

CENTRE FOR
SOCIAL SCIENCE RESEARCH

Aids and Society Research Unit

**Love in the Time of AIDS: The
Relational Gender Dynamics of
Prevention, Testing and Treatment**

Elizabeth Mills
Marina Manuela de Paoli
Arne Backer Grønningsæter

CSSR Working Paper No. 252

June 2009



Elizabeth Mills is Deputy Director of the AIDs and Society Research Unit at the Centre for Social Science Research, University of Cape Town.

Marina de Paoli is a Researcher (PhD) at Fafo Insitute for Applied International Studies.

Arne Backer Groenningsaeter is a researcher at Fafo Institute for Labour and Social Research

Love in the Time of AIDS: The Relational Gender Dynamics of Prevention, Testing and Treatment

Abstract

Gender and sex lie at the heart of South Africa's generalised and heterosexual epidemic. The stark feminisation of HIV in South Africa telescopes research, policy and interventions on to the socio-economic inequalities that make women particularly vulnerable to the impact of HIV and AIDS. There is a corresponding risk of reducing the complex and relational nature of gender down to a binary that positions women as victims and men as perpetrators. Accordingly, we seek to disrupt this dichotomy and point to the multiple ramifications of gender inequality for both men and women's wellbeing in relation to HIV prevention, testing and treatment. The findings are drawn from a qualitative study conducted in Cape Town, South Africa, in 2007 and 2008. The researchers identified three main research groups and corresponding research methodologies to elicit particular information regarding the challenges faced by members of HIV/AIDS non-governmental organisations, medical doctors and people living with HIV. The research methods include: twenty-nine narrative interviews with HIV-positive men and women; three focus group discussions; and eight semi-structured interviews with medical doctors. The findings highlight the relational nature of gender, its intersection with a range of behavioural, social and physical drivers, and the various ways in which both men and women shape their own and each other's health within the sexual relationship dyad. Constructions of tradition and masculinity that valorise unsafe sex emerged as a significant barrier to HIV prevention for both men and women, and deterred men from testing for HIV or accessing critical health care. Women accessed health care more readily than men, but they feared and experienced stigma from their sexual partners, which in turn undermined disclosure and safe sex, compromised antiretroviral adherence, and reinforced mixed infant feeding practices. This paper calls for a more nuanced understanding of gender dynamics that moves beyond the 'victim/perpetrator' dichotomy which lambasts men and pities women. Accordingly, it explores factors that may shift these dynamics and open up space for more constructive engagement that promotes both men and women's health within the matrix of social, economic and emotional wellbeing.

Introduction

Biomedical interventions that promote safe-sex, HIV testing and antiretroviral treatment (ARVs), will continue to fall short of policy targets until we develop sustainable interventions that promote biomedical health as composite rather than constitutive of individual wellbeing. Relational gender dynamics within sexual relationships structure individual wellbeing within a matrix of social, emotional, financial and physical health (cf Mills, 2006). Given South Africa's high levels of gender and class-based inequality, research, policy and interventions have focussed on women as 'victims' who are socially, economically and structurally disadvantaged and biologically more vulnerable to contracting HIV through sex (Farmer, 2004; Jewkes, Levin and Penn-Kekana, 2003). Conversely, men are positioned as 'perpetrators', accorded both agency and blame for HIV transmission dynamics and exhorted to use condoms and to reduce the number of concurrent sexual partners. Research on gender and HIV largely replicates this bifurcated discourse, ignoring the complex relational nature of gender (Persson and Richards, 2008; Ricardo and Barker, 2005; Dowsett, 2003; Peacock, 2003). Given that gender is fluid and relational, this paper argues that typologies which polarise heterosexual relationships into a 'victim/perpetrator' dichotomy obscure nuanced dynamics of gender as a driver of HIV infection for *both* men and women.

Constructions of masculinities that preclude men from acknowledging vulnerability to HIV, and promulgate 'sexual cultures' like concurrent sexual partnerships and 'flesh-on-flesh' sex (Epstein, 2007), have relational and significant ramifications for men and women. This paper proposes that structures which disempower women by asserting men's power simultaneously disempower men by entrenching a discourse of strength that valorises unsafe-sex and deters men from testing for HIV and accessing antiretroviral treatment (ARVs). Within the sexual dyad, responsibility is consequently conferred to women to initiate safe sex and test for HIV (frequently in relation to pregnancy). This dynamic may facilitate women's entry in to the health system, and as such, may enhance women's physical health relative to men who predominantly test for HIV and access health care when they become seriously ill. As argued below, although women's physical health may be a positive effect of relational gender dynamics, knowledge and disclosure of their HIV-status may also place women at risk of stigma and emotional and financial abandonment following disclosure. In order to reduce the risk of discrimination, women may choose not to disclose their HIV-status, engendering the following relational dynamics (and ramifications): woman may continue to engage in unsafe-sex (risking horizontal infection and re-infection), hide their antiretroviral treatment (undermining

treatment efficacy) and practice mixed infant feeding (risking vertical transmission). This paper outlines the complex gender dynamics that structure the matrix of individual wellbeing and considers how these dynamics inform men and women's respective beliefs and practices around HIV prevention, testing, disclosure and treatment.

Gender Dynamics and Drivers of National and Local HIV Epidemics

The victim/perpetrator typology may be crude, but it is not always inaccurate: gender and class-based inequalities are witnessed through high rates of gender-based violence, including rape and sexual abuse that affect impoverished women throughout South Africa. The implications of unequal gender dynamics are borne out in figures that indicate a prevalence of 23.9% for South African women between the age of 20 and 24 compared to 6.0% for men; further, women of all ages between 20 and 64 years have an 18.1% prevalence rate compared to the national average of 11% (Shisana *et al*, 2005). These statistics suggest that young women are almost four times more likely to contract HIV compared to men within this same age group, and that overall, South African women are disproportionately affected by HIV compared to men (cf UNAIDS, 2008 and 2006). Quantitative studies therefore establish an empirical link between HIV infection, prevalence and gender. Quantitative studies and statistics do not, however, explain the qualitative nature of the relationship between HIV and gender.

Research in to social, behavioural and biological drivers of the HIV epidemic points to some factors that may account for men and women's relative vulnerability to infection and illness in Southern Africa. Biological drivers include women's physiological vulnerability to HIV infection given the vagina's mucosal lining and larger surface area, which create more entry points for infection compared to men. Social drivers, like poverty and gender inequality, may exacerbate physiological vulnerability; malnutrition, for example, weakens the immune system, compromises skin integrity and increases susceptibility to infection (Stillwaggon, 2006). Behavioural drivers, like multiple concurrent sexual partnerships, play a significant role in HIV transmission, particularly in hyper-epidemic countries like Uganda and South Africa¹ (see Epstein, 2007;

¹ In 2008, a quantitative study conducted in Cape Town indicated that 17% of adults in married or long-term partnerships report concurrency, with men reporting significantly greater levels of concurrency than women (Mah, 2008a, 2008b). Reported reasons for

O'Manique, 2004). These drivers are interconnected and, together, they support regional and national statistics that point to women's vulnerability to HIV infection relative to men.

