According to the National Department of Health, the difference is most pronounced in the age group 20-24 years where 23.9% of women are infected, compared to 6.0% of men. A marked gender difference is also shown in the age group 75-79 indicating 33.3% for women and 12.1% for men (National Department of Health, 2007c:29). This could be related to power dynamics between men and women, where men usually dictate the terms of sex (Chege, 2005:115). In contrast, in looking at overall adult prevalence, it is estimated that 44.5% of HIV positive people are men and the

<sup>2</sup> The National Department of Health (2007b) reports a decrease in HIV prevalence in the antenatal surveys between 2005 and 2007 (2007b:6).

<sup>3</sup> 'Youth' here is defined between the ages 15 – 24 years (Pettifor, et al., 2004:1)

remaining 55.5% are women (Department of Health South Africa, 2007c:16). Another report estimates that 49.3% of those infected are men and 50.7% are women (HSRC, 2005:21). This shows the disease levelling. 'The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group' (National Department of Health, 2007c:29). The graph below illustrates the age-specific, gendered profile of the epidemic in South Africa.



Graph taken from HIV and AIDS and STI National Strategic Plan 2007 – 2011 (National Department of Health, South Africa, 2007c:24)

Globally, and in South Africa, an HIV positive man is likely to infect more people than an HIV positive woman, for biological and social reasons. The fact that women are biologically more vulnerable is compounded by social gender inequalities between men and women (UNAIDS, 2000: 9)

Although women are certainly not passive victims (they negotiate power where they are able) men, to a large degree, have the power 'to influence and/or determine women's' sexual and reproductive health (SRH) (Chege, 2005:115). The power relations at play between men and women means that the sexual behaviour of men affects that of women, possibly more than women affect the SRH of men (National Department of Health, 2007a:11). It is therefore important for the health of men and women to promote gender equity in relationships, and encourage men's greater responsibility in matters of SRH (UNAIDS, 2000:10).

In heterosexual relationships responsibility for SRH usually falls on the shoulders of women; they typically take responsibility for contraception (Sen, Germain, Chen, 1994:228). The only effective and widely available barrier method, preventing HIV transmission, is the male condom; however, this requires the co-operation of the male partner (Varga, 2001: 176, Walker, Reid and Cornell, 2004: 47). For many women, insisting on condom use is not possible due to unequal power relations with men (Kauffman, 2004: 22-23, Cooper, et al., 2004:74). Research indicates that to improve people's SRH, we need to engage with men and women, and not one sex in isolation of the

other (Morrell, and Ouzgane, 2005:13, Peacock, 2005; Barker, 2005; Chege, 2005). Men need to be brought into the SRH picture.

Not all men subscribe to risky sexual behaviour and many take precautions to protect themselves and their partners from HIV and STIs. Even so, the socially accepted stance<sup>4</sup> that men are entitled to multiple partners puts them and their partners at risk of HIV infection (Barker, 2005:3). Certainly women also play a significant role in the spread of HIV, however, 'it is the sexual behaviour of men that largely drives the epidemic' (Barker, 2005:4).

In some parts of the world, the social attitude has been to blame men for the spread of HIV (Barker, 2005:4). That is not my intention here; both men and women contribute to the spread of HIV. In this dissertation I aim to highlight that while men are individuals and some place themselves and others at risk; it is crucial to be aware that those individuals live in a social environment which influences their behaviour. Gender socialisation aids certain unhealthy behaviours, including sexual behaviour, as well as men's avoidance of health facilities. If voluntary counselling and testing (VCT) is part of HIV prevention, and men do not feel comfortable accessing this service, then gender socialisation of men feeds the epidemic. My focus is on men's health-seeking behaviour (HSB) and how "masculinities" may prevent men from accessing VCT. My interest is whether men perceive a male-friendly facility to encourage them to use VCT.

## **HIV, Gender and Prevention**

### *Gender and VCT*

VCT<sup>5</sup> is recognised as a central aspect of HIV prevention and care (Day, et al., 2003:665, Magongo, et al., 2002:3). Testing for HIV is a voluntary process involving pre and post-test counselling. Regardless of what the result of the test, because of the counselling approach, VCT is an opportunity for education and motivation. Ideally, the VCT participant is educated about steps they can take to protect themselves and their sexual partner/s (Day, et al., 2003:665; HSRC, 2005:85). Furthermore, if one is to test positive, VCT is an entry-point for accessing HIV support, care and treatment (Day, et al., 2003:665-666, Thiede, Palmer and Mbatsha, 2004:1). VCT is not the answer to stopping the epidemic, but as part of a broader system including treatment and structural interventions; it will arguably contribute to lowering infection rates.

Research indicates that men use VCT at lower rates than do women (Peacock, 2005:149; Levack, 2005:5, Makoba, 2006). In 2005, 20% of South Africans had ever used VCT and only one in five of these were men (Bodibe, 2005). A study of 2500 men and women between the ages 15 – 34 showed that only 28 % of men interviewed had ever been tested, in comparison to 58% of women (Peacock, 2005: 149). Over the months of July and September 2006, out of the 50 300 people who tested in Cape Town clinics, only 17 999 (36 %) were men (Makoba, 2006). This gendered disparity is a public health concern in light of the HIV/AIDS epidemic.

---

<sup>4</sup> Men's having multiple partners is often socially accepted among men, and women.

<sup>5</sup> I have included a diagram for the VCT model in Appendix 1

in South Africa, in 2001, it was estimated that only 10% of those who were HIV positive knew their status. The implication is that most infections taking place are between people who are unaware of their status, and therefore not consciously taking steps to protect themselves or their partners (Kenyon, Heywood and Conway, 2001:169). This highlights the urgency with which the profile of VCT needs to be raised.

I propose that the greater recruitment of men to VCT will improve men and women's SRH. While men's health is an issue in and of itself, this is in the interest of women's health too, because of these skewed power relations (Varga, 2001:180). VCT is thought to promote HIV awareness and promote safer sex, potentially leading to the encouragement of partner testing as well as increased condom use (HSRC, 2005:85; Thiede, Palmer and Mbatsha, 2004:1). It is therefore important that VCT is aimed at the greater inclusion of men, which should, in turn, increase women's testing. Because of lower testing rates and gender power relations, I argue that there is a greater urgency to engage men in VCT (Varga, 2001:179). If men practice safer sex, it will have a positive effect on their health and that of their partners. VCT is a public health, and human security issue in South Africa.

### *Human Security*

HIV/AIDS is arguably one of the most overwhelming human security problems confronting South Africa today. The virus targets young adults, those in their economic prime, childbearing and parenting years (Lewis, 2004:97). Curbing the epidemic is therefore of critical importance.

As the term 'security' is re-imagined and given new meaning, human beings become the central security concern, as opposed to previous views whereby state security was threatened by external forces (Wood and Shearing, 2007:63 – 64). The Commission of Human Security notes, 'the interests of humanity, as a collective, become the focus' (Wood and Shearing, 2007:64).

It is in the interests of humanity that the prevalence of HIV/AIDS is greatly reduced in South Africa for reasons of 'development, governance and security' (CCR and RBF, 2006:15). HIV/AIDS is a health crisis, affecting the life expectancy and quality of life of thousands of South Africans. Not only does the virus affect the infected, but also drains resources from households, as they care for AIDS patients.

Beyond the health crisis, HIV and AIDS is a threat to social, political and economic stability (CCR, 2006: 13). Prolonging and improving quality of life through Highly active anti-retroviral treatment (HAART) is a means of reducing this security threat. On top of this, South Africa must prevent the spread of HIV. This is partly done through VCT.

Kofi Annan, former UN Secretary- General, described human security as people's right to 'freedom from fear' (Ndinga-Muvumba and Pharaoh, 2006:15). Fear is directly linked to HIV/AIDS. HIV and AIDS are deeply stigmatised in South Africa. It is therefore a human security issue to reduce this fear, through HIV normalisation, but also to directly reduce the threat of HIV infection. Increasing VCT rates is one means of contributing to the further normalisation of

the preventative practice. Moreover, as a tool of prevention, HIV testing can contribute to the reduction of HIV infection.

VCT, within a larger HIV/AIDS prevention and treatment program, is a crucial aspect of addressing this human security crisis. More people urgently need to use VCT so that they can access HAART, they are educated and more people live without fear. More specifically, there is a greater need to get men to test, for everyone's health.

## **Health and 'masculinities' in South Africa**

### **'Masculinities'**

In understanding male HSB it is helpful to examine constructions of 'masculinity'. It must be noted, though, that these structures are fluid and there exist multiple 'masculinities' (Courtenay, 2000:1387). There is not one masculine identity to which all men ascribe (Courtenay, 2000:1387). Rather, men and women adopt some attributes that contribute to the culturally-defined concepts of 'femininity' and 'masculinity' (Courtenay, 2000:1387).

'Masculinity' can be defined as what men 'should' be, and what they are striving to be (White, 2000:36; Connell, 2005:70). Men, as do women in relation to femininity, conform to some stereotypic behaviour and in turn fulfill expected characteristics in terms of what it (ideally) means to be a man (Courtenay, 2000:1387, White, 2000:36). These socially constructed guidelines of 'masculinity' and 'femininity' direct the beliefs and behaviour of men and women (Courtenay, 2000:1288).

Morrell (2001) notes that 'masculinity' is not inherited; it is learned and constructed, 'in the context of class, race and other factors which are interpreted through the prism of age' (2001:8). There is no single 'masculinity' or 'African masculinity'. I am uncomfortable with this term 'African masculinities' too, which, although admitting diversity, still claims a common 'masculinity' attributed to the sharing of a continent. 'Masculinities' are diverse and numerous across and within nations, language, 'culture', 'race', class and age (Morrell, 2001:8). While there may well be similarities in what it means to be a man, between men sharing the same language or culture, there will be differences too. 'Masculinities' indicates this diversity in ways of being men, while acknowledging there are culturally defined ideals of 'manliness', that many men and women uphold (Varga, 2001:177).

Some 'manly' attributes include independence, physical strength, and emotional control (Addis and Mahallk, 2003:7). Moreover, for some men violence is connected to manliness (Reid and Walker, 2005:7). Violence against other men or women is a means to express physical strength, dominance and independence (because you can look after yourself and others through strength). Having multiple partners is also, for some men, a means of expressing ways of being a man (Reid and Walker, 2005:15). These 'masculine' traits obviously have consequences for men's, as well as their partner's health.

### *Men's Health-Seeking Behaviour*

All these aspects of 'masculinity' may contribute to the trend in which men access health-care less frequently than women.

The archetypal social pressures put on men to prove their 'masculinity', including the demonstration of physical strength which withstands illness and pain, are related not only to expressions like violence, but also in seeking health-care (Courtenay, 2001:1389). This may translate to presenting an image of general well-being, and dismissing ill-health as minor, regardless of its severity (Nattrass, 2006:10; Levack, 2005: 19, Peacock, 2005:149, Beck, 2004:9). Accessing health-care, then, for many men, feels like a demonstration of weakness, something that is *not* masculine. Central to performing hegemonic 'masculinity' 'In a sexist and gender-dichotomous society', then, is the '[r]ejecting what is constructed as feminine', including health-care (Courtenay, 2001:1389).

In South Africa, the 'proportion of men attending government clinics [is predicted] to be 25% lower than that of women<sup>6</sup>,' this is 'because men are less likely to seek medical help than women when afflicted with the same illness' (Nattrass, 2006:11). The social 'norms and practices' which have come to demonstrate manliness, prevent men from seeking help and health-care, including VCT (Varga, 2001: 176; Nattrass, 2006: 3). 'Masculine' behaviours and men's perceptions of health institutions as 'feminine' spaces, must be taken into account when addressing men's low testing rates and the silence among men about using VCT.

## **Rationale and Overview of Study**

### *The Khayelitsha Clinic and its Strategy*

Varga (2001) suggests that greater research in men's 'health service requirements' is needed to address men's low utilisation of health services (2001:190). This paper examines men's experiences at the Khayelitsha Site C, Men's Clinic (MC). An approach to addressing the low attendance of male VCT clients was to form a male-friendly health facility, which takes these factors into consideration.

In a meeting with Wessel van den Bergh, from Hope Worldwide (HWW), in April 2007, I was alerted to the opening of a male-friendly clinic, in Khayelitsha, Cape Town, South Africa. It opened in May 2007 and was designed as a 'catchment'<sup>7</sup> site. It aims to recruit men into the health-care system and provides STI treatment and VCT (van den Berg, 2007, Mesi, 2007). The reason that the clinic was established was because the Department of Health and other organisations including HWW and Medicine Sans Frontiers (MSF), noticed that men living in Khayelitsha were

---

<sup>6</sup> This estimation is taken from Nattrass' (2006) analysis which controls for 'for age, socio-economic status and ill-health'.

<sup>7</sup> The clinic is an entry-point into the health-care system. It is hoped that the clinic, being a new service in Khayelitsha, will arouse curiosity and men will come to investigate, and at that point they will be invited to find out more information about the service, in a personal, one-to-one situation.

accessing STI treatment and VCT outside their community, usually in Salt River<sup>8</sup> (Mesi, 2007). De Azevedo, Khayelitsha manager for City Health, is noted as saying that the Salt River clinic was the only clinic to be addressing male issues in Cape Town. This clinic was unintentionally, but nevertheless, regarded as a male-friendly space. The hope is that by bringing a clinic, with male-friendly characteristics, to the Khayelitsha community, men will not spend transport money to access care, and will get treatment earlier (Mesi, 2007).

van Toms<sup>9</sup>, the former director of City Health in Cape Town, highlighted the significance of this clinic in promoting men's health, and encouraging men to seek health early (Mesi, 2007). Men were noticed to be accessing VCT late in the progression of HIV when their CD4 counts were compromisingly low. The concern was raised that existing clinics in Khayelitsha may not be 'friendly' spaces for men, preventing them from accessing VCT (van den Berg, 2007). Significantly, the clinic is not an exclusively male site. Despite this male-friendly<sup>10</sup> policy, the clinic is marketed as a MC and all staff are male. Women are not turned away from the facility, however. They are provided with available treatment, or referred to other facilities (van den Berg, 2007). P4 points out that the MC is not about treating sexes separately. It is about getting men into the health system<sup>11</sup>.

### *Overview of Aims, Objectives, Methods*

The aim of my research is to investigate whether this male-friendly facility encourages VCT in men. I hypothesise that the male-friendly space is more accommodating to men's health needs, and that men will feel more comfortable seeking VCT in this space. Looking at why this is (or possibly is not) the case is crucial, as it could contribute to greater numbers of people accessing VCT. In this thesis, the primary objectives include,

- First, to see whether the male-friendly space enables testing in men,
- Secondly, relating to the first objective, to probe whether male clients perceive male health workers any differently to women staff with specific attention to confidentiality<sup>12</sup>.
- Thirdly, to evaluate how this environment may contribute to normalising testing in men, as men may talk about it and encourage testing with male friends,
- Finally, to explore how male-friendly spaces may contribute to the greater SRH of men's partners, predominantly women, by exploring whether men are encouraged to discuss testing with their partners and possibly encourage partners to test,

The impact that this male-friendly space could have on encouraging VCT uptake in men was yet to be researched. A MC has now been established in Khayelitsha and it is important to investigate whether this does have an effect on men's HSB, their perceptions of the clinic space and services, and in particular whether it may encourage VCT use. Men's low VCT utilisation is a matter of human security, affecting the lives of both men and women.

---

<sup>8</sup> At Spencer Road Clinic.

<sup>9</sup> Dr Ivan Toms died unexpectedly on 25<sup>th</sup> March 2008.

<sup>10</sup> Male-friendly as opposed to male-only

<sup>11</sup> Either men are accessing treatment for STIs and/or offered VCT at the clinic, or they are referred elsewhere in the township.

<sup>12</sup> Some studies reveal that often men complain about judgemental treatment, real or perceived breaches in confidentiality, and these are largely directed at female staff (Levack 2005:20).

## CHAPTER TWO: LITERATURE REVIEW

### Gender and Health

Like most health issues in the world, the HIV epidemic is a gendered one. In every society, there are overarching ideas of what it means to be a man and what it means to be a woman (Courtenay, 2000:1387; Barker, 2005:16). Gender<sup>13</sup> is one of the most fundamental social divisions which structures daily life. It intersects with other significant variables including socio-economic status, 'race' and age, shaping identities in particular ways. Gender is therefore 'a critical determinant of public health and social well-being' (Peacock, 2005:152). Gender 'has the analytical power to explain the differences between men's and women's susceptibility and exposure to specific health risks' (Astbury, 1999:4). In this dissertation, I argue that gender influences HSB, which relates to men's low utilisation of VCT (Barker and Ricardo, 2005:42). I believe gender is crucial in analysing why this is the case and in thinking how to address it.

### Gender and Access to Care: Barriers to Seeking Health-care and VCT

#### *Possible Barriers*

Research concerned with men's access of VCT services has indicated several reasons why men access health services at lower rates than women. Male-associative traits like not admitting to pain, denying weakness and vulnerability, maintaining emotional and physical control, and dismissing help when it is needed are major factors that inhibit men's use of health-services (Courtenay, 2000:1389). Not wanting to be seen as vulnerable also prevents men from getting help (Addis and Mahalik 2003:7). When this vulnerability is witnessed by women it is especially challenging. Male HSB results in a lower number of men than women using public health facilities, including VCT, in South Africa (Nattrass, 2006: 11).

One important aspect of men's HSB, related to prevention, is that men seem particularly concerned about seeking or being perceived to seek help 'too early' (Courtenay and Keeling, 2000:246). This has implications for VCT because it is promoted as a preventative action which you are encouraged to undertake when you are feeling healthy (Baggaley et al., 2001: 553). Generally, men do not want to be seen to access health care unnecessarily, seeing it as appropriate only when the ailment is obviously serious (Macdonald, et al., 2000:4).

---

<sup>13</sup> 'Gender' is a social construct, meaning that people learn how to behave 'appropriately' as an individual sexed as a 'man' or as a 'woman' (Haralambos and Holborn, 1990:531). The boundaries that define "masculinity" and "femininity" are performed continuously whereby deep-rooted ideas about what it means to be a man or a woman are produced/re-produced (and sometimes challenged). These 'social differences' between men and women do also change over time (Vlassoff and Moreno, 2002:1713). Significantly, there is no single 'masculinity' or 'femininity', and experiences of being a man and a woman differ between communities, and within communities (Connell, 2005:36). Rather, there are "masculinities" and "femininities"

Another factor influencing low utilization of VCT in men includes perceptions that the practice is not 'normal'. In other words, it is not encouraged by those with whom they identify (most likely other men) (Addis and Mahalik, 2003:11, Day et al., 2003:668). It has been suggested that with the 'normalisation' of testing amongst men, stigma decreases and there is improved likelihood that testing will increase amongst men (Cape Gateway, 2006).

The fact that testing is not a routine, and therefore 'normalised', aspect of their health-care relates to the increasing perception of HIV/AIDS as a 'feminised disease'. By continuing not to test, men disassociate with HIV and AIDS, potentially encouraging men to believe they are not at risk (Levack, 2005:17; Nattrass, 2006:2). Media and published research emphasise the HIV burden on women, which although pertinent, may have damaging consequences for men (Nattrass, 2006:2; Beck, 2004: 15). Men may disassociate from the 'risk' group (women). This potentially results in an attitude of denial, seeing little need to test.

Related to this feminisation process is the finding that, men often do not feel comfortable, as men, in health facilities, because they are regarded as female spaces (Levack, 2005; Beck, 2004). In South Africa most primary health clinics have become places staffed and frequented by women (Beck, 2004:23; Levack, 2005:19). This ostracises some men from clinics and VCT. Men feel disassociated from HIV, but also distanced further by their discomfort at clinics.

Contributing further to men's discomfort, is the report that female staff sometimes direct negative attitudes towards men (Levack, 2005:20). Sometimes staff suggest men are *all* promiscuous, inconsiderate or violent towards their partners (Levack, 2005:20-21). Consequently, men feel judged when seeking health services relating to SRH<sup>14</sup>. These conditions are not conducive to encouraging men to use VCT.

Because clinics are dominated by women, they have potentially become a hostile environment for men. What may facilitate men's better use of health services would be to change the environment to better suit men (McCarthy and Holliday, 2004: 26).

---

<sup>14</sup> I am including Voluntary Counselling and Testing (VCT) here in the context of men accessing SRH services.

## *Adapting Health Services for Men*

### **A Culture of respect and independence: An environment unthreatening to 'masculinity'**

McCarthy and Holliday refer to a discussion by Robertson<sup>15</sup> (2001:156) on changing the health-seeking environment for men (McCarthy and Holliday, 2004:26). Robertson (2001) suggests that by making the health-care environment less threatening to 'masculinity', health-seeking will become more appealing and acceptable to men (McCarthy and Holliday, 2004:26). If the environment is not seen to challenge independence and rather to encourage understanding, Robertson suggests this may encourage health-seeking in men (Robertson, 2001:156 in McCarthy and Holliday).

### **Male Staff**

A change in the health environment that may facilitate men's better use of VCT is the creation of 'male-friendly' health facilities where VCT is provided. Beck's (2004) article demonstrates the barrier that women-dominated clinics create for men (2004:16). He emphasizes the need for male health spaces where men feel more comfortable (Beck, 2004:16)<sup>16</sup>. Levack (2005) suggests the possibility for male-only VCT sites (2005:31). Perhaps by emphasising a clinic that is male-friendly, this may increase men's attendance at clinics and increase their use of VCT (Beck, 2004:16). Beck highlights that men generally feel more comfortable when male staff are present and prefer talking to men about their health (2004:16). This suggests that the clinic environment needs alterations to attract male attendance (Beck, 2004:23). The idea has been hypothesized as a possibility which could facilitate men's better use of health-services in general, and specifically in relation to HIV testing and treatment.

Two male-only drop-in centres in Soweto were opened in June 2005 (Medical News Today, 2005). These Imbizo clinics are designed to help bring men into the process of curbing the HIV/AIDS epidemic (Medical News Today, 2005). These sites are staffed by men so that men can access health-care in relative comfort (Medical News Today, 2005). Significantly, these are male-only sites, meaning women cannot receive treatment at these facilities (HIVSA, 2006).

### **VCT combined with other services**

There have been permanent and pilot interventions aimed at men's health, particularly young men, in South Africa and other countries including the USA and the UK (Medical News Today, 2005, Hancock, 2004 and Armstrong, 2003). Internationally, these have largely been facilities focused on SRH. In South Africa, the Imbizo projects focus on VCT and workshops on various conditions regarding men's health (like erectile dysfunction and STIs) (Medical News Today, 2005; PlusNews In-Depth, no date). In the case of the New York clinic, the services are more generalised<sup>17</sup> (Armstrong 2003). Studies on these projects reveal noteworthy data relating to the Khayelitsha MC.

---

<sup>15</sup> Reference in McCarthy and Holliday (2004) : Robertson, J.M. 2001, *Counselling men in college settings* in G.R. Brooks and G.E. Good (Eds.), *The new handbook of psychotherapy and counselling with men* vol. 1 pp 146 – 169 San Francisco: Jossey-Bass.

<sup>16</sup> A respondent in Beck's study actually suggested having a separate entrance for men at the clinic in Khayelitsha where he was accessing ARV treatment, so as to accommodate men's discomfort with the women in the waiting rooms (Beck, 2004: 7). This demonstrates a desire expressed by some men to be in a separate space to women when it comes to health-care.

<sup>17</sup> At the Young MC they do general physical examinations, provide treatment for acne and sports injuries, as well as their main focus, SRH, VCT and condom distribution. Therefore, the services are generalised and not immediately related to SRH (Armstrong, 2003:220).

Hancock's (2004) article works with data emerging out of two male-only projects in the UK. They were established because men were reluctant to access free condoms and get SRH care from mainstream clinics, despite evidence that they wanted to access these services (Hancock, 2004:484). Similarly, the Young Men's Clinic in New York City was established in 1987 with the express purpose to address the SRH needs of young men (Armstrong, 2003:220).

In terms of VCT, it is recognised that women's testing often occurs during pregnancy (Nattrass, 2006: 13). The concept of incorporating testing into gender-acceptable health areas is thought to encourage testing. For men, it has been suggested that VCT services should be combined with tuberculosis and STDs<sup>18</sup> (WHO, 2003a:3). The Khayelitsha Clinic has combined VCT and STI services.

In Focus Group discussions organized with young men in New York City, it emerged that men would prefer a clinic to have broader services so that they were not immediately recognised as going in for SRH (Armstrong, 2003:220). The concern was aggravated if they were forced to go to clinics in their neighbourhood; for fear of being identified by someone they knew (Armstrong, 2003:220).

#### Promoting positive, alternative views of 'masculinity'

The New York Clinic has posters on the clinic walls, promoting alternative views of 'masculinity', like a man holding a baby and other positive images of men (Armstrong, 2003:221). This imagery is important because they are an alternative to negative images of men so often portrayed in the media. By having alternative, positive imagery of men in the clinic waiting room, men may be affirmed by these alternatives, and feel valued, rather than persecuted. These are conditions favourable for men to seek health-care.

#### 'Word of Mouth' and Male-friendly Clinics

Moreover, in a study conducted at the New York clinic, it emerged that many returning clients had told other men about the clinic, and a quarter of new clients were told about the clinic from a previous client (Armstrong, 2003:222). The British male clinic studies all emphasise the key role that 'Word of Mouth' (WoM) promotion plays in raising the profile of SRH services for men (Pearson, 2003:198, Lewis, et al., 2004: 481, and Hancock, 2004:485). The Imbizo clinics similarly 'believe that the most effective way of reaching our target audience is through WoM (HIVSA, 2006). This has implications for the normalisation of VCT in men, as WoM promotes the service and the clinic.

These other facilities provide useful information in analysing the progress and effectiveness of the Khayelitsha MC in terms of whether or not it is encouraging men to use VCT.

The literature review has highlighted emergent questions which I explore in my project<sup>19</sup>.

---

<sup>18</sup> TB and STDs are health areas more acceptable to men (WHO, 2003a:3).

<sup>19</sup> You will find these questions in Appendix 2.

## CHAPTER THREE: METHODOLOGY

### Background

Men's views about a male-friendly space and its influence on VCT uptake have not yet been investigated in South Africa. The Site C MC in Khayelitsha allowed me the opportunity to interview men attending the clinic to explore their perceptions and experiences of VCT at the clinic. The central aim was to explore whether men perceive the facility to be enabling in their decision to use VCT now or in the future. This leads me to my main and subsidiary research questions.

#### *Main Research Question*

Does a male-friendly health facility encourage men's use of voluntary counselling and testing (VCT) services?

#### *Subsidiary Research Questions*

1. Is the male-friendly aspect of the clinic an enabling factor in men's testing?
2. As a result of their experience at the male-friendly clinic, would attendees recommend the service to friends, and therefore promote and contribute to 'normalising' VCT?
3. Do VCT services targeted at men in turn encourage these men to promote testing in their partners?
4. Are male health workers perceived as more trustworthy than female health workers?

