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Community care worker approaches to working with HIV-positive male clients in Cape Town, South Africa

Lesley Gittings

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About the author:

Lesley Gittings is a doctoral student at the University of Cape Town. This working paper is based on her Masters dissertation which explored the role of community care workers in supporting men's HIV and STI health-affirming behaviour in the Cape Town area.

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Abstract

Caring is typically constructed as a feminized practice, resulting in women shouldering the burden of care-related work. Health-seeking behaviours are also constructed as feminine and men have poorer health outcomes globally. Employing men as carers may not only improve the health of the men they assist but also be transformative with regard to gendered constructions of caring. This working paper adds to the small but growing literature on men in caring by focusing on men as community care workers (CCWs) and their male clients.

The empirical analysis draws on the perspectives of eight CCWs and three of their male clients from the Cape Town area. Using semi-structured interviews and observational home visits, this study explores the strategies that community care workers (CCWs) employ in providing support to HIV-positive male clients. In trying to avoid interrupting clients' performance of hegemonic masculine norms, CCWs used techniques such as indirectly broaching sensitive subjects, acting friendly and being clear about the intention of their work.

Introduction

Given that the world is structured by patriarchy, the system of male domination and power (Bradshaw, 1994), the idea that men are also harmed by this system might on the face of it seem incongruous. Despite ensuring that men generally have more power, opportunities and privileges than women, patriarchy can also be understood as a system which is damaging to both men and women, albeit to varying degrees and in different ways (Hooks, 2004). This is evident with regard to health, where norms of masculinity make it harder for men than women to access necessary care because it is seen as a sign of weakness and femininity. In the case of the HIV/AIDS[1] epidemic, the problem is compounded by men

[1] HIV is the human immunodeficiency virus. AIDS is the acquired immunodeficiency syndrome, i.e. the set of illnesses associated with longer term HIV infection.

regarding clinics as female spaces, and by their reluctance to confront and manage the sexually transmitted dimensions of the disease.

This paper explores CCW perspectives on male clients as well as the techniques that they employ to support them. CCWs strive to develop supportive relationships with clients where they can speak openly about issues affecting their health. These relationships are complex and frequently challenging, as intricate power and gender dynamics are negotiated. Through employing techniques such as indirectness, friendliness and being clear about the intention of their work, CCWs try not to challenge hegemonic masculine norms while providing support. Male CCWs oscillate between hegemonic and alternative masculine norms as they navigate their own masculine identities while striving to perform their jobs as effectively as possible.

An estimated 5.7 million South Africans are living with HIV and 17.9% of the adult population is infected (UNAIDS, 2012). In 2012, an estimated 240,000 people died of AIDS-related illnesses. Understandably, the focus of HIV/AIDS resources, programming and research has been placed on women and girls (Sonke Gender Justice, 2013). Men's health-seeking behaviour is a related but distinct issue. Men's poorer health outcomes are damaging to men, families and communities at large and warrant greater attention. It is for this reason that it is also important to consider masculinities and health-seeking behaviour.

Community care is an important aspect of South Africa's health care system, playing an invaluable role in service delivery (Care Givers Action Network, 2013). CCWs are envisaged as continuing to play a central role in delivering primary health care under the proposed National Health Insurance system (Matsoso & Fryatt, 2013; Department of Health, 2011), marking both an acknowledgement and formalization of this important work.

This research draws on the current literature on men, caring and gender transformation to inform the analysis of participant perspectives and experiences. It responds to, and reiterates the call for research to examine the ways in which men are currently involved in care work (Morrell & Jewkes, 2014). It also highlights the importance of further considering ways that men living with HIV can be supported in seeking better health.

The rationale for focusing on male CCWs in this study is two-fold. First, there is a scarcity of literature on men in care work (Morrell & Jewkes, 2014). Second, interviewing men who care for other men is a lens for exploring male CCW perspectives, the male client-CCW relationship and providing insight into male client challenges and preferences.

This research is located within an analytical tradition that sees men's health-seeking behaviour as socially constructed and acknowledges that men can and do change (Hearn, 2001). It is also situated within a gender transformative agenda and aims to deepen understanding about how CCWs and male clients negotiate relationships that are supportive of men's health. Further, it considers what these understandings might lend to the broader context of men receiving and providing care.

Health-seeking behaviour and masculinities

I meet William for the first time on the street outside of a township hospital.

He smiles broadly and shakes my hand. I thank him for agreeing to be part of the research. He is the only male KI CCW in the area and one of five male CCWs in the whole Western Cape region. KI is not unique in the gendered contingent of their CCWs. Indeed, women tend to dominate care professions and are often seen as more 'natural' carers (Morrell & Jewkes, 2011). This is despite research showing that some men feel uncomfortable "being seen by female health workers about intimate concerns" (Faull, 2010: 22). It is for this reason that William is often assigned to work with male clients.

William and I talk about our weekends while we drive to the interview site. He tells me that he injured his shoulder and ankle when he tripped over a curb, which explains why he is wearing a sling and walking with a limp. The sling is composed of a piece of cloth tied around his neck and another around his wrist, with a third attaching the two together in order to support his arm. It is clear that his sling is home made. I ask him if he knows the nature of the injury. He replies that he is not sure because he hasn't gone to the clinic, which seems peculiar because he often works at a clinic and I've just picked him up from the day hospital.

We arrive at the site and sit down for the interview. William is open and expressive, sharing his personal experiences and perspectives on a variety of topics from politics to care work to masculinities and HIV.

I ask him if he notices a difference between how his male and female clients seek health. He responds that men (would) "rather do their home remedies and all their stuff then go to the doctor or clinic for some help. Or they will never (seek medical help) unless it's that urgent."

He then explains that there is stigma around weakness that prevents men from going to the clinic. This explanation echoes some of the key claims in social

science literature on masculine gender norms, in which illness is equated with weakness and weakness with emasculation (Medical Research Council, 2007; Colvin, 2010; Sonke Gender Justice, 2013).

