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**The Transmission of HIV/AIDS  
in Heterosexual Marital Relationships  
in Zambian Rural Communities:  
A Case Study of Petauke District**

by

**Clement Lumuel Sakala**

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## A Dedication

I dedicate this study to my late young brothers Steve, O'Brien, Johnson and more recently my adopted daughter/niece Sarah who was orphaned at a very young age. I further extend this dedication to a number of close friends and relatives among them Uncle Martin, Aunty Mary, my sister in law Rabecca. The experience of loss within my family has given me a further depth of empathy of the sadness, pain and grief that I now share with many people have gone through the tragic loss of loved ones through HIV/AIDS. It is this that inspired this study.

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## **ABSTRACT**

Primarily through a case study of the Petauke District this thesis examines the perceptions of local men and women as a basis for examining the significance of the social construction of masculinity for the transmission of HIV/AIDS in heterosexual marriages in rural Zambia. Further, it explores participants' perceptions regarding two possibly key dimensions to the transmission of HIV/AIDS in heterosexual marital relationships in rural Zambia. These are the interconnections between masculinity and gender based violence as a factor in the risk of infection, and male attitudes to the use or neglect of condoms as a measure of protection against the risk of HIV/AIDS transmission.

This case study is set primarily in a postmodern social constructionist theoretical context. This provides a sensitive means of registering the variety of concepts, perceptions, interpersonal interactions and broader social conditions which feed into masculinity as a social construction. It also facilitates a fine-grained analysis of how notions of masculinity are both context-specific and shift across time. While largely focusing on the illustrative significance of stakeholders' accounts in Petauke District, the study also provides an account of wider socio-economic conditions and the spread of HIV/AIDS, as a backdrop, and a critique of salient features of current health promotion responses.

The case study uses qualitative methods, involving the use of individual interviews and focus group discussions with a sample of thirty men and thirty women, respectively, who were previously or are currently married. A thematic approach is used to analyse the data collected in the field.

The study findings reveal that study participants perceive Petauke district to be undergoing a process of social transformation and it is thus on a 'cultural crossroads'. This is as a result of the growing influence of the media, education, intermarriages and social mobility. This has given birth to new social values which all have an influence on the social construction of masculinity. Challenging traditional and contemporary hegemonic modes of masculinity is perceived as one of the main tools that should be used to address the association between the social construction of masculinity and the risk of HIV/AIDS transmission in heterosexual marital relationships. This includes addressing the intersection between domestic violence and the risk of HIV/AIDS infection and promoting the use of condoms against the risk of infection in marital relationships.

The study concludes by drawing out the implications for health promotion policy and practice. It discusses the need for health promotion to work with male and female stakeholders, and undertake programmes that have as a key strategy the deconstruction of harmful beliefs and ideologies associated with masculinity, in order to address male HIV/AIDS risk taking behaviour in marital relationships in rural Zambian communities.

## Study Outline

This study focuses on what can be learnt about the social construction of masculinity and relates this to the risk of HIV/AIDS in marital relationships in rural Zambia, through analysing the perceptions of local men and women on this issue.

The thesis contextualizes this study in the following ways. First, it examines the value of a social constructionist approach to exploring perceptions and experience of masculinity, and its relationship to the risk of HIV/AIDS transmission in marital relationships. In doing so it identifies domestic violence and men's use or neglect of condoms as two key issues, which it is important to explore. Secondly, it takes account of the wider social context and consequences of the HIV/AIDS epidemic on global, regional, national and local bases. In doing so it develops detailed discussion of the impact of HIV/AIDS on social capital and economic development and in turn the impact of these factors on the spread of HIV/AIDS. Thirdly, it explicates its focus on rural Zambia as reflecting a situation where patriarchal relationships are particularly entrenched and where the rate of HIV infection is increasing.

Finally, in order to identify gaps and opportunities within current health promotion practice that can be utilized to enhance male involvement in efforts to stem the risk of HIV/AIDS infection in heterosexual marital relationships, a review of a variety of health promotion initiatives carried out in the district is conducted. The study concludes with proposals for health promotion practice aimed at promoting male involvement in HIV/AIDS prevention in marital relations in rural Zambia.

The study is presented in eight chapters. Chapter one serves as the introduction to this study. It outlines the aims, objectives, research questions and rationale, and provides a description of the research site and setting. In addition the significance of the study and the expected application of the findings are described.

Chapter Two describes the theoretical conceptualisation and framework which underpin the development of this study. This chapter provides the theoretical background to the study, and the rationale for each of the research questions which inform the main objectives for the study.

The chapter begins by describing the theoretical underpinnings which inform social constructionist theory and the notion of the social construction of masculinity and what it means to be a man. It highlights the degree to which masculine identity and experience develop within specific social contexts. It then identifies the importance of considering how notions of masculinity are reflected in relation to domestic violence and condom use and how these connect with the risk of HIV/AIDS transmission in marital relationships.

Chapter Three analyses the wider social context and consequences of the HIV/AIDS epidemic in Zambia. It starts by describing some of the concerns which have been associated with the spread of the epidemic at the global level, then regional level and finally at national level in Zambia and in the context of rural communities in Zambia. In presenting a situational analysis of the impact of HIV in Zambia, it discusses both macro and micro level epidemiological and social features, which have characterized

the spread of the epidemic and the impact this has had on different facets of human and social capital development in the country. It then focuses on the impact of HIV/AIDS in rural communities.

Chapter Four examines the various theories that inform and account for male identities and their significance for analysing men's role in HIV/AIDS transmission in heterosexual relationships. It explores the different meanings ascribed to the term masculinity and the assumptions that inform these meanings. In order to place this exploration within the context of the HIV risk prevention in health promotion discourse, the chapter begins by drawing attention to a historical account of calls for male involvement and participation in HIV prevention at the international and sub-Saharan regional level. It then relates how theoretically the social construction of masculinity interconnects with the risk of HIV/AIDS transmission in marital relationships.

Chapter Five presents a review and discussion of existing HIV/AIDS risk prevention, health promotion efforts in stemming the risk of HIV/AIDS transmission in heterosexual marital relationships in rural Zambia. The review begins by describing some of the key HIV/AIDS risk prevention activities being carried out in the country and particularly in rural areas. It considers the social marketing strategy for mass awareness of the risk of HIV and the commercial retailing of condoms at subsidised prices. At the rural community level, it discusses some of the community-based approaches being utilised to contain the spread of the epidemic, the extent to which men are involved in HIV/AIDS risk prevention efforts and the need to enhance men's participation.

Chapter Six describes the study's research process. It discusses the methodology and methods used for data collection, the choice of sample and the criteria used to select and recruit participants. It then reviews the ethical issues that informed the study. This is particularly relevant in conducting research on HIV, sexuality and domestic violence. It concludes with a discussion of the process of negotiating access and the practical experience of data collection during the fieldwork for the study.

Chapter Seven presents the analysis of fieldwork data drawing on a thematic method of data analysis. The presentation of the findings begins with a demographic profile of the participants in the study. Employing a qualitative approach, it identifies key themes emerging from the views and ideas of the participants. In an iterative way, emerging themes were cross-checked against data from both interviews with men and focus groups with women. Quotations from verbatim transcripts translated into English, are given to present the voices of the participants.

The findings are presented in four sections in relation to the key themes that emerged from the study. The following are the specific contents of each of the four sections.

- I. Section One presents findings in relation to the participants' perceptions regarding the interaction between the wider social and economic context and the social construction of masculinity. The findings presented in this section provide an understanding of how the different social factors in the environment are perceived to shape and influence the social construction of masculinity.

- II. Section Two presents the study findings regarding the study participants' perceptions of how some of the factors are considered to determine and influence male sexual behaviour in relation to the risk of HIV/AIDS infection. In view of the broad nature of factors associated with human sexuality, this presentation is focused on four aspects of male sexual behaviour, which the participants in the study sites considered to be central to male risk of HIV/AIDS infection. These aspects relate to the social construction of men's sexual behaviour, men's risk of infection through local sexual networks, men's risk of infection through having multiple sexual partners, and the influence of alcohol and migration on sexual behaviour.
- III. Section Three presents participants perceptions on the influence of the social environment regarding gender relations in marital relationships. It shows how different social factors discussed in Section One structure the power relations between men and women in marital relationships and how this impacts on sexual decision-making, which affects the risk of HIV/AIDS.
- IV. Section Four presents the findings in relation to the review of current health promotion practices in within the Petauke District. This section describes the types of activities that have been carried out in the communities and the participant's suggestions of how best health promotion activities can reach men in marital relationships.

V Section Five draws together key findings based on the key themes emerging from the participants' perspectives and experience relating to the to the research questions for this study.

Chapter Eight discusses the findings of the study, and concludes by making proposals on how the key findings from the thesis suggest strategies that can be implemented in health promotion practice to enhance men's participation and involvement in stemming the risk of HIV/AIDS infection in marital relationships in rural Zambia.

# **Chapter One: Introduction**

## 1.0 Study background.

Zambia is one of the countries in sub-Saharan Africa hardest hit by the HIV and AIDS epidemic. Currently the HIV/AIDS prevalence in the country is estimated at 16% in the overall population and at 20% in the population aged over 15 (MoH 1999, Fieldhouse 2001, Garbus 2004, WHO 2004, UNAIDS 2004). It is almost thirty years since the first case was reported in the country, and the tragic severity of the epidemic has continued to destroy families and communities with its full impact being felt across the whole nation. At the family level HIV/AIDS is having a severe impact on thousands of children left orphaned through the deaths of parents and relatives. Writing on the plight of orphans in Zambia Haworth (1991), Nyirenda (1997), UNICEF (1998), Teasdale (1999), Mataka (2001) have noted that as well as experiencing the deep pain of watching their mothers, fathers, aunties and uncles die, many children orphaned by the epidemic are faced with the realities of the loss of their home base, reduced schooling opportunities and hence the long term prospects of a loss of livelihood.

Like other sub-Saharan African countries, Zambia has made tremendous strides in efforts to contain the spread of the epidemic through health promotion interventions (Sulwe 2000, Zambia National HIV/AIDS/STD/TB Council 2000, Lucas 2004, MoH 2004). However, many risk reduction efforts focusing on individual behavioural change have faced difficulties with more complex causal factors because of the interconnection of structural factors and individual behaviour (Hart and Boulton 1995, Lasonde 1995, Webb 1997, Freudenthal 2001). For instance, sexual behaviour which is at the core of the epidemic is influenced by a host of factors, ranging from the daily

and pragmatic such as economic and social circumstances to the complex and abstract such as culture.

Thus, the assumption that people are going to change their sexual behaviour on the basis of information alone, has been found to have its limitations because of the complexity of social factors that shape individual sexual activity. As a result, there are increasing calls to cast risk prevention strategies within a broader reproductive health agenda that takes into account the influence of the wider social economic context in which risky behaviour occurs (Hart and Boulton 1995, Lasonde 1995, Webb 1997, Freudenthal 2001).

From this background, this study explores the perception of both local men and women on how aspects of the social environment influence what it means to be a man in Petauke district. I then relate how theoretically the social construction of masculinity interconnects with the risk of HIV/AIDS transmission in marital relationships. The focus on determining the influence of aspects of the social environment on the social construction of masculinity stems from the consideration that notions of masculinity in any society are likely to be influenced by other factors such as religious formation, political beliefs and values. Some of these factors may be in tension with each other and programmes and health promotion efforts need to be sensitive to this and indeed to the opportunities they may present for exposing contradictions in men's gendered assumptions. Therefore, versions of masculinity and what it means to be a man are socially, culturally and historically constructed (Kimmel 1987, Connel 1995, Edley and Wetherell 1995).

Recognising that masculinities are historically, socially and economically constructed, understanding the perceptions of local men and women of how aspects of the wider social and economic environment influences the social construction of masculinity will help health promotion practice in designing the appropriate interventions to mitigate the spread of infections.

The focus on men in heterosexual marital relationships is against a background that in many sub-Saharan Africa countries, notions of masculinity define men as occupying an elevated status in gender relations (Obbo 1980, Ankrah 1993, Mbizvo and Basset 1996, Heise 1998, Baylies and Bujra 2000). In Zambia, evidence is accumulating, which indicates that the imbalance of power between men and women in marital relationships has (as in many other societies) conferred on men the ability to influence and/or determine the reproductive health choices of women and their risk of HIV/AIDS infection (Macwan'gi 1993, Sulwe 2000).

Furthermore, cross-cultural studies (De Keijzer 1995, Edley and Wetherell 1995, Sampath 1997, Connel 2000, Courtney 2000, Doyal 2000) show that contemporary gender roles have also contributed to compromising men's health. This is through encouraging men to equate a range of risky behaviours such as the use of violence, alcohol and the pursuit of multiple sexual partners and the general domination of women, with being manly; while simultaneously encouraging men to view health-seeking behaviour as a sign of weakness (Heam 1998). Yet, in spite of the pervasive nature of male dominance in all spheres of life; males have not been specifically

targeted in many health research and interventions programmes (Dover 1995, Greg et al 1995, Ndubani 1998, Bergstrom 1999, Foreman 1999).

In tracking the association between the social construction of masculinity and the transmission of HIV/AIDS in heterosexual marital relationships in rural Zambia, the study examines the significance of two specific dimensions to men's attitudes and behaviour in relation to HIV/AIDS. First, the study explores the interconnection between masculinity and gender-based violence and the risk of HIV/AIDS in marital relationships. This is against the background that domestic violence including sexual coercion and rape within marriage is consistently becoming an increasing area of concern in HIV/AIDS literature worldwide (Heise 1998, IPPF 2000, Leye et al 2001). However, in Zambia, although incidences of domestic violence have been widely acknowledged in research, the problem of sexual coercion in marriage is rarely discussed and is not a recognizable offence. Even when this can arguably be recognized in law, it is extremely difficult for a woman to successfully charge her husband with rape or to gain the support of her family or community (Fleischman, 2002). The generally uncooperative attitude of law enforcement officials and the judiciary and the lack of procedural protection for victims lead many such cases to be withdrawn.

Secondly, the study explores the perception of both local men and women about issues surrounding what it means to be a man in the district and on how this affects men's use and lack of use of condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marriages. This is from a background that although condoms have been identified as a way of combating the spread of

HIV/AIDS, promoting their use amongst couples in stable relationships continues to pose a challenge (Jackson 2004). Some men continue to neglect the use of condoms because they consider their use as unmanly. Some men have been reluctant to use condoms because they reduce the pleasurable sexual experience as compared to having sex with out wearing one.

In some societies both men and women may be restricted from using condoms because of religious beliefs. In Zambia for instance the Sexual Behavioural Study (Zambia) (CSOZ 2002) reports that members of the Roman Catholic Church are not allowed to use condoms as they believe that sex is meant for procreation.

At another level, the same study (CSOZ 2002) found that some men believe that condoms are only for sex workers or casual partners. As a result men are more willing to use condoms with sex workers or with casual girlfriends as opposed to using them in marital relationships. For this reason it has been observed in Zambia that marriage is also the relationship with the least documented condom use of all. At the same time although women may want to use condoms this may be dependent on their partner's willingness (Macwan'gi 1993, Heise 1998, Jackson 2004,). Women may further be constrained to suggest condom use for fear their partners will suspect them of infidelity and perhaps react violently (Zambia National HIV/AIDS/STD/TB Council 2000).

