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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment or therapy
ARVs	Antiretroviral drugs
CCMDD	Central Chronic Medicine Dispensing and Distribution
DoH	Department of Health
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
KZN	KwaZulu-Natal
KZNDoH	KwaZulu-Natal Department of health
MMC	Medical male circumcision
NHRD	National health research database
NIMART	Nurse initiated management of ART
OR	Odds Ratio
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SADoH	South African National Department of Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UTT	Universal testing and treating
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In 2014, an estimated 36.9 million people globally were living with Human Immunodeficiency Virus (HIV) or Acquired immune deficiency syndrome (AIDS) with about 2 million new infections, of which 1.8 million were adults. HIV infection among young people aged 15-24 years accounted for approximately 30% of new infections worldwide (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2015:1). Moreover, in 2014, approximately 70.0% of people living with HIV and 66% of all global new HIV infections were in Sub-Saharan Africa, and most (63%) of them were women (UNAIDS 2015a:3).

The global response to AIDS in 2011 led to the majority of the UN member states committing themselves to key targets to halve the sexual transmission of HIV by 2015. This could be achieved by intensifying prevention efforts such as condom distribution and uptake, sex education, voluntary male circumcision, and dealing with gender inequality. Other efforts to prevent the transmission of HIV included antiretroviral treatment (ART), care and support programmes, and scaling-up universal access (UNAIDS 2012:6).

In 2015, the 193 member countries of the UN General Assembly adopted the 2030 development agenda titled “Transforming our world: the 2030 agenda for sustainable development” (UNAIDS 2015b). This agenda has 17 global goals set by the UN, known as the sustainable development goals (SDGs). The third SDG is good health and well-being and the aim is to ensure health for all at all ages by eradicating communicable diseases, including HIV and AIDS, by 2030. Health for all includes reducing the mortality rates of women, men and children at all ages by fighting HIV/AIDS (UNAIDS 2015b:3). Behavioural change programmes that promote safer individual behaviour and change in social norms to generate healthy sexual behaviour have been developed. However, behavioural change depends on a number of factors such as sexual context (UNAIDS 2015b:7).

The fifth SDG is gender equality and targets all forms of discrimination against women and girls, including sexual violence and exploitation and/or harassment in public. Gender inequality and social marginalisation appear to be a serious problem in South Africa because of the high HIV incidence in the country in spite of having the largest ART programme in the world and HIV prevention efforts. Interventions to stop the transmission of HIV include health education to use condoms consistently. The continued increase of HIV infection, however, shows that knowledge does not always translate into behaviour. Jama-Shai, Jewkes, Nduna and Dunkle (2012:462) found that masculinity was associated with no or inconsistent condom use, sexual violence and risk taking especially among inconsistent condom users. Other factors responsible for the high rate of HIV include early sexual debut, multiple sexual partners, lack of knowledge about HIV and AIDS, and people believing that they are at low risk of HIV (Statistics South Africa [Stats SA] 2015:9).

In the light of awareness that knowledge does not necessarily lead to behaviour change, there is a growing need to look at the context that guides the behaviour of the people concerned. Unsafe sex may result in HIV infection and pregnancy. The involvement of young men is necessary to curb the spread of HIV and teenage pregnancy. This motivated the researcher to undertake the study to identify the positive values of masculinity in relation to HIV and AIDS and teenage pregnancy.

South Africa has the highest prevalence of HIV and AIDS in the world, especially among women, with a national prevalence rate amongst antenatal clinic attendees of 29%-30% since 2007. This prevalence has been higher than the general population estimate (17.3%) since 2005. In 2015, 7 million South Africans were living with HIV with a prevalence of 19.25% among adults and 380 000 new infections (UNAIDS 2016a:1). In 2012, an estimated 469,000 children 2 years and older were HIV positive in South Africa. Among adults aged 15-49 years, females were 1.7 times more at risk than males in the same age group. Females aged 15-24 years were over four times more at risk of HIV than their male counterparts, and 24.1% of the HIV infections were among females aged 15-24 years in 2012 (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya, Davids, Ramlagan, Mbelle, Van Zyl & Wabir 2014:xxix).

KwaZulu-Natal Province has the highest HIV prevalence (37.4%) in South Africa (KZNDoH 2013:19). In 2013, the KwaZulu-Natal Department of Health (KZNDoH) introduced a programme to prevent violence against women. In preventing violence against women and children, the programme talks to males as men of essence to respect women. The programme and AIDS Day focused on respect of women by men in the reduction of spread of HIV/AIDS.

The post-apartheid era brought changes through the new Constitution, which makes provision for no discrimination based on gender, religion, culture, race, marital status, origin, sexual orientation and policies such as gender equity. However, male domination and violence against women and children persists in South Africa despite the increase of women leaders in the workplace, politics and churches. Often gender inequality is implicated as a barrier to decreasing heterosexual spread of HIV (Gennrich 2013:7).

South Africa, especially KwaZulu-Natal, has a high prevalence of teenage pregnancy (Stats SA 2015:1). The pregnancy prevalence rates among sexually active teenage girls in South Africa increased from 17.3% in 2002 to 23.6% in 2008 and decreased to 21.3% in 2011 (Jonas, Crutzen, Van den Borne, Sewpaul & Reddy 2016:50). The odds for pregnancy were higher for girls with more than one sexual partner (OR 1.250), girls who drank alcohol before sex (OR 1.373), and those who used mandrax (OR 1.968). Among those who used condoms, the odds for being pregnant were lower (OR: 0.462). Mphatswe, Maise and Sebitloane (2016:153) found high repeat pregnancy, low contraception and high HIV infection rates among KwaZulu-Natal teenage girls. In a study at a KZN hospital among adolescent girls aged 13-19 years who had recently delivered or had terminated a pregnancy, Mphatswe et al (2016:153) found that 17.6% had repeat pregnancies; 17.0% had previously used contraception, of whom the majority (93.1%) had stopped within 12 months, and 30.0% of those with repeat pregnancy were HIV infected. Reducing new HIV infections requires a substantial reduction in sexual transmission, which accounts for the majority of people who are newly infected (UNAIDS 2012:7). Strengthening the positive values of masculinity might help to curb the HIV/AIDS epidemic and teenage pregnancy (Lynch, Brouard & Visser 2010:15-27). There is continued sexual transmission of HIV among young women in spite of behavioural change programmes, such as information provision and counselling which have been found to increase testing and discussion about HIV (Coates, Kulich, Celentano, Zelaya, Chariyalertsak, Chongono, Gray, Mbwambo, Morin, Richter, Sweat,

Van Rooyen, McGrath, Flamma, Laeyendecker, Piwowar-Manning, and Ashleman 2014:e423; Do, Figueroa & Kincaid 2016:2033).

HIV in South Africa was identified for the first time in two homosexual men in 1982, which led to the belief that it was a disease of homosexuals. The first heterosexual cases were diagnosed in 1987 (McNeil 2017). The national HIV prevalence among antenatal clinic attendees increased from 0.7% in 1990 to 30.2% in 2005, stabilising at 29.0%-30.0% in 2007. South Africa became the country with the highest HIV prevalence in the world (National Department of Health [NDOH] 2008a:9). In 2012, South Africa had the world's highest HIV prevalence (26.0%) with an incidence of 14.8% among women in some areas (Nel, Mabude, Smit, Kotze, Arbucle, Wu, Van Niekerk & Van de Wijgert 2012:1). HIV incidence is a significant marker of the HIV epidemic as it assesses the impact of the HIV prevention efforts and behaviour changes (Shisana et al 2014:57). Table 1.1 lists the HIV incidence in South Africa in 2012.

Table 1.1 HIV incidence (%) and estimated new infections by age and sex in South Africa, 2012

Age groups (Years)	Sex	HIV incidence %	Estimated new infections
2 +	Total	1.07	469 000
	Male	0.71	151 000
	Female	1.46	318 000
2-14	Total	0.25	29 000
	Male	-	-
	Female	0.49	29000
15-24	Total	1.49	139 000
	Male	0.55	26 000
	Female	2.54	113 000
25+	Total	1.41	300 000
	Male	1.29	125 000
	Female	1.62	175 000
15-49	Total	1.72	396 000
	Male	1.21	145 000
	Female	2.28	251 000

(Source: Shisana Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya, Davids, Ramlagan, Mbelle, Van Zyl & Wabir 2014:58)

Table 1.1 indicates that the highest incidence was among youth aged 15-24 years where young women were about 5 times (4.6) more at risk than their male counterparts. Violence against women was depicted in the incidence of HIV (0.25%) for young girls 2-14 years while there was no HIV incidence for young boys of the same age.

In 2014, Abdool Karim, Kharsany, Leask, Ntombela, Humphries, Frolich, Samsunder, Grobler, Dellar & Abdool Karim (2014:620) found a high prevalence of HIV and herpes simplex virus-2 (HSV-2) among teenagers aged 15-18 years in KwaZulu-Natal. The HIV prevalence was 1.4% in males and 6.4% in females.

HIV prevalence in uMzinyathi district declined from 2010. According to the KZNDoH (2015:34), HIV prevalence (excluding antenatal care [ANC] attendees) was 22.4% in 2010/2011; 11.3% in 2011/2012; 11.1% in 2012/2013, and 6.7% in 2013/2014. However, HIV and AIDS were among the top five causes of death in the district (KZNDoH 2013:23; 2015:31).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Gender-based violence is a global problem. It has physical, psychological and sexual consequences for both men and women. Gender roles promote male dominance and sexual coercion by men and silence and submission for women. As a result, women usually suffer sexual assault, sexual abuse and rape perpetrated by men and sometimes even approved by women with subsequent risk of HIV infection and teenage pregnancy. Men are brought up to believe that they are tough and dictate terms of sexual encounters with their partners. One of the expressions of masculinity is insisting on having sex without a condom even when the partner does not want it, and rape (De Vries, Eggers, Jinabhai, Meyer-Wetz, Sathiparsad &Taylor 2014:108).

South Africa is one of the countries in the world with high gender violence. Gender violence appeared to be one of the causes of the high prevalence of HIV and teenage pregnancy in uMzinyathi district while sexual violence against women and children increased. An estimated 43.1%, 34% and 48.3% children under the age of 12 were sexually assaulted in 2011, 2012 and 2013, respectively (KZNDoH 2015:34).

Inequality, poverty and unemployment are breeding grounds for physical, sexual and emotional violence. Women and children are subjected to these kinds of violence in the home, school, community and workplace. Due to gender discrimination, girls are often deprived of education leading to dependency on men for livelihood, poor chances of securing well-paying jobs, and poverty. However, equitable gender norms, higher education and employment are associated with condom use among men, not women. In a study among HIV-positive adults in a rural community in KwaZulu-Natal, Fladseth Gafos, Newell and McGrath (2015:5) found that equitable gender norms, higher education and being employed were positively associated with condom use at last sex among men. Male dominance was found to be negatively associated with condom use. Women were more likely than men to report intimate partner violence and have had a partner insist on having sex when they did not want to. They were also not likely to negotiate a condom if the partner was much older (Fladseth et al 2015:6).

Gender violence is also associated with men's beliefs about what sex stands for in a relationship. Many young people in South Africa believe that sex without a condom will depend on how much you love your partner to the point of forcing them to have sex against their will or as compensation for financial dependence. Some believe that when a girl says no she actually means yes. De Vries, Eggers et al (2014:109) conducted a study in KwaZulu-Natal to assess beliefs about forced sex among high school students. They found that boys more than girls believed that it was a sign of love or an acceptable way to satisfy sexual desires and justified if the girl was financially dependent. The boys also believed that it was an acceptable way to punish a girl. They were not knowledgeable about the risk of HIV infection and the legal implications of forced sex. The beliefs that men have uncontrollable sexual urges and should dominate women sexually may also fuel perpetration of sexual abuse and coercion of women. Eaton and Matamala (2014:1443) investigated the relationship between hetero-normative beliefs and approval of and experience with verbal coercion. The study found a positive association between approval of hetero-normative beliefs and verbal sexual coercion as a victim and perpetrator by both male and female college students.

Several studies have investigated relationships between gender norms and demographic characteristics and HIV transmission. This study investigated how masculinity from a positive perspective can reduce transmission of HIV and teenage pregnancy.

1.3 SOURCE OF THE RESEARCH PROBLEM

Gennrich (2013:46) states that in South Africa historical events and particularly colonisation affected the socialisation of Zulu boys negatively. In the pre-colonial era boys were recruited and received military training which was ceased when the Zulu Kingdom was defeated by the British. King Cetshwayo was instructed to stop recruiting and disband his troops. However, he was unable to pay their pension which was in the form of cows so that they could pay *lobola* (bride price), settle down and start their families. These men lost their status and had to find alternative ways to earn wealth. The government of the day imposed taxes on every man in the form of two pounds (*khanda mpondo*) cash. Men were forced to go to the cities in search of jobs to earn wages to pay taxes and for their family needs. The result was a generation of men who grew up without fathers who were supposed to be role models and pass on the values of masculinity. Traditional values of masculinity, such as *ubusoka* (having many girlfriends) and *ukuthwala* (when a girl is voluntarily abducted to marry the man she loves), became distorted. In the pre-colonial era, *ubusoka* did not allow penetrative sex. *Ubusoka* became equitable with having many sexual partners. *Ukuthwala* would be done if a girl did not love the man her family had arranged for her or if two men wanted to marry her. She would choose the man she loved and then she would arrange with her girlfriends, local young men and her boyfriend's family for her to be taken to the man she loved. There was no coercion to marry or to have sex as happens today in some parts of the country such as the Eastern Cape. Both distorted traditions led to violence against women, sexually transmitted infections (STIs), including HIV and AIDS, and an increase of boys who were brought up by men who did not know how to love a woman because they did not see their fathers loving their mothers or were brought up by single mothers in the absence of their fathers.

KwaZulu-Natal Province has the highest antenatal HIV prevalence (37.4%) in South Africa (National Department of Health [NDOH] 2013a:19). Factors responsible for the high rate of HIV include poverty, sexual violence and the low status of women (United Nations Entity for Equality and Empowerment of Women [UN Women] 2016:1). The UMzinyathi District is in a high HIV prevalence area. In 2012, the HIV prevalence in the area was 16-22% with a rate of 12% among females aged 15-24 years (Shisana et al 2014:48).

Gender inequality is often a barrier to reducing the heterosexual spread of HIV. In some societies, polygamy and many women sexual partners are considered a sign of manhood. International legislation to enforce gender equality has been endorsed by many countries. Nevertheless customary law, which promotes the superiority of men and undermines the rights of women, is dominant in many parts of the world. In addition, many churches use Scripture to support male dominance (Gennrich 2013:iii).

Several studies have focused on the masculinity of HIV-positive men. Blackbeard and Lindegger (2014:2301-2218) focused on the emerging masculine identity of an HIV-positive adolescent boy in relation to hegemonic masculinity, while Lynch et al (2010:15) examined the masculinity of a man living with HIV. Sathiparsad, Taylor and De Vries (2010:159) studied the relationship between HIV education and engaging in sexual risk behaviours. Ndinda, Uzodike, Chimbwete and Mgeyane (2011:1) examined gendered perceptions of sexual behaviour in rural South Africa. Gibbs, Sikweyiya and Jewkes (2014:1) explored how young black South African men living in informal settlements in eThekwini district, KZN, construct their masculinity to maintain dignity and respect in relationships with others. Due to inability to secure employment they resorted to violence against and control of sexual partners and having multiple partners and violence against other men to secure respect. Stern, Clarfelt and Buikema (2015:341) conducted narratives between provinces among men aged 18-24, 25-54 and 55 years and above to explore how boys develop the identity as men and how men conform or resist gender norms that are harmful to their sexual and reproductive health.

None of the studies mentioned above focused on positive values of masculinity in prevention of HIV and AIDs and teenage pregnancy. The main focus was on how hegemonic masculinity increased the risk of HIV infection; how HIV infection deterred men from living as ‘ideal’ men, and how men emphasised masculinity and demanded respect in the face of challenges to hegemonic masculinity, such as being unemployed.

There is continued sexual transmission of HIV among young women and high teenage pregnancy in spite of WHO guidelines and the behavioural change programmes provided by the Government and non-governmental organisations (NGOs). The researcher was of the opinion, therefore, that there was a need to focus on masculinity to prevent HIV and AIDS and teenage pregnancy. Consequently, in this study, the

researcher explored masculinity in relation to the prevention of HIV and AIDS and teenage pregnancy.

1.4 STATEMENT OF THE RESEARCH PROBLEM

Creswell (2014:20) defines a research problem as a concern that needs to be attended to. Polit and Beck (2014:100; 2017:69) refer to a problem statement as an argument that explains the need for research.

In South Africa, masculinity is a risk factor for contracting and transmitting HIV infection because it is associated with risky sexual behaviours, promiscuity and risk taking. Risky sexual behaviours associated with masculinity include no or inconsistent condom use, sexual violence, and risk taking, especially among inconsistent condom users (Jama-Shai et al 2012:462).

HIV incidence in South Africa is high especially among girls aged 15–24 years. In 2012 it was about five times higher (2.54%) in girls than boys (0.55%) of the same age group. HIV incidence is a marker of the HIV epidemic as it assesses the impact of prevention efforts and behaviour changes (Shisana et al 2014:58).

The high incidence of HIV infection and teenage pregnancy occurring in South Africa, KwaZulu-Natal and uMzinyathi district is of grave concern that requires increased preventative efforts. The high incidence and prevalence of HIV among young women aged 15-24 years needs the associated social factors, such as gender inequality need to be addressed. In addition, targeted interventions for this age group, over and above the comprehensive interventions designed for the South African population at large, need to be developed and implemented.

High HIV prevalence increases the risk of infection with herpes simplex-2 virus among teenagers 15-18 years in KwaZulu-Natal. The HIV prevalence was 1.4% in males and 6.4% in females in 2014 (Abdool Karim, Kharsamy, Leask, Ntombela, Humphries, Frolich, Samsunder, Grobler, Bellar & Abdool Karim 2014:620).

AIDS is the leading cause of death in South Africa despite great progress in the prevention of transmission and the roll-out of antiretroviral treatment (WHO 2015a:3). In

2015, South Africa had a mortality rate of 41.6/1000, the probability of dying between 15 and 60 years was 386 and 272 in males and females, respectively, and life expectancy of 59 and 66 years in males and females, respectively (WHO 2015b:1). HIV and AIDS are among the top five causes of death in the uMzinyathi district (KZNDoH 2013:23; 2015:31).

Many studies on masculinity have not focused on positive values of masculinity in the prevention of HIV and AIDs and teenage pregnancy. For example in a study of masculine norms that contributed to men's HIV-related sexual behaviours it was found that male sexuality was not associated with intimacy, was uncontrollable, and associated with high-risk sexual behaviours (Fleming, DiClemente & Barrington 2016:788) However, Fleming et al (2016:788) identified gaps for future research such as understanding context-specific masculinities and investigating positive influences of masculinity.

The aim of a study is a statement of intent that tells why researchers want to do the study and what they want to achieve (Creswell 2014:123; Botma, Greeff, Mulaudzi & Wright 2010:93). Much research has been done on risky sexual behaviours that must be avoided. In the researcher's view, it is time to shift responsibility from women to men to prevent new HIV infections. Accordingly, the aim of this study was to (1) determine how young Zulu men experience the positive values of masculinity and (2) explore how they apply the positive values of masculinity in the prevention of HIV and AIDS and teenage pregnancy in a rural sub-district in KwaZulu-Natal, South Africa. The study explored young Zulu men's experiences of positive values of masculinity and how they use them to reduce transmission of HIV and teenage pregnancy.

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study was to explore and describe the positive values of masculinity in the prevention of HIV and AIDS and teenage pregnancy in a rural sub-district in KwaZulu-Natal, South Africa in order to develop a health education handbook for young Zulu males.

1.5.1 Objectives

Polit and Beck (2017:69) describe research objectives as “specific accomplishments researchers hope to achieve by conducting the study”. The objectives of this study were to

- identify expectations of a man of essence / positive values of masculinity
- describe the man’s role in the prevention of HIV and AIDS and teenage pregnancy
- develop a health education handbook for young men in developing positive values of masculinity

1.5.2 Research questions

Research questions are queries to be answered to address the research problem (Polit & Beck 2017:69). In order to achieve the purpose and objectives, the study wished to answer the following questions:

- What are the expectations / positive values of a man of essence?
- What is the role of a man in the prevention of HIV and AIDS and teenage pregnancy?
- What health education can be developed for young men in developing positive values of masculinity?

1.6 SIGNIFICANCE OF THE STUDY

The significance of a study is its potential contribution to the body of scientific knowledge (Polit & Beck 2014:111). Creswell (2014:96) points out that the research problem should benefit participants as well as researchers. The results of this study should contribute to designing a health education handbook from participants’ perspectives to be used in the community to develop young men to be responsible men in the prevention of HIV/AIDS and teenage pregnancy.

Other benefits to the community would include community education on the benefits of positive values of masculinity; adapting own culture in the light of new realistic information about the risks in a way that comes from within the community based on science and not ideology; taking into consideration respect for human rights, the Constitution and the law of the country. The study engaged in a dialogue on gender-based issues and training in non-violent conflict resolution and reflecting on positive values to reinforce them while negative values and behaviour were not reinforced.

Policy makers and programme developers should benefit from the findings in the development of HIV-prevention strategies.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

The Health Promotion Model (HPM) was the theoretical framework of the study. Chapter 2 discusses the HPM in full. Researchers' world-view and philosophy determine how they conduct research.

1.7.1 Research paradigm

It is important for the researchers to know philosophies related to research before choosing the research methods because our actions in life and in practice are determined by our worldview.

A paradigm is a "world view'' or "general perspective of how the world works" (Polit & Beck 2014:6; 2017:9). According to Creswell (2014:6 a paradigm is a general philosophical orientation about the world and the nature of research that a researcher brings to the study". Botma (2014:43) identifies three paradigms that he calls approaches namely positivism, interpretivism, and critical theory. Cresswell (2014:6) and Polit and Beck 2017:9 refer to interpretivism as constructivism. Cresswell calls positivisim postpositivism.

The Positivist worldview is

- applicable more to quantitative than qualitative research
- called the scientific method or doing science research

- called empirical science
- studies causes and outcomes e.g. experiments
- reductionist in nature – reduce ideas to small tests
- develops knowledge by careful observation and measurement - uses numeric measures and study behaviour
- tests theories and laws – research starts with a theory, data is collected to test the theory (Cresswell 2014:8).

The constructivist worldview/Constructivism or Social constructivism

Constructivists believe that people seek to understand their surroundings, develop subjective meanings directed to things they experience and there are many different meanings. Researchers look for multiple views or ideas, ask broad general questions so that participants can construct meaning of situations, focus on specific contexts such as work to understand the cultural setting (Cresswell 2014:8).

The critical theory

Holds that research should be combined with politics and political agenda to change the lives of the oppressed racial, ethnic and minority groups such as the gay and the lesbian, bisexual, transgender, the disabled and queer communities. It includes groups of researchers that are feminists, Marxists, critical and participatory action theorists. Research has action agenda to reform institutions of work of participants and the researcher, address social issues such as empowerment, oppression, domination, alienation and inequality (Cresswell 2014:9).

The choice of a paradigm depends on philosophical assumptions namely, ontology, epistemology and methodology.

- **Ontology (nature of reality).** Ontology refers to the nature of reality. It is concerned with the worldview, ideas about the nature and characteristics of what scientists study. According to positivism, ontology, whether visible or not and understood or not, exists and is controlled by natural causes. Constructivism holds that there are many realities, reality changes, reality is constructed and

interpreted by people who experience it, reality is experienced differently by different people; and reality is contextual.

The researcher prefers constructivist view of ontology because she believes that here are many realities (masculinities), reality (masculinity) changes, reality (masculinity) is constructed and interpreted by those (men) who experience it. It (masculinity) is not controlled by natural causes.

- **Epistemology (relationship between researcher and participants).** Epistemology deals with nature of knowledge, its structure not content, how to know, principles or rules that determine how social phenomena can be known and methods, theories, concepts, rules and procedures (Botma 2010:40). Positivism assumes that the relationship between the researcher and participants is that of independence. The researcher does not influence the research results. Constructivism assumes that the researcher interacts with participants and research results are a result of the interaction between the researcher and the participants.

In this study the researcher takes a constructivism stance because it assumes that the researcher interacts with the participants and influences the research results through beliefs, values, and position in the community

- **Axiology (role of values in research)**. It deals with the role of values in research (Polit & Beck 2017:10) Positivism assumes that values and biases should be excluded and objectivity is necessary. Constructivism holds that subjectivity and values are unavoidable and necessary.

In this study, the researcher takes the constructivist stand which holds that subjectivity and values cannot be avoided and are necessary to construct masculinity.

- **Methodology (how researchers know what they know)**. It refers to the rules and procedures that specify how the investigation must be done (Botma 2019:41). It depends on the researcher's ontological perspective that is the worldview or the nature and characteristics of what is studied, which will determine the research approach.

Table 1.2 Differences between positivist, interpretivist and critical theory

		Positivist	Interpretivist	Critical theory
Ontological questions	Nature of reality	Objective, true, governed by unchangeable natural laws, not time or context bound, can be generalized	The world is complex, dynamic, constructed, interpreted, experienced by people as they interact with each other. Reality is subjective, people experience it differently, language defines a particular reality	Governed by conflicting underlying structures – political, cultural, economic, ethnic gender
	Nature of human beings	Rational, shaped by external factors	Social beings who create meanings and constantly make sense of their words, possess internally experienced sense of reality, engage in a specified behaviour under certain circumstances	Design / construct their world through action and critical reflection
Epistemological questions	Nature of knowledge	Can be described systematically, consists of verified hypotheses , probabilistic, accurate and certain	Based not only on observable phenomena, but also on beliefs, values, reason and understanding, constructed, is about meaning people attach to it in their lives	Knowledge is dispersed and distributed, is the source of power, is constituted by lived experience and social relations that structure experiences, events are understood with social and economic context
	Role of theory	Theories are normative, present 'models', general propositions explain causal relationships between variables	Theories are revisable, approximate truth and sensitive to context	Constructed in the act of critique in a process of deconstructing and reconstructing
	Theory building and testing	Theory can be tested to confirm or reject, prove theory from observable phenomena/behaviour, test theories in controlled setting, empirically supporting or falsifying hypotheses through experimentation	Theories are built from multiple realities – researcher to look at different things in order to understand a phenomenon	Theories are built from deconstructing the world and from analysing power relations
	Role of the researcher	Uncover reality, scientifically explain, describe, predict and control phenomena	Endeavours to understand why people behave in a certain way, grasp meaning of phenomena, describe multiple realities	Promotes critical consciousness, breakdown institutional structures and structures that produce oppressive ideologies and social inequalities, shifts balance of power to be more equitable
	Research findings are true if	Can be observed and measured, can be replicated and can be generalized	It has been a communal process, it is informed by participants and scrutinised and endorsed by others	Can solve problems, if solutions may be applied in other contexts as hypotheses to be tested

		Positivist	Interpretivist	Critical theory
Methodological assumptions	Role of the researcher	Objective, independent from the subject, controls the investigated	Co-creator of meaning, brings subjective experience to research. Tries to understand the whole and how parts connect to the whole.	Is a facilitator who partners with participants to become partners of the research process
	Role of values	Science is value free, value have no place in research – must eliminate all bias	Values are part of social life, there are no wrong values, they differ	can never be separated from facts, values of researcher influence research
	Methods	Empirical, structured and replicable observation, quantification, experimental	Unstructured observation, open interviewing, discourse analysis, capture 'insider' knowledge	Participatory action research, dialogical methods
	Types of studies	Surveys, verification of hypothesis, statistical analysis, quantitative descriptive studies	Field research in natural setting to collect substantial situational information	

(Source: Botma 2014:44).

In this study the researcher took an interpretivist stance to investigate a phenomenon (masculinity) using qualitative methodology with a flexible descriptive and contextual design to a small sample to obtain unquantifiable data that was content analysed with no intent to generalise the findings but to understand the context of a phenomenon.

Interpretivism emphasises the emic (insider's) view of understanding social realities and the role of people in their interaction with the phenomenon under investigation and interpret, respond and give meaning to a situation through sharing. Interpretivists argue that reality is meaningful and that people can interpret it and decide how to act towards it. People generate meaning to a situation by participating in it. Interpretivists emphasise the meaning of the reality as constructed by the people (men) who experience it. Researchers seek to understand meanings, values and ideas that the insiders (men) attach to the phenomenon (masculinity),

The researcher conducted semi-structured interviews with twenty-one participants to collect data for depth and comprehensiveness and not generalisation, with open-ended questions based on

- *Meta-theoretical assumption*: Interpretivism – there are many masculinities.
- *Ontology*: Internal reality of subjective experience of people with first-hand knowledge of masculinity (men).

- *Epistemology*: Contextual constructionism of interpretation of masculinity based on experience.
- *Methodology*: Qualitative enquiry and exploration of masculinity (Botma et al 2010:288).
- *Data collection*: semi-structured interviews
- *Sampling*: snowball to sample participants with different characteristics of age between 18 -24 years, occupation such as level of education (high school, tertiary) and employment status (employed, unemployed, intern, learner) for quality of data.
- *Analysis* – content analysis for themes and sub-themes

Qualitative research is based on the philosophical assumptions that realities are different and many, which make researchers rely on the views of participants about the phenomenon under investigation (Botma et al 2010:288). Researchers ask open-ended questions so that participants can construct meanings of the phenomenon (masculinity).

Researchers listen to participants and watch them as they interact in their natural environment to construct their social and historical meanings through historical and cultural norms. Because researchers realise that their own backgrounds can influence their interpretation, they spend a lot of time with participants to interpret the participants' meanings of their world. Meaning is generated from data (Creswell 20014:7). The researcher collected interviews until no new information emerged (data saturation) and for more than one year from July 2017 to July 2018 (prolonged engagement).

In this study, data was collected in semi-structured interviews to help participants construct their experiences of the positive values of masculinity and how they applied these values in the prevention of HIV and AIDS and teenage pregnancy. Semi structured interviews in private allowed participants to tell their personal stories.

1.8 RESEARCH DESIGN

The researchers' worldview determines the questions they ask and how they answer those questions. The questions may be answered by using quantitative of qualitative research designs.

A research design is a type “of enquiry within qualitative, quantitative and mixed methods” that guides that provides direction for how things will be done in a study (Creswell 2014:12). In this study, the researcher selected an interpretive, exploratory, descriptive and contextual qualitative research design (see chapter 3 for full discussion).

1.9 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. Ethical considerations are essential to the design of any research involving human subjects in order to protect the rights of the research participants. The goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from research activities. In this study, the researcher upheld the ethical principles of permission, beneficence, respect for people and human dignity, and justice.

1.9.1 Permission and protection of the institution and the community

Ethical approval and permission to conduct the study was obtained from the Departmental Higher Degrees Committee of the Department of Health Studies at the University of South Africa (see Annexure 2). Permission to conduct the study was obtained from the Chief (*Inkosi*) and the Headmen (*Izinduna*) of Nquthu sub-district in the north-eastern boundary of UMzinyathi District in northern KwaZulu-Natal Province (see Annexure 4), and from the Department of Health (see Annexure 4). The study was presented to the community at community meetings (*izimbizo*) with the permission of *Inkosi* and *Izinduna* to gain support and cooperation.

1.9.2 Beneficence

According to Polit and Beck (2014:83), participants should benefit from the research. The participants were informed that the results of this study would be used to design a health education handbook from participant perspectives for use in the community to develop young men to be responsible men in the prevention of HIV/AIDS and teenage pregnancy. Other benefits to the community included exploring the positive values of masculinity and their application in the prevention of HIV and teenage pregnancy; community education on the benefits of positive values of masculinity; adapting own culture in the light of new realistic information about the risks in a way that came from

within the community, based on science and not ideology, while taking into consideration respect for human rights, the Constitution and the law of the country; engaging in a dialogue regarding gender-based issues and training in non-violent conflict resolution. Reflecting on positive values would reinforce them while negative values and behaviour would not be reinforced. The principle of beneficence includes the right to freedom from pain or discomfort and the right to protection from exploitation.

1.9.2.1 Right to freedom from pain or discomfort

Researchers must ensure that participants do not suffer physical, social, financial or psychological harm (Polit & Beck 2014:83). No injections or withdrawal of blood was done, participants were interviewed in the comfort of their homes and inclusion and exclusion criteria did not include HIV status or any disease. They would not suffer persecution, stigmatisation or negative labelling by participating in the study. The researcher made arrangements for referral to a psychologist at the hospital for counselling if they showed signs of psychological distress such as crying due to self-disclosure and introspection. The participants were also informed that if they felt uncomfortable during the interview they could withdraw from the study even if they had signed a consent form and they would not be penalised and there would be no hard feelings or accusations. Participants did not travel for interviews and they did not prepare refreshments for the researcher. The interviews were conducted at times and places convenient to them, their homes, according to their preferences. The study was funded, however, before funding was received the researcher paid from private funds.

1.9.2.2 Right to protection from exploitation

The participants information should not be used against them, such as reporting illicit drug use to police, nor should the relationship be changed from researcher-participant to nurse-patient (Polit & Beck 2014:83). No participant confessed crime such as illicit drug use or rape. Even if they had confessed, confidentiality would not have been breached unless the researcher was subpoenaed by the court of law. The researcher obtained informed consent from the participants after explaining the purpose of the study (see Annexure 6). The tapes and transcripts are stored safely in a locked cupboard with limited access in the researcher's office. They will be stored for five years

and then the transcripts will be shredded and the recordings from the tapes will be deleted.

1.9.3 Respect for human dignity

This principle includes the right to self-determination and to full disclosure. In research it means that the participant has a right to freely make the decision to participate after the study and their rights to refuse or withdraw the study even after a consent form has been signed have been explained and received an information document (Polit & Beck 2017:744).

1.9.3.1 Right to self-determination

After full disclosure (explained below) the participants received a participant information document. Participants were informed that they would sign a consent form voluntarily if they wanted to participate in the study and that they could withdraw the consent at any time during the study. Those who were willing to participate were requested to sign consent.

1.9.3.2 Right to full disclosure

The researcher explained the following to the participants before requesting them to sign a consent form: the purpose and objectives of the study, the estimated time of the interview (45 minutes to 1 hour), no payment would be received for participating, benefits for the community in the form of the health education handbook, interviews in private away from other family members and friends, no names but codes would be used during the interviews, and no information would be shared without permission, no names of people would be mentioned in the report, the decision to participate was voluntary, the interviews would be recorded and they could refuse to participate without penalty or accusations.

The participants were also informed that they could withdraw from the study at any time should they so wish.

1.9.4 Justice

This principle includes the right to fair treatment and to privacy.

1.9.4.1 Right to fair treatment

Participant selection should be based on research requirements. Justice also means that those who would benefit from the research should not be excluded and those who refuse to participate or withdraw from the study should not be prejudiced (Polit & Beck 2014:85). The researcher honoured the inclusion criteria (Zulu male aged 1 –24 years of age, residing at Nquthu sub-district) and exclusion criteria (Zulu male <18 year and > 24 years of age or visiting Nquthu sub-district, male 18–24 years of age of another ethnic group residing at Nquthu sub-district because they might be different. There were no special benefits for participating in the study. The researcher honoured agreements with the participants regarding time and duration of data collection, respected their beliefs and lifestyles, and treated them politely and tactfully. The agreed duration of the interview (45 minutes to 1 hour) was not exceeded. Participant were encouraged to express their religious and traditional/cultural beliefs regarding masculinity freely. The researcher treated all participants with respect and did not judge them.

Those individuals who declined or withdrew from the study were treated politely and with tact by accepting their decision without accusations or arguments.

1.9.4.2 Right to privacy

Researchers must ensure that information from participants is not shared without their permission (Polit & Beck 2014:85). The participants' confidentiality and anonymity were maintained at all times. No information about participants and interviews was shared. Interviews were carried out in private away from family and friends and in places and times preferred by the participants, their homes. No names were mentioned during the interview. During result dissemination, no names of people and places would be identified.

Although the researcher would be seen visiting homes of participants, the study did not stigmatise participants because inclusion and exclusion criteria had nothing to do suffering from a disease such HIV or sexual orientation or testing for any disease.

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1.10 DEFINITIONS OF KEY CONCEPTS

For the purposes of this study, the following key terms were used as defined below.

- **AIDS – Acquired immune deficiency syndrome**. AIDS is when the immune system of an HIV positive person is severely compromised and the person becomes sick (Centers for Disease Control [CDC] 2015:2).
- **HIV** infection in adults and children >18 months of age means a positive human immunodeficiency virus rapid or laboratory-based immune-assay test result confirmed by a second and different test. In children <18 months of age it means a positive HIV test result confirmed by two different tests done more than 4 weeks after birth (WHO 2007:8).
- **Man among men** – In this study means a man of essence.
- **Masculinity** – 'what it means to be a man' (Gennrich 2013:6; Stern et al 2015:341); 'positioning in relation to hegemonic masculinity', 'a set of ideals for masculine performance' (Blackbeard & Lindegger 2014:2301-2218) and 'how men evaluate and position themselves within gender and age hierarchies' (Gibbs et al 2014:23676). In this study, masculinity referred to the meaning of being a Zulu man as described by the participants.
- **Positive values of masculinity.** In this study, positive values of masculinity referred to the principles of behaviour of a man that help to prevent HIV and AIDS and teenage pregnancy.
- **Teenage pregnancy rate.** In this study, the teenage pregnancy rate referred to a number of births including stillbirths, abortions and miscarriages per 1000 women aged 15-19 years (Panday, Makiwane, Ranchod & Letsoale 2009:26).
- **Teenage/adolescent pregnancy.** In this study, teenage/adolescent pregnancy meant births including stillbirths, and abortions to women < 20 years.
- **Rural KwaZulu-Natal.** In this study, rural KwaZulu-Natal referred to Nquthu sub-district in KZN.

1.11 OUTLINE OF THE STUDY

The study consists of six chapters.

Chapter 1 Orientation to the study

Chapter 2 Theoretical foundation and framework

Chapter 3 Research design and methodology

Chapter 4 Data analysis and interpretation and findings

Chapter 5 Conclusions, limitations and recommendations

Chapter 6 Development of health education handbook and health education programme

1.12 CONCLUSION

This chapter described the research problem, purpose, aim and objectives, theoretical framework, paradigm and research design of the study. Ethical considerations were discussed and key terms defined.

Chapter 2 discusses the health promotion model (HPM) as theoretical foundation and framework of the study, global and national perspectives on the prevalence of HIV and AIDS and teenage pregnancy, and the literature review.

CHAPTER 2

THEORETICAL FOUNDATION AND FRAMEWORK

2.1 INTRODUCTION

This chapter discusses the health promotion model (HPM) and how it guided the study. The chapter describes the prevalence of HIV and AIDS and teenage pregnancy from a global and national perspective, effects of HIV on women, effects of teenage pregnancy on young girls, and the values of masculinity in relation to the prevention of HIV/AIDS and teenage pregnancy. The values of masculinity are discussed from the psychological, health system, and cultural perspectives.

2.2 HEALTH PROMOTION MODEL (HPM)

The terms *conceptual models*, *conceptual frameworks* or *conceptual schemes* are often used interchangeably because they are related to a common theme. However, they do not explain relationships among concepts and are not tested formally (Polit & Beck 2017:119).

Although generic qualitative researchers are warned against the use of a “priori theory” that is selected before data collection, the researcher selected Pender’s (2011) health promotion model (HPM) as the foundation of the study. Merriam (2009) and Thorne (2008) “leave space for individual researchers to take up theoretical frameworks that make sense in the context of the research question and design of individual research projects” (Kahlke 2014:43). Second Kahlke (2014:43) states that “methodologists who insist that research must fit within an established methodology are engaging in methodolastry” which is criticised for stifling and unnecessary because all methodology has history of change. According to Salowski (in Kahlke 2014:43), it is impossible to practice any research method according to book. With this in mind, the researcher deemed it necessary to use the HPM in this study.

The HPM was selected to guide the design of the semi-structured interview guide and the interviews. It focuses on promoting health through a wellness orientation or

developing resources that maintain or promote health (Polit & Beck 2014:137). The HPM describes factors in context that influence health behaviour on which nurses can base counselling to promote healthy behaviour. It can be used to prevent situations that interfere with health promotion behaviour and promote healthy behaviours that influence the avoidance of unhealthy behaviours. The researcher considered the HPM appropriate for this study that would be done in the context that influences masculine behaviour that promotes or prevents HIV and AIDS and teenage pregnancy from participants' perspectives. Data that was obtained from the study would be used to develop a health education handbook for males for prevention of HIV and AIDS and teenage pregnancy.

2.2.1 Theoretical roots of the HPM

Pender maintained that by participating in their own self-care, patients can prevent illnesses and disease and help ensure they have better overall health. Pender's HPM is widely used to plan for and change unhealthy behaviours and promote health.

2.2.1.1 Expectancy-value theory

According to the expectancy-value theory of achievement motivation, the motivation to perform (in this case, a health promoting behaviour) is determined by how much individuals value the goal or success and whether they expect or are confident to succeed (expectancy or self-efficacy). Motivation depends on expectancy or self-efficacy. No matter how big the value, if expectancy is low, motivation is likely to be low. If the expectancy is high, motivation will also be high provided that the goal is valued (Wigfield & Eccles 2000:68).

2.2.1.2 Social cognitive theory (SCT)

According to Bandura's social cognitive theory (SCT), learning occurs in a social context which includes the physical setting and the culture in which one was raised with a dynamic and reciprocal interaction of the person, environment, and behaviour (McLeod 2016:1). The SCT is based on several basic assumptions, such as (1) learning occurs by observing others (models) who demonstrate the behaviour; (2) learning depends on the ability to perform a behaviour (behavioural ability); (3) internal and external

responses (reinforcements) determine if the behaviour continues or discontinues; (4) expected consequences (expectations) based on previous experience determine success, and (5) individuals' confidence (self-efficacy) in their ability to perform a task/behaviour successfully determines motivation to perform the behaviour (McLeod 2016:1).

2.2.2 Concepts in nursing that are a basis for the HPM

The following concepts are a basis for the HPM.

A **person** is a biological, psychological and social being whose behaviour is shaped by the environment, and who also wants to shape the environment in order to develop and live life to full capacity. A young man's mental and emotional state is shaped by the expectations of the society or community in which he lives. Thus, the relationship between person and the environment is mutual. A person's behaviour is the sum of his attributes and life experiences (Pender 2011:3). In this study "person" referred to a young Zulu man residing in Nquthu sub-district.

Environment is the community-based (social), customs (cultural) and physical setting in which a person lives. It can be changed by individuals to facilitate health-enhancing behaviours. An environment that promotes risky behaviour can be changed by its inhabitants to one that promotes safe behaviour (Pender 2011:3). In this study, the environment referred to the community-based ideas, culture and physical setting of Nquthu.

Nursing is working together with individuals, families and communities to create the most positive environment to promote good 'health and high level well-being' (Pender 2011:3). In this study, nursing referred to working together with the young men, their families and the community of Nquthu to create a positive environment that promotes prevention of HIV and teenage pregnancy.

Health is the realisation of one's intrinsic and extrinsic potential through having purposeful behaviour, the ability to make decisions to be and stay physically and mentally healthy, and having fulfilling relationships with others while making adjustments to live in harmony with the environment (Pender 2011:3).

In this study, health referred to purposeful behaviour and decisions by a young man to prevent acquiring or transmitting HIV or impregnating a girl.

Illnesses are unconnected acute or chronic events throughout life that hamper or ease the pursuit of well-being (Pender 2011:3). In this study, illness referred to events that hampered the pursuit of the prevention of HIV and teenage pregnancy.

2.2.3 Factors that influence health promoting behaviours

This section summarises the literature review on factors that affect performance of behaviour that prevent HIV and AIDS and teenage pregnancy. According to the HPM, health promotion behaviour is influenced by personal elements such as individual characteristics and experiences (personal, biological, psychological and social factors and prior behaviours); interpersonal influences from family, peers and providers; situational influences and behavioural specific cognitions and affects (perceived benefits of action, perceived barriers to action, perceived self-efficacy, and activity related affect).

HIV and AIDS continue to be a significant public health challenge in South Africa. The prevention of this chronic disease requires a combination of behaviours such as safe sex and adherence to ART. It is crucial for young men to adhere to recommended health care programmes in order to maintain an HIV-negative status or prevent transmitting HIV to their sexual partners. The following examples show the relationship between various determinants of health promoting behaviours involved in HIV prevention and the overall health outcomes.

2.2.3.1 Personal factors

The HPM categorises personal factors as biological, psychological or sociocultural. The general characteristics of the individual that influence health behaviour include age, personality, race, ethnicity and socioeconomic status. Individual-level factors include perceptions, beliefs, or emotions (Pender 2011:8).