William illustrates the serious nature of this issue through telling me about how his father died after not visiting the doctor until it was too late:

> '… I spoke to him "Papa wouldn't you rather go to the doctor?" and he said to me "what?! I'm not going to the doctor… only sissies (Cowards) go to the doctor… I'd rather see that I get helped myself… because a clinic or a day hospital is only for the sissies. I'll take my herbs and all that stuff"… the Sunday he passed away… He would rather wake up, get ready and go to work while he's sick, but he would never go to the doctor…'

At the end of the interview the conversation comes back around to William's injuries. I say, "Can I ask you a personal question?... Your arm – you haven't gone to the doctor for your arm and/or your ankle?"
William responds with a laugh and says, "It's the same thing."

The irony isn't lost on either of us. He has seen first-hand how gendered norms and stigma affect men's health-seeking behaviour with sometimes devastating consequences. He works with men daily to support them with these challenges. He has demonstrated an acute awareness of the norms that inhibit men from seeking health and a commitment to supporting men in living more healthily.

Despite all this, he suffered through our interview with a makeshift sling. Indeed the very issues he spends his life supporting others to overcome afflict him as well.

This story sadly agrees with the local and international research on HIV and men's health-seeking behaviour.[2] Despite being less likely to contract HIV, men

[2] The concept of health-seeking behaviour has been criticised for not lending itself easily to an exploration of the relationship between health systems and populations as much as between health systems and individuals (Bedri, Lovel & Mackian, 2004). Health-seeking behaviour is a reflection of a wider social process, but research often portrays it as something that resides in the individual (Bedri, Lovel & Mackian, 2004). Some argue that the dominant ideology of neoliberalism has been a vehicle for this influence (Navarro, 2009) and places the responsibility for success or failure (and in this case health) solely onto the individual (George & Wilding, 1985: 8, 9). All too often, the onus is put on how individuals interact with the environment, without adequately considering the environmental factors that themselves shape these interactions. Despite striving to avoid simplistic, individual-focused explanations on men and health-seeking, this limited construction of health-seeking behaviour has invariably permeated this paper.

seek treatment less and at a later stage (Nattrass, 2008), have lower testing rates and are more likely to be lost to follow-up or die on ART than women (Johnson *et al*., 2013). Women make up 55% of people living with HIV but comprise two-thirds of patients receiving public sector ART (Cornell *et al*., 2010).

The case for increased focus on men and HIV/AIDS is strengthened by the fact that men's poor health-seeking behaviour also puts men's partners at increased risk of becoming infected with HIV and contributes to an "expensive and unnecessary burden on women and health systems" (Sonke Gender Justice, 2013). Indeed, men's poor health outcomes can add to the psychological, emotional and economic burdens of women and children.

The social construction of gender as a tangible binary separates certain behaviours and attitudes into those deemed "feminine" and others "masculine". Here, gender is understood as a "set of socially constructed relationships which are produced and reproduced through people's actions" (Gerson, 1985: 327). The concept of performative gender states that gender is a set of cultural and social practices that are performed by men and women (Butler, 1999). It follows that individuals can assert their gender by engaging in certain types of behaviours.

Health-seeking behaviours, like other social practices, are used to socially structure gender and power, providing avenues to perform according to norms of masculinities and femininities (Courtenay, 2000). Men can demonstrate conformity to hegemonic masculinities by their health behaviours, which can be used as signifiers of masculinity and instruments to negotiate social power and status (Courtenay, 2000: 1389).

"Hegemonic masculinity" is defined as:

> 'the configuration of gender practice which embodies the currently accepted answer to the problem of legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women' (Connell, 1995: 77).

It refers to the dominant form of masculinity within a society (Connell, 1995) and plays a foundational role in the study of masculinities. Considered to be the ideal type of masculinity, it imposes meanings about the position and identity on all other forms of masculinity (and femininity) (Connell, 1995: 47). It is a theoretical concept applied throughout this study's findings.

Hegemonic masculinities theory also recognizes that gender norms are not fixed. Being situated within social contexts, these norms vary between societies, are fluid and changeable over time. Developing more gender-equitable masculinities is thus a focal point in HIV/AIDS care and prevention (Barker & Ricardo, 2005; Stern, Peacock & Alexander, 2009; Reihling, 2013).

Due to societal power imbalances between men and women, men have most of the social determinants of health in their favour (Hearn, 2001), including access to economic and political resources. Despite this, men globally have shorter life expectancies (by approximately seven years) and higher mortality rates for all leading causes of death (Hearn, 2001: 24). Health behaviour paradigms related to norms of masculinity contribute to men's poorer health outcomes (Baker *et al*., 2014). Hegemonic norms of masculinities equate illness to weakness and weakness to emasculation, making it less likely for men to access HIV testing, treatment and support services (Medical Research Council, 2007; Colvin, 2010; Sonke Gender Justice, 2013).

Recent studies in Southern and Eastern Africa demonstrate the harm caused by these constructions of masculinity. Regionally, the 2010 Global Burden of Disease study demonstrated longer life expectancies for women than men, with men in sub-Saharan Africa living on average 5.3 years less than women (Institute for Health Metrics and Evaluation, 2010). Here, hegemonic masculine norms increase men's risk of HIV infection and inhibit health-enabling behaviours such as getting tested, accepting their HIV positive status, and taking instructions from nurses (Baker *et al*., 2014).

There is a small but growing body of research that advocates for the importance of interventions focusing on men, with Cornell *et al*. (2011) stating that "most international and national ART-related policies and programmes in Africa are still blind to men."

An editorial in *The Lancet* entitled "Expanding HIV Care in Africa: Making Men Matter" articulated the need to better engage men in services for HIV/AIDS and the treatment of sexually transmitted infections:

> 'encouraging men to get tested and into treatment is a major challenge, but one that is poorly recognised… addressing these issues effectively means moving beyond laying blame, and starting to develop interventions to encourage uptake of prevention, testing, and treatment for men—for everyone's sake' (Mills, Ford & Mugyenyi, 2009).

The need to improve men's health-seeking behaviour and health outcomes is clear. This would ideally be done through expanding resources for health and should not reduce resources for women and children (Hearn, 2001). Indeed, despite the presence of a strong policy framework, SRH policy implementation and service delivery for women in South Africa have been inadequate (Cooper, *et al*., 2004). Hodes (2013: 234) argues that the programmatic and activist emphasis on providing ART has overshadowed other crucial dimensions of SRH services for women.