Condom use in marriages is also often disregarded as the couple may desire to have children (Baker and Ricardo 2005). These difficulties are further compounded by the fact that female condoms are much less available than male ones, but even if women can access them, their consistent use may still depend on the man's consent (Jackson

2004). This study therefore explores the use of condoms as an important issue for programme design, development and implementation. By understanding the perceptions of men and women concerning issues surrounding the use and non-use of condoms in marital relationships, this can help to develop interventions that will aim to promote their use in this context.

This study is focused on rural communities in Zambia. This is because many such communities are particularly conservative societies, which have entrenched belief systems, and more pronounced patriarchal social relationships. These relationships are characterized by unequal power relationships between men and women (Macwan'gi 1993, Dover 1995, Ndubani 1998, Baylies and Bujra 2000, Sulwe 2000). These same unequal gender relationships have been known to fuel the spread of the HIV/AIDS epidemic.

Further, although HIV prevalence is generally more than twice as high in urban areas compared to rural areas (23 percent and 11 percent respectively), rural areas are beginning to provide evidence for the rapid spread of the epidemic. For example, recent Demographic Health Survey for Luapula and Northern Province (located approximately 1000 kilometers from Lusaka) has one of the highest prevalence rates in the country, indicating an increase of 10 to 13 percent among women and 6-9 percent among men (CSOZ 2003).

The concern for the spread of the epidemic is further aggravated by the wide spread poverty experienced in most rural communities in Zambia. Many of these communities are faced with high levels of poverty, which exacerbates the impact of the epidemic on

peasant farming families. Many rural communities sustain their livelihood by growing crops both for their own consumption and to sell locally. Arguably, the high levels of poverty have been observed to worsen the spread of the epidemic in rural communities (Kurschner 2001, Kelly 2005). This is because, the combination of a high HIV/AIDS prevalence and extreme poverty foster a number of contextual, environmental and social factors, which are almost entirely outside these individuals' control. The poverty and social depression affecting rural communities has a profound and negative impact on the quality of life of most people living in these communities (Kelly 2004). Thus, the presence of HIV/AIDS in families threatened by this additional burden makes life even more difficult, in particular for children.

In the meantime, Cohen (1999) has identified a synergistic relationship between poverty and HIV/AIDS. He observes that HIV can bring poverty and can increase the spread of HIV/AIDS. This is because poverty and AIDS are closely related both in terms of their causes and effects (Cohen 1999). The early death of one or both parents in the family has often contributed to pushing the remaining members of the family into further poverty. In addition, the income situation for the remaining members of the family may become insecure or significantly constrained if the breadwinner suffers sickness and requires care.

Kelly (2004) has further observed that the poor may also be faced with increased vulnerability because their immune system may be depressed even prior to HIV infection, because of poor health and/or nutritional status. Many are faced with an inability to meet the costs involved in accessing health services. In the context of HIV/AIDS, there is also the problem of a greater likelihood of untreated sexually

transmitted infections (STIs) amongst the poor. This is because the poor may not have access or resources to obtain effective treatment for an STI. Furthermore, the presence of a STI is known to enhance the risk of HIV infection.

For this reason, Petauke district has been selected as a site for this study as it exemplifies in key respects the social situation in most rural communities in Zambia. This decision was additionally taken on account of a situational analysis conducted by the Planned Parenthood Association of Zambia which found that many people in the surrounding communities in Petauke district saw HIV/AIDS as their priority sexual and reproductive health concern (PPAZ 2002). Women were particularly concerned about their husband's sexual behaviour, which exposed families to the risk of HIV infection. They highlighted the need for men's participation in efforts to address the HIV situation within the communities (Gordon 2000b).

Against this background and in conjunction with a review of the relevant literature, this study provides insights into the complex challenges facing the promotion of male HIV/AIDS safe sexual behaviour in marital relationships. The study concludes by presenting proposals grounded in the need to engage with the social construction of masculinity to inform health promotion practice in Zambian rural communities. In these proposals I argue in this thesis that while HIV/AIDS is primarily a sexually transmitted infection, health promotion efforts aiming at influencing positive behavioural change particularly among men will remain ineffective unless such efforts move beyond individual behaviour change to address the underlying factors driving the epidemic. In this same vein, I further argue that it is in fact in men's interests to challenge the

current imbalance in the gender order, for the sake of their own health and their family's health.

### **1.1 Aims**

In this study, I aim to examine the perceptions of both local men and women about the ways in which aspects of the social environment in Petauke District in Zambia have influenced the notions of masculinity, and their perception about the interconnection between masculinity and the risk of HIV/AIDS in marital relationships.

Using Petauke District as a case study, I further explore the participants' perceptions about the interconnections between masculinity and gender based violence as a factor to the risk of infection. The study in addition examines how dominant ideologies of masculinity have shaped both men and women's perspectives about masculinity and the way in which this relates to the use and lack of use of condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marriages.

Finally drawing on these findings I review the existing HIV/AIDS prevention strategies in Petauke District. This review is carried out with a view to identifying gaps and opportunities which can be utilized to form the basis upon which health promotion strategies can be developed to incorporate programmes that promote male involvement in HIV/AIDS risk prevention in marital relationships.

### **1.2 Objectives**

The objectives of this study are:

- To examine and elucidate the perceptions of both local men and women on how aspects of the social environment affect and shape notions of masculinity and how this relates to the risk of HIV/AIDS transmission in marital relationships in **Zambian rural communities**.
- To examine and describe the perceptions of both local men and women about the interconnection between masculinity and domestic violence and how this might result in the risk of HIV/AIDS transmission in marital relationships.
- To explore and elucidate the perception of both local men and women on how the dominant ideologies have shaped their perspectives about masculinity and the way in which this relates to their perspectives about the use and lack of use of condoms in marital relationships.
- Based on these findings, to describe ways in which men's active participation and involvement in community-based HIV/AIDS prevention strategies can be improved.

### **1.3 Research questions**

The main research questions in the context of the Petauke District in Zambia are:

1. What are the stakeholder perceptions of the ways in which aspects of the social environment influence notions of masculinity and how these impact on men's risk of infection and HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?
2. What are the perceptions of local men and women on the interconnections between notions of masculinity and gender based violence as a risk factor in HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?
3. What are local men and women's perceptions in rural Zambia of the social and individual behavioural factors which influence men's decisions on whether or not to use condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marital relationships?
4. How can current HIV/AIDS risk prevention strategies be revised and developed to enhance men's participation and involvement in reducing the risk of HIV transmission in heterosexual marital relationships in rural Zambia?

#### **1.4 Rationale**

##### **1.4.0 Why focus on heterosexual men and HIV/AIDS?**

This study is focused on men in heterosexual marital relationships. This is premised on the evidence that more than 80% of HIV infections in Zambia are attributed to heterosexual infections (Fieldhouse 2001; MoH 1999; Garbus 2004; UNAIDS 2004). Evidence suggests that many men do not put themselves or their partners at risk through their sexual practices and behaviour, however without men; HIV would have

little opportunity to spread. Indeed, studies claim that heterosexual intercourse contributes to 80% of HIV/AIDS infections, underpinning the importance of beliefs about masculinity. For this reason understanding the perspectives of both men and women on how they consider the social environment to influence male HIV/AIDS sexual risk-taking behaviour and practices is of fundamental importance to health promotion efforts aimed at stemming the spread of the epidemic.

The focus on the heterosexual mode of transmission is not to ignore, however, the equally concerning dimension of HIV/AIDS transmission through same sex relationships between men. Although it is not the focus of this thesis, men in Zambia have also been associated with the spread of the HIV/AIDS epidemic through same sex relationships (UNAIDS 2004). As is the case in many countries across the world, some men are known to have sex with other men (Rivers and Aggleton 1998, Carovan 1998, Aggleton 2000). Some do so because they prefer men sexually. Most men who have sex with men also have sex with women. Nevertheless, evidence on the extent to which same sex relationships have contributed to the spread of the epidemic is unavailable because of the taboo nature of this subject in Zambia. Same sex relationships in the form of sexual abuse have been publicly acknowledged in places like prisons. However, the prevalence of mutually consenting homosexual relationships in the wider population remains a relatively hidden topic (UNAIDS 2004).

The focus on heterosexual relationships is further coupled with evidence that ordinarily; notions of masculinity ensure that men occupy an elevated status in gender relations (Dover 1995, Ndubani 1998, Foreman 1998, Bergstrom 1999; Panos 2000). The hierarchical nature of marital relationships has, in many societies, meant that men

have the power and influence to determine the reproductive health choices of women. In the face of this inequality, women may have little or no control over sexual decisions in marital relationships. Furthermore, for economic and cultural reasons men tend to have the dominant position in decision-making regarding sexual relationships (Macwan'gi 1993, Foreman 1999, Baylies and Bujra 2000, Sulwe 2000). In Zambia, this has led to the conclusion that most heterosexual transmission has occurred within the context of unequal gender relations.

Concern over men's role in the risk of HIV/AIDS transmission through heterosexual relationships is not unique to Zambia. Since the outbreak of the epidemic in the late 1980's, men's role in HIV/AIDS transmission and risk prevention efforts remain a growing concern for policy and programme interventions at both the international and sub-Saharan African regional level. The International Conference on Population and Development held in Cairo in 1995 which brought together delegates from 180 countries across the globe, and the Fourth Women's Conference held in Beijing in China in 1996 were major catalysts in raising interest in involving men in reproductive health issues and HIV/AIDS risk prevention (United Nations, Beijing 1995; United Nations ICPD, Cairo 1995). Subsequently, cross-cultural studies in different social settings as disparate as Latin America, Europe and indeed within sub-Saharan Africa show that men stand an enhanced risk of infection because they tend to have more sexual partners than heterosexual women (Leopold 1977; De Keijzer 1995; Wegner et al 1998, AVSC 1998; Population Reports 1999, Rivers and Aggleton 1999, Aggleton 2000; FHI 2001). In addition, drug use involving injecting, and failure to employ safer sex measures such as the use of condoms have been identified as exposing men to the risk of infection (Carovan 1998, Rivers and Aggleton 1999, Aggleton 2000).

In sub-Saharan Africa, a region badly affected by the epidemic, social researchers and commentators Obbo (1980), Ankrah (1993), Cornwall (1997), Aggleton (2000), Rivers and Aggleton (1999), Baylies and Bujra (2000) have called for the equal attention of both men and women for HIV/AIDS risk prevention efforts to succeed. The need to focus on men is based on three concerns. Firstly, although it is known that 90% of HIV infections in sub-Saharan Africa have been spread through sex between men and women (Fieldhouse 2001, UNAIDS 2003), men still remain a remarkably under represented sub-population group in HIV risk prevention efforts (Ankrah 1993, Rivers and Aggleton 1999, Aggleton 2000). Furthermore, evidence and lessons learnt from a number of both regional and international studies in addressing sexual violence and HIV indicate that men are also frequently the decision-makers about whether and under what conditions women and girls have sex (Heise 1998, Baker 1999, Jewkes 2002b). It is usually men who decide on the number of and variety of sexual relationships (Foreman 1998, PANOS 2001, UNAIDS 2003). Men also tend to make decisions on the frequency of sexual activity and it is often men who decide about the use a condom or other means of protection against the risk of infection (IPPF 1998b, FHI 1998, UNAIDS 2003).

Secondly, there is an international consensus that little will change for many women in many sub-Saharan African countries unless men change as well (Ankrah 1993, Cornwall 1997, Lamptey 2002, Shelton 2004). For many women, the lack of power to control their sexual and reproductive lives makes them vulnerable to the risk of infection. This is because, for cultural and economic reasons, men are often in a

stronger position in their relationships with women to decide when and where to have sex, as well as whether or not to use condoms (Heise 1998, Caldwell 2000).

It has also been observed that while women have been the targets of many AIDS prevention interventions the reality is that it is difficult for many women to take effective control of a sexual encounter with their husbands or intimate partners. Research indicates that many women continue to experience difficulties in insisting on protection measures within marriages because of their economic dependence on men (Baylies and Bujra 2000, Caldwell 2000). For example, the emphasis on the ABC model (A for Abstinence, B for Be faithful, and C for use a Condom) as a strategy in health promotion for HIV prevention has raised considerable debate on its effectiveness in marital relationships (Lamptey 2002, Shelton 2004). This model has been found to be difficult and inappropriate in many countries where women know little, if anything, about HIV and are afraid to ask their husbands or intimate partners to use a condom. It has further been argued that the ABC model has little relevance to many girls and women; they maybe coerced into early sex, be raped, or resort to transactional sex as the only means to survive, to pay school fees, or to gain material benefits, status and security (Jackson 2004)

Thirdly, despite an acknowledgement that the involvement of men is critical to inhibit the spread of the epidemic, men remain an under-represented population group in HIV risk prevention efforts. Historically, most programmes providing reproductive health services in many developing countries focused attention on family planning and offered their services exclusively to women (FHI 2001, Mbizvo and Basset 1996, Population Report 1999). Most interventions viewed women as their target group and

paid little attention to the role that men might have with respect to reproductive health decisions. The reason for this focus on women was because of the real threat that excessive childbearing posed to women's health. A further justification was based on the strong link and synergy between family planning and women's improved health status and the quality of child and family welfare (Meredith 1998). Although these reasons do justify an emphasis on engaging with women in family planning programs, in practice this has resulted in men being effectively excluded from many programs either deliberately or by default (Meredith 1998).

Furthermore, while efforts have been made to interest men in utilizing such services, it has been shown that men may feel out of place and unwelcome at reproductive health centers and clinics often used by women (FHI 2001). So, while this institutional framework still remains a key outlet for the provision of HIV risk prevention efforts in many developing countries, this shortcoming contributes to a situation where many men have unmet sexual and reproductive health needs despite being widely acknowledged to play a critical role in the spread of the epidemic (Carovan1998, Foreman 1998, Rivers and Aggleton 1999, Panos 2001).

The lack of a consistent and strategic approach to involving men in HIV risk prevention and reproductive health promotion in Zambia as in many sub-Saharan African countries has therefore resulted in a lack of information about men's ideas on reproductive health and in the neglect of appropriate programmes for male involvement and participation in reproductive health matters (Meredith 1998, Population Reports 1999). For these reasons involving men has become one of the major challenges for program interventions. Programs have thus been urged to focus

on both men and women with equal attention in order to prevent the spread of the disease (Ankrah 1993, Cornwall 1997, Baylies and Bujra 2000).

#### **1.4.1 Why a focus on HIV/AIDS in marital relationships?**

My focus in this thesis on HIV/AIDS in marital relationships, is in the context of a situation in Zambia where patriarchal social relationships legitimize men's power in sexual decision-making, coupled with social norms that inhibit women from talking about sex, make marital relationships a potentially high risk arena for HIV/AIDS infection (Macwan'gi 1993, Wallman 1998, Ndubani 1998, Baylies and Bujra 2000, Gordon 2000a). These inequalities are further sustained through traditional practices where girls learn from an early age to submit to the wishes of their husbands; and initiation rites amongst females often reinforce this submission (Fleischman 2002)

Furthermore, although in many Zambian traditions, mutual monogamy in marital relationships is a social ideal, married men may still engage in risky sexual practices such as having multiple sexual partners and not using condoms to protect them from the risk of infection (CSOZ 2003, Ndubani 1998). Thus men in marital relationships are more likely to transmit HIV/AIDS to women in marital relationships through unprotected acts of sexual intercourse than vice versa. Women's risk of infection is further exacerbated because women are physiologically more vulnerable to the virus in an unprotected sexual encounter compared to men (Fieldhouse 2001, UNAIDS 2004).