### Population, Sampling and Data Collection

#### *Research Site*

My research took place at the Site C Male-friendly Clinic in Khayelitsha, Cape Town. Khayelitsha is a large area, on the outskirts of Cape Town, known as the Cape Flats. Site C is an area within Khayelitsha. In 2004, Khayelitsha had an approximate population of 400 000 people (Coetzee, et al., 2004: 888).

The Site C clinic is a joint collaboration between Cape Town City Health<sup>20</sup>, the Western Cape Provincial Department of Health (PGWC) and Non-governmental organisations, HWW and MSF. City Health provides assistance with running the clinic in terms of equipment, medical supplies and technical assistance. The PGWC provides funding for staff salaries. HWW manages the clinic staff. MSF donated the facility and have contributed to the infrastructure establishment (Clinic Partner Interviews, 2007).

As the clinic was still a pilot project, it was a temporary structure. The clinic is painted blue, possibly a male-friendly colour. As you enter the clinic, you walk through double doors and one is faced with a short corridor with doors leading off on either side into rooms<sup>21</sup>. In terms of infrastructure, the facility was equipped to provide services to the community.

Upon entering the clinic, the client will either wait in the waiting-area, if the clinic is busy, or they are seen immediately by a lay-counsellor. The counsellors see all clients before they see the nurse, giving the opportunity to counsel the men in HIV testing<sup>22</sup>. If they need STI treatment, or help other than VCT, they will see the nurse after being counselled. Many of the clients come for STIs<sup>23</sup>, but this method<sup>24</sup> is an opportunity to influence that person's thinking in persuading them to test then or in the future.

### *Method: Qualitative Interviews*

The project involved qualitative interviews with men seeking the clinic services. Initially I planned only to interview men who were using VCT at the clinic, exploring whether men experienced the clinic to be enabling in their decision to test. I decided to expand the project, however, and interview men who declined to use VCT at the clinic too. The hope was that by interviewing non-testers, I could probe why they had not tested, and if this related to the facility itself. Moreover, I wanted to explore whether these non-testing men felt inclined to test in the future as a result of visiting the clinic for STI services and having undergone HIV counselling).

I also interviewed the three counsellors at the clinic and the nurse. I also interviewed the clinic partners, which added valuable data to the client findings. Overall, the field-work, including staff and clinic partner interviews, stretched from the 5<sup>th</sup> October 2007 to the 16<sup>th</sup> November 2007. The client interviews took place from 5 – 27<sup>th</sup> October 2007. I did between 2 and 5 interviews a day and these ranged between 20 minutes to 45 minutes in length. In total, I did 33 client interviews, including 15 men who tested at the clinic and 18 non-testers.

---

<sup>20</sup> From this point referred to as City Health.

<sup>21</sup> These rooms included, on the left, a small kitchen, and three counselling rooms. Then on the right there was the waiting-room area, then the Nurse's consultation room and office and finally a toilet.

<sup>22</sup> If the client decides to test, after pre-test counselling, then the nurse will do the test in front of the client. The lay counsellor then gives the result and goes through the post-test counselling.

<sup>23</sup> Rather than VCT specifically.

<sup>24</sup> This approach verges on routine testing, but it was still called VCT and there was emphasis on counselling, which in routine testing, there is less.

The interviews were qualitative, semi-structured interviews. Being an exploratory study this approach provided reliable data, revealing patterns when different clients were faced with answering the same or similar questions. It also allowed for a degree of flexibility, an important component of explorative studies.

I conducted the interviews with the help of a Xhosa-speaking male assistant, Mr Phumzi Nywagi. Mr Nywagi was invaluable to the project, as he came with his own knowledge on the subject, having worked closely in the field of HIV/AIDS and with men, with an interest in gender. In the interviews, he helped me with translating English into Xhosa and back again, where necessary. Furthermore, being a Xhosa man, he contributed to a relaxed atmosphere for the interviewees<sup>25</sup>.

An English interview schedule was designed and then translated into Xhosa, by a bi-lingual speaker based at the University of Cape Town (UCT). Similarly, the consent form was available in English or Xhosa<sup>26</sup>. It was essential that the interviewees had the choice to speak in Xhosa, their first language. Some of the clients chose to speak in English, while others felt more comfortable speaking in Xhosa. This method allowed me to direct the flow of questions, but also allow the clients to communicate in the language of their choice.

Mr Nywagi and I went through the interview questions together before we began the interviews. A mock interview was also conducted before commencing the fieldwork. A Xhosa-speaking man, posing as a clinic client, was interviewed, and with the help of a bi-lingual observer, the interview questions were reviewed. Several changes were made through this process. It also allowed for the anticipation of any problems that may have occurred in the interviews. Mr Nywagi and I again reviewed the questions after the interviews, as it became clear that a few of the questions were phrased awkwardly and created confusion for the clients. This all helped to refine the interview process, making it clearer.

### *Population*

The population for this study was men<sup>27</sup> accessing services at the Site C MC in Khayelitsha. Initially I focussed on interviewing testers, because I began the project thinking this was my targeted population; however, after 11 interviews with testers, I opened the interviews to non-testers too.

Of the non-testers, 15 interviews were with men who decided not to test, despite the opportunity. 2 interviews were with men who wanted to test, but were unable to because the nurse was unavailable and 1 interview was with a man who had tested one month previously at another facility. In total I interviewed 15 men who used VCT at the clinic, and 18 who did not use VCT at the MC<sup>28</sup>.

---

<sup>25</sup> This was in contrast to my presence, as a white female, which potentially could have been discomforting.

<sup>26</sup> These were reviewed and approved by the UCT Ethics committee.

<sup>27</sup> I did not limit the sample in terms of age, as my interest was in 'masculinities', and these show continuities and variance over a lifespan. As a result I spoke to men over a wide spectrum of ages, including young adolescent boys, middle-aged and elderly men.

<sup>28</sup> Find a table of testers and non-testers and when interviews took place in Appendix 3

### *Sampling*

I requested that the staff help me with recruiting potential interviewees. They asked every potential client whether they would like to participate. Initially, this was testers only. Then I went through a period of interviewing both testers and non-testers over a few days. In the last week, I exclusively interviewed non-testers. This method meant that the staff did not interfere with the sampling process, as they asked each appropriate (either tester/non-tester at different times) client, and if they agreed, they would come for an interview.

Clinic opening hours are Monday – Friday 12:00 – 18:00 and Saturdays 10:00 – 15:00. The first interviews took place on the 5<sup>th</sup> October. After the first week, I took a week break from interviewing, as my assistant, Mr Nywagi was away. This imposed some time off away from the clinic<sup>29</sup>. The next set of interviews proceeded on Monday 22 October 2007. I also visited the clinic on a Saturday, because this was outside of a traditional working week.

The times that I was at the clinic were spread over the clinic opening times, therefore there was no selection bias in terms of the times that I attended the clinic. I also attended the clinic on weekdays and on a Saturday so as to have the opportunity to speak with men who perhaps would not attend the clinic during the week. This is a loose form of random sampling. Having the staff ask each applicable client also reduced bias.

### *Ethics*

I requested permission from all the clinic partners (PGWC, City Health, MSF and HWW) to carry out my research at the clinic, and this was granted. I also went through the UCT Ethics Committee as a way of ensuring my project met ethical standards. They too gave permission for the research to go forward.

### *Consent Procedure*

When recruiting, the counsellors and the nurse gave the men the choice to be interviewed and again I gave them the option in the interview<sup>30</sup>. I explained that they could stop the interview at any point, or refuse to answer questions, without any consequences. Interviews were completely voluntary. Although I gave the participants refreshments in the interview, and reimbursed the clients for transport costs, they were unaware of this until after the interview had taken place.

### *Logistics*

Throughout my interviews I kept a fieldwork diary reporting on the day's proceedings, my impressions and thoughts. This helped me stay grounded in the research process and allowed for an analytical view throughout the interviews. It was also very much a part of the thesis writing process, as I began to record emergent themes, link the theory with

---

<sup>29</sup> This break was potentially advantageous, as my presence at the clinic was not guaranteed, which meant that if clients intentionally came to the clinic for an interview (having heard about it through WoM), after the first week's research, the researcher was not there.

<sup>30</sup> After going through the consent form with potential interviewees, a couple of clients did leave without being interviewed; however most men seemed open to talking with us.

the interview data, and shape my thinking. Some of my findings, discussion and recommendations follow from this writing.

I also recorded the interviews, allowing me to go back to re-listen to the clients' responses<sup>31</sup>.

Although this clinic is male-friendly, rather than male-only, as a woman in a male-targeted clinic, I tried to keep a low-profile. I was given the use of a counselling room to conduct the interviews, which meant I did not interfere with the running of the clinic. I preferred not to make my presence too prominent, as I did not want to cause any discomfort for men by being in the waiting room, or appearing to linger around the clinic unnecessarily.

### *After the fieldwork*

Once the interviews were complete, I found someone to help me transcribe and translate my Xhosa interviews, while I worked on transcribing the English interviews. Ms Gidana, who works in the Public Health department at UCT and is familiar with transcription in English and Xhosa, assisted me with this task<sup>32</sup>.

### *Analysis*

When all the interview transcriptions and translations were complete, I read through each transcript carefully, highlighting significant passages, as they related to my research questions.

After familiarising myself with the transcripts, I moved on to creating a summary of themes by tabulating each interview in a spreadsheet of testers and non-testers and then a combined spreadsheet including all client interviews. This was another way of ordering and storing the data, and it reinforced my engagement with the content.

I then moved to the next stage of analysis where I went through the transcripts in more detail. I compiled notes on my findings, summarising the key information with some initial comments referring to specific passages in the client interviews. I did the same process with the staff and clinic partner interviews<sup>33</sup>.

Following from this I moved into a more in-depth analysis, where I began arranging the data in data-sets, grouping data thematically. These were grouped according to the aims of my subsidiary research questions<sup>34</sup>. After grouping the themed data, I refined each grouping and ordered and analysed it further. I then interwove theory into my findings.

---

<sup>31</sup> Permission was sought from each client, and the recorder was used only once permission from the client was given.

<sup>32</sup> Although Mr Nywagi helped me with translation in the interviews, I was concerned that some of the data may be lost in the immediate translation process, so I felt another, more considered translation, would be beneficial to the quality of the research.

<sup>33</sup> At this stage, I had a good initial understanding of my findings and felt confident to write some preliminary findings for the clinic partners. Over the course of December and January, I submitted two reports, one on my preliminary findings for the client interviews, and another on the findings from the staff and clinic partner interviews. This helped to refine my thinking and order it into a structured format.

<sup>34</sup> I grouped data together which correlated to what a male-friendly clinic was, and whether this was perceived to be enabling in men's use of VCT. I grouped more data which concerned whether the clinic was perceived to be contributing to the normalisation process of VCT among men. I also grouped information relating to how VCT in men was potentially affecting men's sexual partners. Finally, I grouped data according to whether the male clients trusted male health-workers more than female health-workers.

### ***Reliability and Validity***

A potential limitation of my research may be in the form of selection bias, as the men willing to talk to me may not be representative of the clinic population. Because I was open that I was a woman interviewing men, perhaps men who did not want any contact with women at the clinic, would have declined the opportunity for an interview. I do believe, however, that I had a spectrum of interviewees; some were open to discussion, going into detail, while others were more guarded with their answers. This may limit the generalisability of my research to the clinic population. Nonetheless, the research is relevant, because the men who are interviewed are a part of their community and are immersed in shared gender discourses that have shaped their 'masculinity'.

Another potential influence on my research is my identity; being white and female will influence the responses from the participants in a particular way. Every researcher's identity will impact on the research process, but my identity as a white woman is in immediate contrast to my research participants. There will always be particular dynamics played out between the researcher and the participant, depending on their identities. In some ways my immediately apparent difference could be viewed as an advantage, as I am acutely aware of the situation. I discuss my thought processes concerning my position within the research, as a white English-speaking woman interviewing black, Xhosa-speaking men in Appendix 6 entitled, 'The researcher: my positionality'.

## CHAPTER FOUR: INTRODUCTION TO FINDINGS: THE CLINIC AS A GENDERED SPACE

Socially constructed views about what it means to be a man or a woman have a powerful influence on the way we live our lives. Gender partly shapes our behaviour, including the way that men and women seek health-care. Not all men and women behave in the same way, but literature and my interviews suggest that there are commonly-held understandings about how to respond to illness as a man, and how, when, and where you may access help, if any.

Obviously gender is not the only determinant in HSB, and in South Africa a key determinant is socio-economic status. In this study, however, I have largely focussed on the influence of gender on the access of VCT. It is, however, important to note that this research is framed by the fact that patients using public clinics are usually unable to afford private doctors and do not have medical aid.

In this project, I have explored whether men have found the MC in Site C Khayelitsha to be encouraging in their decision to use VCT, or potentially use VCT in the future. I would like to begin my analysis by examining common perceptions expressed by clinic partners and clients expressed about public clinics, and how men experience these spaces. I have worked closely with the interview data throughout my analysis and have supplied many within the text. More quotes in support of my findings can be found in Appendix 4.

### Clinic Partner Perspectives

The clinic partners identified several reasons for establishing the Site C MC.<sup>35</sup>

- Men's low use of health services
- Providing Male Staff for SRH
- Men not unwilling to test and accessing services elsewhere
- Men accessing services when detrimentally ill
- Providing an entry-point into the health system

These are the reasons expressed to me for establishing the Site C, MC in Khayelitsha. I would now like to turn to the 'issues' above, as expressed by the men interviewed. The client interviews largely confirmed the reasons for opening the clinic.

---

<sup>35</sup> Some of these I have already mentioned in the introduction and literature review.

## Client Perspectives

### *Illness and 'masculinity'*

Most of the men I interviewed associated clinic clients and health-workers as female<sup>36</sup>. Not only are clinics gendered spaces, and predominantly associated with women, but the way we seek health-care is linked to gender constructions, defining men and women as different. The generalised construction is that men stay away from clinics, because they are stronger and can resist pain, whereas women give in to illness quickly, because they are weak. They therefore attend clinics more frequently. If women go to the clinic because they are 'scared to be sick' (CT17), then men should, by assumption, be courageous, stay away and face their illness alone. 'Men's denial and disregard of physical discomfort, risk and health-care needs are all means of demonstrating difference from women, who are presumed to embody these "feminine" characteristics' (Courtenay, 2000:1390). This sentiment was repeated by many of the clients displaying commonly held views affecting men's HSB.

'...we as men believe that when you are a man you have to resist to the pain' (CNT26).

'...the women is scared [to be sick, whereas men] brush it off, say no, let's see maybe tomorrow, and then maybe tomorrow they don't go there' (CNT27).

This demonstrates men's perceptions about what it means to be a man when faced with illness. Clients explained that as a man it is understood you are able and must resist pain through inherent, masculine strength. If you give in to the illness, you are being less manly. If you go to the clinic, you are like a woman who gives in to her pain. This association that links 'weak' women with clinics is disconcerting for men, and dissuades them from seeking health-care<sup>37</sup>.

Moreover, clients indicated that it is manly to deny illness and any vulnerability to illness. These masculine traits influencing health-seeking have ramifications for men's use of VCT. If men are to deny their vulnerability as proof of their manliness, then this contradicts the ideology of VCT, which is to take responsibility, be vigilant early, and know your status<sup>38</sup>.

Denial of vulnerability and inherent strength also relate to male views of independence. Other clients suggested that in order to prove your 'masculinity' when faced with illness you should take care of it yourself and not 'run to the clinic,' as women do. Clients described clinics as spaces for women. It is understood that men avoid clinics and this is related to gender constructions.

These attributes of 'masculinity' are also related to how men perceive their risk to HIV. Client 9 expressed his belief that women were more vulnerable to HIV/AIDS, based on the assumption that men are stronger and more physically able to fight the disease.

---

<sup>36</sup> Literature also confirms men's perception of clinics as female-dominated (Beck, 2004:23; Levack, 2005:19).

<sup>37</sup> This includes testing for HIV.

<sup>38</sup> To do this, however, means to admit to being at risk.

Lastly, in looking at client responses indicating the association of illness and clinics with women, secrecy of illness or pain was another masculine trait. This is related to denial, but is subtly different. It is unmanly to be sick, so, as men, the illness should be hidden from the community to maintain your position as a man. This has implications for men's use of VCT, for, if they need to be secretive about illness, then going to the clinic has consequences to their 'masculinity' and how they are viewed as men in their community<sup>39</sup>.

'In most case men tend to hide their sickness...' (CNT21).

The preceding interview quotation demonstrates that these Xhosa men need to be the opposite of what they understand to be the 'weak' behaviour of women<sup>40</sup>. Men 'should' resist pain, be disinterested and dismissive of symptoms, in order to prove their manliness.

This clearly indicates how powerful gender is in shaping HSB in these men. Literature confirms this behaviour: asking for help, and admitting weakness and vulnerability goes against the social messages that men receive about 'the importance of self-reliance, physical toughness, and emotional control' (Addis and Mahalik, 2003:7). The clients emphasise the qualities of strength, independence and denial of risk.

### *Gender and accessing health services*

Getting men to test for HIV is an urgent task for public health in South Africa. If more men are testing, it means more men are aware of their status, and hopefully taking precautions not to spread the virus. Actually encouraging men to test in the face of these gender-constructed obstacles is a mammoth task. In the course of this paper, I will argue that the Site C, MC is a step towards getting more men to use VCT and into the general health-care system. This is a matter of human security, as men's, (and women's health) is in danger as long as men refuse or delay the use of VCT.

This perception that clinics are 'made' for women, as communicated below, means that some men feel they do not have a space to go when they need health-care. Consequently, even by being at a clinic, many men feel less manly; this is a barrier to VCT. The MC, in a sense, provides a legitimate space for men to seek help with less compromise to their ideas of manliness.

'The man does not like to go to a clinic, it's a lady's stuff to go to the clinics' (CNT18).

'I think guys...believe that ...the clinics are made for women' (CNT32).

---

<sup>39</sup> It also has consequences in being HIV positive, because if it is commonly accepted for men to hide their illness, then possibly many are not disclosing their HIV status to sexual partners.

<sup>40</sup> Men must be the opposite of scared, the opposite of weak and the opposite of concerned (the traits associated with woman and health-seeking).

This popular notion suggests that men stop themselves from going to clinics because they are not men's spaces; they are for women<sup>41</sup>.

Client 33 (below) talked about the stigma for men being associated with clinics.

'...you see men sometimes don't want to be seen [in clinics]...it's the stigma behind the HIV... maybe people will say hey this guy is HIV positive, I saw him there...[even if you go] for flu...people will say you are HIV positive. That's why we don't go, but women they do go...women usually go to prevent pregnancy. So, if they are there, no one will say [they are HIV positive]...it's more normal, they [women] usually go all the time' (CNT33).

There are more reasons for women to be at clinics<sup>42</sup>. That means that some people jump to conclusions, or male patients perceive others to be jumping to conclusions, as to why men are at the clinic. If women go to the clinic to use VCT, people do not necessarily assume that because there are a number of other reasons for which they could be there. Men go to clinics less frequently and there are fewer standard reasons for them to go, therefore assumptions are made about their HIV status when they are at the clinic. This prevents them from attending clinics. Both men and women experience HIV stigma and this is a barrier for them, but there is a difference in how men and women experience stigma. It is therefore gendered.

Client 6 described men as being 'afraid' of going to the clinic.

'...Men are scared to come to these places [clinics]...Even if the man is sick, the women is going to push the man to actually go to the clinic' (CT6).

To go to the clinic, then, would mean to contravene gender norms. In the face of this fear, courage is needed to visit the clinic.

'They are scared to be laughed at because they...are traditionalist[s] so they do not have to go to the clinic they use traditional medicines, so there are those ones who come to the clinic and once they go to their places [homes] they are being laughed [at]' (CT16).

Men are afraid of being seen to contravene gender norms by visiting the clinic. The implication is that men should only seek 'traditional' solutions, because this is the manly thing to do. To go to the clinic, means you may be ridiculed by others, because you were not man enough to seek the 'proper' treatment<sup>43</sup>.

---

<sup>41</sup> Client 32 expanded on this saying he does not buy into this thinking that the clinics are for women only. He believed clinics are for everyone, however, this is commonly understood to be the case.

<sup>42</sup> For contraception, pregnancy, Termination of pregnancies, bringing ill children etc.

<sup>43</sup> Traditional medicine

Some men expressed fears that the (female) staff were going to shout at them. If women shout at men (and in public) this is also a contravention of traditional gender norms. In a patriarchal society, women should be submissive to men, particularly in public. The quotation below demonstrates fear of both gender norms, of being at the clinic in a woman's space, but also being shouted at by women.

'The ladies they go to their clinic...so we can't go to the main clinic...because we are a little bit scared the ladies are going to shout at you' (CNT18)

Another client explained 'fear' of the clinic differently. Men are afraid to have their illness or ailment (and therefore weakness) confirmed for them at the clinic.

'The problem I think is we men we are scared to go to the clinic because we are discover something new now, that is why we delay to go to the clinic' (CT7).

The clinic may make a dent to the self-image of manliness. As long as the condition is unconfirmed, the man may live in denial. When the clinic diagnoses the problem, however, it is more difficult to deny your body's failings (and the weakening of manliness).

### *Only accessing care at times of crisis*

Some clients highlighted the common masculine trait whereby they do not attend to their symptoms until it is very late in the illness. Delaying the use of VCT means that men enter the health-system very late, when their immune-systems are dangerously compromised by AIDS, and when ARVs are less effective. It is therefore urgent to get men to test earlier, to help normalise testing when healthy and to get men onto ARV treatment when the time is right. Client 6 and 12 explain this 'masculine' approach to illness,

'...[men say] this is the flu it's going to go away'. But when it gets serious, it's then that he pushes himself to come' (CT6).

'We [men] endure the pain and when we can't take the pain anymore would go to the clinic' (CNT12).

The above quotations indicate that men experience conflict when ill. Knowing they are presenting signs of illness and therefore need help conflicts with societal pressure to be masculine and deny this pain, to the self and others. Gender norms direct them to ignore symptoms of illness. Men may be aware of symptoms, but in pursuit of living up to manly traits, they resist help. Only when it is so obvious, to everyone, and the patient himself, is this a socially acceptable time to seek health-care.

Furthermore, if clinics are associated with women, and if illness is associated with women, then men who learn they are HIV positive, possibly feel emasculated. They are ill, and therefore like women, which to them is shameful. Therefore, why test if you are going to feel less manly?

Men often experience clinics as inhospitable places reminding them of their failure to meet social standards of 'masculinity'. I argue that the MC, however, encourages men who would otherwise avoid health-care to seek help.

'...when I saw the advert outside saying that this is a MC I thought of coming inside and do what I should have done [a] long time ago' (CNT25).

This suggests that by encouraging men into the health-care system, it also brings them that much closer to using VCT<sup>44</sup>.

## Thesis Outline

The preceding discussion on clinic partner and client perspectives has contextualised the research project. In the chapters that follow, I will begin by examining the research findings. The primary objective of this project was to investigate men's perceptions and experiences at the MC, relating to VCT, and whether men felt the 'male-friendly' environment contributed to their decision to test. Therefore, my first findings chapter is titled Male-friendly Clinic Characteristics. Following from this is chapter six Trust in Male Health-workers, chapter seven VCT Normalisation amongst men and chapter eight, Advantages for women's health. Following these findings, I move to a Discussion and Recommendations chapter.

---

<sup>44</sup> This client did not use VCT, but he was introduced to it, and he seemed open to potentially returning with his partner to test in the future.

## **CHAPTER FIVE: MALE-FRIENDLY CLINIC CHARACTERISTICS**

As my central enquiry was based on the influence of the male-friendly environment on men's use of VCT, I also sought to define the characteristics of the clinic that were considered 'male-friendly'. These aspects of the clinic emerged out of staff and client interviews and literature. All these aspects of what makes an environment male-friendly need consideration when a health facility is promoting itself as such (Hancock, 2004:486). It was part of my research project to probe the meaning of a male-friendly facility.

Creating a 'male-friendly' space with good quality service is potentially supportive of men's increased uptake of VCT. Levack (2005) notes that 'poor quality services are probably a significant barrier to men staying long enough to receive their results and subsequently returning for additional HIV tests' (2005: 20). By creating a male-friendly environment, where men are made to feel more at ease, they are more likely to test. 'Privacy and comfort are critical for attracting people and for providing a 'safe' environment for those undergoing [VCT]' (Magongo et al., 2002:39).

From the data I have analysed, most clients (26 of the 31 interviewees) expressed their increased comfort, many describing feeling 'free', at the MC. No clients indicated they were less comfortable, and only a few mentioned there was no difference. I will look at how men perceive this clinic to be more accommodating to men. I will also discuss how men perceived these male-friendly aspects to have contributed to their testing, or to possibly testing in the future. Below I have formed a list of criteria as it emerged through the literature and this research. I then discuss these in more detail. I will show the ways in which these 'male-friendly' attributes may be contributing to men's use of VCT.

### **Defining a Male-friendly clinic**

These are the factors that were described and/or emerged as male-friendly, including:

- **Male Staff**
- **Male clients**
- **A 'Culture' of respect and independence: an environment unthreatening to 'masculinity'**
- **Promoting positive, alternative views of 'masculinity'**
- **Location**
- **Opening Hours**
- **Decentralised service (therefore, not associated with women, mothers and children)**
- **VCT and STI services**
- **Fast and Efficient Service**

I have previously looked at some of the aspects that contribute to men's discomfort and avoidance of general clinics. In the following chapter, I will discuss whether clients perceived these attributes to have encouraged them to test at the MC, or for non-testers, whether they feel encouraged to test in the future.

## **Male Staff**

Clients, staff and clinic partners all mentioned the significance of having male staff at the clinic. This is in a health-care context where nurses and health-care workers are predominantly female. Having male staff does present a male-friendly image for the clinic, which seems to contribute to attracting men to seek health-care (Hancock, 2004:485). Research suggests that services are generally perceived to benefit women, and therefore by putting a male face to the clinic this perhaps promotes a male-friendly image (National Department of Health, 2007a:21).

A study that examined the most important characteristics of a VCT counsellor among youth rated same sex counsellor to client as the fourth most important characteristic of the counsellor<sup>45</sup> (McCauley, 2004:4). The gender of the staff is therefore significant to some clients, but not all. Some studies (Hancock, 2004) question how crucial it is to have male staff, and rather point to the attitude of the staff, that they are empathetic to men (Hancock, 2004:485).

There is truth to this point as evidenced by some clients; however, from the majority of clients I interviewed, it was clear that for these Xhosa men, they were more comfortable seeking treatment from men. In some instances, women health-workers prevent men from seeking health-care, including VCT. Therefore, in the context of this environment, having male staff is a male-friendly attribute and encourages men to enter the health system.