The social contexts and conditions in which men live are fundamental for understanding men's health at individual, national and collective levels. It is within these contexts that men construct their social identities and behaviours. One such behaviour is violence, described by Hearn (2001: 28) as a "graphic form of non-caring". This violence can include health-behaviours that are risky or harmful to oneself or others. Hearn (2001: 28) argues that men's poorer health is linked to dominant and sometimes even oppressive ways of "being a man", citing an "unwillingness to take one's health problems seriously" as a macho risk-taking behaviour.

Study design and rationale

This qualitative study took place in 2013 and 2014 with CCWs employed by Kheth'Impilo (KI). Data was collected using semi-structured interviews, observational home visits and field notes. Male CCWs were the prime focus of the study with six of eight CCW participants being male and two female. Each participant was interviewed at least twice. Interviews took place in the Cape Town townships of Fisantekraal, Wallacedene, Kleinvlei and Mfuleni where the participants live and work. Interviews were complimented by work-shadowing, observational home visits and three in-depth joint interviews with male clients and their CCWs. Additionally, a community focus group of 20 participants, interviews with head office staff of a South African HIV organization, two HIV researchers and activists were conducted to provide context and detail to this study.

The CCW partipants were employed by Kheth'Impilo (KI), a South African not-for-profit organization that supports the South African government in delivering primary health sector HIV/AIDS services. CCWs 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 (Kheth'Impilo, 2011).

Meaning “Choose Life” in isiXhosa, KI is a South African not-for-profit organization that aims to support the South African government in delivering quality services for the management of HIV/AIDS in the primary health sector. KI is funded by international and local governmental and non-governmental organizations (Kheth'Impilo, 2014). For the purposes of this working paper, community care work is referred to in the context of activities carried out by KI CCWs. Such responsibilities include assisting with treatment readiness so that when clients are prescribed ART they have the necessary emotional and logistical support; conducting psychosocial assessments; identifying barriers to adherence and providing pre-treatment initiation education (Kheth'Impilo, 2011). These CCWs also provide support services to suit individual client needs through planned home visits, clinic support and conducting follow-ups (Kheth'Impilo, 2011).

CCWs were selected as they can shine valuable light on the needs and challenges of their clients. First, they have more (and regularly sustained) contact with clients than is the case between health practitioners and their patients in day clinics and hospitals. CCWs typically live in the same communities as their clients and visit them at home, which provides for some contextual understanding of their clients’ needs. Despite that such home visits pose challenges around confidentiality and HIV-related stigma (Vale, 2012b), the richness of CCW experiences and their knowledge in relation to clients’ needs should not be discounted. This study draws on this knowledge in effort to understand how CCWs work with and relate to male clients to support their health.

The limitations of this research should also be acknowledged. The research area was limited and the number of participants was small. For this reason, important intersecting factors such as sexual orientation, gender identity, age, class and urban and rural experiences were not explored. Additionally, the male clients of community care workers are likely unrepresentative of a broader population of HIV-positive men, given that they have entered into the health system and demonstrated, at the very least, a minimal degree of openness to receiving support.

Working with male clients: CCW perspectives and approaches

The experiences and perspectives of the CCWs interviewed resonated strongly with the international literature discussed above. Both male and female CCWs pointed out that male clients have more trouble adhering to medication and are

more likely to die than their female counterparts, with issues pertaining to hegemonic masculine identities complicating the management of client health. CCWs indicated that working with male and female clients require different approaches: "Look, when it comes to males, it was… totally different dealing with them like the way you were dealing with females" (Lebo, Male, CCW).

Thandeka also said that she approaches working with male and female clients differently:

> Interviewer: "Now say you go to visit a man and visit a woman. Would you talk the same?"
> Thandeka: "No I didn't talk the same… because they were different. It's a male and a female, so different" (Thandeka, Female, CCW).

The language that CCWs used to describe working with male clients (as opposed to women) was also notable. Most framed the behaviour of male clients in a negative light, using words to describe their male clients (and their behaviours) such as 'problematic', 'rude' and 'stubborn'. This viewpoint was evident amongst male and female CCWs across the age spectrum:

> 'You see, working with them (male clients) is another story because, if you see, men are very stubborn people, you know? They take things the other way rather than getting the straight, you know?' (MJ, Male, CCW).

> Lusanda: 'It's easier to talk to women… sometimes a man you see that… men are grumpy.' (Lusanda, Female, CCW).
> Sam: 'Men are very problematic.'
> …
> Interviewer: 'So how do they act that's problematic? Like what do they do?'
> Sam: 'Get afraid to talk, they talk little…' (Sam, Male, CCW).

> 'The men is rude *mos*, the women is right.' (Thandeka, Female, CCW).

These varied interpretations of male client's behaviours by CCWs can be understood through the lens of the theory of hegemonic masculinities (Connell, 1995). Hegemonic masculinity(ies) may require that men have the appearance of independence, self-sufficiency and emotional and physical resilience and strength, which makes it difficult for them to acknowledge vulnerability (Erasmus, 1998; Lindegger & Quayle, 2009). These relate to male health behaviour norms where men should act robust, self-reliant and strong

(Courtenay, 2000; Williams & Best, 1990; Golombok, 1994; Martin, 1995). Lindegger & Quayle (2009) argue that these norms are present in the South African context where men are under pressure to perform to physical and emotional strength and resilience. These masculine norms make it difficult for men to receive health care and other forms of help (Peacock, Khumalo & McNab, 2006; Lindegger & Quayle 2009).

If male clients feel the need to perform to physical strength and act unemotional, independent and self sufficient, it is unsurprising that they may find dealing with CCWs to be difficult. This is especially true when they begin to navigate the intimacies of a care relationship with a stranger. In such situations, in addition to hegemonic masculine norms, other, more private norms will also apply.

