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Masculinity, Money and Meaning: Engaging men as HIV community health workers for gender transformation

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Abstract

The HIV epidemic is gendered. Women and girls are more likely to contract HIV for biological and social reasons and men living with HIV are more likely to be lost to follow-up and die while on antiretroviral therapy (ART) than women. Caring is also gendered, with women shouldering the burden of HIV care-related work. This paper considers the potential of male-delivered community health work to improve men's HIV-related health outcomes and shift gendered norms that are related to caring. In doing so, it reviews current evidence on male-focused HIV and sexual and reproductive health (SRH) services, as well as on gender transformation and men in caring. The paper engages the experiences and perspectives of eight HIV community health workers and their clients from the Cape Town area. Findings suggest that meaningfully involving more men in HIV care work may be a means to interrupt damaging hegemonic masculine norms related to caring and health. Barriers to engaging men in this feminized profession are also explored.

Introduction

The HIV epidemic is gendered. Women are more likely to contract HIV for biological and social reasons, and men are less likely to be tested for HIV and more likely to die on ART and be lost to follow-up (Johnson 2012; Cornell et al. 2011; Cornell et al. 2010; Nattrass 2008). Care work is also gendered: the majority of community health workers are women.

This paper considers the potential that community health workers have to support men's improved health outcomes, while also contributing to the formation of healthier and more gender-equitable masculine norms. This is relevant in the context of men's poor HIV-related health outcomes, and limited engagement in their receipt and provision of care. This paper presents findings of a qualitative study conducted in 2013 and 2014 in the Western Cape Province of South Africa. It explores the attitudes and experiences of male community health workers (CHWs) who provide

HIV care and support to men, and situates them within the literature on men, caring, and gender transformation.

It is expected that a large number of CHWs will be hired as part of South Africa's National Health Insurance roll-out. The exact number is still to be seen, but South Africa's National Development Plan (2013) suggests that the country will require over 700,000 additional CHWs by 2030. Michel Sidebe, the Executive Director of UNAIDS, proposed, for example, that South Africa hire 200,000 CHWs by 2020 (Sidebe 2016). *Spotlight*, a publication that monitors South African health system responses to TB and HIV, recommended that hiring 60,0166 CHWs would be 'a good place to start' in order for the 36.1 million poorest South Africans to receive care at a client to CHW ratio of 1 to 600 (Spotlight 2015).

Recruiting, hiring, and training CHWs in these numbers, whether it is 60,000 or 700,000, will require careful planning and thought in order to meaningfully support improved health outcomes (Schneider & Nxumalo 2017; Lehmann & Sanders 2007; Pallas et al. 2013; Naimoli et al. 2014). This paper considers some of the gendered dynamics that will be important to consider in this undertaking and proposes that efforts should be made to actively engage men as CHWs in order to create a more equitable environment in South Africa's future health care sector.

Participants in this study articulated how they understood, experienced and performed the provision and receipt of HIV community healthcare delivered by men. Their narratives demonstrated qualities that they believe to be important in the delivery of community healthcare and what it means to be a man who receives and/or provides care work. This paper situates these perspectives and experiences within a review of the literature on men, caring, and gender transformation.

The paper begins by providing an overview of the literature on male HIV and SRH services, gender-concordant healthcare provider preferences, and gender transformation. It then positions the experiences and perspectives of male CHWs and male clients within this literature and considers how these perspectives frame caring in the context of their masculine identities. The paper concludes by drawing on participant experiences and evidence to explore barriers that prevent men from meaningfully engaging in care work.

Work-shadowing Lusanda and Sam

Lusanda is a CHW and Sam is her supervisor. I have met them twice before: once for an initial meeting and again for an in-depth joint interview.

Lusanda conducts adherence support home visits weekly with each of her clients and today I am shadowing her to observe. Sam sometimes accompanies her on such visits, especially when she visits men.

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

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

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

It is an energizing day meeting with clients who have benefitted from community health work. What we observe dove-tails with Lehmann and Sanders (2007) assertion that despite challenges, and with varying degrees of success, there is 'robust evidence that community health care workers can undertake actions that lead to improved health outcomes…'(Lehmann & Sanders 2007, p.v).

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

On our way back to the clinic, Lusanda tells me that she saw this client very recently. He was a young man, very ill and struggling to take his treatment.