Within South Africa, men and women's lives are shaped by historical trajectories that transect race, class and gender, particularly in relation to formal education and employment. These historical trajectories inform pernicious inequalities, including gender inequality, and have fuelled the feminisation of the HIV epidemic (see Budlender, 1999; Strelbel, 1997; Cock, 1980). Susser (2009) argues that South Africa's colonial history and its post-apartheid shift towards neoliberal policies alongside the burgeoning HIV epidemic compelled women to negotiate livelihoods² through transactional sex. Importantly, although both Susser (ibid) and Leclerc-Madlala (2003) point to the global political economy (cf di Leonardo, 1991; Sack, 1989), they also bring their analysis down to local and personal processes of negotiation. They assert that transactional sex is not necessarily an indication of women's subjugation to men as 'victims' within the perpetrator/victim dyad; instead, transactional sex may point to women's strategic use of social and sexual practices to leverage financial gain within these unequal relationships. The cost of these dynamics, however, is that women are not necessarily in a position to negotiate safe-sex or insist on monogamy with their sexual partners which places both women and men at risk of HIV infection and re-infection (cf Mills, 2004 and 2006).

South African men have also been affected by historical trajectories of oppression that cut across race, class and gender (Morrell, 1998 and 2002). Class and race-based oppression informed and reinforced constructions of masculinities that determined particular migration patterns, certain forms of employment, and expectations of financial commensurability (Hunter, 2005; Morrell, 2002; Campbell, 1995). These historical trajectories have fuelled the feminisation of the HIV epidemic, but they have also significantly undermined

engaging in concurrent sexual relationships range from migration patterns between the rural periphery and urban metropole to transactional sex and gift-giving (Hunter, 2005; Leclerc-Madlala, 2003).

² The post-Apartheid government, however, has an expanded welfare system (for every one taxpayer, South Africa provides grants to three recipients), which suggests that a simple neoliberal agenda cannot easily be mapped on to South Africa's economic history. Further, South Africa's welfare policies also need to be understood through a gender lens: until recently, women received a state pension from age 60 compared to men at age 65; women also receive childcare grants. Notwithstanding women's relative disadvantage to men concerning comparatively poor education opportunities, consequent lack of access to employment and expectations of childcare, women are privileged vis-à-vis men within South Africa's welfare system (<http://www.dsd.gov.za/>, accessed March 2009).

men's health. The feminisation of HIV was spurred, for example, through forced migration as a result of colonial and apartheid policies around Hut and Poll Taxes (which forced rural homesteads to enter the wage-economy), and through the creation of rural 'Bantustans' as consequence of Apartheid policies for 'separate development'. Families and households were stretched across rural and urban centres, connected through emotional and financial commensurability. HIV transmission followed similar routes, with HIV transmission patterns in the urban centre reaching across to rural areas when HIV-infected men returned to their families (see Campbell, 1995).

Historical trajectories and discourses of masculinities that foreground men's strength – financial, emotional and physical - in relation to women's constructed vulnerability have also reinforced men's vulnerability to HIV illness. In his book, *The Three Letter Plague*, Steinberg (2008) unravels some of the interwoven factors that contribute to a young man's reluctance to test for HIV in a rural area in South Africa. Strongly held beliefs around witchcraft and the value of replicating cultural practices around kinship and lineage deterred Sizwe from testing for HIV despite knowledge of HIV and access to clinic resources. Socio-cultural beliefs and practices, as described by Steinberg, are powerful determinants of health seeking behaviours. Steinberg also details some of the deeply personal struggles that he and Sizwe experience in different ways, as men, at an individual level; this moves Steinberg's rich account beyond a critique of behavioural determinants, to a subtle appreciation of the individual as informing and informed by the complex socio-cultural matrix in which we live.

Steinberg's ethnographic account resonates with Nattrass's (2008) quantitative analysis of the gendered nature of health seeking behaviour. Nattrass demonstrates that significantly more women than men are accessing antiretroviral treatment even when accounting for higher HIV prevalence among women and that women's reproductive health needs bring them in to contact with clinics more frequently than men. This study builds on this new field of research: it moves beyond the gendered binaries of that position women as victims and men as perpetrators to explore some of the relational gender dynamics that structure both men and women's ability to negotiate safe-sex, test for HIV, prevent vertical HIV transmission and receive AIDS treatment.

Methodology

This paper is based on a research collaboration between the AIDS and Society Research Unit at the University of Cape Town and Fafo (the Institute of Applied

International Studies) based in Oslo, Norway. Qualitative research was conducted in 2007 and 2008 in a number of urban and peri-urban areas, including Khayelitsha, Nyanga, New Crossroads, Somerset West and Hout Bay. The intention of the qualitative study was to collect a wide-range of information regarding challenges faced by PLWH, community-driven responses to these challenges and overarching recommendations by key stakeholders. For this reason, a number of key stakeholders were identified for participation in the qualitative research, including medical doctors, HIV counsellors, members of NGOs, community workers and PLWH. Respondents were thus purposively selected, and findings from this qualitative study cannot be generalised. Three focus group discussions were held with (i) a group of male AIDS activists and community leaders, (ii) a group of female AIDS activists and community leaders, and (iii) with HIV/AIDS community workers and members of NGOs. Twenty nine semi-structured in-depth interviews were conducted with HIV-positive men and women and eight semi-structured in-depth interviews were conducted with medical doctors working in the public sector throughout the Cape Peninsula. A total of thirty seven interviews and three focus groups were conducted across the identified sample groups. The open-ended and narrative interview methodology enabled the researchers to explore a range thematic issues that emerged and evolved over the course of the research process.

All interviews and FGDs were transcribed and entered in to a computer assisted qualitative data analysis program (OpenCode). Interviews were coded according to key themes, which enabled us to draw up initial comparisons across the different qualitative data sets. In order to ensure close analysis of the research findings, the researchers conducted a second-tier of research analysis and individually coded the transcripts by hand. Using Grounded Theory (see Strauss and Corbin, 1998) we identified main themes that were grounded in the interviews and, as a result, a series of papers emerged from this research process with highly focussed analyses that extends and deepens the study's research objectives as stated above.

The City of Cape Town gave us permission to conduct research in the public health sector. Informed consent was secured with each respondent, and all names and identifying characteristics of the respondents have been removed in order to ensure confidentiality.

A Balancing Act: Engendering the Risks and Benefits of HIV Prevention, Testing and Treatment

This section outlines four interlinked processes that inform (un)safe sex, testing, disclosure and treatment for men and women. One, women and men's perceptions of vulnerability to HIV, and the actions they take to either protect themselves from transmission, or to rationalise unsafe sex. Two, men and women's different approaches to HIV testing and the responsibility of knowledge following an HIV-positive test result. Three, the different ramifications of disclosure for men and women, with corresponding implications for HIV prevention, treatment and testing. Four, perceived and experienced stigma on men and women's sexual relationships, their access and adherence to ARVs and vertical transmission of HIV from mothers to infants.

The first process – sex and HIV infection – hinges around the discursive constructions of tradition and of masculinity that sanction unprotected sex. In constructing tradition, dominant notions of taboos or norms validated and valorised unsafe sex: condoms were described as 'taboo' and its corollary, unsafe sex, described as tradition. Both male and female respondents across the sample groups agreed that men generally disliked using condoms. The respondents in the men's focus group stated two factors that may account for men's reluctance to use condoms. First, they said that tradition stipulates 'flesh to flesh' (unprotected) sex:

“[A] thing which is a barrier: it is a tradition that men believe that they would not have sex with plastic - it is a taboo. Tradition becomes a barrier. Men want flesh to flesh; they believe that what makes man is a flesh to flesh.” (Men's Focus Group, 2007).