In a comparison of geographic network characteristics of Black, White and Latino young men as potential possible risk factors to racial disparities in HIV, Mustanki, Birket, Kuhns, Latkin and Muth (2014:1037) found no racial differences in engagement in HIV risk behaviours. However, racial differences that were found were due to network characteristics of partners such as gender, age and residence in high prevalence areas.

Personal factors in non-adherence to ART include forgetting to take treatment, being away from home, changes in daily routine, alcohol and drug abuse, cost of transport and treatment, age and mental illness. Medication-related factors include side effects and complex dosing (WHO 2016b:255). Mental health problems cause forgetfulness, poor organisation, poor understanding of treatment health plans and depression. Lack of counselling and depression and medical treatment for people with mental health problems may worsen lack of adherence (WHO 2016b:256).

Non-adherence to treatment due to personal factors such as forgetting, medication factors such as side effects and mental ill health such as depression would prevent viral suppression and cause continued transmission of resistant strains of HIV that are difficult to treat.

2.2.3.2 Interpersonal influences

According to the HPM, interpersonal influences include social norms, social support and role models (Pender 2011:8). Young women in southern Africa have the highest HIV incidence in the world, with prevalence increasing rapidly between adolescence and young adulthood due to social and structural factors, such as gendered social norms, which favour male power in sexual relationships and relationships between older men and younger women (Harrison, Colvin, Kuo, Swartz & Lurie 2015:207). Thus men tend to decide when and how to have sex and with whom and make it difficult for women to negotiate condom use.

Noroozi, Esmaili, Tahmasebi and Vahdat (2016:e62592) examined the effect of health-promotion education on adherence to ART and found that family and friend support significantly increased adherence. Going for HIV testing with a sexual partner rather than alone was a motivation for testing as it allayed anxiety and was calming (Logie,

Lacombe-Duncan, Brien, Jones, Lee-Foon, Levermore, Marshall, Nyblade & Newman 2017:21385).

Interpersonal characteristics among college-age men in the United States associated with not disclosing STI status included casual sex partnerships and substance abuse (Pfeiffer, McGregor, Van Der Pol, Hansen & Ott 2016:206). Masculinity is associated with not disclosing STI status. It may also be a reflection of unequal power relations between sexual partners. For every 1-unit increase in masculinity score the chances of disclosing were 15.0% higher among college-age men in the United States. The students had answered questions that measured masculinity such as “a man does not show his true feelings when he is hurt” and “the man gets his way in relationships” (Pfeiffer et al 2016:206).

2.2.3.3 Perceived benefit of action

The perceived benefit of action refers to perceptions of positive results of performing health promoting behaviour (Pender 2011:4). In this study, it referred to perceptions of positive results of behaviours that prevent HIV and teenage pregnancy such as not impregnating a girl. Young men commit to less risky sexual behaviours if they think they will benefit from them.

Knowing one’s HIV status was associated with information to remain negative or stay healthy and accessing ART (Logie et al 2017:21385).

Perceived benefits of HIV testing influenced the decision to get tested for HIV among adolescents and supported the need to increase their knowledge about HIV testing (Schnall, Rojas & Travers 2015:246). The perceived benefit of use of condoms was significantly associated with condom use among adolescents ($p<0.001$) (Xu, Chen, Yu, Joseph & Stanton 2017:31).

2.2.3.4 Perceived barriers to action

Perceived barriers to action refer to perception of the obstacles, stumbling blocks, obstacles and personal price of performing a health behaviour. Perceived barriers can prevent commitment to action, a go-between of behaviour as well as actual behaviour.

For example, if a young man thinks that there are difficult obstacles to performing less risky sexual behaviour, he is less likely to commit to performing behaviour that prevents HIV and teenage pregnancy (Logie et al 2017:21385).

The more/greater the perceived self-efficacy, the less perceived barriers to the behaviour. If a young man is confident that he is able to overcome obstacles to preventing HIV and teenage pregnancy, he is likely not to perceive obstacles (Pender 2011:4).

In this study, it referred to obstacles to performing behaviour that prevents HIV and teenage pregnancy such as unavailability of condoms or HIV testing services (HTS). In a study in Kingston, Jamaica on barriers and facilitators to HIV testing among men, Logie et al (2017:21385) identified barriers such as ill-treatment by healthcare providers, breach of confidentiality and stigma, and facilitators such as benefit of knowledge, social support, and enhanced access to testing.

Breach of confidentiality. Participants explained that HIV services in some clinics were not integrated with other health services which made them fear that they might be seen by members of the community who would know that they went to seek HIV-related services (Logie et al 2017:21385). Similar results were found by Azia, Mukumbang and Van Wyk (2016:a476) who conducted a study in the Western Cape, South Africa on barriers to adherence to ART among patients on ART. The patients feared “unintended disclosure” if they were seen using the ART clinic or interacting with a community HIV health-care provider.

Stigma. Participants expressed fear of stigma related to a positive HIV result due to the perception that HIV infection was life threatening and fear of rejection by friends and sexual partners (Logie et al 2017:21385). I a survey in America in 2012 it was found that stigma was a problem that prevented participants from telling their partners about their HIV status and discussing safe sex with them (CDC 2018:2). In the Western Cape stigma seemed to be an issue in patients who feared being seen at the ART clinic and with the community HIV health care provider and poor handling of HIV results made patients fear stigmatization (Azia et al 2016:a476).

Bullying. Bullying and other forms of violence may lead to mental distress and risky behaviours that increase chances of HIV infection (CDC 2018:2).

High rates of STIs. The presence of an STI increases the chances of HIV infection if exposed to HIV (CDC 2018:2).

Barriers to ART as prevention. In Vancouver, Canada, Knight, Small, Thomson, Gilbert and Shoveller (2016:262) investigated barriers to and opportunities for ART as prevention. Barriers included lack of knowledge regarding effectiveness, side effects and availability ART, and cost of ART. Enhancers included protecting their sexual partners and the interest of public safety. Initially participants stated that they were not well informed about ART and would perhaps consider ART if they knew about its availability and effectiveness. After receiving information about its effectiveness and availability, they expressed concern about cost, especially those living on the street and with addiction issues. After they were informed that ART was free, they wanted to know the risk-benefit ratio in terms of side effects. If side effects were serious, they probably would not consider it. Azia et al (2014:a476) in the Western Cape found the following barriers to ART: stigma, poor treatment literacy, lack of follow-up, alcohol abuse, emotional distress, feeling better, using traditional medicine and forgetfulness.

Perceived barriers to long-term viral suppression were poor socioeconomic status leading to living on the street, lack of daily routine, and lack of food. Previous mental illness was also mentioned as a barrier to long-term treatment (Knight et al 2016:262).

Barriers to condom use. Participants indicated viral suppression as a barrier to condom use (Knight et al 2016:262). Pre-exposure prophylaxis (PrEP) was not found to be associated with decreased condom use (WHO 2016b:55). Cumber and Tsoka-Gwegweni (2016:479) conducted a study on barriers to condom use among street youth in Kenya and found that lack knowledge that condoms protect from HIV infection (15%) was the cause. According to Beksinska, Smit and Mantel (2012:54), in South Africa the following factors were associated with inconsistency (in both sexes) and incorrect use of condoms namely: use of oil-based lubricants, alcohol and drug use, inserting the penis into the vagina before wearing a condom, vaginal practices such as inserting substances to dry the vagina, condom breakage, unacceptability associated with decrease in sexual pleasure, stable relationships and low quality (easy breakage,

unpleasant smell, noiseand too much lubricant. The other factors that they found included gender based violence towards women, socio-economic factors causing women to depend on men and leading to sexual or verbal or physical abuse if they introduce a condom. The service level factor was failure to distribute condoms associated with negative attitudes.

2.2.3.5 Situational influences

Situational influences (options, demand characteristics, aesthetics) refer to perceptions of the compatibility of life context or the environment with engaging in health behaviour. Situational influences (context) can support or discourage commitment to performance of a health-promoting behaviour (Pender 2011:4). Situational influences in this study referred to the environmental factors that prevent or enhance performance of health promoting behaviours that prevent HIV and AIDS and teenage pregnancy, such as peer pressure.

Close proximity to and cost-free HIV testing services promoted HIV testing (Logie et al 2017:21385).

Barriers to adherence to ART include absence of a supportive environment, stigma and discrimination, long distances from health facilities, long waiting times and receiving only one month's supply of ART and stock-outs / running out of supplies. Adolescents have sub-optimal adherence due to peer pressure to conform and inconsistent daily routine, not being involved in decision-making, absence of adolescent-specific adherence counselling package, issues of disclosure to peers or partners, difficulty accessing ART clinics, lack of integration of adult and paediatric services, and inadequately skilled health workers (WHO 2016b:255).

According to Svanemyr, Amin, Robles and Greene (2014:S7), it is necessary to create an enabling environment for adolescent sexual and reproductive health. Svanemyr et al (2014:S9-S14) found the following:

- A parenting programme to improve communication between parents and their teenage children in Miami resulted in decreased incidence of STIs and unprotected sex at last sexual encounter among intervention groups.

- Programmes that promote communication about reproductive health issues between sexual partners, such as peer-focused programmes, mentoring and positive role modelling, promoted equitable gender norms and attitudes, increased condom use and delayed sexual debut, and reduced STIs.
- Empowerment programmes for girls such as cash transfer in Tanzania and Malawi resulted in fewer STIs, lower HIV prevalence and fewer teenage pregnancies by reducing risky sexual behaviour.
- Creating a safe space for girls where they could meet to learn negotiation skills, vocational skills training, literacy training and financial literacy were implemented in Egypt and improved knowledge on health issues.
- Keeping girls at school was found to reduce chances of having sex, prevalence of HIV, early sexual debut and number of sexual partners, and increase condom use in eastern, southern and central Africa.
- Promoting equitable gender norms and discouraging values of masculinity that perpetrate risky sexual and health risks, violence and unequal decision making, heterosexual norms that promote homophobia.
- Promoting alternative ways of understanding masculinity and behaviours among adolescent boys, such as mutual decision making with sexual partners, respect, and involvement of fathers reduced HIV prevalence.
- Mass media campaigns such as *Soul City* improved awareness, knowledge and attitudes to health-promoting behaviours.
- A community intervention called “stepping stones” in South Africa for men and women aged 15-26 years to improve sexual health, gender equitable norms, communication and relationship skills resulted in 33% decline in HIV incidence, lower violence perpetration of among males, reduction of risky sexual behaviours, and reduced acceptability of violence.
- A community programme in Ethiopia to reduce the prevalence of child marriages improved girls’ school enrolment, age at marriage, reproductive health knowledge and use of contraceptives.

2.2.4 Health-promoting behaviours

A health-promoting behaviour is “the desired end point or outcome of health decision-making and preparation” (Pender 2011:4) for HIV and teenage pregnancy prevention

action. The following risk behaviours that predispose youth to HIV infection must be avoided, namely little or no testing; substance abuse; little or no condom use, and having multiple sexual partners (CDC 2018:2).

Consistent and correct condom use, reducing sexual partners, voluntary medical male circumcision (VMMC), HIV counselling and testing (HCT) and adherence to antiretroviral treatment (ART) are health-promoting behaviours.

2.2.4.1 HIV testing services (HTS)

HIV testing services (HTS), are available in all public health facilities in South Africa to scale-up HIV testing in order to identify HIV-infected individuals for ART as soon as possible (NDOH 2015c:14). HTS includes pre- and post-test counselling and linkage to HIV prevention treatment and care services. Its delivery approaches include provider-initiated counselling and testing (PICT), client-initiated counselling and testing (CICT), community-based counselling and testing, partner and couple counselling, and HIV self-testing (HIVST) (NDOH 2015c:14).

2.2.4.2 Adherence to ART as prevention

Adherence to ART enhances viral suppression and reduces the risk of HIV transmission, AIDS and death. According to the WHO (2016b:77), all linked partner infections occurred before viral suppression by ART. No linked partner HIV infections occurred after HIV-infected partners on ART achieved viral suppression (WHO 2016b:77). Before initiation of ART, patients should be counselled about willingness and readiness to start ART, the drug regimens, dosing, benefits, side effects, follow-up care and adherence.

Noroozi et al (2016: e62592) provided two educational sessions to an intervention group with two weeks interval while a control group received routine care. After the intervention, 96.8% of the intervention group had >95.0% adherence to ART versus 56.7% of patients in the control group.

Oral pre-exposure prophylaxis (PrEP) should always be given in combination with the HIV prevention package such as HCT, condom distribution, early diagnosis and

treatment of STIs, adherence counselling and contraception for women. Pre-exposure prophylaxis (PrEP) among sero-discordant couples has proved to be protective to HIV-negative partners if adherence is high. A study comparing PrEP with a placebo showed a 51% risk reduction of HIV infection for PrEP compared to placebo in high adherence groups (WHO 2016b:53). It did not affect the effectiveness of hormonal contraception because no significant relationship was found between higher rates of pregnancy among women on oral contraceptives who used PrEP. Adherence to PrEP may be facilitated by counselling clients to link taking the medication to daily routines, such as a regular meal, or joining a support group, and counselling about the immune reconstitution inflammatory syndrome (IRIS). Counselling should also include informing clients that PrEP can be discontinued when they are no longer at risk and that it is protective after seven doses (WHO 2016b:53).

The WHO guidelines on HIV post-exposure prophylaxis (PEP) do not differentiate between HIV exposure sources but recommend PEP across all exposures. It should be given to HIV-negative clients preferably within 72 hours of exposure to body fluids (excluding tears, non-blood stained saliva, urine and sweat) of HIV-positive sources. However, providers should consider a range of treatment options and referrals for clients who present after 72 hours. It should be taken for 28 days after enhanced adherence counselling which includes assessment of baseline individual needs, adherence counselling and follow-up telephone calls (WHO 2016b:61).

2.2.4.3 Male and female condoms and condom compatible lubricant

An estimated 80.0% reduction in heterosexual transmission of HIV occurs if a male condom is used correctly and consistently. There is limited data regarding the efficacy of female condoms, although they may have a protective effect like male condoms. Condoms should be used even if patients are on ART including PrEP and PEP (WHO 2016b:64).

2.2.4.4 Voluntary medical male circumcision (VMMC)

An estimated 60.0% reduction of female-to-male sexual transmission of HIV was found after VMMC. VMMC is recommended as a strategy for the prevention of heterosexual transmission of HIV to men (WHO 2016b:64). It is also recommended as part of the

comprehensive HIV-prevention package including sex education, HCT and linkage to care, condom distribution and use, and management of STIs (WHO 2016b:64).

2.2.4.5 Prevention of HIV to drug users

Using sterile needles is associated with a reduction of HIV infection to injecting drug users. Substitution of opioids with methadone or buprenorphine for treatment of opioid dependence reduces HIV risky behaviours and transmission through injecting drugs. Substitution of opioids also increases adherence support to patients who are on ARVs (WHO 2016b:64).

2.3 PREVALENCE OF HIV AND AIDS

This section discusses HIV and AIDS prevalence from a global and national perspective to show the immense burden of disease in South Africa.

2.3.1 Global HIV and AIDS

In 2014, an estimated 36.9 million people globally were living with Human Immunodeficiency Virus (HIV) or Acquired immune deficiency syndrome (AIDS) with about 2 million new infections, of which 1.8 million were adults. HIV infection among young people aged 15-24 years accounted for approximately 30% of new infections worldwide (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2015a:1). HIV prevalence in the countries that are deemed to be at a similar stage of newly advanced economic development seems to be low. The HIV prevalence in Brazil and Russia 0.6% and 0.8% respectively in 2016 (CDC 2018:3).

2.3.2 HIV and AIDS in sub-Saharan Africa

In 2014, approximately 25,8 million or 70.0% of people living with HIV and 66% of all global new HIV infections were in Sub-Saharan Africa, and most (63%) were women (UNAIDS 2015a:3). High HIV prevalence countries in Eastern and Southern Africa include Botswana, Lesotho, Namibia, Swaziland, Zambia, Zimbabwe (UNAIDS 2016:13) In 2017 HIV prevalence in Swaziland was 27%, 25% in Lesotho, 21.9 in Botswana and 18% in South Africa (UNAIDS 2018:13).

2.3.3 HIV and AIDS in South Africa

South Africa has the highest prevalence of HIV and AIDS in the world especially among women, with a national HIV prevalence rate amongst antenatal clinic attendees stabilising at 29.0% to 30.0% since 2007. This prevalence is higher than the general population estimate (17.3%) since 2005. In 2012, an estimated 469,000 children 2 years and older in South Africa were living with HIV. Among adults aged 15-49 years, females were 1.7 times more at risk than males in the same age group. Females aged 15-24 years were four times more at risk of HIV than their male counterparts, and 24.1% of the HIV infections were among females aged 15-24 years in 2012 (Shisana et al 2014:xxix). In 2015, 7 million South Africans were living with HIV with a prevalence of 19.25% among adults and 380 000 new infections (Avert 2017a:1).

In 2016, an estimated 7 104 796 people aged 15-49 were living with HIV in South Africa, accounting for 10.0% of the global HIV prevalence. Although HIV is generalised in South Africa, it is over-represented in some populations (sex workers and men having sex with men) and concentrated in teenage girls and young women (UNAIDS 2016b:1).

This is due to orphanhood and sexual abuse in childhood which increase the risk of risky sexual behaviour such as multiple partnership and the probability of HIV infection. Other causes include gender-based violence, gender norms, perceptions of masculinity and power relations that are associated with physical and sexual intimate partner violence. Barriers to accessing sexual and reproductive health and HIV services include age of consent stigma and service provider bias (UNAIDS 2016c:3).

South Africa has the largest ART programme in the world with 3 494 260 people on ART at the end of September 2016. However, more than 3 million people in South Africa are still in need of ART **(**UNAIDS 2016a:3**)**.

2.3.4 HIV and AIDS in KwaZulu-Natal

In 2013, KwaZulu-Natal (KZN) Province had the highest antenatal HIV prevalence (37.4%) in South Africa (NDOH 2013a:19). The general population of KZN had a higher HIV prevalence (16.9%) in comparison to the national prevalence (12.2%).

Approximately, 16% of South African people between the ages of 15-49 years of age who are living with HIV are in KZN (KZNDoH 2016:2). In 2000, the Department of Health (2000:9) indicated that the factors responsible for the high rate of HIV included poverty, sexual violence and the low status of women.

2.3.5 HIV and AIDS in uMzinyathi district

uMzinyathi District is in a high HIV prevalence area. In 2012, the HIV type-2 prevalence in the area was 16-22% with a prevalence of 12% among women aged 15-24 years (Shisana et al 2014:48). HIV AIDS and AIDS-related diseases, such as pulmonary tuberculosis (PTB), pneumonia, meningitis and gastroenteritis, are among the top ten causes of death among adults in uMzinyathi district.

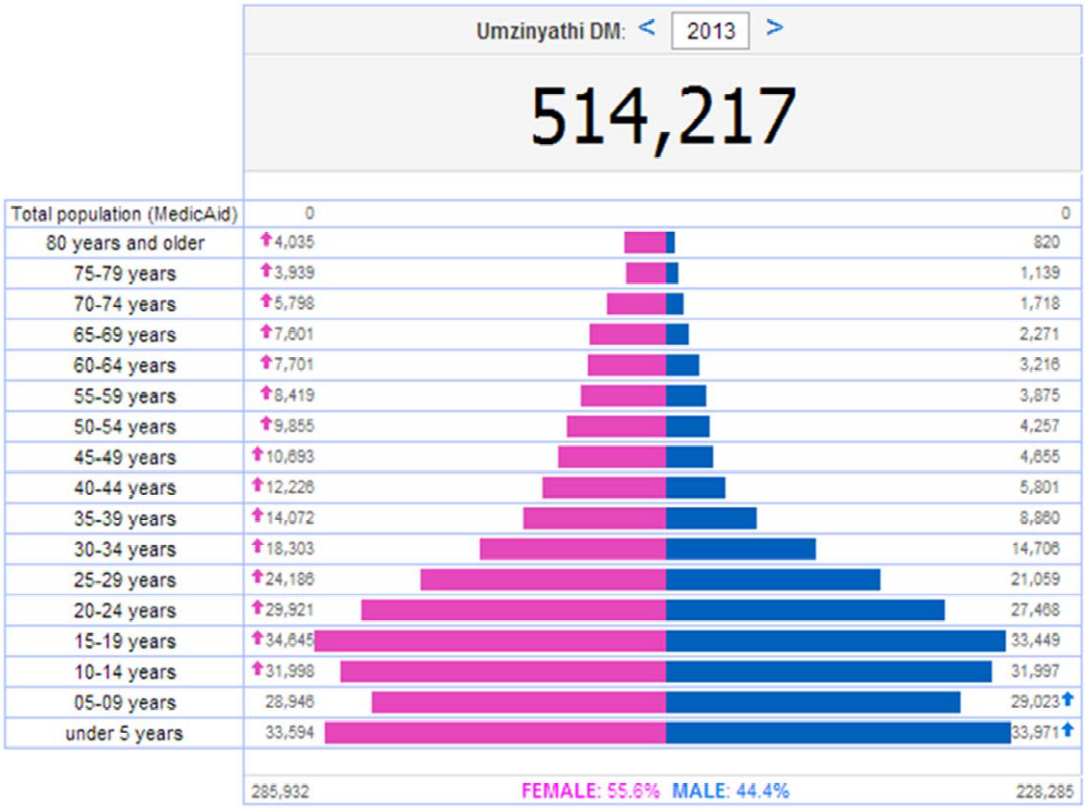

Figure 2.1 Population pyramid of uMzinyathi district, 2011

(Source: *uMzinyathi District Health Plan* 2015/2016:27)

Figure 2.1 indicates that uMzinyathi district has a youth broad base population pyramid, with the majority (72%) under <35 years of age. The young population poses a problem because in South Africa there is a high HIV prevalence rate among youth, especially in

KZN (Shisana et al 2014:48). The tapering of the population pyramid approaching age >35 years indicates that there is a high mortality rate in the district and short life expectancy. The elderly population constitutes only 7.0% of the population. There is a sharp decrease of population aged between 0-5 years, 20-24 and 40-44 years. The decline between population groups aged 20-24 and 40-44 years of age can be attributed to HIV and AIDS, TB and injuries. As a result of a high mortality rate, uMzinyathi has a high rate of child, youth and female headed families (see table 2.1).

Table 2.1 uMzinyathi district organisational unit

Organisational unit	Value
Household head age 10-15 years	0.6%
Household head age 16-19 years	1.9%
Household head age 20-24 years	5.2%
Household head age 25-65 years	74.6%
Household head age 66-84 years	15.9%
Household head age 85 years and older	1.8%
Household head gender – female	59.0%
Household head gender – male	41.0%

(Source: uMzinyathi District Health Plan 2015/2016:26)

Table 2.1 shows that there are households headed by children as young as 10-15 years of age. Males seem to have a lower life expectancy than females probably due to risky occupations and behaviour that may lead to dying prematurely and hence more (59%) households are headed by females. The low life expectancy appears to be responsible for the sharp decline (58.7%) between families headed by 25-65 and 66-84 year-olds. Only a minority (1.8%) of elderly people 85 years and older are heads of families (KZNDoH 2015:26).

2.3.6 Prevalence of HIV among young people

In 2016, an estimated 2 million adolescents globally were living with HIV (WHO 2016a:2). This increases the probability of adolescent death as HIV is the top cause of death among adolescents, especially in Africa. This may mean that more children who survive HIV to adolescence do not receive the care they deserve to prevent death and

transmission of HIV. An estimated 15% of youth between ages 15-24 years who live in sub-Saharan Africa are not aware of their HIV Status (WHO 2016b:1).

2.3.7 Effects of HIV and AIDS

HIV and AIDS infection have a negative physical, psychological and immunological impact on the health of women.

In a study on the prevalence and impact of body physical changes in patients treated with highly active ART, Cabrero, Griffa and Bugos (2010:6) found no significant gender differences in the body physical changes (BPC) of patients receiving antiretroviral treatment. However, women significantly reported more lipo-atrophy of lower limbs and buttocks and lipo-hypertrophy than men. These changes affected their lives negatively due metabolic diseases such as dyslipidaemia, diabetes mellitus and insulin resistance.

According to Ho and Holloway (2016:8), women with HIV infection are susceptible to gender-specific stigma and stereotyping as HIV infection is often associated with transactional sex and other deviant social behaviours. Intimate partner violence and emotional abuse is associated with rapid decline of CD4+ and CD8+ T cell count in HIV-infected women (Jewkes, Dunkle, Jama-Shai & Gray 2015:1).

In 2003, Cruess, Antoni, Gonzalez, Klimas, Duran and Ironson (2003:185) studied the relationship between psychological distress, perceived sleep disturbance and immunological response among HIV-infected men and women. Cruess et al (2003:185) found an association between psychological distress, poor sleep and lower CD4 cell counts. Illangasekare, Burke, McDonnell and Gielen (2013:2831) found that violence, substance abuse, and HIV infection were associated with depression in abused low-income urban women.

2.3.8 HIV prevention activities in South Africa

South Africa responded to the HIV epidemic by introducing a variety of HIV-prevention programmes.

2.3.8.1 Antiretroviral therapy (ART)

Before 2004, ART was inaccessible in the public sector. Those who needed ARVs could only access them in the private sector “through private funds, workplace programmes, research projects or medical aid schemes” which began providing ART in the early 2000s. Medical aid schemes were legally bound to provide HIV care as part of the prescribed minimum benefits (NDoH 1999).

The ART programme in public health facilities started in 2004 in selected districts and sites with guidelines that were in line with those of the WHO. Treatment readiness was based on criteria such as absence of depression and medical criteria such as CD4 count <200 cells/mm^3 or stage four disease, and disclosure to at least one person who would be a treatment supporter (NDOH 2004:2). In 2013 and 2014, the Department of Health (2013a:6; 2015b:5) increased the CD4 count at which HIV-infected patients could be initiated on ART to 350 and 500 cells/mm^3 respectively, allowing more people to access ART. By April 2014, there were more than 3 million (48%) people on ART in the country compared to 31.2% in 2015 (UNAIDS 2016b:1).

In 2016, the Department of Health started implementing universal test and treat (UTT)), according to the recommendations of the WHO to start people living with HIV on ART following diagnosis, irrespective of the CD4 count (NDoH 2016a; 2016b:1). UTT is aimed at eliminating HIV as it reduces HIV infectivity and transmission. It is predicted that UTT will eliminate HIV in South Africa within 10 years (KZNDoH 2016:6).

Nurse Initiated Management of ART (NIMART), a government initiative to facilitate access to ART, is a decentralisation of ART to PHC facilities. Nurses are trained and mentored in NIMART to relieve the burden of uncomplicated cases at hospitals and to strengthen adherence to treatment (Nyasulu, Muchiri, Mazwi & Ratshefola 2013:1). According to the KZNDoH (2016:7), NIMART results in facility decongestion as follows:

- NIMART facilitates access to ART.
- Spaced and fast lane appointment systems also known as Repeat Prescription Collection Strategies. Patients with chronic conditions have a special queue to collect treatment from a pharmacy or consulting room in a clinic.

- Adherence clubs. Patients from same neighbourhood form support groups voluntarily under the facilitation of a community caregiver in order to support and collect treatment for each other.
- Central Chronic Medication Dispensing and Distribution (CCMDD). To facilitate adherence to chronic medication, treatment is delivered by a contracted service provider to a convenient community-based pick up point where patients pick up their treatment at a time convenient to them without waiting in long queues in a health care facility.

In 2015, South Africa was the first country in sub-Saharan Africa to fully approve PrEP to protect HIV-negative people before exposure to HIV and South African guidelines were put in place in 2016. The uptake and impact among women and girls in high HIV prevalence areas such as KZN are being investigated (NDOH 2016b:5).

2.3.8.2 Condom distribution and use

In response to the HIV epidemic, South Africa made free male and female condoms available. Between 2007 and 2015 South Africa increased condom distribution from 308.5 million to 723 million per year. The distribution of female condoms in the same period increased from 3.6 million to 25 million. The targets for condom distribution in 2016 were 1 billion male condoms and 20.7 million female condoms. However condom use in the last sexual encounter fell from 85.0% in 2008 to 68.0% in 2012 among young people aged 15-24 years (Avert 2017b:6).

2.3.8.3 HIV education

South Africa implemented the HIV and AIDS life skills programme in public primary and secondary schools in South Africa from 2000 onwards under the Intergrated School Health Programme (ISHP) (NDoH 2013c) under the mandate of the HIV and AIDS policy in schools (NDoBE 1999). The objective of the ISHP was to make youth-friendly, sexual and reproductive health (SRH) services available in schools, strengthen HIV-prevention efforts and encourage young people who were HIV negative to remain negative (NDoH 2013c:1). However, implementation of the ISHP in schools dropped from 60.0% in 2013 to 20% in 2014. Contributing factors included lack of capacity on SRH issues, resistance due to discomfort regarding sex education. High school

dropouts also compromised HIV and sex education (Amhed, Fisher, Mathews, Mukoma, Jansen 2009:48).

2.3.8.4 HIV awareness

According to Johnson, Kincaid, Figueroa, Delate, Mahlasela and Magni (2013:vi) WHO conducted The Third National Communication Survey on HIV/AIDS in 2012, it was found that HIV communication programmes had a positive effect among youth 15-24 years of age resulting in an increase in condom use and uptake of HIV testing and counselling (HTC) and male circumcision. HIV awareness campaigns included:

- **Love Life**

The Love Life campaign was launched in 1999 as a joint initiative of South African non-government organisations (NGOs) and the Government to use a variety of media to reduce the incidence of HIV among teenagers (12-19) through outreach and support programmes. The programme uses peer educators as facilitators and runs youth centres to provide sexual and reproductive health services (Avert 2017b:7)

- **Soul City and Soul Buddyz**

Soul City and Soul Buddyz are two television series intended to raise HIV awareness and to promote health and social change. Soul City was launched in 1994 by the Soul City Institute for Social Justice and Institute for Health and Development Communication (SC IHDC). Soul City targeted adults and Soul Buddyz targeted children. Both programmes significantly increased knowledge and promoted behavioural change. Topics raised in the series are further debated on radio and have been covered in easy-to-read booklets (soulcity.org.za; Avert 2017b).

- **MTV Shuga**

Shuga, also known as MTV Shuga, is an international TV drama series that was launched in Kenya in 2009. The programme was part of a multimedia campaign to promote responsible sexual behaviour and tolerance commissioned by the Government of Kenya, MTV Networks Africa, PEPFAR (the US President's Emergency Fund for

AIDS Relief) and the Partnership for an HIV-Free Generation (HFG). Season 5 was set in clubs, hangouts and schools of Johannesburg's Braamfontein and the township of "Zenzele" with funding from the Ministry of Basic Education, US PEPFAR, Mary Stopes International and Positive Action (Avert 2017b:8).

2.3.8.5 HIV testing services (HTS)

The national HIV counselling and testing (HCT) policy was introduced in April 2010 (DoH 2010) resulting in in the increase of HIV testing from 19.9% in 2008 to 37.5% in 2012 among men and from 20.7% in 2008 to 52.6% in 2012 among women, respectively. The increase among women was also due to the prevention of mother-to-child transmission (PMTCT) of HIV policy (DoH 2008b). 2013 an HCT revitalisation strategy (DOH 2013), focused on the private sector, farms and higher education, was introduced with the aim of testing 10 million by 2015. An estimated 9.5 million were tested during revitalisation and 35 million since the inception of the HCT campaign in 2010. HIV testing has been associated with a higher level of education, employment, accurate knowledge of HIV, higher perception of risk and living in urban areas (Avert 2017b:5).

In 2015, the Pharmacy Council of South Africa allowed pharmacies to sell take-home HIV testing kits to promote HIV testing (Avert 2017b:5).

2.3.9 HIV and AIDS programme in uMzinyathi district

According to Umzinyathi district health plan (KZNDoH 2015/1:15) the HIV and AIDs programme in uMzinyathi district has progressed steadily (KZNDoH 2015:15).

2.3.9.1 Condom distribution

Between 2012 and 2014, the distribution of male condoms increased from 50 to 83 condoms per client (KZNDoH 2015:15). An estimated 11 348 182 condoms were distributed in 2013/2014 (KZNDoH 2015:15).

2.3.9.2 Male medical circumcision (MMC)

The uptake of MMC increased gradually from 8,843 in 2012/2013 to 8,929 in 2013/2014 (KZNDoH 2015:15). All sub-districts appeared to be struggling to meet the district target of 14,278 KZNDoH 2015:15). This might be due to preference of traditional circumcision to MMC by baSotho in the district which results in loss of statistics.

2.3.9.3 ART and STI programme

All clinics in the district had nurses trained in NIMART. The Central Chronic Medicine Dispensing and Distribution (CCMDD) project was operating with Medi-Post Pharmacy distributing ART to at least 20 clinics. The sexually-transmitted infections (STI) partner tracing and treatment programme was also operating although it was a challenge (KZNDoH 2015:15).

2.3.9.4 HIV counselling and testing

A High Transmission Area Mobile vehicle provided counselling and testing services at long and short distance taxi ranks, a neighbouring college for further education and training (FET), and a nursing school. A sex worker programme was operating in Endumeni sub-district. School-going girls were targeted to know their HIV status through the Zazi camps. The programme was operating in all four sub-districts of uMzinyathi district (KZNDoH 2015:15)

2.4 TEENAGE PREGNANCY

2.4.1 Prevalence of teenage pregnancy

In this study, teenage pregnancy referred to pregnancy occurring in women <20 years of age.

Fatti, Shaikh, Eley, Jackson and Grimwood (2014: 874) refer to teenage pregnancy as a woman being <19 years at first antenatal visit. Kirbas, Gulerman and Daglar (2016:367) describe teenage pregnancy as one that occurs between the ages of 10 and 19 years. Tsikouras, Datopoulos, Trypsinis, Vrachnis, Bouchlarrotou, Liatsikos, Datopoulos,

Maroulis, Galazios, Tetchmann and Van Tempelhoff (2012:1607) said a teenage pregnancy is when the maternal age is <18 years at the time of delivery. These authors referred to teenage pregnancy as occurring between 10 and 19 years of age and agreed that adolescent women were <19 years age.

In 2013, 11.0% of all births worldwide were to 19 year-olds (United Nations Population Fund [UNPF] 2016:1). The Sub-Saharan Africa accounted for almost 50% of all births in the world with an estimated 101 births/1000 to 15-19 year olds. Developing countries accounted for 95% of teenage pregnancies where an estimated 16 million girls aged 15-19 years and 1 million girls aged >15 years gave birth annually (UNPF 2016:1).

Adolescent births seemed to be declining in many countries, while the actual number of births increased due to reduction in births to older women. Although rare in many countries, births to 10-14 year-old girls were up to 12% in some sub-Saharan countries (WHO 2014a:1).

In South Africa, the prevalence of teenage pregnancy increased with age, with the highest in 19 year-olds (12%), and was associated with dropping out of school (Statistics South Africa [Stats SA] 2015:30). According to Sibanyoni (2013:1), 99,000 teenagers fell pregnant in 2013. KZN recorded the highest teenage pregnancy in the country (26,000), followed by the Eastern Cape (20,000) and Limpopo (13,000) (Sibanyoni 2013:1).

2.4.2 Effects of teenage pregnancy

2.4.2.1 Effects of teenage pregnancy on health

Complications of pregnancy and delivery are the second cause of death among girls aged 15-19 years of age globally. An estimated 3 million girls aged 15-19 years globally underwent backstreet abortions annually which contributed to teenage maternal mortality (WHO 2014b:2).

In developing countries, babies of teenage mothers were at 50% risk of stillbirth, neonatal death and low birth weight compared to those born to mothers aged 20-29 years. Other risks included preterm birth and asphyxia. Teenage pregnant mothers had

a higher probability of smoking and drinking alcohol than older women which increased the risk of mortality, low birth weight and morbidity. The risks to babies depended on the mothers; the younger the mother, the higher the risk (WHO 2014a:2).

2.4.2.2 Economic and social effects of teenage pregnancy

Teenage girls, their families and the communities are economically negatively affected by teenage pregnancy. Pregnant girls have a high probability of dropping out of school with a high probability of being unemployed in future due to no education and fewer skills. This costs a country the loss of annual income that young women would have contributed in a lifetime if they had not fallen pregnant during their teenage years (WHO 2014a:2). An estimated 47,000 women worldwide die or have disabilities resulting from unsafe abortions (WHO 2014b:1). Pregnancy is also a risk factor for suicide among teenage mothers and in some cultures is reported as the reason for homicide in order to prevent disgrace to the family (WHO 2012a:2)

2.4.3 Factors that determine teenage pregnancy

According to the WHO (2012a:1), the following are determinants of teenage pregnancy: early sexual debut between ages 15-19 years. The boys have their sexual debut earlier than girls do, and girls usually start sex in forced marriages with older men in developing countries. Teenage girls who are married have a higher frequency of sex hence a higher pro In this study, it referred to perceptions of positive results of behaviours that prevent HIV and teenage pregnancy such as not impregnating a girl.bability of falling pregnant if no contraceptives are used. Teenage pregnancy is higher among single girls in developed countries than in developing countries. The lowest rates are in Africa (WHO 2012a:1).

Low use of contraceptives by teenage girls ranged from 42% to 68% in developed countries and 3% to 49% in developing countries, with the lowest contraceptive rates in Africa. Social expectations led to teenage girls becoming pregnant soon after marriage and some teenage girls were forced to have sex with limited chances of using condoms (WHO 2012a:1).

Other barriers to obtaining contraceptives included unavailability of family regulation services, restrictive laws and policies that forbade teenage girls from accessing contraceptives without parental consent, fear of breach of confidentiality, negative attitudes of providers of fertility regulation services to sexually active teenagers, misconceptions and myths about effects of contraceptives and fear of reactions of others (WHO 2012a:2).

An estimated 30.0% of girls worldwide married before they were 18 years of age. The higher rates of early marriages among teenage girls were in developing countries, especially Africa, compared to developed countries. In developing countries an estimated 14% of teenage girls were married by the age of 15 years (WHO 2012a:2).

Gender norms and social expectations determine attitudes towards marriage and child birth. In some communities, early marriage by teenage girls and proof of fertility before marriage is a norm while boys may be expected to have multiple sexual partners and prove their fertility. In some societies violence against women and girls may put girls at risk of sexually transmitted infections (STIs), including HIV (WHO 2012a:2). Lack of knowledge about sex and family planning contribute to teenage pregnancy. It is worse in developing countries which account for more teenage pregnancies than in developed countries. Furthermore, education protects against teenage pregnancy. The higher the level of education, the lower the probability of falling pregnant and vice versa (WHO 2012a:4).

Access to safe, effective, affordable and acceptable fertility regulation services determines teenage pregnancy. The more accessible the fertility regulation services, the lower the teenage pregnancy. Access includes providing teenage girls aged >18 years contraceptives without parental consent and training health care workers, providing adolescent friendly services, and health education of the community to reduce barriers to access of fertility regulation services (WHO 2012a:4).

2.4.4 Global response to teenage pregnancy

The prevention of teenage pregnancy requires creating awareness about teenage pregnancy; reducing early marriage before 18 years of age; reducing youth pregnancy before 20 years of age; reducing forced sex or pressurising teenagers to have sex;

providing safe abortions; increasing access to contraceptives including the morning after pill by teenagers, and increasing access to maternal and child health services to adolescents (WHO 2012a:4; UNPF 2016:6; UNAIDS 2016b:2). The H4+ initiative aims to reduce gender inequality, child marriage and limited access to education for girls (UNAIDS 2016b:2). The achievement of these recommendations needs the cooperation of political leaders, planners and community leaders to formulate and pass relevant laws, including prohibiting marriage of girls before their 18th birthday.

Families and communities need to be influenced to accept delayed marriages of girls, keeping girls in school, fertility regulation by teenagers, and questioning prevailing gender norms and stereotypes that perpetrate sexual coercion and pressure to have sex on teenagers (UNAIDS 2016b:2).

Adolescent girls need health education on where to access fertility regulation services and how to use them combined with sexuality education to prevent HIV and other STIs and teenage pregnancy. They must also be equipped with knowledge, skills and values to make informed decisions about sexual and social relations, safe abortions, social networks and social supports. Youth and adolescent friendly services are necessary in order to facilitate utilisation of fertility regulation services. Health education on the importance of skilled maternal and child health services should be provided to adolescents, families and communities. Health care providers must be sensitised on the importance of youth and adolescent friendly health services and the support and preparation that teenagers need (WHO 2012a:1).

2.4.5 Role of research in prevention of teenage pregnancy

Research must produce evidence on needs, preferences and contexts of different groups of teenagers on which to support existing, and plan new service delivery programmes, do programme evaluation and implementation research, ensure health information on utilisation of fertility regulation services, understand the role of gender norms in contraceptive use and how to change gender norms about acceptance of fertility regulation (WHO 2012a:1).

2.5 MASCULINITY

The concept of masculinity means different things in different societies and in different communities within a society. It is believed to be changing according the setting depending on the meaning such as family life, sexual relationship and the way in which men perceive themselves and masculinity in the family, and sexual relationships. Boys are raised to perceive themselves and masculinity according to the dictates of acceptable social behaviour based on the dominant masculinity in a society. Masculinity is believed to come into existence as people conduct themselves in life. It has the ability to change because it is constructed and deconstructed, decomposed or replaced depending on the situation. Masculinity may be used to solve problems such as rape, violence against women and children, and guide long-term change by exploring experiences of men wanting or not wanting change (Gennrich 2013:6). With this in mind, the researcher wished to undertake this study.

2.5.1 Types of masculinity

There are different types of masculinity namely, hegemonic, subordinate, complicit, marginal, accessory, inversion, metrosexual and Ubersexual masculinities.

2.5.1.1 Hegemonic masculinity

Hegemonic masculinity is an ‘ideal’ culturally dominant type of masculinity characterised by power, authority over women and other men. It may be violent, competitive and aggressive (Gennrich 2013:6). In South Africa several masculinities enjoy a hegemonic status in their spheres: White, African rural masculinity and African urban masculinity because masculinity in South Africa has been contested on the grounds of race and class and ethnicity (Morrell, Jewkes, Lindegger & Hamlall 2013:7).

2.5.1.2 Subordinate masculinity

Subordinate masculinity refers to men who are not ‘ideal’, who do not behave according to expectations of ‘real man’, such as gay men (Gennrich 2013:6).

2.5.1.3 Complicit masculinity

Complicit masculinity accepts hegemonic masculinity without challenging the oppression of women and other men (Gennrich 2013:6).

2.5.1.4 Marginal masculinity

Marginal masculinity has the characteristics of hegemonic masculinity but men are oppressed in society due to race, class, ethnicity and socioeconomic status. Marginalised men feel inadequate because they cannot provide for their families and as a result resort to other ways of proving that they are men, such as gangstarism (Gennrich 2013:6).

In research masculinity may be used to solve problems such as rape, violence against women and children and guide long-term change by exploring experiences of men wanting or not wanting change.

2.5.1.5 Accessory

Accessory masculinity refers to a type of masculinity where men do not make an effort to display hegemonic characteristics of masculinity due to a lack of strength or desire (Il'inykh 2012:2).

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2.5.1.6 Natural

Natural masculinity complies with male tendencies that are different from those of hegemonic masculinity, such recognising the right to be emotional, unconfident, worrying about the future, caring for family and children (Il'inykh 2012:[sp]).

2.5.1.7 Inversion

Inversion masculinity is when a man displays behavioural characteristics of a woman such as modesty, lack of self-determination, dependency in views and behaviour, and conformity (Il'inykh 2012:[sp]).

2.5.1.8 Metrosexual

A metrosexual man is a heterosexual man who enjoys shopping, has refined taste, manners and clothing; wears designer clothes, and has interests that are associated with women or homosexual men, such as going to fitness centres and spas and beauty parlours (Il'inykh 2012:[p])

2.5.1.9 Ubersexual

Ubersexual masculinity is more concerned with relationships than himself. He dresses for himself not others, buys more sensually, buys clothes that match what he already has and develops a personal style not fashion. His best friends are men (Il'inykh 2012:[sp]).

2.5.2 Reactions to changing values of masculinity

Men react in different ways to changing values of masculinity such as defensive, accommodating and responsive reactions (Gennrich 2013:7).

2.5.2.1 Defensive reaction

Defensive reaction results from men's failure to accept changing gender relations due to insecurity about gender equality and reacting in destructive ways to regain male dominance, such as violent crime, gender-based violence, drug abuse and suicide (Gennrich 2013:7).

2.5.2.2 Accommodating reaction

In accommodating reaction, men accept gender equality passively although they still believe in hegemonic masculinity and do not react violently. In South Africa, many churches accept the law about gender equality, yet continue to preach that hegemonic masculinity is true biblical masculinity (Gennrich 2013:8).

2.5.2.3 Responsive reaction

Responsive reaction accepts changes by accepting both heterosexual and homosexual relationships. Men express this acceptance by challenging violent masculinity and not being afraid to be caring and express emotions which are linked to femininity (Gennrich 2013:8).