She and Sam note that consoling families is a regular part of her job. Their work is challenging, with many clients facing insurmountable barriers to ART adherence.

I ask about the demographics of who is dying. Without hesitation, Lusanda replies '*men*'. Sam nods silently in agreement.

Background

An estimated 5.7 million people, or 17.9% of South Africa's adult population are living with HIV (UNAIDS 2014). Men are more likely to die of AIDS-related illness, as Lusanda and Sam observed. They are also less likely to adhere to ART, and to be retained in the HIV cascade of care (Johnson 2012; Cornell et al. 2011; Cornell et al. 2010; Nattrass 2008). Men's poor health outcomes are related to harmful hegemonic masculine norms, which require men to present themselves as strong, suppress emotion, and equate illness with emasculation (Colvin et al. 2010a; Jewkes et al. 2007; Sonke Gender Justice & MenEngage Africa 2015). As the above story demonstrates, these hegemonic masculine norms and their related health outcomes are damaging to men, families, and communities at large and thus warrant greater attention.

Like the HIV epidemic, the provision of care is also gendered (Meyer, S., V. Reddy, T. Meyiwa 2014). Caring has been constructed as unskilled work that women are naturally predisposed to (Hzenjak 2013), and this is likely why there are significantly more women working in HIV care work. In occupying feminized spaces such as community health work, men may find themselves in conflict with their social identities and devalued in their masculinities (Hzenjak 2013). For this reason, men working in care may be perceived as choosing de-professionalized, downgraded, and feminized work (Hzenjak 2013). This may explain why so few men work as CHWs in South Africa.

Community healthcare plays an invaluable role in service delivery within South Africa's health care system (Care Givers Action Network 2013), including the public sector HIV response. Under the proposed National Health Insurance system, community health work will be scaled up and formalized as a national government initiative (Matsoso & Fryatt 2013; South African National Department of Health 2015).

In 2014, Morrell and Jewkes called for more research to be undertaken on men involved in care work, suggesting that engaging men meaningfully in caring has the potential to shift gender norms, both for men in healthcare and the men they work with (Morrell & Jewkes 2014). This paper explores and affirms this assertion in the context of HIV care work and posits that men's involvement in HIV healthcare may

also shift health-related gender norms for improved HIV-related outcomes. The paper also aims to deepen understandings of the barriers to, and opportunities for, men's involvement in HIV care work. The research presented here adds the crucial voice of CHW perspectives and experiences to the conversation about the gendered dynamics of HIV care work. It draws on a small in-depth study of eight CHWs (six men, two women) to improve understandings of the experiences, practices, and potential of men in South African care work.

Previous results of this study demonstrate a common perception amongst CHWs that men prefer receiving gender-concordant[1] HIV care and that CHWs employ specific strategies of friendliness, non-confrontation, and directness to encourage men to be receptive to their care and support. This paper builds upon these findings by exploring the potential benefits and challenges that emerge by including more men in this work and considers the opportunities that male-delivered care work produces for gender transformation. This research is located within an analytical tradition that sees men's health-seeking behaviour as socially constructed and acknowledges that men's harmful performances of masculinity can and do change (Hearn 2001).

Methods

This qualitative study engaged multiple semi-structured interviews, work-shadowing, and observational home visits with CHWs (n=8, 6 male and two female) employed by a South African non-governmental organization[2] and their clients (n=3). Conducted in 2013 and 2014, the interviews took place in the Cape Town townships of Fisantekraal, Wallacedene, Kleinvlei and Mfuleni, where the participants live and work.

Interviews were semi-structured, focusing on participant conceptions of the provision and receipt of care. All community health worker interviews were

[1] Here 'gender-concordant' is taken to mean receiving care by someone who is of the 'same' gender. That is, clients who identify as male working with care workers that also identify as male.
[2] The CHW participants were employed by a South African not-for-profit organization that specializes in health and community systems and services strengthening. Some of their work included supporting the South African government in delivering primary health sector HIV/AIDS services. CHWs assist clients living with HIV/AIDS and tuberculosis by assessing treatment readiness, conducting psychosocial assessments; identifying barriers to adherence, providing pre-treatment initiation education and providing support services through planned home visits, clinic support and follow-ups.

conducted in English. Client interviews and home visits were conducted in English, isiXhosa and Afrikaans, with community health workers translating between client participants and the researcher when necessary.