Second, men's perception of invulnerability to infection reinforced their belief that they do not need to protect themselves from infection by using a condom:

“They [men] are saying [that] chances of getting AIDS [as a] man is very little because we are not like woman.” (Men's Focus Group, 2007)

Constructions of traditions that valorise unsafe sex and chastise condom use as 'taboo' connect with a hegemonic construction of masculinity that foregrounds men's strength and obscure men's vulnerability to infection through unsafe sex. Men's reported reluctance to use condoms also shapes women's vulnerability to HIV through unsafe sex. The women in the NGO focus group iterated that men were either reluctant to use condoms or simply did not know how to use them:

“I can't trust a man and go to bed with a man who's saying that we're going to use a condom. It's a lie! There are few men who know how to use condom because men never experience it in the first place. Now the condom is new to them, very new to them. So I can't say now I can go with a guy because he will say we going to use condom. It's a lie”. (NGO Focus Group, 2007).

It is noteworthy that the male respondents referred to ‘other’ men who chose not to practice safe sex, highlighting that in their own lives they were careful to use condoms with their sexual partners. Some of the HIV-positive who were interviewed also spoke about the importance of counselling and support groups after they had learnt of their HIV-positive status. Counsellors and members of their support groups encouraged the men to change negative behaviours, like multiple sexual concurrency, excessive alcohol consumption and unsafe sex, as part of living a long life with HIV. Therefore, although the respondents reported behaviour that categorised men as reluctant to practice safe sex, they acknowledged that they had made changes in their own lives to protect themselves and their sexual partners from HIV (re)infection. This dissonance is important as it highlights heterogeneous perceptions of risk and sexual behaviour among men. Further, a large proportion of the male respondents indicated that they felt that HIV-positive women's needs were addressed more frequently than HIV-positive men's needs through the public health system, and by NGOs. As such, they called for a greater number of support groups and clinics that specifically catered to men's needs.

Just as men were chastised by women and other men in the study for not practicing safe sex, men were also labelled as reluctant to test compared to women. The second main finding - gendered testing behaviour – indicates that women seek health care when pregnant and test for HIV through this process. The extent to which the respondents were able to decline an HIV test as part of the antenatal care was not explored in the research; as such, women – like men – may also be reluctant to test, but – unlike men - are compelled to test through the antenatal programs.

HIV testing confers a responsibility of knowledge that may make an individual vulnerable to HIV-related stigma when initiating prescribed positive behaviour change within sexual relationships. Given that women test and access ARVs more readily than men, a double-bind ensues: women test for HIV, thus accessing corresponding health care resources like PMTCT (Prevention-of-Mother-to-Child-Transmission) and ARVs. However, this knowledge confers responsibility for adopting certain practices (like safe-sex and ARV adherence)

that may inadvertently disclose their status, thus making women vulnerable to stigma and discrimination. The responsibility of knowledge and the double-bind entailed in testing for HIV is an important thematic trend that emerges across each section of the findings and warrants further research in to the intersection of HIV knowledge and responsibility placed on women through the gendered nature of biomedical sexual and reproductive health care provision.

The following excerpt from the women's focus group indicates that HIV-positive women chose not to disclose their status to their partner prior to sexual intercourse because they feared stigma. Instead of disclosing their status and insisting on condom use, the women feigned ignorance of their status and encouraged men to go for an HIV test with them prior to sexual intercourse. The female respondents argued that mutual knowledge of both sexual partners HIV-status would distribute the burden of the responsibility of knowledge and therefore, the corresponding responsibility of ensuring safe sex would be shared by both partners:

Respondent 1: It's easy to blame someone else. And you know it's not easy for the guys to go for test. That is why the female partner doesn't want to disclose

Respondent 2: You know I got a problem. I'm experiencing the fact that each and every boyfriend that I'm getting along with I will say to him, 'If you love me, can you go to clinic to test? And the guy would say, 'Ok, I will come tomorrow.' And then I won't see him again.

Respondent 3: I am having trick: each and every guy who comes along with me I'll say, 'No I'm free – I don't mind [having sex]. Just let's go to the clinic for test.' ... You know it's so hard very hard.

Respondent 2: And I thought to myself [that] the one that I will be getting is the one who will be willing to go for test...

Respondent 3: I know as soon I told him to go for test he never came back.

In contrast to women's testing behaviour, the respondents described men as recalcitrant testers who used a form of 'proxy testing' to gauge their status: men tested for HIV by making their partners pregnant. This practice of 'proxy testing' shielded men from the responsibility of knowledge by conferring the onus for testing, through ante-natal care, on to women and simultaneously enabling men to blame their partner for 'bringing HIV in to the home'. It is important to note that although the phenomenon of proxy testing was referred to in the focus groups and in many of the interviews with men and women, it was

not universally described by each of the respondents. This paper, therefore, points to this practice as a phenomenon that requires further research.

As indicated in the quote below, men meted out punishment to women if they disclosed that they tested HIV positive; this suggests that active forms of discrimination, like domestic violence, are intimately connected to the perceived and relational consequences of one sexual partner testing for HIV:

“Men won’t go for VCT [voluntary counselling and testing]. They want to make their partners pregnant. Then if the partner comes back from the clinic and says that ‘I’m negative’, he will be happy because he thinks he is negative. But if the partner says ‘I’m HIV-positive’, that will create domestic violence. He will say, ‘You are the one who came with this thing. You were sleeping around’.” (Men’s Focus Group, 2007)

Assumption of blame for contracting and subsequently transmitting HIV is placed on the first sexual partner to disclose their status within the sexual dyad. This reinforces the assertion above that testing entails a responsibility of knowledge: because women may learn of their status before their sexual partners, they are discriminated against, thus deflecting attention from the potential scenario that the man had, in fact, first contracted and transmitted HIV to his partner.

Another respondent spoke about men’s fear of going in to the clinic, and the practice of ‘proxy testing’ as a means to ascertain their status:

“You would find that men when it comes to VCT, they don’t want to come [forward]... You know, most of our men [in the support group] are still ignorant... They even tell us that, ‘We don’t know our status because we are scared of going there [to the clinic]’. And what I found out is that men want to make their partners or girlfriends pregnant, so that they can find out their status. So they think they know their status, though they don’t know their status.” (Men’s Focus Group, 2007)

The doctors confirmed that they were aware of proxy testing. A doctor describes a conversation that she had with female patients in the clinic:

“I was talking to women. One said they [men] actually prefer the women to get pregnant. They [men will] get to know her HIV test rather than go themselves. Then ... the woman comes back and tells them that they are HIV infected... They don’t want to believe it”. (Interview with doctor, 2007)

While women’s entry in to the health care system may be facilitated through ante-natal care during pregnancy, further research is needed to highlight the

implicit and largely unquestioned societal expectation that women take on primary responsibility for accessing child care. One of the male respondents noted that because women often learn of their HIV status when pregnant, men become invisible in the statistics, and also better able to deflect responsibility for ‘bringing HIV in to the house’ on to women:

“Women found out about their HIV status while they are pregnant. So that is why the statistics show that the most of the people who are HIV positive are women [and] not that the women got that HIV from the man. Always women got HIV from man and always the men do not want to go for HIV test. If the women found that she is HIV positive and the counsellor told that women that you should bring your partner the guy [will] say, ‘No I am not going there. I am not HIV [positive]. You are HIV [positive]’. That is why you find out that most of the children they do not have their fathers. Their father ... died while the mother and children are living.” (Thobani, 36-year-old HIV-positive man, 2007).

In addition to deflecting responsibility for ‘bringing the disease in to the house’, proxy testing may also be related to the perception that clinics are dominated by women and that men are not sufficiently catered for with regards to VCT services. One of the male respondents stated that men are “scared to come forward [because] the women are occupying the local clinic and hospital” (Siphiwe, 32-year-old HIV-positive man, 2007). This finding highlights the importance of understanding the gendered nature of biomedical services: of women’s visibility clinics and the gendered expectations, assumptions and responsibilities placed on women within sexual relationships and in families.