In many sub-Saharan African countries, research has further shown that because of women's economic dependence on men and fear of violence and destitution, many women endure unprotected sex and abusive relationships to maintain their marriages (Baylies 1995, Heise 1998, Jewkes 2002a, Lamptey 2002, Shelton 2004). For instance in Rwanda, where a study was conducted on the risk of infection in marital relationships, it was found that 40% of the women infected with HIV were infected by their marital partners while the women were monogamous (UNAIDS 2000c). The UNAIDS Epidemic Update for 2004 (UNAIDS 2004) further reports that in sub-Saharan Africa one of the main HIV risk factors for a woman is the fact she is faithful to a husband who has (or had) another sexual partner(s). Among sexually active young women aged 15-19 years in the cities of Kisumu (Kenya) and Ndola (Zambia) a multi-centred study reported that HIV-infection levels were 10% higher for young women who were married, compared to those who were sexually active but unmarried (Glynn 2002). Furthermore, data on Kenya and Zambia reveal that the rate of HIV infections in husbands was higher than in the boyfriends of sexually active single teenage women (UNAIDS 2003). In rural Uganda, among HIV-infected women aged 15-19 years, 88% were married (Kelly et al 2004). This is because young women, particularly teenagers, often marry men significantly older than them, and these men are more likely to have had other partners and therefore more likely to have been exposed to HIV.

Alongside this important issue, is a further reason to focus on exploring the behaviour of men in marital relationships in relation to the transmission of HIV/AIDS. This is because of the difficulties that the presence of HIV/AIDS brings in a marital relationship. Schoepf (1995), Baylies (1995), and UNAIDS (2003) and have observed

that an HIV/AIDS infection in a marital relationship has multiple implications for the entire family by affecting their standard and quality of life. Firstly, in the event of an infected wife getting pregnant, there is a risk that a pregnant mother can pass on the infection to the newly born child through mother to child transmission. (UNAIDS 2000b). In Zambia, it is estimated that about 30-40% of infants born to women infected with HIV become infected, with around 21 children becoming infected every year pre-partum or post-partum (Bond, Ndubani et al 1999). Secondly, amongst those most affected by the disease are children orphaned or otherwise burdened by its devastating consequences. Nyirenda (1997), UNICEF (1998), have observed that normal life for many children is often disrupted and dramatically changed. Children suffer the pain of seeing one or both parents getting repeatedly ill, often with acute bouts of illness and subsequently dying from infection. Thirdly, as well as experiencing the trauma of watching their mothers, fathers, aunts and uncles die, many children orphaned by the epidemic are faced with the realities of reduced household security. As one or both parents are taken ill and eventually die from HIV/AIDS children are faced with reduced educational opportunities and hence long-term economic disadvantage in a loss of livelihood.

Children living in households with reduced income are more likely to suffer malnutrition, and be compelled to work in order to survive. Some are forced from their homes due to stigma and discrimination directed at households affected by HIV/AIDS or find themselves at the risk of being sexually abused and consequently being infected with the virus that causes AIDS (Schoepf 1995, WHO 1995, UNAIDS 2000a). A recent Human Rights report documents widespread sexual abuse against girls

particularly amongst those orphaned by AIDS, living in the streets or in extreme poverty (Fleischman 2002).

As primary caretakers of the family HIV/AIDS affects women disproportionately as they are likely to carry the larger share of the burden and to be more extensively affected (Jackson 2004). This is because, in addition to the burden of their own illness, they are expected to provide the first level of healthcare as well as moral support to other family members in times of illness (Jackson 2002). These demands are made even more difficult for women in rural communities, for whom custom dictates other responsibilities such as fetching water, collecting firewood and attending to the other domestic needs of her family.

#### **1.4.2 Why focus on the social construction of masculinity?**

This study focuses on examining both men and women's perceptions of how notions of masculinity are shaped through interpersonal interaction and communication, and how this intersects with the risk of HIV/AIDS transmission in marital relationships. This is from a background that notions of masculinity, which enhance risk taking, are socially constructed (De Keijzer 1995, Edley and Wetherell 1995, Sampath 1997, Connel 2000, Courtney 2000, Doyal 2000). Underlying this theoretical framework is the recognition that individuals, whether male or female, go through a specific process of socialisation with subsequent integration into the wider society in relation to their gender identity and behaviour (De Keijzer 1995, Sampath 1997, Shepard 1998, Baker 1999, Connel 2000). This implies that masculinity is a social phenomenon constructed

within a particular setting and social context. Notions of masculinity will therefore differ according to the social and cultural background in which they are defined. This diversity concerning notions of male identity has given rise to different forms of expressions concerning masculinity, which Connel (2000) describes as the context-bound social construction of masculinity i.e. that the concept of men's masculinity will differ depending on the social cultural and economic environment in which the notions of masculinity are constructed and/or expressed. For this reason, it is more accurate to speak of a context-specific cultural construction of masculinity rather than assuming that the social construction of masculinity takes a universal monolithic form (Kimmel 1987, Connel 2000). From this definition, it also follows that different sub-groups within any one culture may define masculinity and indeed femininity differently according to sub-cultural definitions (Lindsley 1997, Brittan 2001).

In order to fully understand the context-bound social construction of masculinity (Connel 2000) and the manner in which this is associated with HIV risky sexual behaviour it is important to understand the social systems and networks which characterize social interaction. This would include factors such as education, economic status, and the influence of cultural beliefs, practices and the social context (Aggleton 2000, UNAIDS 2000c). These factors are known to powerfully influence sexual risk taking and which can also enhance vulnerability to the risk of HIV infection. For example, the relative powerlessness of women to protect themselves derives not only from differences in the material resources of individual men and women but also from differences in the social positions of men and women which are institutionalised by society (Ankrah 1993; Mbizvo and Basset 1996, Heise 1998; Baylies and Bujra 2000).

In Zambia for example, notions of masculinity assign men an elevated status in gender relations. This has meant that men have the power to influence and/or determine the reproductive health choices of women (Jackson 2004). These notions of masculinity are also known to compromise men's health by encouraging men to equate a range of risky behaviours such as the use of violence, alcohol, the pursuit of multiple sexual partners and the abuse of women while simultaneously encouraging men to view health seeking behaviour as a sign of weakness (Dover 1995; Bergstrom 1999, Greg et al 2000). Therefore, although the determinants that influence individual sexual activity are subtle and complex, it is reasonable to expect that aspects of the social environment may have an important influence and affect the frequency of risky sexual behaviour (Freudenthal 2001, Webb, 1997). It can thus be argued that while HIV/AIDS is primarily a sexually transmitted infection, a proper understanding of the underlying factors driving the epidemic is not possible without understanding the social construction of notions of masculinity which shape sexual behaviour.

Against this background, an examination of how men's masculinity and sexual behaviour are socially constructed becomes necessary for a proper understanding of the spread of the HIV/AIDS epidemic.

#### **1.4.3 Why focus on domestic violence and the risk of HIV/AIDS?**

This study focuses on exploring the interconnection between domestic violence and the risk of HIV/AIDS in marital relationships. This is because there is increased

evidence that there is a connection between these factors. The IPPF (2000) describe sexual violence as including acts of forcing another individual through violence, threats, deception, cultural expectation, or taking advantage of economic circumstances to engage in sexual behaviour against his or her will. In marital relationships, sexual violence can be defined as any intercourse or penetration (vaginal, anal or oral) obtained by force when the wife is unwilling to consent. More specifically, domestic violence perpetrated through rape and sexual coercion, inflicted by men, has become an increasing area of concern within HIV/AIDS literature worldwide.

It has also been reported that for many women, the risk of HIV/AIDS may be occasioned through fear of actual violence arising from trying to persuade their husbands to desist from extra marital affairs or in attempts to encourage their partners to use condoms to reduce the risk of HIV infection (Heise 1998, Bujra 2000). Studies further indicate that female victims of domestic violence are less likely to negotiate safe sexual relationships or family planning. Similarly, men who have been violent at some point in their lives are less likely to be involved in positive ways in reproductive health matters (Wood and Jewkes, 1987) Furthermore, violence and coercive practices limit an individual's capacity for autonomous action and self protection against unwanted sexual intercourse, pregnancy and HIV/STD (Wood and Jewkes, 1987).

In South Africa, Jewkes (2002a) found that women with violent and controlling male partners were at an increased risk of HIV infection. The study further observed that there was a strong possibility that men who were violent and abusive towards women

were more likely to be infected with HIV because of other aspects of their behaviour such as having multiple sexual partners. In addition to exposing a person to the risk of HIV/AIDS infection, domestic violence has a profound impact on the physical and mental health of those who experience it. As well as inflicting physical injuries, domestic violence is associated with an increased risk of a range of mental health problems. It was also observed that domestic violence is an important cause of mortality from injuries and suicide. The issue of the connection between domestic violence and risk of HIV/AIDS infection is an area of growing global debate. However, this interconnection with the risk of HIV/AIDS infection within the context of rural areas of Zambia remains limited in recognition.

Against this background, the rationale for exploring the interconnection between domestic violence and the risk of HIV/AIDS in marital relationships is that many marriages in Zambia, regardless of their cultural environment, experience the problem of domestic violence (PPAZ 2002). In Zambia, as in most other cultures, men often perpetrate domestic violence, with women and children being the most common victims. While domestic violence may be widespread, many traditions and cultures in Zambia differ with the extent to which it is possible to openly discuss the problem of domestic violence within a home. Some of the victims in marital relationships are expected to simply accept that domestic violence is 'a way of life' or at least not to discuss it. Many victims do not talk about it for the protection of their family honour (Green 1999). In Zambia, as in many other countries, sexual coercion in marriage is not a recognizable offence. Even where the law might be brought into play, it is extremely difficult for a woman to successfully charge her husband with rape or to gain the support of her family or community.

Through analysing the perceptions of local men and women I intend in this study, to provide an insight into the issues involved in the interconnection between domestic violence and the risk of HIV/AIDS, in the hope of providing a better understanding. This in turn will assist with the development of the necessary interventions. Furthermore, the community-based contextual analysis it provides might increase the effectiveness of interventions targeted at preventing HIV/AIDS infections associated with domestic violence.

#### **1.4.4 Why focus on men and condom use in marital relationships?**

Although the consistent and correct use of condoms has been widely adopted among various sexually active population groups, marriage is the relationship with the least documented use of all (Population Reports 1999). It is in this light that I will explore in this thesis male and female participants' perceptions of how dominant ideologies of masculinity are reflected in married men's use of condoms as a measure of protection against the risk of HIV/AIDS. Health promotion worldwide has promoted what has become known as the 'ABC' of HIV/AIDS prevention. (A for Abstinence, B for Be faithful, and C for use a Condom). This is because abstinence from sexual intercourse or maintaining a mutually monogamous relationship between partners known to be uninfected is the surest way to avoid transmission of HIV and other STIs. Outside of those conditions, Condoms have been an important and successful intervention in many places, particularly when targeted at commercial and other casual sexual encounters. While no barrier method is 100% effective, correct and consistent use of

latex condoms can significantly reduce the risk of transmission of HIV and some other STIs (IPPF, 1998, UNAIDS 2000a, WHO 2001).

In Zambia as in other countries, condom use has increased significantly amongst most of the sexually active population groups but their use is much lower within marital relationships (Population Reports 1999). This is because marital relations are commonly centred on mutual trust and intimacy, and the proposal to use a condom may appear offensive and threaten the quality of the relationship (Parker 2000). Such a request to use condoms in a marital relationship can be interpreted as evidence that a partner has acquired an infection or is unfaithful or that he or she thinks that the partner is involved in another sexual relationship. Some people do not use condoms because they know little about them; others dislike them; cannot afford them and/or cannot obtain them easily (UNAIDS 2000a, WHO 2001). Others believe, wrongly, that they face little or no risk of infection. The desire to have children would also prevent consistent condom use within long-term relationships (Jackson 2004). Since condoms prevent conception as well as HIV infection they are strongly associated with uncommitted relationships. It is notable in this context that commercial sex workers are often more able to insist on condom usage with clients where an emotional relationship is not involved, and the financial relationship is explicit (Worth 1998).

#### **1.4.5 Why focus on rural communities?**

This study focuses on HIV/AIDS in marital relationships in rural communities in Zambia for a number of reasons. Since the first diagnosed case of AIDS in Zambia in

1984, HIV/AIDS has become increasingly widespread with an estimated adult HIV prevalence of 14% in rural areas of which 28% of those infected are between 15-49 years of age. Although the epidemic is showing signs of stabilization in urban areas, the rates continue to rise in some rural areas (Zambia National HIV/AIDS/STD/TB Council 2000). There is concern for the increased spread of HIV in rural communities, as these tend to be particularly conservative societies, having entrenched belief systems and more pronounced patriarchal social relationships. Interestingly, relatively high levels of poverty also characterize these types of societies. These factors increase the risk of HIV/AIDS transmission in marital relationships and exacerbate its consequences. This leads to poor health, which in turn makes a person more vulnerable to the infection. Poor health can also shorten the incubation period of the virus due to a weakened immunity system, causing symptoms to appear sooner. This situation is especially severe for the rural poor who have the least access to medical care.

The presence of HIV/AIDS has compounded the already difficult circumstances and situations that rural families are faced with. Families affected by the epidemic have experienced loss of adult labour, as adults fall sick and die resulting in a decline in productivity, loss of assets and income. This has, in turn, increased household expenditure to meet medical and funeral expenses. It has further seen a rise in the number of dependents relying on a smaller number of productive family members. Rural communities affected by high HIV/AIDS mortality rates have further responded with changes in land ownership and utilization. This has also been associated with changes in food and cash cropping patterns, reduced food storage and sale of livestock holdings. Diminished adult and child nutrition has also resulted. Adaptation

strategies have included female members of the family being forced to marry at a young age and in some instances, fosterage. Female-headed households tend to be the most vulnerable (UNAIDS, UNICEF, USAID 2004). Orphans are sometimes cared for by grandparents, uncles or aunts or even their own siblings. Children without mothers are more likely to suffer morbidity and mortality because of the absence of mothers who are traditionally caregivers. Children are left emotionally and physically vulnerable by the death of their parents. They may attend to dying parents and witness both parents die. Children will provide care for ill adults and provide considerable assistance in subsistence agriculture and income generation. Adults sometimes see their children die and assume care of their grandchildren (Haworth 1991, Nyirenda 1997, UNICEF 1998).

In summary, high poverty levels, low literacy, malnutrition, lack of ability to mitigate preventable infections and lack of access to healthcare all increase the spread of the epidemic (Panos, 2000). Other barriers include the physical distance between patient and health centers and the fact that patients must pay for drugs. These factors cut dramatically access to life-saving treatments for individuals who live in poor rural areas. Most populations in rural communities are peasant farmers and their income is dependent on seasonal harvests, determined by good weather pattern. In recent times, farmers burdened by the poor results of a harvest after drought have struggled to provide food, even for their own families.

At a health promotion level, the lack of media channels such as radio, television and newspapers in many rural communities of Zambia makes it difficult for the poor to access information. Thus the poor are less able to equip themselves with the

knowledge to prevent the risk of infection. Overall, the poor economic circumstances make it difficult for many people within rural districts to respond to the challenges associated with HIV infection in the family or their communities generally, making life in these rural communities dehumanizing.

### **1.5 Literature Review**

Information for the literature review for this study was obtained using Medline, internet based AIDS databases, global AIDS libraries and the United Nations Development Program (UNAIDS) website and its publications. Other sources included authored books; and internet search of electronically-based databases using subject area keywords, journals and newspapers.