2.5.3 History of masculinity in South Africa

During the pre-colonial era the world-view of masculinity in South Africa had a man at the head of a cluster of nuclear families called a homestead (*umuzi*). The homestead depended on the head of the family who was expected to accumulate wealth through crop and cattle farming, including receiving a bride price (*ilobolo*). Violence against a neighbouring homestead or an individual was not allowed. Boys were socialised to be future heads of homesteads through hunting, herding cattle and milking cows. Socialisation included aggression so that they could be respected by women and other men. Male dominance was based on economy. Colonialist capitalism demanded new ways of acquiring wealth for the homestead, however, in the form of working for wages instead of farming. Masculinity was further challenged by the arrival of missionaries with new ways of behaviour for men and women that were different from the traditional ways, such as barring men from polygamy, carrying sticks, and ancestral consultation (Gennrich 2013:8).

The apartheid era in South Africa also contributed negatively to masculinity by reinforcing family separation, lack of role models and separate development with black men regarded as inferior and treated as such and even being called ‘boys’ by their white counterparts. As a result men resorted to violence (Gennrich 2013:10)

The post-apartheid era brought changes through the new Constitution with provision for no discrimination on the basis of gender, religion, culture, race, marital status, origin, sexual orientation and policies such as gender equity. However male domination and violence against women and children persists in South Africa despite increasing numbers of women leaders in the workplace, politics and some churches. Some churches endorse male domination as biblical, arguing that Jesus chose only male disciples to show that God only wanted men to lead (Gennrich 2013:14).

2.5.4 Masculinity from a sociocultural perspective

Masculinity is socially constructed (Eckert & McConnell-Ginet 2003; Stets & Burke 2010:997; Thompson & Bennet 2015:116; Pitt & Fox 2012:37. It does not depend on what men are born with or have but what they do. Usually roles, behaviours, bodies and identifiers of masculinity vary and this allows social scientists to argue that masculinity is socially constructed. Masculinity varies:

Historically - it changes over time; cross-culturally - its construction depends on culture; psychically - the meaning of being a man changes during a life time, and contextually - it has different meanings to different people within a society at a specific time. In other words not all men in the same society or community are the same, it means different things to different men in different cultures with different historical background (Kimmel & Bridges 2011:1).

According to social constructionism, masculinity is determined by socialisation (Albee [s.a.]). One is born male; however, that does not make him a man. This means that being born male does not determine masculinity. One must meet the social norms of masculinity to be considered masculine. Masculinity is constructed through socialisation. In other words gender is not biologically determined, it occurs through interaction with other people. Nobody is born masculine, it is learned. Being born male does not make one a man, being a man depends on how one behaves as constructed by socialisation. The socialisation process begins at birth when the infant is assigned to a lifetime as a male at the announcement of birth of a male child to the naming event when he is given a male name. In some societies, there are names that are assigned exclusively to males. These events launch a gradual process of being a boy and later a man and seeing others as boys or men. During the early years adults do the gender work by treating him as a boy and interpreting everything he does as that of a boy. Adults will speak of bringing up a boy to him, talk to him and respond to him differently to a girl, and give him boy's toys (Eckert & McConnell-Ginet 2003:2).

As the child grows he will learn to do his gender work himself by growing up to do things as a male. He learns to behave as "a good boy" and imposing sanctions if they see gender inappropriate behaviour done by adults and peers. Men tend to reward gender-

appropriate behaviour more than women, especially to boys. The boys tend to learn that boy behaviour is more valuable than that of girls and are strongly discouraged from doing girl behaviour. Boys tend be made to learn that men are “aggressive, competitive and instrumentally oriented” contrary to women who are passive, cooperative and expressive”. They also learn that it is highly inappropriate for males to wear female clothes although women may wear clothes that are primarily assigned to men. If a boy wants to do a job that is normally assigned to women he may be discouraged and vice versa, however, to the boy that would mean that he is too good to do that king of a job while a girl facing a similar situation is actually told that she is not good enough to do a man’s job (Eckert & McConnell-Ginet 2003**:**3).

Social constructionists believe that there is no single masculinity; there are many masculinities as masculinity is determined by the social context. Therefore more than one masculinity exists as there are different social contexts and more than one socially approved masculinities which have achieved hegemony while subordinating other forms of masculinity. They argue that if gender was not socially constructed all men would have one masculinity (Eckert & McConnell-Ginet 2003:3).

Hegemonic masculinity is related to cultural dominance in a society where one group of people leads the society. So hegemony is aligned to power and authority over women and other men. Although power and authority are not obtained by force alone, hegemonic masculinity is compatible with this. However, its power lies in the idea of male dominance that is culturally accepted. Cultural dominance of hegemonic masculinity leads to heterosexual domination and subordination of other forms of masculinity such as gay masculinity which is easily regarded as femininity. It is assumed that if a man is attracted to another man he is somehow a woman (Pitt & Fox 2012:37-46).

2.5.5 Masculinity from a psychosocial perspective

Two theories explain the psychological development of masculinity, namely psychoanalytic theory (Freud 1927) and cognitive-development theory (Kohlberg 1966 cited in Stets & Burke 2010:997).

According to Thompson and Bennett (2015:115), two ideologies have channelled the psychological studies of men and how men think, behave and feel about being men, namely the trait and normative approach.

2.5.5.1 Psychoanalytic theory

According to psychoanalytic theory, masculinity develops through identification of the boy with the father by the age of six. He learns masculinity from the father. This happens after the boy has ceded desires for the opposite sex parent and jealousy and resentment for the father (Stets & Burke 2010:1000).

2.5.5.2 Cognitive theory

According to the cognitive theory, there are cognitive events before identification with the father that lead to the development of masculinity. There are two stages of development of gender identity, namely acquiring a fixed gender identity and establishing gender identity constancy. Acquiring fixed gender identity begins when the child identifies with the label "boy". By the age of three years the gender label application to himself is fixed. By the age of four years the child can apply the gender labels to others. Within two years the child realises that the gender label will not change even if age and outward appearance change (Stets & Burke 2010:1001).

2.5.5.3 Trait approach

According to the trait approach, masculinity is a collection of socially desirable characteristics that are thought to differentiate a man from a woman measured by traits. The differences in masculinity are due to the degree to which individuals portray the ideal traits of masculinity (Thompson & Bennett 2015:115).

The *Oxford Advanced Learner's Dictionary* (2010:1586) defines a trait as "a particular quality in your personality". Traits are inherited characteristics and not something that can be acquired after birth. People's traits are responsible for producing certain patterns of behaviour which are consistent in various situations. According to the trait approach,

men are born with the characteristics of masculinity and all men are expected to have different degrees of the same characteristics.

2.5.5.4 Normative approach

The normative approach is related to the social norms or standards by which masculinity is measured based on the culture of a society. According to this approach, there is no single norm that measures masculinity. The standards depend on time, place and the society and not on individuals. Initiation to manhood and the ceremony are valued transitional activities in some communities. However, the absence of fathers which historically has been a problem among black South African men and created by apartheid by men leaving families and working away from home in mines, leads to a lack of full transitioning. Normative masculinity often values strength, hegemony, self-confidence, determination, heterosexuality, aggression, authority and power over and devalues traits that are considered feminine, such as compassion, nurturing, expression of emotions, and nonviolence. Normative masculinity does not allow men and women to develop to their full potential but restricts them to fit into categories as prescribed by social norms (Thompson & Bennett 2015:115).

2.5.6 Masculinity from a biological perspective

A person's sex determines whether that person is a male or a female. Sex is determined by the sex organs one is born with which determine whether one has the hormone oestrogen or testosterone. These hormones determine if we are male or female (Stets & Burke 2010:997).

The body does have an important role in construction of masculinity and sexuality. In other words, the body has a role in the social construction of masculinity and sexuality. Gender develops on biological sex. The body is not only biological but takes part in shaping how men behave and are regarded as men. It is not possible to separate the social construction of masculinity from the body. Masculinity attributes are attached to the body and the presence of these attributes without a male body makes proving masculinity difficult. The person with a male body is expected to meet the sociocultural expectations of characteristics of men, such as aggression, heterosexuality, independence, determination (Stets & Burke 2010:999). Assigning a baby a lifetime as

a male begins before birth when people begin to wonder if it is naming which transforms a baby to “him” by giving the baby a male name. The first thing that people want to know about a baby is its sex, which leads to buying blue boy clothes and suitable boys’ toys and bringing him up to be a man. Although masculinity does not naturally flow from sex, sex is the beginning of a lifelong process of developing masculinity (Eckert & McConnell-Ginet 2003:1).

Biology produces two categories of people, males and females, and more. It also produces people who do not fit into female and male categories due to unusual genetic makeup. These babies undergo surgical and hormonal manipulations to “correct” the anomaly so that they can be fitted into one of two acceptable categories of male or female and then brought up according to the chosen category (Eckert & McConnell-Ginet 2003:1). Males in this category may not be able to meet their masculinity characteristics.

A person with a positive body image is likely to have a positive sexual identity and a negative body image is related to negative sexual functioning. In a study to explore the association between body image and psychological, social, and sexual functioning among adult men and women, it was found that a positive body image was associated with a high self-esteem in man. Poor body image was associated with increased social anxiety (Davidson & McCabe 2005:463-475. La Rocque and Cioe 2011:397) found that a negative body image was associated with avoidance of sexual activity.

2.5.7 Masculinity and prevention of HIV and teenage pregnancy

Masculinity has been associated with risky sexual behaviours, promiscuity and risk taking, that increase the risk of contracting and spreading HIV infection in South Africa. In a study on masculinities and condom use among young rural South African men, Jama-Shai et al (2012:462) found that masculinity was associated with no or inconsistent condom use, sexual violence and risk taking especially among the inconsistent condom users.

Stern, Clarfelt and Buikema (2013:1040) explored how men and women negotiated gendered norms and its effect on sexual and reproductive health (SRH) and found that men’s sexuality was described as not associated with intimacy, uncontrollable, superior

to women's and associated with high-risk sexual behaviours. Fleming, DiClemente and Barrington (2016:788) studied specific aspects of masculine norms that shaped men's sexual behaviour and identified uncontrollable sexual drive, capacity to perform sex, and power over others. Fleming et al (2016:788) also identified the need to understand context-specific masculinities and investigate positive influences of masculinity.

Masculinity is associated with lack of support of family planning and misconceptions that affect condom use. Mothiba and Maputle (2012:1) found that teenage boys did not support family planning and were reluctant to use condoms to prevent STIs because they believed that sex with a condom was not enjoyable.

In a study in Zimbabwe, Skovdal, Campbell, Madanhire, Mupambireyi, Nyamukapa and Gregson (2011:1) found that masculinity was a barrier to men's uptake of HIV services. The barriers to accessing HIV services included fear of losing dignity; embarrassment for failing to protect themselves; fear of abandonment by wives or girlfriends and living solitary lives; denial, and perceiving hospitals and clinics as women's and children's spaces. Hegemonic masculinity emerged as a yardstick against which the participants defined themselves as men. They perceived themselves as having a strong desire that needed to be satisfied, naturally strong, resilient, and capable of resisting illness. To meet the sexual desire, they must have multiple sexual partners and extra-marital sexual relationships and were not expected to contact HIV because contacting HIV is a sign of weakness. Those men who had accessed HIV services described themselves as different from other men because of using women's and children's spaces because they had to break away from the norms of hegemonic masculinity and construct a new version of masculinity (Skovdal et al 2011:1). However, women perceived men as not wanting to show that they were afraid and trying to prove that they were strong by not wanting to know their HIV status (Skovdal et al 2011:1).

In South Africa, the US and other countries, men are believed to be tough. Visiting health services (including HIV services) is seen as a sign of weakness. This makes men delay to seek health services for their own health. The US encourages men to seek health services and health information for themselves and for their families through a campaign called "Real men wear gowns (hospital robes)" (Gennrich 2013:75).

2.5.8 HIV and teenage pregnancy prevention among youth Critical analysis of

Regarding the prevention of HIV among young people, Pettifor, Bekker, Hosek, DiClemente, Rosenberg, Bull, Allison, Delaney-Moretlwe, Kapogianinis and Cowan (2013:S156) identified three categories of successful interventions, namely biomedical (some microbicides) antiretroviral therapy for prevention and post-exposure prophylaxis.

In a study among high school students in Cape Town, South Africa, Ybarra, Mwaba, Prescott, Roman, Rooi and Bull (2014:1563) examined the acceptability of HIV information delivery by mode, such as at school, at religious organisations, email, text and internet. Of the participants, 38.0% were tired of hearing about how to prevent HIV and AIDS and STI; 43.0% were interested in how to “refuse sex”; 42.0% in “how to use a condom” and 32.0% in contraception. Males were more fatigued than females. In addition, 85.0% accepted HIV school programmes, 65.0% acknowledged their risk of HIV infection; 54% could access text HIV prevention programmes, and 50.0% of those who were tired of HIV messages were likely to access HIV programmes on line, at school or email.

Ybarra, Bull, Prescott, Korchmaros, Bangsberg and Kiwanuka (2013:e70083) conducted an Internet-based parallel-group randomised controlled trial on adolescent abstinence and unprotected sex. The findings showed that intervention participants and those in booster were likely to abstain rather than control groups and no booster groups. Also in intervention and booster groups less unprotected sex than those in no booster and control groups was reported.

In a study on adapting get yourself tested campaign to reach black and Latino sexual-minority youth in America, Garbers, Friedman, Martinez, Scheimann, Bermudez, Silva, Silverman and Chiasson (2016:739) found that the number of STI tests conducted increased, testing vans attracted a high prevalence sample although there were no increases in absolute numbers. The researchers had developed and implemented health promotion campaigns for Black and Latino sexual-minority youth, with evaluation of outcomes to promote STI testing. STI is an indicator of failure to use or using condoms inconsistently which increase the risk of HIV infection.

In an assessment of the get yourself tested (GYT) campaign, Friedman, Brookmeyer, Kachur, Ford, Hogben, Habel, Kantor, Clark, Sabatini and McFarlane (2016:151) found increased STI testing during the GYT activities and STI awareness month. STI testing and treatment and promotion of condom use are important for HIV prevention

Ybarra, Bull, Kiwanuka, Bangsberg and Korchmaros (2012:1392) conducted a survey on the prevalence rates of sexual coercion victimisation and perpetration among sexually experienced Uganda adolescents. The study found the average age at sexual debut was 12.7 years; no significant differences in condom use; coercion at first sex and dating violence, and perpetrators of coerced sex were significantly more likely to be male.

Devine, Bull, Dreisbach and Shlay (2014:S78) conducted a computer-based survey among minority youth to supplement a teen outreach programme (TOP) for reducing teenage pregnancy. The participants were enthusiastic about text messages complementing TOP.

In Uganda, Hampanda, Ybarra and Bull (2014:1209) examined adolescents' perceptions of health care service and HIV-related health-seeking behaviour. The study found that the participants' health-seeking behaviour depended on their perceptions of how they thought they would be treated when they sought condoms and HIV testing, family support, peer influence, self-esteem and age.

Hoopes, Agarwal, Bull, Chandra-Mouli (2016:137) measured adolescent-friendly health services in India and found improvements in quality and utilisation of services due to NGO initiatives, adolescent knowledge, contraceptive and condom use.

Most of the studies assessed the success of HIV and teenage pregnancy prevention programmes. The researcher found no literature on how young men described the positive values of masculinity and how they used them in the prevention of HIV and AIDS and teenage pregnancy.

2.6 CONCLUSION

This chapter described the health promotion model (HPM); global and national perspectives on the prevalence of HIV and AIDS and teenage pregnancy; effects of HIV on women, effects of teenage pregnancy on young girls, and the values of masculinity in relation to the prevention of HIV/AIDS and teenage pregnancy. The values of masculinity were discussed from the psychological, health system, and cultural perspectives. Chapter 3 presents the research design and methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research design and methodology including the research site, population and sample, data collection and analysis, scientific rigour and ethical considerations.

The purpose of the study was to explore and describe the positive values of masculinity and the role of a man in the prevention of HIV and AIDS and teenage pregnancy in a rural sub-district in KwaZulu-Natal, South Africa in order to develop a health education handbook for young Zulu men.

Research objectives are “specific accomplishments researchers hope to achieve by conducting the study” (Polit & Beck 2017:69). The objectives of this study were to

- identify expectations of a man of essence/positive values of masculinity
- describe the man’s role in the prevention of HIV and AIDS and teenage pregnancy
- develop a health education handbook for young men in developing positive values of masculinity

Research questions are queries to be answered to address the research problem (Polit & Beck 2017:69). In order to achieve the purpose and objectives, the study wished to answer the following questions:

- What are the expectations of a man of essence?
- What is the role of a man in the prevention of HIV and AIDS and teenage pregnancy?
- What health education can be developed for young men in developing positive values of masculinity?

3.2 RESEARCH APPROACH AND DESIGN

A research approach is a plan and procedure for research that is informed by the philosophical assumptions the researcher brings to the study, the nature of the research problem, the researcher's personal experiences and the audiences for the study (Cresswell 2014:3).

There are three approaches to research namely: quantitative, qualitative and mixed methods. The quantitative and qualitative methods are the ends of a continuum and the mixed methods are the middle of a continuum.

Quantitative research collects data in the form of numbers using closed-ended questions. Qualitative research collects data in the form of words using open-ended questions. Mixed methods research collects both quantitative and qualitative data (Cresswell 2014:4).

In this study the researcher chose the qualitative approach because the researcher intended to collect data in the form of words – descriptions of a man of essence and how they protect themselves and others from HIV and AIDS and impregnating a girl.

The decision to do a qualitative study was based on the purpose of the study, questions to be asked and type of data to be collected. Creswell (2014:5) refers to research approaches as philosophical assumptions that a researcher brings to the study. A qualitative research approach is a way of exploring the meaning that persons or communities attach to a social or human problem (Creswell 2014:246). This was an explorative study to obtain data in the form of words rather than numbers, asking open-ended rather than closed question. Data analysis was inductive, building from particular to general themes, rather than using statistical procedures and the report was flexible.

The reason for a qualitative study was to explore and describe the participants' positive values of masculinity and how they applied them in the prevention of HIV and AIDS and teenage pregnancy. A qualitative approach was suitable to capture the description of masculinity by the participants themselves. A natural setting, the researcher as key instrument, multiple sources of data, participants' meanings, and reflexivity are characteristics of qualitative research (Creswell 2014:185):

Natural setting: Data was collected in the natural setting of the participants' homes at times that suited them, by means of semi-structured interviews.

Researcher as key instrument: The researcher personally conducted the interviews with the help of a research assistant.

Multiple sources of data: The semi-structured interviews were audio-recorded with two digital voice recorders, and the researcher and research assistant kept field notes with reflective and reflexive notes and policy documents around HIV and AIDS and fertility regulation on which the handbook was also to be based. The researcher reflected on successes and what needed to be improved in future interviews and the challenges such as the need to add columns to the field notes form, whether the clients were interrupted by interjection or noise. Reflexivity involved thoughts and feeling during the interview, professional, religious and social background and whether it affected or guided the probing or not.

Participants' meanings: This study relied on the participants' perceptions and descriptions of the positive values of masculinity and how they applied them in the prevention of HIV and AIDS and teenage pregnancy.

Reflexivity: Reflexivity is critical reflection about one's biases, and preconceived ideas and values and those of participants that can influence the study (Polit & Beck 2014:390). The researcher critically reflected on the potential of her personal background, culture and values (as a Christian), professional (nurse) and social identity to influence data collection and interpretation of results. Accordingly, the researcher kept reflexive notes on her personal thoughts and feelings, preconceptions, assumptions, reflections, and progress. The researcher also validated her interpretation of what the participants said by paraphrasing and repeating and asking for clarity in order to achieve credibility.

The choice of the research methods is normally determined by research questions that the researcher asks. The design is determined by the type of research strategy (Botma 2014:189). This argument implies that the research procedure a study should follow needs to be problem-oriented, aiming to answer its research questions. That means that

the researchers must identify a fully-justified design to complete their research and achieve their research purpose, in order to satisfy the expectation of the potential audiences of their research.

A research design is a type of a study within a quantitative, qualitative or mixed methods approaches. Quantitative designs include experimental (true and quasi) and non-experimental designs such as surveys. According to Polit and Beck 2014:153), true experiments are characterized by doing something to some participants (intervention/treatment), control into the study usually, a control group that does not receive the intervention, and assignment of participants to a control or experimental group (randomization). Quasi experiments (trials without randomization) lack randomization and some even lack control groups (Polit & Beck 2014:157). Non-experimental/observational studies such as survey “provide numeric descriptions of trends, attitudes or opinions” of a sample

A number of qualitative methodologies broadly classified as interpretive exist namely: phenomenology, ethnography, grounded theory, critical action, feminist and narrative research. The aim of interpretive methodologies is to describe and understand the phenomena. The choice is determined by the emphasis and data collection methods. For instance, emphasis for phenomenology is exploring “lived experiences”, cultural rule for ethnography, empowering women for the feminist, generating theory for grounded theory and change in practice for action research. Observation is the gold standard data collection method for ethnography, in-depth interviews for phenomenology, multiple stages of data collection for grounded theory.

First, masculinity can be regarded as a phenomenon experienced by young men. Therefore, phenomenology may be a more suitable methodology to consider because it aims to identify human experiences about a phenomenon as described by the participants. Percy describes phenomenology as studying the “felt qualities” of a phenomenon such as what anger feels like. The participants would have to describe “experiencing” or what the experience of a being a man is like, such as how it feels to be a man. The generic qualitative inquiry investigates the experience of or what happened or describes occurrences in the participants’ lives such as being angry and not what it feels like to be angry (Percy et al 2015:78). This study investigated what

makes a man, what is expected of a man, not what it feels like to be a man. So phenomenology did not fit.

Narrative enquiry focuses on stories to explore how people interpret events in their lives. The researcher studies the lives of people by asking them to tell their stories. It requires the three voices namely, that of the narrator, which is represented by the tape or text and the theoretical framework which provides the concepts and tools for interpretation. During analysis, the focus may be on content or the interpretation of the story which includes the words used, the feeling evoked by the story, the style of the narrative (Botma 2014:193). Investigating adolescents' and young adults' masculinity requires telling of individual stories of masculinity, so narrative research might be helpful to obtain individual mascunility stories of their lives. A study with different possible research designs of looking at masculinity requiring different qualitative methods, suggests that it is difficult to adopt any single traditional qualitative methodology. Moreover, they cannot be simply mixed in one study, due to the ontological and epistemological differences in these methodologies.

Grounded theory does not begin with a focused research problem. The problem and the solution to the problem emerge from the data. It uses data from people to develop and explain the theory. Grounded theory was not suitable because this study was not intended to develop a theory. It was a descriptive not explanatory study.

Ethnography is concerned with description and interpretation of culture and cultural behaviour of people. It varies from broad culture (macroethnography) to small units of culture (microethnography). It includes language (words) actions (behaviour) and products of group members such as food and clothes. It involves a lot of fieldwork to learn the words, actions and products of a group. The typical data collection strategy is participant observation, which involves daily observation of people in their natural setting. Ethnographers also use key informants to help them understand and interpret events and activities observed. It requires a long time, months to years of observation (Polit & Beck 2014:267). The population for the study was young Zulu men in context predominantly occupied by Zulus, so it could be ethnography. However, ethnography is concerned with description and interpretation of culture and cultural behaviour of people. It varies from broad culture (macroethnography) to small units of a culture (microethnography). It would seem suitable for this study, however, it was not suitable

because the researcher did not want to investigate culture and cultural behaviour and beliefs of a group, but was interested in an account of masculinity that is not determined by culture alone but a complex of other factors such as religious, socio-economic factors etc. The researcher was interested in the complex, controversial and personal nature of information about the phenomenon (masculinity) and semi-structured interviews were the suitable for obtaining a thick description of complex, controversial and personal information about a phenomenon (masculinity) in their homes (natural setting). (Botma 2010:190).

A case study is “an in-depth analysis of case” such as an event, programme one or more individuals (Cresswell 2014:14). Positive values of masculinity are not a case. A case is bound by time and activity. This research was not intended to study a case because there are many masculinities as constructed by participants.

Participatory action research aims not only to produce knowledge but also actions and conscious raising of marginalised groups and oppressed people to change their lives and those of the researchers. It is collaboration between the researcher and participants. The seven key features of participatory action research are that it is critical, reflective, emancipatory, practical, collaborative, a social process, and aims to transform theory and practice. The researcher did to aim to raise consciousness of the oppressed and bring in terms of the action participatory research but to develop a health education handbook to develop positive values.

However, this study did not fit the traditional qualitative designs namely phenomenology, ethnography, grounded theory, participatory action research or feminism. It did not fit the mixed methods approach because it was not the intention of the researcher to mix quantitative and qualitative approaches and methods. The study design was generic qualitative descriptive, exploratory and contextual.

3.2.1 Generic qualitative

According to Percy (2015:78), a generic qualitative inquiry is suitable:

- For investigating “people’s reports of subjective opinions, attitudes, beliefs or reflections on their experiences”.
- When the proposed research problem and question requires qualitative or mixed methods.
- When the content of the desired information does not fit the traditional qualitative research designs such as phenomenology, ethnography and grounded theory and case study.

The generic approach was selected based on two reasons: the study did not fit the qualitative traditional designs as it has already been explained above. Second, this study investigated people’s reports on their experiences as men.

Thus the generic approach seems to be much more flexible. This means that no matter how the young men understand the positive values of masculinity, this approach can always fit this study because generic qualitative researchers want to obtain a “rich description of a phenomenon” that is being studied (Kahlke 2014:39).

3.2.2 Exploratory

Exploratory research is conducted “to develop an initial, rough understanding of a phenomenon … when little is known about a phenomenon” (Polit & Beck 2014:13). Exploratory studies explore the full nature of the phenomenon, the manner in which it is manifested, and other related factors (Polit & Beck 2014:742). In this study, the phenomenon of interest was the positive values of masculinity.

In the literature review, the researcher found several studies on masculinity as a predisposing factor to HIV infection and transmission, risky sexual behaviours, promiscuity and risk taking, that increase the risk of contracting and spreading HIV infection in South Africa. Jama-Shai et al (2012:462) found that masculinity was associated with no or inconsistent condom use, sexual violence and risk taking especially among the inconsistent condom users. Fleming et al (2016:788) identified the

need to understand context-specific masculinities and investigate positive influences of masculinity. Masculinity is associated with lack of support of family planning and misconceptions that affect condom use. Mothiba & Maputle (2012:1) found that teenage boys did not support family planning and were reluctant to use condoms to prevent STIs because they believed that sex with a condom was not enjoyable.

This study explored and described the positive values of masculinity and their application to the prevention of HIV and AIDS and teenage pregnancy from the participants' perspectives in order to develop a health education handbook for young Zulu males.

3.2.3 Descriptive

Descriptive research has as its main objective to "accurately portray the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur" (Polit & Beck 2014:12). A descriptive study identifies a phenomenon of interest and describes variables in a study situation. It is the best method if a researcher wants a straightforward description of a phenomenon (Botma et al 2010:194). Descriptive studies wish to observe, describe and portray accurately the characteristics of specific situations and phenomena as they occur naturally (Polit & Beck 2014:12).

A study or enquiry may be deductive or inductive. An inductive study is not based on a conceptual framework while a deductive study is based on a conceptual framework, model, theory or typology (Botma et al 2010:195). This study was a deductive descriptive enquiry based on the health promotion model (HPM) to describe the phenomenon.

3.2.4 Contextual

Contextual studies focus on specific phenomena, events or cases (Botma et al 2010:195). The researcher adopted a qualitative approach as little is known about the topic under study. Qualitative studies aim to understand a phenomenon as it exists in the real world and as it is constructed by individuals in the context of that world (Polit & Beck 2012:742). Qualitative research is a process of naturalistic inquiry that seeks in-depth understanding of social phenomena within their natural settings. It focuses on the

'why' rather than the 'what' of social phenomena and relies on individuals' direct experiences as meaning-making agents in their everyday lives (Polit & Beck 2014:262; Creswell 2014:246).

Qualitative research is always not meant for generalisation, as it is relevant only in a specific context. Contextual studies focus on specific phenomena because of their contextual significance (Botma et al 2010:195). The aim of qualitative research is to obtain a detailed picture of the phenomenon as it exists and as it is constructed by individuals in their natural setting (Polit & Beck 2014:266).

This study explored and described the positive values of masculinity and the role of men in the prevention of HIV and teenage pregnancy in the context of young Zulu men aged 18-24 years in a rural sub-district in KwaZulu-Natal.

3.2.4.1 Setting

A research setting or site is the place or places where data is collected (Polit & Beck 2014:41). The study was conducted in Nquthu sub-district in the northeastern boundary of uMzinyathi District in northern KwaZulu-Natal Province, South Africa. South Africa is at the southern tip of Africa. It has a surface area of 1,219,912 square kilometres and had an estimated population of 54,490,000 in 2015 it (WHO 2015a:1). South Africa is bordered by the Atlantic Ocean on the west and the Indian Ocean on the south and east. Its neighbouring countries are Namibia in the northwest, Zimbabwe and Botswana in the north, and Mozambique and Swaziland in the northeast. Lesotho is within the southeast part of South Africa, an area almost three times that of California in the United States of America (USA). Cape Agulhas is located at the southernmost part of Africa in the Western Cape Province, approximately 161 km southeast of the Cape of Good Hope (World Atlas 2017).

The country is divided into nine provinces, namely Gauteng, Northern Province, North West, KwaZulu-Natal (KZN), Eastern Cape, Western Cape, Northern Cape, Mpumalanga and Free State. Each province has its own capital (South Africa 2016:vi).

Figure 3.1 Map of South Africa showing KwaZulu-Natal Province

(Source: World Atlas 2017)

Figure 3.2 Map of KwaZulu-Natal showing UMzinyathi district

(Source: Wikipedia 2017)

The KZN province is in the southeast of South Africa, bordered by the Indian Ocean. It is the third smallest province in the country with a surface area of 94 361 km^2 but the second most populous province in South Africa with a population of 11 065 2400 (South Africa 2016:162). It is divided into one metropolitan municipality (eThekwini metropolitan

municipality) and 10 district municipalities, namely Amajuba, Harry Gwala, iLembe, King Cetshwayo, uGu, uMgungundlovu, uMkhanyakude, uMzinyathi (the study site), uThukela and Zululand districts. KwaZulu-Natal is divided into 11 Districts, one of which is uMzinyathi (KZNDoH 2015:23).

UMzinyathi District is in northern KwaZulu-Natal (KZNDoH 2015:12). Its borders are as follows: Amajuba in the north, Zululand in the north east, uThungulu in the east, ILembe in the south and southwest, and Umgungundlovu in the west. It has a population of 514,217 and four district hospitals. It formed part of KwaZulu homeland before the first democratic elections in 1994. The district has an estimated population of 514 839, covers an area of 8589 square kilometres, and has 53 wards and 4 local municipalities: Endumeni, Msinga, Nquthu and Mvoti. Nquthu sub-district, where the study was conducted, is located on the northeastern boundary of uMzinyathi district. Its boundaries are as follows: eMadlangeni and Abaqulusi in the north; Ulundi in the east; Nkandla in the south, and Msinga and Endumeni in the west (KZNDoH 2015:25). It has one district hospital, which is the core of comprehensive health services run through a network of fixed and mobile clinics. The sub-district Hospital is a 349-bed hospital. Its services benefit the people of the sub-district. It receives referrals and provides generalist support to the clinics such as diagnostic, care, counselling and rehabilitation, services. Clinical services include surgery, obstetric and gynaecological, out patients, medicine, paediatric and counselling and rehabilitation. All the clinics are supervised from the hospital and are visited by a hospital doctor every two weeks

The selected sub-district has an estimated population of 166,217 rural, predominantly isiZulu-speaking people. The sub-district covers an area of 1,451 square kilometres. It has nine tribal authority areas each under an *Inkosi* (chief), namely Emandleni, Vulindlela, Sithole, Mbokodwebomvu, Molefe, Mangwe Buthanani, Zondi, Hlatshwayo and Khiphinkunzi. Molefe was excluded because the chief and his people are predominantly Sotho, while the other chiefs and their people are predominantly Zulus. The remaining tribal authorities were randomly allocated numbers to prevent identification. The numbers allocated to the tribal authorities were written on small pieces of paper and placed in a basket. A person who was not involved in the study was asked to pick one paper. Tribal authority eight (8) was selected as the study site.

Figure 3.3 Map of uMzinyathi district and sub-districts

(Source: Wikipedia 2017)

3.2.4.2 Researcher's personal experience

The researcher became interested in HIV and AIDS prevention when she was working for the antiretroviral treatment (ART) programme in one of the sub-districts in northern KZN as a programme coordinator before the roll-out of ART. The programme started as a prevention-of-mother-to-child-transmission of HIV (PMTCT) programme funded by a private sponsor before the roll-out of the government PMTCT programme. This programme facilitated the PMTCT and ART roll-out by the government with training and technical support up to handover to the provincial Department of Health. The researcher's experience with young pregnant and lactating women with HIV and AIDS, including young relatives, raised the question in her mind of what men were doing about the prevention of HIV and AIDS and teenage pregnancy. The researcher felt that HIV prevention strategies mentioned in chapter 2 and ART were not enough to stop HIV. Men have to be engaged because the women, who do not infect themselves, cannot do much alone as their status is subordinate to that of men who presumably head the households and relationships. It felt like men were doing nothing while HIV infected women were facing PMTCT, care for the sick babies and family members while men were continuing to infect more women and babies (indirectly). The researcher wanted

to focus on the positive values of masculinity rather than focusing on the negative ones to develop a health education handbook and role models for future generations of young men to stop gendered norms that perpetrate HIV transmission and teenage pregnancy

3.3 RESEARCH METHODOLOGY

Research methodology is the process of how a study will be conducted. Research methods are the techniques used to structure a study and to collect and analyse data relevant to the research questions systematically (Polit & Beck 2014:741). The research methodology includes the population, sample and sampling, data collection and analysis, ethical considerations and scientific rigour (Botma et al 2010:199).

3.3.1 Population

A research population refers to the entire set of elements, individuals or objects with some common characteristics in which a researcher is interested (Polit & Beck 2017:249). The population is the whole group of people or objects that the researcher is interested in studying (Polit & Beck 2014:51). Botma et al (2010:200) describe a population as all individuals who meet the inclusion criteria in a place where the researcher is interested. In this study, the population was Zulu men aged 18-24 years, residing in a selected sub-district in uMzinyathi district. This age group was selected because they are young and in the early years of development and expression of values of masculinity. As future fathers and role models, the researcher considered it appropriate to enable them to contribute to curbing the HIV/AIDS epidemic by exploring their description of positive values of masculinity in relation to the prevention of HIV and AIDS and teenage pregnancy in order to develop a health education handbook for future use. The selected district is in a high HIV and teenage pregnancy prevalence area and the second most populated area (KZN) in the country. Including young men from this province in the struggle to combat HIV in South Africa might help to contribute to the reduction of the provincial and country HIV incidence and prevalence.

The accessible population is the population that the researcher can reach or the study population (Polit & Beck 2014:249). In this study, the accessible population referred to

young Zulu men aged 18-24 years who attended community meetings (*izimbizo*) or who were identified by peers in the sub-district.

Inclusion criteria are criteria that specify population characteristics for participation in a study (Polit & Beck 2017:250). To be included in this study, the participants had to

- be 18-24 years of age
- belong to the Zulu ethnic group
- live in the selected rural sub-district, including those who worked outside the selected sub-district and visit home regularly

The young men had to be Zulus in an area that is predominantly occupied by amaZulu (Zulus) because the study also included the prevention of teenage pregnancy and men who were not Zulus might be different. Men who resided outside or visited the sub-district might also be different. Zulu men who were 25 years old and above and ones aged 18-24 years who were only visiting the selected area were excluded from the study.

3.3.2 Sampling and sample

Sampling is the process of selecting a group of individuals from a population in order to obtain information (Polit & Beck 2014:177; 2017:250). In this study, the researcher used snowball sampling to select participants for maximum variation, data quality and convenience (Botma et al 2010:201; Polit & Beck 2014:284). The study was introduced at community meetings with the permission of *Inkosi* (chief) and *Izinduna* (head men). At the meetings the researcher explained her role as a researcher, the purpose of the study and the inclusion and exclusion criteria. The research assistant was introduced as a colleague and assistant in data collection. All questions from the community about the study were answered. The most frequently asked question was how the community and the participants would benefit from the study. It was explained that the community and participants would not receive tangible benefits. However, the participants would benefit from introspection and evaluating their behaviour, which would perhaps help them to put a plan of action in place to change their behaviour if necessary. The community would benefit when a health education handbook for young men would be developed from the results of the study. However, young men aged 18-24 years did not attend the

community meetings therefore the researcher had to rely on *Izinduna* to call the young men of this age group to a special meeting and the councillors and research assistant to encourage young men of this age group to attend. After the meeting in each area two participants were approached and asked to participate in the study. These participants were asked to identify other possible participants to be included in the study to achieve diversity in terms of age, employment status, highest educational standard and marital status. The first participants were asked to select participants that they thought were knowledgeable, met the inclusion criteria, and had different occupations.

Snowball sampling (also called network sampling) is a type of non-probability sampling that is used when suitable participants are not known. One to three participants are approached and asked to participate in the study. These participants are asked to identify other possible participants who meet inclusion criteria to be included in the study until data saturation has occurred (Botma et al 2010:201; Polit & Beck 2014:284). The disadvantage of snowball sampling is that the course of identification of participants can easily be broken and participants tend to be restricted to a small circle of friends and acquaintances. The quality of referrals may also depend on how much the referring participants trust the researcher and their willingness to participate. Snowball sampling's strengths include sampling for meaning, maximum variation, high quality data, convenience where access to population is limited, and there are time and cost constraints (Polit & Beck 2017:493; Polit & Beck 2014:284; Botma et al 2010:125).

This sampling method was suitable for the study because the focus was not to generalise the findings but to obtain high quality data about young Zulu men's descriptions of the positive values of masculinity.

A sample is a "subset of the population" or a selected group of individuals who are to be studied from a defined population (Polit & Beck 2014:51, 2017:741; Botma et al 2010:201). Qualitative samples are purposefully selected based on two guiding principles, namely appropriateness and adequacy (Botma et al 2010:199). This means that the selected individuals and the context can give the most and best information about the phenomenon of interest. Researchers need to find participants who know the phenomenon well and a context where the best and most information about the phenomenon can be collected.

In qualitative research, the sample size is guided by two principles, namely sufficiency and saturation. Sufficiency refers to “sufficient number to reflect the range of participants and sites that make up the population” (Botma et al 2010:200). Saturation means that no new relevant information emerges. Data saturation and sample size are determined by factors such as the quality of data, amount of useful information and in-depth or semi-structured interviews. Semi-structured interviews need relatively larger samples because participants respond to a series of questions (Botma et al 2010:200). Percy et al (2015:79) state that generic qualitative studies require larger and more representative samples than other qualitative approaches to obtain a broad range of opinions, ideas or reflections about participants’ experiences. Like all qualitative research there is no need for generalisation of results because the data may not be quantifiable. If the sample is fairly representative and has the needed information the results may be persuasive enough for readers to apply in similar settings (Percy et al 2015:79).

In this study twenty one participants were interviewed until data saturation was reached. The researcher thought data saturation had been reached at 13 participants, however, when the 14th participant was interviewed, he presented new information. The interviews continued until no new information was obtained at participant 21. The sample was fairly representative of the population because the participant characteristics of age, occupation and highest educational standard varied.

3.3.3 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or objectives of the study (Polit & Beck 2014:54). Qualitative researchers collect self-reports on events and issues and usually use unstructured or semi-structured methods of data collection with one-to-one or focus group interviews (Botma et al 2010:205; Percy et al 2015:79).

3.3.3.1 Data-collection method

One-to-one and focus group interviews are the primary means of data collection in qualitative research. The researcher is guided by the most effective method for the kind of data (Botma et al 2010:204). In this study, the researcher wished to explore the

participants' perceptions, thoughts on the positive values of masculinity and the role of men in the prevention of HIV and teenage pregnancy. Accordingly, the researcher conducted semi-structured interviews, which were recorded with two digital voice recorders. The researcher and research assistant also kept field notes with reflective and reflexive notes. Semi-structured interviews were chosen because the issues were personal and sensitive. Data was collected using an interview guide based on the HPM. The theoretical propositions of the model, namely perceived benefit of action, perceived self-efficacy, and perceived barriers to action, interpersonal influences, and commitment to carry out activity and immediate competing demand and choices were used as prompts during the interview, and were also to guide data analysis and data presentation (see Annexure 1). The policy documents around HIV/AIDS, STIs and fertility regulation were to guide the development of the health education handbook (see table 6.1). The results would be part of the content of the handbook.

3.3.3.2 Development of the data-collection instrument

A semi-structured interview guide is used to obtain a detailed account of participants' perspectives about their beliefs or perceptions or complex or personal issues. It is also known as an interview schedule, interview protocol or topic guide. It is a set of three to six predetermined open-ended questions that guide the interview (Botma et al 2010:208). The researcher developed a semi-structured interview guide with open-ended questions under the guidance of the study supervisor. The interview guide consisted of five sections: introduction, opening question (biographic information), key questions, prompts based on the HPM, and closing (see Annexure 1).

Introduction. As introduction, the researcher greeted the participants; introduced herself and the research assistant; explained the purpose of the study, estimated time of the interview, benefits and risks involved; participant autonomy, confidentiality, privacy and anonymity and data management, and use of the voice recorder, and obtained informed consent to participate in the study and to use the voice recorder.

Opening question. The participants were asked to give a brief family background, and biographic data including age, occupation, employment and marital status.

Key questions. Two key questions covered the positive values of masculinity, and their use in the prevention of HIV and AIDS and teenage pregnancy. The interviewer asked two broad open-ended questions focused on participants' experiences of a man one can call a man of essence (a man of a kind; indoda emadodeni) and the role of such a man in the prevention of HIV and AIDS and teenage pregnancy with prompts and probes to enable the participants to talk about their experiences. The questions covered prior behaviour, personal influences, interpersonal influences, social influences, commitment to plan of action, and competing demands (at follow-up).

Prompts based on the HPM. The following phrases and words were used to probe: 'explain more', 'clarify',' what do you mean', 'OK', and 'mmhm'.

Closing. In order to reduce the rapport that had been established, the participants were asked about their hopes for their families for the future and if they had any questions. The researcher thanked the participants for their participation and sharing their experiences.

3.3.3.3 Pilot study

Polit and Beck (2014:387) define a pilot study as "a small-scale version or trial run done in preparation for a major study or to test feasibility". A pilot study determines if the field workers are skilled to conduct research (Botma et al 2010:275).

In this study, the purpose of the pilot study was to ensure that the questions were not ambiguous, to test the time required, and to train the research assistant. The process had been estimated at 1- 2 hours, however it was found to be ranging between 45 minutes to 1 hour. The pilot study was done with three participants from one selected village. Based on the feedback, the main questions were rephrased for clarity. The question "What are the positive values of masculinity in relation to HIV/AIDS and teenage pregnancy prevention?" had to be reworded to "According to your knowledge what is expected from a man that one can call a man among men (a man of a kind or indoda emadodeni)?" because he asked for clarity several times. The two subsequent participants who were asked the reworded question did not seem to have a problem with it at all. The question "How do young Zulu men apply the positive values of masculinity in the prevention of HIV and AIDS and teenage pregnancy?" was reworded

to “what is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl?”

The pilot study also indicated the time needed to explain the study to the participants, obtain the consent, complete the interview and write field notes so that the researcher could estimate the length of time needed to collect data and do transcription.

This helped the researcher to estimate the average number of interviews per 24 hour day and the estimated length of time needed to collect data and do the transcription. The researcher could set targets of number of interviews and transcripts per day, per week and per month in order to estimate expenditure for the cost of hiring and transporting the research assistant. The research assistant was well received by the community as a local and a professional person with a medical background.

Getting started was the number one challenge. Although the study had been introduced at the community meetings getting the first participants was not as easy as it had been expected. Young men 18-24 years of age did not attend the community meetings. The researcher relied on the councillor, research assistant and Izinduna to motivate young people of this age group to attend a special meeting with the researcher in order to explain the study to them and to ask those who were interested to participate in the study.

The research assistant was trained in the use of the voice recorder and taking field notes. Field notes include demographic, observational, theoretical, methodological and personal notes (Polit & Beck 2017:523; Botma et al 2010:218). Demographic notes record time, place and date of fieldwork, and demographic notes about the participants. Observational notes refer to how participants looked, such as tired, happy or sad, withdrawn, enthusiastic, smiling, laughing, nodding, frowning, and cheerful. Theoretical notes record what the researcher thought about the meaning of the observation. Methodological notes refer to thoughts about what works well or does not work and needs to be changed. Personal notes refer to how the researcher felt in the field work and whether their feelings influenced what was seen, including ethical dilemmas (Polit & Beck 2017:523; Botma et al 2010:218).