That women access health care more readily than men may account for men’s delayed access to important health resources (like ARVs) compared to women, but it may also make women more vulnerable to stigma and discrimination within sexual relationships compared to men. The third finding – disclosure – points to the importance of understanding men and women’s different perceptions and experiences of stigma and support within sexual relationships.

Men and women weighed up the risks and benefits of disclosure, and this process generated different outcomes for their social, financial, emotional and physical wellbeing. For women, the risks of disclosure included: rejection from sexual partners and social alienation; re-infection through unsafe sex; undermined efficacy of ARVs through re-infection and poor adherence. Conversely, failure to disclose entails a range of physiological risks for men, including: re-infection through unsafe sex; undermined adherence to ARVs and

reduced efficacy of the treatment due to re-infection with other HIV viral strains. As discussed in detail below, both men and women reported experiences of stigma within their social environment following disclosure.

The female respondents' decisions to test for HIV were, to a large extent, connected to pregnancy and ante-natal care; their decision not to disclose the outcome of their test connects to their fear of stigma and the potential loss of financial and emotional support should their partner abandon them following disclosure. This dynamic is illustrated in the following quote from the NGO focus group:

“You know last year when I was dealing with PMTCT... I discovered that most of the mothers never disclose to their boyfriends... It's like there are many people staying together now but the problem is that it's hard to disclose your status to your boyfriend because this boyfriend might think you is the one brought that disease in to the house.” (NGO Focus Group, 2007)

Fear of stigma was borne out in many of the women's experiences of rejection by their partners following disclosure. For example, after testing HIV-positive, Xoliswa waited for a week before disclosing to her husband. She had been married to him for nineteen years, and they had three children together. Xoliswa's husband left for work after she had disclosed to him, and never returned home, leaving her with the responsibility to care for their children:

“Sometimes he comes to see the kids. [He] stays in a car outside the gate and calls the children to him... I just thought ... maybe it's God's way of separating us.” (Xoliswa, 42-year-old HIV-positive woman, 2007).

Other respondents spoke about the financial strain that their partner's abandonment had on their lives:

“I was suffering, you know? Because I didn't have money for this child of mine. And the father of this child ran away when I told that I am HIV Positive. I have never seen him again.” (Thozama, 30-year old HIV-positive woman, 2007).

Similarly, another female respondent, Simphiwe, described how she had returned home to disclose to her partner after testing HIV-positive during her pregnancy. In the excerpt below, Simphiwe explains that her husband left her in the last two months of her pregnancy and went to live in another city.

Interviewer: He moved?

Respondent: Until now I never saw him... (*Crying*) He never phoned to me to tell what happened. (*Quiet*)... That grant I'm getting there from the

government I must [use to] buy food for my baby. (*Crying*)... But it is not enough. I ask him why he never sends two hundred or three hundred [rand]. I take that money from government. (Simphiwe, 26 year-old HIV-positive woman, 2007).

Later in the interview the respondent was asked what things made her happy or sad. She said that what makes her sad, “Is my boyfriend to leave me like that ... Because it’s my first time to get pregnant. Now I tell myself, I will never ever get another baby.

Interviewer: Never have another baby?

Respondent: Never. So I will try to keep him away in my mind... The only problem is the baby. When my baby says, ‘Where is my father?’ I don’t know how to explain Even my baby I want him to forget about his father. Because even me I’m forgetting about his father. (Simphiwe, 26 year-old HIV-positive woman, 2007).

The fourth factor - stigma - connects to the findings above on sex, testing and disclosure, suggesting a circular dynamic in which the risk of stigma undermines testing and disclosure, which in turn makes men and women more vulnerable to HIV (re)infection through unprotected sex. As described above, women feared and experienced stigma following disclosure to sexual partners, which prompted them to develop ways to protect their financial and emotional wellbeing.

Risks and benefits of disclosure were negotiated by women along two possible routes within their sexual relationships in order to share the responsibility of knowledge and mitigate stigma. The first route, open discussion, is discussed above and relates to women encouraging men to test with them for HIV, thus distributing the responsibility of knowledge and consequent behaviour change across both partners within the sexual dyad. Opting for openness may expose women to stigma. The second route, secrecy, operated a form of social protection for women who knew their status. This route is the corollary to the first; women indicated that they did not want to be the first person to disclose to their sexual partner as this may expose them to rejection, and so they feigned ignorance of their status and suggested that their partner go with them for an HIV test. By concealing their HIV status, the women were able to avoid potential stigmatising consequences of disclosure. As described below, defensive approaches that sustained financial and emotional wellbeing introduced a new set of different risks that undermined both men and women’s physical wellbeing.

If unsafe sex has been the norm within a sexual relationship, insistence on condom use may either indicate that the partner knows they are HIV-positive or it may be construed as a lack of trust in the other partner's fidelity or belief that the other partner is HIV-positive. A catch-22 ensues: disclosure may precipitate stigma and discrimination, and secrecy may increase risk of transmission and re-infection within the sexual relationship. The HIV-positive individual's health may be compromised through re-infection from unsafe sex with an HIV-positive partner, and insistence on secrecy within a sexual relationship may also undermine adherence to antiretroviral treatment.

The medical doctors interviewed in this study noted that fear of stigma from sexual partners was a significant barrier to disclosure within sexual relationships.

“For people HIV is a disease of shame. So why make it such a secretive bloody thing when everybody has got it anyway? I mean we have married couples in here where the one says, ‘You know, I just can’t disclose to my husband’. And we say, ‘You should. He will really just understand’. No, but you can’t say it. You can’t say he’s been on ARVs for three years already.” (Interview with doctor, 2008)

Another doctor concurred, saying that one of the biggest challenges she faces when administering ARV treatment is that the partners do not feel able to disclose to each other. Another doctor said that failure to disclose to household members, including sexual partners, means that many people hide their treatment:

“Generally why they don’t adhere is disclosure. Disclosure is a big thing. A lot of the times they do not disclose to the people they living with... They are having to hide [their ARVs], and they can’t take their treatment as they should.” (Interview with doctor, 2008)

Post-natal transmission of HIV from mother-to-child is a significant consequence of stigma within sexual and social relationships. Female HIV-positive respondents said that they did not tell their partner they were using infant formula from the clinic to feed their child in case the partner realised that they were HIV-positive. One male respondent explained how infant feeding inadvertently disclosed a mother's HIV status to her sexual partner:

“Most of the women in these days there are not breastfeeding. So it ... makes some of the women disclose their status into their partners because they know that once your child not breast feeding there is something you see.” (Thobani, 36-year-old HIV-positive man, 2007)

In some cases, the respondents hid the infant formula and asked for money from the partner to buy food for their child, and then used the money to purchase

general household supplies. In line with the quote at the opening of this section, one of the members of the NGO focus group spoke about her work in PMTCT programs, and the mothers' reluctance to disclose to their boyfriends:

"You know ... I discovered that most of the mothers, they never disclose to their boyfriends that they are HIV [positive]... They never never! Sometimes the boyfriend asks, 'Why do you always want me to buy [formula] milk and you don't want to breast feed? Even if the women visited the in-laws she will hide the fact that she is not breast feeding.'" (NGO Focus Group, 2007).