The literature review of health promotion activities and practices in Zambia involved a review of policy documents, research reports, minutes of meetings and program coverage reports. Other documents reviewed included internationally authored peer reviewed books and journal articles related to the various topic covered in this thesis.

In addition to published materials drawn upon for this case study, supplementary information around the research topic was obtained through interviews and conversations with key reproductive health, family planning and HIV/AIDS experts at various levels of policy development. Project management, NGO leadership, clinic staff, government health specialists and medical personnel also served as key sources of background information for the study.

## **1.6 Methodology and Methods.**

In conjunction with a review of the relevant literature, this study utilized a qualitative approach to collect and analyze data from the field. Data collection comprised the use of semi-structured interviews with 30 married men and two focus group discussions with 30 currently married or previously married women.

All in-depth interviews and focus group discussions were conducted in Nsenga, a local language spoken in Petauke District, recorded on audiocassette and subsequently translated into English for analysis.

## **1.7 Data Analysis**

The processing and analysis of the data used a thematic analysis method. Thematic analysis is a search for themes that emerge as being important to the description of a phenomenon. The process involves the identification of themes through careful reading and rereading of the data to identify recurrent statements emerging from the data.

In the present study the process of data analysis started with the translation and transcription of participant's stories gathered in the field. A close reading of the first several transcripts was done to identify recurrent statements emerging from the data. This formed the basis upon which an initial list of codes was developed.

Using the Nvivo qualitative data management programme this formed the basis upon which the participant's stories were categorized into recurrent statements, patterns of responses and concepts. This in turn formed the basis for categorizing the data into broad thematic areas. These concepts provided a structure of coherence, a sense of order and also an explicit point of meaning to the data. The concepts and themes which emerged at this stage of the analysis were used in the analysis iteratively by going back to check these themes against the text. A detailed account of the methodology and process of data analysis are discussed in Chapter Six.

### **1.8 The specific local research context.**

The study setting of Petauke is a typical rural community in the Eastern province of Zambia with a population of approximately 1,200,000 people (CSO Zambia 2002). HIV/AIDS prevalence in Petauke is estimated at 17% among adults in the general population. The district is located about 320 kilometers from Lusaka, the capital city of Zambia. Administratively, the district falls within the Eastern province of Zambia. It is predominantly a rural district with poor roads, remote villages and few communication channels.

A situational analysis of a project implemented by the Planned Parenthood Association of Zambia conducted in 2000 revealed that many communities see HIV/AIDS as their priority sexual and reproductive health concern (PPAZ 2002). Women were particularly concerned about their husband's sexual behaviour, which exposed families to the risk of HIV infection. This project highlighted the need for

men's participation in efforts to address the HIV situation in the communities (Gordon 2000b).

The main occupation among adults in Petauke is subsistence farming with many families experiencing seasonal food shortages. The literacy levels amongst both men and women are low (CSO Zambia 1992). Educated young people migrate to the urban settings of the country in search of employment and economic sustainability. Social services such as health, education and the supply of clean water are rudimentary and basic. Preventable illnesses such as malaria, dysentery, and diarrhoea are endemic.

An additional consideration for choosing Petauke is that in many rural communities there is a kinship system, which legitimizes the social and cultural practice in which men occupy an elevated position in their social relationships with women in both the public and private sphere. As such, men may wield power against women, which carries implications in sexual behaviour and domestic violence. Men may also serve as community 'gate keepers' for social change and community-based resources, and influence decisions regarding the provision of health services. Men can therefore become powerful allies in the fight against the spread of the epidemic.

### **1.9 The significance of the study.**

This study is unique as it addresses a relatively unexplored area of the association between the social construction of masculinity and the risk of HIV/AIDS in marital relationships. While a number of notable studies focusing on the social construction of

masculinity and HIV/AIDS have been conducted in many different settings, the focus on the risk of infection of HIV/AIDS in heterosexual marital relationships in sub-Saharan Africa still remains a relatively unexplored area. Some of the notable studies within context of sub-Saharan Africa and in relation to this topic so far, include a study on the social construction of manhood in Nigeria: Implications for male responsibility in reproductive health (Olawoye et al 2000); a study entitled Men, masculinities and development : Broadening our work towards gender equity by Greg et al, (2000); Young men and the construction of masculinity by Baker and Ricardo (2005), Men's role in HIV/AIDS prevention by Aggleton (2000) and a more recent study by Anthony Simpson (2005) entitled Sons and Fathers/Boys to men in the time of AIDS: Learning Masculinity in Zambia. All these studies have illuminated and provided a useful insight on how the influence of the social environment and childhood socialisation process including peer pressure all play a role on what it means to be a man. They highlight the influence of how a number of societal factors such as cultural roles and expectation, religious influence and the economic environment determine male attitudes and behaviour.

My study takes this understanding a step further by elucidating the association between the social construction of masculinity and male sexual behaviour in relation to the risk of HIV/AIDS transmission in marital relationships. It extends the body of literature by providing an insight for health promotion practice in addressing the challenges of the risk of HIV/AIDS in a marital relationship. A particularly unique feature in addressing the problem of HIV/AIDS in marital relationships is that many marriages in Zambia as is the case in most parts of the world are often considered as stable institutions, where the risk of infection is not as pronounced as would be with

other populations such as amongst commercial sex workers, truck drivers or men in uniforms. As a result of these assumptions increased emphasis in AIDS research has been focused on understanding the dynamics of the spread of infection amongst populations considered at high risk of infection. This has left out other vulnerable groups such as the population groups which this study has focused upon (This is a personal view point of the author after a long experience in participating in HIV/AIDS research in Zambia).

By focusing on men, I do not seek in this thesis to replace the important work to reduce vulnerability and the risk of infection among women and girls but rather to complement these efforts. My work is driven by a conviction that parallel programs for men and boys are crucial in ensuring that men protect not only their own health but also the health of their intimate partners and families. Furthermore, men have a personal investment in challenging the current gender order for their own health reasons and that of their families and also because they do not want to place the women they care about at risk of HIV/AIDS infection. Thus, by focusing on developing working partnerships with men it is hoped that men can be seen as part of the solution to preventing the spread of the infection.

While there is no one set of interventions that will work in every context, the findings of this study could, to some extent, be utilised as a 'blue-print' for transfer to other marginalized and impoverished communities that have circumstances similar to the social setting in Petauke. The sharing of knowledge resulting from this study will be achieved through a wider dissemination of the findings through publications, internet exchange, seminars and consultations with various interest groups such as

humanitarian associations, development agencies, practitioners, and other relevant professionals.

**Chapter Two:**

**Theoretical Background  
&  
Conceptual Framework**

## **2.0 Introduction**

In this chapter, I describe the theoretical conceptualization and framework which guide the development of this study. First, I introduce and critique the main theoretical perspective which informs this thesis, namely a social constructionist approach to masculinity. I then discuss the justification for taking this standpoint forward through my examination of the interconnections between domestic violence, and men's use of condoms and the risk of HIV/AIDS transmission in marital relationships. I then briefly outline existing health promotion approaches, indicating that they do not take account of how masculinities are historically and socially constructed, including the potential for change this offers. For this reason I argue for the need for health promotion practice to accord weight to a social constructionist approach and, as subsequently explored in this thesis, that this may identify some promising ways in which HIV/AIDS can be combated in Zambia.

### **2.1 Social constructionist perspective.**

This study is informed by a social constructionist perspective. This perspective argues that the idea of an objectively knowable truth is unsustainable because what we see and understand is always subject to our interpretations. Such interpretations will also always be profoundly influenced by the language and social discourses within which we frame our understandings (Hoffman, 2001). From this perspective knowledge is therefore not 'out there' to be discovered by the dispassionate scientist, rather we construct knowledge through inter-subjective 'meaning-making' activities that are

shaped by our cultural context (Tiefer 1995). It is only through the interaction between the intrapersonal self (ideas, beliefs, history) and social cultural processes that the construction of knowledge is nurtured. 'Reality', then, is socially constructed (Berger, 1967). An individual's 'reality' is a fluid social phenomenon developed within the cradle of human communication (Hoffman 2001).

Broadly, the social constructionist perspective is anchored in four key assumptions that:

- 1) The way we go about studying the world is powerfully influenced by available concepts, categories and methods. Our concepts often incline us toward or even dictate certain lines of inquiry while precluding others, making our results the product of our language, or discourse rather than of empirical discovery.
- 2) The concepts and categories we use vary considerably in their meaning and connotations over time and across cultures. However we often assume that the concepts we use relate to permanent human experiences.
- 3) The popularity or persistence of a particular concept, category or method depends more on its usefulness (political, usefulness particularly) than on its 'validity'.
- 4) Descriptions and explanations of the world are themselves forms of social action and have consequences.

Against this background, social constructionists can look for diverse meanings in relation to particular phenomenon within and between social groups (Thompson 1992).

This is from a premise that identical acts may have different social and personal

meanings depending on how they are defined and understood in their different cultures and historical periods (Vance 1991).

For instance, human sexuality within a social constructionist perspective is never viewed as a fixed, biologically determined question because desire and sexual identities are seen to be shaped by complex processes of socio-cultural and interpersonal negotiation (Baber and Allen 1992). In exploring ideologies, definitions and regulations of sexual experiences, social constructionists are able to show how what might seem to be deeply personal identity choices are influenced by cultural and political discourses (Vance 1991).

This theoretical understanding resonates with Foucault's (1978) account in his *History of Sexuality* where he states that there is no such thing as an internal force or drive because sexuality is socially manipulated. Sexualities are constantly produced, expressed and modified, within the nature of discourse regarding sexuality and change accordingly.

For social constructionist theory, then, 'what it means to be a man' (or woman) is not simply a matter of biological endowment nor simply passed down by one generation to another, but rather comes from social transactions within an environmental, cultural, linguistic and historical context (Courtney 2000, Connel 2000). In other words, gendered identities are dynamically constructed through social interactions which are expressed within available concepts, language, discourses and conditions. Being male or female does not simply represent passive states of inheritance or

socialization but the outcomes of 'doing' gender in our daily transactions with each other.

If the reality of maleness and femaleness varies significantly between cultures, communities and over time, the impact of gendered behaviour on well-being will vary too. For instance, a man or woman's definition of health will be very different depending on whether the maleness or femaleness in question is mediated through poverty or wealth, through an urban cosmopolitan existence or life in a traditional village (Doyal 2000).

Connell argues that masculinity, as a practice, cannot be isolated from its social and institutional context because people's experiences, attitudes, behavior, physical and psychological functioning are inextricably linked to the social environment and the social structures in which they live. Similarly, Hess (1988) has noted that these dynamic social structures and lived experiences affect all human beings irrespective of sex age, social economic status and ethnicity. Thus one cannot be masculine in a particular way without being affected by the conditions in which that form of masculinity arises and is expressed in the dynamics of local transactions between the sexes. There is no *one* version of masculinity, rather there are multiple masculinities influenced by a host of different factors and histories. Thus the range of possible contextual, individual 'realities' implies that men experience their manhood very differently and that generalizations about men and masculinities need to be made with caution because local interpretations may undermine them.

## **2.2 A Critique of social constructionism.**

In adopting such a social constructionist perspective, this study does not do so uncritically. As subsequent discussion will show, it draws on this perspective, but its approach is mediated in the following main ways:

- First, its standpoint is sensitive to the dangers highlighted in Archer's critique (2000), which has argued that it is important to continue to take account of human beings' embodied nature, and human agency as a critical dimension of this. Archer has maintained:"

"Constructionism...impoverishes humanity, by subtracting from our human powers and accrediting all of them – selfhood, reflexivity, thought, memory and emotionality – to society's discourse', (2000: 4).

Other writers such as Burr (2003) have argued for a mid-way position, recognizing that the 'Individual/society dichotomy', (p.184) is an unresolved analytical issue for theorizing from a social constructionist perspective.

"Both micro and macro forms of social constructionism are ultimately unable to tell us to what extent we are able, either individually or collectively, to reconstruct ourselves and our society' (p.184).

This thesis reflects this standpoint. Both in its detailed review of social constructionist perspectives on the development of masculinity (see Chapter 4), and in the design and analysis of fieldwork, this study explores the complex ways in which human agency is defined and shaped through social interaction and language, but it does not adopt the position that analytically, human agency should be regarded as non-existent.

- Secondly, this thesis argues that men construct their masculinities in the social context in which they find themselves. It concentrates on exploring how male and

female participants at the local level in rural Zambia perceive masculinity to be defined and expressed through interpersonal interaction and language. This is in the interests of the study unraveling the significance of this process for the transmission of HIV/AIDS in marital relationships. However, it does not wish to fall into what has been typified as the trap of 'micro' social constructionist perspectives:

“The question of the extent to which our use of discourse is constrained or influenced by wider social and material circumstances is not really addressed”, (Burr 2003: 184).

Therefore, it provides an account of the intersection of social capital and economic development on an international, national and local scale, with the spread of HIV/AIDS, as the wider context in which the perspectives of interviewees in this study have developed. Accordingly, this is the focus for Chapter 3, and is seen as complementary to the major thrust of the thesis, which focuses on the particularities of what analysis from a social constructionist perspective of participants' perspectives and experience of masculinity yields.

### **2.3 The significance of local context**

An analytical approach that emphasizes the need to take account of the influence of the wider social environment on risk taking and the rise of HIV/AIDS has been advocated in a number of international protocols. Among these are the International Conference on Population and Development held in Cairo in 1995, and the Beijing Program of Action. Both these events called for the need to locate reproductive health behavior within wider social contexts (Lassonde 1995). This is in order that account is taken of how powerful factors such as poverty, the legal system, religious and cultural

practices are understood to expose both men and women to reproductive health risks, including HIV/AIDS (Lassonde 1995). This perspective is also reflected in the work of Farmer (1997) in Haiti, and Campbell (2004) in South Africa who explore how complex social environments influence individual risky behaviours.

Close to Zambia, in Zaire, Schoepf (1995) used a theoretical framework, which highlighted the entrenched nature of a poor economic environment as a key factor that shaped the community's sexual behavior and practices. However, his perspective also placed emphasis on exploring precisely how societal factors and networks influence and shape HIV outcomes for an individual living in a specific local community (Hart and Boulton 1995).

This thesis reflects this approach. While it is important to acknowledge the influence of yet wider social contexts, it argues that we also need to excavate and grasp the locally negotiated gendered meanings, which make sense of how HIV/AIDS is transmitted. It is on the basis of knowing more about these meanings that we can formulate local health promotion strategies more effectively.

For example, the association of masculine identities with risk taking behavior (e.g. having multiple sexual relationships) clearly has a bearing on health promotion matters, particularly in relation to HIV/AIDS and other sexually transmitted diseases. Although this association of risk taking with masculinity is generally acknowledged, awareness of how such notions of masculinity may be socially constructed in local communities has yet to significantly inform local strategies for HIV/AIDS intervention (Sumartojo 2000a).

## 2.4 Domestic violence and the risk of HIV/AIDS

This thesis explores local perceptions regarding the association between the social construction of masculinity and its connection with domestic violence as a risk factor for HIV/AIDS transmission, against a background of evidence that men employing violence as a strategy to maintain women in a subordinate situation is common in many societies (Heise et al undated, Heise 1998, Leye et al 2001, Jewkes 2002a, Lichstein 2004).