Their discomfort is likely to find expression through the creation of barriers such as acting in a 'problematic' manner, being 'quiet', 'stubborn', 'grumpy' and 'rude'. In this way, they can resist behaviours that directly contrast hegemonic masculine norms such as speaking about issues of health and receiving support from care workers. 'Stubbornness' in HIV-positive men's health-seeking behaviour was also noted by Beck (2004) who argued that it was employed as a conscious, rather than unconscious defensive tactic. Regardless of whether this type of behaviour is conscious or not, it limits the development of a relationship where clients can receive adherence support from CCWs, and thus potentially undermines their health.

The norms associated with hegemonic masculinities may limit men's ability to relate to others because emotions other than anger are considered to be a sign of weakness (Seidler, 2006). There is some literature that contests this assertion, demonstrating that some expressions of emotion in certain contexts by men are acceptable. Such research includes Langa's (2010) study of adolescent boys with absent fathers and Mfecane's (2012) research on masculinities and disclosure. This study found that expressions of emotion and relating were often constrained, especially at the beginning of the CCW-client relation. Lindegger & Quayle (2009: 43) argue that due to such constraints turn relationships into spaces of performance rather than relating. Although this argument is renderred in the context of intimate relationships, it has relevance here: through refusing to receive health care support from CCWs, clients are performing to masculine norms of toughness, strength and independence. They do this through putting forth the illusion of invulnerability, suppressing emotion and being unwilling to speak about the issues surrounding their health.

In contrast to the majority of participants who used negative language when describing male clients, Lebo understood men's challenges around health-

seeking behaviour as stemming from their sense of vulnerability and need for privacy:

> 'The reality is, men are a little bit sensitive and when you talk to them, you need to understand that they, uh, they don't really talk to anyone about their private life and health to males is very private. And for you to know that they are HIV+, you need to understand that it is something very special because they are very secretive about their status, about whatever sicknesses they are having, diseases. So, ya it was, the approach was completely different… as I said, men, we are very sensitive' (Lebo, Male, CCW).

Lebo's description of men as 'sensitive' is also seen in a qualitative study by Chadwick & Foster (2007) of young white South African men. Some participants spoke of men being inherently sensitive, framing this sensitivity as a fixed, trans-historical truth that has not always had free expression (Chadwick & Foster 2007). In Lebo's interpretation, the sensitivity or vulnerability comes from having to share personal, and potentially stigmatizing information about one's health. If sickness is emasculating (and HIV especially so given that it can complicate sexual relationships), it is unsurprising that Lebo considers health information to be 'sensitive' and personal. To Lebo, knowing someone's HIV status is 'special' because of the vulnerability of sharing such personal information. Men's disclosure of HIV-positive status is a complex process influenced by multiple factors such as conventional views of male identity and a fear of negative consequences such as shame, isolation of loved ones and secondary stigma (i.e. stigma by associaton) (Iwelunmor, Sofolahan-Oladeinde & Airhihenbuwa, 2014).

The far reaching effects of stigma and fear of stigmatization on HIV non-disclosure, prevention and treatment have been well documented in a local body of literature (such as Simbayi *et al.*, 2007a; Mills & Maughan-Brown, 2009; Maughan-Brown, 2007; Kahn, 2004; Maughan-Brown, 2004). Studies considering the impact of HIV stigma on men in a few African contexts (including Beck, 2004; Wyrod, 2011; Colvin, 2010) indicate that HIV stigma affects men and women differently. Wyrod (2011) argues that an HIV positive status to be a barrier to conforming to hegemonic masculine norms because it is considered to be a barrier to having intimate relationships, having children and breadwinning for families (the same challenges that men face in living up to local ideals of masculinity, respect and status). Similarly, Steinberg (2013: 506) argues that for some South African men, being HIV positive "is a mark of their diminishment, a biological manifestation of their social uselessness". Living in a context where many men do not have the material resources necessary to start families within the traditional institutions that legitimize them as men, HIV

status represents men's failure to to procreate as partriarchs do (*ibid*, Steinberg, 2008).

Despite having different perspectives and value judgments around male client behaviour, CCWs held a common belief that male clients struggle with accepting and sharing issues related to their health. As Hearn (2001) argues, the problems that some men create (collectively and individually within a context of male dominance) and the problems that some men experience, such as poor health outcomes, cannot be separated from one another. "Men's accumulations and practice of power" both benefit some men and also harm them, as seen with risk taking behaviour and illness (Hearn, 2001). Thus it is possible for clients to be sensitive and problematic at the same time. Men are beneficiaries of a system that privileges men (albeit at varying levels) and at the same time, this system marginalizes men who do not reproduce it.

Some CCW accounts (by men and women) of male clients' resistance to support also spoke of anger and violence:

> 'This man I was visiting, this one want to hit me. He says he don't want to disclose to anyone in the house, even his sister...ya this man, I don't know what is wrong with this man. That's why this man is so angry. Because he didn't disclose his status…' (Thandeka, Female, CCW).

Lindegger (2009) and Seidler (2006) assert that performing toughness hinders men's ability to acknowledge emotional vulnerability and deflects emotion into anger and violence. This behaviour both affirms male identities and leaves men more vulnerable. Campbell (1992) argues that violence is a compensatory mechanism for men with limited opportunities to assert their masculine power. It is perhaps for this reason that men who feel emasculated due to their illness may resort to physical violence, or threats of violence.

Four participants spoke about violence by male clients against female CCWs. In these areas, it was common practice for female CCWs to work in pairs.

> 'Like you know men, they like to take advantage, you know? So if it's a woman visiting you at the house regularly, then it is another story, you know. They will take that advantage of "yo, these ladies now visiting me, let me do that or let me approach her."' *(*MJ, Male, CCW).

> 'The other men I don't trust. If I'm going to visit another man I don't want to go because the other man maybe they're going to rape you if

> you're going alone. That's why sometimes I'm working with Kholiswa… We're going with two in the house when the man is staying alone there because I don't trust some of the (male) clients…' (Thandeka, Female, CCW).

Reading these quotes in the context of the gendered power dynamics between male clients and female CCWs creates quite a complex picture. Vale (2012a) investigated CCWs in Cape Town, finding that male clients challenge the authority of female CCWs through threats of violence. She argues that CCWs are constantly negotiating authority and are faced with the task of challenging traditional authority structures in the very spaces that reproduce them (*ibid*).