In addition to the actual feeding practice, the tins in which clinics distribute formula milk can also denote the mother's HIV positive status:

"We have this hysterical policy that all infants [of mothers] who are HIV-positive get Pellagon... It's some particular kind of formula in an orange tin. Everybody who gets the orange tin knows that the mother is HIV positive... It does put some mums off, and some mums will actually go and buy Nan³ so that nobody knows that they are HIV positive." (Interview with doctor, 2007)

The women's fear of being identified as HIV-positive extended from a fear of stigma within sexual relationships to a fear of stigma within social contexts. Consequently, women sometimes felt compelled to breastfeed their child in social settings, particularly among other mothers who were breastfeeding:

"Women have to go to the clinic to get that Pellagon. I think it's a stigma for them [to get Pellagon]. Sometimes these women are not ready to disclose. In the part of the clinic where women sit with their babies, some [HIV-positive] women breastfeed because they not ready to disclose and then the children get infected." (Nosiphiwe, 30-year-old HIV-positive woman, 2007)

Another HIV-positive female respondent noted that she too had been concerned about stigma associated with her decision to not breastfeed her child in the clinic:

"I wanted to go out of the hospital because, you know, it was not nice the way women in the room were staring. Some were breast feeding and I think it was one or two of us who were not breast feeding." (Thozama, 30-year old HIV-positive woman, 2007).

Decisions to protect the child from vertical HIV-transmission are therefore fraught with difficulties for HIV-positive mothers. Mixed feeding practices (alternating between breast feeding and infant formula milk) may jeopardise the child's health, but formula feeding may force HIV-disclosure and precipitate stigma for the child's mother.

³ Both Pellagon and Nan are commercial brands of infant formula milk.

Discussion: Engendering HIV Prevention, Testing and Treatment

Constructions of masculinity that promulgate men's strength vis-à-vis women's weakness make both men and women vulnerable to HIV infection and morbidity, thus challenging typologies that polarise heterosexual relationships and position women as victims and men as perpetrators. Scholars of gender and HIV argue for greater attention to be paid to men and women's different lived realities, however, most studies move to focus specifically on women, and gender is subsumed by one-sided analysis that foregrounds women's subjugation and men's domination (see Persson and Richards, 2008; Leclerc-Madlala, 2003; Schoepf, 2001). As stated above, women are disproportionately affected and infected by HIV in South Africa, and it is crucial to understand the range of social, behavioural and biological drivers that may fuel South Africa's national and local epidemics in order to stem HIV incidence and promote treatment. However, as the findings indicate and as argued below, one-sided approaches that focus on women fail to acknowledge the nuanced dynamics of both men and women's vulnerability and the multiple ways in which these dynamics drive local epidemics.

Constructions of masculinity that prescribe strength, socially and physically, in opposition to women's constructed vulnerability create two negative consequences for men and women's wellbeing. First, perceptions of invulnerability to HIV infection, and appropriation of cultural beliefs to characterise condoms as 'taboo' and 'flesh-on-flesh' sex as 'tradition', render men and women vulnerable to HIV (re)infection through unsafe sex. Men were blamed by the respondents for placing themselves and their partners at risk by insisting on unsafe sex. As stated above, this insistence emanates from discursive constructions of masculinity that construct men's strength in opposition to women's vulnerability to disease; this is reinforced through constructed traditions that proscribe safe-sex and label condoms as 'taboo'. Parallel to the findings of this study, Nattrass (2008) asserts that importance of understanding masculinities and sexual cultures in order to reduce risk for both men and women:

“[T]he flip side of the norms and practices that oppress women are those that define masculinity in ways that put both men and women at risk, such as the linkage of male identity with an unwillingness to negotiate sexual behavior with women, ‘skin-on-skin’ penetrative sex,

and multiple sexual partnering... Reaching out to men and boys to challenge these behaviors is thus also necessary.” (Nattrass, 2008: 20)

‘Sexual cultures’ like multiple sexual partnerships and, in the case of this paper, taboos that prohibit condoms use, are therefore powerful behavioural drivers of HIV infection at a local level and, importantly, they reinforce *both* men and women’s vulnerability to HIV (re)infection through unsafe sex (cf Epstein, 2007; Campbell, 1995).

In line with this paper’s call for a more nuanced understanding of gender dynamics that moves beyond finite dichotomies, Morrell (1998) asserts that masculinities are fluid and constantly shifting. Similarly, Connell argues that masculinities are “not fixed character types by configurations of practice generated in particular situations in a changing structure of relationships” (1994: 12). Similar to Connell (*ibid*) and Morrell’s (1998) assertions that masculinities are contested and dynamic, Epstein (2007) also reinforces the notion that gender identity and sexual cultures are fluid through her description of changes in sexual practices in Uganda and Tanzania. The contested nature of gender is also illustrated in the qualitative study on which this paper is based: the men in the FGDs and interviews chastised other men who, they claimed, subscribed to dominant notions of masculinity that proscribed safe sex and placed both men and women at risk of infection or re-infection. The research participants, therefore, indicate a critical awareness of gender dynamics through their reflections on other men and women’s sexual relationships in the interviews. This suggests scope for further research on men’s perceptions of gender inequalities and the potential for men to engage with women and gender activists in shifting sexual cultures that proscribe the acknowledgement of vulnerability and prescribe particular constructions of strength among men.

Studies in South Africa have recently started to broach the possibility of engaging men in promoting gender equality. For example, Skhosana, Struthers, Gray and McIntyre argue that,

“There remains a need to understand ‘what makes men tick’ in order to introduce programmes that will attract them and impact on their behaviour. To this end there remains a need to destabilise those destructive social constructions of masculinity which encourage reckless sexual behaviour and lack of cooperation with initiatives against the spread of HIV/AIDS.” (2005: 19).

Constructions of masculinities that may deter men from practicing safe sex and accessing health care resources, like VCT and ARVs, have negative

ramifications on women's sexual health. Findings from this study indicate that women's ability to negotiate safe sex by numerous factors, including fear of HIV-related stigma and withdrawal of financial and emotional support. This resonates with the dominant theoretical framework that foregrounds the impact of unequal gender relations on women's sexual health (Jewkes et al, 2003; Leclerc-Madlala, 2003; Schoepf, 2001; Strebel, 1997).

In line with Jewkes et al.'s criticism of simplistic categories that typecast women as victims, I concur that, "the often repeated statements that gender inequalities reduce women's ability to protect themselves against HIV are over reductionist." (2003:233). This study indicates that although women's ability to negotiate safe sex was limited, women still found dynamic ways to negotiate sex that did not necessarily entail condom use. In weighing up the risks and benefits of safe and unsafe sex, the female respondents described how they 'tested' potential sexual partners by encouraging them to test for HIV. If men and women both test for HIV, and are open about their status to each other, then the responsibility for ensuring safe sex falls on both partners within the relationship and does not only lie with women who already know their sero-status. This 'relationship test' shields women from the risks entailed in insisting on safe-sex use, and distributes the weight of responsibility for behaviour change and condom use across both partners in the sexual dyad.

Men and women's differential engagement with health care resources is a second important consequence of gendered constructions of masculinity that reify tradition, prescribe strength and proscribe safe-sex. Men's reluctance to test for HIV contrasts with the implicit responsibility placed on women who undergo an HIV test when accessing antenatal health care. 'Proxy testing' places responsibility on women for testing, disclosure and related behaviour change and removes accountability and responsibility from men. As such, 'proxy testing' is a passive action on the part of men to ascertain their status indirectly through the active role that women take to receive antenatal care, thus disrupting the simplistic dichotomies of passive victims and active perpetrators. Men may initially benefit from distancing themselves from the disease, refusing to test and stigmatising their partner when she discloses her status, but in the long term, men compromise their health: VCT facilitates entry in to treatment programs that enable long-term health. In a study of sero-discordant couples in Australia, Persson and Richards (2008) found a similar phenomenon, which they term 'proxy negativity'. Persson and Richards show that men's sense of heteronormative masculinity was destabilised when they tested HIV-positive given the prevailing association of HIV with sexual deviance and homosexuality in Australia. By having sex with an HIV-negative partner, the men were able to

construct and re-establish heteronormative dynamics through their partner's 'proxy negativity' (ibid).