The extent of domestic violence is reflected in Heise's review of twenty studies from a wide variety of countries. She reports that from one quarter to over one half of women in many countries of the world identify as having been physically abused by a present or former partner. She concludes that the most endemic form of violence against women is wife abuse, or more accurately, abuse of women by intimate partners. In marital relationships, sexual violence can be defined as any unwanted intercourse or penetration (vaginal, anal or oral) obtained by force when either partner is unwilling to consent (IPPF 2000). Studies of marital rape have included couples that are legally married, separated, divorced or co-habiting. Most research on marital rape concludes it is an abuse of power, which usually involves the husband attempting to establish dominance and control over his wife (Yllo 1985, Dobash and Dobash 1989, Russell 1990). Some researchers have noted other risk factors; include drug and alcohol use by the abuser.

The International Planned Parenthood Federation (IPPF) (2000) describes sexual violence as including acts of forcing another individual through violence, threats, deception, cultural expectation, or taking advantage of economic circumstances to engage in behavior against his or her will. At its most fundamental, sexual violence represents the deliberate use of sex as a weapon to demonstrate power and to inflict pain and humiliation upon another human being (Bergen 1999). In circumstances of sexual violence, a person has no choice to refuse or pursue other options without severe social, physical or psychological consequences.

Studies are beginning to show that domestic violence does not only have a profound impact on the physical and mental health of those who experience it but there is now evidence that this to expose a person to the risk of HIV/AIDS infection.

In terms of sexual health and reproductive rights, such abuse diminishes women's capacity to express and enjoy their sexuality and to control fertility, while increasing their risks of pregnancy complications and of acquiring STIs including HIV/AIDS (see also Leye, et al 2001). Lichstein (2004), Jewkes (2004) and Heise (1998) have further argued that there is a strong correlation between sexual and other forms of abuse against women and women's chances of being HIV-infected. For instance, forced vaginal penetration increases the likelihood of HIV transmission. In addition, the fear of violence prevents many women from asking their partners to use condoms, accessing HIV information, and from getting tested and seeking treatment, even when they strongly suspect they have been infected.

If HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls. Acts of sexual violence and sexual abuse including rape, forced, or coerced sex have been identified as enhancing the risk of HIV/AIDS in marital relationships (Heise 1998, IPPF 2000, Jewkes 2002b). Similarly acts of domestic violence perpetrated through fear or threats that prevent women from persuading their husbands to desist from extra marital affairs or prevent women from encouraging their partners to use condoms to reduce the risk of HIV infection have been identified as contributing to the risk of infection (Heise 1998, Bujra 2000).

In South Africa Jewkes (2002a), found that women with violent and controlling male partners were at an increased risk of HIV infection. Men who were violent and abusive towards women were found to be more likely to be infected with HIV because of other aspects of their behavior such as having multiple sexual partners. Furthermore, the emerging literature on the connection between domestic violence and HIV/AIDS points to growing evidence that a large proportion of new cases of HIV infection are due to gender-based violence (Heise 1998, UNAIDS 2003). Additional research confirms a further vicious circle: that many women are in danger of being beaten, abandoned or thrown out of their homes if their HIV-positive status is known (Jewkes 2002a).

Evidence suggests that the problem of gendered domestic violence has existed in Zambia for a long time (YWCA 1999, Zambia Gender Policy 2002,). It is manifest in many different ways such as femicide, spouse battering, property grabbing, and rape in and outside marriage and other forms of domestic violence including incest especially of girl children (Fleischman 2004). Although instances of both men and

women being victims of gender violence have been reported it is women who are predominantly subject to physical, sexual and psychological abuse (Zambia Gender Policy 2002, YWCA 1999). Nevertheless, despite these Zambian studies, and the international studies reported above, there are presently no studies in Zambia that elucidate the connection between notions of masculinity reflected in domestic violence and how this may HIV in heterosexual marital relationships enhance the risk of HIV/AIDS transmission in marital relationships.

Against this background, this study aims to take current knowledge and understanding forward. It also provides a thorough analysis of the local perceptions of the interconnections between domestic violence and the risk of HIV/AIDS which is essential to inform interventions that aim to reduce the risk of HIV/AIDS in marital relationships. From a social constructivist perspective, we need to know how men and women 'do' gender in the context of the power relations between them as reflected in domestic violence, in specific local contexts, by gathering and analyzing the kind of data I present in Chapter 7.

## **2.5 Men and Condom use in Zambia**

The enquiry into men and their use of condoms as a measure of protection against the risk of HIV/AIDS transmission in a marital relationship is premised on the evidence that, although the correct and consistent use of latex condoms has been promoted globally as one of the most effective strategies for containing the spread of the epidemic, their use in marital relationships still remains problematic (Family Health International 1998, Population Reports 1999). Studies have shown that one reason

why the use of condoms in a marital relationship is difficult, is that as marital relations are centered on mutual trust and intimacy, and the proposal to use a condom may appear offensive and threaten the quality of a relationship (Parker 2000). In addition, marital relationships ideally enhance a partner's sense of interpersonal familiarity and mutual affection, thus leading to a lower judgment of HIV risk and the perception of safety. This may also lead to defensive denial that a partner may be at risk of infection. In general Willing (1994) observes that people in long-term relationships are less likely to use condoms than in short-term relationships.

These issues are further compounded by unequal gendered power relations in marriage. Women experience difficulties in suggesting the use of condoms as they may want their partners to use condoms, but this is dependent on their partner's willingness. As discussed earlier, such suggestions may also be met with the threat of violence or actual violence (Heise 1998). A number of women also think that in a long-term relationship in which they trust their men, they can stop using a condom because they are not at risk. The desire to have children may also mean the avoidance of a condom within a long-term partnership. At the same time, a woman may be worried that her suggestion to use a condom may undermine the mutual trust in a relationship by acknowledging that her husband may not have been faithful to her.

Furthermore, the inquiry into the use of condoms in marital relationships stems from documented evidence highlighting some of the difficulties that both men and women face in negotiating the use of condoms (IPPF 2000, Population reports 1999, Path 2001). The Zambia Sexual and Behavioral Study indicates that condom use within marriage or other consensual unions in Zambia is very low. It found that the failure of

married men to use condoms is commonly connected to embarrassment in buying them, because condoms are normally associated with casual sexual encounters, and as such are associated with promiscuous sexual behavior (ZSDS 2000). Others do not use them because of the belief that they reduce sensitivity and therefore sexual pleasure (UNAIDS 2000a). Further, many men who *do* use condoms with casual sexual partners' tend to stop using them when they assume that they have developed a trusting sexual relationship, without testing for HIV to confirm either partners' HIV status. As Jackson (2004) has found men are also less likely to use condoms with a long-term girlfriend because they trust that these partners will not pass on an infection to them. Intimate relations do not just happen; they are a product of continual negotiated transactions. Thus condom use is clearly linked to a complexity of gendered values, and meanings associated with intimacy, as this study of rural Zambia will explore.

## **2.6 Review of health promotion practices**

The purpose of reviewing current health promotion practice in relation to the risk of HIV/AIDS transmission is in order to identify opportunities for how existing HIV/AIDS health promotion interventions can be developed to enhance men's role and involvement in HIV/AIDS risk prevention efforts.

In Zambia as in other countries, health promotion remains a key public health strategy in efforts to address the spread of the epidemic (Oakley 1995, Aggleton 2000). The contextual framework for health promotion is reflected in the Ottawa Charter principle on Health promotion (WHO 1986). It is defined as a process of enabling people to

increase control over and to improve their health. In this respect, the Charter identifies three basic strategies for health promotion; advocacy aiming at creating the essential conditions for health; enabling all people to achieve their full health potential, and mediating between different interest groups in society in pursuit of health (Baric 1991, Bunton and McDonald, 1998).

Two prominent health promotion strategies have been utilised in Zambia to address the spread of the epidemic in both the rural and urban areas of the country. At the national level, these approaches involve a social marketing strategy, focused on the use of the mass media to disseminate information on condom use and protection. This approach utilises commercial marketing techniques for the promotion and retail distribution of condoms and the mass media to create awareness on the risk of infection. An evaluation of the programme in 2000 by the Society for Family Health in Zambia revealed that this strategy had contributed substantially to slowing the spread of infections in the country (SFH 2000). However, although this approach has made a significant contribution to reducing the rates of infection, this still leaves a huge need for further reduction in transmission rates, as discussed in more detail in Chapter 5.

At the grass-roots level, community-based health promotion efforts have been structured within the context of the Alma Ata declaration on Primary care, which seeks to foster, intersectoral collaboration between the community, policy and local interest groups (WHO 1978). Many of the efforts carried out at grassroots level have been directed towards awareness creation and the provision of education about the spread of the epidemic.

Another approach that seeks to address these concerns has been to raise the communities' critical consciousness of the social circumstances that expose and enhance vulnerability to ill health. These approaches are largely based on Freire's *Pedagogy of the Oppressed* (1972) and seek to enable the community to understand the causes of ill health so that they are better able to develop interventions that seek to address its causes (Baric 1997, Bunton and Macdonald 1992, Helman 2000, Kerr 2000). However, the extent to which addressing the formation of gendered ideas and assumptions is incorporated into this approach remains unclear.

Further activities, notably the ABC Approach, (discussed in greater detail in Chapter 5) have been directed at promoting a consistent, proper and correct use of condoms in sexual encounters with a person of unknown HIV/AIDS status, abstinence or maintaining a mutually monogamous relationship between partners known to be uninfected with the virus that causes AIDS. In order to achieve this, a variety of psychological and social psychology theories such as the Health Belief Model (Becker and Joseph 1974), Social Learning Theories (Bandura 1977) have been utilized. These approaches propose that giving the appropriate information about risk behavior and the risk involved in unprotected sex to an individual can justifiably be expected to lead to behaviour change.

Health promotion approaches based on awareness training and on getting the right information across have been critiqued by Singer and Weeks (1996) on the basis that they erroneously appeal to people's rationality and thus ignore the emotional processes and investments involved in the construction of gendered identities. Although the efforts described above have undoubtedly played a crucial role in

achieving significant behavioural change and should be acknowledged as such, the continued severity of the epidemic in the country requires moving beyond simply accepting the efficacy of such strategies, and points to the importance of a review of the premises on which they are based .

As Webb (1997) comments, and this study will reflect, the social epidemiology of HIV has to be about the study of constantly changing interrelationships between culture, individual action and social and political factors, instead of a narrow focus on behavior defined on an individual basis.

## **2.7 Conclusion**

This thesis acknowledges influences from the wider social economic context that contribute to shaping men's risk of infection and transmission but argues for the value of a micro social constructionist analysis of negotiated gendered transactions, in their local context. Understanding the interconnections between the social construction of masculinity and HIV/AIDS transmission, by this means it aims to better inform health promotion practice, to produce a more focused and thereby effective intervention for HIV/AIDS risk reducing behaviour.

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**Chapter Three:**

**Socio-economic Context  
&  
Consequences of HIV/AIDS in Zambia.**

### **3.0 Introduction.**

This chapter situates the analysis of the HIV/AIDS epidemic in its wider economic and social context in Zambia. In examining the prevalence and determinants of HIV/AIDS, this analysis highlights the impact that HIV/AIDS related illness and death is having on different sectors of the economy and socio institutions. I begin by describing the nature of the epidemic. I then describe the scale of the epidemic at International level, its manifestation at the sub-Sahara regional and Zambian level and finally specifically in rural Zambia where it is arguably having the most devastating impact.

In the analysis on the impact that the epidemic is having on different sectors of socio economic fabric in Zambia, I discuss some of the key dimensions including: Zambian health/social policy; labour and productivity; major social institutions and households and families. Focusing on rural communities, I will examine some of the coping mechanisms adopted by families, individuals and groups in an attempt to mitigate the impact of the epidemic. I conclude this chapter by highlighting the negative implications that the epidemic is having on sustainable development in the country, and therefore the importance for intensifying strategies aimed at reducing the spread of the epidemic.

### **3.1 Description of HIV/AIDS**

HIV is an acronym for Human Immunodeficiency Virus. The virus is a member of the Retroviridae family of viruses (commonly known as 'retroviruses'), and classified in the subfamily 'lentiviruses'. Human infection with HIV results in a complex clinical disease known as Acquired Immune Deficiency Syndrome (AIDS), a clinical syndrome resulting in damage to the immune system (Fieldhouse 2001, Hubley 2002, Jackson 2002).

The Human Immunodeficiency Virus principally attacks T-4 lymphocytes, a vital part of the human immune system. As a result, the body's ability to resist opportunistic viral, bacterial, fungal, protozoal, and other infection is greatly weakened. By infecting CD4 T-lymphocytes, (a type of white blood cell) HIV substantially weakens the immune system and leaves the infected individual vulnerable to potentially fatal infections. This, in turn, leads to a group of various illnesses that together characterize a disease condition called AIDS.

According to WHO (2003), Fieldhouse (2001), Hatcher (2002) there are four major modes of HIV/AIDS transmission. These are:

- Unprotected sexual intercourse with an infected person
- Transfusion of infected blood
- Transmission from mother to child during pregnancy, labour delivery or breast feeding
- Injections with contaminated needles.

Worldwide, the most common route of HIV/AIDS transmission is through vaginal and anal sex with most of the infections being caused through heterosexual sex (UNAIDS 2004) i.e. sex between a man and a woman. A small fraction of infections occur through mother to child transmission, unsafe blood transfusion and the use of unsafe injection equipment. This means that anyone who is sexually active, even with only one partner is at risk of contracting HIV. The more sexual partners people have, whether at the same time (casual sex) or consecutively (serial monogamy) – the more they are at risk of contracting the virus and of passing it on to others (Hatcher 1997, Hunter 2001).

While sexual behaviour is the most important factor influencing the spread of the epidemic, such behaviour is itself influenced by a host of reasons ranging from daily and pragmatic factors, such as economic and social circumstances, to the complex and abstract, such as culture (Webb 1997, Freudenthal 2001). Furthermore, sexual attitudes and behaviour (including any prior conduct) varies significantly across different age groups, cultures, socio-economic class and gender. As a result, the interconnection of multiple factors obscures causal linkages and prevents categorical conclusions on the factors driving the epidemic. For this reason, no single factor, whether biological or behavioural, has been determined as the primary cause of the spread of the infection. At best, evidence from African studies suggests that the two most common biological and behavioural factors associated with the highest HIV prevalence are a) the young age at which women have their first sexual intercourse, and b) the young age at which individuals are married. Other contributory factors include lack of condom use; the age difference between spouses, and unequal sexual

decision-making in gender relationships (Jackson 2002). These issues will be discussed in detail within this thesis.

### **3.2 Available therapies**

As yet, no vaccine has been developed to prevent the HIV/AIDS infection. Prevention initiatives, for example, in public education programmes, therefore remain the primary approach to prevent the spread of the epidemic. However, as medical science obtains a better understanding of the character of the immunodeficiency virus a number of drugs have been developed in the treatment of HIV infection. These drugs are called antiretroviral drugs (ARV's) (Jackson 2002, Hubley 2002). These powerful medication regimes, also known as 'highly active antiretroviral therapy (HAART)' have had dramatic effects in reducing rates of AIDS-related illness and death. An effective regimen of antiretroviral drugs rapidly suppresses the viral load to very low levels that it cannot be detected by the most sensitive tests available. However, this profound viral suppression does not mean that the virus has been eradicated and the patient is cured; HIV persists at very low levels in the blood and tissues such as the lymph nodes, and if therapy is stopped, the viral load rapidly rebounds. Although successful viral suppression does appear to reduce the infectiousness of infected individuals, it does not eliminate it and cases of HIV transmission from individuals with suppressed viral load do occur.