Many CCWs, clients and KI head office staff purport that the clients who do not disclose their status and speak about their health have poorer health outcomes. Indeed, disclosure of status has been documented as a predictor of likelihood for adhering to ART (Cluver *et al*., 2015; Agwu & Fairlie, 2013; Hardon & Posel, 2012), and despite the ethical implications discussed in Vale (2012a), is a prerequisite for determining that a client is ready to start treatment. Beyond disclosure, which is often used as proxy for a level of acceptance of status, participants spoke broadly about the importance of "being open" and speaking "freely" about issues affecting them in seeking better health. Participants believed that speaking openly was an important component of a supportive client-CCW relationship. Speaking openly was important in that it: 1) allowed CCWs to provide more relevant support through an understanding of their clients' needs; 2) demonstrated a client's receptivity to receiving support; and 3) provided a tool for clients to work through emotional challenges related to their health.

CCWs noted that speaking openly was a challenge for many male clients, making it difficult for them to develop an effective support relationship. This was put bluntly in a joint interview between a client and his care worker:

> William: 'Women are more open when it comes to, especially health issues. But when you speak to a man he will tell you just to shut up. And *ya*, men is not very open when it comes to health.' (William, Male, CCW).
> Jaap: (agrees) 'Men don't usually talk.' (Jaap, Male, Client).

That speaking about health is more difficult for male clients is not surprising given that the expression of emotion contradicts hegemonic or ideal norms of masculinity (Connell, 1995; Lindegger & Quayle, 2009; Seidler, 2006). In addition, talking about issues of illness would contradict performances of masculinity in which sickness is denied or ignored.

In dismissing their need for help, men are denying weakness and vulnerability and putting forth the appearance of being strong and robust (Courtenay, 2000). This may negatively impact client health and also reinforce cultural beliefs that men's bodies are superior to women's bodies, that men are more powerful and less vulnerable and that caring for one's health and asking for help is feminine (Courtenay, 2000).

Lusanda spoke about the impact of men not accepting and talking about their health issues:

> 'And usually me, most of the time when I interview men, I will tell the men that "if you can see more women that are HIV-positive, that look bright. You can see them, they look healthy and vibrant. More men are dying because they don't want to accept or don't want to go out there. You see?"' (Lusanda, Female, CCW).

She also shared how she encourages clients to accept and speak about their HIV positive status:

> '…you didn't buy the HIV. You never stood in a counter to buy it. And for you to be free in your spirit, you should talk. Because the heart pain, you see the wound in the heart, it's more painful. Like you get stressed under the circumstance of that denial, of that closet that you are sitting in. But if you start talking, you are getting free, you are getting even feel like healthy. You're not always sick because you are always worried about people around you but if you are, if you have spoken to yourself, you don't care about people. Not that you don't care but you aren't that worried about people who are whispering or what, you think they talk about you' (Lusanda, Female, CCW).

A male client said that speaking about his challenges improved his physical and emotional health:

> 'You can't be sane otherwise - you must talk, you must be open. If you keep it to yourself you're going to get sicker if you keep it to yourself' (Jaap, Male, Client).

Later he spoke of how talking helped him address his anger.

> Jaap: 'If you don't talk to other persons you got lot of anger.'
> Interviewer: 'So talking to people helps with the anger?'

> Jaap: '*Ja* it takes the anger out of you, it takes the anger out of you. It makes the anger free. *Ja* it makes the anger free out of you' (Jaap, Male, Client).

Jaap's experience agrees with the literature (Lindegger & Quayle, 2009; Seidler, 2006) that posits that men deflect emotions into anger, an acceptable 'masculine' emotion. Jaap's anger receded when he moved away from performing toughness in conformation to masculine norms and began to speak about his physical health and the emotional implications. Jaap's process is also demonstrative of his struggle, and eventual success, in coming to terms with his vulnerability and illness.

Jaap's CCW also spoke of the importance of CCWs encouraging open communication with clients:

> 'I believe that in the health profession, if you don't speak to your client or patient on a regular basis, you'll never know what that client or patient is going through. And just to get rid of the anger and the frustration, you have to speak to them. And that makes it easier for them to open up to you. And that's what I experienced… if people do accept then they comply to the treatment, they're very open, they can speak about it and all that stuff' (William, Male, CCW).

Here William speaks not only of the importance of clients opening up but of the role that the care worker must play in supporting clients to do so. The type of communication that he highlights here provides an example of how the CCW-client relationship can challenge prevalent notions of masculinity. Similarly, Colvin (2010) saw male support group members contesting dominant understandings of masculinity in Gugulethu through therapeutic discourse.

In summary, participants believed that opening up (disclosing, discussing emotions) was important for clients' emotional and physical health and that this was more difficult for male clients than their female peers. In addition, some CCWs also said that the opening up process takes longer for men than for women:

> 'To be honest with you, they open up slowly. Once they know you, then they will open up' (William, Male, CCW).

> 'It's not like women…, it isn't rapid. It's slowly, you see?' (Lusanda, Female, CCW).

Despite noting the reluctance and speed with which male clients open up, participants did not hold the belief that men have less to say. The stereotype that men are not emotionally expressive can be (re)considered in light of the argument that male babies cry longer and louder than female babies (Hooks, 2004: 35). Here she argues that boys "enter into the world wanting to be heard".

Participants in the study also challenged the assumption that men are inherently less emotional, emphasizing the importance of verbal expression to men's health. One CCW spoke of his surprise over how much male clients actually want to share once they become comfortable with their CCW: "I never knew that men offload so much. Especially when it comes to this illness and all that stuff" (William, Male, CCW).

In response to their observations that male clients have more trouble opening up and are less likely to be receptive to support, participants all said that they consciously employ specific techniques when working with male clients. Tentativeness and a 'feeling out' process characterized the beginning of their working relationship with male clients. At this point, CCWs seemed to be seeing how best to forge a support relationship that may contradict societal norms of what it means to be a man, in the knowledge that this might be foreign to some clients.

CCWs made it clear that negotiating a support relationship with clients (and male clients in particular) is fraught with vulnerabilities which if not handled gingerly could limit their ability to work effectively to support their health.