Before the pilot study mock interviews were done to practise taking field notes and using the digital voice recorder. The results of the pilot study were analysed with the main study and a process evaluation included (see Annexure 8).

3.3.3.4 Data-collection process

Data collection took place at places convenient to the participants. The researcher collected the data personally with the assistance of a research assistant. The researcher used the interview guide and encouraged the participants to talk freely about the areas covered in the interview guide (Polit & Beck 2014:290). The semi-structured interviews provided privacy and a sense of freedom to the participants, as they disclosed their behaviour about sensitive sexual issues in order to obtain detailed descriptions of positive values of masculinity.

The participants were Zulu males aged 18-24, and the data was verbal (words) and recorded in two audiotapes. The researcher and research assistant also kept field notes and summaries. The interviews were transcribed verbatim by the researcher and the research assistant. The researcher translated data into English (the language of research) and then translated back to IsiZulu by the research assistant to prevent loss of the participant voices.

3.3.3.5 Role of the researcher

The researcher was the interviewer with the responsibility of becoming acquainted with the participants by starting a conversation about everyday issues, creating an environment that enabled them to share their experiences freely, explaining consent, note-taking and tape-recording, confidentiality and privacy, anonymity, establishing rapport, showing an interest in the participants' experiences, being non-judgemental verbally and non-verbally (respect). She was also responsible encouraging them to talk, using pauses and probes effectively, clarifying and paraphrasing, asking open-ended questions, avoiding offering personal points of view and endorsing a particular view, and closing the interview (Hennink, Hutter & Bailey 2012:124, Botma et al 2010:207).

3.3.4 Data analysis

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2014:291). Content analysis was done. It consists of coding the data, categorising the data into main and subcategories, labelling the categories, integrating the categories into themes and integrating all the data (Botma 2014:222). Data analysis was done concurrently with data collection and write up. At the end of each day the researcher analysed the data collected in the interviews. In generic qualitative analysis, data is analysed for themes. Six data-analysis steps were followed (Creswell 2014:197; Botma et al 2010:224):

Step 1: Organise and prepare the data. The researcher and the research assistant transcribed the interviews verbatim and compared the transcriptions with the recordings to ensure accuracy. The researcher read through all the transcriptions carefully in order to get an overall picture and jotted down ideas as they came to mind.

Step 2: The researcher read through each transcription to examine the meaning, tone and impression of what participants said. Thoughts, topics and ideas that emerged were written down in the margin.

Step 3: The researcher identified topics and themes that emerged from the data in the transcriptions. Topics that related to each other were grouped together and themes identified. The researcher wrote topics next to appropriate segments of text, checking to see whether new themes emerged.

Step 4: Formulate topics. The researcher wrote topics next to appropriate segments of text, checking to see whether new themes emerged.

Step 5: The topics were turned into categories by finding descriptive wording, finding final abbreviations for categories, and arranging them alphabetically. The researcher grouped related topics together and drew lines to show interrelationships. Codes were formulated for each theme developed. Codes were formulated for each theme developed.

Step 6: Assemble coded data and do preliminary analysis. The researcher assembled the coded data for the topics and preliminary analysis done. All data belonging to a category were assembled in one place and preliminary analysis was done. Recoding of

data was done where necessary. In this study narrative passages were used to convey the findings.

3.3.5 Scientific rigour

Scientific rigour is concerned with qualitative reliability, validity and the trustworthiness of the study (Botma 2010:230).

3.3.5.1 Qualitative reliability

It indicates that the researcher's approach is consistent. It can be checked by accurate and comprehensive documentation of data, checking the transcripts for correctness, regular communication meetings with the coders in the case of team research and cross-checking codes by researchers and reaching intercoder agreement (Botma 2010:231). In this study interviews were audio recorded for accuracy, the researcher checked the assistant's transcripts for accuracy by listening to the voice recorder while reading the transcripts for correctness.

3.3.5.2 Quality validity

Quality validity means that the researcher checks the accuracy of findings by using strategies namely: triangulation, member checking, rich and thick description including a description of the context, participants, methodology, analysis and interpretations, clarifying bias of the researcher by self-reflection, prolonged engagement and peer review (Botma 2010:231).

- Triangulation refers to multiple sources of data (Botma 2010:231). In the study the sources data were the voice recordings, transcripts, field and reflective notes and policy documents around HIV and AIDS and fertility regulation which were used to guide the development of the health education handbook.
- Member checking means checking the accuracy of findings by giving participants feedback about emerging interpretation or taking the final report back to participants (Botma 2010:231). During data collection the researcher asked for clarity where she did not understand the participant and paraphrased to confirm what she thought the participant was saying.

- Rich and thick description including a description of the context, participants, methodology, analysis and interpretations is provided in this report.
- Reflectivity refers to retrospective analysis of previous action and thoughts about what works well or does not work and needs to be changed (Polit & Beck 2014:295). The researcher kept a reflective journal about challenges that she had during the fieldwork such as interruptions by other family members and how the situation was handled, noise in the neighbourhood during the interview, and whether field notes forms needed additional headings or columns for description of the environment or behaviour of the participants.
- Reflexivity refers awareness that what the researcher brings to the research can affect the research such as the background, set of values, and social and professional identity. (Polit & Beck 2014:295; 2017:522). The researcher kept a reflexive journal on how she felt in the field work and whether her feelings, personal values as a Christian, and age influenced her observation about the participants' behaviour, or her personal values guided the probing that she did to participants or a participant is hiding or saying something or evading the question based on her age or work place (hospital). However, her social standing would not affect the participants because she is not a member of the community and not well known to community members. The researcher continuously self-interrogated and reflected to position herself well to probe deeply to obtain the participant perspectives on the values of masculinity.
- Peer review refers to the discussion with peers not involved in the study. The researcher held discussions with peers who are also PhD students at other universities. They listened to samples of interviews (audio recorder) while reading the transcript to evaluate the interviewing skills of the researcher and the accuracy of transcripts. Discussions of areas that needed improvement such as interrupting the participant, not asking leading questions, and not allowing values, background to guide the probing were held, to improve data quality.

3.3.5.3 Trustworthiness

Trustworthiness is "the degree of confidence that qualitative researchers have in their data" (Polit & Beck 2014:292).

Trustworthiness has four epistemological standards namely truth value, applicability, consistency and neutrality.

The truth-value refers to confidence of truthfulness of findings discovered from experiences as lived and perceived by the participants. Truth-value establishes the researcher's confidence in the accuracy and truth of the findings based on the research design, participants and context (Polit & Beck 2017:559). It is obtained through credibility, prolonged engagement, reflexivity of the researcher, triangulation, peer review (Botma 2014:233). In this study it was obtained through data triangulation and reflexivity discussed above. The researcher achieved prolonged engagement by collecting data for over 1 year (July 2017–July 2018).

Applicability refers to degree to which findings can be applied to other contexts and group, the generalizability of findings to larger populations through transferability (Botma 2014:233). It was achieved by data saturation, and thick description. The researcher continued with interviews until no new information was obtained and describing in details how the research was done.

Consistency refers to whether the findings will be consistent if the study was replicated with the same participants and in similar context (Botma 2014:233). It was achieved by dependability, triangulation of data sources, peer review and co-coding of data that have been described above.

Neutrality

Neutrality means freedom from bias during the research process and results description. The strategy to achieve it is confirmability through audit trail, triangulation, and reflexivity (Botma 2014:233). It was achieved by keeping field notes reflective and reflexive diaries, transcripts and policy documents around HIV and AIDS and fertility regulation.

In the following section is the discussion of strategies of trustworthiness that were used in this study. Triangulation, member checking, peer review and reflexivity were discussed in qualitative validity above.

- Credibility validates that there is a match between the participants' experiences and the researcher's reconstruction and representation of them. Credibility was

achieved by keeping field notes, voice recordings, transcripts and sampling till data saturation occurred. Data saturation occurred at participant 21 when no new information was obtained during the interview. The researcher also validated interpretation of what the participants said by paraphrasing, repeating, and asking for clarity.

- Transferability refers to fittingness or applicability; that is, whether the findings fit in other contexts or settings. Transferability was achieved by sampling participants with different characteristics of age, employment and highest educational standards.
- Dependability refers to the stability of data over time and context. It is a question of whether the same or similar results would be obtained if the study were to be replicated to same or similar participants in the same or similar context (Polit & Beck 2014:323). It was achieved by conducting a pilot study to exclude ambiguity in the interview guide and keeping an audit trail of tapes, transcript, field notes and policy documents around HIV and AIDS and fertility regulation.
- Confirmability requires auditing to determine acceptability and agreement between the researcher's interpretation and the actual findings (Polit & Beck 2017:559). Confirmability was achieved by means of a detailed description of the research process, keeping reflective and reflexive field notes (described above) and policy guidelines around HIV and AIDS and fertility regulation (in chapter 2 and 6).
- Prolonged engagement refers to spending a long time in the field in order to develop an in-depth understanding of the phenomenon (masculinity) under study, in a natural setting, participant homes in Nquthu from participants (men). The researcher collected data for more than one year, from July 2017 to July 2018 until data saturation was reached.
- Data saturation refers sampling until "no new information is obtained" or to a point of redundancy. In this study the researcher thought she had reached saturation by participant 13 participant, however, when the 14th participant was interviewed new information emerged. Interviews continued until no more new information emerged and sampling stopped at the 21st interview.

3.3.6 Ethical considerations

Ethics deals with matters of right and wrong. Ethical considerations are essential to the design of any research involving human subjects in order to protect the rights of the research participants (Polit & Beck 2014:84). The goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from research activities. In this study, the researcher obtained permission to conduct the study from the University of South Africa, the KZN Department of Health, the chief (*Inkosi*) and the headmen (*Izinduna*); obtained informed consent from the participants, and upheld the ethical principles of respect for human dignity, beneficence, and justice (Polit & Beck 2012:748). The results were a true reflection of what the participants said and there was no fabrication, falsification, exaggeration or manipulation of the data or findings (Botma et al 2010:26). The ethical principles were discussed in detail in chapter 1.

3.4 SCOPE OF THE STUDY

The study was confined to one health sub-district in KwaZulu-Natal and data was collected from twenty one participants by means of semi-structured interviews and field notes. The sample size was determined by sampling until no new information was obtained (data saturation) and sampling participants with different characteristics of age, occupation, highest educational standard (maximum variation).

3.5 CONCLUSION

This chapter described the research design and methodology. The researcher selected a generic qualitative, descriptive, exploratory and contextual research design.

Chapter 4 discusses the data analysis and interpretation, and findings with reference to the literature review.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION, AND FINDINGS

4.1 INTRODUCTION

Chapter 3 described the research design and methodology for the study. This chapter discusses the data analysis and interpretation, and results. The findings are discussed with reference to the literature review.

4.2 DATA MANAGEMENT AND ANALYSIS

Data collection and analysis occurred concurrently. The researcher conducted semi-structured interviews in isiZulu, which were recorded with two digital voice recorders, with the participants in their homes. The researcher and research assistant also kept field and reflective notes. Semi-structured interviews were chosen because the issues were personal and sensitive. Data were collected using an interview guide based on the HPM. Follow-up interviews were conducted with three of five participants who had committed to develop a plan of action to change behaviour to determine the successes or challenges they encountered trying to implement the action plan. Two were lost to follow up due to proceeding to higher education institutions. Most of the participants did not have a plan of action (16). The researcher wrote field notes immediately after each interview to prevent distraction and loss of concentration (Botma et al 2010:217). Only observational notes and keys to follow-up questions were written during the interviews. Permission to use a voice recorder and to write follow-up questions was obtained from the participants to ensure accuracy and to allow the researcher to concentrate during the interviews. Field notes refer to documentation of what is heard, seen, felt and thought by the researcher during an interview or focus group (Botma et al 2010:217). The observational notes recorded the participants' actions and how they looked, such as tired, happy or sad, withdrawn, enthusiastic, frowning, nodding, smiling, laughing, and shaking the head (Polit & Beck 2010:295; 2017:521).

The researcher listened to the tape-recorded interviews soon after the interviews to check whether they were audible and complete for reconstruction, if necessary; identify

possible follow-up questions, and critique her interviewing style in order to improve in subsequent interviews. The audio-recorded interviews were transcribed verbatim by the researcher and the research assistant. Transcribing included sigh, laugh, pause, confident, hesitant etc to enrich the depth of data. The data that was transcribed by the research assistant was verified by the researcher for correctness by listening to the tape while reading the transcript. The transcripts were then read and reread and broadly coded by the researcher according to the questions and prompts and probes in the interview guide. The left and right margins were left to make notes, one for personal notes such as thoughts, feelings and the other for categories

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2014:378). Content analysis was used to analyse the data by breaking it down to smaller units, coding and naming it according to the content they represent such respect, love, mentor etc. The steps that were followed were described. Data analysis was done concurrently with data collection and write up. At the end of each day the researcher analysed the data collected in the interviews.

Qualitative data is in the form of verbatim text of dialogues between the researcher and participants (Polit & Beck 2017:530). Qualitative analysis is the process of making sense of text and image data. It almost always occurs concurrently with data collection; there is no clear distinction between the end of data collection and the beginning of data analysis. However, there is gradual phasing out of data collection and phasing in data analysis (Botma et al 2010:220). The data analysis revealed the themes, categories, and subcategories that emerged from the data. The researcher conducted 21 interviews in and 3 follow-up interviews. Follow-up interviews were conducted with participants who had committed to develop a plan of action to prevent HIV and teenage pregnancy to determine the successes or challenges they encountered trying to implement the action plan and to verify correctness of findings.

The interview guide consisted of two key questions:

- What is expected of a man that one can call a man among men (a man of a kind or *indoda emadodeni*)?
- What is the role of a man in the prevention of HIV and AIDS and teenage pregnancy?

Prompts based on the HPM (see Annexure 1) were also used to guide the interview. The participants' responses are presented in their own words.

4.3 RESEARCH RESULTS

This section describes the participants' demographic profile, and the themes and sub-themes that emerged from the data. To protect the participants' anonymity, privacy and confidentiality, numbers were used. Tribal authority number 8 was selected and villages numbered 3, 7 and 9 were selected as the study areas. The twenty-one (21) participants were selected from these villages.

4.3.1 Participants' demographic profile

The participants' demographic profile included age, marital status, highest educational level, and employment status.

4.3.1.1 Age

The participants were aged 18-24 years with an average age of 21 years.

4.3.1.2 Highest educational level

The participants' educational level ranged from Grade 7 to tertiary education. Of the participants, 3 had tertiary education; 7 had passed Grade 12; 1 had failed Grade 12; 3 were high school dropouts, and 7 were in high school.

4.3.1.3 Occupation/employment

Of the participants, 3 were employed full-time; 8 were unemployed; 2 were interns; 1 was a student at a tertiary institution, and 7 were at high school.

4.3.1.4 Residential area

The participants were from villages 3, 7 and 9 in tribal authority 8. Of the participants, 8 were from village 7, 7 were from village 9, and 6 were from village 3.

4.3.1.5 Marital status

All the participants were single.

Table 4.1 presents the participants' demographic profile.

Table 4.1 Participants' demographic characteristics (P)

P No	Age in years	Highest educational level	Occupation/employ-ment status	Residential area	Marital status	Religious denomination
P1	19	Grade 10	Learner	Village 3	Single	Christian 4
P2	19	Grade 9	Learner	Village 3	Single	Christian 3
P3	19	Grade11	Learner	Village 3	Single	Christian 3
P4	21	Grade11	Unemployed	Village 7	Single	Christian 3
P5	24	Tertiary	Intern	Village 7	Single	Christian 5
P6	21	Grade 12	Employed	Village 9	Single	Christian 3
P7	18	Grade 10	Learner	Village 7	Single	Christian 4
P8	21	Grade 12	Unemployed	Village 9	Single	Christian 3
P9	20	Grade 12	Unemployed	Village 9	Single	Christian 4
P10	21	Tertiary	Intern	Village 3	Single	Christian 3
P11	23	Grade 10	Unemployed dropout	Village 3	Single	Christian 3
P12	19	Grade 12	Unemployed	Village 3	Single	Christian 3
P13	20	Grade 12	Unemployed	Village 9	Single	Christian 3
P14	24	Tertiary	Employed	Village 7	Single	Christian 1
P15	24	Grade 12	Employed	Village 7	Single	Christian 2
P16	21	Grade 12	Learner at tertiary	Village 7	Single	Christian 3
P17	19	Grade12	Learner	Village 9	Single	Non-Christian 1
P18	20	Grade 11	Learner	Village 9	Single	Non-Christian 2
P19	21	Grade 12	Learner	Village 9	Single	Christian 1
P21	23	Grade 7	Unemployed dropout	Village 7	Single	Christian 3
P22	18	Grade 7	Unemployed dropout	Village 7	Single	Non-Christian 1

Table 4.1 indicates that all (100%) the participants were rural residents because Nquthu sub-district is a typical rural tribal authority area under *amakhosi* (chiefs) and *izinduna* (headmen) (KZNDoH 2015:25). Nquthu is in a district (uMzinyathi) that has a 39.6%

unemployment rate (KZNDoH 2015:28). There are socio-economic, equity and infrastructure problems in the district with a poverty index of 93%. Poverty was one of the drivers of sexual crime in Ghana (Wrigley-Asante, Owusu, Oteng-Obabio & Owusu (2016:32) and risky sexual behaviour (Jennings, Mathai, Linnemayr, Trujillo, Mak'anyengo, Montgomery & Kerrigan 2017:2784; Pascoe, Langhaug, Mavhu, Hargreaves, Jaffar & Hayes 2015:e0115290). The mountains and deep valleys in the area compound the problems and difficulties of service delivery resulting in a lack of basic infrastructure, including safe drinking water, sanitation and access to electricity. Geographic-related problems are associated with problems to access to HIV care services (Lankowski, Sieder, Bangsberg & Tsai 2014:1199). Of the participants eligible for employment (excluding learners and interns), only 3 out of 12 were employed. The participants' educational level ranged between Grade 7 and tertiary level. All the participants who were still in high school were aged 18 and older. All the participants were single. Most of the participants were unemployed, dependent and living with their parents. The participants' mean age was 21 years.

4.3.2 What is expected of a man one can call a man among men a man of a kind or *indoda emadodeni*?

The participants expressed different expectations of a man of essence, including traditional, religious (Christian and non-Christian), modern or general views and attributes (see table 4.2).

Table 4.2 Participants' expectations of a man among men (a man of essence)

Question	Themes (No of P)	Subthemes (some indicated more than one)
Expectations of a great man	He is the head	A man is superior (2) He is the head (1) A woman is inferior (2) Cannot listen to a woman (1) Cannot be told anything by a woman (1)
	Providing for the family (7)	Feed the family (3) Take care of family (3) Support (1) Look after (1)
	Self-esteem (3)	Self-esteem (2)

Question	Themes (No of P)	Subthemes (some indicated more than one)
		Loves himself (1)
	Loving and supportive (5)	
	Not engaging in risky behaviour (1)	Crime (1) Alcohol (2) Cheating (2)
	Busy (5)	Gardening (3) Herding cattle (2) Community development (1) Hard working (2) Helping (3)
	Respectful (3)	Respect (2) Not insolent (1) Does not look down on others (1)
	Role modelling (4)	Role model (2) Precept and example (2)
	Mentor (5)	
	Treats women well (6)	Treats her well (3) Respects women (5) Protects women (1)
	Communication skills (1)	
	Married (2)	
	Has a house (2)	
	Against violence	Physical abuse Raises voice Emotional abuse
	Values education (1)	
	Humble (1)	Says sorry when necessary (1)
	Focused (1)	
	Counsellor (1)	
	Independent (1)	
	Trustworthy (2)	

4.3.2.1 He is the head

The participants who indicated the position of a man of essence seemed to subscribe to hegemonic masculinity because they said that he is the head of the household. Women and children who are his subordinates must listen to him. Some participants said his word is law, but his partner could voice her opinion although he is the final decision maker.

According to participants:

> A man of essence, yes madam, he is in charge at home, it is a man (*ubaba*). Yes, his word is strong madam, he is, and he is a male (*ungowesilisa*). It is the law of the household just like that madam. She can talk to him but the man's word is law of the household. (Participant 21, 23 years old, unemployed high school dropout from village 7)

> In Zulu tradition or culture I have heard that a man, a man is superior, he is the head. So even as we start a relationship, we adopt that style because it is something we heard that a man is supposed to be superior and a woman is supposed to be inferior, you see. I cannot listen to a woman, I cannot be told anything by a woman. (Participant 14, 24 years old, Christian denomination1, from village 7)

These findings are disturbing because Albee [s.a.] found that socialization of a hegemonic male seemed to be the root of gender violence.

However, the participant indicated further that there is a change in male domination if a man is a believer:

> But in believing (eku*kholweni*), love needs to dominate, because love must dominate even if you see that you are superior to the woman (*nom' uyabon' ukuth' umkhulu kunowesifazane*) it [love] will end up humbling you (*lukuthobisa, lukwehlisa*). (Participant 14, 24 years old, Christian denomination1, from village 7)

About gender equality, participants' views differed:

> I do not agree with a woman equal to a man. A man is supposed to be superior (*ubaba kumele abe mkhulu*) to a woman. A woman is supposed to be inferior. She is supposed to listen to him all the time, to what he says to her, and do as he says. (Participant 21, 18 years old, high school dropout from village 7, emphatically)

> The head of the household is a man (*ubaba*). They talk to each other; I can say the two should cooperate. I am not against human rights. Madam, if we say the

> rights of men are superior, women will be abused. If we say those of women are superior, women will run on top of men's heads. They should be equal, which is 50/50. (Participant 22, 18 years old, high school dropout from village 7)

In urban informal settlements in South Africa, Gibbs et al (2014:15) found that men control women and may even use violence to achieve respect or restore their dignity and respect. Controlling behaviour includes checking their partners' cell phone messages, blocking messages, calling them even at night and expecting them to reply. Violent behaviour may include beating or hitting them. Reasons for violence against women may include alleged disrespectfulness due to financial independence, alleged cheating and refusing to have sex (Gibbs et al 2014:15).

Ratele (2015) found resistance to gender equality and progressive masculinities among boys and men. According to tradition, the position of a man is superior and head of a woman in a relationship who must respect the man (Ratele 2015:151). In a study on socio-cultural factors influencing HIV disclosure among men in South Africa, Iwelumor, Sofolahan-Oladeinde and Airhihenbuwa (2015:195) found that men's perception of superiority was accompanied by the notion of not being susceptible to HIV infection. HIV was considered something remote that they would never contract. Gendered social norms that favour male domination in sexual relationships are risk factors for HIV infection among young women (Harrison et al 2015:207).

In a study in Ghana, Ganle (2015:763) found that although young people were aware of risk factors of HIV and AIDS infection, hegemonic masculinity and a perception of not being vulnerable to HIV were negatively associated with HIV-prevention behaviour. However, Dworkin (2013:181) found that men who had completed a "One Man Can" (OMC) workshop run by Sonke Gender Justice in South Africa had a better understanding of how masculinity and subordination of women were related to violence and the risk of HIV infection.

4.3.2.2 Providing for the family

Some of the participants described a man of essence in terms of his responsibilities.

Participants used the words *provide*, *look after*, *take care of*, *buy clothes*, *see to the needs of* and *feed* interchangeably to express the role of a man as a provider. Some participants expressed more than one way of providing for the family, others were not specific, and most concentrated on food. According to participants:

> It is a person who works with dedication (*osebenza ngokuzinikela*) to take care of his family by all means. Yes he is responsible for taking care of his family and his children. He is hunter to feed them (*abondle*). I can say that a man is provider like a root of a tree that provides for the whole tree; it is the one that must do what he needs to do. Yes, he is the one who is responsible for looking after his family and his children. He is the one who sees what is needed at home, all of that is his responsibility as a man, including food. (Participant 5, 21 years old, employed, from village 7, confidently)

> What is expected of me as a man is that I should be able to feed my family, be able just like my father to be able to help wherever he can. (Participant 1, 19 years, Grade 11 high school learner, from village 9, nervously).

> What I can say is that men should be able to take care of their families so that they are protected eh so that if you are a man, you are able to handle and rule your family, not only your family eh the whole community. If they are both working, both buy clothes for them. (Participant 6, 24 years old, from village 7)

> I see feeding (family) as a good thing because if you buy food at home or you buy clothes for a child, you are growing that child so that he would also want to do it or say when I start working, I would want to do this to my nephews or my sisters that I live with. I see it as a good thing for a man to buy clothes for children. (Participant 4, 21 years old, unemployed, from village 7, relaxed)

> To support means your family will not be hungry. (Participant 9, 20 years old, unemployed, from village 9)

> According to my knowledge, I can say that eh a man among men is a person who takes care of his family, who takes care of his family. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> The way I see it, a person who is a man among men is a person who can afford to take care of his family; to take care of especially women and children. (Participant 8, 21 years old, unemployed, from village 9)

In a study in Nigeria to investigate desirable qualities of a marriage partner among female undergraduate students, Onu & Armstrong (2013:84) found that "financially comfortable" was ranked the seventh (4%) quality by the participants. This implied that they did not want to lack anything after marriage (Onu & Armstrong 2013:84). In this study, the participants stated that a man must be able to provide for his family. In a study on masculinity and poverty among urban marginalised Kenyan men, poverty associated with inability to provide for the family was a constraint to masculinity and being a "proper" man (Izugbara 2015:121-137).

4.3.2.3 High self-esteem

Some of the participants described a man of essence in terms of his personal attributes, such as self-esteem, loving, and supportive. According to participants:

> A man among men is a person that I can describe as having a high self-esteem and who loves himself." (Participant 4, 21 years old, unemployed, from village 7)

> A man knows that this word that says 'I am a man' I must live up to this word. So man makes sure that he lives up to this word 'I am a man'. (Participant 8, unemployed, from village 9)

A perceived low self-esteem (positioned as children) among men was found associated with dependency on other family members (Gibbs et al 2014:13). In a study on the relationship between perceived self-esteem and sexual risk behaviour among males 14-18 years old, Ramiro, Teva, Bermudez & Buela-Casal (2013:181) found that low self-esteem was associated with risky vaginal, oral and anal sex.

4.3.2.4 Loving and supportive

In this study some participants expressed the need of loving relationships with fathers:

> What I expect from my father is that as his children, eh, is that he treats us equally, not love this one more than that one, to treat them (children) nicely, love them, because it would be a problem if maybe he were to love one more, buy this one clothes and leave this one. He must just love them equally. If he does something, do it for all (boys and girls) of them because if he loves boys more it is unfair. He better love them all equally. (Participant 2, 19 years old, Grade 11 high school learner, from village 3)

> My father gives every child the love he or she needs, such as eh when you ask for something, he does it for you. When he cannot afford it, he tells you that my child I do not have this but this is what I can give you. (Participant 1, 19 years old, Grade 10 high school learner, from village 3)

> According to me, a man is a person who has a lot of love, who can really love his wife and his children. (Participant 9, 20 years old, unemployed, from village 9)

> He is a loving person who puts his family first, who does not put himself first. (Participant 8, unemployed, from village 9)

> He is supposed to support his wife in all circumstances she meets, when she is sick or in whatever she is going through always give her his support. (Participant 5, 21 years old, employed, from village 9)

The loving relationship between father and son reduces the chances of early sexual debut in boys (Noguiera Avelar E Silva, Van de Bongardt, Van de Looij-Jansen, Wijtzes & Raat 2016:e20160782). Perceived social support from friends and parents among adolescents reduces risky sexual behaviour (Ramiro et al 2013:181; Cluver, Orkin, Yakubovich & Sherr 2016:96). Regarding associations between fathers' and sons' sexual risk in rural Kenya, Giusto, Green and Puffer (2017:219) found that a loving relationship between a father and a son positively influenced the son's sexual behaviour. If a father did not engage in risky sexual behaviour and had a loving father-son relationship with his son, his son was likely to be sexually inactive. If a father who was engaging in risky sexual behaviour had a very strong loving relationship with his son, parenting had a positive effect on his son's behaviour (Giusto et al 2017:219).

4.3.2.5 Not engaging in risky behaviour

Some of the participants' description of a man of essence was based on behaviour.

In this study only a few participants said that a man should not engage in risky behaviour such as crime (Romero, Teplin, McCleland, Abram, Welty & Washburn 2007:e1126), alcohol and drug abuse (De Vries, Child, Bacchus, Mak, Falder, Graham, Watts & Heise 2014:379; Shorey, Stuart, McNully & Moore 2014:365), and having multiple sexual partners.

4.3.2.5.1 Not committing crime

One participant stated that a man should not commit crime.

> There are no criminal cases against him. He should not be a troublesome young man. (Participant 5, 21 years old, employed, from village 9)

Crime is associated with risky and persistent sexual behaviours thereby increasing the risk of HIV infection. A study to determine the prevalence, development and persistence of drug and sex risk behaviours among juvenile prisoners three and fourteen years after prison, found that males had a higher persistence of sexual risk behaviours and had even developed new ones (Romero et al 2007:e1126).

4.3.2.5.2 Not drinking

Two participants indicated that a man should not abuse alcohol. One said that even if he drinks his family need not know about it. According to the participants:

> He does not forget when he gets paid and drink alcohol and forget his family. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> Even if he drinks, he says that his family should not know about it because it is very important. (Participant 8, 21 years old, unemployed, from village 9)

An investigation into the relationship between partner physical or sexual violence and alcohol consumption revealed an association between alcohol use and intimate partner physical and sexual abuse among women (De Vries, Child et al 2014:379). Alcohol consumption was also associated with male-perpetrated sexual dating violence (Shorey et al 2014:365). These behaviours increase the risk of HIV infection. One of the risk factors associated with HIV infection is alcohol abuse (Sandfort, Lane, Dolezal & Reddy 2015:2270).

4.3.2.5.3 He does not cheat

The participants indicated that a man among men did not cheat:

> He should have one partner, not cheat. A man that does not have one partner, but has this partner then that partner ends up having children by different women because that is eh, eh the main cause of infection with HIV most of the time. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> He does not sleep around. His faithfulness comes from within and he does not lie to the other person. (Participant 5, 21 years old, employed, from village 9)

> This person does not cheat, he sticks to his wife. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> He does not cheat; he does not commit adultery. (Participant 12, 19 years old, unemployed**,** from village 3)

> I think this is a person who is faithful to the person he is in relationship with. (Participant 19, 21 years old, grade 12**,** from village 7)

A study in Kenya to determine whether sexual risk may be inherited through generations of men found that if fathers engaged in high risk sex, their sons were more likely to have sex (Giusto et al 2017:219). Undergraduate female students in Nigeria ranked “God fearing” as the first desirable quality for a marriage partner. This implied that a God fearing man would not cheat because of the fear of God (Onu & Armstrong 2013:83).

In this study, six participants stated the value of not cheating or having one partner or not sleeping around for fear of HIV infection which is associated with multiple sexual partners (Kim, Parekh, Umuro, Galgalo, Bunell, Makokha, Dobbs, Murithi, Muraguri, De Cock & Memin 2016:7).

4.3.2.5.4 Busy

Idleness is associated with high-risk sexual activities. A study to investigate sexual behaviour among street youth in Gondar, Ethiopia, revealed that street youth were vulnerable to HIV and AIDS due to engaging in high-risk sexual behaviour, such as inconsistent condom use, multiple sexual partners, and substance abuse. Street youth included young people who had no home but the streets, and some who visited their family regularly, who might even sleep at home every night, but spent most days and some nights on the streets (Negash, Tadesse, Zelalem & Kefyalew 2013:234).

In this study, some of the participants indicated household chores that men should do, such as gardening and herding cattle. Some were not specific but stated that a man should be available to help whenever necessary.

4.3.2.5.4.1 Gardening

According to the participants:

> At home there are things that I am expected to do so that there is no need to ask people from outside while I am here and capable of doing them, such as gardening (*njengokucenta*). Gardening is my duty as a man; it is my duty to look after the home. (Participant 1, 19 years old, Grade 11 high school learner, from village 3, shyly)

> Yes, food and looking after the home, also seeing what is going on in the yard, yes, all those things are his responsibilities. (Participant 5, 21 years old, employed, from village 9)

> Duties such as those that cannot be done by women, such as looking after the premises, it is a man's responsibility to look after the premises. (Participant 7, 18 years old, Grade 11 high school learner, from village 7, confidently)

4.3.2.5.4.2 Herding the cattle

According to the participants:

> Maybe herding the cattle, maybe there are cattle, people from outside should not be involved. It is understandable if I am working because I cannot do it. Involving people from outside, no, I would rather do it. (Participant 1, 19 years old, Grade 11 high school learner, from village 3)

> Usually boys bring cattle home and some do not do anything at all, saying that because he is a boy he will not do anything, which is bad. (Participant 5, 21 years old, employed, from village 9, boldly)

4.3.2.4.5.3 Helping whenever there is a need at home and in the community

According to the participants:

> His presence in the household should show by what he is doing, not by doing (only) big things, just helping wherever there is a need, even if he is unemployed. Show that there is a young man in the home, who helps his parent when he or she asks him to do something for him or her, do it. When his mother asks him to help, she gets helped. It is just that I like to be a helpful person in the community. (Participant 4, 21 years old, unemployed, from village 7)

> He is helpful here and there where he can help. (Participant 5, 21 years old, employed, from village 9)

> He should be able to help other people, not be selfish. Maybe such as when he or she is working, be helpful to the needy. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

4.3.2.5.4.4 Community development

One participant indicated that a man should participate in community development:

> As community members we should unite, fight poverty in our communities; help each other because you cannot do anything alone. You should unite as a group; one brings an idea and you work on it to come up with something that will be helpful to all community members. (Participant 4, 21 years old, unemployed, from village 7)

In a study in Kampala, Uganda, to assess the impact of a community mobilisation intervention to prevent violence against women and reduce HIV, Abramsky, Devries, Kiss, Kyegombe, Starmann, Cundill, Francisco, Kaye, Musuya, Michau and Watts (2014:122) found that the intervention was associated with lower social acceptance of intimate partner violence (IPV) among women and greater acceptance that women had a right to refuse sex; lower physical and sexual IPV, and greater community support of women who experienced IPV.

4.3.2.5.4.5 Hardworking

Some of the participants said that a man should also work hard. According to a participant:

> Oh he works hard (*ngokuzikhandla*) or with dedication (*noma ngokuzinikela*). (Participant 5, 21 years old, employed, from village 9)

> A person who is a man among men is a person who can work hard if he has children when he does that job. (participant 21, 23 years old, unemployed high school dropout, from village 9)

Onu and Armstrong (2013:82) found that female undergraduate participants listed being hard working as one of the qualities in the ideal man.

4.3.2.6 Respectful

Some of the participants indicated respect for other people, young and old, including women, as a positive value of masculinity. According to the participants:

Eish, I think also that as a person who is a man (*futhi njengomuntu owubaba*) respect also is important, that you respect the people you live your life with at home. (Participant 1, 19 years old, Grade 11 high school learner, from village 3)

He is a person who knows that in this world as we live you respect the old and respect the young (*uhlonipha omdala uhloniphe omncane*); a person who respects his family. Even if he drinks, he says that his family should not know about it. (Participant 9, 20 years old, unemployed, from village 9)

Because he is agreeable to living with other people, he gives them that respect because he knows that a person respects the young and the old. (Participant 8, 21 years old, unemployed, from village 9)

Behaving well, I can explain it, eh, as taking interest in another person's needs, not to be insolent or look down upon other people. (Participant 6, 24 years old, employed, from village 7)

There is an association between delinquent youth and the risk of HIV and other STIs. Romero et al (2007:e1126) found a high prevalence, development, and persistence of HIV/STI risk factors in delinquent youth.

4.3.2.7 Good role modelling

The participants indicated the positive value of being a role model and that a man should be a role model for his family and the community. According to the participants:

If you buy food or buy clothes for a child, it motivates the child to want to do it or say 'when I grow up I want to do this for so and so', such as nephews or sisters. (Participant 4, 21 years old, unemployed, from village 7)

He is also being a good role model in the community. (Participant 5, 21 years old, employed, from village 9)

Also in the community he should be a good role model. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> He is a man that knows that as a man he should live according to the words “I am a man”. (Participant 8, 21 years old, unemployed, from village 9)

Hurd, Zimmerman and Xue (2009:777) found that role models increased the resistance of youth exposed to negative behaviour.

4.3.2.8 Mentor

The participants felt that parents should communicate with their children about responsibility, including sexual behaviour.

A review of studies on the impact of parent-child communication interventions on sex behaviours among Black/African-American and Hispanic/Latino youth found a significant reduction in sexual risk behaviour due to parent-child communication (Satton, Lasswell, Lanier & Miller 2013:369). Positive parenting was associated with reducing HIV-risk behaviour among adolescents in South Africa (Cluver, Orkin, Boyes & Sherr 2014:S389).

4.3.2.8.1 Gives advice

According to a participant:

> He is able to give good advice to others. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.8.2 Precept and example

According to a participant:

> I see feeding (family) as a good thing because if you buy food at home or you buy clothes for a child, you are motivating that child so that he would also want to do it or say, when I start working I would want to do this to my nephews or my sisters that I live with. I see it as a good thing for a man to buy clothes for children. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.8.3 Teach

According to the participants:

> A man among men is a person who by all means does what he has to do. He knows what he is supposed to do, such as being a teacher to his children, teaching his children how they should live so that they grow up the way he wants them to grow. He teaches the boys what they should do, that boys and girls are equal, and there are no household chores that can only be done by boys or girls. (Participant 5, 21 years old, employed, from village 9)

> Eh to be a man is to be able to manage not only your family eh, so that the whole community benefits such as when he says so and so my child, you are not supposed to do like this, like this, like this and like this. (Participant 6, 24 years old, employed, from village 7, stuttering)

> A man should also educate his children on how to behave. (Participant 9, 20 years old, unemployed, from village 9)

> A father teaches his children that everybody passes through adolescence and its temptations but you should not give in to temptations; do not have many girlfriends, and always remember that AIDS kills. (Participant 8, 21 years old, unemployed, from village 9)

4.3.2.9 Treats women well

The participants expressed different views on how women should be treated from treating her well, respecting her by giving her her place, allowing her to express her opinion, involving her in decision making, helping her, protecting her, to not being abusive to women, including not shouting at her and not beating her.

According to the participants:

> It is expected that he treats a woman well and does things that they never agreed or spoke about. (Participant 1, 19 years old, Grade 11 high school learner, from village 3)

> The way I see it is that we should treat girls well because a man cannot have a home without a woman who can assist him to complete the family. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)
>
> I can see that it is important to treat women well. (Participant 4, 21 years old, unemployed, from village 7)
>
> He is a person who can treat women well. He does not abuse them, beat her. He treats people of the opposite sex well. (Participant 10, 21 years old, intern**,** from village 7)
>
> If you are a man among men, you are supposed to treat a woman you live with well. Do not beat her; it is wrong to beat a woman, it is a crime. Do not fight with her, but talk together as people. You do not put your hand on her or chase her back to where she came from. Do things with justice. (Participant 11, 21 years old, high school dropout**,** unemployed, from village 3)

Regarding the prevalence of and factors associated with male perpetration of intimate violence in Asia and the Pacific, Fulu, Jewkes, Roselli and Garcia-Moreno (2013:e188) found physical, sexual, emotional, and economic violence prevalent. Moreover, factors such as gender and relationship practices experiences of childhood trauma, alcohol abuse, low education, and poverty contributed to violence.

Men who commit violent crimes against women, including serial raping, are angry because they may have been abused or neglected as children. They take out their anger on women because they are easy targets (SABC 2, *When duty calls*, 21 September 2017, 22:00). Interventions should include men and boys to change social norms on relationships between men and women to reduce violence against women and girls (Jewkes, Flood & Lang 2015:1581).

According to UNAIDS (2015a), gender inequality leads to lack of decision making which perpetuates poverty and the risk of early pregnancy and HIV infection. Ending discrimination against women and girls helps to improve economic growth and development.

4.3.2.9.1 Respects her

According to the participants:

> A man among men when it comes to treating women, firstly respects a woman, does not take her anyhow. Maybe they are in a relationship, respects her, listens to the woman's opinion, not his word is final (*kungabi uzwi lakhe*), as I am the boss (*kuthiwa yimina obusayo la kule*) relationship. I think he is a person with respect towards a woman who seeks her opinion (*abazobonisana*), something like that. We know that most of the time things happen in relationships. There is woman abuse, he is not the person you find out he is physically abusing a woman. He beats her, he calls her names, he insults her, I mean such things. (Participant 14, 24 years old, employed, from village 7**,** from Christian denomination 1)

> I think when it comes to relationships, the way I think, I think a man among men means you must be ready for a relationship before you start. Know that as a man what you need to do when you are in a relationship, such as respecting, give each other time to voice her or his opinion, discuss. If it is wrong, and change it. Maybe the woman says something you do not agree with, you tell her in a good manner explaining to her what you mean, not in a manner that will make you to quarrel and end up fighting, something like that maybe even with words (*seniphikisana ngamazwi*) which may be painful sometimes. (Participant 16, 21 years old, learner at a tertiary institution, from village 7, from Christian denomination 2)

> He does not do things they did not agree or talk about. He talks to his wife to hear how she feels about it because it is not good if all the time what he says is what happens. (Participant 1, 19 years old, Grade 11 high school learner, from village 3, with a lot of effort)

> He is not a troublesome young man at home. When his mother asks him to do something for her, he does. (Participant 4, 21 years old, unemployed, from village 7)

> You respect her and give her a place as your woman. She must be allowed to voice her opinions just as you are allowed to voice yours. You do not make

decisions without your wife. You both discuss issues and reach consensus. (Participant 5, 21 years old, employed, from village 9)

4.3.2.9.2 Protects her

According to a participant:

> Eh to protect her in many things. Protect her when, for example, they look down upon her or they discriminate against her, or bully her or abuse her. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.9.3 Does not abuse her

According to the participants:

> We should avoid being at loggerheads. If we do not see eye to eye, we must resolve our issue without shouting, but sit down and talk until we resolve the issue. I have seen it (violence) on TV and it is not a good thing. (Participant 4, 21 years old**,** unemployed**,** from village 7)

> He does not beat his wife, he protects her. He helps her and does not allow her to be overworked. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> Eh *eish*, the way to protect a woman, concerning sex, you as a male you do not abuse a woman. That is a way to protect a woman, to see that as the one who is close to her make sure that she is not sexually abused. Also, if you know someone who is sexually abusive, you can take steps to protect a woman. (Participant 10, 20 years old, intern**,** from village 3, after struggling with words)

> He knows that when there are problems, then he sees that OK there is my punch bag at home, only to find out that his punch bag he is talking about is the person he is married to. Although it happens, they are not supposed to argue. A man is supposed to take care of his family, protect it at all times, make sure that his family is right. (Participant 8, 21 years old, unemployed, from village 7, angrily)

It is not a man of essence who likes violence because if you are man, we believe that you fix things with your mouth (*ulungise izinto ngomlomo*), not fighting. You cannot say you are a man but you beat your wife … There is no need to beat her. Killing her is worse. If she does not love you, there are so many women out there; there is no need to kill her. You should move on with your life." (Participant 12, 19 years old, unemployed, from village 3)

He does not abuse her. Like when there is a dispute between them, to usually sit down and talk and resolve it without having to beat her. I also think that not talking to her when you have a dispute, just leaving her like that … just leaving the house is a form of abuse because she does not know what you think; she does not know what you think as you leave. I think that is a kind of abuse. (Participant 19, 21 years old, high school learner, from village 9.

This thing [sexual abuse] is not right; you really and truly (*kahle kahle*) have not shown that you are a man in that case. My father told me that a woman is respected; you talk together, if you agree with each other or you do not agree you understand. No this thing [rape] is not right because in that case you are not acting like a real man. I do not support it, eh, because everyone knows that in this world we talk together. Do not force her, do not make her do anything against her will or do something to her that she does not like. (Participant 8, 21 years old, unemployed, from village 9)

I think it happens sometimes. We youth, it happens to us that you use your money to make her happy expecting that she will also do a favour for you of ending up sleeping with you only to find out that she was not of that mind. She was thinking that you are making her happy. When she refuses, it is when you force her to sleep with you. No, it is a very bad thing, you should talk to her; if you really love you will talk to her and not force her if she is not ready to sleep with you. (Participant 19, 21 years old, high school learner**,** from village 9)

In a study in urban informal settlements in South Africa, Gibbs et al (2014:23676) found that participants indicated that a man talks well with his wife and is not violent.