I will now discuss the ways in which men experienced the presence of male staff to be 'male-friendly'.

### ***Man to Man***

Many men emphasised that they chose the MC specifically because they knew or hoped that there would be male staff and this greatly contributed to their increased comfort.

'I'll be more relaxed when there's men' (CT6)

'...we came here because...we will be speaking to man and in most clinics the majority of the staff is women, men are the doctors that we do not see and you find that you do not talk everything to women...' (CNT31).

This client feels more able to disclose information to another man. His greater honesty means he is likely to get better care, because the health-worker will be able to respond accordingly.

---

<sup>45</sup> This was after knowledge, friendliness/non-judgement and the counsellor having tested (McCauley, 2004:4).

Client 9 mentioned his approach to parenting, which to me indicated aspects of the socialisation process contributing to men's comfort when talking to men about SRH.

'...it would be difficult to speak with my daughter... her mother must talk with her and I would talk with my son about [HIV and AIDS]' (CT9).

These quotations indicate that many of the clients specifically sought out a clinic where they would be attended by men. The MC appears to be bringing them closer to using VCT.

### *Man to Woman*

Clients expressed the hindrance that speaking to women health-workers has on their ability to be honest about SRH. This barrier means that men are less comfortable when discussing HIV and AIDS with women, and they are therefore less likely to use VCT (Magongo et al., 2002:39). The quotations below express the limitations that some Xhosa men experience when talking to female staff<sup>46</sup>.

'This clinic you feel free. And then you meet...men here. Sometimes on the other clinics when you got a problem a lady helps you, and then it's difficult to tell her what was the problem, because this is a woman. You don't feel free. So in this clinic...you tell all your story, you don't have to hide' (CNT23).

Many of the clients talked about feeling 'free' at the MC, expressing conditions appropriate to encouraging clients to use VCT (Baggaley, et al., 2001:556). This suggests that as a man, there is certain information that should not be disclosed to women. To do so would potentially mean compromising the perceived gender distinction between man and woman. This shows a boundary that some Xhosa men do not feel they can cross, even in health-seeking, preventing them from accessing health-care, particularly with regard to STI treatment and VCT.

'I will meet a lady who is a doctor or a sister or a nurse, and you will feel like not starting to open up for the problem that you are there for, so you ending up going home without having not the right thing that you were there for' (CT15).

'...maybe you have pimples in your private parts you see... So when you go to the clinic and meet with a lady...you will never be able to show her...I wouldn't feel comfortable speaking with women no, no the talk wouldn't be the same' (CT4).

The above quotations suggest that men are getting better health-care because of the clinic's staffing policy. If men go to a general clinic, despite their discomfort with talking to women, when faced with the situation itself, they may not feel able to share their problem and therefore get the care they need. While some men may take the step of seeking

---

<sup>46</sup> Talking to women is particularly difficult with regards to SRH.

help, with relative ease, it is the issue of speaking to a woman, and possibly the type of interaction<sup>47</sup> between the health-worker and the client, that prevents the client from fully disclosing his reason for being there.

In contrast, there is a more extreme reaction whereby men avoid health facilities entirely, despite knowing something is wrong. These men clearly felt more comfortable talking to male staff about SRH. Because STI treatment is an entry-point to VCT, it is beneficial that men feel able to entirely disclose their situation and be comfortable in discussing sensitive topics with the counsellor. This contributes to a more conducive VCT setting.

### *'Traditional Confidentiality'*

Some men expanded on their hesitation to speak to women health-workers, saying they were prevented from talking openly because of 'cultural' beliefs. There are some subjects [sexual matters] about men that women should not know. This is explained below, relating men's discomfort to long-standing Xhosa gender codes,

'...we as African [Xhosa] guys...it is difficult to go to the lady... the female doctors, you have to say "Can you help, I've got some pain in my private parts". No, but it's a lady, no no no no no no...According to my own tradition it's difficult... in my own culture, traditional, there's no way, I cannot tell this [sexually related matter], because it's a lady. So, it's a man, even now, I can take my things [my penis], to show you... it's so much better with a man'(CT8).

His emphatic and repeated 'no's' indicate that the examination of men, by women, in the genital region is a social taboo. This is related to comfort, but it goes further too; there are clear 'cultural' boundaries in place preventing men from talking to women – it is not seen to be 'culturally' appropriate.

Client 6 talked about the significance of being able to talk to another man in the context of a health facility. This was in contrast to being forced or obliged to tell women things that ordinarily they would never tell a woman outside of the health-care context. There is a sense that his self-respect is in part eroded because of this obligation at general clinics.

'Because...when you come to a man... if this guy wants to know anything about me, I wouldn't have a problem telling him, because I know, when I turn my back he's not going to go around looking for me... I'm not saying women do that, but...there are things, especially in our culture [Xhosa culture], there are things...you don't really have to say to a woman. But...in a clinic...you are obliged to say...because you need help' (CT6).

One of the staff summarized this strong, 'cultural' influence for me, calling it 'traditional confidentiality'. He explained that in Xhosa culture,

---

<sup>47</sup> This is particularly the case if the interaction is judgemental or unsympathetic

'...[men] go to the bushes for circumcision. It's a taboo...to be handled by females...especially in the genital parts...it's a matter of privacy and...traditional confidentiality should be maintained at the highest level... there are no women allowed...when they are doing circumcision, so when you take that back to the health institution whereby you take away that traditional confidentiality...they feel...less man' (HW5).

This indicates that when Xhosa men seek help from women in the health system, they feel emasculated through the experience, particularly when it concerns SRH. It also relates to VCT, however, because in the counselling session, it is potentially an opportunity to talk about SRH, contraception and partners (Baggaley et al., 2001:557). If a man does not feel he can talk to a woman about these issues, this means they may avoid seeking help, and VCT, to maintain their 'masculinity'.

### *Someone like me*

The client interviews revealed a common assumption and unquestioned acceptance among men, that men can be completely open with one another, because of shared experience, and shared knowledge. There is an assumption that women cannot understand men's perspectives because men and women are presumed to be so different – physically, emotionally and spiritually. When men speak to other men, the assumption is that they are speaking to someone who understands them entirely. In contrast, if they confide in women, the suggestion is that they cannot understand men.

'...you are speaking with people [men] who understand exactly, because maybe they have been in the same situation' (CT2).

'...men's issues are...common to discuss to another man, maybe one of the counsellors ...had the same problem...so...he could advise [you about] what to do...as compared to discussing issues with a female' (CNT29).

The implication is that woman will not know or understand men's problems. This places specific emphasis on SRH. In this environment there is particular anxiety around speaking to women. There is an assumed affinity between men here, and clients clearly communicated their increased comfort and ability to talk openly as a result of talking to 'men like me'. The rationale is that women on the other hand cannot understand men, their thinking or behaviour. This is because they are physically and socially different and most importantly they have not gone through initiation as Xhosa men do. The perception is that they are missing this understanding of manhood.

### *An exception to the rule*

Contrary to much of the preceding information, Client 28 expresses that he was not necessarily against receiving treatment from woman instead the context of the MC is the significant difference. His perception was that if there was a woman working in a MC, she would be sympathetic to his needs and not judge him.

While this indicates some variance in men's experience of female staff and is in line with Hancock's (2004) argument where he places more importance on staff attitude rather than gender, the large majority of men expressed their increased comfort dealing with male health-workers. By having male staff, this gives men the opportunity to be open in their health-seeking and get the help they require. It also means men's level of comfort is possibly increased and therefore they may be more inclined to use VCT (Magongo, et al., 2004:39).

## **Male clients**

Staff and clinic partners have emphasised the male staff as the primary male-friendly attribute of the clinic. What emerged in my client interviews was that while this is significant in creating a male-friendly health-facility, another factor is the gender of the patients. Although this was not directly investigated, 7 clients voluntarily expressed anxiety around the presence of women in clinic waiting rooms and a lack of trust directed at female patients. While men are more comfortable with male staff, and there does seem to be greater trust,<sup>48</sup> the female patients<sup>49</sup> appear more anxiety-provoking than staff, in terms of confidentiality.

### *Greater trust in male patients*

'...the [female] staff was fine it's the people who knew me [in the waiting room] they would ask me why I'm there. I told them, but I was not comfortable' (CT10).

Many men complained that often women ask other patients about their conditions and/or make assumptions, spreading rumours in their communities about them. Men specifically referred to being more comfortable around fellow men attending the clinic.

'I could come here because there is only men this side, so they are not curious about other people's issue...when [men] are told something they don't pass it; they keep [this information to themselves]...I will trust that he [fellow client] will not say it to anyone else because he doesn't know my problem and he is not going to pass my problem and I'm not going to pass his problem' (CT10).

This expressed men's greater trust in other men, as they feel that if they are seen by men at the clinic, their condition will remain confidential. There is this assumed understanding that they will respect one another's privacy. If there are women clients, the worry is that they will spread rumours about their condition.

---

<sup>48</sup> See chapter six for discussion on this.

<sup>49</sup> This is particularly significant because the women would probably be from the same community, meaning they may well know the male client, or know of them. The threat is therefore heightened because if the women talked to others about seeing the male client at the clinic, the man's privacy is compromised.

Clients 10 and 16 explained that at general clinics, women enquire about your condition, making assumptions about HIV status. Both clients believe this will not happen at the MC, because it is predominantly male patients who attend, and the assumption is that they can trust men.

On one occasion while I was at the clinic I did notice some women lingering in the waiting area. They did not appear to be there for medical assistance. Client 7 reacted to their presence<sup>50</sup>. He was evidently uncomfortable about their presence at the clinic.

'I wanted to ask...[the counsellors], what is ...those ladies sitting outside there [for]?... because it's male clinic. If this place was only for women, men would not allow to come inside here...I can see someone [referring to my presence at the clinic] who is coming here for a reason. I think these people are here for just... chatting' (CT7).

He distinguished between women who were at the clinic for a 'legitimate' reason (like me, or women being helped) as opposed to women who were socialising at the clinic. This demonstrates that he accepts that the clinic is not male-only, but that women should only be present if they are seeking medical treatment or other 'significant' reasons. He explained why these women caused him distress, and why it was different with men,

'Maybe I'm from testing there, and ...they...see my attitude [and assume from my attitude whether I am HIV positive or negative]...if you are only men, or these [men] working here, or these [men] coming here... then they [we] won't worry' (CT7).

This client's reaction was evidence to what many other clients had spoken of in relation to women patients in public clinics. It was clear that men felt safer amongst male patients, as there was no perceived threat to confidentiality.

Generally, this perception of increased confidentiality amongst patients is a further contributing factor in encouraging men to use VCT at the MC. This factor adds to creating a male-friendly space. The gentleman above had come to the clinic to test precisely because he felt increased trust and comfort in the facility. 'External factors affecting HIV test participation include perceived levels of stigma and support, confidentiality and quality of services' (Mundy and Dickenson, 2004: 178). The interviews revealed that greater confidentiality increased the likelihood in using VCT (and therefore the less likely possibility of stigma for the testing client).

## **A Culture of Respect and Independence: Unthreatening environment to 'masculinity'**

### *Emasculating experiences at Public Clinics*

In the client interviews, I enquired about experiences at public clinics, particularly as they related to staff. Clients described some uncomfortable and dehumanising episodes related to health-seeking. These complaints were often<sup>51</sup>

---

<sup>50</sup> This was mentioned, without my bringing attention to it.

directed at women health-workers. Regardless of gender, these encounters at health-facilities seem to undermine social and self-perceptions of manliness, and indicate therefore that these spaces are often experienced as unfriendly to men, even emasculating.

'...women would shout at you...Sometimes women [cannot keep secrets] and sometimes she would call you in front of other people [waiting area] about your secret' (CNT12).

This experience indicates a lack of trust and loss of personal safety at the clinic, as medical conditions are exposed publicly. This is directed at women staff. Moreover, this demeaning treatment is in conflict with the image of a self-respecting, independent male. It is therefore threatening to men's self-perceptions of manliness.

Clients suggest a sense of defeat, unfairness and powerlessness when faced with situations where female staff shouted at them. Some would rather avoid the clinic altogether than having to face this kind of (mal)treatment.

A few of the clients mentioned the greater sense of care they experienced at the MC in comparison to their experience at other public health facilities. Some of the men reported disillusionment at the lack of sympathy at public clinics generally.

Significantly, one client partly took responsibility for his negative experiences at public clinics. Client 30 explains,

'I'm not the person who likes to be in the clinic...so...every time...whenever you are in the place and...you have the attitude.... [You go there] with that attitude, that I don't like the place, maybe I worsen the case...because each and every mistake, I'm saying, these people, they are treating us like this...like that' (CNT30).

These experiences, where staff shout at patients, where patients are unfairly prioritised because they have connections with staff, goes against what Xhosa men believe should be the gender codes of their 'culture'. It is a dehumanising and emasculating experience, where men are undermined as people and men<sup>52</sup>. Levack's (2005) study specifically highlighted complaints that men have made about women's judgemental treatment, mocking men for 'sleeping around' or 'charming' the women into bed with them (2005: 20-21). This kind of approach casts all men in the same light and only serves to ostracise them from the service. This kind of environment is unappealing to men, and unlikely to encourage them to use VCT. Non-judgement is said to be a VCT-encouraging factor (Baggaley, et al., 2001:556).

### *Men's Clinic accommodates 'masculine' traits: Respect and autonomy*

The MC, in contrast to the experiences voiced above, seemed for all the clients a positive experience, and affirming of their 'masculinity', as they interacted with other men. Robertson (2001) suggests that critical in establishing a male-

---

<sup>51</sup> But not always directed at women specifically.

<sup>52</sup> They are not recognized in these encounters to be respected, powerful members of society.

friendly space is creating an environment unthreatening to 'masculinity' (in McCarthy and Holliday, 2004:26). The episodes above threaten 'masculinity', as dignity and autonomy are eroded. The experiences at the MC indicate that men feel a certain degree of agency and respect, accommodating to 'masculinity'. This is significant in creating an environment conducive to testing for men.

Many of the non-testers seemed more open-minded to testing, having gone through the counselling session. 17 of the 18 non-testers said they would return to the MC if they were to test in the future. The fact that the client could speak to a man, one to one, in privacy, seemed to be encouraging to this non-tester.

'That male counsellor advised me and I feel more comfortable now I will get tested but not today. . I have to think about this thoroughly but he gave me courage that testing is the last thing I have to be afraid of. He advised me not to be afraid...because I might get help before getting very sick ...I'm going to test soon at least now I'm not afraid as I used to' (CNT12).

As a result of the counselling session, many non-testers felt encouraged to test, but they expressed the need to make the decision for themselves. They did not want to feel pressured into testing and wanted to give the matter more thought. This was common among many of the men, as they asserted a masculine trait of needing to make a considered decision on their own, rather than feeling someone persuaded them to do it.

Clients 8 and 10 also emphasised the voluntary nature of their opting to test. The quotation below emphasises the space given to the client's decision-making in choosing to test. His response relates to my question of whether the clinic encouraged him to test. There is an emphasis on his choice and his ability to decline and he asserts his independence and 'masculinity' in this way. He did not feel pressured to test, which in turn encouraged him to use VCT. It was his decision.

'They asked me, if you want to test, you can test. And I said Ja [yes], hmm, fine...you can check if there's something, if you want' (CT8, emphasis is clients own).

The quotation below suggests that this client felt he was consulted, he was respected; he remained 'manly' throughout the counselling session. An environment of respect and non-judgement are conducive to VCT uptake (Baggaley et al., 2001: 555). It implies that at other clinics which are perhaps less male-sensitive, he feels undermined, and they do not take the time and patience to seriously talk to you, to persuade you.

'There's a lot of say in this clinic, as compared to other ...clinics... Sometimes...even with a minor thing, they [staff] just shout...They don't try to convince you,...Like, you don't have a say' (CNT20).

Client 23 explained his experience of disrespect and the lack of personal decision-making at public clinics. He explained a prior testing experience which occurred at another health facility. He seemed disillusioned and angry at this testing experience, because he did not feel that he had a choice in whether or not to test. Without having been to

the MC, he assumed that it would allow him more agency. At the MC he feels empowered to make the decision himself, with his partner, when he is ready. This approach is more accommodating to 'masculinity' and is perhaps more likely to succeed in encouraging him, and his partner, to test.

There was a case in the short time I was at the clinic, where a man initially came for STI treatment, and chose not to test, but then returned to the clinic two days later to use VCT. He had thought it through, and made his own decision to return for testing and mentioned his acceptance of either outcome. Client 7 explained why he returned,

'I would think about [testing]. Then I tell myself today ...I must come, whether I am positive or negative I will accept it' (CT7).

Many men who did not test indicated that they needed to be at peace within themselves, with either outcome, if they were to test, and they needed time to come to this point. It was as though they could not trust their reaction if they tested positive. Many of the non-testers indicated that this was a prerequisite to testing. The impression given was that the male clinic gave space for men to reach this acceptance. Some testers had never considered testing before and had tested, and some non-testers had changed their position from never intending to test, to being more open to it. The clinic's non-pressured approach allows for this development, whereby men get to a point where they are more accepting of either result, and therefore open to testing.

Another 'excuse' given for not testing, was the desire to treat one ailment at a time<sup>53</sup>. It was suggested that if men get the treatment for their STI, feeling encouraged, they could return for VCT. Many non-testers said they wanted to return to test once their 'other problem' had healed. As Client 27 says,

I can test yes...when I see the progress in what [I] have come for [STI] then I would test' (CNT27).

This indicates that the clinic is possibly encouraging men to test.

The space given to men to return to test, of their own accord, could be a positive reinforcement for men. I feel this approach is more likely to be effective in getting men to voluntarily test. Another possibility, however, is that men may be evading testing entirely in saying they want to treat one condition at a time. Although they say they may consider testing once their other condition heals, it could be possible that the fear of testing still prevents them from following through with VCT.

### *Counselling: a threat to 'masculinity'?*

I perceived the counselling method itself to be potentially threatening to 'masculinity' for some men. Pre and post-test counselling are opportunities for the VCT client to express emotions, concerns and views about HIV and AIDS (Baggaley et al., 2001:557). Counselling, generally, is connected to femininity because it is seen to be related to 'emotional expressiveness' (Wisch et al., 1995:80).

---

<sup>53</sup> i.e. first deal with their STI and then use VCT

Despite this gendered view of counselling, there was also evidence that counselling was effective in persuading men to test and opening them to the possibility in the future. Client 14 explained that a friend of his who had visited the MC to use VCT tried to encourage him to test, but he declined. This client puts himself in the category wherein he would never test, until he became detrimentally ill and was unable to avoid it; however, once he visited the clinic for other reasons, the counsellors managed to 'convince' him (CT14, p3). Client 12 also noted that through the counselling session, he felt more open to the idea of testing.

Many of the men did voice discomfort with the counselling method, though, either as they experienced it at the MC or at other health-facilities. Client 7 explained that he wanted the counselling to be quick and to the point.

'...when I was coming here I thought maybe before I would ask some questions. But when that guy was counselling me, then I was scared...I was hurry! I wanted just to make quick... so I could get...the results because I was scared!' (CT7).

'I asked questions from the doctor when she started to explain I said she must not explain... Because those questions were going to scare me' (CT11).

This shows that counselling was anxiety-provoking for some clients and potentially puts men off testing.

Similarly, Client 6 talked about how men just want to know the result and the 'next steps', briefly, instead of delaying the inevitable information. Some clients specifically connected this 'drawn-out' process with women, because there is a perception that women talk on unnecessary tangents and some men prefer a 'to the point' approach.

## Promoting alternative views of 'masculinity'

Armstrong (2003) mentions the role of positive imagery as a contributing factor of a male-friendly environment (2003:221). Young African men are often, without necessarily having acted accordingly, blamed for the spread of HIV/AIDS, labelled partner-abusers and other negative stereotyping<sup>54</sup> (Barker and Ricardo, 2005:2). Similarly, in South Africa, men have been accused of fuelling the HIV/AIDS epidemic as well as blamed for the high occurrence of domestic violence and child sex abuse (Reid and Walker, 2005:9). Men are lumped together as perpetrators, often before they have committed any such crime.

Creating a non-judgemental environment, with the use of imagery, contributes to showing appreciation for men. To re-emphasise these negative masculine tropes and connect the participants with these negative images would be alienating. When 'masculinity' is predetermined through such labels, and no alternative is given, it becomes a threatening and self-realising construct, with grave health consequences. The MC in Khayelitsha has several posters, in English and Xhosa, on the walls of waiting rooms and counselling rooms which show alternative 'masculinities'.

These messages around the clinic contribute to creating a *male-friendly* environment, where men are valued, rather than pathologised.

I would also suggest that the male nurse and counsellors are positive models of 'alternative masculinity' for the clients. Here are men in traditionally 'female' roles helping men. They are living examples of this alternative, healthy and positive 'masculinity'.

Although these male-friendly messages are not directly encouraging men to test for HIV, they are creating a positive environment, wherein men can hopefully feel valued and comfortable, which are conducive to encouraging them to test.

## Location

The location of the clinic in Khayelitsha is very deliberate. All clinic partners acknowledged that men from Khayelitsha may not be accessing health-care in Khayelitsha, but accessing care outside their community, especially at the Spencer Road clinic in Salt River. Spencer Road, although not exclusively a MC, has the reputation of being one<sup>55</sup>. Clients 1, 8 and 11 all referred to Spencer Road<sup>56</sup>, describing it in similar terms to the MC in Site C.

<sup>54</sup> Men are often stereotyped as criminals, delinquents, troublemakers and predators (Barker and Ricardo, 2005:2).

<sup>55</sup> The Spencer Road clinic is known to have male doctors and male nurses and that they treat large numbers of men for STIs.

<sup>56</sup> They referred to Spencer Road clinic without being asked about it.

According to a clinic partner, 25% of the clients attending Spencer Road were from Khayelitsha. Moreover, PGWC reported that self-referral VCT use for men was very low in Khayelitsha. There was clearly a need for a STI and VCT facility for men closer to them. Most of the clients who I interviewed were from Khayelitsha, and only one (Client 27) lived in Nyanga, indicating that men from the direct vicinity are accessing this clinic. This demonstrates that the clinic location is male-friendly.

The clinic is situated next to the Site C taxi rank and is located in a busy area, where there are street vendors. The site is part of a bustling area, but also removed from the busy surroundings, as it is an enclosed area<sup>57</sup>. It is said that 'Locating services nearer the sites of men's work and leisure time...were identified as important first steps in improving accessibility [for men]' (National Department of Health, 2007:21). The immediate location is significant as many men use the taxis travelling to and from work. This is a male-friendly design, as it attempts to accommodate the schedules of men, making the facility accessible to them in environments familiar to them.

## Opening Hours

Public clinic opening hours are largely considered inhospitable to men, especially employed men, decreasing their opportunity to access services (National Department of Health, 2007a:21). The MC is open from 12:00 to 18:00 from Monday to Friday and open from 10:00 – 15:00 on Saturdays. These hours are considered 'male-friendly' because they are specifically structured to accommodate working men by extending the clinic opening hours during the week and being accessible on Saturdays.

One client mentioned the accommodating hours in a positive light, specifically connecting it to gender.

'...in [another clinic]...they always ask...why you say late...why you coming by this time, and shouting bla bla bla. So...this clinic...it's only for men, they understand why, and I'm happy to explain I'm late because of my work' (CNT20).

At the MC, he implies, they understand men's circumstances. Here it is an acceptable 'excuse' to be late because of work, whereas, the implication is other clinics do not understand men's circumstances.

In contrast, Client 9 indicated his preference for the clinic to be open earlier so as to be able to go to the clinic before work.

---

<sup>57</sup> This location was potentially positive in that those attending the clinic can do so in relative privacy, but also access the site easily. On the other hand, the clinic is slightly hidden away and some clients found it difficult to find. A counsellor explained what the surrounding buildings were. This helped to contextualise the clinic space. The site is a community area with community buildings. There is a sports hall, which also seemed to be used for community meetings and activities. There is an African National Congress community building on site. There is also a building which offers activities to various groups within the community, including the elderly. A client also mentioned that his wife came to the site to get her government child grant. The clinic shares its site with these other buildings.

The clinic is open later than others in the community and therefore more likely to attract and encourage men to use the clinic and possibly VCT. If the clinic is open later, that means more men are able to access the VCT service at a time that is convenient for them. This is another enabling factor of the male-friendly clinic.

## **Decentralised Service/Non-clinical Site**

In a study conducted in Zambia<sup>58</sup>, 'Three times as many people accepted testing at the non-clinic locations compared to the clinic location' (McCauley, 2004:5-6). This indicates that many people prefer a decentralised<sup>59</sup> service when accessing VCT. Relating this to significance for men, separating the Men's site from a generalised clinic was an attempt to disassociate from women and children. This is a further attempt at making the facility male-friendly<sup>60</sup>.

I also think that the decentralised service assists men in actually taking initiative in their health-seeking. The decentralised service disassociates the link of weak man asking for help, and instead, it is a place where 'we men can go', lessening anxiety and allowing for greater initiative in help-seeking (Robertson, 2001:148 In McCarthy and Holliday, 2004:26).

## **VCT and STI treatment**

Literature suggests it may be advisable for public health facilities to link VCT to 'gender-acceptable' health conditions. This 'allows' men to seek treatment, or be seen to seek treatment for another condition, but also receive VCT (WHO, 2003a:3). STIs are one suggested condition, and the MC has significantly combined these services. I believe this to be male-friendly and encouraging of VCT as men can be seen to be getting help for STIs rather than testing for HIV. In the context of HIV/AIDS stigma, this is a greatly significant aspect of the clinic, whereby men going to the clinic are not immediately labelled as going for VCT<sup>61</sup>.

In the New York Clinic, this was also a factor. Men preferred generalised services, rather than sexually related issues only, so as to lessen the stigma of attending the clinic (Armstrong, 2003:220). As the MC in Khayeltisha is an entry-point into the health-care system, the site is not likely to expand further services at this time<sup>62</sup>. Nevertheless, combining VCT with another service is male-friendly, and de-stigmatising (and therefore encouraging of men to test).

---

<sup>58</sup> The study involved 2400 people being offered VCT (McCauley, 2004:5-6).

<sup>59</sup> By decentralised, I mean not linked to a general clinic offering a broad range of services.

<sup>60</sup> This element was not directly noted by any of the clients. However, the several references to feeling uncomfortable around women, and feeling more comfortable at the MC, indicate that this facility is disassociated with women and children, and therefore more inviting to men.

<sup>61</sup> Furthermore, STI patients are also more at risk for HIV, and it is logical to combine the services of VCT and STI treatment.

<sup>62</sup> Moreover, if the service became generalised, it would likely attract more women, which in turn would make the service less appealing to men.

## **Fast and Efficient Service**

Client 5 had preconceptions about the clinic being less busy, based on gender stereotypes:

'I thought...it won't be packed...Because it's only men, men come, they do their thing, they just go...[men] come and go. Women always sllittttting, occupy...spaces...They [women] talk. Ask men, ok I've got this problem. Solve this problem. Ok, thanks My Bru. I'm gone.' (CT5).