In order to provide context and detail to this study, a community focus group of 20 participants was also conducted, as well as interviews with the head office staff of a South African HIV organization, and two male HIV researchers and activists.

Interviews were audio recorded with the consent of participants, then transcribed and manually coded by the researcher. From this coding, themes were identified, reviewed, and defined. Field notes captured observations and were used to contextualize and analyze themes. Given the problem-driven nature of the research, the themes that emerged most strongly from the data were used in the final analysis.

The primary ethical concern with this research was to ensure that it did not make participants more vulnerable, either as a result of the research process itself or any of its outcomes. In order to keep identities confidential, ages and work locations are not specified, and pseudonyms have been used. The author conceptualized this research and was responsible for primary data collection and analysis.

The recruitment process for male care workers for this study was simple because of the dynamics of men in community health care work. Despite having large teams of carers in many areas of the Western Cape province, there were only 6 male care workers and supervisors working at the organization, all of whom were interviewed. These men made up a small proportion of the organization's largely female workforce. This is perhaps unsurprising given the aforementioned gendered dynamics of masculinity and caring.

Literature Review

Male-focused HIV and SRH services

This study draws on a crucial body of literature which focuses on men's provision and receipt of HIV and SRH services. Pearson (2003) argues that if men are to be encouraged to access SRH services and treatment, it is important that health services are reflective and responsive to their needs. Similarly, the World Health Organization's *Global strategy for STI control and prevention* recommends 'male involvement, male motivation, and services for men'(World Health Organization

2007). The International Men and Gender Equality Survey (IMAGES) (Levtov et al. 2014) assessed men's gender equality related attitudes and practices in eight low and middle-income countries and demonstrated that health-sector approaches making SRH services more convenient and acceptable to men have been impactful in engaging men in health services (Levtov et al. 2014).

Studies have documented a strong preference on the part of South African men to go to men's only or male-friendly clinics, where they can be seen by male nurses and counsellors (Leichliter et al. 2011; Faull 2010). The rationale for male-friendly spaces includes the commonly held perception that public clinics are for women, have long waiting times, inconvenient hours, and lack confidentiality, which deter men from visiting (Faull 2010; Leichliter et al. 2011; Orner et al. 2008). In addition, male clients have complained of poor treatment by clinic staff, including rude and judgmental female nurses[3] (Faull 2010; Colvin et al. 2010a; Levack 2005; Leichliter et al. 2011). The findings of this study suggest that many men may prefer a gender concordant CHW for reasons of similarity of experience, comfort, and in some cases, perceptions of women as untrustworthy gossips (Gittings 2017).

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

Responding to men's preferences for gender concordant care workers – best practice or bad idea?

As has been shown, many men may prefer to receive HIV and SRH care services from other men. In considering how to best support men living with HIV through gender-concordant HIV community healthcare, there are several separate but

[3] This is not to say that clinics are 'women friendly' either. Women are commonly subject to unfriendly and oppressive treatment in clinics but may not have the option of choosing not to access services due to the necessity of maternal and childcare (Wood and Jewkes 2006; Hodes 2016; Bradford 1991; Dickson et al. 2003).

interrelated factors to be taken into consideration. There is (1) the practical matter of supporting male clients for improved health outcomes; (2) the complex power and gender dynamics implicit in encouraging male participation in paid HIV community health work; and (3) the potential for gender transformation through the non-traditional brokering of relationships between men and the enactment of more caring masculinities.

An example to illustrate these considerations is that of male clients refusing to work with female CHWs, which CHWs in this study described as a common occurrence. Such refusals, and their relation to the discomfort and assertion of male power, have also been documented by Vale (2012) and Mfecane (2012).

Given that a care worker's primary function is to provide ART adherence support, it could be argued that the care work organization should make efforts to provide the client with a male CHW. This logic could be applied to other client requests such as afternoon visits - if operationally possible, the organization would meet the client's needs in order to provide the most amenable care services.

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

Both of the above interpretations of a male client's refusal to work with female CHWs are plausible, but they remain overly simplistic. Findings from other aspects of this study found that many male clients prefer male CHWs for a variety of reasons, and their motivations for doing so range from embarrassment to feelings more closely related to expressions of male power. A pertinent question, then, is whether it is possible for male CHWs to support male clients' health-affirming behaviour, while simultaneously promoting more gender equitable masculinities.