This study resonates with Persson and Richards' (2008) findings in so much as men constructed part of their identity as HIV-positive or negative according to their partner's status. However, Persson and Richards' study also differs from the findings discussed in this paper given that the men they studied in Australia had actively tested for HIV, whereas this study suggests that some men in South Africa are reluctant to test for HIV and instead test by proxy through their sexual partner. A study on gender and VCT in Côte d'Ivoire similarly suggests that men are reluctant to test, and that most women test for HIV through antenatal care programs (Desgrees du Lou, 2005). These programs offered the male partners an opportunity to test with their pregnant partner, at no cost, in order to establish parity in knowledge within the sexual dyad. Only one in five men took up this opportunity; the rest of the male partners believed that their status would be the same as that of their spouse (ibid). Consequently, women who test HIV-negative have very little room to negotiate safe-sex with sexual partners who refuse to test and erroneously assume their status to be the same as their partner's status (ibid; Desclaux and Desgrees du Lou. 2006).

Although both women and men may be reluctant to test, women's reproductive responsibilities compel women to test whereas men's reproductive roles do not explicitly require this of them. I argue that the connection between women's preponderance and men's absence in clinics is more complex than the cause and effect model which states that men are reluctant to enter clinics because they are viewed as 'women's spaces' (see Richey, 2006; Beck, 2004). A circular dynamic may explain the vicious cycle that reinforces men's invisibility and women's visibility in clinics: men perceive women to be more vulnerable to HIV than they are. In turn, men take less action to protect themselves from HIV transmission through unsafe sex, and as described above, because women may struggle to negotiate condom use, like men, they are also vulnerable to HIV infection. Unlike men, however, women become pregnant through unsafe sex, and then move in to the health system to access antenatal care and AIDS treatment, thus making women more visible than men in clinics. This, in turn, perpetuates the gendered assumption that women are weak because they are seeking health care, confirming men's assumption of strength relative to women. The perception that men are absent from clinics because they are less susceptible to infection, reinforces the fallacy that men are strong and women are weak, and when men do become ill, the social construction of male virility prohibits men from acknowledging illness and accessing corresponding health resources.

The study's findings reflect a broader trend of fewer men accessing health care compared to women, with a range of contingent consequences for both men and women's health. As discussed above, Natrass (2008) finds that more women access health care than men, even when accounting for the fact that women are more vulnerable to HIV infection, and that they access antenatal and postnatal health services more readily than men. When controlling for these two factors, Natrass further illustrates that women are still accessing ARVs in significantly greater numbers than men in South Africa (ibid).

This national trend is iterated at local levels; for example, the following researchers note the relative absence of men compared to women accessing health services in a HIV/AIDS Wellness Clinic:

“It remains a puzzle why men are not taking a much more active role in accessing HIV/AIDS services. Our experience at the Perinatal HIV Research Unit is that far fewer men than women attend the HIV/AIDS-dedicated Wellness Clinic and take part in clinical trials.”
(Skhosana, Struthers, Gray and McIntyre, 2005: 23)

The findings above shed light on the puzzle of men's health seeking behaviour: constructions of gender that position men as strong and women as weak make it difficult for men to acknowledge vulnerability to disease, and consequently discourage men from seeking medical attention and accessing health resources like ARVs. In his study with a group of HIV-positive men living in Khayelitsha, Beck (2004) also found that expectations of masculinity that subordinate women are also oppressive to men; as men transition from being young boys in to mature adults, they are accorded more responsibility and it becomes difficult for them to be viewed as weak. Given the constructions of masculinities along clear lines of physical and social strength, illness was perceived by men as an indication of social and physical weakness (ibid).

Like Skhosana et al (2005), Beck (2004) also found that clinics were perceived as the 'realm of women' by men and that HIV was associated with weakness and therefore with women. The perception that clinics cater predominantly to women is supported by the gendered distribution of personnel within clinics: many more women than men work as receptionists, counsellors, nurses and doctors. Further, the visibility of women as clients within clinics also fostered the men's perception that clinics mainly catered for women's health needs. This does not indicate, however, that men are not seeking support. In place of HIV testing and accessing biomedical AIDS treatment, men may be drawing on alternative health care practitioners, including traditional healers (see Natrass, 2005a and 2005b; Beck, 2004).

Steinberg (2008) similarly suggests that illness and healing cannot simply be understood within a biomedical paradigm⁴; instead, he carefully outlines a complex set of factors, including the importance of social status and its corresponding risks, which may include witchcraft, along with the value placed on kinship and lineage (Ibid). In the context of South Africa's medical pluralism, individuals conceptualise health and illness in a range of ways, and thus health seeking behaviours engage with a range of health care practices. Regression analysis, using the Demographic and Health Survey, of the gendered nature of health seeking behaviour in South Africa posits that men may seek traditional healers more frequently than women (Nattrass, 2008). This was further borne out in data from a panel survey conducted in Khayelitsha with a sample of patients on ARVs and a corresponding control survey with a matched subsample among the general population in this area. Although these findings were not statistically significant, they point to a possible correlation between gender and perceptions of biomedical and traditional health services (ibid).

The 'victim/perpetrator' typology is not only empirically simplistic, but it also erroneously shapes the way that policy makers and researchers develop, implement and monitor health interventions. The dichotomy draws attention to women's vulnerability, and the corresponding approach is therefore to empower women to negotiate safe-sex and access appropriate health resources like PMTCT and ARVs. By positioning men as perpetrators, researchers and policy makers fail to develop interventions that address men's vulnerability to HIV infection and their reluctance to test for HIV and commence ARVs; interventions that support men in practicing safe sex, testing for HIV and accessing ARVs are therefore of critical importance for enhancing both men and women's health⁵.

The 'victim/perpetrator' dichotomy also generates an oppositional response from gender activists who insist on resisting and changing hegemonic and oppressive masculinities as a means to achieving gender equality. While this is an important approach, we suggest that there is also value in working with, and not only against, constructed masculinities to support men's health. As argued

⁴ Steinberg's ethnographic account challenges the *Medicines Sans Frontiers* biomedical assertion that provision of good medicine and corresponding health information will encourage people to access biomedical health resources, including voluntary counselling and testing, and antiretroviral treatment.

⁵ Organisations like Sonke Gender Justice (<http://www.genderjustice.org.za/>) and Engender Health are pioneering new interventions in South Africa that reconfigure oppressive gender dynamics which have negative ramifications on both men and women's health. Further, men-only clinics have been set up in Khayelitsha in order to encourage more men to access health services.

elsewhere (see Mills, 2005 and 2008), the way in which individuals understand illness informs the methods they draw on to establish wellbeing. The biomedical construction of illness is individual-centred, and highlights the potency of the virus and the weakness of the body to withstand infection. Constructions of masculinities that foreground strength and vilify weakness may deter men from acknowledging individual vulnerability to infection within a biomedical paradigm. Conversely, traditional healing allows for a range of illness aetiologies that externalise the locus of illness on to social malevolence; illness is located in the social or metaphysical realm, through witchcraft accusations for example, which dislocates and externalises disease from the individual body. In turn, this healing cosmology may also remove accountability and attendant blame from the individual and mask individual vulnerability under the premise of social dysfunction (see Wreford, 2005 and 2008; Mills, 2006; Kleinman, 1988). Masculinities that celebrate and construct strength in opposition to vulnerability to illness could potentially integrate traditional healing cosmologies with biomedical health care; the former allows men to externalise illness whereas the latter locates illness, and hence vulnerability and responsibility, on the individual. An integrated healing paradigm, therefore, may offer a positive and viable alternative for providing care to men in the ‘treatment gap’ between initial HIV diagnosis and AIDS-illness. While addressing social malevolence and supporting men’s social, spiritual and physical wellbeing, traditional healers can also work with biomedical practitioners to encourage VCT and prompt commencement on ARVs when men become AIDS-sick (cf Wreford, 2005 and 2008).