Many men complained about having to wake up early to attend general clinics. Partly this seems to be blamed on women, because of preconceptions around women's overstaying at the clinic, due to unnecessary chatting. Many men mentioned the quick service at the MC as a positive aspect. It was implied that this further encouraged men to use the facility.

## **Is the male-friendly aspect of the clinic an enabling factor in men's testing?**

The client interviews have clearly communicated that generally, men feel increased comfort at the MC. Levack (2005) proposes that increased comfort encourages men to use VCT (2005:20). While clients did not refer to all of these male-friendly aspects, many of the clients spoke directly to these attributes. Men reported that certain male-friendly aspects contributed to their testing. The male-friendly environment meant men felt less anxious about contravening gender norms: in asking for help or being counselled<sup>63</sup>.

The male-friendly attributes that appeared most significant included male staff, male clients, and an accommodating environment to 'masculinity', with particular emphasis on respecting independence and decision-making.

Also significant were the clinic location, opening hours, and perceptions of a more efficient service. The linking of the STI service with VCT seemed also to encourage men to test, as some of the men came for STI treatment, rather than testing in and of itself<sup>64</sup>. The decentralised service seemed another factor encouraging men to test, as the clinic became dissociated with asking for help, women and children.

All these factors contribute to making the Site C MC a male-friendly space. The testing clients have shared how this contributed to their decision to test, and the non-testing clients seem more open to the possibility of testing, having visited the clinic for STI treatment. This all indicates that men perceive the clinic as enabling in accessing health-care, and using VCT.

---

<sup>63</sup> Possibly, their comfort increased partly because they were counselled by men.

<sup>64</sup> 6 of the 15 testers tested, although they had not initially intended to do test.

## CHAPTER SIX: TRUST IN MALE HEALTH-WORKERS

As I mentioned in chapter five many of the men seemed at greater ease with male health-workers. Perceived confidentiality between patient and health-worker certainly contributes to the client's level of comfort, but one does not equate to the other. There were several aspects contributing to men's increased comfort with male staff. Many of the men did refer to distrust of women health-workers as an inhibiting factor, but more often, the breaches in trust were directed towards female patients<sup>65</sup>.

### Factors contributing to Trust in Health-workers

It is understandable, in the context of HIV/AIDS stigma, that patients want their HIV status to be confidentially handled. Different factors contribute to people feeling more or less trusting of health-workers. The client interviews revealed that gender was a factor, as well as anonymity. For others, they trusted the health profession itself to maintain high standards of confidentiality.

Some clients<sup>66</sup> did raise concern over confidentiality, either directly relating it to women staff, or comparing general clinics in contrast to the MC<sup>67</sup>. Studies also confirmed that many men direct their concerns about confidentiality towards women health-workers (Levack, 2005:20).

If men distrust health-workers based on gender, this is a major obstacle to their accessing VCT. Research has shown that people often do not use VCT because they are anxious about confidentiality breaches (McCauley, 2004: 5). Many men were more open to testing because of increased trust in male staff. The ability to trust staff potentially encourages people to use VCT.

In the following discussion, I will examine some prejudices men have about women's ability to maintain confidentiality, and therefore, how male staff are perceived to be more trustworthy. For some men, this greater trust in men, and the ability to consult with men at the clinic, is an encouraging factor in their decision to test<sup>68</sup>. Taking into consideration the clients who were asked if they felt they could trust MC staff to keep their status confidential, 29 out of 31<sup>69</sup> clients indicated they had confidence in the clinic to keep their status confidential, and 2 clients were unsure<sup>70</sup>.

Out of the clients who were asked whether they trusted staff at other public clinics, 10 patients out of 19<sup>71</sup> indicated they did not trust other clinics, while the remainder indicated they did. One client explicitly made the distinction that

---

<sup>65</sup> Female and male patients share waiting-room areas in general clinics.

<sup>66</sup> 11 of 33 clients raised concern over confidentiality.

<sup>67</sup> This indicates gender indirectly, as public clinics are female dominated.

<sup>68</sup> It is also potentially encouraging to those planning to test in the future.

<sup>69</sup> 2 clients did not answer this question.

<sup>70</sup> One of these was client 7 who was anxious over the presence of women in the waiting area at the clinic, which seemed to compromise his trust in the clinic and the staff.

<sup>71</sup> The remaining 14 clients did not answer this question.

while they trusted the staff at general clinics they did not trust the female patients<sup>72</sup>. I will now examine the interview data which explored whether male clients expressed their greater trust in male or female staff.

### *'Men will keep it inside'*

There is anxiety for some men around trusting female health-workers. I have previously mentioned what was described to me by one of the male, Xhosa-speaking staff members, as 'traditional confidentiality'<sup>73</sup>. The confidentiality I refer to here is different. It entails the client feeling safe with the staff in keeping their HIV status private. Many men expressed greater trust in the confidentiality at the MC because they were dealing with men. This was explained to me because many men, it seems, believe that women are inherent gossipers, and their HIV status is not safe with women.

'...this kind of a clinic is unfamiliar because we would have problems but we are afraid to come forward... Because we don't feel comfortable when there are women...because once a woman sees you in some places she would talk about that... But I feel comfortable talking my problem with a man...' (CNT12).

Client 22 thinks that this clinic will encourage men to test because

'...they are being tested by other men who will keep it inside' (CNT22).

The implicit implication is that women health-workers would spread the test result around the community. Client 30 says that if he was going to test, he would only test at the MC because of this preconception of women.

These are non-testers<sup>74</sup> and they indicate their greater trust in male health-workers. The assumption is that men will not tell others about the patient's HIV status. If men feel that they cannot trust female staff, this will hinder them from testing at public clinics. Testers expressed similar preconceptions about women health-workers.

Some clients did not directly say they had greater trust for male staff, but this was implied, because they identified better privacy with the MC, and lack of confidentiality with public clinics – which are associated with female staff.

It is clear that many men share a perception about women as unable to keep information to themselves. While most distrust was aimed at female patients, many men also applied this sexist stereotype to women staff.

The increased trust in the staff, at the MC, meant that men felt safer going for testing at a MC, where they perceive it to be more private. 16 out of 16 non-testers<sup>75</sup> said that if they were to test in the future, they would test at the MC

---

<sup>72</sup> I discuss this further in chapter five.

<sup>73</sup> This seems to exist as an understanding between Xhosa men. It is based on shared experience through initiation into Manhood, and the exclusion of women in this process (see chapter five for more on this point)

<sup>74</sup> These patients did not test at the clinic, but they appeared open to the possibility in the future.

<sup>75</sup> The remaining non-testers did not answer this question.

rather than any other facility. This demonstrates that the MC is an enabling environment for men to use VCT, partly because they possibly trust male health-workers more.

### *Anonymity between client and staff*

For other clients the most important aspect contributing to their trust in health-workers was their anonymity rather than the health-workers' gender.

'It's not easy to trust, because some of them I know them, it's the people that are staying there, so I cannot say I trust this person, because this person knows and maybe he can go or she can go and tell them hey, he has tested positive...when I don't know them, it's easy to trust' (CNT33).

This suggests that rather than gender, it is anonymity that allays fears of confidentiality breaches for some clients. This confirms data suggesting some men seek health-care outside of their communities (Mesi, 2007). The quotation below combines concerns about gender and being known by clinic workers.

'I'm not saying here, in Site C specifically, I'm staying in Harare so it's better to come here in Site C, because some of the women they know me, so I don't want to deal with people who know me' (CNT32).

32 of the 33 clients interviewed were from the Khayelitsha community, which indicates that men in the area are accessing this service, in spite of the trend to seek health-care outside of your community<sup>76</sup>. 11 of the 33 clients voluntarily specified they were from Site C, where the clinic is immediately located. The clinic location<sup>77</sup>, while easily accessible, is also relatively private. It is enclosed on a piece of land, away from the busy street and taxi-rank surrounding it, which may also contribute to men's feeling their status, is being handled confidentially.

Being able to trust the staff doing your HIV test, is affirming, because of the stigma attached to having the virus. I think this stigma is gendered, as men associated with clinics, HIV, or illness is a dent to perceptions of manliness, because conceptually these are linked to women (Courtenay, 2000: 1389).

Some clients expressed their need to investigate the clinic before going through with testing, seeing whether they could entrust their status with the staff. After coming to investigate and seek advice, Client 31 is satisfied that he can trust the staff.

'I could see they [the staff] meet [with each other] but there is nothing about somebody's status...they do not talk about that. They keep that very confidential like I was talking to one of them and when some of them came we switched to something else' (CNT31).

---

<sup>76</sup> Admittedly, Khayelitsha is a large area, made up of several 'sites', with an approximate population in 2004 of 400 000, so the facility may still be far from the clients' immediate community (Coetzee, et al., 2004: 888).

<sup>77</sup> I describe the clinic location in chapter five.

He trusts that the staff do not talk about their clients' status amongst themselves which is assuring to the client. Being unable to trust the person who conveys your HIV status is bound to put anyone off testing. Therefore, it is important to create conditions where patients do feel able to trust health-workers. Client 31 was due to return to the clinic to test in two days time, and this trusting environment contributed to his wanting to return to use VCT.

Ideally, it is best to strive towards trust across gender distinction, but in the time being, creating an enabling space where those men who do distrust women, can test, is important. The clinic itself should not agree with this distrust of women health-workers. Nevertheless, their work as male health-workers is valuable and filling an important gap, because it means that some men, who would not otherwise test, are more likely to test because they trust male staff more than women. A greater project is needed to challenge these imbedded prejudices about woman's trustworthiness, so that men can test comfortably, not only at the MC, but at general clinics.

Noting this distrust of women health-workers among some male clients, it is conclusive that having male staff at the MC contributes to men testing at the clinic. The 'Male staff' element of the MC once again contributes to some men feeling encouraged to test at the facility, when they would not test elsewhere.

## CHAPTER SEVEN: VCT NORMALISATION AMONGST MEN

### Testing as unusual and silenced among men

One contributing factor to men's reluctance to use VCT is the rarity of testing amongst men, or the silence surrounding those that do test (Addis and Mahalik, 2003:11, Day et al., 2003:668). Addis and Mahalik (2003) emphasise that health-seeking is restricted among men 'when they perceive other men in their social networks as disparaging the process'<sup>78</sup> (2003:11). If men see themselves as belonging to a group, it is harder for them to go against the 'norm' of this group. The interviews revealed that Xhosa men feel they have a uniting commonality: the experience of initiation and the mark of circumcision. Xhosa men belong to the category 'men' because of this life experience<sup>79</sup>. The staff expressed situations where older men came into the clinic and would want to know whether the counsellors had been to the bush<sup>80</sup>, before they talked to them. This initiation experience unites these men in some way. There is therefore a sense of belonging to a group. This means the pressure to live up to the gender code is strong. To do something unusual, like using VCT, is therefore challenging, if other men are not being seen to actively support it.

Day et al.'s (2003) study amongst mine-workers indicates that for some men, they would feel encouraged to test if they saw their role models<sup>81</sup> testing (Day et al, 2003:668). If men see male role models testing, this will contribute to normalising testing.

The comment below refers to the importance of role models, and leading by example. The client emphasises the importance for the counsellors to have tested, so that there is meaning behind their encouraging clients to test.

'You must lead by example... I've tested. You can see the result. You can test... So that person will be motivated. Don't say ja, test, ja you are a doctor, but you are afraid of testing, but you are telling me to test. No, no. You must test first Bhuthi. Like the president, you must lead by example...' (CT5).

The above extract indicates that when men recognise other men to have tested, this is encouraging in their decision to use VCT. In 2006, there were calls for the South African President, President Thabo Mbeki to take a public HIV test, but he infamously refused the opportunity. The consequences of this kind of message are monumental on many levels. To the nation and to those living with HIV/AIDS, he is denying the threat of HIV/AIDS to himself and others. He

---

<sup>78</sup> This social pressure not to seek help 'is especially so if (a) other men are perceived as unanimous in their attitudes, (b) a large number of men express similar attitudes, (c) men see themselves as quite similar to the members of their reference groups' (Addis and Mahalik, 2003:11).

<sup>79</sup> I discuss this in more detail in chapter five.

<sup>80</sup> The 'bush' means to have gone to initiation school and to be circumcised. According to Xhosa 'cultural' belief, you are not a man unless you have been circumcised. You will remain a boy until doing so.

<sup>81</sup> A role model is 'a person looked to by others as an example to be imitated' (Oxford English Dictionary). Role models could be high-profile men in the media, or simply other men with whom men identify.

is sending a message that he will not be associated with the virus. HIV and AIDS therefore become more pathologised, rather than working towards de-stigmatisation. In reference to gender, as a man, President Mbeki has actively made a decision that takes men steps away from using VCT. It sends a message that 'we do not need to test. I am strong enough. I will not be touched by HIV/AIDS'. This is such a damaging message to send to a nation struggling with an HIV/AIDS epidemic, wherein men are largely not testing or disclosing that they are testing. The social message that would be sent by a male, South African President testing, would be a powerful step to increasing men's association with VCT.

As it stands, with so few men testing, and those few who do test not disclosing they have, it means testing is unusual for men. If more men tested, it would become more 'normalised' and therefore more acceptable to go and be seen to test, as well as to talk about it with other men.

Clients used words like 'rare' and 'unfamiliar' in relation to men's use of VCT, which means men are aware that if they use VCT it is going against the norm of what men do in the community. This societal 'norm' is difficult to go against; if being tested means you are being less manly.

Interviews indicated that men usually wait a long time before testing, until they are detrimentally ill<sup>82</sup>. Moreover, some clients connected testing to being HIV positive, rather than the possibility of either outcome. It seems men perhaps do not talk about testing because people will assume they have HIV/AIDS.

There is a reluctance to undergo testing when you are healthy as many men seemed to equate testing for HIV as having AIDS, rather than seeing it as a responsible, precautionary measure where the result could be positive or negative (Levack, 2005:13). The assumption is that men who test are already sick. In Day et al's (2003) study, most of the men who had used VCT had done so because of being ill (2003: 668). This is linked to men's reluctance to seek help early on, at the first signs of illness. Seeking help at the first signs of illness goes against men's socialisation, where they are told to be real men by showing physical endurance and inherent strength (Courtenay and Keeling, 2000:246).

Among the clients, 15 out of 30 said that they wait a long time before they seek medical help. Half the number of men asked this question reported that they delayed treatment. Significantly, and somewhat surprising, is that in my study there was no apparent connection between testers and seeking help quickly<sup>83</sup>, or non-testers and waiting to get medical help<sup>84</sup>. This indicates that although many men are reluctant to seek medical assistance early, many do, despite societal pressures. Both literature and interviews indicate that many men delay getting tested until they are very ill. Men are therefore less likely than women to 'survive' AIDS (Nattrass, 2006: 21). This creates a connection between testing and being ill, or even death. The fact that those who tested are not necessarily men who seek health-care quickly, however, means there is space to work with men to encourage them to test as a preventative step.

---

<sup>82</sup> This contributes to the association between testing and being ill, and ill with AIDS.

<sup>83</sup> Of the testers, 8 said they waited before seeking help, and 7 sought help quickly.

<sup>84</sup> Out of those non-testers who answered the question, 8 said they waited before seeking help, and 8 sought help quickly.

## Self-efficiency and Life Chances

### *Self-care*

Client 19 connects VCT to women, as though there is something in their nature<sup>85</sup> that drives them to take care of themselves.

'It is mostly women who are confident and like to take care of themselves [by testing] from such things' (CNT19).

This puts men and women on two different sides of HIV testing: women test, men do not, re-enforcing the rarity of men's VCT use. It also reinforces gender socialization whereby women are thought to look after their health, whereas men do not (Plusnews, 2005:3).

This quotation also indicates an awareness of men somehow failing with regard to HIV testing. This man shows insecurity over looking after his well-being, and expresses a lack of initiative in self-care.

Some men did demonstrate the initiative to look after their health before becoming very ill.

'I don't want to go to the doctor when I'm weak. Just like now, nobody can say I'm sick now' (CT7).

This man wants to look after his health and to anticipate the worsening of his condition. Another client spoke similarly about accepting treatment and his willingness to take the steps he needs to live his life if he was infected with HIV. This suggests that some men can be encouraged to use VCT when they are healthy.

It seems common that men are not proactive in looking after their health, and need someone else to convince them to get help. For some, this is their wife. Women encouraging men to seek health-care is also related to VCT, as Client 24 says,

'...she [my girlfriend] even pushed me to come here to check my status' (CNT24).

Beck's (2004) study revealed that some men only seek help if a person of authority<sup>86</sup> encourages and tells men to go (2004: 8). Makoba (2006) reports a similar trend whereby men resist taking the initiative to test and only going when advised by their doctor<sup>87</sup> (Makoba, 2006). Client 9 said the wife may go to her husband's family and appeal to them to encourage her husband to seek help.

---

<sup>85</sup> And therefore, the thinking follows that if it is in woman's nature, it is not in men's.

<sup>86</sup> Perhaps a father figure.

<sup>87</sup> A doctor being an authority figure, and usually male.

This lack of initiative is an obstacle to men's health. Many men do not actively seek health-care. The irony is, according to gender 'norms', men 'should' be self-reliant, preventing them from seeking help, which may result in them becoming more dependent<sup>88</sup>. It also means that because they are not proactive in health-care, they need others to coax them to accept help – which is another kind of dependence. Men's resistance to help is a means of demonstrating manliness<sup>89</sup>. This can be viewed differently.

The numbers of people using VCT could increase greatly if men took more initiative with their health. Being proactive about self-care needs to become masculinised, related to independence and decision-making: the independence to make the decision to care for the self. Men need more role-models who are proactive in self-care, who they can see are testing.

### *Life Chances*

Another important finding was that testing is not common because men do not see the value in knowing their status; this is because many of them live lives of risk. A non-tester and tester expressed this commonly held view. Both men talk about other men saying this, so it is clearly a view known to be shared amongst men, and therefore contributes to the disassociation of men from VCT.

'...some men say, "No, I don't go there [to test] it's...going to be the same, if I got HIV/AIDS, I'm going to die, I don't care, I'm not scared of die, so there's no use to go to the clinic"' (CNT18).

'it will take time for you to say, let me accept this...most of us, this is the end of the world to me. If they say I'm positive, then it means I'm going to die, so let me just die then' (CT6).

Men often mistakenly see HIV as a death sentence, rather than a manageable disease. The second quotation suggests the possibility of men committing suicide if they are HIV positive<sup>90</sup>. It worryingly seemed an accepted way for men to cope with a positive status, as though it were better to die now than live with HIV. HIV/AIDS is sometimes viewed as a death sentence that they either impose on themselves<sup>91</sup> or is imposed on them, so they would rather not know and continue living unaware.

### **Routine Testing contributing to VCT normalisation**

---

<sup>88</sup> This is because they become more ill in their resistance to seeking help.

<sup>89</sup> Manliness here is connected to the quality where men 'should not' give in to pain.

<sup>90</sup> While I was at the clinic, a few men mentioned suicide in relation to a positive status.

<sup>91</sup> Through suicide.

The approach of the clinic whereby each client is offered VCT, whether or not that is the reason for their clinic visit, contributes to the normalisation of testing in men<sup>92</sup>. Normalising is in part about de-stigmatising VCT, so that it is a more acceptable and regular activity. Routine testing is thought to contribute to VCT de-stigmatisation/normalisation (De Cock et al., 2006:440-441). This is precisely because testing is offered to everyone, rather than the occasional person requesting the service. This opt-out approach means the opportunity to test is more commonplace, contributing to normalising testing.

## Talking about testing with male peers

### *Attempts to encourage other men to test are often ineffectual*

Many of the testing clients expressed their friends' resistance to their encouraging them to test. Some of the testers expressed their frustration at their unsuccessful attempts at encouraging male peers<sup>93</sup>. The men identified several reasons for their friends' resistance, including denial of risk, lack of knowledge and more immediate threats to their lives. Client 5 below impersonates the reaction of his friends when he attempts to encourage them to test.

'For what? We don't have AIDS. For what?' (CT5).

These friends assume that you only test when you have AIDS, when you are showing signs of illness. Implicit in this is either a complete denial of risk or a disjunction between testing and prevention. The test does not change your status, only your knowledge thereof – this does not seem to be the view of VCT in this instance, however. Rather, the client tells how his friends associate the act of testing with being infected, instead of being part of prevention.

Contrasting to this is friends 'choosing' denial based on the possibility of being at risk, and not wanting to know about their vulnerability. There is evidence of passive denial above, and also deliberate ignorance of status.

'My friends do not want [to test]...They say they are scared...HIV is killing so it is better to stay unaware of your status' (CT11).

Many men just don't want to know their status, and do not see the point in knowing (Levack, 2005:16).

Some men indicated while they are able to talk about HIV/AIDS generally with their friends, talking about testing is considered too personal. HIV/AIDS stigma prevents men from talking about VCT, particularly from a personal perspective<sup>94</sup>. I believe this silence around testing is more apparent for men, and therefore men are more reluctant to be open about having tested.

---

<sup>92</sup> This approach is known as routine testing.

<sup>93</sup> Levack's (2005) study also confirmed this experience (2005:24).

<sup>94</sup> Here is the link between testing, AIDS and death.

## Less direct, 'Word of Mouth' Marketing

Central to the success of this normalisation is the role of WoM, as those who work, and those who have attended, the clinic, talk to others about the clinic's services.

Literature examining MCs in other parts of the world indicates the key role that WoM plays in the growing success of a clinic ((Pearson, 2003, Lewis, et al., 2004 and Hancock, 2004). In a study that examined the most successful means of promoting SRH services, male interviewees described hearing about the service from friends as the most effective means of promotion (Pearson, 2003:195). In a similar project, Lewis et al. (2004) learned that most clients were attending the services because of WoM (Lewis et al., 2004:482). This applied to the MC in Khayelitsha too, as almost a quarter of participants confirmed this to me (8 out of 33 clients)<sup>97</sup>. While a variety of media sources proved the most effective, followed by referrals from other clinics, my client interviews revealed that WoM played a significant role in marketing the clinic. As other men told potential clients about the clinic, this led them to attend it themselves. Other clients<sup>98</sup> asserted that WoM is the key to marketing the clinic services.

Client 12 heard about the clinic through WoM, notably from a stranger. While many men are uncomfortable talking to women about SRH, this demonstrates that some men are so comfortable with men that they will talk to strangers about SRH. Consequently, this led Client 12 to the clinic<sup>99</sup>.

'...a guy I met yesterday told me that there is a MC in Site C...I met him on my way from work and I told him about my problem...I asked him where I can go because I don't want to go back to [Clinic A] because there are lot's of women there so they want to know my problem' (CNT12).

This also shows that those men who have been to the clinic are telling others about the facility which is contributing to normalising the clinic among men in the community<sup>100</sup>.

Similarly, Client 17 heard about the clinic from people chatting in his community.

'I heard people talking about it [the clinic]...Like I heard in my community people talking about it and I decided to come and see for myself if it is true that it's a MC' (CT17).

This Client came to investigate as a result of people talking in his community, and consequently, he tested. WoM is therefore promoting the clinic, and significantly not only through personal networks. In part, through WoM, the clinic is successfully getting men to test.

<sup>97</sup> Men also reported hearing about the clinic from other clinics (10 out of 33), others from media sources including local radio station, Zibonele, TV, newspapers, billboards and the clinic launch (12 of 33) and others from a Men's group (2 of 33).

<sup>98</sup> When asked how best to improve VCT among men, men talked about word-of-mouth as most effective.

<sup>99</sup> Client 12 went to the clinic because of word-of-mouth, but he did not use VCT.

<sup>100</sup> This quotation also confirms the discomfort Client 12 feels at having to seek STI treatment from women health-workers.

Other clients mentioned the key role that WoM marketing will have on improving testing in men, as the clinic profile is raised in the community<sup>101</sup>.

'...those people that have already come in here, like [me] would go out there and encourage their friends, family...and partners to come and...have VCT or...other sexual infections... So I think that's the only way we can further...the information about this clinic' (CT15, p5).

The client above sees WoM as the only means of promoting the clinic and VCT.

'...another time you have told the person [to test] but he did not move [he was not motivated to go] but when he is told by someone who comes from here [the clinic] you can say, "here man you can also go"' (CNT22).

The preceding comment shows that people respond to personal experience<sup>102</sup>, relating to role-models and being encouraged when you associate with the people using VCT.

'I think it doesn't have to maybe to end on advertisement on TV or Radio, people maybe can come door to door...but it doesn't happen you...just see maybe a pamphlet about it, and people go [indicates through body language that people are disinterested and throw the pamphlet away]...if a person is talking to you now you can begin to understand' (CNT33).

Client 33 makes a key point about promotion campaigns; it is important for people to talk to one another about HIV, because it is easy to throw away or dismiss pamphlets and adverts. It is more difficult to shut out information when coming directly from another person. Clients suggested that people would be motivated to attend the clinic, if they heard personal accounts about it. The information must come from those who work at, or have been to, the clinic. Client 26 identifies that person to person marketing is going to be the most effective in making the clinic successful and getting more men to test. This emphasizes the key role that the counsellors must play at the clinic<sup>103</sup>.

Client 30 believes that this clinic will have a positive effect on getting men to test, but more people need to hear about the clinic.

'...if they can go out there and market this place, I think so [this clinic will encourage men to test], because all men's are the same...at least you believe in other men' (CNT30).

---

<sup>101</sup> These quotations were said in the context of answering an open question about how to improve testing among men generally.

<sup>102</sup> Perhaps ineffectual attempts to encourage peers to test are partly because of a lack of personal experience. Having been to the clinic and experienced treatment and service, friends may be more willing to listen. This is possibly because a level of the unknown is diminished with a personal, positive report on the service, from someone they trust and identify. Levack (2005) also noted that male friends can be encouraging of their peers, demonstrating the potential in this marketing method (Levack, 2005:24).

<sup>103</sup> In the time that I was at the clinic, there was little evidence of this sort of outreach beyond the clinic walls.

Literature and interviews indicate the significance of WoM in changing perceptions and raising the clinic profile. This is a slow means of marketing, but it also the most effective (Pearson, 2003:198). It is hoped that '[o]nce a core of young men attends a service and passes on (hopefully) positive comments to male peers, a 'snowball' effect should result in increased male service uptake' (Pearson, 2003:198). If men begin to talk about testing, the community will begin to associate testing with men, and VCT will become de-stigmatised. This will contribute to encouraging men to test. Some of the clients attended the clinic because of friends, family or other men telling them about the service. This led to 3 of the 8 clients testing, and others being open to it in the future. While other clinics are sending most of the clients to the MC, the clients themselves refer to WoM as the most effective means of promotion. All these forms of normalising the facility and VCT should continue, but special focus should be placed on clinic staff and clients spreading the word about the clinic. The information is therefore passed between people, and probably between men, with whom other men identify. The affinity and trust apparent between men means that this is one way to normalising VCT and promoting the clinic.