Unfortunately, the high cost of these kind of multi-drug combination therapy regimens has placed strain on the health services and has to date rendered them almost entirely inaccessible for the developing world, where most cases of HIV infection occur

(Hubley 2002, Jackson 2002, and Panos 2000). In recent years, pressurized by the increasing rates and impact of HIV in the developing world, legal actions, and activist campaigns, a number of pharmaceutical companies have made anti-HIV drugs available to developing countries at or below the price they cost to produce. Nevertheless, fewer than 4% of people in need of antiretroviral treatment in low- and middle-income countries were receiving the drugs at the end of 2001.

### **3.3 A Global Epidemic**

Since the early 1980's when HIV/AIDS was first described, it has grown to become a global epidemic (Fieldhouse 2001, UNAIDS 2004). The joint United Nations Programme (UNAIDS) which charts the spread of the epidemic reports that since the early 1980's when the epidemic first broke, more than 60 million people have been infected with the human immunodeficiency virus (HIV) and more than 20 million people have died from the resulting disease, acquired immunodeficiency syndrome (AIDS) (UNAIDS 2004). Out of the total number of people infected by the virus that causes AIDS world wide, sub-Saharan Africa is the most affected region in the world. Between 65-85% of HIV/AIDS infected people are found in sub-Saharan Africa. An estimated 26.6 million people are living with HIV/AIDS and approximately 3.2 million new infections occurred in sub-Saharan Africa in 2003 (UNAIDS 2004). In 2003 alone over 3.2 million young and adult men and women and children died as a result of HIV-related infections (UNAIDS 2004).

While there are indications that the spread of infections is beginning to stabilise in the worst affected countries, projections by UNAIDS suggest that the spread of the

epidemic is slowly getting out of control in China, the Far East and Eastern Europe and particularly the Russian Federation, where figures on the rates of infection have almost doubled annually since 1998. Data from Asia appear low but masks localised epidemics and infections in Myanmar, Cambodia and Thailand. In these countries, the spread of the epidemic is in the region of 2%-4% range and similar to the prevalence levels found in many West African countries, while India is second to South Africa in the number of persons currently infected (UNAIDS 2000b).

Recent findings indicate that HIV/AIDS is increasingly affecting a greater number of women. Today, more than 20 years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide. In sub-Saharan Africa, young women aged 15 to 24 are more than three times as likely to be infected as young men. In the worse affected countries, life expectancies have fallen by an average of 18-23 years (UNAIDS 2003). In many countries, trends of a decline in child mortality rates are reversing, and in the countries worst affected infant and child mortality rates are expected to double by 2010.

The impact of HIV/AIDS on children is seen most dramatically in the rising numbers of those orphaned by the epidemic. The UNAIDS, UNICEF and USAID (2004) report entitled 'Children on the Brink', observes that there are presently 14 million children under the age of 15 who have lost one or both parents to the epidemic and approximately 80% of them living in sub-Saharan Africa. By 2010, it is projected that as many as 25 million children will be orphaned as a result of the disease (UNICEF 2003) Orphans and other children made vulnerable by HIV/AIDS are in many societies

stigmatised, isolated, discriminated against, disinherited and often deprived of basic education, care and financial resources.

Thus, the ever-growing magnitude of the epidemic has prompted the UNAIDS to warn that the epidemic is still in its early phase and there could be more than 68 million HIV related deaths between 2000 and 2020 unless prevention and treatment programmes to combat the disease are expanded drastically (Fieldhouse 2001). For this reason, the UNAIDS (2004) has designated efforts to stem the spread of the epidemic as a core priority for states, institutions, communities and individuals.

#### **3.4 HIV/AIDS in Zambia and its social consequences**

Zambia is one of the countries in sub-Saharan Africa worst affected by the HIV/AIDS epidemic (MoH 1999, UNAIDS 2000c). The first case of HIV/AIDS was detected in the country in the mid-1980. Although initially concentrated in urban areas the epidemic quickly spread to semi-urban and rural areas (Flykesnes et al 2001). Current estimates indicate that by the end of 2003, from a population of 10 million people, 29% of the sexually active population were living with the infection, of which 60% were women. Estimates further suggest that for every boy aged 15-19 years old who is infected, there are approximately 5-6 girls infected within the same age group (UNAIDS 2000c). The same report indicates that during 2001, there were an estimated 120,000 deaths attributed to HIV-related illness and an estimated 1.2 million adults and children were living with HIV.

The Ministry of Health situational analysis on HIV/AIDS (MoH 1999) indicates that some of the key risk factors responsible for the spread of the epidemic in the country include unprotected anal and vaginal intercourse and having multiple sexual partners. According to the Zambia Demographic Health Survey (CSOZ 2003) other contextual factors include: early initiation of sexual behaviour; untreated sexually transmitted diseases; sex with a partner of unknown HIV status; partner commitment and women's inability to negotiate safe sex.

The epidemic is concentrated in two age-groups: new born children who acquire it through mother to child transmission, and adults aged between 15 and 50 years, who acquire it through sexual transmission (MoH 1999). There is also a marked geographical distribution of the rates of infection between the urban and rural areas. In the rural areas the average infection rate is around 10-15% of the population, while in the urban areas the prevalence is estimated at between 25-30% (Webb 1996a, 1996b). Evidence further suggests that rates are still rising in rural areas whereas they have stabilized in some urban areas.

Drinkwater (1993) and Bond et al (1999) have aptly described the impact of HIV/AIDS as a long wave of disasters. Individuals and households go through processes of experimentation and adaptation as they attempt to cope with immediate longterm demographic changes. They observe that over a period of five years, one episode of illness may be followed by another, which gradually depletes the resources and labour supply of one or more interdependent households. The loss of adults in the most productive and reproductive age group is having a much more significant impact on the economy at micro level than the absolute number of HIV deaths might suggest.

Although there are some areas in the world where AIDS has been effectively addressed, the impact of the epidemic in Zambia is still deepening. This is evidenced by the worsening reduction in human development indicators such as infant and child mortality rates and in the life expectancy. The Human Development Report (UNDP 2004) indicates that a number of human life indicators as reflected in the Human Development Index (UNDP 2004) are deteriorating as the impact of the HIV/AIDS epidemic strengthens. Lamptey (2002) alludes to a similar observation, indicating that this is typical of many countries in the developing world affected by the HIV/AIDS epidemic, where the wide prevalence of infections is reversing hard-earned improvements in health made over the past 50 years. For instance, rates of Tuberculosis, which had been contained in Zambia, is now one of the most serious public health problems (Zambia National HIV/AIDS/STI/TB Council 2000)

As in many other countries, the HIV/AIDS epidemic is different from most other major disease outbreaks. This is because the epidemic primarily affects adults in their economically and most productive years (Bollinger and Stover 1999, UNAIDS 2003). Adults aged between 15 and 50 years hold the largest concentration of HIV/AIDS infections in the country, and are usually the backbone of their families and communities with both young children and elderly parents relying on them for support. Furthermore, the illness and death of men and women in their active and economic prime has resulted not only in lowered incomes for surviving family members, but also in other sequelae of poverty, including worsened health and reduced investment from the surviving individual's future productivity (Bollinger and Stover 1999, Sulwe 2000). As a consequence, the HIV/AIDS epidemic in Zambia has negatively impacted the

social and economic spheres and has contributed to the reversal of many of the development indicators that were achieved before the advent of the epidemic (Zambia National HIV/AIDS/STI/TB Council 2000). This situation has further been exacerbated by the high levels of poverty in the country. According to the Zambian Ministry of Finance and Economic Development report, more than 80% of Zambians live in abject poverty (MoFED, 1996). This manifests in chronic poverty, poor sanitation, nutrition and other multiple factors, which also make people more vulnerable to illness. As such, HIV/AIDS in Zambia is no longer just a health problem, but affects, and is affected by, all aspects of human development.

The UNAIDS (2003) report on the global HIV/AIDS epidemic observes that women in Zambia, as in many other sub-Saharan countries, generally have a significantly higher risk of infection than their male counterparts. According to the recent Demographic and Health Survey (DHS), adult HIV prevalence in Zambia is 18% among females and 13% among males (aged 15-49) (CSOZ 2003). This is because, physiologically, women are more vulnerable to being infected than males. In addition, women's lower social economic status and cultural status makes it difficult, even dangerous, for them to negotiate safe sex, with many exposed to gender violence or rape as a consequence (Macwan'gi 1993, Fleischman 2002). This is further compounded by the insecure economic climate in a country where young girls living in poverty are often enticed or coerced to engage in transactional sex or enter sex work to pay for school fees or support themselves or their families.

Women's control within relationships may also be weak if their partner is several years older than they are, which is often the case within Zambian families. Within the context

of the HIV/AIDS situation in the country, the age difference between men and women in a relationship might be as a result of an older man seeking out virgins or a young woman, in the belief that they will be HIV-free. Some women are drawn into sexual relationships with an older man to raise money to meet their financial needs. Further data from the Zambia Sexual and Behavioral Study (2000) found that women in Zambia have little power in sexual negotiation. Of those respondents who had heard of STIs, less than half of the men (49%) agreed that if a woman's husband had an STI, then she could rightfully either refuse to have sex with him, or ask him to use a condom.

The epidemic has not only created severe social and economic consequences for the country, but has also caused profound pain and suffering for many families through illness and the extensive loss of life (Bollinger and Stover 1999). This has imposed heavy burdens on families, communities and economies. In general, what makes the HIV/AIDS epidemic so serious is that it has a pervasive impact on virtually all aspects of development and society in Zambia: health, education, agriculture and the transport sector. There can be no doubt that the HIV/AIDS epidemic is having a profound and negative impact on many of the social and economic developmental sectors in the country; in particular, children and women are feeling the full impact of these consequences. I will continue by examining these areas in more detail below:

### **3.5 The impact of HIV/AIDS on labour and productivity**

Productivity, the quality of the labour force and labour costs are significantly affected by the HIV/AIDS epidemic (Bollinger and Stover 1999, UNAIDS 2000b). In Zambia,

the impact of HIV/AIDS is concentrated within the age group 25-29 years. This is considered the most productive and reproductive age group in Zambia. As the epidemic affects young adults of productive age, companies in both the private and public sectors are experiencing the direct impact of the loss to productivity and labour due to illness and death of its employees. Experienced, qualified, and trained personnel: professionals from all sectors of industry are being lost to the epidemic, leaving organisations with dramatically reduced productivity levels (UNAIDS 2000b).

Productivity levels are also due to the fact that the epidemic is characterised by recurrent periods of sickness, absenteeism and subsequently loss of labour. Infected workers may become too ill to work effectively, or to work at all and may eventually die, causing distortions in the productive capacity of industry. When an employee falls ill, the industry not only has to manage without his or her labour contribution but also with the loss of labour from those who have to care for the sick family member (Bollinger and Stover 1999). Companies have also experienced increased expenditure on benefits such as health care, sick leave and death benefits as well as the additional cost of recruiting and training new employees.

A study conducted at Barclays Bank in Zambia showed that the death rate among workers had increased from 0.4% in 1978 to 22% in 1992 because of HIV/AIDS. At the same time, medical expenses and training costs increased, while actual labour hours were reduced (Nyirenda 1993). Baggaley et al (1994) obtained similar results in reviewing the records of 21 companies in Lusaka and the Copperbelt (with a total workforce of 6,447). HIV was felt to have affected productivity in 48% of companies and recruitment in 19%.

The loss of workers and productivity and the cost of providing health care benefits and death benefits due to HIV/AIDS have had a serious effect on employers. The reduction in productivity has also had a direct relationship to the country's capacity for economic development, both in terms of life expectancy and economic growth. This is because a reduction in productivity lowers the country's Gross Domestic Product (GDP). This therefore reduces the levels of financial investment possible within its social sector such as education, health, transport and agriculture. This subsequently affects the quality of life for the population as a whole.

Another way in which HIV/AIDS is affecting the country's economic growth potential is through the reduced earnings of an employee as a result of illness, care demands, higher expenditure on health care and premature death. The result is an overall reduction in possible savings rates and disposable income. In the long-term, this has the combined effect of reducing the consumer market for business, particularly in markets outside the basic necessities of food and housing. In turn, this leads to a reduction in the total resources available for production and investment and thus leads to an overall decline in economic growth.

### **3.5.1 The impact of HIV/AIDS on Agriculture**

HIV/AIDS impacts on agricultural production and household food security in various ways. A direct impact is that of the loss of household labour (MOCA, 2003). In Zambia as in many other sub-Saharan African countries, farming and other rural occupations is labour intensive (FAO 2003). As discussed above, by its nature, HIV/AIDS is unique

in that it attacks the most productive segment of the agricultural labour market, thus robbing households of adult labour and knowledge. Studies at household level have shown that when HIV/AIDS strikes, the pattern of agricultural production changes. In rural areas, agricultural output falls. This is because, with limited technology, the loss of life and illness of large numbers of people expected to perform these activities, affects the quality and quantity of food production.

A number of other consequences follow the spread of AIDS in households: The presence of an infection in a household affects the availability of labour, as time spent on caring for afflicted household members impacts upon time spent on agricultural activities and other household activities. As a result, households reduce and/or delay the amount of weeding and often choose to plant less labour-intensive crops on smaller areas of land. Children may be withheld from attending school; elderly people may not have anyone to act as their carer; the cost of healthcare may impact upon savings; other assets such as home, land or livestock may be sold on order to pay for medical treatments (Wallman 1998). In areas with high HIV/AIDS mortality rates, families have coped by initiating changes in land ownership and utilisation, changing food and cash-cropping patterns, reducing food storage and selling livestock. Baylies (1995) reported from fieldwork in agricultural households in Eastern and Lusaka province, that AIDS-affected households concentrated on maize production at the expense of non-stable foods, once loss of labour was a factor. These factors have contributed to the reduced levels of adult and child nutrition, deterioration in the living standards of many people and greater food insecurity.

Sulwe (2000) observes that traditionally, local residents have joined together to offer assistance to those in need during periods of adversity or crisis. However, as the number of HIV/AIDS cases increase, the need for assistance is overwhelming the support system and these traditional coping mechanisms are beginning to breakdown. HIV/AIDS has further severe consequences for rural widows of AIDS victims. In many sub-Saharan Africa countries, women contribute to more than half of the food production and are also usually involved in labour-intensive farming activities (UNAIDS 2000a). However, when HIV/AIDS strikes, this cultural gendered division of labour has, in some cases, made it impossible for women to perform the farming tasks of their husbands and they are forced to abandon farming altogether. This makes women more vulnerable to the negative impacts of HIV. Furthermore, the stigma of the disease may inhibit widows from seeking community and extended family support, which are crucial 'safety nets' to individuals in rural areas.

### **3.5.2 The impact of HIV/AIDS on the health care sector**

The HIV/AIDS epidemic has affected the health sector in Zambia in various ways (MOH, 1999). Amongst the ways in which the epidemic is having a negative impact on the health sector is through high morbidity and mortality among health workers themselves. Despite the high levels of training and medical knowledge, health professionals remain a population that is vulnerable to HIV/AIDS (Feeley et al 2004). Like other people in the general population, health workers are vulnerable to the same route of infection as the general public, but in addition they may contract the virus through contact with AIDS patients.