4.3.2.9.4 He is not a blesser

> Today there are these people who live under the thing called ‘blesser’. No, it does not suit him (a man among men) ... pause ... it does not suit him. (Participant 9, 20 years old, unemployed, from village 9, disgusted)

> The blesser, too, promotes teenage pregnancy and the spread HIV because it may happen that one of them knows he is sick (with HIV) and is taking ART, a young girl because she is poor, needs money, and they will sleep without a protection [condom]. (Participant 8, 21 years old, unemployed, from village 9)

One participant said that he did not believe that a man could rape a young girl:

> *Eish*, this thing ... it is difficult. I do not believe it, but we do not know because a man who is a man among men (*ubaba oyindod’ emadodeni*) will not will not (*ngeke, ngeke*) abuse his daughter sexually. It can happen, but I do not believe it ... pause ... it happens. It can happen that an adult man sexually abuses a young child sexually is not right. (Participant 9, 20 years old, unemployed, from village 9, with disbelief)

4.3.2.9.5 Helps her

According to a participant:

> When she needs something, you must be able to help her. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.10 He is married

The participants were not married. Two participants stated that a man of essence is married:

> He is a married man and has a house, not the one who is not married. Those that are not married are not real men. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> He is a married man who lives with his children. (Participant 9, 20 years old, unemployed, from village 7, boldly)

One participant did not say "married", but used "adultery" (*ukuphinga*) and "does not bring infections home" to show that he was talking about a married man:

> He does not cheat, putting it right; he does not commit adultery (*akaphingi*). If it happens that he cheats, he uses a condom so that he may not bring pandemic infections home (*ukuze ngingeke ngilethel' umuntu lo wasendlini izifo lezi esezigcwel' emhlabeni*). (Participant 12, 19 years old, unemployed, from village 3)

Marriage is a rite of passage to establishing his own household and becoming a respectable man (*umnumzane*) in Zulu culture (Maureau 2014:152). The participants also associated being married as a sign of masculinity.

In an examination of the prevalence and incidence of HIV infection, trends, and risk factors among persons aged 15 to 64 years Kenya to identify factors associated with HIV infection, marriage was not protective to both sexes, instead being separated, divorced or widowed was associated with undiagnosed HIV infection (Kimanga, Ogola, Umuro, Ng'ang'a, Kimondo, Murithi, Muttunga, Waruiru, Mohammed, Sharrif, De Cock & Kim 2014:s13-s26). In China, a study to investigate sexual behaviours in a city with a high prevalence of STIs and HIV it was found that respondents engaged in risky social behaviours including sexual activity among never married men and women (Huang, Abler, Pan, Henderson, Wang, Yao & Parish 2013:118).

In their investigation of behavioural, biological, and demographic risk and protective factors for new HIV infections among youth in Rakai, Uganda, Santelli, Edelstein, Mathur, Wei, Zhang, Orr, Higgins, Nalugoda, Gray, Wawer & Serwadda (2014:393) found that married and single participants did not practise protective sex.

4.3.2.11 Values education

In this study only one participant indicated the importance of education generally. Some participants specifically referred to the importance of educating girls for various reasons

such as preventing dependence on men, poverty that can lead to transactional sex, helping their families, and helping the community with their skill. According to the participants:

> The first thing is to know that education is important before you do other things not to waste the opportunity given to you to get educated. *(*Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> It increases chances of living your life independently. (Participant 17, 19 years old, grade 12 learner**,** from village 9)

> You end up being independent because you find that many uneducated people need things to be done for them by men. But if one is educated, you get a job; earn your own money (*ethi wena*). (Participant 18, 20 years old, high school learner, from village 9)

> It is important for girls to be educated. Yes, so that she can be independent, that she gets what she wants when she wants it, not to depend on a man or the father of so and so [her child] … She will not be dependent on a man … and only need a man in her life not because he is going to be her breadwinner … She may end up selling her body [engaging in transactional sex] if she is not educated. (Participant 12, 19 years old, unemployed, from village 3)

> I see education of girls as important because life is difficult for an uneducated woman because women cannot live a good life without education because when she has children and there is no one else to help her feed the children it becomes difficult for her to feed the children alone. Yes the poverty level goes down because they get educated and succeed, get employed and then it is easy to support themselves because most of the time women can support themselves if they are educated these days. If not educated, they can end up selling their bodies [engaging in transactional sex], something like that, because they do not know what to do. (Participant 13, 20 years old, unemployed**,** from village 3)

> *Hawu* (oh my word), it is the right thing, madam. You know, it happens sometimes that you do not educate a girl; maybe it would be the girl who will help. You see that, madam. Even when she is married, here at home she helps. You see that. Maybe she is married, the month is in a bad way, you see that, madam, maybe she is educated, she is going to try [help] you with whatever she

can (*uzokhon' ukuthi akuzame ngalokho akuzama ngakho*). She can be very helpful if a woman is educated, she can be really helpful. (Participant 22, 18 years old, from village 3, surprised at the possibility of not educating girls deliberately)

I agree with that because most of the time they give us knowledge, they end up being nurses nursing men in hospitals. Those people are educated. Yes madam, concerning health I can say they help in many things because they acquire a lot of knowledge, they are educated, they educate, and they are teachers concerning health. Today they can, they educate our children at the schools today. They can teach. Those are educated people, madam. Poverty, eh, you can see the person who is not educated. (Participant 21, 23 years old, from village 3)

Low education and poverty were among the factors associated with intimate partner violence (IPV), including sexual violence (Fulu et al 2013:e187-e207).

There was a positive association between transactional sex and HIV (Wamoyi, Stobeanau, Bobrova, Abramsky, and Watts 2016:20992)

4.3.2.12 He is against violence

The participants stated that a man should be against violence in the household and in the community, including violence against women.

4.3.2.12.1 Violence among family members and children

According to the participants:

Physical violence against each other as family members does not unite the family. Sometimes, you see, violence is most of the time the cause of divisions in the family. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

When you are at home, you should not be verbally or physically abusive to the children. If a child has been naughty, do not beat him or her, no. Sit down with the child and talk to him or her about the unacceptable behaviour so that when he

or she grows up he or she knows that a child who is misbehaving is rebuked in order to change his or her behaviour. (Participant 4, 21 years old, unemployed, from village 7)

Taking care, we can say that your family should not experience this thing called abuse. You make sure that they hear about it from TV or maybe from the radio but they should not experience it. (Participant 8, 21 years old, unemployed, from village 9)

4.3.2.12.2 Violence against women

According to the participants:

I do not recommend violence, it is very bad. We boys should protect women. We are supposed to avoid drug abuse that leads to violence against women. We men are supposed to protect women. We must resolve our issues without shouting but sit down and talk until we resolve the issue. I have seen it (violence) on TV and it is not a good thing. (Participant 4, 21 years old, unemployed, from village 7)

The way to talk to her when you are with her should not include vulgar language. You respect her and give her a place as your woman. (Participant 5, 21 years old, employed, from village 9)

He should be able to protect her from bad things … advise her on how to protect herself. He should look at a woman and not think about raping her. It is bad; it is corrupt to rape a woman. A woman should be respected. (Participant 6, 24 years old, employed, from village 7)

He does not beat his wife, he protects her. Women are not supposed to be beaten, because they are helpful people. They give birth and they also cook. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

4.3.2.12.3 Violence among community members

According to the participants:

> Take, for example, a child that beats a neighbour's child can end up causing hatred among neighbours. He may have started physical violence at home, hitting family members, growing up with the habit of physical violence and that he or she is good at it. Beating someone is actually physical abuse which makes the victim live in fear. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> If someone in the community is doing something wrong to him, he should not be easily provoked to use violence. (Participant 8, 21 years old, unemployed, from village 3)

4.3.2.13 Humbleness, counselling and good communication skills

One participant indicated the attributes of humbleness and counselling, and two referred to good communication skills as positive values of masculinity. Men's idea of being tough and unemotional does not include these attributes. Boys are socialised not to show vulnerability or caring. They learn to suppress their emotions from an early age (Heath, Brenner, Lannin, Vogel & Strass 2017:95). However, gender and relationship practices such as sexual, physical, emotional and economic abuse are associated with IPV (Fulu et al 2013:e188).

4.3.2.13.1 He is humble

According to a participant:

> When he is wrong he humbles himself and says sorry. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.13.2 Counsellor

According to a participant, a man should have counselling skills:

> He should be able to counsel a person. (Participant 4, 21 years old, unemployed, from village 7)

4.3.2.13.3 Good communication skills

According to two participants:

> He should be able to engage in a conversation, able to talk with people. (Participant 4, 21 years old, unemployed, from village 7)

> A person who knows that my children I must communicate with them, they are not supposed to be afraid of me. He must understand that he must laugh with them and also talk to them. (Participant 8, 21 years old, unemployed, from village 9)

According to Satton, Lasswell, Lanier and Miller (2013:369) parent-child communication interventions decreased risky sexual behaviour among youth thereby decreasing sexually transmitted infections including HIV.

4.3.2.14 Independent

One participant indicated independence as a positive value:

> In the community, I must be an independent person, be an independent man. (Participant 4, 21 years old, unemployed, from village 7)

Independence is a characteristic associated with masculinity and socially perceived as positive (Trillo & Redondo 2013:508; Gibbs et al 2014:23676).

4.3.2.15 Focused

One participant stated that a man should be focused.

> What is expected of a man is that a person should know what he wants. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

4.3.2.16 God fearing

Two participants stated that a man should fear God:

> Another thing, a man is a strict person (*umuntu oqotho*) who is supposed to have Jesus. This is very important to be able to be a man among men (*indod'eqotho*) because He teaches how a man should live. *Indod'eqotho* is a man with Jesus. … He [Jesus] is very helpful (*uyelekelela)* in many things … because there are things a man cannot succeed to do well without Jesus. (Participant 9, 20 years old, unemployed, from village 9)

> A man among men (*indod'eqotho*) knows that when things are tough, I go to my room and kneel down on my knees (*ngihlabe ngedolo phansi*) to talk to God and tell him all my sorrows because He is the one who understands everything. I can say that those who have their hope in God have eternal life, they have intelligence and they have wisdom (*banobuhlakani futhi banakho ukuhlakanipha*) like Samuel who heard and listened when God was calling him. (Participant 8, 21 years old, unemployed**,** from village 8)

Onu and Armstrong (2013:82) studied factors that influence the choices of mate selection among undergraduate females in Nigeria and found that the man that will win their love must first be respectable and God fearing. These girls probably hoped that the man would refrain from risky sexual behaviour with the risk of contracting HIV and other STIs out of the fear of God.

4.3.2.17 Forgiving

According to one participant:

> No, a man among man we can say that he can manage whatever situation at any time; a person who knows that a child (including a woman) of mine can disappoint me at any time. However, a day is not supposed to end without talking together and making peace (*singaxoxisananga saxolelana*); a person who knows that peace must be made before bedtime. (Participant 8, 21 years old, unemployed, from village 9)

4.3.2.18 Trustworthy

According to one participant:

> I think that he is a trustworthy person to the person he has a relationship with. He is trustworthy all the time; he has no secrets from the woman he is in love with. He does not hide anything from her. He is always trustworthy to her. (Participant 19, 21 years old, Grade 12 high school learner**,** from village 9)

4.3.3 What is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl?

The participants indicated different methods of protection against HIV and AIDS, mainly condom use. Most of the participants from Christian and non-Christian denominations indicated avoiding relationships until being physically and financially ready to marry. Traditionalists referred to special traditional methods and ceremonies of getting into a relationship that avoid engaging in sex prematurely, such as "*ukuqoma ngeduku*". One participant stated five preventive measures (abstain, be faithful, condomise, circumcise, and know your status).

Some participants' responses indicated inconsistent condom use while a few indicated knowing one's and the partner's HIV status. Abstinence was indicated after probing and one participant stated that abstinence was irrelevant these days because it does not happen. None of the participants indicated adherence to antiretroviral treatment (ART) as a preventive measure for HIV infection because they were not on ART or did not know about it.

Table 4.3 lists the participants' religious, traditional and modern methods of prevention of HIV and teenage pregnancy.

Table 4.3 Participants' views of their role as a man in the prevention of HIV and AIDS and teenage pregnancy

Question	Themes	Sub-themes
What is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl?	Avoid premarital sex	Sex before marriage is a sin. (5) Avoid relationships. (4) Break up relationship. (1) *Isoka* has nothing to do with sex. (1) Sleeping together must be avoided. (1) Sleeping with her is not a priority. (2) Avoid visiting each other. (1) Meet in public places. (1) Be friends with people of the same mind. (1) Be in a relationship with a person of the same mind. (1)
	Alternative ways to demonstrate love (2)	
	Wait for traditional ceremonies	Wait for rites of passage such as *umhlonyane*, *umemulo* and *ukuya uphondweni*.
	Avoid abduction of women	*Ukuthwala*
	Pay damages	Pay damages (4) Restore dignity of girl's home (1) Cleanse girl's home (2) Cleanse the girl (1)
	Non-penetrative sex	*Ukusoma* (sex between the girl's thighs or breasts) (2)
	Choose a lover or girl to marry	*Ukuqoma ngeduku* (6) Wait until you are old enough and financially ready to marry (1)
	Modern prevention	Abstain (4) Be faithful (3) Condomise (8) Circumcise (3) Know your status (6) Protective clothing (2)

The participants' methods are discussed next.

4.3.3.1 Avoid premarital sex

Christian and non-Christian participants indicated avoiding premarital sex. Several participants stated avoiding relationships until a man is old enough and financially ready to pay the bride price and marry the girl he has chosen. Christian participants stated that sex before marriage is a sin while Traditionalists believed that it was culturally

unacceptable and if it happened that a man slept with a virgin or impregnated a girl he should pay.

4.3.3.1.1 Sex before marriage is a sin

Some Christian and non-Christian participants believed that it is a sin to have sex before marriage as it is fornication and fornicators will not see the kingdom of God:

> We were taught that we should behave well and not have sex while we are still young. (Participant 12, 19 years old, unemployed**,** matriculated**,** from village 3, from Christian denomination 3)

> When we talk about relationships, it is not good and is not right to have sex out of wedlock, and fornicators will not see the kingdom of God (*kanjalo nezihlobongi aziyikuwubona umbuso kaNkulunkulu*). That means that there is no sleeping out of wedlock. When it comes to a relationship, it means I have to change that person I am in a relationship with so that according to religion you will be in a relationship (without sex) until you get married; then you do whatever you want to do (sex) in marriage. Yes eh, sisters in Christ are there, you see them every day in church, however if you have surrendered your life, according to my knowledge, if you are a child of God, you keep yourself pure while you grow up, study and start working until such time that you want to find a person to be in a relationship, pay *lobola* for that person and marry her. Yes, when you want to get married, you pay for that person, *ilobolo*, and get married. Then you can start a family according to my knowledge. (Participant 14, 24 years old, employed**,** from Christian denomination 1).

> According to faith (*inkolo*), sex is a sin before marriage. I can say that it applies to those who have surrendered their lives because they know that it (sex before marriage) is sin… They do not get infected with HIV and do not impregnate girls because they know that it is sin, instead they should keep themselves pure because it (sex before marriage) is sin. (Participant 18, 20 years old, grade 11 learner, from village 9, from non-Christian denomination 2)

One participant believed that both being in a relationship and sleeping together out of wedlock were sinful:

> What I know and what I was taught is that it is sin to have a relationship and sleep with a person you are not married to. It is a big sin. I am not sure about being in a relationship but I think it is sin because it wakes up feelings (sexual arousal). (Participant 19, 21 years old, high school learner, from village 9, from Christian denomination 1, hesitantly)

When asked what engaged couples should do about sex, two participants said that they should wait until they are married:

> *Eish*, when they are engaged, no, they can be engaged but they should be able to control themselves, you see, until they get married. (Participant 19, 21 years old**,** high school learner, from village 9, from Christian denomination 1, slowly, deep in thought)

> According to my knowledge, I know that eh when you are a child of God you surrender your life while you are still young. You surrender your life and keep yourself pure whether you are male or female while you are still young. You surrender your life and keep yourself pure. I am talking mainly on behalf of males (*abantu besilisa*). (Participant 17, 19 years old, high school learner**,** from village 9, Christian from non-Christian denomination 1)

According to IsiZulu culture, sex before marriage is avoided as a sign of respect for the girl and the father who taught him (Maureau 2014:152).

4.3.3.1.2 Avoid relationships with women until you are ready to marry

Most of the Christian participants who had committed themselves avoided being in a relationship for fear of being tempted to engage in sexual intercourse. According to the participants:

> I am not in a relationship. There is no one that I can say I am in a relationship with. As a believer, there are many things that I avoid as a person who accepted Jesus as Lord and saviour; there are dos and don'ts; there are things you can do and things you cannot do. So I avoid all don'ts as I have explained that once you are in a relationship in the long run you will end there (sex) in trouble of ending up having sex. So you have to withdraw from that danger that you may fall into, that sin. To us as believers, it is a sin as the Bible says it is sin. So I am avoiding that

> sin by avoiding a relationship because I may end up engaging in premarital sex, so I am avoiding that temptation that will make me fall into that sin. Yes, there are girls that you see every day in church, however, if you have surrendered your life you wait while you grow up, study, start working until that time when you get into a relationship with a person (girl), pay the bride price for her and marry her. (Participant 14, 24 years old, employed, from village 7**,** from Christian denomination 1, seemingly happy that he was not in a relationship)
>
> Yes, religiously I think the way to avoid having sex is avoiding a relationship. If you are in a relationship, you are likely to be tempted. Just wait until you can afford (*Belinde baze babenamandla*) the bride price. Then when you can afford it is when you can get yourself a person you can take [marry]. (Participant 19, 21 years old, high school learner, from village 9, from Christian denomination 1)
>
> You should have no relationship until you are ready to be married (*uze ube usukulungele ukuthi ungaganwa noma ungashadwa*). (Participant 16, 21 years old, student at a tertiary institution, from village 7, from Christian denomination 3)

Christianity views courting and sexual experimentation, such as *ukusoma*, as a form of sex that needs to be avoided as the body is the temple of God (Nelson 1982: 2 Corinthians 4:19).

4.3.3.1.3 Break up relationships

One Christian participant from a non-Christian denomination 1 who was in a relationship felt that he would need to leave his girlfriend in order to avoid the temptation of engaging in sexual intercourse:

> No, eh, I can say that no, I have got one girlfriend, there are not many. There are those things that you do not get rid of easily. Yes, it is difficult but I hope I will pass through this. It is difficult to separate with her, but trusting God to help me I hope to pass this. I am still holding up, I have not started having sex. Maybe it will help to drop her because she might pressurise me; I am not sure I will be able to avoid sex for too long. Maybe it will help me to leave her (*mhlampe kungangisiza ukumyeka*). (Participant 17, 19 years old, high school learner, from village 9, Christian from non-Christian denomination 1, hesitantly)

4.3.3.1.4 Nothing to do with sex (Ubusoka/having persuasive skills)

According to one participant:

> *Isoka* is a man who is known for his ability to persuade women to be in a relationship with him. Some would agree to be in a relationship with him. It has nothing to do with sex. (Participant 18, 20 years old, Grade 11 high school learner, from non-Christian denomination 2, from village 9)

Isoka refers to a man who is popular with women (Hunter 2004:130). In the 1800s when a young man could not afford to get married and become a respected man (*umnumzane*), he proved his masculinity by having many girlfriends. However, there was no penetrative sex with them (Hunter 2005:389, 391). In the 1940s, the word *isoka* evolved to mean a man with many sexual partners, however, he would eventually marry all of them (Hunter 2004:131). In the 1970s the word meant that the man had many girlfriends and was not expected to marry any of them. Today, a man with many sexual partners receives the same respect as a man who had many wives in the 1940s (Maureau 2014:157; Hunter 2004:125).

Gennrich (2013:46) states that traditional values of masculinity such as *ubusoka* (having many girlfriends) became distorted after colonialism. In the pre-colonial era, *ubusoka* did not allow penetrative sex. Later, *ubusoka* became equated with having many sexual partners (Gennrich 2013:46).

4.3.3.1.5 Avoid sleeping together (sex not a priority; not visiting each other; alternative ways to demonstrate love; waiting for traditional ceremonies)

Avoidance of sleeping together included sex not being a priority in a relationship, avoiding it even during negotiations of bridal price (*lobola*); not visiting each other; using alternative ways to demonstrate love, and waiting for traditional ceremonies before engaging in sex or choosing a girl to marry.

4.3.3.1.5.1 Sex not a priority

According to the participants:

> If a man has chosen a girl whom he is going to marry and they have agreed that they want to be together, the man would send a delegation to the girl's family. Sleeping with her was not a priority even after he had started the negotiations. The girl's family would make sure that she sleeps at home every night until the negotiations and the bride price has been paid then she was allowed to go and marry him. Sleeping together was avoided; there were few pregnancies among youth in the olden days. (Participant 17, 19 years old, Grade 12 high school learner, from village 3)

> Among elders (*abadala*) I think sleeping together was regulated. You would start a relationship. However, sleeping together, I think, was not number one in a relationship or they did not think that to demonstrate that you really love each other you should sleep together. It was really not like that in the olden days. (Participant 19, 21 years old, Grade 12 high school learner**,** from village 3)

According to the Zulu tradition, young girls and boys would be allowed to start *ukusom*a by *iqhikiza* (peer adviser/educator) after they had received education about a variety of alternative sexual practices without penetration (Maureau 2014:103). When a young man came to visit his girlfriend at night (without the parents' knowledge), he would be met by the girl's older sister who would take him to a vacant hut where he was going to spend the night with his girlfriend. The girl's older sister would tell the boy to behave himself meaning that he must not have penetrative sex with the girl. The girl would also be warned by her sister to protect her virginity when she would tell her not to "expose (their) fathers' cattle (*ungazeneki izinkomo zikababa*)" (Maureau 2014:103).

4.3.3.1.5.2 Avoid visiting each other

According to a participant:

> Even when they were in the process of negotiations, sleeping together was avoided. The negotiations (*lobola*) had started, but sleeping with her was avoided by watching her so that she did not disappear at night, she had not gone to visit him (fiancé) until negotiations were done. Then she could go to marry him (*usengahamba ayomgana*). (Participant 17, 19 years old, Grade 12 high school learner, from village 9)

4.3.3.1.5.3 Meet her in public places

According to a participant:

> A woman can pressurise you to have sex even when you do not think about going there (*uthol' ukuthi wena awukho lapho*). I try to meet her in public places not in private rooms (*hhayi emakamelweni*). (Participant 16, 21 years old, student at a tertiary institution, from Christian denomination 3, from village 7)

4.3.3.1.6 Be in a relationship with a person of the same mind

Some participants believed that Christians should be in a relationship with a Christian who will understand the Christian principles and not lead you into temptation:

> Okay, I see that when we have found grace when we now believe, you have been lucky. You must be in a relationship with a woman who is a believer so that you can, who has knowledge. (Participant 16, 21 years old, student at a tertiary institution, from village 7, from Christian denomination 3)

> If you believe that the Bible says do not be yoked with unbelievers, you cannot be in a relationship with a girl who is not following you; who is an unbeliever, someone who is walking there maybe she drinks then you find a pig mixed (yoked) with a goat. It is up to you that as you say that you are a believer, you cannot just take any girl and bring her to father (pastor) and think that you will be of the same spirit. (Participant 15, 24 years old, employed, from village 7, from Christian denomination 2)

People who are not of the same mind or spirit should not be in partnership (Nelson 1982: 2 Corinthians 6:14; 2 Kings 6:11)

4.3.3.1.7 Be friends with people of the same mind

According to a participant:

> You must be friends with people who have the same goals as yours in life because if not, they may lead you astray. (Participant 17, 19 years old, high school learner, from non-Christian denomination 1)

4.3.3.2 Alternative ways to show love

According to the participants:

> I say love is not something that you say with your mouth, but actions should show love (*kodwa yizenzo ezikhombis' uthando*). If there is a problem, maybe she has run out of toiletries she cannot suffer while I am here, she comes to me and says I have run out of this and I give her. It means that now that I am here, I help there and there. (Participant 15, 24 years old, employed, from village 7, from Christian denomination 2)

When asked if he did not expect sexual favours for his help, the participant replied:

> That does not mean I demand (sex) because that would mean I buy her. (Participant 15, 24 years old, employed, from village 7**,** from Christian denomination 2)

> No there are many ways of demonstrating love besides sleeping with her; you treat her well, meet her needs, if there is something she needs or wants. You do it for her. Maybe there is something she had asked from you, you give her what she had asked for. (Participant 13, 20 years old, from village 9**,** unemployed, from Christian denomination 3).

> By being faithful and having no secrets, you show her love by not hiding anything from her, being faithful to her at all times, and supporting her decisions. (Participant 19, 21 years old, Grade 12 high school learner, from village 9, from Christian denomination 1)

According to a participant, who seemed appalled by hearing that some say sex is the true way of demonstrating love:

> I am against that, I am against that. Yes I can say, madam, besides that (sex). They say that, they say that, madam? Besides that, you show a person not by

> way of sex, there are many ways madam; there are many ways. (Participant 21, 23 years old, unemployed high school dropout, from Christian denomination 3, from village 7)

4.3.3.3 Waiting for traditional ceremonies

The participants said that traditional ceremonies, such as the rites of passage (*umhlonyane* and *umemulo*) and *ukuy' ophondweni* which follows *ukuqoma ngeduku*, helped to delay starting relationships with girls and intimacy.

4.3.3.3.1 Rites of passage

According to participants:

> They tell us that in their times a person would sleep with that person at the time they were expected to do it. The right time, to explain the right time to engage in that activity, that he can get involved in sex, he is grown up, maybe she has had *umemulo* and other traditional ceremonies. (Participant 10, 21 years old, intern, from village 3)

> The girl must have finished school and be at least 20 years old and have had traditional ceremonies such as *umhlonyane* and *umemulo*. (Participant 12, 19 years old, unemployed, from village 3)

Umhlonyane is a traditional Zulu ceremony that is held to celebrate a girl's first menstruation. It is followed approximately ten years later by *umemulo* (coming of age), which is a ceremony to acknowledge that a girl is old enough to get married (Turner 2018:165).

4.3.3.3.2 Ukuya ophondweni

The participants said that this ceremony took place after *ukuqoma ngeduku* and there would be no visiting each other before it was done:

> They will not visit each other until they have had another traditional ceremony (*Bese kufika ilanga leli lokuthi eh kuyiw' ophondweni*), that is when they will start

> sleeping together, but before that ceremony they do not sleep together. That evening young women and young men will meet in an open space for the special ceremony. Then the lovers will disappear in the dark and we do not know where they go to but the elders will say that the two are gone down to strengthen their relationship/love and we think that they do it by sleeping together (*ngokuthi beyolala sosho njalo*) (not sure). I have a friend whose girlfriend brought a flag (*owaqonywa ngeduku*). We asked him when she is coming to visit him. He said that they will have to do the second ceremony (*Wasitshel' ukuthi kusamele kuyiw' ophondweni kuqala khath' ekhon' ukuzomvakashela*) before she can visit him. If a young man and a young woman start their relationship like that (*mayeqome ngeduku*), the relationship is forever. (Participant 11, 23 years old, unemployed dropout, from village 3)

When asked what he thought about this traditional way, he said:

> I think it was good, really good because if you have chosen a girl you will end up marrying her. (Participant 11, 23 years old, traditionalist, from village 3)

Another participant seemed to have forgotten the name of the ceremony that followed *ukuqoma ngeduku*, but explained events that took place:

> After some time the girl's family brings a letter in which they write, maybe one needs a bicycle and another one this and another that, including the girl's and her mother's needs. These things are bought and sent. Then after that, the girl comes to the man's home with *iqhikiza* (peer adviser) to see the room where she will stay when she visits. (Participant 22, 18 years old, unemployed dropout, from village 7)

The journey to marriage for the couple involves a series of traditional ceremonies that involve the exchange of gifts until they are allowed to be together (Maureau 2014:145).

4.3.3.4 Avoid abduction of women

The participants did not condone abduction and forcing women to marry against their will:

> In the olden days I know that they would go and take the girl to the man's house, to marry him whether she liked it or not. However, she would end up loving him … no now it is not allowed. I think maybe it is the time we live in. (Participant 17, 19 years old, Grade 12 high school learner, from village 9).

> I do not think it is right; she has never talked to him. They just say here is the person that we have found for you. Even if she does not like, she will agree because the elders have said so. (Participant 13, 20 years old, unemployed, from village 9

According to Gennrich (2013:46), in *ukuthwala* (voluntary abduction of a girl to marry the man she loves) the girl would be involved in planning her abduction to the man she wanted to marry her. She would marry voluntarily and would not be coerced to have sex as happens today in some parts of the country, such as the Eastern Cape.

4.3.3.5 Pay damages, restore the dignity or cleanse a girl's home

Three participants described the consequences of misbehaving as paying damages, restoring dignity, or cleansing a girl's home if a young man slept with or impregnated a girl:

> What I remember is that if it is known that so and so's son has slept with so and so's daughter who had not slept with another man before, he had to pay to restore the dignity of the girl's home or cleanse the girl's home because he had lured a girl who was brought up properly. Yes he had to pay to cleanse the homestead according to their demands. Yes I can say that in Zulu tradition, if you slept with a girl, you had to pay damages and … you would not sleep prematurely. (Participant 18, 20 years old, Christian, Grade 11 high school learner**,** from village 3)

> The demands of the girl's family for cleansing their homestead if a man sleeps with her made it not easy for a young man to be naughty by sleeping with girls because when you are young, you would realise that it would be difficult to pay the demands of the girl's family and wait until you realise that even if you become naughty you can pay. (Participant 17, 19 years old, Grade 12 high school learner, from village 3)

> I can say that if you sleep with a girl and impregnate her, you have to pay for damages there and then. You need to do so, and you do not have sex before time. (Participant 12, 19 years old, unemployed, from village 3).

One participant indicated that payment of damages for a woman who has not been chosen was indicated by raising a flag (*ukuqoma ngeduku*):

> If they have not chosen each other by raising a flag, he has to pay, madam. He has to pay, madam, and cleanse her, pay a goat to the girl's family. He is showing respect truly and really. (Participant 11, 23 years old, dropout, unemployed**,** from village 3)

Concerning the chosen one (*oqome ngeduku*), however, she is allowed to sleep with him. He does not pay damages because he has committed to a lifelong relationship:

> Yes she is allowed, madam, she has a person who chose her, because he has chosen her and said she is mine, the only one for him. (Participant 11, 23 years old, unemployed high school dropout**,** from village 3)

Penetrative sex is not allowed before marriage in traditional Zulu culture as it leads to teenage pregnancy. This is a serious embarrassment for the family for failure to discipline their son. The boy's family would lose a herd of cattle as "damages" for the girl's family to compensate for the loss the girl's family would suffer when she gets married for failing to protect their daughter's virginity (Maureau 2014:100).

4.3.3.6 Non-penetrative sex (ukusoma)

Some participants indicated the traditional non-penetrative way of sexual satisfaction called *ukusoma*:

> The girl puts her thighs together and the young man does not really sleep with her, he ends between the thighs. (Participant 15, 24 years old, employed, from village 9, boldly).

> *Ukusoma* is when you have sex but you do not use that part (vagina). Some say in the thighs and in the breasts, things like that. (Participant 18, 20 years old, Grade 11 high school learner from village 9, hesitantly)

According to Zulu culture, education of boys and girls about sexuality rules used not to be done by parents, but by elder women and elder men during puberty rituals through songs, dances and talks. Another source of information was older sisters for girls and older brothers for boys. They listened to their siblings' discussions and advisors who talked openly about courting and watched courting couples to gain skills. Sexual experimentation without penetration, one way of which is *ukusoma*, to prevent teenage pregnancy was taught (Maureau 2014:100).

In *ukusoma*, the girl lies in the left lateral position with legs crossed and thighs very tight together so that the penis ends at the clitoris. She catches semen with the left hand and wipes it over the thigh and leg until dry (Krige 1968, cited in Maureau 2014:152). Before marriage the couple may be intimate by practising *ukusoma* to protect the girl's virginity. It is not considered as sex in Zulu culture and respecting the girl's virginity is also a sign of respect for the girl by the young man and respect for his father who taught him to respect girls (Maureau 2014:152).

4.3.3.7 Choose a lover and/or choose a girl to marry

The participants said that traditionally a relationship becomes official when the couple make it known to the parents and the community by raising a flag (*ukuqoma ngeduku*) at the man's home. The raising of the flag signifies the permanence of the relationship and intentions to marry. It is an announcement that they are no longer available. This is done before the actual *ukucela* (beginning of marriage negotiation).

4.3.3.7.1 Ukuqoma ngeduku

According to the participants:

> If a man finds someone he loves, they two would talk about what they want to do in their relationship. Then they would inform the families who would then make

the necessary arrangements for the marriage to take place. (Participant 18, 20 years old, Grade 11 high school learner, from village 3)

Eish, according to isiZulu, when a girl agrees to be in a relationship with a young man a flag is raised in the young man's home (*ukuqoma ngeduku*). The girl brings the flag and a ceremony is held such as exchanging gifts and then the elders go and see the girl and praise the young man for having got himself a real woman (*Bese beyayibona abant' abadala leyo ntombi bese beyasho ke ukuthi hhayi cha hhay' akufani uthole yon' intokazi*). (Participant 11, 23 years old, unemployed high school dropout, from village 3)

Although I do not know how it (*ukuqoma ngeduku*) is done, it means a girl has been chosen or she has been chosen by a certain family. Then she goes to raise the flag on a tree or a pole. Then their relationship will be for a very long time or permanent. (Participant 19, 21 years old, Grade 12 high school learner, from village 3)

When you choose that young man, according to Zulu tradition, you have to raise a flag (*umqoma ngeduku*); with a flag, madam (*ngeduku mah*). The family of the girl comes to the family of the young man (*umfana*). Oh, the girl's family because the girl has to bring things. My family helps me to prepare, for instance, beer to make people happy, madam. They bring something, a flag, toiletries, grass mats etc (*nokunye*). They bring for the groom's family, they bring for everyone. There are things we buy to give them, madam, such as grass mats, things according to Zulu culture. (Participant 21, 23 years old, unemployed high school dropout, from village 3)

Ukuqoma ngeduku means she is your person (*umuntu wakho*), you have chosen each other, you will live with her until death or until you pay the bride price and marry. It is your person, it is well known in the community. Everyone knows no, no (*hhayi cha*), so and so is in love (*uthandana*) with so and so. The girl dresses in a respectful way to show that she has been taken. Even if you are still at your home, you dress respectfully. You dress respectfully to show that you have a lover. (Participant 11, 23 years old, unemployed dropout, from village 3)

The participants described religious choosing of a partner as meaning the same thing as the traditional *ukuqoma*. However, the participants did not refer to any special

ceremonies. Some participants said waiting until one is old enough and financially ready to marry before they choose their life-long partners in the church.
According to a participant:

> You behave well madam, you do not go about smoking in the streets, you do not sleep with girls, things like that. If you are in love with that person, you are in love with her alone, until you grow up and are old still in love. Yes until I marry her and introduce her to my family. (Participant 11, 23 years old, unemployed, high school dropout, from village 3)

> Eh Christians, the ones that say they are saved madam, oh these ones that say they are saved they absolutely do not get into relationships at all, those people (*abajoli sdalo labo bantu*). Yes madam they do not get into relationships. They walk according to the truth of God; they do what they know about God. When they are supposed to get married, oh madam, when they are supposed to get married, I think they choose each other in the church where they worship. Also those who worship on Saturday (*abasabathayo*), yes they are like Christians. Eh madam, those ones who worship on Saturday, I can say, madam, they choose each other in the church, madam. They do not have relationships. If they do, they do it in secret. Basically madam they do not have relationships (*ngokomthetho abajoli*). You are not expected to have a relationship or you do not have to persuade a girl into a relationship (awesheli). Awesheli madam even when you want to get married, awesheli, you choose. They give you a chance to choose madam, to choose that person madam. (Participant 21, 23 years, unemployed high school dropout, from village 7)

According to the participants, choosing a partner of the same faith concurred with the biblical principle “Do not be unequally yoked” (Nelson 1982: 2 Corinthians 6:14).

4.3.3.8 Modern ways of protection

The participants referred to modern ways of protection.

4.3.3.8.1 Abstain

Some participants referred to abstaining from sex:

I can say that I have one girlfriend but we do not sleep together. (Participant 18, 20 years old, Grade 11 high school learner, from village 9, from Christian denomination 3)

To abstain also and do nothing protects. (Participant 4, 21 years old, unemployed, from village 7, from Christian denomination 3)

Abstain and condomise and be faithful to your person. (Participant 5, 21 years old, employed, from village 9, from Christian denomination 5)

If you believe (*uma nikholwa*), there is no other way but to control yourselves until it is time you get married (*kuze kushay'isikhathi sokuthi niyashada*). (Participant 19, 21 years old, Grade 12 learner**,** from village 9, from Christian denomination 1)

4.3.3.9 Be faithful

According to the participants:

You should not sleep around, be faithful. You should be the first one to be faithful and do not lie to the other person. (Participant 5, 21 years old, employed, from village 9, from Christian denomination 5)

Yes, I personally do not see it as being a man to sleep around with all the girls because, according to my knowledge, a man is a person who behaves well, who sticks to one woman who is his (*oqondene naye*), he is married to (*usuk' eseshadile, eseganiwe*). I would not say that I am a man if I sleep with women you do not really know. I do not see it as the right thing. (Participant 11, 23 years old, unemployed high school dropout**,** from village 3, from Christian denomination 3)

Being a man is having one person you are in love with, a person you know that she is the one (*owaziyo futhi ukuthi wuye wuye*), the only one. You do not move from one to the next (*ungahamb' ugcogcoma*), being in a relationship with many people, because you will end up getting diseases unawares. At the end you will be forced to choose one to live your life with. You will not spend your life with all these people you are in a relationship with. You will not make a family (*ngek' ukhand' umuzi*) with all these people you sleep with. You will be forced to choose

one to live your life with and to make decisions with. (Participant 13, 20 years old, unemployed, from village 9, from Christian denomination 3)

Behaving well truly is like respecting one's self from the inside; that you do not sleep with all the women you meet. (Participant 18, Grade 11 learner, from village 9, from non-Christian denomination 2)

4.3.3.10 Condomise

According to the participants:

Always to use condoms if he shares sexual partners. (Participant 2, 19 years old, Grade 10 learner, from village 3, from Christian denomination 3, confidently although seemingly ignorant about the risk of sharing sexual partners)

To use protection so that I prevent, prevent teenage pregnancy and also because sleeping without a condom is the cause of the spread of certain diseases. To protect yourself, you need to protect yourself. (Participant 4, 21 years old, unemployed, from village 7, from Christian denomination 3)

To prevent the spread of HIV I think a condom is number one, protection is number one. It must always be used. (Participant 9, 20 years old, unemployed, from village 9, from Christian denomination 4)

As men we should be able to protect our women from diseases such as AIDS; wear a condom when we have sex, wear a condom. (Participant 6, 24 years old, employed, from village 7, from Christian denomination 3)

I can say that one should always use a condom whenever he has sex, always. If he is married, use it because you can never trust a person. (Participant 7, 18 years old, Grade 11 high school learner, from village 7, from Christian denomination 4)

I think that doing safe sex, using a condom always when you have sex, is protective. (Participant 19, 21 years old, Grade 12 high school learner, from village 9, from Christian denomination 1)

Use condoms because they were made in order to be used. They are available at the schools and shops. (Participant 11, 23 years old, unemployed, high school dropout, from village 3, from Christian denomination 3)

They advise us to have sex with a condom, to use a condom, something like that. (Participant 13, 20 years old, unemployed, from village 9, from Christian denomination 3)

A man among men if he is naughty protects himself with a condom madam if he sleeps with someone. He uses a condom. That is a man of essence madam; madam because he prevents HIV, we are talking about a man of essence. He uses a condom when he is cheating madam." (Participant 21, 23 years old, from village 7, from Christian denomination 3)

Although he said boldly that a man of essence uses a condom he also added that when he is cheating and that men are different, some like a condom while others do not. He also did not indicate whether this cheating man of essence uses a condom all the time (with his wife, true love) which implied inconsistency of condom use**.**

Yes madam but what I think when you see a girl and persuade her to a relationship (*shela*) here outside you have to use a condom because I think there are many others that she has agreed to sleep with madam, just like that (*kanjalo*). Some of us do not like a condom, we are different as people. (Participant 21, 23 years, unemployed high school dropout, old from village 7)

4.3.3.11 Circumcise

Regarding circumcision, two participants said:

Circumcision is something important. (Participant 8, unemployed, from village 9)

I believe that if you are circumcised, just after you have had sex with a woman you go out and wash. (Participant 19, 21 years old, grade 12 learner, from village 9)

In a study in Uganda, Mbonye, Kuteesa, Seeley, Levin, Weiss and Karnali (2016:211) found that although community health education was given to the community that voluntary male medical circumcision did not provide complete protection against STIs, some men in fishing communities in Uganda still believed that circumcision was fully protective.

4.3.3.12 Know your status

According to the participants:

> Also know your status and your partner's status. Both of you should visit the clinic to get tested for HIV and go together. You must also know your HIV status and that of your partner, first priority. There will come a time when you will not use a condom. Make sure you go to test together because one may be infected and then not disclose. (Participant 5, 21 years old, employed, from village 9)

> After all these I go to check my HIV status to know my status how it is. I do not mean that maybe you are sick but you know that in love you have to know how each other's status, you know mine and I know yours. Then we went to have an HIV test. (Participant 10, 21 years old, intern, from village 3)

> The one you live with at home madam I think you have gone to test madam and found that you have nothing *(nathol'ukuthi aninalutho).* (Participant 21, 23 years old, unemployed high school dropout, from village 7)

4.3.3.13 Avoid injecting drug use

This participant was the only one who volunteered information about injecting drug use without any probing. However, he did not say that it must be avoided. He just mentioned that users are spreading HIV with their blood.

> "Drugs also I can say also those, madam, are spreading the germ because that blood that enters has the germ." (Participant 21, 23 years, unemployed**,** high school dropout, from village 7)

Most of the participants knew about a condom as preventive measure for HIV infection and unwanted pregnancy. However some participants referred to inconsistent condom use.

According to Shisana et al (2014:1) and Idele, Gillespie, Porth, Suzuli, Mahy, Kasedde and Luo (2014:S144) lack of knowledge about the prevention of HIV is a risk factor for increased risky sexual behaviours. They conducted studies on risk factors for HIV infection.

4.3.4 Prompts based on the HPM

This section discusses the participants' responses to the prompting questions the researcher asked.

4.3.4.1 Prior behaviour

4.3.4.1.1 What have you been doing in the past as a man to prevent contracting HIV and/or impregnating a teenage girl?

The participants' age group of 18-24 years put them at risk of HIV infection because the age groups 15-24 years have been found to engage in risky sexual practices and alcohol and drug abuse. Unmarried young men are at risk of sexual temptations that may result in STIs, including HIV and AIDS, and teenage pregnancy. Most of those who had passed Grade 12 and were unemployed had had not been to a tertiary institution due to lack of funds. According to the South African Multiple Deprivation Index (SAMDI) uMzinyathi district falls into socio-economic quintile (SEQ) 1, the lowest quintile among the poorest districts in South Africa (KZNDoH 2015:12). The majority of the participants reported that they were sexually active, although none indicated having casual relationships. Most reported that they were using condoms consistently.

The preventive measures that participants used included no relationships, avoiding sex; condoms; abstain or used to abstain; know HIV status and that of partner, and have one partner.