Normalisation of VCT amongst men is integral to men's increased uptake thereof. If men are seen to use VCT, particularly male role models, this is bound to contribute to its normalisation. It is also likely to contribute to breaking the silence that currently surrounds men using the service. This silence is about HIV/AIDS stigma, but this stigma is also gendered, because of the feminisation of HIV and VCT. WoM and personal experience are a powerful tools contributing to this normalisation process. The MC is contributing to the normalisation, and therefore de-stigmatisation of VCT amongst men. This is arguably encouraging of VCT uptake.

## CHAPTER EIGHT: ADVANTAGES FOR WOMEN'S HEALTH

Arguably, VCT services targeted at men also serve in the interests of women's SRH. When people use VCT, it is thought that they become more aware of their own and others' health (Day, et al., 2003:665; HSRC, 2005:85). This is not always the case, as one of the clients expressed; If you hear you are HIV positive, your thought is not to die alone, but to bring others down with you (Leclerc-Madlala, 1997).

In spite of this, with a counselling approach that focuses on the benefits of testing, highlighting treatment, and appealing to men's socialised 'provider' role, this possibility is potentially lessened. Beck's (2005) interviews with men in Khayelitsha revealed that 'during rites of passage'<sup>104</sup>, males were lectured on the responsibilities of manhood (Beck, 2005:20). Although illness can be viewed as removing the ability to provide for the family, the understanding of having an HIV test for prevention or to access treatment, links testing with the ability to continue to provide, rather than being ill and therefore failing in this role.

If men become more aware of their own, and partner's, vulnerability through VCT, this is positive for both the tester and their partner. Moreover, men who test are more likely to be accepting of their partners testing, and partners using ARVs (IRIN, 2005). It also means men, who usually access ART very late, are more likely to access it sooner, which has advantages for the partner too (IRIN, 2005).

I would now like to examine the interview data on this subject. I was interested in whether men who used VCT at the clinic had consulted their partners in their decision to test. I also investigated whether they would talk to their partners about VCT after testing.

I would like to begin this analysis by looking at a key factor of the clinic, that being that although it is targeted at male clients, the clinic does not turn away women seeking help.

### Male-friendly as opposed to Male-only

The fact that the clinic is male-friendly<sup>105</sup> is an important feature of the facility. Because STIs and HIV involve sexual partners, it is important not to turn away female partners. As HW5 outlined, the male client

'...has the potential to have the same problem again if you don't consider [his partner]' (HW5).

Many of the partners, and the staff indicated their belief that you have more chance of reducing the spread of HIV when treating the couple.

---

<sup>104</sup> 'Rights of Passage' here means Xhosa initiation/circumcision.

<sup>105</sup> 'Male-friendly' rather than exclusively male.

While the clinic is primarily marketed towards men, it does not turn away women. The clinic encourages initial visits from client partners, but is likely to refer women to other clinics, as medical stock is largely supplied for men (HW5). The clinic has the capacity to be an entry-point for women too<sup>106</sup>.

To see men's reactions to the presence of women at the clinic, see chapter six.

## **Improving the SRH of both men and women**

The relation between SRH and sexual partners leads me to the connection between interventions that specifically focus on men as a means to improving the SRH for men and women (Varga, 2001: 176). An important clinic aim in terms of partner health is the reduction of proxy-testing in the community.

### *Addressing proxy-testing for the benefit of men and women*

A *Cape Times* newspaper article<sup>107</sup>, reports on a growing trend in the Western Cape where men impregnate their partners. The assumption is that the partner will undergo VCT during pregnancy and the man will learn his HIV status through his partner, rather than undergoing VCT himself (Makoba, 2006). This extreme action not only contravenes a women's autonomy, as they are potentially impregnated or made to test against their will, but it also shows men's overwhelming discomfort with the health system and particularly testing for HIV (Makoba, 2006). Proxy-testing is also known to not only centre on partner pregnancy, but men encouraging partners to test, as a means of finding out their own status. This matter of proxy-testing was identified as a problem by one of a staff member and a clinic partner too. This trend of proxy-testing must end, as it is essential for both partners to know their status, and it is contravening women's rights.

There was evidence of proxy-testing in the client interviews too.

'So now my girlfriend she wants to test... she's negative. So now without [testing], I know I'm healthy, so I don't have a problem...because she's the only girl... that I'm involved with [sexually]... So now I didn't see any symptoms, I walk, I'm eating. So now I'm saying it's ok...because since 2005 my girlfriend say is negative...so maybe she is negative, even me is negative, is negative' (CNT29).

Because he has no symptoms he thinks he is healthy. He does not see himself at risk because his girlfriend has tested for HIV. Counsellors need to stress that HIV can be dormant for years before showing symptoms and it is possible to have a different HIV status to your partner.

---

<sup>106</sup> Women may be referred elsewhere, but they will be directed to a facility where they can receive the care they need

<sup>107</sup> Dated November 2006

Out of the 18 non-testers, 7 reported that their partners had tested and 2 were unsure. The two who were unsure expressed distrust towards their partners. The partners had said they tested, but the men were not entirely convinced. In other words, 9 women had told their partners they had used VCT. 9 non-testers reported that their female partners had not tested. Half of the non-testing men's partners had reportedly tested and half had not.

Of the 12 testers who were asked whether their partner's had tested, 6 said their partners had tested, and 4 were unsure. Approximately half of the non-testing and testing female partners were thought to have tested. This indicates that one more woman was thought to have tested than the number of men I interviewed; however, if we include the 'unsure' answers to mean they had tested, this would mean 18 of the 33 partners had tested. This follows the trend that says more women are getting tested than men. It does also show, however, that there are still many women who are not testing.

### *'Bring in the males so they ...would be part of the couple'*

In the past, many HIV/AIDS interventions have focussed on empowering women in their ability to negotiate safe sex, and be aware of their rights in their sexual relationship. These approaches have largely been in isolation of men and therefore, inadequate. As P4 explains,

‘...we do this for women, and the men are out, but what use is it to...[women], so the women know all about it, but they go home ...they can't [practice their new knowledge] because they have to practise those things with a man who is not informed, not interested, and he's probably going to misunderstand<sup>108</sup>...you don't empower women...in isolation of men. Empowerment means there is some balance...how can you elevate the power of women, what you put on the other side of the scale to accept that empowerment...to do specific programs for the women, in isolation of the man is not going to be worthwhile. We need both' (P4).

P4 mentions the need for addressing the couple<sup>109</sup> or to work with sexes differently, but in alignment with a partner program. It is now widely acknowledged<sup>110</sup> that intervention programmes are only successful if both sexes are included (Chant, 2000:11). The clinic is targeted at men, but both partners can come to the clinic. Moreover, the thinking is that the MC is a means to balance the scale spoken of above, as men are educated on the importance of condom use and so will hopefully be more accepting of 'empowered' women.

‘If you treat the males on one side, and the females on another side, it's not good. So we thought let's bring in the males so they are a part of the picture, so they would be part of the couple...What I think is the most worthwhile is couple counselling, couple testing, couple treatment...to me that is the solution' (P4).

---

<sup>108</sup> The men may misunderstand why the women are asking them to use condoms, implying one of the partners has been cheating.

<sup>109</sup> Treat the couple rather than one sex at a time in isolation of each other.

<sup>110</sup> P1 and P4 specifically mentioned this.

The above quotations demonstrate that the intention of the clinic is not to give men preferential treatment above women, but rather that both men and women will benefit from this approach, as men are brought into the VCT picture. The concept 'male-friendly', in this context, is therefore also encouraging of couple-based approaches.

STIs and HIV are related, and as we are aware, when you have an STI, you are more at risk of HIV infection (Fleming and Wasserheit, 1999). Therefore, STIs should also be treated as a sign of potential HIV infection. The approach for STI treatment is also partner-based, whereby partner slips are issued so that the patient's partner can be treated too. STI treatment is a means to try and encourage couples to engage health-services together. This method has a potential impact on encouraging partners to use VCT too because,

'...once they [the female partners] are in the system for STI's, they must be offered VCT' (P2).

The success of this referral relies on the partner passing on the slip, and the other partner's willingness to seek treatment and therefore be offered VCT. It also depends on whether they accept VCT when it is offered and whether it is offered. Significantly, if they do enter the health-system for STIs, they should be offered VCT<sup>111</sup>, through an opt-out approach, bringing them that much closer to testing. There is a concern that

'...the number of people that go for HIV testing because they have an STI, it's less than half of the STI cases. Now we are not 100% sure whether the offering [of VCT] is only half, or if the patient says no, I don't want to have an HIV test' (P4).

This is a concern because if we do not know the situation, it is difficult to know the right response to it – either it is staff not offering, or it is patients refusing VCT, or perhaps a combination of both. STI treatment is an important means of getting patients to use VCT, and therefore the situation needs to be clarified. The MC can and must play a part in this too, as they deal exclusively with STIs and HIV – and this link must be capitalised on, so as to get more men to test. Every man with an STI must be offered VCT.

The MC is an opportunity to educate men about safer sex in a one-on-one situation wherein each client is counselled. Moreover, it is evident that couple counselling and testing needs to be a priority for the clinic. To be an effective intervention both members of the couple must be reached. Some of the clients were unaware they could bring their partners to be tested at the clinic – this message must be more clearly communicated.

### *Promoting Dialogue between partners*

Encouraging partners to test is a complex matter and potentially a topic of misunderstanding. A number of clients explained the problems of discussing testing with their partners:

---

<sup>111</sup> P2 and P4 confirmed that every STI patient should be offered VCT when presenting at a health facility.

'...if you are saying to your partner that she must go and get tested she might have question marks "why are you pushing me to go and get tested? Do I have Aids? We might as well (better) break-up if you like" you see' (CT4, p10).

In spite of this difficulty, nearly all the men who tested (14 of the 15 testers) said that they would talk to their partners about testing at the clinic. This indicates positively that the MC is potentially promoting conversations between sexual partners about SRH, and particularly HIV which may lead to both partners testing.

'Maybe next week I will come with her here and she can come to test even?'<sup>112</sup>, (CT8, p7).

This quotation shows that men are encouraged to think about their partners testing once they have used VCT.

Unfortunately, few of the testers (4 out of the 9 testers who came to the clinic intending to test, and 1 non-tester who had wanted to test, but was unable because the nurse was not present) had discussed their intention to test with their partners before visiting the clinic. The intention they expressed to speak to their partners afterwards is nevertheless a move in the right direction, towards testing awareness and partners potentially using VCT.

## Testing together or testing alone?

### *Testing alone*

While the clinic partners and many of the staff acknowledge the importance of treating the couple, it was clear that for many of the men, they wanted to test alone and then return with their partner. Treating individuals rather than the couple is not ideal, but it is better than their not testing at all. This is still potentially beneficial to both partners.

'...I didn't even tell her [my partner]...I'm going to come here to the male clinic. I said to her, I was going somewhere else. Then I decided to come here...because I was not happy at home'<sup>113</sup>...That Monday I told her I come from this place. Then I told her ...they ask me to test. Then she asked me what did you say? I said no, I was scared. She said to me, we must come. I said no, she must wait. I'm not ready. Then I will tell her when I've decided to come. Then she said when she's ready, she wants to come. ...Then I didn't tell her. I decided myself...I will come alone...I will tell her now...I wanted to know first for myself' (CT7).

As demonstrated, a discussion arose merely from the client coming to the clinic. He did not test on his first visit to the clinic, but it encouraged him to think about testing and talk to his partner about the possibility. The counselling

<sup>112</sup> I did not ask the client whether he would bring his girlfriend to test, I asked him if he would tell his partner if he had tested, and the above was his answer. I therefore do not think his telling me this was an attempt to please me.

<sup>113</sup> The Client was worried at home with his thoughts.

session, the conversation with his partner, all contributed to making him aware of the importance of testing. He then returned to the clinic to use VCT. Testing does seem to invoke dialogue around the topic between partners.

The quotation is also a warning against pushing couple-based services prematurely, when one of the partners is not ready to test.

As another client explained, his partner had encouraged him to test after she had been tested during pregnancy

'She asked me, you must go to test...the baby she is fine, and she said no man, it doesn't mean you...are safe because I am safe...then I did go to the doctor, but because I got flu that's why I get the chance to test' (CNT18).

This indicates two critical points; firstly conversation is a probable consequence after testing and potentially encourages the other partner to test. Secondly, this man felt comfortable being tested, because he was seeking treatment for something else (flu). This confirms that the clinic, in its offering a service beyond VCT is male-friendly. Men's fears are reduced as there is less reason for others in the community to jump to conclusions regarding why the client is seeking help<sup>114</sup>. This is a further enabler at the clinic in men's use of VCT.

This phenomenon, being tested whilst seeking treatment for other health problems, is known as routine testing (WHO, 2003). This means clients are encouraged to test, even if that was not their intention when visiting the clinic.

Client 11 explained that he did not tell his partner that he was intending to test, but that he would do so after testing. He explained that the reason he did not discuss this was because it was a spontaneous decision to come to the clinic, and it would have cost time and money to go home to discuss it with her first<sup>115</sup>. Having tested that day he did want to '...try to bring her [to the clinic to be tested]' (CT11).

Client 15 is a case where he tested by himself, but then told his partner about it afterwards and came back with her so she could test. These examples suggest that dialogue between partners, about testing, occurs for many clients after one partner has tested for HIV. This also potentially leads the non-testing partner to testing.

Considering men wanted to return to the MC with partners to test, it was a concern that some were unsure whether they could bring their partners to the MC. The fact that partners can be tested at the clinic clearly needs to be made more evident to clients at the clinic.

A concern about partners testing alone is whether the clients' decision to talk to their partners would be altered according to their status. This could not be explored as I did not discuss HIV status with interviewees.

---

<sup>114</sup> Admittedly, having an STI is not as neutral as flu, but it is not as stigmatising as HIV, and therefore having STI treatment on offer at the clinic is helpful in facilitating men's testing.

<sup>115</sup> This highlights the influence of socio-economic status on men's health-seeking too, and potentially limiting equitable relationships between partners. Lack of money literally prevents some partners from engaging in such a conversation prior to testing.

### *Testing together*

Significantly, some of the non-testers (3 of the 18) spontaneously expressed their wish to test with their partner, rather than testing alone<sup>116</sup>.

'...when I want to test I must come with somebody I trust because I do not have one girlfriend...I must come [to test] with this one [girlfriend] I stay with' (CNT19).

This same client explained that he did not know the HIV status of his other girlfriends,

This client is clearly at high risk of HIV and is afraid to test. Being encouraged to test with his partner is crucial in getting him to use VCT.

The client below expresses his preference to test with his partner so that they hear their results together.

'...[my partner and I] have to go and test, both of us, because if you are going alone and test alone when the bad outcomes of that results comes you are going to be scared to tell your partner, but if you go both of you one time, then you feel free, you don't have a problem...That's why I take this decision we must test both of us' (CNT23).

This is in keeping with popular knowledge whereby the partner that tests first is sometimes blamed for bringing HIV into the relationship. If you test together, then the news is given at the same time, and therefore the 'blame' is shared.

This suggests that it is important to emphasise that men can bring their partners to test at the facility. This would clearly be in the interests of both partners. It also demonstrates that both options of testing alone and testing with your partner should be options at the clinic and be understood to be options at the facility. This will accommodate different preferences for testing.

### **Do VCT services targeted at men in turn encourage these men to promote testing in their partners?**

From my interview data, I cannot conclusively say that men's testing for HIV encourages their partners to test too. What does seem clear, however, is that merely by visiting the clinic, and having a counselling session, some men, whether they have tested or not, go home to discuss VCT with their partners.

---

<sup>116</sup> Testing alone was more prevalent among the men who actually did use VCT at the MC.

A few of the non-testers wanted to return to the clinic with their partners to test (3 of the 18 non-testers). Many of the testers said they would talk to their partners about testing<sup>117</sup>. This indicates a positive impact of the MC, not only on men's, but also women's, health. Research recognises that women cannot be empowered in isolation of men; men and women both need to be targeted through campaigns (Chant, 2000:11; Morrell, and Ouzgane, 2005:13, Peacock, 2005; Barker, 2005; Chege, 2005). The MC is one way of bringing men into the VCT picture. Men now have a place where they can more comfortably use VCT, whether they prefer to test alone, or with their partners. The latter is the preferred approach, but individual testing is accepted.

Evidence above demonstrates that men are likely to talk to their partners about testing, if the male partner has been tested. This shows that VCT is being normalised and encouraged between partners, contributing to more women testing as a result of men testing.

---

<sup>117</sup> 13 of the 13 testers who were asked this question indicated this.

## CHAPTER NINE: DISCUSSION AND RECOMMENDATIONS

In this chapter, I will discuss key and unexpected findings, as well as recommendations for the clinic and public health approaches to the challenge of recruiting more men to VCT. I will look at each findings chapter and elaborate on core issues and recommendations with relation to gender.

### Male-friendly clinic characteristics

#### *An Apparent Contradiction: Qualitative vs. Quantitative data*

My study explored the assumption that a male-friendly health facility will encourage men's use of, or future use of VCT. We already have the quantitative data showing that men are not testing at the same rate as women in South Africa. A qualitative study undertaken by Levack (2005) in Soweto explored the reasons why men were not testing. My study explored whether men using VCT at the Site C MC, perceive the male-friendly environment to be enabling in their testing.

Through 33 qualitative interviews, I examined men's perceptions around whether the male-friendly clinic was indeed 'male-friendly' and whether they perceived this to be enabling in their use of VCT. From my data, the men overwhelmingly felt more comfortable at the MC. Of the 29 clients asked about comfort levels, 27 indicated they felt more comfortable at the MC, while two felt the same level of comfort. Increased comfort levels are favourable to VCT use (Baggaley, et al., 2001 and Magongo, et al., 2002).

Men expressed their preference in speaking to male staff, facilitating VCT use in men. Many of the non-testers expressed reassurance after their counselling sessions, reflecting an open-ness to testing in the future. The MC adopts an unthreatening environment where men feel comfortable returning to the clinic according to their own decision, rather than feeling coerced into testing. The non-testing clients indicated this to be positive in their likelihood of testing in the future. Men asserted their hope in the clinic and expressed motivation to tell others about it and the services offered. With WoM promotion, this will contribute to normalisation and de-stigmatisation of men using VCT, and men's attendance at clinics more generally. My data gathered from 33 interviews overwhelmingly argues the case that the MC in Site C, Khayelitsha, enables men's use of VCT.

Contrary to my research, however, is quantitative data reflecting a different story. In Khayelitsha, the MC has the lowest acceptance rate for VCT at 46% (6% of the 727 VCT clients were female), while the next lowest is 83% (59% of the 435 VCT clients were female) acceptance rate (Cape Town City Health, unpublished data, 2007a). This highlights that many men are still refusing VCT, even though they are in a male-friendly space. Moreover, it demonstrates that the MC is not as successful at persuading men to use VCT. Spencer Road, which is predominantly a male-servicing

clinic, has a 73% acceptance rate for VCT (22% of 1269 VCT clients were female). This is disconcerting data, as it is in contradiction to my qualitative data which reflects positive feedback from the male clients using the facility.

I believe there are several factors to consider in light of this apparent contradiction. I will discuss these below and highlight recommendations where applicable.

### *A Slow Start*

My data was gathered after the facility had been running officially for 5 months (May – October 2007). The number of men who had visited the Site C clinic between May – September was 754 clients (Cape Town City Health, 2007a). One of the Imbizo drop-in centres in Klipfontein, Soweto, reflected similar numbers after a 5 month period. Approximately 622 men had visited the centre between January - May 2005 (Medical News Today, 2005). The MC in Khayelitsha has therefore fared marginally better than this other South African example. Furthermore, while clinic partners have been discouraged by the slow uptake of VCT among men, again this seemed a pattern in the Klipfontein centre, where only 140 men tested between January and April 2005. A significant contrast between these two clinics was in the number of male condoms distributed. While the Imbizo clinic distributed 70 620 condoms between January - May 2005, the MC in Khayelitsha distributed 18 670 in a similar five month period (Medical News Today, 2005 and Cape Town City Health, 2007a). This is clearly an area of concern that needs to be addressed at the Khayelitsha clinic.

Internationally, these trends also seem to follow this slow start: 506 clients visited the Young MC in New York in 1998, a total of 908 times. The New York Site did show notable improvement: by 2002 1452 men visited the clinic 2522 times (Armstrong 2003:220). Armstrong concludes that 'The increasing number of clients visiting the Young MC challenges the notion that men are hard to reach and demonstrates that ... men will engage in programs that are accessible, affordable, culturally sensitive, rooted in the community and tailored to their needs' (Armstrong, 2003:222). I therefore believe that this initial data from the Site C MC, although disappointing at first glance, is in line with other examples that have proven worthwhile and enabling for men in their health-seeking. The MC in Site C, Khayelitsha does appear to be accessible, is affordable and culturally sensitive for men in the predominantly Xhosa-speaking community.

**Recommendation**

Based on the experience of other male-friendly services, I believe it is imperative to continue providing these services at the MC in Khayelitsha. I recommend that the Clinic Partners allow more time before making a considered evaluation of the clinic's success in including men in VCT and STI treatment.

***Community***

In terms of the clinic being 'rooted in the community and tailored to [its] needs' (Armstrong, 2003:222), one of the staff members did raise concern over this issue. He was concerned that the clinic had not consulted with the community itself in establishing the clinic. He thought that with the support of a community health committee, the clinic would be marketed effectively through the community itself. He argued that this would increase attendance at the clinic.

**Recommendation**

The clinic is for the community, and therefore, with further support from the community, the clinic may be even more successful. It is therefore recommended to consult with the Khayelitsha community, particularly Site C where the clinic is situated, about the best ways to promote the clinic.

***New Concept***

A clinic partner suggested that because the MC is a new concept in the community, people may be unfamiliar with the type of facility and its services. This is a further reason to consult with the community, but also a possible explanation for the slow start for the clinic.

**Recommendation**

It may very well be a new concept for the community in general as there have never been services like these offered in Khayelitsha, however, it may be important to link it to what the community does know, for instance making a correlation with the Salt River clinic. This could help men in the community identify with the service and access it more readily.

***Marketing Campaigns***

Client 16 points out the importance of verbal advertising in the context of high levels of illiteracy.

'...if they can put an advertisement over the radio, television and posters maybe that could inform the public more especially on television cause most people cannot read so at least on a television they could see and decide' (CT16).

At least when people are told about the services, they have the choice whether or not to use them; when it is printed, and people can't read, that choice is taken away from them.

Indeed, there is evidence that radio advertisements have been effective in bringing in clients to the MC (3 of the 33 clients had heard an advert on a local radio station), while one of the health-workers expressed most of his clients, in June and July, had heard about the clinic through the radio.

#### Recommendation

Radio marketing should continue to be given high priority as a means to advertise the clinic, as a means of reaching those who cannot read.

#### *Word of Mouth promotion*

The other point I believe needs consideration, is that all of the MCs, both nationally and internationally, have voiced WoM as the most effective means of promoting the facilities. Indeed, as I have shown, the clients in my study reinforced this view too. I think what needs to be taken into consideration is that while this method is probably the most effective, it is also initially slow. If only a few clients are attending the clinic, they may tell a few more about it, but growth will be gradual. When the numbers grow, however, as they continue to do so at the MC, it should follow that more and more men should hear about the clinic via WoM, and be encouraged to attend. A quarter of new clients attending the Young MC in New York heard about the clinic through another man who had attended the facility (Armstrong, 2003:222). This demonstrates that WoM can be a powerful tool, but it is also initially a slow means of marketing.

Client 14 highlights the importance of marketing and advertising and telling others about the clinic. He thinks that all men, if they know about this service, will come.

'...they will come. Because...Most of the people who are here [in Khayelitsha] don't know this clinic, they don't know there's a clinic here for men. They don't know. Because my friend he stays here<sup>118</sup> ... I'm sure they [other people] don't know. They don't know. Because I was surprised to be here also' (CT14).

The MC is likely to contribute to normalising testing in men in Khayelitsha. It is through men talking about VCT and men identifying with those who are testing, that it will become normalised. Men will be encouraged to seek help if they see other men in their reference group seeking health-care (Addis and Mahalik, 2003:11).

<sup>118</sup> This client only knew about the clinic because his friend stays near the clinic.

#### Recommendation

It seems that personal experience is the most effective form of WoM marketing, and so attending the clinic gives clients that personal upper hand. Clients could be encouraged to tell friends about the facility. Pamphlets with directions could be made available for men to take to friends, if they preferred, which would bolster this personal marketing approach.

As already mentioned in chapter seven, Client 33 advised that the key to marketing is in fact WoM and personal testimonies. This is because posters and pamphlets are impersonal and easily disregarded. If one-on-one outreach, or at least more personalised marketing, could be prioritised, this may be beneficial to the clinic and the community.

#### *Staff*

The staff too can contribute to WoM marketing. Many of the non-testers seemed more open to testing, as a result of their counselling session, which means this could also be effective in the community too. I believe it is vital that this one-on-one marketing goes on beyond the clinic walls so that more men know about the facility.

The Clinic Partners were aware of and concerned about this lack of staff promotion in the immediate and surrounding community.

'I don't think they are being proactive enough in going around and calling the people and making them aware that the clinic is there and it is open...' (P4).

I understood from the clinic partners that integral to their work as lay counsellors, the staff were meant to do this outreach, periodically, to promote the clinic. In the time I was there, I was unaware of any activity on a day-to-day basis; however, the staff were involved in VCT drives on some days and were promoting the clinic at these events.

While staff initiative in this area seemed to be lacking all the staff-members appeared enthusiastic and motivated about their job, enjoying the meaning it brought to theirs and others' lives.

'...each and every day I feel like I am happy to be here...I just ask myself, what am I going to learn today and what am I going to deliver to those people I am going to see...' (HW2).

#### Recommendation

The staff need to be made aware of this critical outreach role. Possibly a formalised roster of who goes into the community when, should be implemented.

Another aspect that I think contributed to the lack of promotion by staff was that there seemed to be confusion about where the clinic fits into the health-care system and its role as an entry-point. There is a lack of understanding on this point as expressed by one of the health-workers

'...what is the point of finding out people's status when you are not going to help them anyway' (HW3).

The health-workers voiced frustration with not being able to help patients, having to send patients elsewhere, only to find they have not received the help they need at other clinics.

#### Recommendation

While there are certainly limitations to the work the clinic is doing, as they are forced to refer clients elsewhere<sup>119</sup>, it would be beneficial for the staff to understand the integral role that the clinic is playing within the wider health-system<sup>120</sup>. This increases meaning as to why they are promoting the service. With improved understanding, motivation and morale are likely to be boosted which will inspire the staff to go out and promote the clinic services.