‘Archetypal’ male characteristics and beliefs, as described by Beck (2004), include denial of HIV or of their HIV-status, and a stubbornness to seek help. These characteristics parallel findings in this paper: men insisted they were invulnerable to HIV infection compared to women, which placed both men and women at greater risk of infection through unprotected sex; “[w]hat emerges is a picture of a ... man that is both bound by expectations of responsibility, and raised on beliefs that resist help-seeking.” (Beck, 2004: 11). Uncritical assumptions that men are driven by ‘traditions’ which encourage unsafe sex problematically assign agency and blame to men and position women as passive victims of men’s unbridled and nonnegotiable passions. In this paper we demonstrate that both men and women are negatively constrained by hegemonic constructions of masculinity. Further, gendered constructions that foreground men’s strength compared to women’s weakness may not only negatively affect men’s health, but they may also have a corresponding and positive effect on women’s health; unlike men, it may be more socially acceptable for women to access care through clinics. Men may trade-off their physical health for social

and emotional wellbeing in order to conform to socio-cultural expectations of men that proscribe safe-sex and valorise physical strength. Conversely, women may trade-off their physical health in order to avoid stigma or rejection following insistence on safe sex or disclosure in order to secure their emotional and financial wellbeing within their sexual relationship. Thus, men and women may risk HIV (re)infection because they fear losing social standing or their emotional and financial support respectively.

A further important finding from this study relates to the gendered dynamics of stigma: men and women expressed different fears and experiences of HIV-related stigma within sexual and social relationships. The women noted difficulty in disclosing their status to their sexual partners because they feared that they would be blamed for bringing HIV in to the relationship. Not only did fear and experience of stigma differ for men and women, stigma also had different and significant consequences on men and women's health and general wellbeing: women noted experiences of serious emotional and financial disruption following disclosure to male partners who blamed women for 'bringing HIV in to their home'. Men were less concerned about stigma within sexual relationships compared to stigma, in the form of gossip, within their social community. Research on HIV, stigma and disclosure suggest that disclosure decisions balance the need for social support necessary for coping with HIV (like adherence to ARVs for example) with the potential loss of generally supportive relationships (Almeleh, 2006; Kalichman, DiMarco, Austin, Luke and DiFonzo, 2003). Further, studies on the gendered dynamics of disclosure and secrecy indicate that, on the whole, HIV-positive people prefer disclosing to female relatives and friends, and that women are less willing to disclose to their partners compared to men (Norman, Chopra and Kadiyala, 2005; Kalichman et al, 2003).

In contrast to research on HIV, stigma and disclosure in South Africa, the findings of this study indicate that decisions to disclose are not predominantly based on the desire to access support (see Almeleh, 2006), but that fear of stigma for both men and women was a significant determinant in the respondents decision not to disclose their status. Consequently, fear of disclosure undermined safe-sex, adherence to ARVs, and contributed to mixed infant feeding practices which also placed children at risk of vertical transmission. The negative ramifications of disclosure, on the other hand, include stigma and withdrawal of financial and emotional support. The risks and benefits of disclosure versus secrecy were weighed up differently by men and women, with different ramifications on the matrix of wellbeing for men, women and children. This finding highlights the value of further social research on the

subtle manifestations of stigma within sexual relationships and the value of reconfiguring simplistic dichotomies to support the nuanced and relational implications of gender on both men and women's health and wellbeing.

Conclusion

Gendered dichotomies that align illness with weakness and women, and invulnerability to illness with strength and men are useful in understanding some of the social dynamics that may drive men's reluctance to practice safe sex, test for HIV, and receive treatment compared to women. However, these dichotomies also reinforce the victim/perpetrator model that implicitly places blame on men, and fails to acknowledge account for the range of ways in which men and women negotiate structural and social constraints as they navigate their physical, economic and emotional wellbeing.

Three key conclusions and corresponding recommendations emerge from this study. First, constructions of tradition and masculinity undermine HIV prevention. Before chastising men as the problem, we need to assess the role that sexual cultures serve within various socio-economic contexts, including unprotected sex, sexual concurrency and transactional sex. Only after we have an understanding of the nature of these practices will it be possible to develop interventions that will negotiate and reconstitute them to support both men and women's health. Second, health care is gendered. Biomedical health services that cater for women's reproductive health may implicitly place the responsibility for knowing one's HIV-status on women. Although active participation in clinics may enhance women's physical health, it may also undermine their wellbeing by placing the responsibility of knowledge, and the onus for instituting behaviour change through disclosure, on women that in turn may make women vulnerable to HIV-related stigma within sexual and social relationships. Further, men's sense of invulnerability to HIV infection and their perception of clinics as 'women's spaces' may reinforce men's reluctance to test and delayed access to ARVs, which in turn, undermines men's health. As such, traditional healers may play a valuable role in supporting men's wellbeing, and they may also facilitate men's entry in to clinics through collaborative engagement with medical practitioners. Third, disclosure has significant and different consequences for men and women. Disclosure decisions are shaped by perceptions of support and stigma within sexual and social relationships, and are carefully managed to mitigate the risk of stigma and to facilitate positive health behaviours (including treatment adherence, safe-sex and PMTCT). These differential experiences and fears of stigma have significant consequences on the

health and well-being of both partners within heterosexual relationships, as well as their children.

In order to address the feminisation of the HIV epidemic we need to disrupt reified dichotomies that place women and men in respective categories of victim/perpetrator, passive/active, weak/strong, deserving of sympathy/blame. This paper argues that it is fundamentally erroneous to construct HIV prevention and treatment interventions that focus on women as the solution and men as the problem. Beyond failing to address the relational nature of gender, these interventions create further damage by reinforcing unconstructive dichotomies and alienating men from constructive engagement with women to ensure gender equality as a means to achieving wellbeing within the matrix of social, emotional, financial and physical health. In demonstrating the various points at which gender intersects with HIV prevention, testing and treatment, this paper calls for renewed attention to the myriad ways in which men and women's wellbeing are inextricably connected, thus pointing to the value of engendering an integrated response to the feminisation of HIV in South Africa.

References

- Almeleh, C. 2006. Why do People Disclose their HIV Status? Qualitative Evidence from a Group of Activist Women in Khayelitsha. *Centre for Social Science Research Working Paper 163*. University of Cape Town: Cape Town.
- Beck, D. 2004. Men and ARVs: How does being a man affect access to antiretroviral therapy in South Africa? An investigation among Xhosa-speaking men in Khayelitsha. *Centre for Social Science Research Working Paper 178*. University of Cape Town: Cape Town.
- Budlender, D. 1999. *The Fourth Women's Budget*. Idasa: Cape Town.
- Campbell. 1995. Male Gender Roles and Sexuality: Implications for Women's AIDS Risk and Prevention. *Social Science and Medicine* 41(2): 197–210.
- Cock, J. 1980. *Maids and Madams: a study in the politics of exploitation*. Ravan Press: Johannesburg.
- Connell, R. 1994 *Masculinities*. Polity: Cambridge.
- Desclaux, A. and Desgrées du Lou, A. 2006. African women faced with the AIDS epidemic. *Population and Societies*.
- Desgrées du Loû, A. 2005. The couple and HIV/AIDS in sub-Saharan Africa: telling the partner, sexual activity and childbearing. *Population-E*, 60(3): 179-198
- di Leonardo, M. 1991. Introduction: Gender, Culture, and Political Economy: Feminist Anthropology in Historical Perspective. *Gender at the Crossroads of Knowledge: Feminist Anthropology in the Post-Modern Era*. di Leonardo, M. (ed). Pp 1-48. University of California Press: Berkley.
- Dowsett, G. 2003. Some Considerations on sexuality and gender in the context of AIDS. *Reproductive Health Matters* 11(22): 21 – 29.
- Epstein, H. 2007. *Invisible Cure: Africa, the West and the Fight Against AIDS*. Farrar, Straus & Giroux: United States of America.
- Farmer, P. 2004. *Pathology of Power: Health, Human Rights, and the New War on the Poor*. University of California Press: Berkley.