4.3.4.1.1.1 No relationship

According to the participants:

> I am not in a relationship. There is no one that I can say I am in a relationship with. As a believer there are many things that I avoid as a person who accepted Jesus as Lord and saviour. So I am avoiding a relationship because I may end up engaging in premarital sex, so I am avoiding that temptation that will make me fall into that sin. (Participant 14, 24 years old, employed, from village 7, from Christian denomination 1, seemed happy that he was not in a relationship)

> I avoid having a relationship because I am young; it is still a long way before I am ready to be married. (Participant 18, 20 years old, high school learner, from village 9, from non-Christian denomination 2, boldly)

> Eh, no, let me say madam, it is something that I do not do, really and truly I have not come to that level. (Participant 22, 18 years old, unemployed high school dropout, from village 7, very shyly)

4.3.4.1.1.2 Choosing a lover

According to a participant who had already chosen his lover (traditionally married):

> I took her because I saw that she can be trusted, I took her when I was 19 years. I live with the mother of my children. (Participant 21, 23 years old, high school dropout, unemployed, from village 7, affectionately)

One participant, 18 years old who was waiting until he was old enough to choose his lover, responded as follows when he was asked how he was protecting himself from HIV and impregnating:

> I will do as I have explained how my brother did, I will also do like him, that like him I will choose a lover using a flag (njengaye ngiqonywe ngeduku njengaye)." (Participant 22, 18 years old, high school dropout, unemployed, from village 7)

4.3.4.1.1.3 Meet in public places

According to a participant who was practising persuasion skills as prevention:

> A woman can pressurise you to have sex even when you do not think about going there (*uthol' ukuthi wena awukho lapho*). I try to meet her in public places not in private rooms (*hhayi emakamelweni*). (Participant 16, 21 years old, student at a tertiary institution**,** from village 7)

4.3.4.1.1.4 Abstain and used to abstain

According to participants:

> I used to abstain because I was still schooling, yes I used to abstain. (Participant 4, 21 years old, unemployed, from village 7)

> No, according to what I was taught, it was said that I can do it after I get married. I have never done it. I was taught by my mother. (Participant 7, 18 years old, Grade 11 high school learner, from village 7, boldly)

> No, I am still putting up, not to start hurrying. It could be her who is in a hurry. (Participant 17, 19 years old, high school learner**,** from village 9)

> I have only one, but we do not have sex ("cross the fireplace"). (Participant 18, 20 years old, Grade 11 high school learner, from village 9)

4.3.4.1.1.5 Be faithful

According to the participants:

> Honestly, I can say that I told myself that one woman is enough and that it takes one woman to get infected; one woman is enough for me. I do not change them now and again. (Participant 8, 21 years old, unemployed, from village 3, after laughing)

> Eh, I, it is just that I love one person. (Participant 9, 20 years old, unemployed, from village 9, confidently)

I have only one. (Participant 18, 20 years old, grade 11 learner**,** from village 9)

4.3.4.1.1.6 Condom use

According to the participants:

I use a condom if I ask somebody to visit me. That is when I use it. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

Like myself, to speak the honest truth, I usually use protection which is a condom. (Participant 4, 21 years old, unemployed, from village 7)

To protect myself, to protect myself is important. To protect myself, I use a condom, yes, so that I do not get AIDS. (Participant 6, 24 years old, employed, from village 7)

Eh, I, it is just that I love one person and also protection. A condom is also important; I use it. (Participant 9, 20 years old, unemployed, from village 9, confidently)

If you love a person, you can end up sleeping with her not knowing that you are putting yourself in danger if without a condom. (Participant 8, 21 years old, unemployed, from village 9)

I use a condom all the time I have sex with my girlfriend, always. (Participant 5, 21 years old, employed, from village 9)

The way I behave, yes I have many people that I am in love with. Yes, they are there, I will not hide that. To be safe from having a baby at this stage is that I use a condom. Even when you know the HIV status, just use a condom, use a condom, so that you are protected from HIV because we are not only talking about HIV but also about drops, sexually transmitted diseases. (Participant 10, 20 years old, intern, from village 7)

4.3.4.1.1.7 Circumcision

According to participants:

I use … circumcision, I have been circumcised. (Participant 10, 21 years old, intern, from village 3)

4.3.4.1.1.8 Know your status

According to the participants:

I also know my girlfriend's HIV status. (Participant 5, 21 years old, employed, from village 9)

To protect myself is to be able to take my partner to go and confirm that she does not have the germ. Before we started engaging in sexual intercourse, we had a test first. We went together and we found out that we are not having the germ (HIV). Then after that we started using a condom to protect ourselves. (Participant 6, 24 years old, employed, from village 7)

Yes, even testing, we usually do it because temptation is always there. If you love a person, you can end up sleeping with her not knowing that you are putting yourself in danger if without a condom. (Participant 8, 21 years old, unemployed, from village 9)

Before you involve yourself in sex, you need to know her status and your status. Know your status, how it is, and that of that person before you sleep with her. (Participant 10, 21 years old, intern, from village 3)

4.3.4.1.2 What did you learn from these experiences?

According to the participants, the lesson was "do not drink and have sex":

It happened when I was drunk; I used a condom, but not properly. Luckily I did not get infected and everything was fine. From then on the lesson I learnt is that do not drink and have sex. Drinking and sex do not go together because mistakes happen. Even when you are sober there is a bond that develops between two people that makes them forget the condom. How much more when they are drunk, the condom is the last thing. (Participant 8, 21 years old, unemployed, from village 9)

> What made me to stop drinking alcohol, I realised that it made to touch girls when I was drunk and realise in the morning when I wake up, when I look next to me, oh my word *(hawu),* this sister *(lo sisi)* who is sleeping here, where is she from? When I look at this person she is older and I do not know her, I saw her for the first time the previous day. Then she became my responsibility. No I said it is better to stop drinking. (Participant 11, 23 years old, high school dropout, unemployed, from village 3)

According to the participant, “do not do sex hurriedly”:

> She fell pregnant, I do not know how. I learnt that you need to take your time before you do sex and not hurry. (Participant 9, 20 years old, unemployed, from village 7)

4.3.4.2 Personal influences

4.3.4.2.1 How do you think you would benefit from preventing HIV and teenage pregnancy?

The participants expressed benefits to themselves, their families and their children. Some participants expressed benefits in the form of disadvantages if one gets infected or impregnates a girl.

4.3.4.2.1.1 Disadvantages

The participants indicated dropping out of school; poverty; shame, and baby not loved as disadvantages.

4.3.4.2.1.1.1 Dropping out of school

According to the participants:

> You will have to drop something and do something else to feed and clothe your baby, like school and look for a job. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> For example, if I impregnate a girl now as I am doing Grade 12, I drop out of school. (Participant 3, 19 years old, Grade 12 high school learner**,** from village 3)
>
> It is worse if your partner is a school learner and you are working. It is bad that now she is pregnant, she will interrupt her education when it is time to give birth or she may miss writing her examinations while you continue with your work without interruption. Sometimes she will have to repeat a grade because she is left behind. (Participant 6, 24 years old, employed, from village 7)

4.3.4.2.1.1.2 Competing with the baby for love of your parents

According to a participant:

> We young people, if you happen to have a baby, your baby will also need the love that your parents give you. (Participant 2, 19 years old, Grade 10 high school learner**,** from village 3)

4.3.4.2.1.1.3 Poverty

According to participants:

> If you impregnate a girl that will increase number of uneducated people who are likely to barely succeed in life because they will work low paying jobs. Out there I will increase the unemployment rate. Take years sitting at home, creating expenses for one while still young, dependent on your mother and father for clothing. Now you impregnate a girl, your parents have to feed you and your baby. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)
>
> See, now there are people who have children, children that they cannot support because they are not working, they are still at school. Their children are now suffering or poor because of them. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

4.3.4.2.1.1.4 Shame on family and community

According to a participant:

> I think that it is bad to impregnate a woman before the right time because it is unacceptable. Even you, you feel bad about it thinking that 'Oh I have done it prematurely instead of waiting for the right time'. (Participant 5, 21 years old, intern, from village 9)

4.3.4.2.1.1.5 The baby is not loved

According to a participant:

> I think there are benefits because it is where we can say 'I do not expect a baby' and helps because a baby does not come unexpectedly who ends up called bad names because it was not planned because really, really, sex was unplanned. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

4.3.4.2.1.2 Benefits

The participants indicated health; carefree; focus on the future; no extra financial burden for parents, and parents being proud of their children as benefits.

4.3.4.2.1.2.1 Health

The participants identified protection from diseases; healthy life; safe; healthy; fit; normal CD4 count, and do not get sick. One participant said not being infected itself is an advantage. According to the participants:

> It also protects us from diseases. You do not get infected with diseases. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

> I do not get sick now and again. I live a better life than others, I am healthy. (Participant 5, 21 years old, intern, from village 9)

> You are safe. (Participant 8, 21 years old, unemployed, from village 9)

> You are healthy, you are fit, your CD4 count is normal. (Participant 9, 20 years old, unemployed, from village 9)

You do not impregnate or become a parent early in life and you do not get infected with sexually transmitted diseases. (Participant 10, 20 years old, intern, from village 3)

4.3.4.2.1.2.2 Carefree

According to the participants:

Nobody bothers me saying, the baby this and the baby that, such things. (Participant 5, 21 years old, employed, from village 9)

You enjoy your money. (Participant 8, 21 years old, unemployed, from village 9)

You enjoy your youth without financial responsibilities of having a baby. (Participant 9, 20 years old, unemployed, from village 9)

Nobody gets stress; there is no stress at all. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

I have no stress. (Participant 5, 21 years old, employed, from village 9)

She does not have much stress. When the baby has a problem, she affords to fix that problem; such as when the child is sick, she takes her money and take the baby to the doctor. (Participant 11, 23 years old, high school dropout, unemployed, from village 3)

4.3.4.2.1.2.3 Preparation for the future

According to the participants:

When the time comes I want to *lobola* (pay the bride price), get married and then have children. (Participant 5, 24 years old, employed, from village 7)

I think it will help me because I will not make my child suffer or impoverish my child. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> You focus on your life; you take things step by step. Unlike when you get a baby while still young, you jump a step, you do not enjoy your money, now you also have to look after your family. You can also save for the bride price for the right person because you may find out that the mother of your baby is not the one and you have to move on, which puts you at risk of getting sick because you did not plan properly. (Participant 8, 21 years old, unemployed, from village 9)

4.3.4.2.1.2.4 No extra financial burden

According to a participant:

> It helps me because I do not add an extra burden to my parents. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

4.3.4.2.1.2.5 Parents are happy and proud of their children

According to a participant:

> I want to make my parents happy by getting to this age without having a baby. Recently both of my parents thanked me for coming to this age without giving them problems, saying that they know that these days youth do this and that (*lokhu nalokhu*) (sex). (Participant 6, 24 years old, employed, from village 7)

4.3.4.2.2 What problems (barriers) might you have trying to prevent HIV and teenage pregnancy?

The participants stated that most problems came from peer pressure, lack of self-efficacy or ignorance, and pressure from family members. Access to condoms was not a problem.

4.3.4.2.2.1 Peer pressure

According to the participants:

What I can say about friends is that you make your own decisions because they have pressure, because many already have children. (Participant 5, 21 years old, employed, from village 9, laughing)

Now there is a thing called discrimination. They say, this one does not have a girlfriend; this one cannot get a girlfriend. What happens is eh, eh your friend pressurizes you (*uyakuhlohla*), your friend tries to get a girl for you … when sitting as friends … you discuss who has many girlfriends. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

I can say that I have never been in a relationship, but I have been tempted to have it. You know, there is this to us young men, you say, I cannot afford to grow up to adulthood without having experienced persuading a girl or having a girlfriend until you get married. I have started; I am gaining knowledge that is a provision so that I will not be in trouble. The way to grow if you are a young man is to persuade a girl or to have girlfriend so that when you have grown; it is the way to grow. There are those who are married, even believers went through this stage of being young men. They are married today because he went through this stage, they can persuade a girl so that he can get married. (Participant 16, 21 years old, student at a tertiary institution, from village 7)

If you do not do sex, you are not a real man (awuyona *indoda kahle*), it shows that you do not love each other or you do not love that person or you are not in love (*anikho othandweni*). And questions you meet such as, you do not love me or you do not trust me when you want to use a condom. (Participant 10, 21 years old, intern, from village 3)

Sometimes a person just comes, when he has had sex, maybe the previous day, and tells you, and you feel pressurised to do it too. (Participant 10, 21 years old, intern, from village 3)

4.3.4.2.2.2 Low self-efficacy

According to the participants:

I ended up not being able to control myself … that a girl is for pleasure for those fifteen minutes… not seeing why I should respect girls. (Participant 9, 20 years old, unemployed, from village 9)

Like when you have a girlfriend at school, when you do not learn that day or they release you early, it is difficult to ask (for a condom) from someone else and you say you will see how I deal with it (*usuke uthi hhayi ngiyobona phambili*). I think it is arousal, I think it is high sexual arousal (*imizw' isuk' isiphezulu*). (Participant 19, 21 years old, Grade 12 high school learner, from village 9)

I have met problems: maybe you want to use a condom, she says, do you not trust me or you do not trust yourself? Or is there something that you have? The girl ends up not trusting you, telling herself that there is a certain disease that you have. She loses interest to have sex with you. (Participant 13, 20 years old, unemployed, from village 9)

Women also should not rely on a man because men easily forget about protection when they realise that there is a possibility of having sex. (Participant 5, 21 years old, employed, from village 9, putting responsibility on women)

In the relationship, it does not happen the Biblical way because along the way sin sometimes overpowers me and I end up doing what we are not supposed to do (sex) because even the woman if I am in a relationship with her would go out telling others saying *hawu* (oh my word), there is nothing like this, I am dumping him he thinks I am his vase, something to put there saying, no the day I buy flowers I will put them here (*hawu ayikho le nto, ngiyamyeka, ucang' ukuthi ngiyivazi yakhe mina, into yokubekwa kuthiwa hhayi mhla ngatheng' izimbali ngozifaka lapha*), ending up saying I am not his picture, I am dumping him, I am leaving this young man because he is wasting my time. (Participant 15, 24 years old, employed, from village 7**,** from Christian denomination 2)

Sometimes I forget even when it is there, just forget it. It is when the mind has gone, gone. There is some confusion of some sort. (Participant 10, 21 years old, intern, from village 3)

Sometimes you do not use it, sometimes you sit down and explain that I do not want to ruin your future by impregnating you, I am also not ready to be a father

yet. When she has said you do not trust me, I do not use it. (Participant 10, 21 years old**,** intern, from village 3)

4.3.4.2.2.3 Pressure from home

Some of the participants who were Christians said that they were pressurised by family members who were not Christians:

> If it is that your father is not a believer, your father will ask as you son come close to talk. When you come close he says, tell me, yesterday you slept so much yet I did not see makoti (daughter in law or girl), what is going on with you? May be you say, father she is there. How come because I have never seen her (*Ukhona kanjani ngingakaze ngimbone*)? Or your brothers now say that they have never seen any girl in the premises, where do you stand, what is going on (*umiphi, kwenzakalani*)? Then you realise that you need to have a girl so that father can see that I am not gay (*ukuz'ubaba azobon' ukuthi angiyon' inkonkoni*). At home maybe you are trying to do according to the Bible, then your father says there is nothing like that, you are playing games with me, you are gay, you do disgusting things in my yard, something I have never seen (*ayikho lento yakho wena udlala ngami uyinkonkoni wena. Uzongigilela imikhuba la egcekeni lami, int' engikaze ngiyibone*). That then puts you into pressure to, no, no, I have to really get a girlfriend. (Participant 15, 24 years old, employed, from village 7, from Christian denomination 2)

> No there is pressure at home, yes, yes. You end up keeping at least one girl. (Participant 17, 19 years old, Grade 12 high school learner, from village 9, from non-Christian denomination 1)

4.3.4.2.2.4 Ignorance

According to the participants:

> But not all the time; it does not mean I use it all the time. (Participant 10, 21 years old, intern, from village 3)

> Women also should not rely on a man because men easily forget about protection when they realise that there is a possibility of having sex. (Participant 5, 21 years old, employed, from village 9, not really aware of consequences)

> It may not work with the real girlfriend (*Kongqo nom' ingasebenzanga*). (Participant 9, 20 years old, unemployed, from village 9, seemed to lack knowledge)

> I think if you are talking about me now, I would say 3 because it is difficult to refuse these days because this person would hesitate, would maybe say maybe he is from somewhere because now I say let us do it (sex) and he says no. I am afraid to hurt her. (Participant 15, 24 years old, employed, from village 7, bold but lacking self-efficacy and knowledge)

> When she has said 'you do not trust me', I do not use it. (Participant 10, 20 years old, intern, from village 3)

These results concur with those of Muchiri, Odimegwu & De wet (2017:105) who found that "perceived risk of HIV infection had no significant impact on consistency in use of condoms".

4.3.4.2.3 How would you overcome (self-efficacy) these problems?

The participants' responses about self-efficacy and its rating on a scale of 0 to 10 varied. Some indicated inconsistent use of condoms and several lacked self-efficacy and gave in to pressure and fear. According to the participants:

> We went to do HIV testing then started using the condom again. It means that a condom must always be used. You cannot trust anyone these days because there are many temptations. (Participant 8, 21 years old, unemployed, from village 9, not with confidence)

> No, no, no, I would not follow others (*Hhayi ngeke, ngeke ngilandel' abanye*). (Participant 7, 18 years old, Grade 11 learner, from village 7, boldly regarding overcoming peer pressure)

I want to make my parents happy by getting to this age without having a baby. (Participant 6, 24 years old, intern, from village 7, shyly)

We are taught that it is really much better not to have a girlfriend because you cannot be tempted to sleep with someone who is not there. (Participant 17, 19 years old, Grade 12 high school learner, from village 9, Christian from non-Christian denomination 1)

As a believer, I think the best way to avoid sex is not to have any girlfriend because you may be tempted. I think you should wait until you are able to pay the bride price, then you are ready, you can find one to marry. Even when you are engaged, you should wait until you are married. When you are believers, there is no way better than not engaging in sex until that time when you get married. (Participant 19, 21 years old, Grade 12 high school learner, from village 9, from Christian denomination 1)

I talk to her and explain what the problem is that I have to use a condom. I tell her that no, I am not sick. The problem is that I am preventing that she may fall pregnant, things like that (*izint' ezikanjalo*). (Participant 13, 20 years old, unemployed, from Christian denomination 3, from village 9, confidently)

No, I for now would rate myself at 8-9. (Participant 14, 24 years old, employed, from village 7, from Christian denomination 1, boldly)

I rate myself at 5. I fear losing her. I said that I love her; it is possible that I do not want to have sex. However, now when you are a believer, it is said that you must have one girlfriend. Now that she is the only one, if I lose her, you are left with no one. (Participant 16, 24 years old, employed, from village 7**,** from Christian denomination 3, hesitantly)

At 10, there would rather be no sex (without a condom) if she refuses, because it means there is something she has, maybe she wants to spread it. I become suspicious, just like that. I refuse because really and truly it is something I am meeting for the first time from her. (Participant 13, 20 years old, unemployed, from village 9, from Christian denomination 3**,** confidently)

> I rate myself at 7. From what I have heard from my uncles, I can stand the pressure. (Participant 18, 20 years old, Grade 11 high school learner, from village 9, from non-Christian denomination 2)

4.3.4.3 Interpersonal influence

4.3.4.3.1 Social norms – tell me about what your family members or friends would expect from you regarding prevention of HIV and teenage pregnancy?

A study in America to determine the role of parent-adolescent communication in shaping sexual behaviour among adolescents found that parents emphasised delaying sexual debut (Guilamo-Ramos, Lee & Jaccard 2016:14). In this study, some participants said that parents, grandparents and peers expected them to be sexually active with or without a condom. Some stated that they were expected to be sexually inactive at home or from a religious background.

4.3.4.3.1.1 Sexually active with one sexual partner

According to a participant:

> My grandfather told me that things have changed these days; it is different from olden days. One should have one sexual partner, not to sleep around as they used to do, he never said that (abstain). (Participant 5, 21 years old, employed, from village 9)

4.3.4.3.1.2 Sex with or without a condom

According to participants:

> My father recently gave me a box of condoms and told me to protect myself so that I don't get a baby. Friends do not discourage having sex, however, we do encourage each other to use condoms. (Participant 9, 20 years old, unemployed, from village 9)

What I was taught at school and in conversations with parents, they said it helps and it is important to use a condom. (Participant 4, 21 years old, unemployed, from village 7, very shyly)

My parents say that they know that these days, youth do this and that (*lokhu nalokhu*) (sex). (Participant 6, 24 years old, employed, from village 7)

They tell me that when I have sex with the person I am in love with, I must use a condom, you see, to prevent contracting HIV and impregnating because, especially I do not have a good job. (Participant 13, 20 years old, unemployed**,** from village 9)

Me as a male, it is needed that I have many people; more than one that I am in a relationship with or that you sleep with; many, just like me, people more than five, you are a boss you can catch babes (*uyazibamb' izingane izint' ezinjengalezo*), such things, such things. It is said if you have one lover (*awukh' ezintweni*), no you are not in style or it does not go like that, you do not go with the babes (*awuhambi nabantwana*). It is expected that you have at least three people that have passed through you; that you are recognised as person who can catch the babes. (Participant 10, 20 years old, intern, from village 3)

So when they love each other, they are supposed to have sex. It is something that must happen now to show how this love is, whether it is alive. It is how we show love. If you do not do it, it means that there is someone else with whom you do it; it means here with me you are just a statue. They [peers] also say that you cannot buy a pig in a sack, so you cannot get into marriage without having slept with her you will start sleeping with in marriage. How do you get into marriage with her when you have never slept with her? It is a belief; you need to get into marriage having been sleeping together. (Participant 14, 24 years old, employed, from village 7)

OK, buy something that you see in front of you. Something in the sack? Never. We cannot see in marriage (*Soze sibone sesishadile*), you must first taste. You may hope that she is a virgin, you cannot find out after the wedding. (Participant 16, 24 years old, employed, from village 7)

> Things have changed now. I find myself a girlfriend here and ask her now to visit me and then things happen. (Participant 11, 23 years old, unemployed, high school dropout, from village 3)

> No, what is expected from us [youth] is that we can have sex using a condom. (Participant 13, 20 years old, employed, from village 9)

4.3.4.3.1.3 Sexually active with many partners with or without a condom

According to participants:

> It is either we talk about who did what over the weekend, such as sex. One will say I have scored (slept) with so many or I have reached this score for instance during school holidays. (Participant 3, 19 years old, Grade 12**,** from village 3)

> If you have only one, you are seen as just a small person (*ungumuntu nyana nje*); you are not a full person. However, the way I do it when it comes to a point where we have to do sex, I use a condom, I use it. (Participant 10, 20 years old, intern, from village 3)

So girls still appear to be a commodity, something to be used to score esteem.

4.3.4.3.1.4 Abstain

According to participants:

> We encourage each other as friends not to have sex, but there were some who did not because they were already engaging in sex. Both my parents encouraged me to abstain and recently they thanked me that I have not engaged in this and that (sex) because they know that many in my age group these days do this and that (sex). (Participant 6, 24 years old, employed, from village 7)

> I was taught by my mother to do it (sex) when I am married; I do not do it. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> My father is the one who has a lot to say. He says do not involve yourself in sex at an early age, it does not help but it destroys. It destroys your future and

> eventually you find that you are infected with diseases; you do not progress. You end up sick and die. (Participant 10, 21 years old, intern**,** from village 3)

4.3.4.3.1.5 Be faithful

According to a participant:

> The elders do not recommend that we have many people. What they say, such as my mother, my father too and my grandmother, do not have many people that you are in a relationship with. (Participant 10, 20 years old, intern**,** from village 3)

4.3.4.3.2 Social support – tell me about family members and friends who would encourage you to prevent HIV and teenage pregnancy

Perceived social support for adolescents from friends and parents reduces risky sexual behaviour (Ramiro et al 2013:181; Cluver et al 2016:96). The participants indicated that they obtained information about the prevention of HIV and teenage pregnancy from nurses, parents, friends, media, and events such as International AIDS Day. Some participants were supported by parents, grandparents, teachers and health care workers. Friends seemed to give them mixed messages, mainly about condom use, being faithful, getting tested, and abstaining.

4.3.4.3.2.1 Parents and grandparents

According to the participants:

> I can say that both my parents encouraged delaying having sex and children. Both my parents encouraged me to abstain and recently they thanked me that I have not engaged in this and that (sex) because they know that many in my age group these days do this and that (sex). (Participant 6, 24 years old, employed, from village 7)

> I was taught by my mother to do it (sex) when I am married. I do not do it. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

> What I learnt at school, including conversations with my parents, they say it helps when you grow up like myself, that if I sleep with a woman it helps me and it is

important to use protection to prevent pregnancy. Sleeping without a condom spreads diseases; using a condom is right; and abstaining too. (Participant 4, 21 years old, unemployed, from village 9)

My parents encourage me. They tell me that when I have sex with the person I am in love with, I must use a condom, you see, to prevent contracting HIV and impregnating because, especially I do not have a good job. They say if I get a baby, I will not be able to afford to support it. (Participant 13, 20 years old, unemployed, from village 9)

My grandfather has played a big part about preventing HIV and impregnating a girl; he used to encourage me. (Participant 5, 21 years old, employed, from village 9)

Oh we talked once with my father. He encouraged me to use a condom if I engage in sex. (Participant 19, 22 years old, Grade12 high school learner**,** from village 9)

My father and mother told me that you should not be a father early because there may be problems, such as you cannot afford, you are not working in order to raise the baby, and you have no money to raise it. (Participant 10, 20 years old, intern, from village 3)

4.3.4.3.2.2 Teachers

According to participants:

Teachers teach us during Life Science and Life Orientation lessons. They teach us this and that, and that you should abstain, or condomise. (Participant 4, 21 years old, unemployed, from village 9).

To be honest, it is something that I learnt from school that sex is not right, especially if you abuse it. (Participant 8, 21 years old, unemployed, from village 9)

4.3.4.3.2.3 Friends

According to participants:

> There is no encouragement from friends. Some friends encourage, others do not. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

> We encouraged each other as friends not to have sex, but there were some who did not because they were already engaging in sex. Both my parents encouraged me to abstain and recently they thanked me that I have not engaged in this and that (sex) because they know that many in my age group these days do this and that (sex). (Participant 6, 24 years old, employed, from village 7)

4.3.4.3.2.4 Health care workers

According to participants:

> At school we were visited by nurses from the hospital that came to give us health education as today's youth about what HIV does; how you can get infected, and other sexually transmitted infections that you can get if you engage in unprotected sex. They also told us that as a young man, if you do not want to be a father at an early age, you must always have protection (condoms). (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

> In events like the World AIDS Day, you get health education about abstaining; a condom is important, and that HIV test results become positive or you get a baby if you do not use a condom. (Participant 8, 21 years old, unemployed, from village 9)

> I get encouragement from the clinic when I go to check for HIV. They encourage me on ways to use when doing sex with my girlfriend and how to avoid sexually transmitted diseases. (Participant 5, 21 years old, employed, from village 9)

4.3.4.3.2.5 Siblings and cousins

According to participants:

My younger brothers and my aunt's sons also live in the area. We discuss when we are chilling that, no brother, to avoid impregnating a girl, we should use protection. To protect yourself, you must use a condom. (Participant 4, 21 years old, unemployed, from village 7)

Brothers tell us about the problems they have encountered as young fathers. (Participant 10, 20 years old, intern**,** from village 3)

4.3.4.3.2.6 Media

According to participants:

It is said that TV and health go together, so what you watch, teaches. There are dramas that play and you see or actually experience, especially one called *Shuga*, the life of drugs. I have learnt a lot from TV programmes. I believe that thing that happen in TV also happen in real life. (Participant 8, 21 years old, unemployed, from village 9, apparently with a lot in mind)

Knowledge is available from the radio and TV, that when you have sex, you should use a condom. (Participant 18, 20 years old, Grade 11 high school learner, from village 9)

4.3.4.3.2.7 Uncles

According to a participant:

Eish, they told me, however, not formally. They said sex with a young girl is not right. (Participant 9, 20 years old, unemployed, from village 9)

4.3.4.3.2.8 Social workers

According to a participant:

They are there, although they were not talking to me alone. They taught us how to behave concerning sex and protecting yourself from the germ. It was at school, it was social workers. (Participant 19, 21 years old, Grade 12 high school learner, from village 9)

4.3.4.3.3 Role models – Tell me about family members and friends who are your role models

Few participants expressed having role models. After an explanation of what role models among family and friends were, one participant referred to people whom he respected, such as teachers. The participants indicated grandparents, uncles, siblings, and neighbours as role models. None of the participants indicated their fathers as role models.

4.3.4.3.3.1 Neighbours

According to two participants:

> So-and-so is my neighbour. Oh, I like the way he lives his life; him as a person, and the way he did things. He grew up loving school, and became successful in everything he did in good time. He does not have children yet and he is still single. (Participant 5, 21 years old, intern, from village 9)

> I have seen some role models among neighbours, who were able to respect their parents until they finished school without having a baby. I was also encouraged and thought that this is the right thing to do, so that even if your parents were to die, they would be proud of you. (Participant 6, 24 years old, employed, from village 7)

4.3.4.3.3.2 Role models

Regarding role models, according to participants:

> I regard my teachers as role models, as people who teach me or give me advice. You spend very little time at home when you are still schooling. You leave home very early in the morning and come back in the afternoon. You spend most of your time with the teachers, go home in the afternoon and go back early the following morning. I was able to see that when the teacher says something like this, he is right. Even in the community, if an elder or uncle speaks, you listen.

My uncle says that I should not do drugs although he smokes. (Participant 4, 21 years old, unemployed, from village 7)

No, no, there is no one (*hhayi cha akekho*). You mean someone I look up to, no there is no one. No, there is no one, there is no one (*akekho*). (Participant 7, 18 years old, Grade 11 high school learner, from village 9, after a long silence, shaking his head emphatically)

There is no one in the neighbourhood. (Participant 8, 21 years old, unemployed, from village 9)

Not among older brothers, none, none (*Hhayi kobhut' abadala, abekho, abekho*). (Participant 19, 21 years old, Grade 12 learner, from village 9, emphatic that role models were not among older brothers but the elders)

Role models we can say maybe more women than men. There are no men who are role models. (Participant 14, 24 years old, employed, from village 7, boldly)

Role models among young men, if they are there, then a few, because we do not know a person's personal life out there. You may never be sure he does not sleep with someone; you may never be sure. (Participant 16, 21 years old, student at a tertiary institution, from village 7)

4.3.4.3.3.3 Grandparent

One participant indicated that his grandfather was a role model:

I do not have a role model of my age. My grandfather is my role model. He has Jesus and he does everything for his family and he has never been unfaithful to my grandmother. (Participant 9, 20 years old, unemployed, from village 9)

4.3.4.3.3.4 Celebrity

One participant indicated a celebrity as his role model:

I can say that although there is no one where I live, there is an artist called So-and-So. He is still young. You know, these days, young people don't really take

marriage seriously. They believe in having many partners. He is married and he loves his family. He confesses that he loves his family. (Participant 8, 21 years old, unemployed, from village 9)

4.3.4.3.3.5 Unidentified elders

According to one participant:

> Yes, yes, role models are there … they are my role models. They are married and they have been married for a long time. When I do research about them, I find that even the man had no relationship and slept with no one else except the one he is married to and he has no children out of wedlock. He only has children with the one he is married to. (Participant 19, 21 years old, Grade 12 high school learner, from village 9)

4.3.4.3.3.6 Siblings

According to one participant:

> No they are there, my brothers, they are my role models. They did not have children while they were still young. They got children after they could, they had something. They got children when they could support them; they got children when they were already working. (Participant 13, 20 years old, unemployed, from village 9)

4.3.4.3.3.7 Uncle

According to one participant:

> It is said my uncle was a person who loved school and did not pay attention to girls and girls would sometimes be the ones who want to be with him. He did not pay to attention to them until he finished school, got a job and got married. He has his family today. He had his children in marriage; he does not have any outside his marriage. (Participant 17, 19 years old, Grade 11 high school learner, from village 9)

4.3.4.4 Situational influences

This section discusses the availability of condoms, and situations which do not promote the prevention of HIV and teenage pregnancy.

4.3.4.4.1 Where can you find condoms of your choice?

The participants obtained condoms from the health care facilities and shops.

4.3.4.4.1.1 Health care facility

According to the participants:

> I usually go to the hospital when I go with my mother when she visits the sick, look if I can find condoms in the boxes. If they are available, I take them and store them in my room so that when a situation arises then I can use them. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> Condoms are available at the clinics, hospitals and shops. (Participant 4, 21 years old, unemployed, from village 7)

> I get condoms from the clinic or buy them if they have run out. I have never had a situation where I did not find them at the clinic. (Participant 5, 21 years old, employed, from village 9)

> I get condoms from the clinic. I am satisfied with them; I do not have problems with them. (Participant 5, 24 years old, intern, from village 7)

> Free condoms are available in clinics. There is no shortage of condoms; they are available everywhere. (Participant 8, 21 years old, unemployed, from village 9)

> Free condoms are available at the hospital, if you do not have money to buy. (Participant 9, 20 years old, unemployed, from village 9)

4.3.4.4.1.2 Public places

According to some participants, condoms were available at public places:

> Free condoms are also available at the shops. (Participant 9, 20 years old, unemployed, from village 9)

> There are shops where they are placed so that people can protect themselves. Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> Condoms are available at clinics and shops. There are also those that are for sale. I usually buy them at the shops and sometimes I use the government supplied ones. (Participant 4, 21 years old, unemployed, from village 7)

> Free condoms are available in all the shops in this area. They are also available in taverns. Even now you can get them from any of the shops around here. (Participant 8, 21 years old, unemployed, from village 9)

> They are available at schools and shops. (Participant 11, 23 years old, unemployed, high school dropout**,** from village 3)

4.3.4.4.1.3 Buy them

Some participants indicated clearly that they preferred condoms they bought because they were not confident about the free ones. It was of concern to note that participants preferred to buy condoms rather than use the free government supplied ones.

> Free condoms are available at the hospital if you do not have money to buy. I do not trust the free ones but I use them because money is scarce. (Participant 9, 20 years old, unemployed, from village 7)

> At the shops they are available. (Participant 12, 19 years old, unemployed, from village 3)

> *Hawu* (oh my word), they are available at the shops. Those free ones have problems. (Participant 13, 20 years old, unemployed, from village 9, boldly)

Ashmore and Henwood (2015:1) conducted a study on the popularity of alternative condoms to Choice condoms in a youth clinic in Khayelitsha, Cape Town and found that flavoured condoms were the most popular, followed by extra-large condoms. Moreover, regular condoms in bright packaging were more popular than Choice condoms.

4.3.4.4.1.4 Not easily available

One participant said that condoms were not easily available because children played with them:

> These days, condoms are not easily available although there are shops where they are placed so that people can protect themselves. Children see them as balloons. They take them from the shop, inflate and burst them as they walk home, and when men or women need them when they want to do it (sex), they do not find them and end up sleeping together without a condom. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

4.3.4.4.2 What can you do to avoid situations which do not promote the prevention of HIV and teenage pregnancy?

The participants indicated avoiding risky places with drugs and alcohol, such as parties and taverns, to prevent involvement in substance abuse that is a risk for HIV infection. According to a participant:

> I have not been to a tavern. Yes, I do walk around, but I have never been drunk. Even when I drink, I do not drink to get drunk. I just drink a little and stop before I get drunk. No, getting drunk, I have never been drunk. As for drugs, I have never even smoked. I have never used them. (Participant 4, 21 years old, unemployed, from village 7)

4.3.4.5 Commitment to a plan of action

The participants were asked whether they were ready to set goals and develop a plan to prevent HIV and teenage pregnancy. Most of the participants did not commit to a plan of action because they were satisfied with what they were doing. Two were prepared to

change their behaviour. One participant appeared to have low self-efficacy, and another resolved to talk to younger boys. According to the participants:

> This morning I got a challenge from a certain person on WhatsApp. He asked if one would be able to be in a relationship for 8 years without engaging in sexual intercourse. I think if I really love that person, I can do that. You see if I make that decision today and not listen to what people say that can happen and not happen because friends can pressurise or fool you. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> No, I can see that I need to make decisions from the time when I will have thought about it. I think I am going to make a decision to separate myself from the friends that I have because I can see that I am easily influenced. Now I see that I am going to separate my friends from the friends that I have. The other decision I am going to take is among the girlfriends that I have, I am going to decide to continue the relationship with maybe only one. I will ask the others that it is over because I need to prepare for my future and that also my behaviour in the community, you see, neighbours can see how we behave and keep quiet, and although I have not heard that there is any soap that can wash a person's name, but I will try to change how I behave. I mean I will also try to change these many girlfriends that I had; try to warn them that we were actually deceiving each other in our relationship. We really need to relook at the reason because we can say we love each other those few weeks or few months but, in actual fact, we do not have a future together because I am still growing. I am still going to travel places, see many different people. You are also going to grow, travel places and see many people, including young men and realise that I was nothing as I will also see that no, really, you were also nothing. This means there is no future together. Even if you can try to, because these days it is a known fact that girls say I will pin him down with a baby, I have to have his baby, it will not work. Even if you do get pregnant and maybe I admit that the baby is mine, I will take my baby to live with me, but I do not love you anymore. You will have lost a lot. Even If they would think they will pin me down with babies, they will not succeed because I will always have a condom and ask her if she agrees to have sex with a condom because I want to build my future, get educated and make my parents happy, and do for them whatever I want to do. Then I will consider having a baby with my wife. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)
> This participant spoke remorsefully from his heart about his behaviour and how

he wanted to change his outlook on women and change even his girlfriends' behaviour. He was also determined not to have a baby before marriage.

I am going to talk to young boys who are still growing and warn them about the dangers of starting sex early and advise them not to start doing it before time ... laughing ... to start in marriage ... laughing ... I think I made a mistake. (Participant 5, 21 years old, employed, from village 9)

I have not thought about a plan because what I am doing is working for me. (Participant 4, 21 years old, unemployed, from village 7)

I would tell them, young boys, to stop deceiving each other about having many girlfriends in order to be recognised as a man. That can bring you problems such as some have committed suicide because they have HIV because they do not know that HIV is something you can live with. (Participant 12, 19 years old, unemployed, from village 3)

What I can say about being in this conversation is that it has helped me because there are things that I see that I need to change; things that do not help me to be in a relationship with one person. (Participant 10, 21 years old, intern**,** from village 3)

When I sleep with a woman I will use a condom. I will start using a condom. (Participant 21, 23 years old, unemployed, high school dropout, from village 9, cheerfully)

4.3.4.6 Competing demands and preferences (at follow up)

4.3.4.6.1 What problems did you encounter trying to prevent HIV and teenage pregnancy?

The participants encountered problems due to peer pressure as a way of earning respect from peers, such as alcohol abuse and skill in condom use. Adolescents who identify strongly with a group (relational identity) may think that their relationship with peers improves their self-identity leading to risky sexual behaviour (Railford, Seth, Braxton & Diclemente 2013:466). The participants indicated that mixing sex and alcohol frequently results in failure to use a condom or not being able to use it properly. This

concurred with a study among African-American men on the role of masculinity and perceived skill in condom use that found a need to address men's condom use skills and masculine norms (Railford et al 2013:467).

According to the participants:

> There was a time when we hosted a house party where, you see … we just invited girls, a group of girls to where we were going. In a house party, there is alcohol and other drinks and some are smoking. There is also this game called "spin a bottle on the floor". If the bottle points to a girl and a boy, that means they will stand up and stand in the middle and then take a long kiss until you separate them. As time goes on, oh, the girls will stand on one side. The boys will then ask which girl is the best kisser because maybe one will have kissed one of them. Then you will be told to kiss this one or that one that has not been kissed. Then it will depend on how many rooms there are in the house. Eh, eh, then if you say "*ek sê suster*", calling one of the girls saying that she must come to help you with something knowing that you are not calling her to help you, but because you want what you want, such as sleeping together with her. By that time you are all drunk, no one cares what the others are doing. A condom is not used in that case. The girls are also drunk so they do not refuse. (Participant 2, 19 years old, Grade 10 high school learner, from village 3)

> The way I see it concerning the difficulties we encounter when we want to use a condom, sometimes when you are with a girl and wanting to use a condom, the girl asks if you do not trust her or if you do not love her. When she asks if you do not trust her, what can I say? You are now not thinking straight because you are thinking about immediate gratification; you do not think about your future. When she asks if you do not trust her, you put the condom away because now you want what you want, and not thinking about the future. My friends laughed at me for some days because some of the girls I dumped attend the same school … I was humiliated. (Participant 3, 19 years old, Grade 12 high school learner, from village 3)

> As friends, we pressurise each other and make you end up doing bad things, such as when a friend pressurises you to do this and that (*lokhu nalokhu*), and to have a girlfriend. At school, you even boast to each about having this girlfriend, that and that girlfriend. (Participant 4, 21 years old, unemployed, from village 7)

It happened that I used protection, but *eish*, she fell pregnant. I don't know what happened. Now you cannot trust them (condoms) and whether you are safe or not. (Participant 9, 20 years old, unemployed, from village 9)

The difficulty is eh when you see your friends walking with their girlfriends you feel that pressure of remembering that person you left… now I do not feel lonely anymore, I am happy about my decision because I can see that life goes on without it (sex). I will see what to do when I finish school but no for now. (Participant 2, 19 years old, Grade 10 learner, from village 3, seemed to have low self-efficacy)

It happened that when I put on a condom she told me that it hurts her, I must remove it. She also asked if I do not trust her, why I am using a condom with her. (Participant 12, 19 years old, unemployed, from village 3)

I encountered a situation wanting to use a condom, when she said you do not trust me or you do not trust yourself or maybe there is something that you have. She ends up not trusting you, thinking that you have a certain disease and loses interest in having sex with you. (Participant 13, 20 years old, unemployed, from village 9)

I used to drink alcohol. It was making me touch girls when I was drunk and discover in the morning when I woke up, when I looked by my side, *hawu* (oh my word), who is this woman, where does she come from. When I look at her she is older, and I do not know her. I saw her for the first time the previous day. (Participant 11, 23 years old, high school dropout, unemployed, from village 3)

4.3.4.6.2 How did you overcome these problems?

According to the participants,

If you say to yourself, I do not want a girlfriend now because I want to focus on what I want to do, you do not listen to your friends; you ignore peer pressure. I listened to those people who taught me, including the teachers who educated me, that if I do not have a condom I must not sleep with a girl, I listened to what they said because I was thinking that extra cost my mother would have to bear

having to support me and my baby. (Participant4, 21 years old, unemployed, from village7)

No, no, I will not do what others do. (Participant 7, 18 years old, Grade 11 high school learner, from village 7)

We went to have an HIV test then we started using the condom again. (Participant 8, 21 years old, unemployed, from village 9)

As long as I know why I took the decision, for what reasons, and also I see the results because I got a lot of time focusing on my school books. I raised the standard; it was like I am addicted. I had very little time for girls. My friend, who is my role model, supported me when I told him, brother, I want to distance myself from many girlfriends. (Participant 3, 19 years old, high school learner, from village 3)

I have never (had sex) since then. I started by leaving the phone at home, not having a phone and concentrated on studying. I was unable to communicate with many people. I also changed the phone; it helped because I do not have old contacts, only a few. I talked to the one I left on the phone. I do not whatsapp any more. I did not want to meet her. If I saw her coming, I took another way. Also I told them I am going away…I just do not like parties any more. Alcohol, alcohol; I drink seldom when it happens when I get that one I am used to; the one with a low percentage of alcohol such as 5.0% not 7.0% no, I do not drink that one. (Participant 2, 19 years old, Grade 10 learner, from village 3, who so far had stopped having sex)

I used to abandon the idea of sex, if you ask me if I don't trust you or I am hurting you because I saw that there is something big you want to do to me. I would also explain that it is not because I do not trust her, maybe it is the first time we have sex, we do not know each other, I do not know her past and more so that is why I am using a condom. After I have been with her for a long time, we know each other and we have been to the clinic in order in order to trust each other sure, sure, sure. (Participant 12, 19 years old, unemployed, from village 3)

Even at our homes, we get pressurised; it is true, we get pressurised at home. However, as I have already mentioned, it depends on you who is receiving the pressure, how you respond and how much you believe in what you believe, you

> see. So even if maybe there is peer pressure, but it is up to you that you do not. I know where I stand, I stand on the truth or how I stand when peer pressure comes there is that thing, those thoughts that you know what, we need to speak as children of God and again you remember oh no this this thing that is happening, I know that it is passing. (Participant 14, 24 years old, employed, from village 7**,** from Christian denomination 1)

> I talk to her and explain why I use a condom. I tell her that, no, I am not sick. The problem is that I am avoiding her getting pregnant, things like that. (Participant 13, 20 years old, unemployed, from Christian denomination 3, from village 9, boldly)

4.4 FINDINGS

The study found that according to the participants, a man of a kind is the head of and provider for his family; treats women well, and uses a condom to prevent HIV and AIDS and teenage pregnancy. According to social norms, the participants were expected to have sex with a condom and their social support came from parents, grandparents, teachers and health care workers. Several participants indicated a lack of role models in their families. Some preferred to buy condoms rather than use the free ones available at the clinics and public places. Some indicated that they were using condoms inconsistently. The main problem was peer pressure to have sex and some alcohol abuse.

4.5 DISCUSSION

The purpose of this study was to explore and describe the positive values of masculinity in the prevention of HIV and AIDS and teenage pregnancy. The findings reflect that according to the participants, a man of essence is the head of and provider for his family, treats, women well and uses a condom to prevent HIV and AIDS and teenage pregnancy. The participants' views regarding the headship seemed to be in a continuum with total subordination of women on the other side and men and women discussing issues to arrive to a consensus on the other. Christian participants' view seemed to occupy a middle position. Although the Christian participants acknowledged the superiority of a man, however, they maintained that a man must head with love. The provider role of a man seemed to be highly regarded by the participants although most

of them were unemployed. The superiority of a man is supported by Gibbs et al (2014:15), that heading the family is very important to men where they went to great length (including violence and controlling women) to maintain their position. However, what men did to maintain their dignity in Gibbs study is inconsistent to the findings of this study. The participants maintained that women and children must lack nothing because that might drive women and girls to prostitution (selling their bodies) (Wamoyi et al 2016:20992). Those participants who were unemployed were doing peace jobs to provide for themselves and their loved ones and maintained that it is their duty to do so. Financial security is also important to women in their choice of marriage partners. The undergraduate students in Nigeria ranked “financially comfortable” seventh among the desired qualities of a prospective marriage partner (Onu and Armstrong 2013:84). This calls for community development projects as one of the participants alluded that a man should be a community developer to alleviate poverty which is associated with intimate partner violence including sexual violence (Fulu et al 2013:e187-e207).