While all the clinic staff were men, implying a 'male-friendly' image, all appeared to be young men. This may be appropriate for some male clients, but there was evidence that diversity in age was possibly wanting.

A clinic partner mentioned how counsellor diversity would be a welcome addition to the clinic, so as to accommodate different men, and men of all ages (P4). '[T]here is no single, ideal model of VCT service delivery', but rather 'different approaches are required to reach different populations' (McCauley, 2004:5). This supports the clinic partner's concern, as a variety in age would possibly meet the needs of different men.

Two of the health-workers highlighted the age issue too. Some clients have asked them whether they are men<sup>121</sup>, because they are not comfortable talking to 'boys' about men's problems.

'...some of [the clients] ask us, if we are coming from the bush because they do believe that they won't be [able to] tell like boys their problems...so we know their problems. Exactly, so they feel comfortable to tell us *everything*' (HW2, emphasis his own).

'...first...when we opened...the clinic, some of them, the taxi owners, they are the old men... They were having a problem for us, they say 'wow you are young, but I'm supposed to tell you my problem' (HW2).

This suggests some clients are not comfortable speaking to uncircumcised 'boys'. Similarly, the men are not comfortable talking to women about their problems. There is a link about shared experience here, and the assumption that boys and women do not understand the experiences of men. Moreover, it seemed that some of the

<sup>119</sup> And these referrals may mean patients do not get the care they need in time, or cannot face going to public clinics for help.

<sup>120</sup> In terms of the clinic's role as an entry-point

<sup>121</sup> In this context, 'men' means they have been to the bush to be circumcised.

men do not respect the younger counsellors because of their age, and demand that they see the nurse, rather than going through the counselling process.

The counsellor below compares his current job to another where he worked with youth,

'...they were listening to me because I...am older and wiser...So the guys here, the older ones, the other ones they say, no we don't want counselling we want to do VCT, if they want VCT, or some of them they say we are not here to do the VCT, so don't counselling me, just send me to the nurse, I need treatment for STI' (HW2, p7).

The implication is that the youth looked up to him because he was older than them, but the older men who are coming to the clinic, are struggling to do so, because he is apparently younger which, superficially, implies a lack of experience.

The above comment also suggests that some men do not want counselling, and there may be room for routine testing<sup>122</sup> where counselling is not as central to the testing process.

While the counsellors seem to be aware and sensitive to the variety of men attending the clinic and the need to adapt their approach to a young teenager and an elderly man (as expressed below), age diversity does seem to be preferable.

'I have to know what language I should use when I speak to an elderly person, what language I should use when I speak to a young boy who is 17 or 18 years. I have to develop that understanding, so that they can feel comfortable...[to say] whatever problem they have with me...you have to be...flexible...A boy...if I use very formal language he would feel totally out, he does not feel comfortable. I have to use the language that he understands...Like the slang...when I speak to an elderly person...I have to go to that level...as much as I want to help you...I also respect that you are older than me and you have experience than me...I don't... judge you' (HW3).

This health-worker is conscious about the need to adapt to different clients, which is a positive, affirming characteristic of the lay counsellors. This shows the staff recognise the need for diversity in VCT approaches. Obviously, not all men are the same, and so it follows that adaptability and availability of different VCT approaches is preferable. The *HIV and AIDS and STI National Strategic Plan for South Africa, 2007-2011*, states this goal: '[South Africa aims to] Increase access to VCT services that recognize diversity of needs' (National Department of Health, 2007:14). The MC is a means of diversifying VCT services, but data suggests the clients may benefit from further diversity within the clinic too.

**Recommendation:**

<sup>122</sup> | discuss this further under 'routine testing'.

This suggests that it may be helpful to have counsellor diversity, particularly with reference to age, to accommodate different client needs. If this is not possible, then nurturing this awareness of variance in client needs is advisable.

In terms of women health-workers at general clinics, as discussed in chapters five and six, men may be open to going to the clinic, but it is when faced with speaking to a woman about SRH, that the client shies away from full disclosure. On the contrary, when speaking to men, it is my perception that, with increased comfort, the probability of their using VCT is higher.

### *A 'Culture' of respect and independence: an environment unthreatening to 'masculinity'*

I discussed Robertson's (2001) suggestion in altering the health-care environment with a view to attracting more men to seek help. I have looked at some successful projects in South Africa and internationally which have made such adjustments. Significantly, these have largely been discussed in separate spaces for men, and not integrated into a generalised service. A concern, however, is of course that health facilities become more male-focussed and therefore the reverse occurs, where women then feel alienated from the environment, or that resources are shifted away from women's health. I believe adjustments can be made to existing health-care services that are gender-sensitive and gender inclusive.

Moreover, the male-accommodating aspects, like health-workers showing respect and non-judgement are not only applicable to men. Men and women benefit in a health-care environment when they feel respected and understood. These are also noted to be VCT accommodating attributes for all (Baggaley et al., 2001:555).

#### **Recommendations**

While the comfort of men should be considered, and making changes to the health environment to attract men to VCT should be taken into account, changes should not be made at the expense of women's health. Rather, both men and women's health should be prioritised through a gender-aware approach.

Given these reflections I also recommend that staff and environments should be gender sensitive and aware of masculine traits. A staff attitude of non-judgement and empathy should be encouraged, irrespective of either client or health-worker gender.

#### **Location**

Client 1 read about the MC in a newspaper advertisement, but he had trouble locating the clinic, reportedly spending three days trying to find it. He went to look in two areas before he found the right area. Eventually he asked one of his colleagues who directed him to the taxi rank. Client 8 also had difficulty locating it and asked a colleague, living in the area, for directions.

'I was coming with my colleague...She is staying in Site C. I asked her, where's this clinic because I didn't know where it is in Site C. The time I was reading the paper, I know it was here, this clinic but I don't know...where it is exactly' (CT8).

Client 30 had a similar experience. He saw the clinic advertised on TV. He did not know where the clinic was exactly, so he had to ask around, eventually finding someone to give him directions (CNT30).

'I have seen it many times and I was just passing because I did not know it was a clinic' (CT16).

#### Recommendation

In light of the above scenarios, where clients cannot find the clinic, it is suggested that signage for the clinic is increased, so that clients can locate the clinic. Having to ask others for directions is potentially scary for clients, so an increase in signage is likely to bring more clients to the clinic to use their services. There is the desire to keep the clinic profile discreet, in terms of the stigma associated with SRH and VCT; however, signage could merely mention 'Men's Clinic' rather than advertising the services offered.

#### *Opening Hours*

Although the MC opening hours are largely male-friendly, because they are open on Saturdays and open longer than other public clinics in the area, some men mentioned that if the clinic was open earlier, this may be beneficial to employed men too.

#### Recommendation

Therefore, if the clinic proves to be a beneficial addition to the health service, it would be beneficial if opening hours remained late, but that the clinic opened earlier too, so that men could go to the clinic before going to work, in the mornings. This would cause other complications, I realise, with increased staff, costs etc.

#### **Trust in Male Health-workers**

In chapter six, I explored whether the male clients trusted male staff more than female staff, particularly with regard to HIV results. I quoted a few men who were of the strong opinion that women could not keep information to themselves. The implication was that there was something innate in women, preventing them from keeping information confidential. This seems to be a socially constructed, and yet powerful, view of women. It has consequences for men's accessing of health-care. If they cannot trust the person doing their HIV test, then there is little chance they will go through with having it.

Ultimately, these assumptions need to be challenged. Just as Client 6, who had worked in a health-facility, indicated, he had the knowledge which allowed him to trust female staff, because he knew 'confidentiality' and 'professionalism' to be central to primary health care. He stated his preference to be helped by a man because of comfort, but he did have trust for both men and women in the health profession. This knowledge needs to be shared in the community so that men can learn to trust women health workers, thereby making public clinics accessible places for these men to test.

I am concerned that the clinic possibly perpetuates this sexist belief; the belief that women are intrinsically unable to keep secrets. The concern is that men will go to the MC because they trust men rather than women, and this belief is

left unchallenged. In this scenario, they do not come into contact with women staff, potentially forcing them to question these misconceptions.

Structural change is needed to challenge this distrust of women, but this is something that will not take place overnight. It is a priority, but a long-term one. In the meantime, it is important to get as many men testing as possible, even if the clinic in some ways perpetuates these sexist views (not by upholding them, but by accommodating men's prejudices).

#### **Recommendations**

Perhaps it is necessary to campaign about the role of confidentiality in the health profession, so that the public knows this is central to the work they do. Highlighting the role of confidentiality in the profession could help curb this prejudice against women health-workers. This will be ongoing work, and the MC can successfully bring in men to test who would otherwise avoid VCT. It is necessary that these sexist assumptions are slowly eroded.

An unexpected finding which emerged out of my interviews was that for some men, the problem was not in fact the gender of clinic staff, but the gender of the clinic clients, with whom men share the waiting room area. I discussed this in detail in chapter five. Men expressed their complete trust in other men to keep their condition private, while distrusting women clients. Men expressed that women pry in and then spread rumours about the person's condition. I am unsure how much of an issue this is in reality, but certainly many men felt uncomfortable at sharing waiting rooms with women. This was illustrated most especially to me when a client 7 reacted to the presence of a few women at the MC. He had just tested and he expressed his anger at their lingering in the clinic corridor. He was worried that they would make assumptions about his HIV status.

#### Recommendation

Posters could be put in public clinics expressing the right to privacy, encouraging patients to respect one another's privacy regarding their condition. This may contribute to creating a culture of mutual respect, which men seem to perceive between each other, and it may contribute to lessening the anxiety of those clients who do not want to disclose their reason for being at the clinic. The posters may give them confidence in feeling they do not need to feel pressured into sharing their health status with people in the waiting room.

The male-friendly approach is positive, as the clinic is marketed towards men, but does not turn away women, meaning both men and women can access care. I do, however, think that women should not linger unnecessarily at the clinic, insofar as female visitors or friends of staff should not be seen to mingle with the staff. This makes some clients anxious. Women at the clinic, as with the men, should be there for clinical reasons, rather than social calls. This creates a male-friendly environment, more conducive to VCT use.

### **Men's Clinic contributing to the Normalisation of VCT amongst men**

#### *Testing is unusual for men: Feminisation of the Clinic, HIV and AIDS and VCT*

In the Literature Review, I discussed how the clinic has become a feminised space. HIV and AIDS, and VCT have also become associated with women. Popular thinking places women on the side of those who test and use clinic, and men on the side that do not. As a result, men may not recognise that they are at risk, because of the feminisation of the disease. Of the 25 interviewees asked who they thought were more at risk of HIV infection, between men and women, 6 indicated they thought women were more at risk and the same number thought men were more at risk. The remaining 13 felt both men and women were at the same level of risk. This is a positive move in the direction of men recognising they are at risk, however, there is still evidence that men dissociate with the disease, and therefore the need for VCT. If VCT in itself is feminised, then there is a 'common-sense' connection that you are less manly if you want to know your status. Therefore, VCT is not something men necessarily want to be associated with. Women often get tested when they are pregnant which reinforces this feminisation.

The MC contributes to fighting this trend by connecting men with VCT. The linking of VCT and STI service works to disassociate testing with pregnancy and therefore, women. This connection needs to be taken further. One of the clients suggested the following:

'If we can put up more billboards about this clinic like as we can see that women are the most people who have rights in everything if we can try to make men see that they also have equal rights like women maybe they will have that freedom of mind and become free in everything like women' (CNT31).

The discussion above highlights that men are feeling ostracised in the media, because women 'have [all the] rights'. If men feel valued, and that they are contributing and succeeding by testing, perhaps this will encourage them to test.

'Men need to give greater consideration to AIDS as it affects the family; fathers and future fathers need to consider the impact of their sexual behaviour on their families' (UNAIDS, 2001: 8). The UN highlights the importance in highlighting sexual behaviour, but this relates to VCT and SRH more generally too.

#### Recommendation

If clinics could be promoted as spaces for everyone, for men, women, elderly, children, this may contribute to de-stigmatising the clinic for men. Perhaps posters of a variety of people seeking help could promote the idea that it is not only women who attend clinics.

Campaigns need to be informed by this 'feminisation' of HIV and VCT, but encourage men to use VCT. It is critical that the connection between VCT and men be emphasised. Further to this is the need to link positive images of men with VCT. For example, instead of testing being associated with weakness (women), the emphasis could be on their socialised role as the 'provider'.

There needs to be a shift in thinking here, whereby men are encouraged to respond to the male attributes of responsibility, for themselves and their family by testing so as to prolong their life. VCT needs to be marketed as a responsible act to do for yourself, your partner and your family or future family. This may encourage men to take more initiative in their health.

A goal for public health, rather than a recommendation, is that HIV and AIDS needs to become de-feminised. South African media needs to change popular views of HIV by showing that men can live healthy lives with the virus. Having an HIV test for prevention or treatment should be linked to testing with the ability to continue to provide, rather than being ill and therefore failing in this role (Beck, 2005:20).

#### *Routine testing: an opt-out approach*

In one of the Partner interviews the ACTS method was mentioned as an approach to testing in Youth Clinics. The ACTS approach was explained to me as follows,

'...they are offered testing, and the nurse will ask if they are ready. If they are ready they get tested, and then they get supported afterwards, so it doesn't go through the formal VCT process. It's called ACTS – where basically you Assess, you get Consent, you Test and then you give Support afterwards. And so in that way...we find that there's more uptake in the youth services' (P2).

'One-to-one counselling and the time required to provide it are possible disincentives for people who wish to be tested on a more routine and perhaps less conspicuous basis' (WHO, 2003:2). The incorporation of other services with VCT makes it easier for some people to access the service in the context of HIV stigma. This is because they can access VCT without others knowing they are seeking an HIV test (UNFPA and IPPF, 2004: 4). This approach also increases VCT access to patients, as they are routinely offered the service, which is an opt-out approach, rather than the conventional opt-in VCT approach (WHO, 2003:1). Routine testing is an opportunity to move 'beyond the model of provision that relies entirely upon concerned individuals seeking out help for themselves' (WHO, 2003:1). Because men often do not seek help for themselves, this opt-out approach incorporated into other services is a means of bringing them into the VCT picture.

The comments about counselling discussed in chapter five suggest that for some men, the VCT model is uncomfortable. This finding made me wonder whether the ACTS approach may be better, or at least another, alternate approach, if men display discomfort with the counselling method.

This could be an option for the MC. If men are uncomfortable with the counselling process, but willing to test, ACTS may be a better approach. The decision to opt-out must always be an option, but I think that possibly the counselling is anxiety-provoking and prevents some men from using VCT. The counsellors should be encouraged to have a flexible approach towards how much time they spend on counselling. If the client shows discomfort, pre-test counselling may be lessened, and depending on the HIV result, post-test counselling may take more emphasis.

### *Role Models*

When asked how we could possibly increase the number of men testing for HIV, two clients stressed the contribution of role-models testing publicly, or being open about testing. Client 5 and 8 below also mention President Thabo Mbeki (I discuss this in more detail in chapter seven).

'You must test first Bhuthi. Like the president, you must lead by example, you see' (CT5).

'...if one person Nelson Mandela, or Thabo Mbeki they can advertise on the TV, maybe people can watch it, or else if you are a sportsman or then you are a coach for the clubs. You can talk about this issue, maybe they can allow to come to test' (CT8).

### **Recommendations**

As shown above, high-profile, respected men talking about testing and being seen to test, would contribute enormously to the task of recruiting more men to VCT. While City Health may not be able to get national figures like Mandela or President Mbeki, they may be able to get a respected, local figure to do this<sup>124</sup>.

<sup>124</sup> I understand from the partner interviews that some high profile athletes did come to the Clinic launch. To take this further and get them to test publicly, would go that much further in encouraging more men to test.

### *Testing in times of crisis*

Literature suggests that many men wait until they are very ill before getting tested. Among those in Day et al.'s (2003) study, most of those who had used VCT had done so because of signs of illness (2003:668). Moreover, this trend seems to be commonly known to be acceptable among men, delaying testing until there is no use in denying the possibility of HIV any longer (Levack, 2005:13). I discussed in chapter seven that this trend in delayed testing creates a connection between testing and being ill.

A somewhat surprising, but important finding is that in my study there was no immediate connection between testers and seeking help quickly, or non-testers and waiting to get medical help. The fact that those who tested are not necessarily those who seek health-care quickly means there is space to work with men to encourage them to test as a preventative step.

Using VCT does not mean you have AIDS, as one does not equate to the other. More men need to be recruited into testing when they are healthy, so that this association is weakened.

A client worryingly suggested that because he has no symptoms of HIV, he must therefore be fine, and there is no reason to test.

#### Recommendation

This cognitive connection between testing and being ill needs to be broken. VCT must be promoted amongst men as a precautionary and responsible act towards their health to protect themselves and their families<sup>125</sup>. This will help to disassociate testing and being HIV positive. Perhaps a media campaign emphasising that the test does not make you ill, it only empowers you with the knowledge of your status, could be beneficial in this regard.

Counsellors must be equipped to deal with the scenario where men feel they do not need to test because they are asymptomatic. Counsellors must emphasise that knowing sooner (when they are still healthy), rather than later is advantageous, not disadvantageous. The advantage being that the sooner you discover you are positive, the sooner you can get the help you need to live a healthier life.

I believe that images or voices of men living with HIV would help this situation enormously. Men may be able to begin to recognise that HIV is not a death sentence, but rather a manageable health condition.

---

<sup>125</sup> Possibly appealing to socialised masculine traits

## **Advantages for women's health**

As I have noted, 13 of the 15 testers said they would tell their partners about their testing experience. This shows that those who test are motivated to talk to their partners, which potentially encourages partners to test. Something to consider is whether this is true regardless of the test result. I did not know the results of those who tested, as this was not part of the research.

As discussed in chapter eight it seemed that while some of the men voluntarily reported a preference to test alone, some of the non-testers indicated their preference to test with their partners. Having the option for either individual or couple-based counselling is therefore important. Among those who preferred testing alone, there was a warning against pushing couple-based counselling too soon, as one or other partner may not be ready.

I referred to the emergent trend of testing by proxy, where a man 'tests' through his partner's results. The MC contributes to lessening this trend, by making the clinic environment more appealing to men, and therefore encouraging them to test. Despite this, one of the clients actually mentioned that he believed his status to be negative because he showed no systems, but more importantly because he knew his status through his partner. This belief is therefore circulating among men, and it needs to be counteracted in some way.

### **Recommendations**

Counsellors should encourage all those who test to talk to their partners about testing, and ensure that they know where their partners can go for VCT, including the MC, if they preferred.

Men attending the clinic, whether they use VCT or not, should be made aware that individual or couple-counselling is an option at the clinic, so that men who want to test with their partners, but are reluctant to go to a general clinic, can return with their partner to test.

A sensitive approach to couple-based counselling, where there is the risk of one or other partner not being ready to test, could be to engage the couple in counselling, followed by time to discuss the potential testing together. This may be a more considered approach to couple-based approaches.

Counsellors need to be made aware of the practice of proxy-testing. There was evidence of this knowledge, which is positive. Counsellors must be equipped to convince their clients that they need to know their status for themselves, and indeed, they cannot know their HIV status through their partners. This is in the interests of men's and women's health, as each partner is aware of their own status.

Moreover, while it is positive to see that some workers at the MC have identified proxy-testing to be a problem and are trying to address it directly, it is necessary to take this beyond the clinic walls, so that more men are encouraged to use VCT. Campaigning against proxy-testing and making it common knowledge that you cannot know your status

through anyone, but yourself is crucial in curbing this epidemic, so that each person takes responsibility for their own status.

The above discussion suggests some potential changes and additions to the campaigns and approaches to getting men to test<sup>126</sup>. I believe the central challenge is to work towards de-feminising clinics by campaigning against this and bringing in more male staff. This is a long-term project, however, and in the short-term, I believe the MC is bringing male-friendly attributes together so as to encourage men to use VCT. The men I interviewed seemed more open to testing because of the male-friendly environment. Disappointingly, the quantitative data does not reflect these findings. My suggestion here, however, is persistence, as I believe word-of-mouth from staff and clients, and community support will slowly contribute to raising the number of clinic attendees, and clients using VCT.

---

<sup>126</sup> For a table summary of recommendations, please see Appendix 5.

## CHAPTER TEN: CONCLUSION

The Site C MC is designed as a male-friendly facility. To answer whether the clinic was male-friendly, I sought to define what these characteristics were. Through mine and others' research I compiled a list of male-friendly components and discussed these in chapter five. Indeed, these factors did seem to contribute to creating an environment perceived to be 'safe', private and, where the service is of a high quality. These are conditions favourable to VCT uptake.

Clients expressed greater disclosure and honesty with regard to SRH, when speaking to male staff. This increased ease with the health-worker suggests that the client is more likely to have their health needs met in this situation. This relates to the ability to talk about HIV, AIDS and sexual risk with women, which is related to using VCT (Magongo et al., 2002:39). As discussed in chapter five, the men I interviewed expressed greater ease discussing SRH with other men, which is conducive to encouraging VCT.

Related to this point of being more at ease with male staff, was the issue of clients having greater trust in male staff, as explored in chapter six. Trust is obviously an encouraging factor for those using VCT, in the context of HIV/AIDS stigma. VCT clients want to have the assurance that their results are confidential. This seemed a further enabling factor in encouraging men to use VCT.

Somewhat surprising was the finding that the gender of the patients contributed to men's feeling safer at the clinic. The large majority of clients are male at the MC, and as discussed, men trust other men to keep their medical condition private. Not only does this include staff but also clients. This seemed to be a major factor in facilitating testing, as clients felt 'safer' in this environment, in the absence of women.

Men talked about the MC as allowing them more say. Clients reported feeling more independent at this clinic and praised the way they were treated, both in terms of attitude and medical service. I have called this a culture of respect and independence, and this fits into Robertson's (2001) concept of creating a male-friendly environment. Positive masculine imagery also contributes to a male-welcoming facility. If men feel welcomed by the VCT environment, they are more likely to utilise VCT. This was in contrast to reports of other clinics where they felt patronised and unfairly treated.

Levack (2005) mentioned that the lack of good quality service may prevent men from waiting for HIV test results, or returning for tests in the future (2005:20). Aspects of the facility that contributed to providing a high standard of service, especially for men, included the opening hours, location and efficient service. The clinic is conveniently situated next to a taxi rank, which means men in the community can access it with relative ease. The opening hours are specifically designed to accommodate working men by being open later and on Saturdays. There was evidence of men testing outside of conventional clinic hours. The efficient service seemed to impress the clients too. These

elements seem to contribute to a positive view of the clinic, and therefore not only accommodate and value men, but in so doing, contribute to an environment conducive to men's VCT utilisation.

The clinic approach to VCT is also potentially encouraging of men's VCT uptake. Because the VCT service is combined with STI treatment, every client is counselled for HIV testing. In this way, the process becomes an opt-out one, rather than opt-in, and contributes to normalising VCT as every male client is offered the service. There is evidence that this opt-out approach is effective in getting more people to test.

Normalisation is believed to be a key factor contributing to the greater uptake of VCT. Because testing is seen to be unusual amongst men, and because silence surrounds those who are testing, it means testing amongst men remains unusual. My study revealed that the MC encouraged other men to tell peers about the facility. In talking, this contributes to normalisation among men. Word of mouth was highlighted not only in the literature, but also in my research, as integral to this normalisation process. There was evidence of this happening, and therefore it should follow that more men will attend the clinic and more men will use VCT.

Getting more men to test is likely to mean they get onto HAART sooner, if positive, and if negative, it may mean they will take precautions to stay negative. While it is critical to get men to test for their own health, arguably it is in the interests of women's health too. This is insofar as men will be able to continue to be a part of the couple and family, they may be able to work longer and the couple can take precautions together to safeguard their health. The MC has a male-friendly policy meaning that couples can test together, which is possibly the best approach to VCT. Interview data suggested that those who tested at the clinic were likely to talk to their partners about it afterwards. Some of the non-testers hoped to return with the partners to test in the future. I therefore conclude that data suggests VCT services, targeted at men, are likely to benefit women too.

In the course of this thesis, I have examined the male-friendly attributes of the clinic, and explored whether men perceive these to be encouraging of their use of VCT, or potential use of VCT. The Site C Men's Clinic has several characteristics making it a welcoming environment for men. Most men expressed an increase in comfort and personal safety at the facility, for the reasons discussed above. These are valued attributes of a VCT facility. Although the quantitative data indicates a slow and disappointing start for the clinic, based on the perceptions expressed by these clients, the facility is filling an important health service for men. It is likely to encourage more men to access VCT, because men feel confident in the service and staff. This is arguably in the interests of men and women's health.

I have noted that the MC is serving an important health requirement in the context of a human security crisis: the HIV/AIDS epidemic and men's disassociation, denial, disinterest and silence around testing. There is a need for substantial structural societal change in terms of gender relations, particularly in terms of men's seeming inability to trust women, whether staff or clients. Gender-sensitivity and non-judgemental attitudes are needed in public clinics so as to encourage men to attend these facilities, and not only the MC. Having more male staff available at general clinics would also be beneficial. These are long-term goals, in the context of an immediate crisis. Men's Clinics are not

the solution to men's low utilisation of VCT; however, my research has indicated men perceive the male-friendly service to be encouraging of men's VCT use.

## REFERENCES

Addis, M and Mahalik, J., 2003, Men, Masculinity, and the Contexts of Help Seeking in *American Psychologist* Vol. 58 (1), pp5-14.

Armstrong, B., 2003, The Young Men's Clinic: Addressing Men's Reproductive Health and Responsibilities in *Perspectives on Sexual and Reproductive Health*, Vol. 35 (5), September – October, pp 220 – 225.

Astbury, J., 1999, Gender and Mental Health, *Working Paper of the Global Health Equity Initiative project on Gender and Health Equity based at the Harvard Centre for Population and Development Studies*.

Baggaley, R., Kayawe, I., and Miller, D. 2001, Chapter 23: Counseling, Testing and Psychosocial Support in Lamptey, P., and Gayle, H., (Eds.) *HIV / AIDS Prevention and Care in Resource-Constrained Settings: A Handbook for the Design and Management of Programs*, Family Health International AIDS Institute, Arlington, pp 547 – 578 [Online] Available: <http://www.fhi.org/NR/rdonlyres/e6b0ncd1wzuid22vn5zuid6720b5xon32lwver6u6wlvvvc4a4cixu67ulvcxif2zer4dz73rbo/PCHandbook23enhv.pdf> [Accessed 16 March 2008].

Barker, G., 2005, *Dying to be Men: Youth, Masculinity and Social Exclusion*, London and New York: Routledge.