MJ, a CCW in Fisantekraal spoke of making sure not to "cross the line" and broach sensitive topics too directly or too early: "Visiting a man? You see when you visit a man you should prepare yourself. In other way that you might not cross the line or talk other things" (MJ, Male, CCW).
Other participants also spoke indirectly of the presence of this invisible, yet highly important line. The picture that emerged was one of CCWs carefully searching for this invisible line, over which lies a highly fraught emotional ground. This line delineates private and intimate matters that are too uncomfortable to speak of, the crossing of which could upset clients and harm the support relationship they are trying to build. Restrictive masculine norms seemed to create a very small and tentative space in which CCWs could respectfully engage with their clients at first. It was the aforementioned masculine norms of physical and emotional toughness that constrained the negotiation of a support relationship.

In describing their techniques used to move clients into a place of openness and receptivity, a number of participants noted (either explicitly or implicitly) two

phases in the client-CCW relationship. The first phase was characterized by tentativeness or resistance on behalf of the client and the accompanying need for the CCW to approach working with the client in a sensitive and cautious manner. After moving past this phase, a second phase (characterized by a degree of comfort between the CCW and client) was noted. It is during this second phase where the client and CCW can speak more openly about the challenges affecting the client.

> '…there is a time like you start with the client. When your client is still new, you need to be sensitive in a way… but as the time goes by, you build that relationship with your clients and they become comfortable with you and once they are comfortable with you and they understand also the work that you are doing... So, from there, that's where you move another step. That's where you can try to talk about, like, anything, but you just mind the way you are saying it. So, that is it. It's not that you can't talk about some things, you can, but at the right time. And you find a way of like, talking about them, like in a very respectful manner' (Lebo, Male, CCW).

MJ speaks about moving into a more comfortable phase with his male clients where they feel free to open up and the relationship between the CCW and client deepens:

> '…then the second step is its him that is going to speak. You know he's going to tell you "hey man, you see now what is happening, I have been there doing what what what what what, and doing the job because of this or that" then the friendliness start there, you are becoming connected' (MJ, Male, CCW).

In recognizing that there are many constructs of masculinity, it is also necessary to note "the relations between the different kinds of masculinity: relations of alliance, dominance, subordination" (Connell, 1995: 37) in which the male body is often used as a vehicle of these negotiations (Courtenay, 2000). As such, men often use their physical strength and abilities to demonstrate their power and dominance over each other, which explains why men who embrace hegemonic norms may not want to admit illness. CCWs aim to connect with their male clients beyond these limited and fraught types of relating.

Despite indications that male CCWs embrace alternative masculine norms, they also sometimes conform to hegemonic norms of masculinity when working with their peers and clients. While receiving and providing health care is considered to be a "feminine" practice, the provision of health care also constructs and

reproduces gender hierarchies. Physicians, the most respected health providers are often men:

> 'maintaining power and control over the bodies of men who are not physicians, the bodies of women, as well as over male and female health professionals in lesser positions of power, such as nurses and orderlies' (Courtenay, 2000: 1395).

Beck (2004) argues that there is a certain necessity of authority required in compelling men to respond to their HIV status in a way that supports their health. The findings of this research challenge this assertion in some ways as participants spoke of approaches such as being friendly, open and gentle as strategies to reach their male clients. However, certain hegemonic masculine norms and attitudes did emerge in conversations with some participants.

MJ spoke about being persistent with his clients until they did what he wanted them to: "If he desert[s] me today, then I have to come tomorrow. I have to keep going, yes, until I get them where I want him to be" (MJ, Male, CCW).

Sam spoke about how he has techniques for getting male clients to disclose: "I've got my own way to make that guy to disclose but I'm giving him enough chance" (Sam, Male, CCW).

William spoke of how he uses male power in his job:

> William: 'It's only one (male CCW) and it's me. I'm the shepherd, they're the sheep. That's what I call them'.
> …
> Interviewer: 'How does it feel to be the only man?'
> William: 'It feels great because I can raise my voice when something's not going according to plan, especially when it comes to patients. Then I can raise my voice and then they can sense "oh wow, there's a man in the house, oh". It's really good.'
> Interviewer: 'So the patients will listen more?'
> William: 'Oh yes' (William, Male, CCW).

These quotes from MJ, Sam and William all demonstrate a certain sense of power and dominance that they sometimes bring into their work. This dovetails with Campbell's (2003) finding that peer educations often use their positions to promote themselves as poweful and important. Despite that the male CCWs that participated in this study all demonstrated on many levels (including the fact that they are working in a female dominated field) that they embrace alternative masculinities, they still in some ways perform to hegemonic masculine norms.

These examples speak to the complex nature of performative gender and the ways in which men may conform to, and resist hegemonic norms of masculinity. Moreover, they speak to the way that male CCWs may simultaneously hold two seemingly contradictory positions: on one hand, they are asserting dominance over their clients and on the other hand, they are doing it in their role as men working in a "female" profession. They are embracing an alternative masculinity through providing care, while sometimes using elements of power and dominance in their work as carers. The participants' rationale for this power and dominance is clearly situated in their belief that these performances are part of the care that they are providing to male clients in support of their well-being.

As CCWs navigate the way they relate to clients, they employ different strategies and embody different masculine norms. This agrees with Vale (2012a) who demonstrates that CCWs use a range of techniques from lecturing and threatening clients to telling stories and speaking "on their level".

The delicate dance described by CCWs in working with male clients seemed to involve tip-toing to the edge of the aforementioned line which delineates intimate matters, and gently pushing it back when possible to bring issues to the fore for discussion. A variety of techniques were employed to avoid stepping into a space where client's hegemonic norms of masculine behaviour were threatened. These techniques were characterized largely by CCWs being clear with their intentions, friendly and indirect. These approaches were employed with an aim to move clients into the 'second phase' where they were more comfortable to open up and receive support.

A key approach that some participants employed in developing a supportive relationship with their male clients was to ensure that the client understands the purpose of their visits.