The finding on male domination needs to be attended for the following reasons: socialization of a hegemonic male might be the root of gender violence (Albee [s.a.]), male superiority may be accompanied by the notion of not being susceptible to HIV infection (Iwelumor et al:2015:195) and gendered norms that favour male domination in sexual relationships are risk factors to HIV infection among young women (Harrison et al 2015:207). The implication is that communities have to relook into the socialization of the boy child for prevention of HIV and health care service providers to establish youth programmes to discuss gender equality.

This finding about treating women well is giving hope for the future in this day and age of violence against women and children in South Africa. However, this finding is contrary to the findings of Gibbs et al (2014:15), South Africa, and Izugbara (2015:121), Kenya, who found that poverty threatened masculinity. In South Africa men resorted to violence to obtain power and control over women. In a similar situation of poverty and unemployment poverty might threaten masculinity of young men in this study.

According to social norms, the participants were expected to have sex with a condom and their social support came from parents, grandparents, teachers and health care workers. This finding is important, however, communities have a pivotal role to play to support health promoting behaviour and reduce risky sexual behaviour. In Kampala,

Uganda, social mobilization to prevent violence against women lowered social acceptance of violence against women and increased community support of women who experienced intimate partner violence. Communities need to be engage in discussions to promote healthy behaviours that prevent HIV and teenage pregnancy in order to support young people. Support by family members is consistent with Satton et al (2013:369) who studied the impact of parent-child communication on risky sexual behaviour and found that open communication decreased risky sexual behaviour among youth thereby decreasing sexually transmitted diseases including HIV.

Several participants indicated a lack of role models in their families. Some preferred to buy condoms rather than use the free ones available at the clinics and public places. Some indicated that they were using condoms inconsistently. These problems might be linked to peer pressure that was experienced by participants in this study. It is consistent with Railford et al's study (2013:466) who found that youth who identify strongly with a group are at risk of risky sexual behaviour and alcohol abuse leading to HIV infection. Communities, health care providers and researchers need to join hands in dealing with issues in these findings.

4.6 CONCLUSION

This chapter discussed the data analysis and interpretation, and results, with reference to the literature review.

Chapter 5 briefly discusses the conclusions and limitations of the study, and makes recommendations for the handbook, practice and further research.

CHAPTER 5

FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter briefly presents the findings and limitations of the study and makes recommendations for health promotion and the prevention of HIV and teenage pregnancy, and further research.

5.2 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to explore and describe the positive values of masculinity and the role of a man in the prevention of HIV and AIDS and teenage pregnancy in a rural sub-district in KwaZulu-Natal, South Africa in order to develop a health education handbook for young Zulu men.

The objectives of the study were to

- identify expectations of a man of essence/positive values of masculinity
- describe the man's role in the prevention of HIV and AIDS and teenage pregnancy
- develop a health education handbook for young men in developing positive values of masculinity

This chapter summarises the findings with regard to the first two objectives of the study. The last objective is presented in chapter 6.

5.3 FINDINGS

The findings are presented according to the sections of the semi-structured interview guide.

5.3.1 Participants' demographic profile

The participants were young Zulu men aged 18-24 with an average age of 21 years from a poor rural area, mostly unemployed and with high school education.

5.3.2 Expectations of a man one can call a man among men

The participants expressed different expectations of a man of essence, including traditional, religious (Christian and non-Christian), modern or general views and attributes. In summary, according to the participants, a man among men

- is the head. However, if he is a Christian love must dominate in the relationship, not the superiority of a man and the inferiority of a woman
- provides for the family (feeds; takes care of; supports; looks after)
- has good self-esteem
- is loving and supportive
- does not engage in risky behaviour (crime, alcohol abuse, cheating)
- is busy (gardening; herding cattle; community development; hard working; helping) and respectful (respect; not insolent; does not look down on others)
- is a role model (by behaviour and example)
- is a mentor (talks to, advises, encourages)
- treats women well (respects and protects women)
- has good communication skills
- is married
- has a house
- is opposed to/against violence (physical, verbal and emotional abuse).
- values education
- is humble (says sorry when necessary)
- is focused, independent, and trustworthy

Concerning gender equality, the participants stated that women should be treated with respect with no physical, sexual and emotional abuse and should also be involved in decision-making.

5.3.3 Role of a man in the prevention of HIV/AIDS and teenage pregnancy

The participants first considered the role of a man in the prevention of HIV and teenage pregnancy and then answered the question: What is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl? The participants' views of their role as a man in the prevention of HIV and AIDS and teenage pregnancy can be summarised as follows:

- Avoid premarital sex. Christian and non-Christian participants indicated avoiding premarital sex. Christian participants stated that sex before marriage is a sin while Traditionalists believed that it was culturally unacceptable and if it happened that a man slept with a virgin or impregnated a girl he should pay. Traditionalists referred to special traditional methods and ceremonies of getting into a relationship that avoid engaging in sex prematurely, such as *ukuqoma ngeduku*.
- Avoid relationships.
- Sleeping together must be avoided; meet in public places; be friends with people of the same mind; be in a relationship with a person of the same mind.
- Alternative ways to demonstrate love: respect her, be faithful to her, involve her.
- Wait for traditional ceremonies (rites of passage such as *umhlonyane*, *umemulo* and *ukuya uphondweni*).
- Non-penetrative sex (*Ukusoma*).
- Choose a lover or girl to marry (*Ukuqoma ngeduku*); wait until you are old enough and financially ready to marry.
- Alternative ways to show love: Love is not something that you say with your mouth, but actions should show love (*kodwa yizenzo ezikhombis' uthando*). Treat her well; meet her needs, if there is something she needs or wants; do things for her.
- Preventive measures to prevent HIV and teenage pregnancy. The participants indicated traditional and modern methods to prevent HIV and pregnancy. Condoms were the method most used.

The participants expressed benefits for themselves and their families in preventing HIV/AIDS and teenage pregnancy. The benefits or advantages included health; being carefree; being able to focus on the future; no extra financial burden for parents, and parents being proud of their children. The disadvantages if one gets infected or impregnates a girl included dropping out of school; poverty; shame, and a baby not loved or wanted.

Regarding teenage pregnancy, the participants stated that a man of essence is not a “blesser” (a man who uses his money to get sexual favours with young girls in need).

To end poverty and prevent dependency on men, the participants stated that women should be educated in order to get jobs and maintain themselves and their families.

5.4 LIMITATIONS OF THE STUDY

The study was confined to Nquthu sub-district in uMzinyathi District in northern KwaZulu-Natal Province, South Africa. This is a poor rural area.

Data collection was limited to twenty one semi-structured interviews. The participants were young Zulu men and the researcher was an older female. Same sex interviews by a person of approximately the same age group might have produced more and richer information.

The questions elicited self-report on sensitive information on sexual behaviour and HIV and AIDS. The participants might consequently have been biased in their response to such information. However, their anxiety was allayed by explaining confidentiality and conducting the interviews in private.

Data depended on recall and truthfulness. Recall can overestimate consistency of condom use because participants tend to reflect on the short term. However, assurance of confidentiality, anonymity and privacy might have reduced these problems.

5.5 SIGNIFICANCE OF THE STUDY

The findings of this study should assist all stakeholders involved in the development and implementation of programmes for the prevention of HIV and teenage pregnancy in Nquthu sub-district and elsewhere. Benefits to the community would include community education on the benefits of positive values of masculinity; adapting own culture in the light of new realistic information about the risks in a way that comes from within the community based on science and not ideology (customary beliefs). The young male participants were generally aware that using a condom is the key to the prevention of HIV and teenage pregnancy. However, inconsistent use of condoms, lack of role models in the community, social norms, and the lack of confidence in free condoms supplied by the Department of Health were of concern. Health care workers, district managers and the community need to consider issues recommended in this research.

5.6 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for managers and health care providers, community leaders, and youth, and further research.

5.6.1 Managers and health care providers

Clinic managers and health care providers should introduce youth programmes in clinics on sex and sexuality, HIV, and gender equality.

5.6.2 Community leaders

Community leaders, including chiefs, headmen, church leaders, elders, parents and church groups/sodalities should introduce youth programmes in the community and community conversations on issues of HIV and teenage pregnancy, the rights of women, and gender equality.

Adult community conversations in the community should include issues of parenting boys for the prevention of HIV and teenage pregnancy. Youth programmes in the community should include life skills.

5.6.3 Further research

Further research should be done on

- women's perceptions of men of essence and their role in the prevention of HIV/AIDS and teenage pregnancy, and gender equality
- the upbringing of boys and gender equality for the prevention of HIV and teenage pregnancy
- the role of gender equality in the prevention of HIV/AIDS and teenage pregnancy
- exploration of positive values of masculinity in prevention of HIV and AIDS and teenage pregnancy in a wider context among other language and ethnic groups and in urban and rural areas

5.7 CONCLUSION

This chapter summarised the findings of the study, described its limitations and made recommendations for practice and further study. This study was qualitative, the participants were young Zulu heterosexual men between the ages of 18 and 24 years, residing in Nquthu sub-district. The purpose was to explore the positive values of masculinity and the role of a man in the prevention of HIV and teenage pregnancy in order to develop a health education handbook for young men to be health educated in prevention of HIV/AIDS and teenage pregnancy.

he objectives of the study were achieved. It was found that young men were generally positive about prevention of HIV and teenage pregnancy although there are challenges that need to be addressed. There were differences in self-efficacy which might be improved by addressing social norms and a health education handbook designed to address the needs of young men.

Although there are programmes to reduce and halt HIV transmission, the researcher found no research on the positive value of masculinity in the prevention of HIV and teenage pregnancy. This study is a stepping stone to addressing the context of HIV and AIDS transmission and teenage pregnancy from a masculine and positive perspective.

The participants were aware of and used condoms to prevent HIV transmission and teenage pregnancy.

In the researcher's view, the development of a health education handbook for boys for use by all health care providers, especially those engaged in the prevention HIV/AIDS and teenage pregnancy and school health services, would promote awareness; improve the use of traditional and religious methods to regulate sex for both boys and girls; promote gender equality and reduce discrimination of women and girls. Moreover, the handbook and programme should positively impact on consistency of use of condoms by young men, and motivate them to accept condoms offered by their sexual partners (gender equality), be the role models and educators of the younger generation, who will pass these roles on to generations to come, and contribute to the overall prevention of HIV/AIDS and teenage pregnancy in future.

Abraham Lincoln, 16th President of the United States of America, was well known for many sayings that inspired people to be better. One of them is "It's not the years in your life that count. It's the life in your years" (Rosecrans 2017). In the researcher's view, this is a fitting and inspirational message for the prevention of HIV and teenage pregnancy.

Chapter 6 presents and discusses the HIV/AIDS and teenage pregnancy prevention health education handbook for young Zulu men that was developed from the findings of this study. The handbook is the attainment of the third objective of this study.

CHAPTER 6

HIV/AIDS AND TEENAGE PREGNANCY PREVENTION: A HANDBOOK FOR YOUNG MEN IN DEVELOPING POSITIVE VALUES OF MASCULINITY

6.1 INTRODUCTION

The purpose of this study was explore and describe the positive values of masculinity and the role of a man of essence (a man of a kind or *indoda emadodeni*) in order to develop a health education handbook for young Zulu men for use in Nquthu sub-district and elsewhere in the country. This chapter describes the contents of the handbook to help and guide young men develop positive values of masculinity that will be used in the community in Nquthu sub-district and elsewhere. The researcher based the handbook on the WHO (2014) guidelines on HIV prevention, diagnosis, treatment and care, which is in line with the national guidelines.

6.2 CONTRIBUTIONS OF THE STUDY

This study fell within the WHO (2014) guidelines on HIV prevention, diagnosis, treatment and care; UNAIDS (2015) Sustainable Development Goals (SDGs), and the national HIV/AIDS and STD strategic plan, and millennium development goals to combat HIV/AIDS, malaria and other diseases (NDOH 2000; 2015a). The focus was on SDG 3: good health and well-being, which is closely linked to SDG 5: gender equality and SDG 1: no poverty.

SDG 3: Good health and well-being for all at all ages

This study focused on adolescents and youth up to 24 years of age. The main focus was on ending the HIV epidemic by 2030 by concentrating on the prevention of HIV.

SDG 5: Gender equality

This SDG is aimed at eliminating violence and sexual exploitation of women, including sexual harassment in public office, and abolishing harmful traditional practices and all forms of discrimination against women, including exclusion of girls from education. The participants stated that men should treat women with respect with no physical, sexual or emotional violence against them. Sexual violence is associated with HIV infection and teenage pregnancy.

SDG 1: End poverty

The participants stated that women should participate in decision-making. According to SDG 1 gender inequality leads to lack of decision making which perpetuates poverty and the risk of early pregnancy and HIV infection. Ending discrimination against women and girls helps to improve economic growth and development. One participant mentioned that men should be involved in community development.

The study developed more understanding and awareness of the role of men in the prevention of HIV and teenage pregnancy from religious, traditional and modern or general perspectives. The study also revealed that activities to reduce HIV infection were being implemented in the community and challenges that need to be addressed. The findings provided deeper understanding of the context of HIV prevention in Nquthu sub-district, in uMzinyathi district.

The health education handbook should raise young men's awareness of positive qualities of masculinity and their role in the prevention of HIV and teenage pregnancy. The use of this handbook should assist the community to improve their role in the prevention of HIV and teenage pregnancy in Nquthu sub-district and other areas of the country with a similar context.

6.3 DEVELOPING AND COMPILING THE HANDBOOK

6.3.1 Developing the handbook

The researcher developed the handbook from the health promotion model (HPM), the findings and recommendations of the study, the literature review and global and national guidelines and policies and the findings and the recommendations of the study.

6.3.1.1 The role of the HPM

The HPM guided the literature review and the interviews regarding factors that influence health promoting behaviours such as personal and interpersonal factors, perceived barriers of action, perceived benefits of action and health promoting behaviours.

6.3.1.2 The role of the findings of the study

The following themes and subthemes from findings on expectations of a man of essence informed the content of the handbook to develop a man of essence.

- is the head. However, if he is a Christian love must dominate in the relationship, not the superiority of a man and the inferiority of a woman
- provides for the family (feeds; takes care of; supports; looks after)
- is loving and supportive
- does not engage in risky behaviour (alcohol abuse, cheating)
- respectful (respect; not insolent; does not look down on others)
- is a role model (by behaviour and example)
- is a mentor (talks to, advises, encourages)
- treats women well (respects and protects women)
- has good communication skills
- is opposed to/against violence (physical, verbal and emotional abuse).
- values education
- is focused, independent

The following themes and subthemes from findings on the role of a man in the prevention of HIV and teenage pregnancy informed content for development of awareness to prevent HIV and AIDS and teenage pregnancy.

- Avoid premarital sex. Christian and non-Christian participants indicated avoiding premarital sex. Christian participants stated that sex before marriage is a sin while Traditionalists believed that it was culturally unacceptable and if it happened that a man slept with a virgin or impregnated a girl he should pay. Traditionalists referred to special traditional methods and ceremonies of getting into a relationship that avoid engaging in sex prematurely, such as *ukuqoma ngeduku*.
- Avoid relationships.
- Sleeping together must be avoided; meet in public places; be friends with people of the same mind; be in a relationship with a person of the same mind.
- Alternative ways to demonstrate love: respect her, be faithful to her, involve her.
- Wait for traditional ceremonies (rites of passage such as *umhlonyane*, *umemulo* and *ukuya uphondweni*).
- Non-penetrative sex (*Ukusoma*).
- Choose a lover or girl to marry (*Ukuqoma ngeduku*); wait until you are old enough and financially ready to marry.
- Alternative ways to show love: Love is not something that you say with your mouth, but actions should show love (*kodwa yizenzo ezikhombis' uthando*). Treat her well; meet her needs, if there is something she needs or wants; do things for her.
- Preventive measures to prevent HIV and teenage pregnancy. The participants indicated traditional and modern methods to prevent HIV and pregnancy. Condoms were the method most used.

6.3.1.3 The role of the literature review

Most literature that was used to develop the handbook were global and national policies surrounding management of HIV and AIDS and teenage pregnancy.

Table 6.1 presents the guidelines and policies on the prevention of HIV and STIs.

Table 6.1 Guidelines and policies on the prevention of HIV and STIs

Guidelines	Activity	Rationale	Recommendation and guidance
National consolidated guidelines for prevention of mother-to-child-transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, 2015 (NDOH 2015b)	HIV testing and counselling (HCT)	HCT provides an opportunity to give information about safe sex and risk reduction and reflect on the result.	Provider-initiated HCT offered routinely at health facilities is not coercive. HCT should be linked to treatment and care.
		Post-test counselling provides an opportunity to talk about: • Risk reduction which includes MMC and condom use • Safe sex and condom use • Partner and children testing • Repeat testing of HIV negative • Linkage and referral to HIV-related services • Barriers to linkage to care	
	Post-exposure prophylaxis (PEP)	Reduces the probability of acquiring HIV infection after exposure, including consensual sex.	PEP should be started within 72 hours of unprotected sex. A 28-day course should be completed
Guidelines on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, 2015 (WHO 2015b)	Initiate antiretroviral therapy in adults living with HIV irrespective of CD4 count	Viral suppression reduces the risk of HIV transmission	Prioritise those with severe or advanced HIV

Guidelines	Activity	Rationale	Recommendation and guidance
	Oral pre-exposure prophylaxis for preventing acquisition of HIV infection	Oral pre-exposure prophylaxis prevents HIV infection before exposure to HIV	It is not limited to special groups but also recommended for people who are in a relationship with an HIV-positive partner. It should be provided together with other HIV prevention strategies such as consistent use of condoms. It is effective when offered as a choice and adherence is necessary.
HIV testing and counselling consolidated guidelines, June 2013: couples (WHO 2013)	Couple HTS	To identify sero-discordant couples who can receive ART and adherence counselling	Health care providers to be aware of potential intimate partner violence (IPV) and support those who prefer testing alone
Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. (WHO 2016b)	VMMC PrEP PEP	To increase the uptake of ART, VMMC, PrEP and PEP	Part of Comprehensive HIV prevention package – sex education, HTS, condom distribution and and management of STIs
Guidelines on HIV self-testing and partner notification (WHO 2016c)	HIV self-testing (HIVST) and partner notification	To increase the number of people who test and know their status	HIVST is not a diagnostic test, a confirmatory test is necessary if the result is positive.

The following documents guide fertility regulation and adolescent health:

- *National Contraception Clinical Guidelines: a companion to the National and Fertility Planning Policy and service delivery Guidelines, 2012* (NDOH 2012a).
- *National Contraceptive and Fertility Planning Policy and service delivery Guidelines: a companion to the National contraception Clinical Guidelines, 2012* (NDOH 2012b).
- *National Adolescent and Youth Policy, 2017* (NDOH 2017).

Other documents

- *How to use a male condom*. Brighton, 2017 UK 2017C: Avert.
- *Adolescents: health risks and solutions fact sheet 2016a*.

6.3.2 Compiling the handbook

The handbook is compiled into chapters a follows:

Chapter 1 HIV and AIDS transmission and prevention

- Definition of terms
- Transmission
- Prevention
    - Religious perspectives
    - Traditional perspectives
    - Modern ways
- Risks associated with HIV and AIDS

Chapter 2 Prevention of Teenage Pregnancy

- How does one become pregnant?
- How can you prevent pregnancy?
    - The morning-after pill

- Double protection
- Risks associated with teenage pregnancy

Chapter 3 Benefits of preventing HIV and teenage pregnancy

- Benefits of preventing HIV infection and transmission
- Benefits of preventing teenage pregnancy
- How can you help other young men to prevent HIV infection and teenage pregnancy?

6.4 THE DESIGN OF THE HANDBOOK

The size of the booklet will be a pocket size of about 13 cm long, 8 cm wide and 0. 5 cm thick with approximately 60 pages.

Font - Arial size 10

The layout is as follows:

- Cover – paper back, colour blue
- Title page with author
- Preface, publisher and acknowledgements
- Table contents

Chapter 1: HIV Transmission and Prevention

Chapter 2: Conception and prevention of teenage pregnancy

Chapter 3: Benefits of preventing HIV and AIDS and teenage pregnancy

6.5 CONTENTS OF THE HANDBOOK

This section discusses the contents of the handbook for young men based on global care policies and guidelines, the local situation, the conceptual framework (HPM) and the literature review.

The handbook is divided into sections based on the themes that emerged and the policy guidelines on the management of HIV and teenage pregnancy.

Section 1 discusses HIV, its transmission and prevention, and risk reduction and risks associated with HIV. Section 2 discusses how pregnancy occurs, its prevention, and risks associated with teenage pregnancy. Section 3 presents the benefits of preventing HIV and AIDS and teenage pregnancy.

6.5.1 HIV and AIDS transmission and prevention

HIV stands for Human Immunodeficiency Virus. This is the virus that causes deterioration of the body's immune system, resulting in the body's inability to protect itself from some infections and diseases. HIV infection in adults and children older than 18 months of age means a positive HIV rapid or laboratory-based test result confirmed by a second and different test (WHO 2007:8).

AIDS stands for Acquired Immune Deficiency Syndrome. It is an advanced stage of HIV infection when the person is sick with some diseases or related cancers (Centers for Disease Control and Prevention [CDC] 2015:2).

6.5.1.1 Transmission of HIV

HIV can be transmitted in many ways including:

- having sex without a condom with an HIV-positive partner
- receiving contaminated blood, blood products or tissue
- sharing contaminated needles and syringes
- using contaminated sharp equipment, such as razor blades or piercing and tattooing equipment

- transmission from a mother to her baby during pregnancy, labour, delivery and breastfeeding

6.5.1.2 Prevention of HIV

6.5.1.2.1 Religious perspectives

From a religious perspective, irrespective of denomination, believers are advised to distance themselves from relationships, and choose a marriage partner of the same mind.

6.5.1.2.1.1 Avoid relationships

Believers of most denominations (Christian and non-Christian), you are advised to avoid relationships to prevent the temptation of engaging in sex before marriage. You are not expected to persuade women (*awesheli*) into a relationship (*awujoli sdalo*). You do not need to practise persuasion skills (*ubusoka*) to get a marriage partner.

6.5.1.2.1.2 Break up relationships

If you were in a relationship or relationships before you committed to religion consider breaking up to prevent temptation.

6.5.1.2.1.3 Meet in public places

Before you break up, meet her/them in public places, not in private places (*hhayi emakamelweni*). This also applies while you are preparing for marriage.

6.5.1.2.1.4 Choose a marriage partner

You are expected to choose a marriage partner when you are physically and financially mature to marry. You will be guided by the leaders in your denomination on what to do. In some denominations, you are actually given a chance to choose a marriage partner so persuasion skills are not necessary. There is no need to concern yourself about practising these skills.

6.5.1.2.1.5 Do not be unequally yoked

Avoid being unequally yoked in all relationships, including friendships and courting. It is very important to surround yourself with people who are of the same mind in order to succeed and achieve your goals.

6.5.1.2.2 Traditional perspective

Traditionalists may use traditional ways to prevent HIV, such as *ubusoka* which has nothing to do with sex; *ukuqoma ngeduku, ukuya ophondweni, ukusoma, umemulo* is not permission to have sex.

6.5.1.2.2.1 Ubusoka has nothing to do with sex

Isoka means possession of persuasion skills. If as a young man you have these skills, you may be able to successfully persuade many women to be your girlfriends. However, the word itself has nothing to do with sex. *Ubusoka* has nothing to do with sex or sleeping with many women.

6.5.1.2.2.2 Ukuqoma ngeduku

Ukuqoma literally means “choosing a lover”. *Ukuqoma ngeduku* means choosing a lover by raising a flag at the young man’s family during which the girl’s family bring gifts for the young man’s family. It is the beginning of a life-long relationship between a man and a woman. It means that the two young people have chosen or are committed to each other. It is a traditional way of going public with a relationship. The whole community is made aware that they are no longer available and their relationship is meant to be permanent. It is not permission to engage in sex.

6.5.1.2.2.3 Ukuya ophondweni

This ceremony follows *ukuqoma ngeduku*. During the ceremony the young man’s family bring gifts for the girl’s family. Young people are not allowed to visit each other until they

have been through the traditional ceremony called *Ukuya ophondweni* or *impahla* as some call it.

6.5.1.2.2.4 Ukusoma

Young people may become intimate by engaging in non-penetrative sexual contact called *ukusoma*. It means sex between the thighs (interfemoral) or breasts of a girl and it is not regarded as sex in Zulu culture. The practice is a sign of respect for your girlfriend's virginity and for your father who taught you to respect women. It also saves you from having to pay the damages (*inhlawulo*) to cleanse or restore the dignity of the girl's home.

6.5.1.2.2.4.1 How to do inter-femoral sex

Make sure that your girlfriend's skin is intact. The girl sleeps on her side with legs crossed and thighs held very tight together so that your penis does not go beyond her clitoris. Semen is wiped with tissue.

6.5.1.2.2.5 Umemulo is not permission to have sex

Umemulo is the rite of passage of a girl from adolescence to young adulthood. It is a traditional ceremony that is done by her parents to thank her for her good behaviour and also to make young men aware that she is a grown up woman who can get married. It is not permission to have penetrative sex.

6.5.1.3 Modern ways of preventing HIV

HIV may be prevented in the following ways:

- Always use a condom when you have sex.
- Know your status to prevent transmission.
- Avoid injecting drug use or use sterile needles and syringes.
- Get voluntary medical male circumcision (VMMC).
- Adhere to your treatment if you are on ARVs to prevent infecting your sexual partner.

- Use post-exposure prophylaxis if you have been infected or pre-exposure prophylaxis if you are engaging in high risk behaviour.
- Treat sexually-transmitted infections because they increase the amount of HIV in semen and vaginal fluids.

6.5.1.3.1 Always use a condom when you have sex

The National Department of Health (NDOH) (2012a:43) defines a condom as "a thin rubber covering that is worn on a man's penis during sexual intercourse". When used correctly, condoms prevent HIV, pregnancy and most sexually-transmitted infections (STIs).

- Use it every time you have sex, even with your real partner (*ungqo* or *umaqondana*) to protect yourself and your partner from sexually-transmitted infections.
- Use a condom always even if you and your partner know each other's status because you may have been in the window period or unfaithful.
- Use a new condom for each round.
- Put it only after the penis is hard.
- Do not let the penis touch the genitals before putting on the condom.
- Always use a condom, even when you and your partner are on ARVs.
- Always use a condom, even when your viral load is undetectable because:
    - Viral load measures the amount of HIV in the blood; HIV may still be present in body fluids (semen and vaginal fluids).
    - Viral load may also increase between tests thus increasing the probability of transmitting HIV.
    - You or your partner may have other sexually-transmitted infections that increase the amount of HIV in semen and vaginal fluids (WHO 2016b:64).
    - Use a new condom if you are changing from anal to vaginal or oral sex because many STIs can be transmitted from the anus to the vagina or mouth.

6.5.1.3.1.1 How does a condom work?

Sexual fluids such as semen, vaginal fluids and blood can transmit HIV and STIs. A condom forms a barrier between these fluids and entry points into the body. Some STIs can also be passed on through skin-to-skin contact (for example, genital warts). Condoms still minimise the risk of these infections.

6.5.1.3.1.2 When to use a condom?

You can use a condom to protect yourself and your partner from HIV and STIs:

- During vaginal, anal and oral sex.
- Every time you have sex.
- When sharing sex toys (wear a new condom on for each partner).
- Wearing a condom before any contact between the penis and a partner's genitals or mouth minimises risks to both of you.

6.5.1.3.1.3 How to wear a condom

Condom packets have instructions on how to put on a condom, however here are a few simple steps:

- Check the expiry date on the condom. An expired condom is more likely to break.
- Check that the packet is not torn and has a South African Bureau of Standards (SABS) stamp or mark on it. This means it has been tested and complies with safety standards.
- Open the packet carefully with your fingers so you do not tear or damage the condom. An arrow on the packet will guide you in the direction you should open it. Do not use your teeth or scissors and be careful not to damage it with sharp fingernails or jewellery.
- Ensure that the condom is not inside out and do not unroll it before placing it on the penis.
- Ensure the penis is hard before attempting to put the condom on. Always put the condom on before the penis touches a woman's or man's genitals or mouth.

- Place an unrolled condom on top of the erect penis. Pinch the teat at the end of the condom to remove air before you start to roll it down the penis. Pinching the teat will also ensure that there is room for the semen at the end of the condom.
- Roll the condom down to the base of the erect penis. If it is done correctly, it will roll downwards easily. If it is difficult to roll it down, you probably put it on the wrong way.
- Remove it and try again with a new condom. Even if the man has not ejaculated, there might be some semen on his penis, therefore it is very important to wear a new condom.

Figure 6.1 How to use a condom

(Source: Avert 2017c)

6.5.1.3.1.4 How to remove a condom

- Only remove the condom when the penis has been withdrawn completely but while the penis is still hard. Most men's penises soften very soon after they ejaculate.
- Do not wait too long to withdraw the penis to prevent the risk of semen spilling out, or the condom slipping off.
- Hold the rim of the condom when removing it to prevent spilling semen.

Tips for using a condom

- Do not use two condoms at the same time. Using two condoms at the same time, such as a female and a male condom at the same time, does not increase protection. It increases friction and makes it more likely for the condom to break.
- Practise putting on a condom a number of times before you actually need to put it on in order to have sex. This will make you feel confident when you actually need to use it. After all, practice makes perfect.
- Use a lubricant. A lubricant makes using condoms feel more comfortable and makes sex more enjoyable. It also reduces the risk of the condom breaking. Put a lubricant on the outside of the condom. However, do not put it on the inside of the condom or directly on your bare penis. This will make the condom come out. And remember to only use a water-based lubricant suitable for sex, such as KY jelly. Oil-based lubricants (such as baby oil, tissue oil, Vaseline, massage oils or hand cream) may weaken and cause a condom to break.
- Talk to your partner about using condoms. Some people feel embarrassed to talk about using condoms, especially if it is early in a relationship. But protecting yourself and your partner should be a priority for both of you. If your partner refuses to use a condom, do not feel pressured into having unprotected sex – remember you have the right to decide when and how to have sex. It is also your responsibility to protect yourself and your partner. If you talk about condoms with your partner, it does not mean you love or trust him less. It means you are making responsible decisions about the consequences of engaging in sexual intercourse. Knowing you are safe should help you both feel comfortable and you can just enjoy sex.

- Never use a condom after the expiry date. It may break easily during sex.
- Make sure that a condom is of good quality. Check if it has the South African Bureau of Standards (SABS) mark on it.
- Never use a condom more than once. It may break easily during sexual intercourse.
- Do not store a condom in a pocket; it may be subjected to wear and tear.
- Do not store condoms in direct sunlight, such as windows, or in high environmental temperatures, such as a boot of a car. Rubber is damaged and weakened by heat.
- If you are sensitive to latex, use latex-free condoms made of polyurethane or polyisoprene instead. Female condoms are also latex-free, so you could try those instead.

6.5.1.3.1.5 What to do when a condom breaks or slips off

It is very rare for a condom to break if it has been put on and used correctly. However, if it breaks or slips off:

- Withdraw the penis immediately.
- Remove the condom immediately.
- Your partner should wash immediately to remove as much semen as she can.
- You and your partner should not wash inside (douching) as this can increase the risk of infection or cause irritation.
- Your partner should get emergency contraception (morning-after pill) if you and your partner are not using any other contraceptive method, such as the pill or injection. Encourage her to visit a clinic or a chemist and request emergency contraception. She will receive two doses of treatment that will reduce the probability of her becoming pregnant.
- You or your partner should get post exposure prophylaxis (PEP) within 72 hours if one of you is HIV negative or if you do not know each other's HIV status. You and your HIV-positive partner should tell each other if either of you is on ARVs and should have undetectable viral load for at least the last six months. If this is the case, the probability of HIV transmission if a condom breaks is very low.

- If a condom breaks and you or your HIV-positive partner are not on ARVs or not taking ARVs, you will definitely need PEP to prevent HIV transmission.
- You or your partner's negative HIV status will need to be confirmed before you are given PEP. You will be given PEP if you visit the clinic or chemist within 72 hours. You will be required to take it every day at the same time for 28 days.
- You will also be advised to have a test for sexually transmitted infections (STIs) around 10 days after a condom breaks or earlier if you are worried about any symptoms. The test will be repeated about three months later. This is because different STIs are detectable at different times after infection.

6.5.1.3.1.6 How to safely dispose a condom

- Tie the open end of the condom to prevent spillage
- Wrap it in toilet paper or tissue, and throw it in a dust bin or toilet pit
- Empty the dust bin to prevent bad odour
- Do not flush condoms down the toilet. Most septic tanks can't handle them and
- It may block up the toilet.

6.5.1.3.1.7 Where to find condoms

Free condoms are freely available at public health care centres, such as clinics and hospitals. They are also available at public places such as shops and taverns.

6.5.1.3.2 HIV testing

HIV testing helps to identify those who need treatment.

The World Health Organisation (WHO) recommends self-testing and partner notification. The guidelines on HIV self-testing and partner notification recommend initiation of ARVs for all who are HIV infected irrespective of the CD4 cell count as soon as possible after they have been diagnosed with HIV (universal test and treat). The guidelines also expand pre-exposure prophylaxis to beyond the previously selected groups (men who have sex with men and sex workers) (WHO 2016c).

You can request pre-exposure prophylaxis if you are in a relationship with an HIV-infected partner (WHO 2016b:76).

6.5.1.3.2.1 Partner and couple HIV counselling and testing

Any two people who are in an on-going relationship or who want to start a relationship are a couple. Couple HIV counselling and testing means sexual partners are counselled, tested and receive their results at the same time. Partner testing is when partners test separately and may not necessarily disclose their HIV status to each other. Couples who test together are able to make decisions together about HIV prevention, prevention of pregnancy and mother-to-child transmission of HIV. It also prevents transmission of HIV to the negative partner (National Department of Health [NDOH] 2015b:41).

6.5.1.3.2.2 HIV self-testing (HIVST)

HIVST is when a person voluntarily collects a specimen of body fluid, such as saliva or blood, from him/herself alone or with someone he/she trusts, tests it and interprets the results. It is not recommended for those who are on ART because of the possibility of a false negative.
If the result is negative, prevention of infection is important and needs to be repeated in 6-12 weeks.

A positive result needs to be confirmed with a different test (WHO 2016c:10)

6.5.1.3.3 Avoid alcohol and injecting drug use

When people are drunk or high, they are likely to take risks they would avoid under normal circumstances, such as forgetting to use a condom; not realising that a condom has slipped or broken; not able to give consent to have sex; not remembering if they engaged in unprotected sex; sharing sex partners, and sharing needles for injecting drugs and straws for snorting drugs. Always use sterile needles and syringes. Drugs and alcohol reduce the ability to say “No” to sex. To protect yourself, limit alcohol consumption, never accept a drink from a stranger or a person you do not trust, stay

away from strangers and people you do not trust, and if you are struggling with addiction get help.

6.5.1.3.4 Voluntary male circumcision (VMMC)

Male medical circumcision refers to when a doctor cuts the foreskin of male babies, adolescents or adults. One is offered testing before VMMC. VMMC reduces sexual transmission of HIV from women to men by up to 73%. However, because it is not 100% protective to HIV-negative men and it does not protect women from HIV and other STIs, it must be used as part of the HIV prevention package including:

- HIV testing and counselling
- Correct and consistent use of condoms
- Avoidance of penetrative sex
- Adherence to ART for those who are HIV infected (WHO 2012b:1)

6.5.1.3.5 Antiretroviral treatment (ART) as prevention

- Antiretroviral treatment is a combination of drugs to treat HIV.
- It does not cure AIDS.
- It stops HIV from multiplying in the immune cells. The amount of HIV in the blood is called the viral load. The higher the viral load, the higher the chances of transmitting HIV such as in recent infection. Taking ARVs reduces the viral load to very low levels so that it is less likely for HIV to be transmitted to the sexual partner. If your viral load is low, your immune cells protect you from infection and you remain healthy and live longer.
- If you do not know your status, go for HIV testing. You can obtain a test kit from the chemist to test yourself, if you like. If you test positive, go to the clinic for confirmation of results. You will be put on ARVs there and then to suppress your viral load.

If you are already HIV infected:

- Take your treatment daily at the same time

- Take your treatment even when you do not feel well; report to the health care worker if treatment makes you ill (WHO 2016b:72).

6.5.1.3.5.1 Pre-exposure prophylaxis (PrEp)

Pre-exposure prophylaxis is antiretroviral treatment (ART) that is prescribed to be taken daily to reduce the risk of HIV infection if a person is in an ongoing relationship with an HIV-infected partner or if they do not know their partner's HIV status. It is effective if it is used with condoms (WHO 2014c:44; 2016b:52).

6.5.1.3.5.2 Post-exposure prophylaxis

This is ART that is used by an HIV-negative person after exposure to HIV infection such as unsafe sex or when a condom bursts and in a needle stick accident. Treatment must be commenced within 72 hours of exposure. It must be taken daily at the same time for 28 days. Treatment is obtainable from a chemist or a clinic if exposure to HIV infection is reported within 72 hours (WHO 2016b:61).

6.5.1.3.5.3 Elimination of mother-to-child-transmission (EMTCT) of HIV

EMTCT services are available at health facilities in your area. If your partner is pregnant, encourage her to visit the nearest clinic to have an HIV test. If she tests positive, she will receive ARVs to lower her viral load and limit the chances of her transmitting HIV to your unborn child. ARVs will also keep her alive and healthy so that she can raise the child (WHO 2016b:81). EMTCT is achievable, according to the WHO (2017a:9), in 2015, Cuba became the first country in the world to be declared as having eliminated MTCT of HIV and syphilis. In 2016, Armenia, Belarus and Thailand were also declared as having achieved EMTCT of HIV (WHO 2017a:9).

6.5.1.3.6 Avoid risky sexual behaviours as follows:

- Reduce the number of sexual partners. More sexual partners increase the chances of getting a sexual partner with a different HIV status and the risk of contracting or transmitting HIV and other STIs.

- Do not be fooled by your peers who say “everybody is doing it (sex)” or “I have also done it” or “you get sick if you do not do it”. Not everybody is having sex and not everybody is expecting you to do it. Not having sex does not make anyone sick.
- Avoid alcohol and drugs. When you are drunk, you do not think straight and you are unlikely to use a condom or to use it properly.

6.5.1.3.7 Risks associated with HIV and AIDS

These include the following:

- Change in body shape
- Depression
- Premature delivery
- Low birth weight
- Stigma
- Poor sleep especially if depressed

6.5.2 Prevention of teenage pregnancy

6.5.2.1 How does one become pregnant?

A pregnancy occurs when a sperm meets an egg. Pregnancy begins when a fertilised egg attaches itself in the lining of the womb. When a fertilised egg attaches itself in the womb, it releases hormones that prevent the lining of the womb from shedding so that the pregnant woman does not get her periods during pregnancy. If the egg does not meet a sperm, or a fertilised egg does not attach itself in the womb, the womb lining is shed and it leaves the body during a period (Nolte 2013:32; Fraser, Cooper & Nolte 2013:35).

6.5.2.2 How can you prevent a teenage pregnancy?

As a man you need to take responsibility for preventing teenage pregnancy. Believers, traditionalists and modern men approach prevention differently. Abstinence is the best.

However, if you are sexually active, always use a condom. It will prevent the sperm from meeting an egg. It will also protect you and your partner from sexually-transmitted infections, including HIV.

Believers, stick to the principle of not starting relationships with women until you are old enough and ready to pay *lobola* and marry to prevent the temptation of committing sin (sex before marriage). This sin can also lead to premature fatherhood.

If you are already in a relationship when you commit yourself to religious ways, consider ending it or make sure that she has the same intentions as yourself to avoid being pressurised to have sex. If not, end the relationship until you are ready physically and financially to pay *lobola* and marry. This will help you to focus on your studies in preparation for your future and prevent premature fatherhood.

Avoid spending time alone and in private with a girl even if she is also a believer. Even if you are an unbeliever, you are welcome to adopt the principles of believers because they may save you from HIV and premature fatherhood.

Traditionalist, stick to the traditional ways of getting into a relationship such as *ukuqoma ngeduku*, with a woman who has been through the rites of passage from adolescence to adulthood, namely *umemulo*. This is a traditional way of announcing that she is old enough to get married, not a permission to have sex. This also means that you must be old enough and financially ready to pay *lobola* and marry her.

If you sleep with a girl, remember that a traditional man among men takes responsibility for his behaviour and pays for damages to restore the dignity of the household.

You are not expected to be visited by a young woman unless your families have granted permission and you have had the rite of passage (*ukuy' ophondweni*) of acknowledging that you and your girlfriend are in a permanent relationship and you will soon be getting married.

Practise other ways of sexual satisfaction without penetration such as *ukusoma* (interfemoral sex), fondling, and body contact.

If the girl's family wants you to marry her first before you engage in a sexual relationship, also respect that.

Respect the rights of women and do not take a woman to be your wife against her will. It is a crime and a violation of women's rights to make their own choices freely.

Do not get into a sexual relationship with an adolescent girl; a teenage pregnancy may be the end of her school days. Respect the right of girls to have education by preventing a teenage pregnancy and contributing to ending poverty. Women who are educated have a better chance of getting good jobs (when jobs become available) and not depending on men to support them and their children. If they do not get such support, they may end up selling their bodies (engaging in transactional sex) in order to survive. This promotes transmission of HIV.

A girl who traditionally has had a rite of passage from childhood to adolescence (*umhlonyane*) is not old enough to marry. *Umhlonyane* is a traditional ceremony to recognise that she has had her period. Do not sleep with her. It is a crime if she is still less than 18 years old and disrespectful of traditional ways. Men of essence do not sleep with young girls. They marry girls that they have chosen and who have had *umemulo*.

Do not force your partner to have sex against her will. It is a crime. Your partner has a right to decide when and how to have sex. Respect her by discussing when to have sex with her and arrive at a mutual decision. Do not force her by being violent with her. You cannot show that you love her by forcing yourself on her.

Do not feel pressurised to have sex. Do not be fooled by your peers, they may be lying to you or they may regret that they have had sex and want you to feel the same. Many people around you do not expect you to have sex now. Focus on your future, focus on your education in preparation for the future. You and your partner do not have to prove your fertility to anyone. If you feel that or anyone pressurises you to have sex, it is probably a sign that you are not ready for sex. If your partner is pressurising you to have sex, it may be time to break up with her.

If you are a believer and your relatives, such as your parents and siblings, are pressurising you to have a girlfriend to prove that you are a man, always remember why you chose not to have a girlfriend in the first place, to avoid the temptation of committing a sexual sin, and stick to it. You are also protected from HIV.

Avoid alcohol drugs and places that promote alcohol abuse, such as parties. When you are drunk, you are likely to make irrational decisions. You are also likely to be unable to use a condom properly.

Surround yourself with people that support your decision to prevent HIV and teenage pregnancy. Drop friends that pressurise you to have sex or use alcohol and drugs. Start a new circle of friends who share your sentiments about sex and teenage pregnancy. Do not spend time alone with a girl if you want to stick to your decision to abstain.

Your partner also needs to use at least one other birth control method, such as the pill or injection or patch, in addition to a condom to make sure that she does not get pregnant in case a condom breaks, slips off or spills. Your partner will need your support and reassurance that you love her. Tell her you do not think it is a good idea to get pregnant at an early age. It is a risk to her and the baby and you are not ready to be a father.

6.5.2.2.1 The morning-after pill (emergency contraception)

This is a fertility regulation method that is used by a woman who is not using another contraceptive method, such as the pill or injection, after unprotected sex or when a condom breaks or slips off. It is effective in more than 95% of cases. Emergency contraceptive pills are effective if used with 72 hours of unprotected sex. A copper-bearing intrauterine contraceptive device (IUCD) must be inserted within 5 days. Emergency contraception does not protect against HIV infection and other STIs. It is available at the clinic or chemist (NDOH 2012:38; WHO 2017b:1).

6.5.2.2.2 Double contraception (dual protection)

Only abstinence from sexual intercourse guarantees protection from pregnancy and STIs, including HIV. However, for sexually active people dual protection is the best

protection. It is the use of two birth control methods, such as a condom and the pill or injection or patch, at the same time. If a condom breaks or slips off or spills, the woman is protected from pregnancy by the pill or injection or patch (NDOH 2012:9).

6.5.2.3 Risks associated with teenage pregnancy

Teenage pregnancy is the second highest cause of death of girls between 15 and19 years old due to complications of pregnancy and delivery that may be related to backstreet abortion.

Girls who fall pregnant are at risk of dropping out of school resulting in few skills and ending up with low paying jobs and poverty. Other risks include HIV infection, suicide and death.

Babies born to teenage mothers are at risk of being born prematurely, dead (stillborn), or dying early in life. Children may be stigmatised by name calling such as *umlanjwana* ('illegitimate' child).