- Jewkes, R. Levin, J. and Penn-Kekana, L. 2003. Gender inequalities, intimate partner violence and HIV preventative practices: findings of a South African cross-sectional study. *Social Science and Medicine* 56 (1): 125-134.
- Hunter, M. 2005. Cultural Politics and Masculinities: Multiple-partners in Historical Perspective in KwaZulu-Natal. *Culture, Health and Sexuality* 7(4): 389–403.
- Kalichman, S. DiMarco, M. Austin, J. Luke, W. and DiFonzo, K. 2003. Stress, Social Support, and HIV-Status Disclosure to Family and Friends Among HIV-Positive Men and Women. *Journal of Behavioral Medicine*, Vol. 26, No. 4, August 2003.
- Kleinman, A. 1988. *The illness Narratives*. Basic Books: The United States of America.
- Leclerc-Madlala, S. 2003. Transactional sex and the pursuit of modernity. *Social Dynamics*, 29(2): 213-233.
- Mah, T. 2008a. Concurrent sexual partnerships and HIV transmission in Khayelitsha, South Africa. *Centre for Social Science Research Working Paper* 225. University of Cape Town: Cape Town.
- Mah, T. 2008b. Concurrent Sexual Partnerships and HIV/AIDS among Youths in the Cape Metropolitan Area. *Centre for Social Science Research Working Paper* 226. University of Cape Town: Cape Town.
- Mills, E. 2004. Beyond the Disease of Discrimination: A Critical Analysis of HIV-Related Stigma in KTC, Cape Town. *Centre for Social Science Research Working Paper* 100. University of Cape Town: Cape Town.
- Mills, E. 2005. HIV Illness Meanings and Collaborative Healing Strategies. *Journal of Social Dynamics*. 31 (2): 126 – 160.
- Mills, E. 2006. From the Physical Self to the Social Body: Expression and Effect of HIV-Related Stigma in South Africa. *Journal of Community and Applied Social Psychology*. 16: 498 – 503.
- Mills, E. 2008. “Swimming in Confusion’: A Qualitative Study of Factors Affecting Uptake and Adherence to Antiretroviral Treatment in South Africa”. *CSSR Working Paper Series*. University of Cape Town: Cape Town

- Morrell, R. 1998. Of Boys and Men: Masculinity and Gender in Southern African Studies. *Journal of Southern African Studies* 24 (4): 605 – 630.
- Morrell, R. 2002. Men, Movements, and Gender Transformation in South Africa. *The Journal of Men's Studies*. 10 (2): 309 – 327.
- Natrass, N. 2005a. A Quest for Healing in South Africa's Age of AIDS. *Journal of Social Dynamics*. 31(2): 1 – 23.
- Natrass, N. 2005b. Who Consults Sangomas in Khayelitsha? An Exploratory Quantitative Analysis. *Journal of Social Dynamics*. 31(2): 161 – 182.
- Natrass, N. 2008. Gender and Access to Antiretroviral Treatment in South Africa. *Feminist Economics*. 14 (4): 19 – 36.
- Norman, A., Chopra, M., and Kadiyal, S. 2005. HIV Disclosure in South Africa: Enabling the Gateway to Effective Response. *Regional Network on HIV/AIDS, Rural Livelihoods and Food Security*. <http://www.ifpri.org/renewal/pdf/RENEWALSADisclosure.pdf>, accessed September 2008.
- O'Manique, C. 2004. *Neoliberalism and AIDS Crisis in Sub-Saharan Africa: Globalisation's Pandemic*. New York: Palgrave Macmillan.
- Peacock, D. 2003. Men as Partners: South African Men Respon to Violence Against Women and HIV/AIDS. *Journal of Social Work Perspectives*: 33 - 46
- Persson and Richards. 2009. Vulnerability, Gender and 'Proxy Negativity': Women in relationships with HIV-positive men in Australia. *Social Science and Medicine*. 67: 799 – 807.
- Ricardo, C. And Barker, G. 2005. Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict and Violence. *Social Development Papers*. Paper No. 26. June 2005.
- Richey, L. 2006. Gendering the Therapeutic Citizen. *Centre for Social Science Research Working Paper 100*. University of Cape Town: Cape Town.
- Sacks, K. 1989. Toward a Unified Theory of class, Race, and Gender. *American Ethnologist* 16 (3): 534-46.
- Schoepf, B. 2001. International AIDS Research in Anthropology: Taking a critical perspective on the crisis. *Annual Review of Anthropology* 30: 335-61

Shisana, O., Thomas R., Leickness S., Warren P., Khangelani Z., Arvin B., Cathy C., Sean J., Victoria P. 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Cape Town: Human Sciences Research Council Press.

Skhosana, N., Struthers, H. Gray, G. and McIntyre, J. 2005. HIV disclosure and other factors that impact on adherence to antiretroviral therapy: the case of Soweto, South Africa. *African Journal of AIDS Research* 5 (1): 17 – 25.

Steinberg, J. 2008. *The Three Letter Plague*. Cape Town: Jonathan Ball.

Strauss, A. and Corbin, J. 1998. *Techniques and Procedures for Developing Grounded Theory*. Sage Publications, Thousand Oaks London New Delhi.

Strebel, A. 1997. Putting Discourse Analysis to Work in AIDS Prevention. Chapter 8 in *Culture, Power and Difference: Discourse Analysis in South Africa*, Ann Levett et al (eds), Zed Books Ltd/University of Cape Town Press.

Stillwaggon, Eileen. 2006. *AIDS and the Ecology of Poverty*. Oxford: Oxford University Press.

Susser, I. 2009. *AIDS, Sex and Culture. Global Politics and Survival in Southern Africa*. Wiley-Blackwell: Chichester.

UNAIDS. 2006. *UNAIDS/WHO AIDS Epidemic Update for Sub-Saharan Africa*. UNAIDS: Geneva. <http://www.unaids.org>, accessed March 2008.

UNAIDS. 2008. *Report on the Global HIV/AIDS Epidemic*. 2008. Geneva, UNAIDS. <http://www.unaids.org>, accessed March 2008.

Walby, C., Kippax, S. And Crawford, J. 2003. Research Note: Heterosexual men and 'safe sex' practice. *Sociology of Health and Illness* 15 (2): 246 – 256.

Wreford, 2005. Missing Each Other: Problems and Potential for Collaborative Efforts between Biomedicine and Traditional Healers in South Africa in the Time of AIDS. *Social Dynamics* 31 (2): 55 – 89.

Wreford, 2008. Involving African Traditional Health Practitioners in HIV/AIDS Interventions [Scientific Letter]. *South African Medical Journal*. 98(5): 374.