> 'What we want is just be polite. Try to make him see why you are here and why is it important of me being there' (MJ, Male, CCW).
>
> 'They need to understand the work that you are doing. They need to understand your stance' (Lebo, Male, CCW).
>
> 'I will do my utmost best to make sure that client understands and when I leave that client is at rest. So when I come back the next time then he must feel more free to open up because for the past month, I experience, most men, I never knew that men offload so much. Especially when it comes to this illness and all that stuff' (William, Male, CCW).

It is certainly understandable that clients want to understand why someone is coming to visit them in their home and speaking with them about highly personal subjects such as their lifestyle and adherence to medication. Being clear and informative about the purpose of their visits was a way to make clients feel comfortable. Providing information to clients allows them an increased sense of control and sets the ground for a space where they may feel safer receiving support.

The importance of being friendly and open with clients is perhaps unsurprising but nonetheless notable. CCWs spoke about approaching clients 'as friends' with an aim to put them at ease. This approach serves to minimize perceptions of power dynamics between the CCW and client, which might impede on the client's ability to receive support.

That health care facilities in South Africa are not 'male friendly' has been widely documented.[3] Deterrents for men accessing health services include lack of service provider training/skills for men's health issues, unwelcoming, poorly equipped clinics, bad attitudes from health providers (Sonke Gender Justice, 2013), inaccessible hours and the perception of public clinics and hospitals as "women's spaces" (Faull, 2010). Another common complaint by men as to why they don't access health services is that clinic staff treat them in an unfriendly or disrespectful manner (Colvin, 2010). As a result, CCWs try to demonstrate that contact with health care can be a pleasant experience:

> 'To be honest I'm a very polite and friendly person. I don't act like I'm from the clinic. Especially when there's other people around and I come to visit that person, I will act like we know each other and we're friends and all this stuff. And that is when they start to open up' (William, Male, CCW).
>
> 'You see for them to accept me it's to talk with them. To sit down, you see, make friends' (MJ, Male, CCW).
>
> 'It is just to educate first and to feel free to talk. Then it will convince him that he must also feel free to talk to me' (Sam, Male, CCW).

These quotes show that the gesture of friendliness and warmth by the CCW towards the client are not just functions of goodwill. They also help develop a relationship with the client where they are more likely to open up, and in turn

[3] This is not to say that clinics are "women friendly" either. Indeed, women are also commonly subject to unfriendly and oppressive treatment in clinics. This has been documented by researchers such as Wood & Jewkes (2006).

become receptive to a relationship that supports their wellbeing. Vale (2012a) also found that some CCWs aim to speak to clients "on their level" so that clients don't feel infantilized.

Male peers sometimes struggle supporting each other because men have been socialized to be independent, with male relationships being defined by hierarchy and deference rather than cooperation and support (Wyrod, 2011). Being friendly allowed for some CCWs to negotiate within a space to build a supportive relationship.

Jaap, one of William's clients, spoke of the difference it made to him to feel cared about by his CCW:

> 'For me it's nice because somebody came out to me and showed me that somebody cares about other people. It's his work that he do but this just one thing that I know, he cares for other persons. And somebody cares for me, I also cares for him. That's why. 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, Client, Male).

In observing Jaap and William's interactions, it was obvious that there was mutual respect and a level of warmth and friendship in addition to an acknowledgment of the practicality of William's role as a supporter.

In taking a warm, open and friendly approach, male CCWs are also demonstrating an alternative, more caring masculinity. This might enable male clients to also embrace alternative masculinities themselves and to speak openly, share feelings and acknowledge issues around physical and emotional wellbeing.

Taking an indirect approach to speaking with male clients was the most commonly citied technique in this study. By speaking indirectly about issues, CCWs could create a degree of distance from the sensitivity of health issues and the discomfort of accepting support. CCWs tried to avoid 'crossing the line' by depersonalizing the conversation while still indirectly providing support or advice. Hardon & Posel (2012: S3) challenge the dominant discourse "in which silence and secrets are seen to undermine well-being and perpetuate (HIV-related) stigma" arguing instead that a more subtle and cautious approach may be waranted because of the potentially adverse effects of pre-mature disclosure and openness. Such a subtle and cautious approach can be seen in the way CCWs were careful not to push clients to acknowledge illness or to directly share feelings. This approach allowed them not to directly challenge hegemonic male norms or undermine clients' façade of toughness.

> ‘Some of the things you can’t really say them directly in a way, you need to consider that some of the things that you might say, they might be offensive to that person’ (Lebo, Male, CCW).

Lebo would speak indirectly so as not to offend (male) clients. He was also careful not to force conversation on sensitive issues. If he sensed a topic was sensitive, he would change the subject and then revisit it later.

> ‘Like, *ja*, “what do you think of this?” And then someone will give you an answer and you say “ok cool” then when you get back then you say “ok, this is the question that I wanted to ask.”’ (Lebo, Male, CCW).

In not wanting to cross the invisible line and ask too personal a question, Lebo would near the line, retreat and then inch forward again in hopes of addressing certain issues without offending clients.

MJ also spoke of the indirect approach that he uses when he starts working with a male client:

> ‘Put all these things that you know that they are main problem of us men not wanting to accept. Put them, put them… don’t say “you know, you do this, you don’t want to do that, you don’t want to go to the clinic, what what”, no just tell the guy that “if it happens that if you are not going to the clinic, you will die you see? You will become sick, you see?” and tell them that many men are dying because they don’t want to do that. Not trying to tell them that “you aren’t going to the clinic.”’ (MJ, Male, CCW).

In taking such an approach, MJ was also trying to negotiate doing his job and not entering into potentially volatile territory with clients. In addition to speaking indirectly, he also spoke of giving options rather than outright advising male clients:

> MJ: ‘You must try to be friendly first, then make points instead of telling what to do.’
> Interviewer: ‘So what would you say for example?’
> MJ: ‘So for example I’m trying to tell you if you are a man visiting you, the man then I will talk the views so that you will choose from. I will state all the facts that “this is what is happening outside here. Many men are dying of HIV because of what what what what”…

(speak) around (the issue) so that they could choose… so that they could make the decision.
After all, then it will get into him "oh, you are right" you see "you are right - I know that that is that, that is that[4]" you see, then you will start following you see. You will see him come into the clinic, you see?'
Interviewer: 'And after that when you visit him?'
MJ: 'After that when I'm going to the regular visits, then the normal thing, we are friendly now. All the stuff, now we are friends. No more argument or stubbornness' (MJ, Male, CCW).