Many teenage mothers and fathers do not eventually marry each other; so children born to young parents are not likely to be brought up by both their parents.

6.5.3 Benefits of preventing HIV and teenage pregnancy

6.5.3.1 Benefits of preventing HIV infection and transmission

- You will be safe from HIV and other STIs. If you are already HIV positive, you will be protected from getting new HIV infections and new STIs.
- If you are not HIV infected, you will not be sick often and you will not have to take lifelong treatment, such as ARVs, in order to live.
- You will not worry about the viral load and transmitting the virus to your partner
- You will be a role model to your peers, younger generations and your children.
- Being a role model will also improve your self-esteem.
- You will speak from experience when you educate others and your children in future about the prevention of HIV.

6.5.3.2 Benefits of preventing teenage pregnancy

- You are probably carefree with no stress at all if you do not have a baby yet. Nobody says “baby this” and “baby that” to you.
- When you start working you will enjoy your money with no financial burden.
- You are enjoying your life with no pressure to drop out of high school or tertiary education to look for a job in order to support your baby.
- Your parents do not have an extra financial burden to feed and clothe you and your baby and they are proud of you.
- You can focus on preparing for a bright future when you will be ready and be able to pay the bride price (*ilobolo*) and marry a girl of your dreams and have children with no regrets about your past.
- Planned children are often loved by their parents and relatives and there is no stigmatisation against them.
- Your children will be proud to have a father who is a role model.
- You will also be healthy because you will not be at risk of contracting HIV infection and other STIs, such as syphilis and gonorrhoea.
- You will have a good reputation due to your good behaviour. There is no “soap that can wash a person’s name” but his behaviour.

6.5.4 How can you help other young men to prevent HIV and teenage pregnancy?

- Talk to your siblings and other younger boys and warn them about the dangers of engaging in sexual intercourse at an early age, such as HIV infection and teenage pregnancy and the responsibilities that come with them.
- Promote a culture of respecting the decision to abstain from sex for whatever reason, such as religious, personal or cultural/traditional. Do not pressurise other young men to have girlfriends and to sleep with as many as possible. Do not humiliate but encourage those boys who do not have girlfriends yet to keep it that way for as long as they possibly can.
- Encourage other young men to respect and protect girls and not look at them as sex objects. Do not promote the competition of sleeping with as many girls as

one young man possibly can. It is disrespectful to women and girls. Using a condom is also a sign that you love and respect your girlfriend.

- Encourage those that are sexually active to use condoms consistently, even if they have achieved viral suppression or know their partner's HIV status to prevent HIV and other STI infection and teenage pregnancy. They must not allow girls to pin them down with a baby by using a condom inconsistently when they have sex or engaging in unprotected sex in order to show that they love and trust their girlfriends. Inform them that using a condom does not mean that they love or trust their girlfriends less but is part of being a responsible man. It is also a sign that you truly love and respect your girlfriend.
- Tell your peers about the benefits of preventing HIV infection and teenage pregnancy, such as being carefree and not dropping out of school. Encourage them to focus on the future.
- Be a role model by focusing on your studies in preparation for your future. Your peers and younger boys will notice your behaviour and some will want to be like you.
- Discourage other young men from forcing girls to have sex against their will by using violence or threats. Sex should be always consensual, otherwise it is a crime. Young men must negotiate when and how to have sex with their partners.
- Promote a culture of couple counselling and HIV testing.

6.6 EVALUATION OF THE HANDBOOK

A handbook is "a book giving instructions on how to use something or information about a particular subject" (*Oxford Advanced Learner's Dictionary* 2010:677). Evaluate means "to form an opinion of the amount, value or quality of something after thinking about it carefully; assess" and evaluation means "an assessment of something; to recognise, establish worthiness" (*Oxford Advanced Learner's Dictionary* 2010:501). In this case it refers to the evaluation of the handbook: **HIV/AIDS AND TEENAGE PREGNANCY PREVENTION: A HANDBOOK FOR YOUNG MEN IN DEVELOPING POSITIVE VALUES OF MASCULINITY**

The handbook was evaluated by experts in the field of HIV and AIDS prevention and care service provision working for the KZN Department of Health. The handbook was

evaluated for clarity, simplicity, scope and purpose, relational structure and operational adequacy.

6.6.1 Lucidity and interrelatedness

People working in the field of HIV and AIDS and fertility regulation were selected to serve as reviewers for the handbook. The reviewers were composed of technical experts and experts in HIV and AIDS, STI and TB (HAST) programme management.

Prospective reviewers were contacted individually per telephone to make an appointment for a face-to-face meeting in their workplaces and asked to review the handbook. Three people accepted to participate in the evaluation process. Electronic copies of the handbook and a brief description of the processes followed by the researcher to develop the book were sent by e-mail to each reviewer. The reviewers were asked to evaluate the handbook for credibility, language and structural intelligibility and to respond in writing or face-to-face discussions with the researcher within one month, depending on their preference. Some reviewers provided written comments while others preferred discussions with the researcher. All comments were compiled and used to update the handbook.

6.6.2 Simplicity and comprehensiveness

The handbook was evaluated to establish its suitability and applicability in the health education of young men in the prevention of HIV and AIDS and teenage pregnancy. For a young man (teenage and young adult), in order to be simple and comprehensive, the handbook has to be pocket-sized with all the relevant topics about HIV and AIDS and teenage pregnancy in simple and clear language.

6.6.3 Scope and purpose of the handbook

The handbook was developed to enable young men to make informed decisions about HIV prevention strategies and services, to understand all prevention, treatment and care options, to make decisions consistent with their values and preferences and to become role models and mentors of future generations of men in prevention of HIV and teenage pregnancy.

6.7 PROPOSED PLAN FOR IMPLEMENTATION OF THE HANDBOOK

This section outlines the plan for implementing the handbook which is an output of this study.

6.7.1 Qualifying of the handbook

It is impossible to expect that a handbook for programmes as complex as HIV and AIDS and fertility regulation can cover every scenario. For that reason, it is therefore expected that there will be situations where this handbook will not offer solutions or guidance and reasonable reasons not to act according to the recommendations provided in the handbook.

6.7.2 Proposed implementation strategy for the handbook

The HAST and fertility regulation programme teams of the KZN Department of Health oversee the development, publication, dissemination and implementation of any clinical practice guidelines for HIV/AIDS care and fertility regulation, in collaboration with other stakeholders, including people living with HIV (PLHIV) funding and implementation partners in KZN based on the National guidelines. Therefore, the researcher will consult a development partner at the district office to advocate for the adaptation of this handbook for young men in the prevention of HIV and AIDS and teenage pregnancy in Nquthu sub-district.

6.7.3 Proposed plan for dissemination of the handbook

The handbook will be disseminated to health care providers and end users through presentation at workshops, symposia, conferences, seminars, and pre and in-service training. Other distribution methods include soft copies through KZN DoH intranet, internet and hard copies for those who have no access to the intranet and internet.

6.7.4 Tools for implementation of the handbook

This handbook cannot be implemented in isolation. The following national and WHO guidelines (which are the basis for national and provincial guidelines) are necessary to support its implementation:

- *National consolidated guidelines for prevention of mother-to-chid-transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, 2015* (NDOH 2015b).
- *National Contraception Clinical Guidelines: a companion to the National and Fertility Planning Policy and Service Delivery Guidelines, 2012* (NDOH 2012a).
- *National Contraceptive and Fertility Planning Policy and Service Delivery Guidelines: a companion to the National Contraception Clinical Guidelines, 2012* (NDOH 2012b).
- *National Adolescent and Youth Policy, 2*017 (NDOH 2017).
- *Guidelines on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, 2015* (WHO 2015b)
- *HIV testing and counselling consolidated guidelines, June 2013: couples* (WHO 2013).
- *Guidelines on HIV self-testing and partner notification* (WHO 2016c).

6.8 CONCLUSION

This chapter described the handbook for the prevention of HIV and AIDS and teenage pregnancy for young men in Nquthu sub-district and elsewhere in the country. The handbook was developed to enable young men to make informed decisions about HIV prevention strategies and services, to understand all prevention, treatment and care options and to make decisions consistent with their values of masculinity and preferences.

It is recommended that the KZN Department of Health, in collaboration with other stakeholders, should make use of the handbook as an additional resource material to strengthen the engagement of men in the implementation of HIV and AIDS and teenage pregnancy prevention programmes.

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ANNEXURES

ANNEXURE 1
DATA COLLECTION GUIDE

PROJECT TITLE: **POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA**

INTRODUCTION

Greet the participant
Introduce self and research assistant
Explain the purpose of the study
Explain the estimated time of the interview
Explain that no cost will be born be the interviewee
Explain benefits of the study
Inform participant about autonomy, confidentiality, data management and anonymity of data
Ask for permission for audio-recording and explain what will be done with the recording.
Ask for consent
Ask audio recording consent

OPENING QUESTION: to build rapport

Tell me about your family

KEY QUESTIONS

According to your knowledge what is expected from a man that one can call a man among men (a man of a kind or indoda emadodeni)?
What is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl?

PROMPTS BASED ON HEALTH PROMOTION MODEL

Prior behaviour

What have you been doing in the past as a man to prevent (contracting) HIV and or (impregnating) a teenage girl?
What did you learn from these experiences?

Personal influences

How do you think you would benefit from preventing HIV and teenage pregnancy?
What problems **(barriers)** might you have trying to prevent HIV and teenage pregnancy?
How would you overcome **(self-efficacy**) these problems?

Interpersonal influence

Social norms – tell me about what your family members or friends would expect from you regarding prevention of HIV and teenage pregnancy.

Social support – tell me about family members and friends who would encourage you to prevent HIV and teenage pregnancy.

Role models – tell me about family members and friends who are your role models.

Situational Influences – where can you find condoms of your choice? What can you do to avoid situations which do not promote prevention of HIV and teenage pregnancy?

Commitment to a plan of Action: are you ready to set goals and develop a plan to prevent HIV and teenage pregnancy?

Competing demands and preferences. What problems did you encounter trying to prevent HIV and teenage pregnancy?)
How did you overcome these problems?

CLOSING

What are your hopes for your family in future?

Ask if the participant has any questions

Thank the participant

ANNEXURE 2

ETHICS CLEARANCE

PROJECT TITLE: POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

7 December 2016

HSHDC/566/2016
Mrs IN Mthiyane
Student: 0503-651-8

Supervisor: Prof BL Dolamo
Qualification: D Cur
Joint Supervisor: -

Dear Mrs IN Mthiyane

Decision: Ethics Approval

Name: Mrs IN Mthiyane

Proposal: The use of positive values of masculinity in the prevention of HIV and AIDS and teenage pregnancy in a rural sub-district in Kwazulu-Natal, South Afirca.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 7 December 2016.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

Open Rubric

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
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ANNEXURE 3

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

PROJECT TITLE: POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA

To _____

_____

I Italia Nokulunga Mthiyane am employed at Charles Johnson Memorial Nursing Campus as a lecturer. I am a PhD student at the University of South Africa under the supervision of Professor BL Dolamo. I hereby request permission to conduct a study at Nquthu sub-district in partial fulfillment of the requirements for the abovementioned degree.

The **purpose** of the study is to explore positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy in order to develop a health education handbook to develop young men to responsible men in prevention of HIV and AIDS and teenage pregnancy.

The objectives are to:

1. identify the positive values of masculinity
2. describe the man's role in the prevention of HIV and AIDS and teenage pregnancy
3. develop a health education handbook for young men in developing positive values of masculinity

A written consent will be obtained before semi-structured interviews with participants. Confidentiality and privacy will be maintained at all times. The study will be explained to participants verbally, and they will receive a participant information document.

Interviews will be conducted at participants' homes and or sports grounds according to participants' options and times.

Thank you

Signature  Date_____

IN Mthiyane

ANNEXURE 4

PERMISSION FROM KZN DOH

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X9051 PMB, 3200
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: HRKM100/17
KZ_2017RP38_742

23 March 2017

Dear Mrs N I Mthiyane
(University of South Africa)

Subject: Approval of a Research Proposal

1. The research proposal titled **'THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at Umzinyathi District Community.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified community before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 27/03/17.

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 5

PERMISSION FROM GATEKEEPERS

PROJECT TITLE: POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA

I Inkosi/Induna THATHEZAKHE JOSEPH freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

Signature of the Inkosi/Induna — Date: 08/02/2017

Signature of the witness — Date: 08/02/2017

KHIPHINKUNZI TRADITIONAL COUNCIL
2017 -02- 08
P.O. BOX [illegible] QUTU 3135
UMZINYATHI DISTRICT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna CHRISTOPHER NHLEKO freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

M C Nhleko
Signature of the Inkosi/Induna

08/02/2017
Date

I. I. Ulaka
Signature of the witness

08/02/2017
Date

KHIPHINKUNZI
TRADITIONAL COUNCIL
2017 -02- 08
P.O. BOX 666 NQUTU 3135
UMZINYATHI DISTRICT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna SONO ABNER KHUZWAYO freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

S A Khuzwayo — 08/02/2017

Signature of the Inkosi/Induna — Date

Sme Buthelezi — 08/02/2017

Signature of the witness — Date

KHIPHINKUNZI
TRADITIONAL COUNCIL
2017 -02- 08
P.O. BOX 666 NQUTU 3135
UMZINYATHI DISTRICT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna Sifiso M Buthelezi freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

SM Buthelezi — 08/02/2017

Signature of the Inkosi/Induna/IKHANSELA — Date

S A Khuzwayo — 08/02/2017

Signature of the witness — Date

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna MTHANDENI MESHACK BUTHELEZI freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

Signature of the Inkosi/Induna — Date: 15/02/2017

Signature of the witness — Date: 15/02/2017

KHIPHINKUNZI
TRADITIONAL COUNCIL
2017 -02- 15
P.O. BOX 666 NQUTU 3135
UMZINYATHI DISTRICT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna NTATHELI NGOBESE freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

X — 15/02/2017

Signature of the Inkosi/Induna — Date

[signature] — 15/02/2017

Signature of the witness — Date

KHIPHINKUNZI
TRADITIONAL COUNCIL
2017 -02- 15
P.O. BOX 666 NQUTU 3135
UMZINYATHI DISTRICT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I Inkosi/Induna GCINOKWAKHE NGOBESE freely consent that Mrs IN Mthiyane may conduct research in the community regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

G Ngobese — 15/02/2017

Signature of the Inkosi/Induna — Date

[signature] — 15/02/2017

Signature of the witness — Date

KHIPHINKUNZI
TRADITIONAL COUNCIL
2017 -02- 15
P.O. BOX 666 NQUTU 3135
UMZINYATHI DISTRICT

ANNEXURE 6

PARTICIPANT INFORMED CONSENT

PROJECT TITLE: THE USE OF POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA.

I _____freely consent that Mrs IN Mthiyane may ask me questions regarding positive values of masculinity and their application to prevention of HIV and AIDS and teenage pregnancy.

I confirm that the research study has been explained to me verbally and I received a document of explanation from Mrs Mthiyane. I understand what my involvement in this study means and I voluntarily agree to participate.

_____ _____

Signature of the participant Date

_____ _____

Signature of the witness Date

ANNEXURE 7

COPY OF ONE INTERVIEW TRANSCRIPTION

POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV/AIDS AND TEENAGE PREGNANCY IN RURAL KWAZULU-NATAL

TRANSCRIPT DETAILS

PI : PRINCIPAL INVESTIGATOR

P : PARTICIPANT

DATE : 12 JULY 2018

PI : According to your knowledge what kind of man is a man among men (indod' emadodeni.

P : It is a person who is a man among men according to my knowledge is a person who can work hard, who can if he has children he can when he works just like myself I carry people's luggage can say I am a man of essence I carry luggage I left my family what I get no matter how small I feed my family, show them that no I do get something no matter how small I mean those cents try to

P1 : Is there anything else that you can mention besides working to feed his family?

P : Yes madam, a man among men madam is a man who does not like women that much madam.

PI : Mh mh.

P : I mean madam that I be in love with the one I am in love with, I do not have another one, I am truthful, I tell her everything even secrets.

PI : Mh mh.

P : I tell her just everything.

PI : Mh mh.

P : Yes madam.

PI : you have no secretes, you do not cheat.

P : I do not cheat.

PI : Oh in everything.

P : No.

PI : Is that all?

P : Yes.

PI : Oh, about eh oh how do you treat eh your woman?

P : I treat her well I do not do bad things to her.

PI : Will you explain?

P : I respect her, I respect her madam, I do not have other women madam, I respect her.

PI : Tell me more.

P : Like madam you buy her something madam, things that she loves, clothes and things she wants like food.

PI : What do you say about those who say that that you show the person you love by sleeping with her? What do you say to that?

P : I am against that, besides that, I am against that (sex). Yes I can say madam besides that, I am against that. Yes on my side, they say that, they say that. Besides that, besides that you show a person.

PI : It is not how you show her.

P : Is not by way of sex there are many madam.

PI : There are many ways.

P : There are many ways.

PI : I do not know if you want to continue on that. OK may be according to Zulu tradition or traditionally, how can you describe a person who is a man among men, his position or his place in his family?

P : In his family I can describe him as a, I can say as a man (ubaba / respectable man).

PI : Mh mh, ubaba

P : Oqotho mama (a man of essence madam).

PI : How is ubaba oqotho?

P : Ubaba oqotho madam is a man who has truth madam, who wants, who does not want us to do nonsense in his household as young children.

PI : Mh mh.

P : Who wants us to come home on time. Yes a father who can tell mother my secrets when I have been scared to tell mother but can tell her my secrets even if I had asked him to keep them but he can tell her.

PI : That is a man of essence.

P : A man of essence, yes madam.

PI : OK. What about his position, who is in charge at home?

P : In charge.

PI : In charge, who is in charge in the household?

P : At home?

PI : Yes.

P : It is a man (ubaba).

PI : A man, what about women and children?

P : They are not in charge, they listen to a man (ubaba).

PI : They listen to him, is his word final?

P : Yes, his word is strong madam, he is, he is a male (ungowesilisa).

PI : It is his word that is law of the household.

P : It is the law of the household just like that madam.

PI : The woman has no word or opinion.

P : She can talk to him but the man's word is law of the household.

PI : Oh it means it is his word that succeeds as a person in charge, OK. You said he treats his woman well or his lover or his wife. Oh I have heard about the traditional way of choosing a lover (ukuqomana), how is it done? How do you choose a lover according to Zulu tradition?

P : When it said you are getting married (umakuthiwa ngiyashada)?

PI : Yes.

P : According to Zulu tradition when you love a young man

PI : Mh mh

P : When you choose that young man according to Zulu tradition you have to raise a flag (umqoma ngeduku).

PI : You raise a flag.

P : With a flag madam (ngeduku mah).

PI : Can you explain to me.

P : The family of the girl comes to the family of the young man (umfana).

PI : Mh mh.

P : His family goes to the woman's family madam. The young man's family madam, oh the girls family because the girl has to bring things. My family helps me to prepare to for instance beer to make people happy madam.

PI : What does the girl's family bring, do they bring anything?

P : Yes. They bring something, a flag.

PI : They bring a flag and what else?

P : Toiletries, grass mats.

PI : To whom do they bring them?

P : They bring them to whom? ; They bring for the grooms family.

PI : The groom or for everyone?

P : Yes they bring for everyone madam that is what I say.

PI : Oh, everyone gets.

P : Everyone gets.

PI : Does it mean that you also buy gifts for them too?

P : Yes it happens madam.

PI : Will you explain to me?

P : Yes madam, there are things we buy to give them madam such as grass mats, things according to Zulu tradition.

PI : Mh mh

P : Yes madam (Yebo mama)

PI : What does it mean to choose a lover (ukuqomana)?

P : It means it your person (lover), you have chosen each other, you will live with her until death or until you pay the bride price and marry. It your person, it is well known in the community. Everyone knows no no (hayi cha), so and so is in love (uthandana) with so and so.

PI : Ok.

P : You (girl) dress in a respectful way to show that she has been taken.

PI : Even if you are still at home you dress respectfully. You dress respectfully to show that you have a lover PI You have been chosen.

P : The isoka (lover) has paid something because you do not just do these things without having started paying.

PI : What happens when a young man has defiled a girl? (Eyonile intombazana)?

P : What happens?

PI : According to Zulu tradition.

P : According to Zulu tradition, they sit down and talk, the two of you.

PI : I mean he has slept with the girl.

P : He has slept with someone else.

PI : No. I mean the young man has slept with the girl, what is he supposed to do according to Zulu.

P : If they have not chosen each other by raising a flag?

PI : Let us say they have not done it.

P : He has to pay madam, he has to pay madam and cleanse her, pay a goat to the girl's family.

PI : Cleanse, what does he cleanse?

P : He is showing respect truly and really.

PI : Does it mean that after they have raised a flag (eseqome ngeduku) she can sleep with him?.

P : Yes she is allowed madam, she has a person who chose her.

PI : Why?

P : Because he has chosen her and said she is mine.

PI : Mh mh.

P : The only one for him.

PI : They will never part.

P : It might be due to serious reasons.

PI : The intention is to be together always.

P : Yes madam.

PI : According to religion how does a man behave or a young man?

P : You behave well madam, you do not go about smoking in the streets, you do not sleep with girls, things like that. If you are in love with that person, you are in love with her alone.

PI : Until when?

P : Until you grow up to and be old still in love.

PI : Until you get married.

P : Yes until I marry her and introduce her to my family.

PI : How old are you when you start your relationship if you are believers?

P : You start, the way I see it you can start while you are young (silence).

PI : Does it mean she is yours forever?

P : Yes madam, no, I can say that it happens that she yours forever madam.

PI : Which religion says that? Is it Christians or a certain denomination?

P : Yes madam a certain denomination (non-Christian denomination 1).

PI : Oh.

P : You choose her in the church.

PI : You choose her in the Church.

P : Yes madam.

PI : Is there anything about other denominations?

P : In other churches too they choose her in the Church.

PI : Oh.

P : Yes.

PI : What about Christians?

P : What about Christians, how madam?

PI : Christians like these that say they are saved, I am making an example.

P : Eh Christians, the ones that say they are saved madam.

PI : Yes.

P : Oh those ones that say they are saved they absolutely do not get into relationships at all those people (abajoli sdalo labo bantu).

PI : Those ones what you know is that they do not get into relationships.

P : Yes madam they do not get into relationships. They walk according to the truth of God; they do what they know about God.

PI : What do they do when they are supposed to get married?

P : When they are supposed to get married, oh madam, when they are supposed to get married, oh madam, when they are supposed to get married I think they choose each other in the church where they worship.

PI : Ok those are saved. Eh there are also those who worship on Saturday (abasabathayo) besides the ones you mentioned, yes.

P : Yes they are there like Christians so and so denomination .

PI : They worship on Saturday. What do they do concerning relationships and choosing a lover?

P : Eh madam these ones who worship on Saturday I can say madam they choose each other in the church madam. They do not have relationships. If they do they do it in secret.

PI : Basically they do not have relationship (ngokomthetho abajoli).

P : Basically no madam, they do not have relationships.

PI : To which of these do you belong? Do not call it by name. Is it the saved Christians or others?

P : I am a Christian.

PI : So in your church you were taught that you do not get into relationships.

P : We were told that we do not get into relationships.

PI : So you do your own thing.

P : Yes you just do your own thing because you make your choice in the church; that person that you love.

PI : The person you love that you marry.

P : Yes madam to live your life with, a person who knows the (umthetho wesonto) expectations of the church she attends, because madam if you are in a

relationship with someone who does know, who does not want the expectations of that church.

PI : Mh mh.

P : She does not want the expectations; when you say let us do this she does not want to go along the expectations of that church.

PI : Oh.

P : It is better to take a person you attend the church with, it is better madam.

PI : Because you know its expectations if you are from a church where you are not expected to have relationships.

P : You are not expected to have a relationship (*awesheli).*

PI : You *shela* when you want to get married.

P : No you do not, *awesheli* madam even when you want to get married, *awesheli*, you choose.

PI : Oh you choose. You are given a chance to choose in the church.

P : Yes they give you a chance to choose madam, to choose that person madam.

PI : Oh, according to what you have told me you said that all these people you told me about you said they choose partners.

P : Yes madam they choose.

PI : Mh ok, according to *IsiZulu* you said *baqoma ngeduku.*

P : Yes madam according to *IsiZulu* that is how it is done, *ukuqoma ngeduku.*

PI : What about the elders?

P : I have heard about *ukuqoma ngeduku,* they say the girl would come to the young man's home and there would be a lot of people.

PI : When they have agreed with each other.

P : Yes, when they have agreed with each other so that it is well known madam that that girl has been chosen by so and so.

PI : Ok, ok. Eh what do you say about gender equality (ukulingana kwabesilisa nabesifazane).

P : Equality like what?

PI : Equality of men and women, we talk about equality of men and women according to the law of the country for example.

P : I do not know, I mean that is not law.

PI : You do not agree with it.

P : I do not agree with it, a woman equal to a man! A man is supposed to be superior (ubaba kumele abe mkhulu) to a woman. A woman is supposed to be inferior.

PI : Ok.

P : Like what madam, we males we go out to the graveyard to dig. A woman cannot do that, to dig in the grave yard, work hard, no (cha bo).

PI : Mh, that means you are not equal, who is superior.

P : A man (ubaba).

PI : And the woman.

P : She is supposed to listen to him all the time, to what he says to her, and do as he says.

PI : What do you say about the education of women, to go to school until they end up getting jobs?

P : Yes I agree with that.

PI : Explain to me why

P : I agree with that because most of the time they give us knowledge, they end up being nurses nursing men in hospitals. Those people are educated.

PI : Mh mh.

P : Yes madam.

PI : What about life in general.

P : Concerning health I can say they help in many things because they acquire a lot of knowledge, they are educated, they educate, they are teachers concerning health.

PI :Mh mh.

P : Today they can, they educate our children at the schools today. They can teach. Those are educated people madam.

PI : Ok, what about the quality of life, or about poverty?

P21 : Poverty, eh you can see the person who is not educated.

PI ; What do you say about *ukuthwalwa (*abduction of a woman for the purpose of forcing her to marry*)* because I have heard that they are abducted to marry against their will. What do you say?

P : I can madam, I do not agree with that because madam; it is parents who have chosen a man and that man you do not love at all (awuyithandi sdalo) and there is nothing that you can do, you parents say go to that man to live with. I can live but I do not agree with that madam.

PI : Sometimes some are taken still young and still attending school. What do you say to that?

P : I do not agree with it. There is no agreement and they end up quarreling saying in the first place my parents forced me. There was this girl I was in love with; I was forced now that you see me here

PI : What about a man who was not forced by parents? He sees a girl, the girl refuses *ukumqoma* (to choose him as her lover), then he abducts her. What do you say to that?

P : No, it is wrong.

PI : I have heard about beating of women and some are killed.

P : It is true madam.

PI : What do you say to that?

P : I do not agree with it madam.

PI : OK you do not agree with that. Now let us talk about prevention of HIV, what is he supposed to do? How is he supposed to behave concerning prevention of HIV and pregnancy young girls (teenage girls)?

P : A man among men if he is naughty protects himself with a condom madam if he sleeps with someone. He uses a condom. That is a man of essence madam; madam because he prevents HIV, we are talking about a man of essence, however, he should hide it from the one he lives with if he is naughty out there.

PI : When you say the one he lives with what do you mean?

P : The person I live with I am in love with, I can say so.

PI : Oh, In this area does it happen that when you have chosen each other you are allowed to live together, it is known that you are married traditionally (*niganene).*

P : It is known, yes.

PI : When you say the person you a living with (umunt' ohlala naye) you are referring to the person you are traditionally married to (oganene naye).

P : Yes *oganene naye*.

PI : Do you mean he hides it if he is cheating?

P : He hides madam so that *oganene naye* does not find out.

PI : That a man of essence.

P : That is a man of essence madam.

PI : Ok, ok he uses a condom.

P : He uses a condom when he is cheating madam.

PI : To *oganene naye* at home he does not use a condom with her.

P : The one *oganene naye* I think you have gone to check (HIV testing) madam and found that you do not have anything (aninalutho).

PI : So you go to check?

P : Yes madam but what I think when you see a girl and *shela* her here outside you have to use a condom because I think there are many others that she has agreed to sleep with madam, just like that (kanjalo). Some of us do not like a condom, we are different as people.

PI : Mh, explain to me not liking it.

P : As people yes we are different, we as people. There are those who do not like a condom who just sleep without it a condom and there those who like it.

PI : You, what do you say about the ones who do not like it?

P : I say those ones are bad (*bayabheda)* because they spread the germ. Helping those who are injured madam you are supposed to wear gloves. Drugs also I can say also those madam are spreading the germ because that blood that enters has the germ.

PI : It means they must wear gloves

P : Gloves madam when helping a person wear gloves, I can say so madam. When you sleep with a woman wear a condom.

PI : Mh mh.

P : The one you are love with wear a condom madam. Even the one you are in love with wear a condom the time you want to prevent that you get children, however, I am not thinking about the HIV germ.

PI : Prevent HIV?

P : I do not think you prevent it. You can prevent it from others when you are naughty / cheating (uma uganga).

PI : To your real partner (*ungqo*) you do not wear it.

P : You do not wear it. If you do not want children because I think you have gone to check both you. Yes madam you can just prevent children madam if you do not want children just like that madam.

PI : Ok you trust your *ungqo*, the one *oganene naye,* you are sure that she does not cheat.

P : Yes madam I trust her.

PI : Laughs.

P : I took her because I saw that she can be trusted.

PI : Have you taken (married) already (surprised).

P : Yes madam I have taken.

PI : Oh *hawu* (oh my word) people from this area take at a young age.

P : Laughs.

PI : At 23 years you have already taken.

P : Yes madam.

PI : Hawu (oh my word) (surprised).

P : I took her when I was 19 years.

PI : Is it still the same person?

P : I live the mother of my children (affectionately).

PI : You live with the mother of your children, are you married or *niganene*?

P : Yes (Yebo).

PI : Have you paid *ilobolo (bride price)?*

P : I have not paid, I will lie, I still have to lobola

PI : Ok, ok. According to yourself how do you think you benefit from protecting yourself from HIV germ, how does it help you?

P : Silent

PI : To be protected, to protect yourself from infection

P : How does it help? It helps by eh what can I say madam, it helps by, you can, I do not know how to put it, it helps by, madam at the end you are not infected with that germ

PI : Mh mh.

P : I can say no way when you wear a condom.

PI : How do you benefit from not being infected?

P : Yes you benefit by not being infected.

PI : How does not impregnating help?

P : By not having to feed (support) madam. You are free from feeding. It helps, you see that.

PI : Mh, it helps you by not feeding (supporting). I have heard that if you are a man they praise you if you have many girlfriends you sleep with. What do you say to that?

P : I do not agree with that because at the end there are diseases, you become sick and die. They are mocking you when they say you are a man of essence (serious).

PI : When you sleep with many.

P : Yes madam you are not a man of essence, you are being mocked really I can say so.

PI : Have you had many?

P : I can say madam yes I have had them.

PI : Did you experience problems when you want to protect yourself for instance wanting to use a condom and meet with problem?

P : No

PI : You have never had problems

P : No (voice pitch lower and looking sad).

PI : Has your partner ever refused a condom?

PI : She has never refused. So have you ever put yourself in a situation that can make you get infected such as alcohol and drugs, going to parties?

P : What I can say madam I did not use it with a girl I can say she is passing by madam.

PI : No I should not see her. You did not use it.

P : It was painful madam I did not use it.

PI : You did not use it. What happened?

P : I can madam I did not have it and I felt that the feelings were high (highly sexually aroused).

PI : Oh, high sexual arousal was the problem.

P : Yes.

PI : But you regret that.

P : I regret it because I heard after some time that she is on treatment. I went to check and it did not appear I do not know how, I do not know.

PI : Oh, oh, you found out she is on treatment.

P : After some time I went back to check. I was told to come back. I did not go back.

PI : Why not?

P : When I returned they did not pay attention to me. I came and they did not pay attention to me for a long time, then I decided to go.

PI : Are you not sick now?

P : I do not know madam, I can say I am sick, I will not lie.

PI : You did not go to test after three months.

P : I did madam.

PI : After three months.

P : Yes.

PI : And you found out that you did not have it.

P : I found out that it is there (sad).

PI : The HIV germ.

P : Yes.

PI : Oh. So you think you got it from the girl when you did not wear a condom.

P : Yes.

PI : Did you tell *oganene naye*?

P : Yes I told her madam.

PI : What did you do?

P : She has got it madam. We were told to wear a condom when we sleep together. She went to get treatment.

PI : She is on treatment.

P : Yes (wipes his eyes).

PI : You have started treatment.

P : No.

PI : Why not?

P : I have been there (clinic) madam, I have been there. Nobody pays attention and then I leave.

PI : Do you have children?

P : We have one.

PI : You want more?

P : We do.

PI : Now what are you going to do about treatment because both of you need to be on treatment so that the levels of the germ are low, so that it is low.

P : They do not pay attention to me madam.

PI : What do you do about it, you are supposed to go to the clinic early, wake up early in the morning and go there.

P : Yes madam.

PI : and explain to them in the consulting room that it is like this and this, you have come to ask for treatment. Today it does not matter how many body's soldiers (CD4s) you have, you get treatment on the same day. Your partner is on treatment. You said so.

P : Yes.

PI : Yes, both of you need to take it, treatment that is taken by people who are HIV infected.

P : Silent.

Pi : Do you understand what I am saying, that you need to take treatment?

P : I understand madam.

PI : Are you going to go (to the clinic) now?

P : Yes madam thank you. Thank you madam for counseling me (ngokungeluleka).

PI : You need to get up early in the morning, in the consulting room tell them that I was tested but I never took treatment, I have come to ask for it. You talked about you and a partner. What about others?

P : No I do not have them.

PI : You do not have others, ok. Let us say you get one, how is your confidence (self-efficacy) about refusing to sleep without a condom? How much confidence in a scale of zero to ten (0-10)? Zero means you have none, you sleep without a condom as soon as she says you do not trust me for instance. Ten means you say we would rather not do it without a condom.

P : I can say madam I would put myself at ten madam because she has already said she does not trust me.

PI : You mean you would refuse to sleep because you know you your status. Let us say you do not know her HIV status.

P : I would try madam to tell her. Is she continues to refuse I would sleep with her.

PI : How do you know that she is not going to give you another hiv strain that is stronger?

P : No madam I would not refuse.

PI : You would do it.

P : Yes

PI : So where do you rate yourself?

P : I put myself at zero.

PI : You would agree.

P : Yes

PI : Yes, ok. According to the community or this area what is expected from the youth, to sleep or not to sleep?

P : That we do not sleep.

PI : The community does not expect youth to sleep.

P : Yes, that is what they expect.

PI : That is what you know is expected from you as youth.

P : Yes.

PI : Does that mean that even at your home they do not expect that a young person does have sex?

P : Yes.

PI : If it like that how is it young people engage in sex?

P : No madam, the world is corrupt (umhlaba usewangcola) it is not like the olden days.

PI : Ok

P : May be they copy from their parents

PI : Ok

P : That they were born this way, yes madam or some parents drink and end up doing things that children see.

PI : Ok are there family members or friends that encourage you to protect yourself?

P : Yes there are.

PI : Who are they?

P : Their names?

PI : No, brother or mother or grandmother?

P : I can say it is my brothers.

PI : Your brothers, what do they say to you?

P : They say if I sleep with a woman if I do not trust her I must use a condom. I agree with what they tell me but it happened that I did not do that (regretting).

PI : Ok.

P : Yes.

PI : Who are your role models?

P : Silent.

PI : Those who behaved well, maybe they have not impregnated while they were still young or.

P : They are there.

PI : Who are they?

P : I can say it is my sister.

PI : Your sister, why?

P : She controlled herself.

Pi : She behaved well.

P : Yes.

PI : How old is she?

P : She is older than me.

PI : What about her children.

P : Yes, two. She got them after she got married.

PI : She got married having had no child.

P : She also finished school.

PI : Without a child.

P : Yes she got married without having had a baby.

PI : Ok.

P : She got them after she got married.

PI : Laughs. Ok where do you get condoms of your choice?

P : Madam?

PI : Where do you get condoms of your choice?

P : I can say a get them from the clinic and shops.

PI : Which ones do you prefer?

P : From the shops.

PI : Why?

P : They are different.

PI : How different are they from those from the clinics.

P : The ones from the clinics madam they burst easily. Those from the shops are right madam; they do not burst easily.

PI : Mh. You said from your family your sister was a role model. Are there any among friends?

P : No.

PI : There is none among friends. What have you been doing about encouraging each other?

P : To sleep with many girls.

PI : So that they can accept you.

PI : Laughs.

P : Laughs.

PI : Ok, Now that we have had this conversation what are going to change from what you have been doing?

P : Yes there is.

PI : Like what?

P : That when I sleep with a woman I use a condom.

PI : Mh mh

P21 : And fetching treatment from the clinic.

PI : Now you are going to change that.

P : Yes

PI : Mh mh. Do you ever sleep without a condom with your trusted one?

P : Yes it happens. I will start using a condom.

PI : You are going to change that too.

P : Yes (smiling).

PI : What about taking treatment.

P : Yes, do all we were told to do.

PI : What about lobola.

P : Yes, I will pay lobola.

PI and P laugh

P : I am about to go

PI : I am about to finish. Did we talk about problems you had trying to protect yourself?

P : No.

PI : Oh, that is my last question.

P : We were about to sleep madam, I said it is better to use a condom. She asked me if I do not trust her. She said we would rather not do it. I did not wear it.

PI : Why?

P : Because I was highly aroused.

PI : You rated yourself at zero.

P : Yes madam.

PI : Laughs.

P : Laughs.

PI : Ok. Now what will you do in a similar situation?

P : In a similar situation?

PI : Yes.

P : I will say let us use a condom. If she says no I will try to explain my situation (HIV Status).

PI : what about pregnancy besides the situation?

P : Pregnancy madam, I want a child.

PI : Impregnate another woman?

P : Not another one but the one I married to (*esiganene naye)*.

PI : Laughs. You can ask any question.

P : No, I do not have them.

PI : Thank you for your participation.

P : Thank you madam.

ANNEXURE 8

THE PROCESS EVALUATION OF THE PILOT STUDY

PROJECT TITLE: **POSITIVE VALUES OF MASCULINITY IN PREVENTION OF HIV AND AIDS AND TEENAGE PREGNANCY IN A RURAL SUB-DISTRICT IN KWAZULU-NATAL, SOUTH AFRICA**

1. INTRODUCTION

This process review is a description of experiences of the researcher during the pilot study such as community entry, methods, data collection, lessons learnt and challenges. The purpose of the pilot study was to ensure that the questions were not ambiguous and to train the research assistant. Data were analysed with those of the main study.

2. METHODS

2.1. SELECTION OF THE PILOT SITE.

The tribal authority where the study was conducted was randomly among tribal authorities with similar characteristics as a pilot site. One tribal authority was excluded because the chief and his people are predominantly Sotho speaking. Each tribal authority's name was written on piece of paper that was folded and placed in a container. After all the papers with the names of all tribal authorities were placed in a container and mixed, someone who was not involved in the study was asked to pick one of the papers. The name of the tribal authority in the picked up paper was one where the study was done. The names of areas in the selected tribal authority were each written on a piece of paper. The same procedure as for selection of the tribal authority was followed to select the pilot site. Casino area was selected.

2.2. TRAINING THE RESEARCH ASSISTANT

The research assistant was trained to write field notes and to use the digital voice recorder.

Field notes means documentation of what is heard, seen, felt and thought by the researcher during an interview or focus group (Botma 2015:217). According to Polit and Beck (2017:523) and Botma 2015:218) types of field notes include demographic information, observational, theoretical, methodologic and personal notes.

Observational notes

These are records of observed events, conversations, actions and how the participant looked such as tired, worn out, happy or sad, withdrawn, enthusiastic, bright and cheerful, frowning, nodding, smiling, laughing, and shaking the head (Polit & Beck 2010:295; Polit & Beck 2017:521).

Methodologic notes

These are thoughts about what works well or does not work and needs to be changed such as whether field notes forms need additional headings or columns for description of the environment or residence (Polit & Beck 2014:295).

Personal notes

Refers to how the researcher felt in the field work and whether their feelings influenced what was seen including ethical dilemmas are recorded such as when the researcher feels that her personal values guide the probing that she does to participants or a participant is hiding something or evading the question.. The researcher may also write personal notes about challenges that she had during the field work such as interruptions by other family members and noise in the neighbourhood during the interview (Polit & Beck 2014:295; (Polit & Beck 2017:522).

Demographic notes

These are records of time, place and date of fieldwork and demographic data about the participants such as age, marital status, occupation, highest educational standard (Botma et al 2010:219).

Before the pilot study we had mock interviews to practice taking field notes and using the digital voice recorder.

2.3. COMMUNITY ENTRY

After permission to conduct the study was obtained from the chief (Inkosi) and the headmen (Izinduna), village community meetings were attended with the permission of each Induna who informed the ward councillor for the area. At the community meeting the researcher explained her role as a researcher, the purpose of the study and the inclusion and exclusion criteria, benefits and cost. The research assistant was introduced as a colleague and assistant in data collection. All questions from the community about the study were answered.

2.4. DATA COLLECTION

The participants were interviewed by the researcher using a semi-structured interview guide with the assistance of the research assistant who was responsible for recording the interviews and taking notes. Demographic data about the participants' such as age, occupation and marital status were also collected. Three participants were interviewed in the pilot study ensure that the questions were not ambiguous. Data was collected to answer the following questions:

What are the positive values of masculinity in relation to HIV/AIDS and prevention of teenage pregnancy?

How do young Zulu men apply the positive value of masculinity in the prevention of HIV and AIDS and teenage pregnancy?

3. LESSONS LEARNT

The pilot study gave us a clue about the length of time it takes to explain the study to the participants, obtain the consent, complete the interview and write field notes. The process had been estimated at 1- hours, however it found to be ranging between 45 minutes to 1 hour. This helped the researcher to estimate the average number of interviews per 24 hour day and the estimated length of time needed to collect data and

do the transcription. The researcher could set targets of number of interviews and transcripts per day, per week and per month in order to estimate expenditure for the cost of hiring and transporting the research assistant. The research assistant was well received by the community as a local and a professional person with a medical background.

However, one participant voiced out he was uncomfortable to be interviewed in her presence as she was well known and respected member of community and requested her to leave. Training was also easy because she understood issues of confidentiality and anonymity and research terminology.

Explaining long term benefits of the study to the participants and the community was also helpful at entry and made the gatekeepers very helpful and cooperative.

4. CHALLENGES

Getting started was the number one challenge. Although the study had been introduced at the community meetings getting the first participants was not as easy as it had been expected. Young men 18-24 years of age did not attend the community meetings. The researcher relied on the councillor, research assistant and Izinduna to approach young people of this age group to a special meeting with the researcher in order to explain the study to them and to ask those who were interested to participate in the study.

Another challenge with the first participants (three) was that they were of the same age (19 years) and same occupation (high school learners), however they came from different high schools and were in different grades (10, 11 &12)

During the interview of the first participant, the question “What are the positive values of masculinity in relation to HIV/AIDS and teenage pregnancy prevention?” had to be reworded to “According to your knowledge what is expected from a man that one can call a man among men (a man of a kind or indoda emadodeni)?” because he asked for clarity several times. The two subsequent participants who were asked the reworded question did not seem to have a problem with it at all. The question “How do young Zulu men apply the positive values of masculinity in the prevention of HIV and AIDS and

teenage pregnancy?" was reworded to "what is your role as a man among men in protecting yourself and others from HIV and AIDS and from impregnating a girl?"
The first participant also seemed to be tense from the start up to end of the interview He seemed to be struggling to answer questions as if he was trying to tell us what we wanted to hear. When we asked the second question on his role in the prevention of HIV and AIDS and teenage pregnancy he became restless. He did not the answer the question at all. He had long pauses interrupted by 'eish' in between. It felt like he was hiding something or was reluctant to speak freely may be because of age and gender differences of the researcher and the research assistant or because the research assistant is a member of the community. Eventually he asked us to stop because he needed to go. We realised that answers to questions are not as easy as they may seem to participants and that sometimes even with probing and prompting participants may not be answer questions freely.

The other two participants seemed to be relaxed and they seemed to be answering the questions from their hearts which were the same questions we had asked the first participant.

ANNEXURE 9
LANGUAGE EDITING CERTIFICATE

Cell/Mobile: 073-782-3923

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Doringkloof
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1 November 2018

TO WHOM IT MAY CONCERN

I hereby certify that I have edited Italia Nokulunga Mthiyane's doctoral dissertation, **Positive values of masculinity in the prevention of HIV/AIDS and teenage pregnancy in rural KwaZulu-Natal**, for language and content.

IM Cooper

Iauma M Cooper
192-290-4

ANNEXURE 10

TURNITIN ORIGINALITY REPORT

TurnitinOriginality Report

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