Men, caring and gender transformation

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

A growing body of research has shown that efforts to engage men via well-designed health and social services have proven that men and boys can and do change their beliefs and behaviours (Levtov et al. 2014).

Specific to caregiving, Shefer (2014) argues that men's engagement in care may be a 'key strategy' for challenging the social devaluation of care practice. This engagement can also contribute to the larger project of shifting harmful gendered norms by challenging gender inequality (Shefer 2014). Similarly, Hzenjak (2013) suggests that including men in care work can foster more caring, gender equitable socializations, while desegregating the labour market and altering traditional masculinities.

Morrell and Jewkes (2014) also promote encouraging and supporting men to undertake care work because of its ability to shift gender norms and constructions of masculinity. They argue that this is specifically relevant in South Africa for two reasons: (1) there is a need for more carers who can support the large numbers of sick and disabled people as a result of high rates of HIV infection, violence, and injury and; (2) that South Africa has a policy environment conducive to gender equality but still has high levels of gender inequality and violence (Morrell & Jewkes 2014, p.326). This provides space for 'kinder, gentler, masculinities' to be constructed through the entrance of men into care work (Morrell & Jewkes 2014, p.326). Hzenjak (2013, 359) found his male participant experiences of caring to 'loosen men's identity formations within the limits of hegemonic masculinity and leave them greater opportunity for alternative ways of being male.'

In her study on how 'tradition' is re-invited, Sideris (2004) posits that it is through practice that new ways of relating with others are produced. In accordance with the above studies, she finds that social support is fundamental to developing alternative masculine practices and shifting power dynamics. Similarly, the IMAGES study

findings suggest that it is necessary to create lived experiences of gender equality through structural and policy approaches, as well as to take programmatic approaches that change attitudes (Levtov et al. 2014). Thus, engaging male clients with male care workers who demonstrate alternative, more caring masculinities provides an entry point into the modelling of more gender equitable practice and better health-seeking behaviour. Likewise, involving and supporting men as CHWs within a gender transformative agenda can provide the means through which to create lived gender transformative experiences in both health-seeking behaviour and through caring.

The next section situates the above evidence in the context of HIV care work by exploring observations, experiences, and perspectives of HIV male community health workers, their male clients, and key informants.

Findings and discussion

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

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

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

> 'I'm one beneficiary of a peer education model. As peers, and as men, we are able now to talk to our peers, change their perceptions, change their beliefs. you understand? But we need other men to stand up and start the journey. You understand? Then other men will draw from and

be inspired by that.' (Sihle, Male, Masculinities NGO founder and activist)

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

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

The article argues that far more work is required in South Africa to shift both men and women's perceptions of the value of gender justice for boys and men, and in facilitating a more authentic investment for boys and men in their own and social change.

In her reflections on the findings of the IMAGES survey, Shefer (2014) argues that more work is needed to shift perceptions about the importance of gender work for men and boys in South Africa. She recommends that gender work should refocus away from problematizing men and forefronting the negative aspects of hegemonic masculinity (Shefer 2014). Rather, she argues for focus to be placed on the ways in which men are already practicing more gender-equitable masculinities, resisting harmful gender norms, and strategically engaging with and acknowledging equitable and constructive practices, such as taking part in feminized labour.

Like Shefer (2014), Lebo, a young male community health worker, believes in the importance of showcasing gender equitable men, who are positively involved in their communities:

'In the communities, there is the role models, there is the guys that are doing good, but nobody's talking about them. Which is the other

problem I have… with the media and whatever. Because sometimes they focus on the negative and they don't focus on the positive. Most of young boys… the people that they talk about and they look up to are those people that are doing wrong things. And they end up following them because they are the only people that they have been exposed in the communities… it's like when they talk about a guy who's selling drugs, that guy will be having a nice car, having a nice house and stuff. But they will never talk about the guy who doesn't have all that stuff but who is living a very good life in the community, who's doing good perhaps in trying to help other people… Because you can't just get a youngster to change to good if there is nothing that inspires him or motivates him to go into good. You need to show him good so he can go into good and if you show him bad, he will look for good in bad.' (Lebo, Male, CHW)

That some men chose to enter into caring out of a spiritual, religious or political conviction (Morrell & Jewkes 2014) was also evident in this study. The following excerpts from conversations with William, MJ and Sihle are demonstrative, as tnye highlight how they focused on supporting the wellbeing of individuals and the communities in which they live:

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

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

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

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

These findings align with a literature that documents how taking responsibility for the welfare of others is a highly valued characteristic in certain hegemonic masculinities (Davies & Eagle 2010). Colvin et al. (2010) found that Khuleka, a men's Gugulethu-based support group interpreted 'responsibilized citizen' messages as caring for themselves and the social through active membership in their families, communities, and social movements.