Such an approach empowers male clients with information while allowing them to maintain a sense of control. Essentially, they are provided with information that they can use to make their own choices without being told what to do. In depersonalizing issues by making them hypothetical, CCWs can avoid situations of confrontation. Beyond avoiding confrontation, telling clients what to do is unlikely to result in behaviour change. In her study on condom use in mines, Campbell (1997) argues that the broader social context of "masculine" and "feminine" identities creates a complex environment for behaviour change, where telling someone what to do is ineffective. The lesson she drew is relevant here. Indeed, approaches that provide information about health risks and how to avoid them are often ineffective, especially in low health communities (Campbell, 2001). There is a body of literature that suggests that positive health outcomes may be associated with social capital, and which suggest that enhancing social capital in low health communities via targeted policy and programming may yield better health outcomes (*ibid*).

Some participants noted that confrontation is not conducive to the development of an effective support relationship. One CCW spoke of how he responds to such situations where male clients become confrontational.

MJ: 'No, (I am) not raising my voice. Because if you are also raising your voice then it's a fight. That's what we don't want. What we want is just be polite. Try to make him see why you are here and why is it important of me being there.'
Interviewer: 'So if he's raising his voice, you keep just talking around?'
MJ: 'Talking around, he try to run away from that thing, you see.
Interviewer: So he's trying to run away from it if he's raising his voice?'

[4] In context, MJ was conveying "this is that, this is that" to express that the client was making sense of things on his own.

> MJ: 'Yes if he is raising his voice he is trying to run away from your point, from what you are trying to tell him, you see? But if you keep trying and making other things…' (MJ, Male, CCW).

As evidenced by this quote, MJ believes that if a client is being confrontational, he is avoiding the topic at hand. This agrees with the aforementioned literature saying that men seeking conformity to hegemonic norms of masculinities deflect vulnerability and emotions into anger, which is an acceptable feeling because it does not denote weakness (Lindegger & Quayle, 2009; Seidler, 2006).
In her work on authority and CCWs, Vale (2012a) speaks of different techniques that CCWs employ to assert authority over clients. One such technique is the use of stories to illustrate consequences. This is consistent with the indirect approach noted here where CCWs speak hypothetically rather than directly. One way of doing this is through sharing their own stories.

William uses his own story as a way to address sensitive topics with his clients. In this way he demonstrate openness and provides advice without seeming patronizing. Not only does this avoid challenging his male client's performance of masculinity by not drawing attention to their behaviour, but through sharing his story, he is also able to model a more vulnerable alternative masculinity.

> 'I'll be honest with you. When I talk to them about sex, when I open the HIV story, I've been HIV-positive for more than 16 years now... And for me it's very easy to talk to them about it. When I see the signs and symptoms that there's a risk…I'll speak to them about that and bring the sex topic in. and then it makes it easier for me… then that helps them open up' (William, Male, CCW).

The use of personal examples may also serve a purpose in relation to behaviour change. Lewin (1958) argues that people are more likely to change their behaviour if they see that those in their peer group are also committed to behaviour change. Thus male community care workers may provide an opportunity to demonstrate alternative masculine norms, which can support more positive health-seeking behaviour.

Conclusion

This research combines conceptual frameworks by integrating literature on gender, masculinities and HIV with that of community care work and men in caring. Through doing so, it aims to contribute to expanding this critical but small body of literature. The context of this study is multifaceted. Complex gender dynamics are interwoven with other complicated factors such as high

HIV prevalence, restrictive socio-economic conditions that preclude comprehensive access to care, and the decentralization of the ART program. At the same time, the issues of patriarchal hegemonic masculine norms, health and caring are issues of global importance. Men worldwide have poorer health behaviours and participate unequally in caring which is damaging to men, women and societies at large.

The stories and perspectives of the participants are rich, complex and point to the need for a greater recognition of the potential of men in care work. They suggest that CCWs work with male and female clients differently. With male clients, they aim to interact in ways that do not challenge hegemonic masculine norms by using techniques such as speaking indirectly about sensitive issues, acting friendly and being clear with the purpose of their visits. In this way, they navigate around hegemonic masculine norms that require men to act tough and suppress emotion. They do so as a way to develop open and supportive relationships with male clients within the context of constraining hegemonic masculine norms. As such, they serve to minimize or avoid destructive masculine power dynamics, reduce perceptions of hierarchy and put clients at ease. Some techniques provide male clients with empowering information so that they can make decisions about their health. Other techniques are employed to avoid situations where male clients feel that their masculinity is being challenged by being told what to do or being forced to address sensitive issues before they are ready.

While these techniques were used specifically in the context of male clients, it is not to say that CCWs do not employ them with other clients as well. Indeed, a critique that has been rendered against some male-friendly interventions is that the needs of women risk being side-lined. While acknowledging the importance of employing techniques to support men in seeking health, I am also operating on the assumption that women also appreciate being addressed in a friendly manner and like to be provided with full information about the purpose of their CCWs visits. Further research could interrogate these assumptions and address the question of whether women tolerate a more direct communication style. Given that this was not a subject of enquiry, it is unclear what kind of specific approaches CCWs use in working with women. It is important to acknowledge that everyone is deserving of respectful and informative health services. While striving to shift gender norms, it is important to consciously reject the reproduction of patriarchal values that prioritize men over women.

Some might argue that these aforementioned techniques are ways that CCWs pander to male dominance and power so that they can do their jobs. Others might argue that CCWs are drawing on a toolkit which has a variety of practices, including some that resemble oppressive masculine norms. Such

analysis does not seem relevant in the context of the broader gender transformative agenda in which this research is situated.

If the goal is indeed gender transformation and healthier individuals and societies, tiptoeing around client's identities of masculinity is not an end in itself. Rather, the objective is to develop supportive relationships in which clients can improve their health behaviours for the benefit of themselves and their societies.

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