Barker, G and Ricardo, C, 2005, *Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence* [Online]. Available: [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/06/23/000012009\\_20050623134235/Rendred/PDF/327120rev0PAPER0AFROyoung0men0WP26.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/06/23/000012009_20050623134235/Rendred/PDF/327120rev0PAPER0AFROyoung0men0WP26.pdf) [Accessed 18 Feb 2007]

Beck, D., 2004, Men and ARVs: How does being a Man affect Access to Antiretroviral Therapy in South Africa?: An Investigation among Xhosa Speaking Men in Khayelitsha, *CSSR Working Paper no. 80*. Cape Town: Centre for Social Science Research, University of Cape Town. [Online] Available: [www.cssr.uct.ac.za](http://www.cssr.uct.ac.za), [Accessed: 7 June 2007]

Bodibe, K., 2005, *Men and HIV testing* [Online] Available: [http://www.health-e.org.za/news/article\\_audio.php?uid=20031283](http://www.health-e.org.za/news/article_audio.php?uid=20031283), written 28 July 2005 [Accessed 25 February 2008].

Burris, Scott, 2004, 'Governance, Microgovernance and Health' in *Temple Law Review*, Vol. 77, pp 335-362.

Cape Gateway, South African National Government, 2006, *2006 HIV/AIDS Prevention Strategy: Synopsis of the Accelerated Prevention Strategy*, [Online] <http://www.capegateway.gov.za/eng/pubs/policies/H/149491/1>

[Accessed 25 February 2008].

Centre for Conflict Resolution (CCR), Cape Town, and the Rockefeller Brothers Fund (RBF), New York, 2006, *AIDS and Society in South Africa: Building a Community of Practice*, a report from this policy and research seminar, 27 – 28 March 2006, Cape Town, South Africa.

Chant, S, 2000, 'Woman-Blind' to 'Man-Kind': Should Men Have More Space In Gender and Development?, in *IDS Bulletin* Vol. 31(2), pp 7 – 14.

Chege, J., 2005, Interventions linking gender relations and violence with reproductive health and HIV: rationale, effectiveness and gaps in *Agenda: Special Focus, Gender, Culture and Rights*, pp 114 – 123.

City Health, 2007a, dataset spreadsheet: *Male clinic VCT Q3 07*, unpublished data.

City Health, 2007b, dataset spreadsheet: *RMRSept. 2007*, unpublished data.

Coetzee, D., Hildebrand, K., Boulle, A., Maartens, Louis, G F., Labatala, V., Reuter, H., Ntwana, N., and Goemaer, E., 2004, Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa in *AIDS*, Vol. 18, pp 887–895.

Connell, R.W., 2005, *Masculinities*, 2<sup>nd</sup> Edition, Cambridge: Polity Press. 1<sup>st</sup> edition published by Polity Press in 1995.

Cooper, D., Morrioni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L., and Hoffman M., 2004 Ten Years of Democracy in South Africa: Documenting Transformation In Reproductive Health Policy and Status in *Reproductive Health Matters*, Vol. 12 (24), pp 70 – 85.

Courtenay, W., 2000, Constructions of masculinity and their influence on men's well-being: a theory of gender and health in *Social Science and Medicine*, Vol. 50, pp 1385 – 1401.

Courtenay, W.H. and Keeling, R.P., 2000, Men, Gender, and Health: Toward an Interdisciplinary Approach, *College Health*, Vol. 48, pp 243 – 246.

Daftary, A., Padayatchi, N., and Padilla, M, 2007, HIV testing and disclosure: a qualitative analysis of TB patients in South Africa in *AIDS Care*, Vol. 19 (4), pp 572 – 577.

Day, J.H., Miyamura, K., Grant, A., Leeuw, A., Munsamy, J., Baggaley, R. and Churchyard, G., 2003, Attitudes to HIV voluntary counselling and testing among mineworkers in South Africa: will availability of antiretroviral therapy encourage testing? In *AIDS care*, Vol. 15 (5), pp 665 – 672.

De Cock, K.M., Bunnell, R., and Mermin, J., 2006, Unfinished Business – Expanding HIV Testing in Developing Countries in *New England Journal of Medicine*, Vol. 354 (5), pp 440 – 442.

England, K, 1994, 'Getting Personal: Reflexivity, Positionality, and Feminist Research' in *Women in the Field* Vol. 46 (1), pp 80 – 89.

Fleming DT, and Wasserheit, JN, 1999, From Epidemiological Synergy to Public Health Policy and Practice: the Contribution of other Sexually Transmitted Diseases to Sexual transmission of HIV infection, in *Sexually Transmitted Infections*, Vol. 75, pp3 – 17.

Hancock, J., 2004, Can Mainstream services learn from male only sexual health pilot projects? In *Sexually Transmitted Infections*, Vol. 80, pp 484 – 487.

Haralambos, M, and Holborn, M., 1990, *Sociology: Themes and Perspectives*, 3<sup>rd</sup> Edition, London: Unwin Hyman Limited.

HIVSA, 2006, *Community Projects: Men's Health*, [Online] Accessible: [http://www.phru.co.za/hivsa/projects/community\\_menshealth.stm](http://www.phru.co.za/hivsa/projects/community_menshealth.stm), updated 4 August 2006, [Accessed 25<sup>th</sup> February 2008].

HSRC, 2005 *South African National HIV Survey 2005: Results* [Online] Available: [www.hsrbpress.ac.za/freedownload.asp?id=2134](http://www.hsrbpress.ac.za/freedownload.asp?id=2134) [Accessed 10 June 2007]

IRIN, 2005, *Men Falling through the Cracks*, 25 July 2005, from *Integrated Regional Information Network (IRIN)* [Online] Available: <http://www.iris.com/news/irin/2005/IR050766.html> [3 April 2007]

Kauffman, Kyle, (2004) 'Why is South Africa the HIV Capital of the World? An Institutional Analysis of the Spread of a Virus' in Kauffman, K. and Lindauer, D. (ed.) *Aids and South Africa: The Social Expression of a Pandemic*, Hampshire: Palgrave Macmillan, pp 17-30.

Kenyon, C., Heywood, M. and Conway, S., 2001, Mainstreaming HIV/AIDS Progress and challenges in South Africa's HIV/AIDS campaign in *South African Health Review*, pp 161 – 184.

Leclerc-Madlala, S., 1997, Infect one, Infect all: Zulu youth response to the AIDS epidemic in South Africa in *Medical Anthropology*, Vol. 17(4), pp 363-80.

Levack, Andrew, 2005, *Understanding Men's Low Utilization of HIV Voluntary Counselling and Testing and Men's Role in Efforts to Prevent Mother-to-Child HIV Transmission in Soweto, South Africa*. An unpublished thesis submitted in partial fulfilment of the requirements for the degree of Master of Public Health, University of Washington.

Lewis, DA, McDonald, S., Thompson, G., and Bingham, JS., 2004, The 374 clinic: an outreach sexual health clinic for young men in *Sexually Transmitted Infections*, Vol. 80, pp 480 – 483.

Lewis, J., 2004, Assessing the Demographic and Economic Impact of HIV/AIDS in Kauffman, K. and Lindauer, D. (Eds.) *Aids and South Africa: The Social Expression of a Pandemic*, Hampshire: Palgrave Macmillan, pp 97-119.

Macdonald, JJ., McDermot, D., Woods, M, Brown, A., Sliwka, G., 2000, *A Salutogenic Approach to Men's Health: Challenging the Stereotypes*. Presentation at 12<sup>th</sup> Australian National Health Promotion Conference, 30<sup>th</sup> October – 2<sup>nd</sup> November, Melbourne.

Magongo, B., Magwaza, S., Mathambo, V., and Makhanya, N., 2002, *National Report on the Assessment of the Public Sector's Voluntary Counselling and Testing Programme*, Pretoria: Health Systems Trust, pp 1-82.

Makoba, N., 2006, Some men check HIV status by getting girlfriends pregnant in *Cape Times*, 13 November, p 5.

McCarthy, J., and Holliday, E., 2004, Help-Seeking and Counselling Within a Traditional Male Gender Role: An Examination From a Multicultural Perspective in *Journal of Counselling and Development*, Vol. 82, pp 25 – 30.

McCauley, A., 2004, *Equitable Access to HIV Counselling and Testing for Youth In Developing Countries: A Review of Current Practice*, The Population Council inc, pp 1-18.

Medical News Today, 2005, *Imbizo Male-Only Healthcare Facilities Open in Soweto, South Africa*, [Online] Available: <http://www.medicalnewstoday.com/articles/25450.php>. [Accessed 24 February 2008].

Mesi, J., 2007, *Men get own clinic*, 6 September, [Online] Available: [http://www.news24.com/Regional\\_Papers/Components/Category\\_Article\\_Text\\_Template/0\\_433\\_2178292~E.00.htm](http://www.news24.com/Regional_Papers/Components/Category_Article_Text_Template/0_433_2178292~E.00.htm) ], [Accessed 20 September 2007].

Morrell, R., 2001 *The Times of Change: Men and Masculinity in South Africa* in Morrell, R., (Eds.) *Changing Men in Southern Africa*, London: Zed Books, p3 - 37.

Morrell, R., and Ouzgane, L., 2005, African Masculinities: An Introduction in Ouzgane, L and Morrell, R. (Eds.), *African Masculinities: Men in Africa from the late nineteenth century to the Present*, New York: Palgrave Macmillan, pp1-20.

Mundy J., and Dickenson, D., 2004, Factors affecting the uptake of voluntary HIV/AIDS counselling and testing (VCT) services in the workplace in *HIV/AIDS in the Workplace: Symposium Proceedings, University of Witwatersrand, Centre for Health Policy*, [Online] Available: [http://www.hst.org.za/uploads/files/wits\\_symp.pdf#page=180](http://www.hst.org.za/uploads/files/wits_symp.pdf#page=180) [Accessed 16 March 2008]

National Department of Health South Africa, 2007a, *Men, Health and Gender Equality: A report on the National Men's Imbizo*, September 6-7<sup>th</sup> 2007, South Africa, conference report, pp1 – 42.

National Department of Health South Africa, 2007b, *Report: National HIV and Syphilis Prevalence Survey South Africa 2006*, South Africa 2006, Pretoria, pp 1 - 31.

National Department of Health South Africa, 2007c, *HIV and AIDS and STI Strategic Plan for South Africa, 2007 – 2011*, unveiled by the Deputy President at the National Consultation Conference on 14 March 2007.

Nattrass, N., 2006, *AIDS, Gender and Access to Antiretroviral Treatment in South Africa, CSSR Working Paper 178*, Cape Town: Centre for Social Science Research, University of Cape Town. [Online] Available: [www.cssr.uct.ac.za](http://www.cssr.uct.ac.za) [Accessed: 7 June 2007]

Ndinga-Muvumba, A., and Pharaoh, R., 2006, *HIV/AIDS and Human Security in South Africa*, a policy seminar Report, conference held in Cape Town, South Africa, 26 – 27 June 2006, Centre for Conflict Resolution (CCR), Cape Town.

*Oxford English Dictionary*, [Online] Available: [http://www.askoxford.com/concise\\_oed/rolemodel?view=uk](http://www.askoxford.com/concise_oed/rolemodel?view=uk), [Accessed 28 February 2008].

Peacock, Dean, 2005, *Urgency and Optimism: Masculinities, Gender Equality and Public Health in Agenda Special Focus 2005, Gender, Culture and Rights*, p146 – 153.

Pearson, S., 2003, *Promoting Sexual Health services to Young Men: Findings from focus group discussions in Journal of Family Planning and Reproductive Health Care*, Vol. 29 (4), pp 194 – 198.

Pettifor, AE., Rees, HV., Steffenson, A., Hongwa-Madikizela, L., MacPhail, C., Vermaak, K. and Kleinschmidt, I., 2004, *HIV and Sexual Behaviour among young South Africans: a national survey of 15-24 year olds*. Reproductive Health Research Unit (RHRU), University of the Witwatersrand, Johannesburg, South Africa, [Online] Available: <http://www.rhru.co.za/Downloads.asp> [Accessed 8 February 2008] p 1-2.

PlusNews in-Depth, no date, *South Africa: the World's Biggest ARV Programme? SOUTH AFRICA: A battle of the sexes over national ARV programme*, in *PlusNews*, [Online] Accessible: <http://www.plusnews.org/InDepthMain.aspx?InDepthId=40&ReportId=70991> [Accessed: 25 February 2008]

Reid, G. and Walker, L. (2005) 'Masculinities in question' In Reid, G. and Walker, L. (Eds.), 2005, *Men Behaving differently: South African men since 1994*, Cape Town: Double-Storey, p1-17.

Seetharaman, D., 2007, Men stand up against gender violence, *Cape Argus*, 27 May, p 5.

Sen, G, Germain, A., and Chen, L., 1994, Population Policies Reconsidered: Health, Empowerment, and Rights, *Harvard Series in Population and International Health*, Boston and New York: Harvard University Press.

Schwalbe and Wolkomir, 2001, Interviewing Men, in Gubrium, J., and Holstein J., (Eds.) *Handbook of Interview Research*, Sage Publications, California, pp203-219.

Thiede, M., Palmer, N. and Mbatsha, S., 2004, South Africa: Who Goes to the Public Sector for Voluntary HIV/AIDS Counselling and Testing? *HNP Discussion Paper: Reaching the Poor Program Paper No. 6*, October 2004, Washington, DC: The International Bank for Reconstruction and Development/ The World Bank, p1-14.

UNAIDS, 2000, *Men and AIDS: a gendered approach*, UNAIDS: Geneva Switzerland, [Online] Available:

[http://data.unaids.org/pub/Report/2000/20000622\\_wac\\_men\\_en.pdf](http://data.unaids.org/pub/Report/2000/20000622_wac_men_en.pdf)

[Accessed 6 February 2008], p1 -26.

UNAIDS, 2001, *Working with men for HIV prevention and care*, Geneva, Switzerland, [Online] Available:

[http://data.unaids.org/Publications/IRC-pub02/ic543-workingwithmen\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/ic543-workingwithmen_en.pdf) [Accessed 20 July 2007] p 1 -43.

UNAIDS, 2007, *Fact Sheet: Key facts by region – 2007 AIDS Epidemic Update*, UNAIDS: Geneva. [Online] Available:

[http://data.unaids.org/pub/EPISlides/2007/071118\\_epi\\_regional%20factsheet\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/071118_epi_regional%20factsheet_en.pdf) [Accessed 6 February 2008]

p1 -3.

UNFPA and IPPF South Asia Regional Office, 2004, *Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers*, New York and London, pp1 – 78.

van Den Berg, Wessel, ([wessel.vdberg@hwwafrica.org](mailto:wessel.vdberg@hwwafrica.org)) 2007, *My Research Project*, 26 June 2007. Email to Maria Faul ([miarafaul@gmail.com](mailto:miarafaul@gmail.com)).

Varga, C.A., 2001, The Forgotten Fifty Per Cent: A Review of Sexual and Reproductive Health Research and Programs Focused on Boys and Young Men in Sub-Saharan Africa in *African Journal of Reproductive Health*, Vol. 5, No. 3, pp 175 – 195.

Vlasshoff C., and Moreno, C.G., 2002, Placing gender at the centre of health programming: challenges and limitations in *Social Science and Medicine*, 54 pp 1713 – 1723.

Walker, L., Reid, G., and Cornell, M., 2004, *Waiting to Happen: HIV/AIDS*, South Africa, Cape Town: Double Storey.

Warren, C.A., 2001, Qualitative Interviewing in Gubrium, J., and Holstein J., (Eds.) *Handbook of Interview Research*, Sage Publications, California, pp83 - 102

White, S., 2000, 'Did the Earth Move?' The Hazards of Bringing Men and Masculinities Into Gender and Development in *IDS Bulletin*, Vol. 31, No. 2, pp33 – 40.

WHO, 2003a, Integrating Gender into HIV/AIDS Programmes: A Review Paper

WHO, 2003b, THE RIGHT TO KNOW: New Approaches to HIV Testing and Counselling [Online] Available:

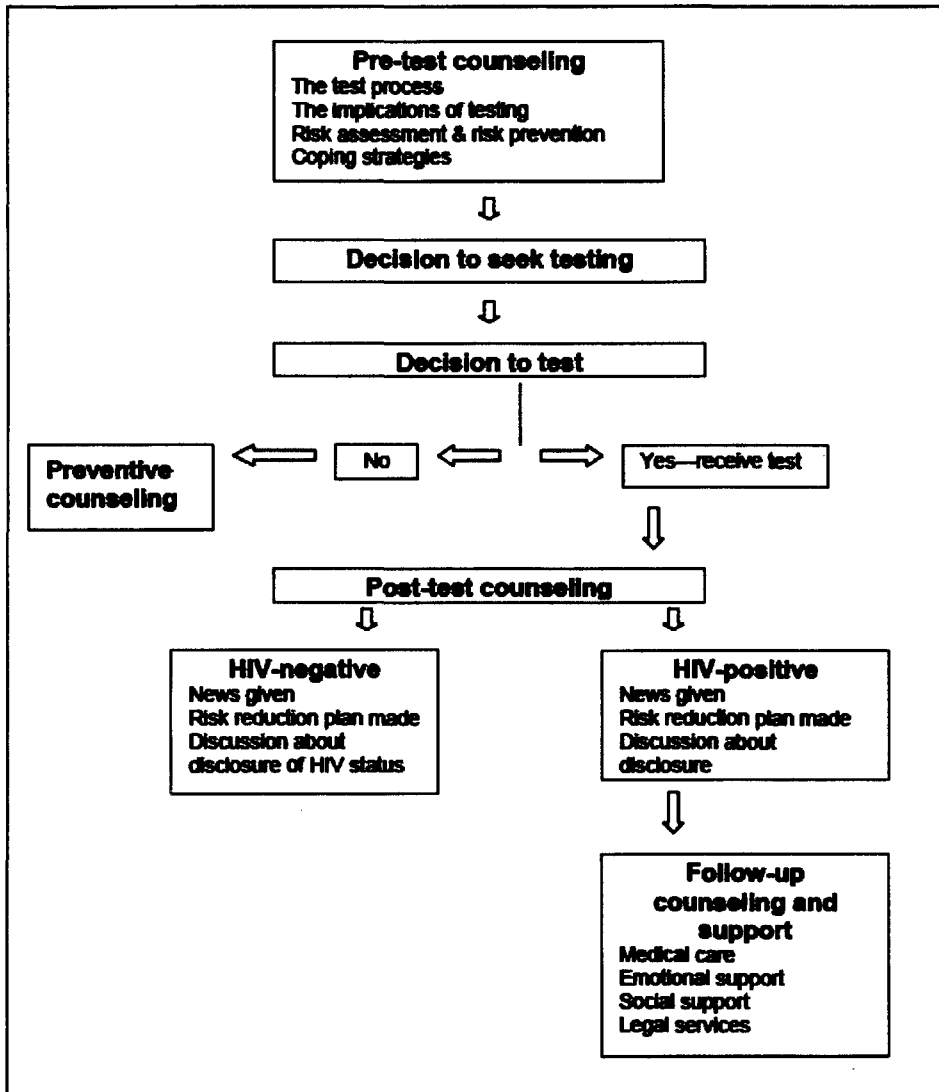
<http://www.emro.who.int/aiecf/web53.pdf>

[Accessed 11 March 2008]

Wisch, A., Mahalik, J., Hayes, J and Nutt, E., 1995, The Impact of Gender Role Conflict and Counselling Technique on Psychological Help Seeking in Men in *Sex Roles*, Vol. 33, Nos. 1 and 2.

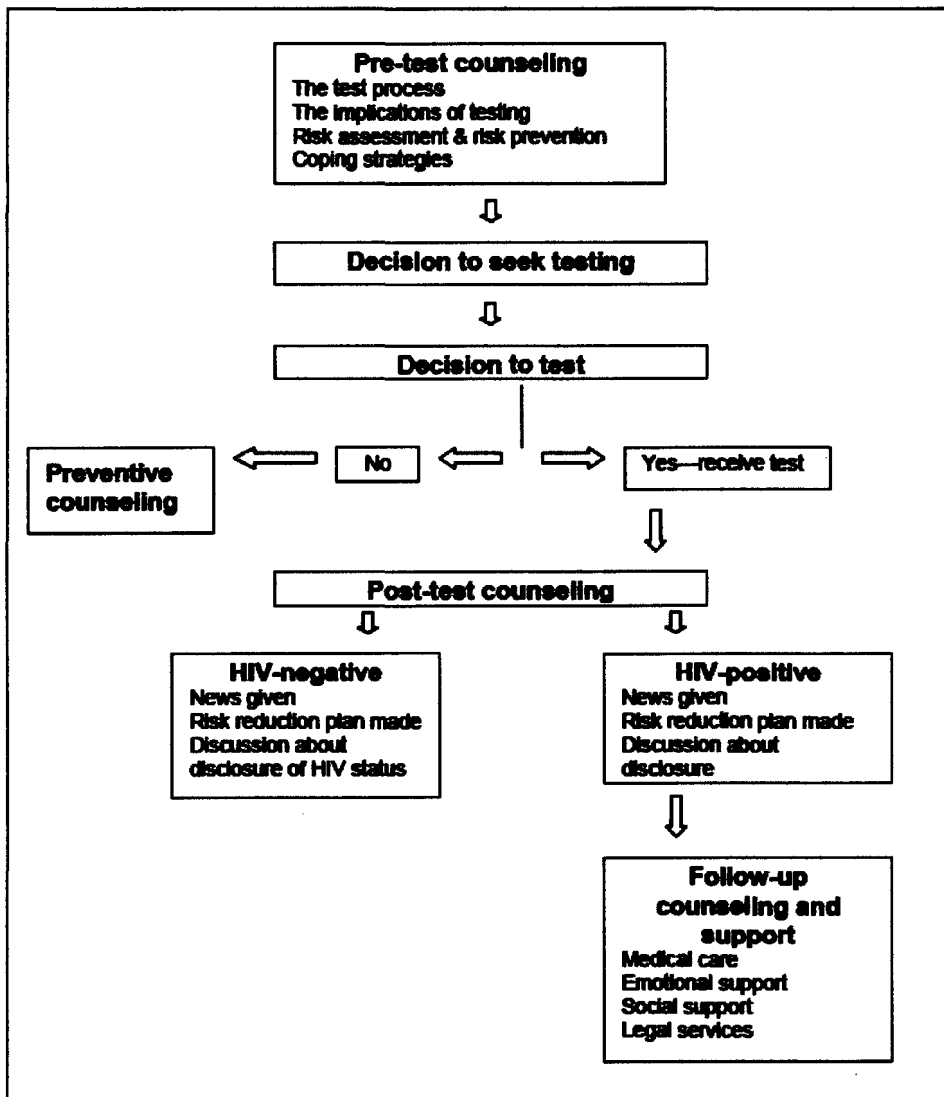
Wood, J., and Shearing, C., 2007, *Imagining Security*, Devon: Willan Publishing.

**APPENDIX 1**  
**VCT MODEL**



VCT Model diagram from McCauley, 2004: 18

**APPENDIX 1**  
**VCT MODEL**



VCT Model diagram from McCauley, 2004: 18

## APPENDIX 2

### Questions

#### Do men perceive the male-friendly clinic to be enabling in their testing?

1. What is a male-friendly site? What characteristics of a health facility are considered male-friendly?
2. Is this male-friendly aspect of the clinic an enabling factor in men's testing?

#### Do male clients trust male staff more than female staff?

3. What have men's experience of public health clinic staff been? Have they had positive or negative experiences?
4. Do male clients trust the men's clinic to keep their HIV status private? Do they place trust in other health facilities?
5. Are male health workers perceived as more trustworthy than female health workers?

#### Does the male-friendly clinic contributing to normalising testing among men?

6. Do men talk about HIV/AIDS and testing with male friends?
7. As a result of their experience at the male-friendly clinic, would attendees recommend the service to friends, and therefore promote and contribute to 'normalising' VCT?
8. Is word of mouth significant in marketing this clinic and its services?

#### Is men's use of VCT encouraging of women's use of VCT?

9. For those who tested, did they talk about their decision to test with their partner? Will they talk about it afterwards?
10. Do men think that VCT services targeted at men in turn encourage men to promote testing in their partners?

### APPENDIX 3

**Table of testers and non-testers**

<b>INTERVIEW DATE</b>	<b>TIME</b>	<b>INTERVIEW LANGUAGE</b>	<b>CLIENT NUMBER</b>	<b>TESTER/NON-TESTER</b>	<b>LIVING LOCATION</b>
05/10/2007	13:47	English	Client 1	Tester	Khayelitsha
05/10/2007	15:51	English	Client 2	Tester	Khayelitsha
08/10/2007	13:00ish	Xhosa	Client 3	Non-Tester	Khayelitsha
08/10/2007	15:18	Xhosa	Client 4	Tester	Khayelitsha
08/10/2007	17:15	English	Client 5	Tester	Khayelitsha
10/10/2007	12:59	English	Client 6	Tester	Khayelitsha
10/10/2007	13:34	English	Client 7	Tester	Khayelitsha
10/10/2007	14:32	English	Client 8	Tester	Khayelitsha
11/10/2007	12:46	Xhosa	Client 9	Tester	Khayelitsha
11/10/2007	13:33	Xhosa	Client 10	Tester	Khayelitsha
11/10/2007	14:47	Xhosa	Client 11	Tester	Khayelitsha
12/10/2007	12:39	Xhosa	Client 12	Non-tester	Khayelitsha
12/10/2007	13:45	Xhosa	Client 13	Tester	Khayelitsha
12/10/2007	14:22	English	Client 14	Tester	Khayelitsha
12/10/2007	14:41	English/Xhosa	Client 15	Tester	Khayelitsha
12/10/2007	15:27	Xhosa	Client 16	Tester	Khayelitsha
12/10/2007	15:55	Xhosa	Client 17	Tester	Khayelitsha
22/10/2007	12:48	English	Client 18	Non-tester	Khayelitsha
22/10/2007	14:55	Xhosa	Client 19	Non-tester	Khayelitsha
22/10/2007	17:20	English	Client 20	Non-tester	Khayelitsha
24/10/2007	12:59	Xhosa	Client 21	Non-tester	Khayelitsha
24/10/2007	13:31	Xhosa	Client 22	Non-tester	Khayelitsha
24/10/2007	13:56	English/Xhosa	Client 23	Non-tester	Khayelitsha
24/10/2007	14:58	Xhosa	Client 24	Non-tester	Khayelitsha
24/10/2007	15:29	Xhosa	Client 25	Non-tester	Khayelitsha
24/10/2007	16:04	Xhosa	Client 26	Non-tester	Khayelitsha
25/10/2007	13:09	Xhosa	Client 27	Non-tester	Nyanga
25/10/2007	14:04	English	Client 28	Non-tester	Khayelitsha
25/10/2007	14:36	English/Xhosa	Client 29	Non-tester	Khayelitsha
25/10/2007	15:18	English	Client 30	Non-tester	Khayelitsha
27/10/2007	11:28	Xhosa	Client 31	Non-tester	Khayelitsha
27/10/2007	12:01	English	Client 32	Non-tester	Khayelitsha
27/10/2007	12:21	English	Client 33	Non-tester	Khayelitsha

## APPENDIX 4

### Additional Interview quotations

#### Chapter Four: Introduction to Findings: The Clinic as a Gendered Space

##### *Illness and Masculinity*

'...we as a Xhosa people we believe women are weaker than men' (CNT30).