Men in occupations that have been constructed as female may maintain their hegemonic identity and values (Williams 1995). Men in paid care work tend to distance themselves from the nurturing and feminine aspects of care, emphasizing instead the 'masculine qualities of caring' (Hanlon 2012). Hzenjak's (2013) findings on male care workers in Slovenia confirm this – in her study, participants did not define themselves differently from hegemonic masculine norms, although they did develop and negotiate ways to perform their caring through a masculine lens. Likewise, in Davies and Eagle's (2010) study of young South African male volunteer counsellors, participants construed their identities as CHWs as proactive and dynamic in relation to their work. These findings were similar to this study, where participants emphasized the importance of their work and the impact that it makes in their communities.

The findings presented in this paper draw parallels with Nguyen's (2005) work on therapeutic citizenship and Robins' research on (2008) health citizenship. Their work highlights the ways in which people living with HIV negotiate multiple moral economies and perform HIV-related health behaviours (namely exemplary adherence to ART). There are notable similarities between the way that participants in this study negotiate caring and health as a man through drawing on valued hegemonic masculine characteristics.

Interpretations of care, conviction and duty

The findings presented above demonstrate the impact of the receipt and provision of care work on study participants. They also explore the meaning of the delivery of care work on some participants' lives, and how they relate the act of caring to their masculine identities.

However, different interpretations of care by the study participants could be observed in their level of engagement with clients during, and outside of, home visits. It was clear that some male CHWs spent a significant amount of time engaging with clients' emotional and material needs, such as helping with grant applications or listening and providing advice. By contrast, others counted pills quickly and left.

The male participants who demonstrated a deep emotional investment in their work (the more actively engaged participants discussed above), were also very involved in caring outside of their jobs. For example, before and after interviews, William spoke effusively about his volunteerism, which includes public speaking about HIV and participating in local politics. When Lebo and I saw each other for the first time in three years, he updated me on the important developments in his life by showing me pictures of his two-year old daughter and the youth club he started in his community. Lebo also spoke about his strong belief in the importance of his work, and demonstrated a commitment to modelling alternative ways of being a man:

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

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

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

A model entitled *Building Male Involvement in Sexual and Reproductive Health Rights* was developed by Sonke Gender Justice with an aim to achieve gender equality through including men in SRH. This model acknowledges that men might be involved in health seeking and caring in different ways, and suggests that ‘the ideal’ ways through which gender transformation can be achieved are for men to be involved in health care as clients, equal partners, and agents of change (Sonke Gender Justice 2012). In this model, the involvement of men in health promotion and service delivery is considered fundamental to achieving better health outcomes. Thus, engaging men as CHWs could be interpreted as men’s involvement in the sector as agents of change. However, without such involvement in other areas of their lives, this might not create an ideal environment for gender transformation.

Being involved in paid care work creates opportunities for men to experience the provision of care, and in doing so, may challenge the social devaluation of care work (Shefer 2014). That being said, as stated by Williams (1995), men’s working in feminized jobs ‘does not by itself necessarily mean actual transformation of the existing gender regime’. As per Ratele (2014), gender equality may exist in the abstract and not result in changes in practice. For this reason, it is not enough just to call for more male CHWs. As outlined above, a commitment to involving more men in caring and actually creating gender transformative experiences through the inclusion of men in caring are two very different things. Men’s commitment to gender equality requires that carers demonstrate an emotional and/or political commitment, rather than interpreting care solely as a functional activity (Morrell & Jewkes 2011). Such commitment signals that this kind of care moves beyond an abstract support for gender transformation into actualized practice.

As Reihling (2013: 104) points out, the ‘work does not stop with becoming a health and human rights activist or a sudden transformation into a “gender equitable” individual’. Gender equality efforts must address the factors and circumstances that contribute to rigid and harmful gender norms and the role that men play in challenging and perpetuating them (Levtov et al. 2014: 495).Participants also spoke about challenges faced in recruiting and retaining men as CHWs, related to pay and community perceptions of their work. The next sections explores these challenges

and reviews how they relate to the current literature on barriers to involving men in care work.