At the institutional level, the epidemic is having a negative impact on the already over-stretched medical sector (Zambia National HIV/AIDS/STD/TB Council 2000). The treatment of opportunistic STD infections in HIV-infected persons is expensive and has placed an unprecedented burden on the delivery of comprehensive healthcare. Furthermore, the high prevalence of HIV/AIDS-related illnesses and infections are contributing to increases in health expenditure in both the public and private sector. The Government of Zambia estimates that 45% of all hospital beds in the country will be occupied by AIDS patients by 2010 (Zambia National HIV/AIDS/STD/TB Council 2000)

At another level, caring for AIDS patients is an extremely demanding and stressful role for health professionals. High levels of stress may lead to greater absenteeism and staff may refuse to be transferred to regions of high HIV/AIDS prevalence within the country. Some health workers may have concerns about being infected in the process of providing medical care to patients. At the individual level, people living with HIV/AIDS generally have a range of health care needs, spanning diagnostic tests, primary health care, specific treatment of infections, hospitalisation and psychosocial counselling (Lamptey 2002). Where antiretroviral drugs are available, healthcare systems need to regularly monitor patients and manage their complex treatment regimes.

### **3.5.3 The Impact of HIV/AIDS on education.**

As in other sectors of social and economic development, the high HIV/AIDS prevalence in the country is having a distinctive negative impact on the educational

sector. Kelly (2004) has observed that the HIV/AIDS epidemic has affected the education sector in Zambia in at least three ways. Firstly, the impact of the epidemic has reduced the number of teachers through illness and death: this seriously compromises the quality and quantity of education, even where teachers are available, they may be sick and prone to absenteeism due to illness, attendance at funerals, patient care at home and psychological trauma. As a result, poorly qualified or inexperienced teachers are recruited to supply temporary cover. Many rural schools and colleges already suffer from limited numbers of qualified teachers, as they may opt for employment nearer to urban centres which offer better living standards and healthcare services. In 1998, the ministry of education in Zambia reported that 1,331 teachers died as a result of AIDS (Zambia National HIV/AIDS/STD/TB Council 2000). There is also an estimated of 40% HIV/AIDS prevalence among teachers. Apart from school being understaffed because of the high mortality rates among teachers, the productivity of teachers has dropped in part as a result of absences due to illness. Higher educational institutions are also affected, for instance in some universities deaths of administrators and academic staff mean that important experience and knowledge is lost. Another related factor is an increase in the average time that teachers take off work to attend funerals for their colleagues or students. Even when teachers are present in class, the Zambia National HIV/AIDS/STD/TB Council (2000), observes that many teachers suffer from exceedingly high levels of stress, attributed to trying to tackle the immense and complex social situations associated with HIV/AIDS.

Secondly, the epidemic has had an impact on the number of children being kept away from attending school. This is because the children might be needed at home to care

for sick family members or to work in the fields. Thirdly, some children have been forced to drop out of school because their foster parents or guardians cannot afford to send them to school, due to reduced household income as a result of an HIV/AIDS-related death or illness. At sub-Saharan Africa level, more than 130 million children aged 6-12 years are not in formal education, two thirds of whom are girls (World Bank, 2002). Of those who enter school, one out of ten does not complete an education because of losing their parents and/or the support that allows them to go to attend.

The fundamental need for education in the building of a prosperous nation and democratic societies has meant that this problem has become a major concern in a number of sub-Saharan African countries. Education enables individuals and societies at large to absorb knowledge and adapt to technological changes. It has a direct influence on national productivity, which determines living standards and a country's ability to compete in global markets (World Bank 2002). Research indicates that economic growth increases with more education and declines with less.

The death of teachers arising from the spread of the epidemic has also resulted in the loss of valuable social capital and signifies potential long-term damage accruing to human capital development efforts in the country. The effects of lowered investment into human capital of the younger generation will affect and undermining the prospects for economic and social development for the future. Lack of education also limits access to information about prevention and treatment of HIV/AIDS and related issues, perpetuating the problem.

#### **3.5.4 The Impact of HIV on households and families**

Many households in Zambia have felt the immediate impact of the HIV epidemic. This is because many families are the primary unit for coping with the disease and its consequences (UNAIDS 2000c, MoH 1999). The social and economic impact of HIV/AIDS begins as soon as a member of the household starts to suffer from an HIV/AIDS-related illness. As HIV-related illnesses begin to take hold, the family's source of livelihood is compromised as well as the capacity to purchase food and support their children.

Families are then affected by the gradual physical decline of the ill person and the need for personal care. Families in which the infected person is the breadwinner suffer financially through increased expenditure for medical care. During the long periods of illness, the loss of income and the cost of caring for family members impoverish households. This puts tremendous pressure on household lives. Sulwe (2000) points out that households with AIDS typically spend a year's annual income meeting AIDS treatment and funeral costs. Furthermore, the disease draws on family resources and reduces the amount of time that adults have for outside income generating activities. As a result, many families end up being impoverished by illness and death, particularly those with little savings. Sulwe (2000) has observed that families also sell their meagre assets in order to raise money for the medical treatments.

Furthermore, the relationship between poverty and the cost of AIDS to households can be visualised at two levels. First, AIDS can push households into poverty. Mounting expenditure and loss of income of the AIDS patient may result in impoverishment of

the household. Poorer households may be more severely affected than better-off households. Secondly, households that are already poor, may become further impoverished. In the event of death from the disease, funeral and other costs may also add to the burden of the household. In addition, in an environment of relative poverty and without savings, many families and children are destitute after the death of their parents.

It has also been noted that the spread of the epidemic is significantly impeding efforts to reduce poverty in the country (Kurschner 2001). As in many other countries, HIV/AIDS has been found to have a synergistic relationship with poverty. HIV can bring poverty and can promote HIV/AIDS, and the two are closely related, both in terms of their causes and effects (Cohen 1999). While poverty has long existed in Zambia, it is clear that the HIV/AIDS epidemic has exacerbated this condition. The early death of one or both parents in the family has often contributed to pushing the remaining members of the family into poverty. The immediate impact on the loss of a breadwinner in the family has left the remaining members of the family facing the risk of constraints in cash resources. The income situation may be constrained or become quickly insecure in times of sickness of the breadwinner or need to care for a sick family member.

The high poverty prevalence levels in the country further exacerbate the impact of HIV/AIDS. More than 70% of the population in Zambia live in abject poverty. The high levels of poverty limit the exploitation and accessibility of social and economic rights such as education, health care, employment and social services, factors that, in turn, promote the spread of the epidemic (Zambia National HIV/AIDS/STD/TB Council

2000). In rural areas HIV/AIDS in families has been associated with decreased productivity and increased household insecurity. For example, results from a FAO baseline study in Southern Province attribute a strong decrease in agricultural production and lower nutritional status among vulnerable households, i.e. households with chronically ill members; households headed by widows and households fostering orphans of HIV (FAO/FASAZ,2003).

A family may also experience a decline of outputs from income generating activities, which will lead to a reduced access to healthcare and other services. Studies have, in addition, found that the loss of a breadwinner tends to reduce the economic viability of the households. It has thus become common for relatives to take orphans into their own home but this rapid rise in the number of orphans has overwhelmed the traditional support system and extended family (UNICEF 1998). Frequently, many of the households fostering orphans are themselves poor and taking in orphaned children represents a significant burden and may lead to a cycle of poverty.

### **3.5.5 The impact on HIV/AIDS on demography.**

The high HIV/AIDS prevalence in Zambia has resulted in an increased loss of life, which is having a devastating demographic impact on the population profile of the country (Fieldhouse 2001). Demographic indicators such as life expectancy in Zambia has dropped from 56 years in the 1970s/1980s; 45.5 years in 1995 and 37 years in 1998 (UNDP 2004). Without AIDS, life expectancy might have remained at 56 years. In the current circumstances life expectancy is expected to decline further by 2010.

Furthermore, the impact of HIV/AIDS on the demographic profile of the country is evidenced through a sharp increase in adult and child mortality rates. According to Baylies et al (2000), since the country attained independence in 1964, Zambia had experienced a drop in the child and adult mortality rates. The country had managed to develop the rudimentary welfare systems they had inherited at the time of independence and improved the living standards of their population (Baillies 2000). Death rates had begun to fall, childhood illnesses were being brought under control, health expectations rose and an increased number of children were able to benefit from the opportunity of an education. However, sadly, these positive gains are now being reversed, most appallingly revealed in the high mortality rates I have described above. The UNAIDS (2003) has further observed compelling evidence that suggests that the trend in HIV infections, resulting illnesses and deaths will continue to have a profound impact on rates of infant, child and maternal mortality, life expectancy and economic growth well into the future.

### **3.5.6 HIV/AIDS In rural communities**

While HIV infections may occur across different households, the extent to which people become vulnerable and affected by HIV/AIDS will differ significantly depending on their level of relative poverty (Kurschner 2001). In many Zambian rural communities, the combination of a high HIV/AIDS prevalence and extreme poverty has created a number of contextual, environmental and social factors, almost entirely outside the control of most people. The poor inhabit rural communities in Zambia most of whom are peasant farmers. They sustain their livelihood by growing cash crops both for their own consumption and to sell locally. Kelly (2004) has observed that

these poor families may be faced with increased vulnerability because prior to HIV infection, their immune system may already be depressed due to their poor health and/or nutritional status. Many are faced with an inability to meet the costs involved in accessing health services. In the context of HIV/AIDS, there is also the problem of a greater likelihood of untreated sexually transmitted infections (STIs) amongst the poor. This is because the poor may not have access or resources to obtain effective treatment for an STI. The presence of a sexually transmitted disease is known to enhance the risk of HIV infection.

In addition to the risk of having an STI, most rural areas lack facilities for HIV/AIDS voluntary testing and counselling (VCT) (Kelly 2004). This leads to the lack of information on their own status or that of their sexual partner. In addition, Lamptey (2002) has observed that there is also an increased possibility of high-risk behaviour because of limited ability to access and/or store condoms correctly. Furthermore, the poor are also vulnerable to increased exposure to other health hazards such as malaria, TB or gastro-intestinal problems resulting from poor sanitation (Kelly 2004). Brummer (2002) has further observed that the poor in rural communities may also be exposed to the risk of infection as they migrate from place to place to in search of work and better living conditions. However, because of limited employment opportunities, many people who migrate from the rural areas to the urban areas often end up exchanging unemployment for over-crowding, poor housing, inadequate sanitation, poor health and educational facilities with similar situations elsewhere. Migration often places men in close proximity to high-risk sexual networks and often results in having an increased number of sexual partners. Furthermore, the absence of a male partner

may also lead to women in rural settings relying on sex to supplement their income while their male partner is away from home for long periods.

### **3.5.7 HIV/AIDS and orphans**

One of the tragic consequences and legacies of the epidemic is the impact it is having on children. As the epidemic is predominantly affecting young adults in their reproductive years, it is creating a new generation of orphans. In Zambia it is estimated that there are close to 1,000,000 orphaned children (UNICEF 1998). The majority of these orphans have to live with extended family members or neighbours with 6% becoming homeless, and less than 1% living in orphanages. Many orphans do not attend school or are forced out of school (Zambia National HIV/AIDS/STD/TB Council 2000). In most cases grandparents are left to care for the young, and this is usually in a situation where these grand parents have little or no source of income. A new phenomenon in the country is a child-headed household: where altruistic children look after their own, younger siblings. As a result, many of these children are deprived of basic needs such as shelter, food, health and education.

This vulnerability of children orphaned by AIDS, and that of their family starts well before the death of their parents, however. Haworth (1991), Nyirenda (1997), UNICEF (1998), Teasdale (1999), Mataka (2001), UNAIDS/UNICEF/USAID (2004) observe that the emotional anguish of the children begins with their parent's distress and progressive illness. This is compounded as the disease causes drastic changes in family structure, taking a heavy economic toll, requiring children to become care takers and bread-winners and fuelling conflict as a result of stigma, blame and rejection.

Children may care for dying parents and then see one or both parents die, with the emotional trauma that this involves. They then have to adjust to a new situation with little or no support. Not surprisingly, many suffer exploitation and abuse (UNAIDS 2000b).

The impact of orphans has had a tremendous strain on the extended family and the social systems to provide orphans with care, resources and social guidance. Although child-fostering was common in many rural societies - not just as a means of providing for orphans, but as a normal part of offering emotional support within the extended family- in light of the harsh economic realities this is now becoming increasingly difficult. Many families that would ordinarily accept orphans are themselves already faced with problems providing adequate nutrition and welfare for their own families and may lack the necessary resources to support an additional member of the family. For this reason many orphans found in this situation live in disadvantaged conditions, including being removed from school because their guardians cannot afford their education. It has also been found that some orphans may experience high morbidity and mortality due to poor nutritional status. Children not accepted by the extended family system can become homeless.

Coping strategies differ between families and may include female members of the family being married at a younger age or being fostered by another family. The incidences of fosterage are counterbalanced however, by the need for child labour in the household. Female orphans are often preferred over male orphans because they can provide domestic labour as well as a 'bride price' on marriage (Sulwe 2000).

### **3.5.8 Impact of HIV/AIDS on prospects for sustainable development**

Undoubtedly, the devastating effects of AIDS among individuals and families is affecting the country's overall economic performance (Bollinger and Stover 1999). This has become an issue of concern at both national and household levels. At the national level, the loss of experienced workers and of young professional, men and women who are expected to contribute to the development of the country is erasing gains that had been made in social capital development.

At household level, it is observed that because of illness or death among adults, many poor households are unable to afford to send their children to school. Adults aged 15-50 are usually the economic 'backbone' of their families and communities, on whom both young children and elderly parents rely for support. The illness and death of these individuals in their active and economical prime results not only in lower incomes for surviving family members, but also in all other sequelae of poverty, including decreased health and reduced investment in the survivors' future productivity. As a direct consequence of this scenario in rural communities, Wallman (1998) in a study conducted between 1996-1997 in Southern Province in Zambia, found that in a number of rural communities, teenage boys were vulnerable to being taken away from school in order to assist with farm duties when their parents died.

As previously discussed, women suffer a greater likelihood of being infected by HIV/AIDS, especially when young, and in addition, women and girls are commonly the first victims of the economic crisis that AIDS brings to the household (Sulwe 2000). When adult household members become sick with AIDS the household income falls,

and living costs and the burden of caring rise considerably. This often leads to girls being withdrawn from school, both in order to economise and because girls are traditionally expected to look after the sick, the young and the old. In situations of poverty, girls who find themselves in extremely difficult family circumstances because of HIV/AIDS are at risk being drawn into transactional sex. Understandably, sex may be perceived by them to be the only sellable commodity that they can offer to earn money to support their family.

The pattern of children being denied their education is being repeated countrywide with orphans who have lost one or both parents being less likely to attend school (World Bank 2003). These are children already living in an impoverished environment and the lack of education and parental care raise serious concerns for the children's own personal growth and development. A specific concern raised by the World Bank (2002) is that the lack of education is likely to affect the country's capacity for sustainable development. The lack of education threatens the lack of accumulation of social capital and its transfer within or between generations. The concept of social capital is variously defined in the sociological and development literature. One of the most well known proponents of social capital is probably Putman. He describes social capital as a feature of civic and community social organisation such as trust, norms and networks that work to improve the health, wealth and industry of a community. In Campbell et al (1999) Putman defines social capital in terms of four characteristics. These are: the existence of community networks, civic engagement (participation in these community networks) local identity and a sense of solidarity and equality with other community members and norms of trust and reciprocal help and support. Bebbington (1999) demonstrates that it is the interaction between natural capital,

human capital, cultural capital and produced capital which enhances human wellbeing and development.