'Most of the people that attend clinic are women because women cannot resist from pain, as compared to men. Men tend to wait for a longer time and they die trying to prove their manhood. As a man you have to be strong, you mustn't be like a woman. So there's that comparison between a man and woman that you must prove that you are a man...' (CNT29).

'...women do not resist, the way we resist as men, and women are not ignorant like we [us] because we resist things and leave them' (CNT25).

'...Women are not able to tolerate pain' (CNT19).

'...when it's...pain [women are] going to run the clinic, but I will try, let me treat myself...before going to the clinic' (CT5).

'...us guys...we say, I'm not sick, I'm a man. The man does not like to go to a clinic, it's a lady's stuff to go to the clinics. We are strong enough...' (CNT18).

'Most people that are so much vulnerable at HIV are women because men the way they are built is much strong compare to a woman... Yes women are at risk and women are vulnerable to HIV, man are stronger than women...Men have strong[er] immune [system]' (CT9).

## Chapter Five: Male-friendly Clinic Characteristics

### *Male staff*

#### Man to Woman

'I know many people, if maybe I will come here, and they were ladies, especially like doctors and the people who have to do counselling with, it will be a bit of a problem because... I have to tell someone else of the opposite sex that this and this and this situation that I'm in now [how I've come to have an STI]. It makes it difficult. You don't actually open up, maybe you end up lying just to get out of here. So, it wouldn't be a good service' (CT1).

'I feel free to talk about my problem here unlike when I would speak to a woman I would not be able to speak about everything...[men] do not get help because if you are a man speaking to a woman you do not talk about everything...I am comfortable here because I can talk about everything' (CNT25).

#### 'Traditional confidentiality'

'...as a Xhosa person, as a traditional person, you know, so because...most of the time, if maybe you go to the public clinics...there a lot of women there, you know, if maybe you want to check the penis, then she's the one who checks here... or one who puts the injection, so now male clinic... like according to me the male clinic, it's private, the man can understand you...' (CNT29).

'...with the clinics when there's everyone sometimes you are being inspected by the women, you know showing your private parts, we [Xhosa people] have that belief that...it's disgusting [laugh] showing your [penis to] the opposite gender, ja [yes], you[r] private parts and so on and so on. Especially with the problems that we are dealing with and then we have to see someone, at least it's a man rather than a female' (CNT30).

'They are have that thing that they are African men (Xhosa men) who don't talk men issues with women' (CT10).

'You can't say a lot to a woman [because] women must not know certain things' [the client and the male translator laughed as they share this 'inside' joke to my exclusion] (CNT27).

#### Greater Trust in male patients

Client 4 indicated his preference of coming to the MC because there are a

'...lot of ladies that side [another clinic]...when we are in that side they think we are there for contraception' (CT4).

'I feel comfortable because it's only men coming here' (CT7).

'...when it is men only ...[men] will be able to come secretly...Sometimes a lady would act silly to the men they saw here [at the clinic], maybe she will talk about somebody's sickness. So that is why majority of [men] would not come when they see ladies' (CNT19).

### *A Culture of Respect and Independence: Unthreatening environment to 'masculinity'*

#### **Emasculating experiences at Public Clinics**

'Because here it's only men who come here and I am the man as well...from that general side most people who goes there are women and they always curious to know why were you at the clinic, so from men's side everybody is minding his own business no one will ever ask you that we met at the clinic why did you go there, what was wrong, no men don't do that' (CT16).

'From hearing and from what I see the staff at the clinic I see that sometimes they lose respect for people who are sick, you know the sick person does not answer back at that time because he knows that he needs that help from that person' (CNT31).

'...sometimes the nurses shout at you when you are late and she would swear at you asking you why are you late why you did not take the treatment so one would decide there and then to go back home and never return' (CNT19).

'They [the staff] would shout at people; they have favours if they don't know you [you] will be the last to be served or they would assist some [people] who came after you, whereas you've been there before that person' (CNT27).

'...they are shouting at people, you see. I think a nurse are trained to care for people, but when...that person when he is a professional person or she is a professional person they get angry, it's kind of like surpris[ing]' (CNT33).

'At most of the clinics they are treating me bad...They shout. So they treat you, so, like if maybe you take your children to the hospital, to the clinic...he [the staff] have no care about you about the children, at the clinic....' (CNT28).

#### **Men's Clinic accommodates 'masculine' traits: Respect and autonomy**

'it's good to know your status. I have to think about it, no matter if I'm HIV I accept it, because I decided to come. Nobody pushed me...it will be my decision' (CNT20, emphasis added).

'The reason I did not test today I did not plan that I will test. For me, in order to test, firstly I must prepare myself for the situation so that if they say I have the disease I must understand because there are parents to tell so that means I cannot just test I must plan to do testing...I want to get out there [facing the day] knowing that I am going for a test' (CNT26).

'No [I] decided for me, I decided by myself to come here' (CT10).

'...when I hear about this clinic I feel...[encouraged] Because on the other clinics, where you go, maybe you got problems, sexual problems, and then they force you for blood tests, they cannot help you without blood, yes. So first they take you for the blood tests, you see it's difficult for you because they force you. It's difficult to accept what what was... the outcome of the results, because it's not your choice, maybe they force you. It's difficult even to tell your partner at home because you've been forced there, but you have to make your own decision with your partner' (CNT23).

'I had the same problem [STI] I do have now, I went to the clinic in [X] and they forced me to the blood test and after that, I told them I don't want to hear about the outcome of the blood test because it wasn't my choice. I was here for the treatment for the problem...that time, not for the testing' (CNT23).

'I still need my own time...Because it might change my whole life, ja [yes], maybe it can make it better, it can worsen, I really don't know' (CNT30).

'I didn't come to, really come to test. So I got the pains, so now I just want to, if those pains come down and then maybe next week I come to test. I don't scared to test...if I got no more problems then maybe I come next week, then I can come for HIV test' (CNT28)

'...because I not want two things at one time, so I like to do one thing first and then when I'm finished I want to take another step...You see if you put everything in your own head, then at the end of the day you've got a stress...One at a time. So you just, you are feeling free. Like I don't know more, but me, if I do one thing at a time, every time I'm feeling free' (CNT28).

### **Counselling: A Threat to Masculinity?**

'Hay! [No], man, just tell me, ok, I've got this, ne [right?]? Right, I've got it, so what's the plan? Ok' (CT6).

'I feel comfortable if I'm talking to the man, yes, most of the time, especially in the clinics...Because the men they don't go to talk like there [on a tangent], they just talking straight with this thing. If

something is wrong, just talk this thing and this thing is wrong...most of the women, if you are talking like this, just they go there [they go on a tangent and talk about something else], you see so now they confuse me...so they not talking about this situation' (CNT28, emphasis is client's own).

### *Promoting alternative views of 'masculinity'*

'I am a partner...in my relationship...I communicate my needs, fears and dreams'

'I am a partner...in my relationship...I am faithful to my partner'.

'My strength is not for hurting: So when I didn't know how she felt, I asked. Men can stop rape.'

'My strength is not for hurting: So when I wanted to, and she didn't, we didn't. Men can stop rape'.

'My strength is not for hurting: So when I paid for our date, she didn't owe me. Men can stop rape'.

'My strength is not for hurting: So when she said no, I said ok. Men can stop rape.'

### *Location*

'There is a clinic from Salt River is here now' (CT8).

'...it is always women are full in the clinic except it is a MC like the one in Salt River' (CT11, p1).

'While I was going to work, so I'm using these taxis at the back when I'm travelling... So I was walking around looking at the billboards' (CNT18).

### *Opening Hours*

'...it could be fine if the time could suitable for every one because sometimes you have to go to work but you have to go to the doctor also for your doctor's appointment. It will be convenient for you if you came early maybe at around eight and by nine you will be already gone [on your way to work]' (CT9).

## **Chapter Six: Trust in Male Health-workers**

## *Factors contributing to Trust in Health-workers*

### **'Men will keep it inside'**

'Because...I have a trust in men, even if I'm going out that gate, it won't be everyone's news that I'm positive...I think the man is the one will understand me better as a man how to consult me...I've got that belief that sometimes women cannot keep things on their chests. Like, maybe immediately they will go out that door...she will say to her colleague look at him...he's positive' (CNT30).

' [no], I don't trust women. But...[when I tested before] I did not know that there was a MC. Whatever in trouble they [women] will laugh you. They will gossip you...[women] always do that, but men will come to you, like give you advice...my secret is safe here with the mens, not the womens' (CT5).

'I would say this side [MC] is better than that side [another public clinic] because that side has women, and women are not trustworthy because she might talk...that so and so has HIV/AIDS...There are no women in this clinic and you would talk with a ma.... So there's no one who is going to gossip about you...' (CT4).

'I made sure I looked for a man's clinic, because I feel more comfortable. Like any public clinic, I know...they say...it is like private between a patient and a doctor, but sometimes I don't feel that it stays that way, so I prefer coming to a MC' (CT1).

## **Chapter Seven: VCT Normalisation amongst men**

### ***Testing as unusual and silenced among men***

'...we [male friends] do talk about sexual issues and testing. But you would find that when it comes to VCT it's quite difficult for them to volunteer themselves...to go for a test; they say they would go when they are very sick you see. So it's quite rare for us as men to just to volunteer [to test]; it's unfamiliar' (CNT12).

'...it's rare to hear a man who has gone for testing you see, they always hide the fact that they HIV or I'm positive you see. So most people don't want to go to the clinic [and] men are worse' (CT4).

### ***Self-efficiency and Life Chances***

'...my wife would insist that I go to the clinic she would tell me I will not go to work whilst I'm sick' (CT9).

'...you can die anywhere you can get stabbed at school and die...' (CT9).

### ***Talking about testing with male peers***

'Because even somebody else that also have the same problem, I will encourage them to also come' (CT1).

'I would tell the other people that there's MC this side so they can come and have a test so that they can know their status...' (CT10).

'I will tell them that I have tested so they should test too' (CT17).

### ***Less Direct, Word of Mouth Marketing***

'...it should work [the clinic] if we should start talking about it amongst friends and we go out and speak to people, make them understand that it is very important to test and to know your health status especially to men' (CNT26).

## **Chapter Eight: Advantages for women's health**

'...because I'm a man, if I was positive, and then this wouldn't make me not to sleep with my woman, with my girlfriend because I'm positive....because...I don't want to die alone. Let me just spread it around, and I'm not going to tell you that I'm positive, I'll spread it and spread' (CT6).

## *Improving the SRH of both men and women*

### **Addressing proxy-testing for the benefit of men and women**

'...men would force their female partners to go and test, so it's almost a proxy test for themselves, so if the partner is positive, then there's a likelihood that they are maybe positive as well, and if she's negative it's also likely he's negative, and so...part of the thinking was that we would stop that practice of proxy-testing so that men can actually know their status themselves' (P1).

### **Promoting Dialogue between partners**

'...each and every time that we indulge ourselves in these conversations [about testing and contraception], she doesn't feel good' (CNT30).

'...it's not easy to bring that [the topic of testing up] when you having fun so when you mention the word test it's going to be [un]friendly' (CNT31).

## *Testing together or testing alone?*

### **Testing alone**

'I'd rather go on my own to test so that I can take you [his partner] back' (CT5)

'I just came alone...I told her about it afterwards. Then we decided to come here together' (CT15).

'But now I don't know whether she's going to be accepted here, because it's a MC' (CT5).

### APPENDIX 5: RECOMMENDATIONS TABLE

<b>Recommendations</b>		
<i>Marketing</i>	<i>Staff training</i>	<i>Operations</i>
<ul style="list-style-type: none"> <li>• Consult with Community</li> <li>• Relate the clinic to what is known: Salt River Clinic</li>   <li>• Radio marketing to continue</li>   <li>• Word of mouth is key</li>   <li>• Clinic signage</li> <li>• Campaign showing clinics for everyone</li>   <li>• Positive imagery of men testing</li> <li>• Positive imagery of men living with HIV</li> <li>• Testing does not equate to AIDS - appeal to provider role</li> <li>• Role models to publicity</li> <li>• Highlight role of confidentiality in health profession</li> <li>• The right to privacy</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasise word of mouth</li> <li>• Explain role of the clinic within wider health system</li>   <li>• Awareness about diversity of client needs</li> <li>• Gender sensitivity among all health-workers</li> <li>• Knowledge about proxy-testing and how to deal with this</li> <li>• Communicate the advantages of testing early</li> <li>• Couple and partner counselling should be promoted to all clients</li>   <li>• Adaptability in counselling method</li> </ul>	<ul style="list-style-type: none"> <li>• Formalised roster for staff outreach</li>   <li>• Counsellor diversity advantageous</li> <li>• Recruitment of more male health-workers in general clinics</li>   <li>• Open the clinic earlier, if possible.</li> <li>• Have the ACTS approach as an option alongside VCT.</li>   <li>• Unnecessary visitors at the clinic discouraged</li> </ul>

## APPENDIX 6

### The Researcher: My Positionality

I am taking the following extracts from writings I did before, during and after my research. I began recording my thoughts on the subject of my identity as it related to my research, in early September 2007, but had been thinking about it since March/April 2007.

The first time I became aware of my 'positionality' as a researcher was in my 'Gender Research Methodologies' class with Prof Jane Bennett. She highlighted the feminist approach which emphasises the need for the researcher to place herself within, and in relation to, the research. The researcher, as consciously as possible, situates herself/himself in the research rather than assuming the position of all-knowing, objective researcher. The 'researcher's identity and biography directly affect[s] fieldwork and that fieldwork is a dialogical process which is structured by the researcher and the participants' (England, 1994: 80). I felt challenged by this notion, not sure how I would approach this task of reflexivity as a woman researching men. After all, most feminist research is women situating themselves in relation to other women (although this has also been done on the rarer occasion when feminist men study women and when women study men). I began being more aware of this relation between myself and the participants, and imagined how I would respond to questions of my positionality. This approach highlights your own vulnerability, as you bring attention and awareness to the subject of your identity and how it relates to the research (England, 1994:87).

I felt that I needed to address my position when I wrote my research proposal, but my thinking had still not matured into a response to the questions that might arise. It was only on receiving a written response to my research proposal, from the clinic partners, where they raised their concerns about my identity, that I felt directly challenged, and therefore in need of concrete answers. They questioned my suitability as a researcher in terms of my femaleness, and my culture, both of which I cannot hide, as I inhabit a woman's body and have a white skin and am unable to speak Xhosa fluently, all of which are immediately apparent to my research subjects. My first response was one of defensiveness. I felt particularly winded by their questioning my 'cultural' suitability, as I felt I was doing research as a South African about South Africans about a subject, HIV and VCT, important to our society. Of course I had been aware that there was a difference of skin colour between researcher and researched, but I had (perhaps naively) hoped our commonality would outweigh the difference. I thought that this interview experience could potentially be a means of crossing boundaries, while respecting difference, but acknowledging and working with connections. Sadly, even in post-apartheid South Africa, society is still pre-occupied with 'race' and as a result it remains a powerful signifier. I felt my legitimacy was in question. It was as though I was being labelled according to my 'race' and my gender, and not as a researcher, and these were obstacles in my research. The more I thought on the subject, I began to wonder whether it was possible that they could also be considered advantages in my research.

Upon speaking to my supervisor, Dr. Colvin, about the challenges posed by my identity, he pointed out that with any research pairing there are a set of advantages and disadvantages, and certainly some have more than others, but there will always be biases involved.

I found a chapter helpful on this topic of interviewers identities; 'Interviewing Men'. It highlighted that men may feel threatened depending on the interviewer's identity (Schwalbe and Wolkomir, 2001:206). The authors imply that the more similar the interviewer and interviewee are, the less threatening the encounter (Schwalbe and Wolkomir, 2001:206). This is further emphasised elsewhere in the book which states, 'women interviewing men presents special problems, given the obduracy of the interpersonal dominance involved' (Warren, 2001:96). This is quite a one-dimensional view of 'masculinities', but, I feel it is important in this situation to be aware of the 'threat potential' imposed by the interviewer and to adapt the interview where necessary in response to this (Schwalbe and Wolkomir, 2001:206).

I believe I handled this in the interviews accordingly. If at any stage I sensed the client's discomfort in answering a question, I would frame it further with 'you don't have to answer this, but...' or 'we do not want to know your medical status, but we are interested in your experience at this clinic...' so as to reassure the client that we were not wanting to pry too deeply into their health situation. If the participant was open, I encouraged them to speak more, but only gently, never forcefully. And, if the client was resistant to my questions, I did not force them to divulge any more than they were willing. At all times I tried to maintain a dynamic where I was learning from them. The clients were the experts on the topic, and they were educating me. I believe this contributed to interactions of mutual respect. The process of listening to my interviews as I was doing the research also helped me to keep myself in check, and if I sensed a situation that I should have handled differently, I made a mental note and kept this in mind in future interviews. For example, I was aware of the dynamic that three people can have, wherein someone can feel like an outsider. I was concerned that this may be the case as Mr Nywagi and I had a working relationship, but we did not know the clients. I did not want them to feel excluded. I tried to be inclusive at all times, even when doing the interview through translation, by making eye-contact with the client, rather than only with Mr Nywagi (the translator).

Schwalbe and Wolkomir (2001) emphasised the preference for sameness between interviewer and interviewee. With this in mind, as Dr Colvin explained, there would be biases involved with any research pairing, whether it was a Xhosa woman/white man/Xhosa man researcher, and so on researching a Xhosa man; albeit those differences may be less conspicuous. I think that one instantly assumes that a Xhosa male researcher would be the best option and in many ways this is preferable. Contrary to this assumption, it can also be argued that Xhosa gender norms could be so pervasive, and 'normal' that they would not be identified and unpacked and accepted as normative. In fact I observed this happen a few times during my research between my translator, Mr Nywagi and the clients, sharing unexplained and accepted inside knowledge. My positionality as someone outside the community, as a white woman, meant that I had a different understanding and therefore had legitimate reasons to ask the questions I was asking, because I did not know. After our second day of client interviews Mr Nywagi pointed this out to me. He reflected to me that he thought that in some ways it is more beneficial that I am the one doing the interviewing, rather than a Xhosa man, as

the men feel they need to explain information to me in more detail. He said that if he was doing the interviews the information between the interviewer and interviewee would probably be taken for granted and the participant would not feel he needed to explain because they are both from the same culture and therefore there is an assumed common understanding. Furthermore, I was in a position to offer insights that would potentially go unseen by someone fluent in the cultural and gender codes. Thirdly, Dr Colvin pointed out that the scope of the study is not especially personal and although it should be handled with sensitivity, this race/gender 'dynamic' should not adversely affect my research.

I felt encouraged after this conversation with Dr. Colvin. I then spoke to a friend about these same concerns raised by the clinic partners. She brought out other aspects of who I am that could be advantageous in my research. She is a Canadian researcher and has found that many interviewees open up more than they do to other South African researchers, precisely because of her difference to them. Although I am aware that I am South African, being 'different' in appearance to my interviewees may be advantageous, particularly in the subject of HIV/AIDS where people are acutely aware of damaging perceptions within their communities. Even if the researcher is not asking about HIV status, just talking about HIV/AIDS can be a sensitive topic. Not being immediately a member of the Khayelitsha community may have contributed to men's honesty in the interviews. Therefore, while recognising the limitations, I also see my identity as a potential advantage. This is because I am so obviously not a part of the clients' direct community, and they may perceive their confidentiality to be even more upheld in this instance.

A second issue that was raised in this conversation was the fact that I was raised in a family with a mother who is a social worker/Jungian therapist. This undoubtedly has contributed to my ability to empathise. I am acutely aware of other people and how they might be experiencing time spent with me. I believe this was advantageous to me in the interviews as I was aware of clients' comfort levels. I think I approached the research with sensitivity and discretion. This approach, based on empathy and mutual respect, is one adopted by most feminist researchers (England, 1994:82). This method gives power to the research participants, placing them as the expert on the subject, rather than the researcher (England, 1994:82; Schwalbe and Wolkomir, 2001:208). In reading some interview techniques, I found advice suggesting that I give the participant the space to ask the first question to lessen any perceived dominance in the interview (Schwalbe and Wolkomir, 2001:208). I believe this contributed to the increased comfort of the clients.

My Canadian friend even encouraged me to ask the clients directly how they felt about my presence and my doing the research, and whether my femaleness was awkward for them. I pondered this and came up with a few potential questions. I then broached the subject with Mr Nywagi the first time we met to discuss his involvement in the project on the 10 September 2007. I asked him if he anticipated my doing the research as a problem. He said that if my presence was ongoing at the clinic, this would be awkward, but as I was only there for a short period of time, he thought my presence was relatively unproblematic. He actually challenged my bringing attention to these attributes of whiteness and femaleness.

I also tested these questions in the mock interview process, and the questions felt awkward. I therefore decided to leave them out of the interview, but remain open to talking about it, if the opportunity arose with the interviewees.

With this increased sense of confidence, the chapter 'Interviewing Men' (Schwalbe and Wolkomir, 2001:203-219) again challenged my intention of interviewing men as a woman. It suggests that for men, an interview may be both an opportunity to demonstrate 'masculinity', but also a moment where they feel their 'masculinity' is threatened (Schwalbe and Wolkomir, 2001: 205). It is a moment to demonstrate 'masculinity' in that the interviewee is in control of what he says and how he says it, but it is a threat to 'masculinity' because the interviewer controls what is being asked and when it is asked (Schwalbe and Wolkomir, 2001:205). It is suggested that interviews dealing with gender may further aggravate this sense of threat to 'masculinity' as the 'subject's identity as a man [is] more salient to the interaction' (Schwalbe and Wolkomir, 2001: 206). As Dr Colvin advised, this is a very reductionist view of "masculinity", limiting men to the experience of only two forms of 'masculinity' within the interview process. Nevertheless, it continued my thinking and I pondered the potential power dynamics at play within the interview.

The relationship between the researcher and researched is unequivocally hierarchical (England, 1994:86). Reflexivity does not remove this power relationship, but it does allow the researcher to be conscious thereof (England, 1994:86). As England (1994) explains, '...reflexivity is self-critical sympathetic introspection and the self-conscious *analytical* scrutiny of the self as a researcher' (1994:82, emphasis author's own). I believe I approached my research with reflexivity, constantly questioning how I related to the research and the participants.

I felt it was important to tell the clients before being interviewed that the interviewer was a woman. I did not want any of the interviewees to feel uncomfortable because of this arrangement. Although I did request that when recruiting clients to participate in the interviews the staff tell the clients that they would be speaking to a woman, unfortunately, it did seem that on occasion some men were surprised that a woman was doing the interviews. In the interview itself I impressed on them that the interview was voluntary and that they did not have to speak to me. I think two men declined the interview after initially agreeing to it. This may have been because they felt uncomfortable talking to a woman, or it may have been they felt uncomfortable about the interview material, or perhaps it merely was, as they said, that they did not have enough time.

When men did bring my identity to attention, I invited them to talk about it. We sometimes laughed about it, and other times they explained my presence for me.

Client 5 joked about my presence with me.

'Ok, it's a men's clinic, ok, because I have this problem, let me go to the Men's Clinic. That's why I've asked you a question 'What are you doing here? (laughs)...it's a men's clinic. That's why I expect men only, no women. That's why I tried to chase you away. But you were lucky [laughs]...that I didn't chase you away (laughs). (CTS, p3 and p5).

On the one hand, Client 5 is asserting his dominance and 'masculinity' in this exchange. He is asserting this space as his own, and I am a foreigner to it, but he is also joking with me, and inviting me to share in the laughter with him, making me feel welcome in his space.

Client 7 explained that because I am doing research I have cause to be at the clinic. This was said in contrast to some women visiting the clinic, apparently socially, rather than for medical reasons, which caused this client discomfort.

'I can see someone [referring to my presence as a woman at the clinic] who is coming here for a reason' (CT7, p5).

Generally, it seemed the men were not uncomfortable in the interview because of my gender. I think this was partly because I did not pry too deep into their personal lives or their sexuality. I felt uncomfortable at times myself, but this was more to do with age than gender, when I was asking older men questions, although, at times, my gender was a factor.

For example in the exchange below, I was interviewing an elderly man. He spoke in Xhosa and so Mr Nwyagi was translating the interview.

He talked about how the Men's Clinic was different to other general clinics, because of the male health-workers.

'You can't say a lot to a woman' because 'women must not know certain things' [Mr Nwyagi and the client then laughed] (CNT27, p9).

The two Xhosa men seemed to share an 'inside joke' together, and I felt excluded, primarily on the level of gender, because 'women [me] must not know certain things', but also in terms of age, language and culture. Other men went into more detail about what these 'certain things' [sexuality] are, but some, like this man, wanted to keep me ignorant on this topic. This was not my overriding impression of my interviews, and I only felt this occasionally, but I was aware of my exclusion and my lack of access, which of course, to a degree, must limit the research.

In the exchange like the one above, I did feel that I was imposing on a territory I was not necessarily welcome in. I felt this, at times, at the clinic itself, where I kept a low profile, in the hope that my presence at the clinic would not be felt too considerably. Because the clinic was male-friendly, rather than male-only, women are able to come to the clinic. In the time I was there, I saw a few women at the premises, including members of an NGO, a cleaner, client partners and the female 'visitors' who I refer to above. This meant that the idea of women at the clinic was not entirely foreign, which further encouraged me in my research endeavour. My anxiety over keeping a low profile said a lot more about me, I think, than the clinic or the atmosphere therein. I was not made to feel uncomfortable by staff or clients, but because of the clinic partner concerns, and my own acute awareness of the situation, I think I tried to be as inconspicuous as possible. I felt that regardless of my identity, as the researcher, I wanted to make as little disruption to the running of the clinic, as possible. Keeping a low profile therefore, was partly because of my own

gender consciousness, but also about not being a part of the usual clinic operations, which meant I did not want to disrupt the running of the clinic because of my research.

I realise that there are all sorts of advantages and disadvantages associated with who interviews whom. I realise that my position may be seen, by some, as mismatched within this research. In terms of the fact that I am a woman interviewing men, and the concerns around men feeling the need to overemphasise their control in the interview due to the patriarchal norm where men dominate women. I believe my situation is not altogether this clear cut, and indeed few are ever this clear cut. Because I am not only different in terms of gender, but also 'race', language and 'class', I believe this need for over-assertion of power may be reduced, and in fact my 'otherness' could be seen as an advantage to the interview process. England (1994) suggests that the way to approach the power between the researcher and researched is to 'expose the partiality of [my] perspective' (England, 1994:86). Indeed, my research cannot fully speak for Xhosa men in Khayelitsha and their experience at the Men's Clinic, but even though it is limited in some ways that is not to say it is any more limited than other qualitative research. Indeed, each researcher affects the research process through their identity; it is to say that I am acknowledging and owning this.