Barriers to men in care work: money and manliness

Despite the potential of engaging more men in HIV care work, there are significant barriers to attracting and retaining men as CHWs. The very few male CHWs employed by the organization with which this research was conducted are reflective of the feminized nature of care work. Women shoulder the burden of care, with 70% of AIDs-related care in South Africa being done by women (Steinberg et al. 2002). Hegemonic norms of masculinity serve to construct certain jobs as 'feminine' and therefore lower in status or value than 'masculine' occupations. These jobs are typically relatively poorly paid, as can be seen with care work. The 'unmanly' nature of care work can therefore deter men from being involved in caring (Morrell & Jewkes 2014). This may explain the paucity of male care workers in South Africa.

Social relations of work represent how much gender is performed, including how masculinity is constructed and how identities are formed. Given that caring has been constructed as unskilled work that women are naturally predisposed to, in occupying the feminized space of community health work, men may find themselves devalued in their masculine identities (Hzenjak 2013). Thus, men working as community health workers may be perceived as choosing de-professionalized, downgraded, and feminized work (Hzenjak 2013).

Paid work is considered to be a source of men's identity and can signify power and status. Local research on male care workers such as that of Shefer (2014), Davies and Eagle (2010), as well as Morrell and Jewkes (2014), highlights stigma and the social questioning of masculine identities as barriers to involving men in care. Findings in this study agreed with these factors.

The importance of a man's ability to be an independent provider is linked closely to what it means to be a man in South Africa (Richter & Morrell 2006). A conversation between two care workers Lusanda (female) and Sam (male) highlighted the challenges this poses for recruiting male CHWs:

> Lusanda: 'They're (men) not applying. I think because the community work doesn't pay much. When you're a man, you don't have power when you work in the community.' (Lusanda, Female, CHW)

> Sam: ‘But that doesn’t make sense because most of them they are there, now at home, they do nothing.’ (Sam, Male, CHW)

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

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

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

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

Despite the poor pay, the above participant still viewed his work as important. This was also seen in other participants, who believed their jobs to hold social significance and value in their neighbourhoods. Lebo, for example, described CHWs as:

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

Thus, we see a tension between male CHW perspectives on the importance of their work, social status, and poor pay. As Morrell and Jewkes suggest (2014: 340), changes are required to encourage men’s entry into care work, in particular with regards to the constructions of male identity and what is accepted as ‘men’s work’. Men must be able to feel ‘manly’ or at least uncompromised by working in care (Morrell & Jewkes 2014). Despite these barriers, there may be a unique and

important role that male CHWs can play in the lives of HIV positive men in their communities.

Conclusion

This paper reviewed the literature on masculinity, HIV and community healthcare and considered the perceptions and experiences of male CHWs and their clients. It explored the impact of such care in men's lives, different interpretations of duty associated with care work, and the potential of community health work to be gender transformative. It suggested that involving men in HIV community health work may not only support improved ART-related outcomes for men living with HIV but contribute to the broader gender transformation agenda in South Africa. For these objectives to be achieved, it will be crucial to ensure that women's contributions to care work are not side-lined.

By building on previous work that demonstrates that men might prefer receiving HIV and SRH services from other men, this paper made the claim that meaningfully involving more men in care work may be a way to interrupt damaging hegemonic masculine norms related to caring and health. Given the pending roll-out of the National Health Insurance in South Africa, the issue of engaging more men as CHWs is not only timely but also a crucial opportunity for improving men's HIV-related health outcomes.

Study findings agree with Morrell & Jewkes' (2014) assertion that political, emotional or spiritual commitment to care work is required to transform gender norms and encourage healthier, more equitable masculinities. Thus, efforts to hire and sensitize men who men who are committed to healthier, more gender equitable masculinities are important.

Barriers to recruiting men as community health workers include the perception of caring as downgraded, unprofessional and feminized work; a further contributing factor concerns poor pay. However, even if these barriers are overcome, involving more men in care work is not an easy or 'silver-bullet' solution. Efforts to involve men as carers with a goal of gender transformation requires more than simply employing more men in care work. Despite these challenges, the care workers and clients involved in this study point to the possibility of meaningful male engagement in community healthcare.

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