When these concepts are applied to the problem of HIV/AIDS, it becomes evident that one of tragic consequences of the epidemic – as I have examined in detail throughout this chapter - is the loss of human life and resources which subsequently affects the levels of social capital available for sustainable development. As Bourdieu (1997) observes, sustainable development can only be achieved and sustained by enhancing the wellbeing of today's individuals as well as that of future generations. According to Bourdieu (1997), this requires both the protection of and increasing the reserve of available human capital and social capital. With the increasing large numbers of professionals such as teachers and administrators dying from infection, coupled with the denial to the young generation of quality education, the spread of the HIV/AIDS epidemic is increasingly threatening the prospects of sustainable development for the country. This portends a decrease in social capital accumulation, which in turn, will affect social cohesion.

To cite one example, education and health can be an important starting point for sustainable development (Oxfam 2003). As well as being a human right, literacy and numeracy skills are one of the most significant factors in poverty reduction equity and participation in civil society. It yields both private and social returns. As observed by Becker and Joseph (1974), continued education and professional experience, of regular good health care and adequate food and nutrition provide a solid foundation for sustainable development. The scale of HIV/AIDS infections coupled with the social and economic consequences that the epidemic is having on the population and

particularly on the poor in rural communities necessitates the urgent need for intervention.

### **3.6 Zambia's response to the HIV/AIDS epidemic**

The Zambian Government and various stakeholders have long identified the need to stem the spread of the epidemic because of the social and economic consequences it is having on the country. For this reason, in the absence of a vaccine and/or a cure for HIV/AIDS, prevention has been the cornerstone to the national response through the coordinated efforts of the Government and of civil society (MoH 1999, Sulwe 2000, Zambia National HIV/AIDS/STD/TB Council 2000, Lucas 2004). To this effect, the major interventions for HIV prevention have been raising awareness and influencing behaviour change, voluntary counselling and testing, prevention of mother to child transmission, promotion of condom use, case finding and treatment of STI's and provision of safe blood and blood products (Zambia National HIV/AIDS/STD/TB Council 2000). This coordinated response was initiated early at the onset of the epidemic when it was recognised that the epidemic was cross-cutting and multi-dimensional as evidenced in its impact on all sectors of the economy. Hence, the responses required needed to be broad and multi-dimensional. This has shaped the ensuing response to the HIV/AIDS epidemic.

To this effect, the National AIDS Surveillance Committee (NASC), charged with the task of formulating policies and co-ordinating all activities regarding the prevention and control of AIDS, was established in 1986.

The first Medium Term Plan (MTP 1 1988-1992) focused on ensuring blood safety, promoting awareness and HIV/AIDS knowledge, establishing HIV counselling services, developing clinical AIDS management guidelines and minimizing stigma. Zambia was among the first countries to recognize and respond to AIDS. In contrast to North America and Europe, where *community* organizations led AIDS responses, in Zambia as elsewhere in Africa, the *Government* led the response, and successfully instilled widespread awareness and factual information. However, neither effective STI treatments nor condoms were widely accessible. Increased awareness and knowledge was not translated into safer sex behaviour. The campaign did not challenge the different sectors of society to define their own initiatives, assume responsibility and leadership and develop their own social norms in support of safer sexual behaviour.

The second Medium Term Plan (MTPII: 1994-1998) represented a major step forward. To ensure a coordinated, rationalized response the AIDS, STI and TB programmes were integrated. The integrated programme sought to foster political commitment at the highest level, develop intersectoral approach encompassing all government ministries, the private sector and civil society, fully involve people with HIV/AIDS, increase access to STD care, strengthen condom promotion and distribution, control TB and develop effective AIDS impact mitigation strategies. This approach was based on the premises that while the NASTLP would continue to carry out its mandate, each Government ministry would be a partner in the effort to combat HIV/AIDS. Each ministry has subsequently appointed a Focal Point Person(s) (FPP) to coordinate the work related to HIV/AIDS using their comparative advantage.

The term 'comparative advantage' refers to the opportunities an organization or institution has to influence activities in its mandated area of operation. Instead of duplicating the activities of the Ministry of Health and other government ministries, NGO's and the private sector are encouraged to incorporate anti-AIDS strategies into their normal programme activities. To facilitate this process, they are encouraged to develop micro level HIV/AIDS policies that harmonize with macro level policy guidelines and strategies in their mandated areas of operation.

Since 1996 the government has sought to harmonize AIDS responses with the health reforms, which seek to streamline and integrate vertical programs within the central Board of Health and to emphasize consolidated district level capacity building. To date, there have been significant and encouraging achievements in all five areas of response which are: Information and Communication (IEC); Epidemiology; Clinical Support and Laboratory Services and Management. However, implementation is hampered in these sectors, at national, provincial and district levels, by lack of resources. This includes the lack of experienced personnel; integration of AIDS work into Primary Health Care (PHC) structures; civil services (workplace) decentralization of AIDS management (especially at district level) and development of integrated community-based responses to HIV/AIDS, despite the community-based nature of the required interventions.

### **3.7 Impact of prevention measures.**

As a result of these interventions, there are a number of achievements that have been made to address the high HIV/AIDS prevalence in the country. Some of the significant

outcomes of these interventions are that the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that the rate of infection across the country among pregnant women under the age 20 dropped from 2% to 17% between 1993 and 1998. In the rural areas, infection rates in this group dropped from 14% to 6% in the same period (UNAIDS 2003). The country has also seen a decline in HIV prevalence and likely incidence (the rate of new infections) among the youth in urban areas (Bessiger et al 2003). These declines are attributed to various HIV/AIDS prevention intervention that have been carried out in the country. The study found that both young men and women in Zambia, especially in urban areas, delayed their first sexual encounter by one year. The percentage of 15-19 year old urban women reporting ever having sex dropped from 56% to 40% between the early and late 1990's. For urban males, an even sharper decline from 67% to 34% took place between the middle and end of the decade.

### **3.8 Conclusion**

This chapter has fully described the HIV/AIDS epidemic in Zambia. It has highlighted that the HIV/AIDS epidemic is driven by forces of social and economic vulnerability that inhibit people's capacity to control their risk of infection. Similarly, the social and economic impact of the epidemic depletes the capacity of a society and individuals to respond. Using empirical findings from various studies, I have shown in this chapter that the impact of the epidemic is evident across all social and economic areas. In both the private and public sectors, HIV/AIDS is affecting productivity through its burden of sickness, absenteeism and loss of life.

At the macro level, in addition to having a sustained impact on all sectors of social and economic development, the epidemic has, over the past 30 years, evolved into a major and complex public health concern with large numbers of young adults, both men and women, dying in their most productive and reproductive ages. As a consequence, the epidemic has decreased the rate of life expectancy, leaving many orphaned children (Jackson 2002, Hubley 2002, Fieldhouse 2001).

Although a national survey of sexual behaviour provides evidence that high risk sexual practices are on the decline (CSOZ 2002), the current trajectory of the HIV/AIDS epidemic is unlikely to change quickly unless the country scales up its response to the spread of the epidemic. The growth of the epidemic will continue to pose a serious health concern for many Zambians and the numbers of adults becoming newly infected with HIV/AIDS will increase.

Given that 80% of infections in Zambia are transmitted through heterosexual intercourse, this underpins the necessity for men's active role and participation in HIV/AIDS risk prevention efforts. This is further augmented by that fact that in many societies contemporary notions of masculinity ensure that men have an influential role in sexual decision-making. This subsequently influences the capacity for a family to protect themselves against the risk of infection, and for this reason, men constitute a special interest group in the fight against HIV/AIDS.

It can therefore be argued that men are important allies in efforts to address the spread of the epidemic. This is emphasized by the number of studies which have shown that most heterosexual transmission of the infection has taken place within the

context of unequal gender relations. The call for male involvement in HIV/AIDS prevention is further supported by empirical findings that men who are educated about reproductive health issues are more likely to support their partners in reducing the risk of HIV infection in a marital relationship (FHI 1998)

Although there are a small number of projects that target men for enhanced involvement, this approach remains a relatively novel concept in Zambia. For this reason most of the projects promoting the concept of male involvement in HIV/AIDS risk prevention in the country are small-scale and many have not been well evaluated with respect to their impact on women, men, or their cost effectiveness. Furthermore, although men share the same patriarchal divide, it is difficult to extend the lessons learnt from these projects to other communities because of the differences in the social, cultural and economic context that may exist in different settings and which may influence the social construction of masculinity and HIV/AIDS sexual risk-taking behaviour.

This shows that it is difficult to use one example of success as a model of good practice. Furthermore, changing HIV/AIDS sexual risk-taking practices requires the need to challenge gender inequalities and the dominant concepts of masculinities, often at the centre of the HIV/AIDS epidemic. To succeed, such efforts are dependent on challenging the socialization processes, the social economic and cultural context in which such masculine identities are constructed. For this reason, one of the key and fundamental issues in the discussion of male involvement in HIV/AIDS risk prevention is the need for a critical analysis of the particular context in which masculinities are shaped, this is before any intervention involving men can begin.

Therefore, the purpose of this study is to obtain a sound contextual analysis, which can thereby increase the efficiency in programme development and planning of interventions aimed at male involvement and participation in HIV/AIDS risk prevention efforts. There are various theoretical concepts that underpin notions of masculine identity and how these are constructed, which relate to wider social conditions in the Petauke district. With the objective of achieving a better understanding of male HIV/AIDS risk-taking behaviour in marital relationships, it is to these issues that I will turn to in the next chapter.

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# **Chapter Four:**

## **Theorising Masculinity**

#### **4.0 Introduction**

This chapter explores the construction of masculine identity and its relevance to the analysis of the risk of HIV/AIDS transmission in heterosexual marital relationships. It acknowledges that there are several prominent perspectives on this issue. These perspectives include a biological determinist theory, the psychoanalytical perspective, and a number of social constructionist approaches.

I will begin by discussing the contested nature of different meanings ascribed to the term 'masculinity' and the assumptions that it is based upon, as well as the implications that ensue from these meanings. Specifically, and for the purpose of this chapter, the key theoretical perspectives mentioned above are discussed, and how these provide an understanding of how masculinity is constructed. This analysis argues in favour of a postmodern social constructionist perspective as a basis for exploring the association between masculine identity and the risk of HIV/AIDS in heterosexual marital relationships. The discussion then further highlights the significance of this standpoint for specific features of men's health behaviours, relevant to HIV/AIDS transmission.

In conclusion, I argue in this chapter that if the masculine identity that men adopt is socially constructed it may be possible, in the interest of HIV/AIDS risk prevention, to 'remodel' gender identities. This means challenging the harmful ideologies of what it means to be a man in a specific locality and which sustain and reproduce gender inequalities between men and women, and in turn, enhance the risk of HIV/AIDS transmission in heterosexual marital relationships.

#### **4.1 The concept of masculinity.**

To begin, it is evident from the available literature that the definition of the term 'masculinity' is problematic. Many disciplines have discussed masculinity in often quiet polarized discourses. Resulting theories and accounts have failed to describe adequately its complex structure. This has led to the failure to provide a robust model of masculinity (Imms 2000). Writers on the subject of men and masculinity such as Connel, (1995), Kimmel (1987), Sabo and Gordon (1993), Edley and Wetherell (1995), point to the difficulty in arriving at a conclusive explanation of what determines masculinity, which arises in part from the divergence and complexity of ideological positions on the subject. For this reason, the explanation of what accounts for men's identities and social behaviour continues to remain highly contested. In the light of this diversity, there is a continuing debate as to whether it is nature or nurture, which shapes masculinities. This complexity has led Edley and Wetherell (1995) to describe masculinity as both a social and psychological phenomenon, inextricably bound up with history, culture and systems of the structures of power. They further observe that:

"In viewing men from a number of different theoretical perspectives, we are trying to emphasise that there is no single correct theory on masculinity. Perspectives cannot be labelled right and wrong. (For example), as one walks around a sculpture or any other three-dimensional object, the views one obtains are all in some sense equally valid. However this in no way implies that they are always equally useful or insightful." (Edley and Wetherell 1995:106)

While keeping this caveat firmly in mind, in this thesis I aim to work from a social constructionist theoretical perspective, as the basis for analyzing the association between masculinity and the risk of HIV transmission in marital relationships. The

choice of this theoretical perspective is because many social scientists and epidemiologists have come to recognize the importance of social and cultural practices in explaining the construction of men's masculine identities (Connel, 1995, Hearn 1998, Kimmel 1997, Brittan 2001, Sabo and Gordon 1993). This theoretical perspective develops from the assumption that the construction of masculine identity is a complex process, mediated and reproduced through individual perspectives, interpersonal interactions, social practices and cultural adaptation (Sabo and Gordon 1993). From this perspective, women and men think and act in the ways that they do, not simply because of role identities or psychological traits, but because of concepts about masculinity and femininity that they adopt from their culture (Pleck et al 1993).

While a social constructionist perspective has taken precedence in the social sciences, its influence in shaping men's identity has strongly been contested by biological determinist theory. The divergent positions on whether it is nature or the environment which influences the construction of a masculine identity are reflected in what has popularly come to be known as the 'nature and nurture' debate on gender identity. While both schools of thought believe that masculinity is a useful tool to explain men's standpoint and behaviour, these polarized propositions diverge in their account of what determines men's masculinity (Greg et al 2002). Proponents of the biological determinist theory argue that gender differences are physiological in origin, derived from instinctual, hormonal, morphological, neurological or phylogenetic endowments. Because biological determinism challenges a more social, cultural view of the concept of masculinity, I will briefly outline the key features of this perspective.

#### **4.2 Biological determinist theory.**

From a biological determinist perspective, there are fundamental physiological differences between men and women. For instance, it is argued that men's nature is determined by the presence of the Y-chromosomes and high testosterone hormones in their bodies. Proponents of this perspective argue that masculinity in the form of male attitudes and behaviour follows as a consequence of this organic structure, particularly through the stimulation of the production of male sex hormones (androgens), which act directly upon the body's vital organs including the brain.

This perspective further argues that one of the ways in which male behaviour is distinguished from female behaviour is that males appear to be more aggressive than females. For this reason, it is further argued that this behaviour has historically improved male chances of survival and that men's political, economic and cultural privileges arise from this biologically determined masculine advantage. Goldberg (1998) argues that men are different from women because of genetic coding and the high levels of testosterone and physical energy, which encourage men to aspire to levels of authority and risky behaviour. He further argues that this is also variously reflected in genetic predisposition to aggression (in contrast to the passivity of femininity), physical strength (in contrast to the weakness of femininity) and sexual drives (in contrast to the sexual reserve of femininity). Essentially, this explanation sees masculinity as man's nature, including male violence as a biological attribute.

This approach to understanding men's masculinity has however been criticized for its reductionist explanation of the influence of complex social networks that construct men's masculinities. Thus, men's nature cannot be reduced to just flesh and blood;

biological determinism cannot take account of the role of complex and diverse social systems and conditions shaping and influencing male attitudes and behaviour.

### **4.3 Psychoanalytical perspective**

A second influential perspective on masculinity is derived from psychoanalytic theories (Connel 1995, Edley and Wetherell 1995). According to those working within the psychoanalytical tradition, the reproduction of masculinity is not a matter of genes and hormones but feelings and thoughts, fantasies and experience. They locate the reproduction of masculinity as generally lying within family relations. In this, the work of Freud, in the late nineteenth and early twentieth centuries was of seminal importance. Freud hypothesized that children come into life with certain innate drives that push them towards particular forms of action and physical satisfaction. For this reason, Freud saw the process of raising a child, male or female, as inevitably a troubling business, full of conflict, censorship and repression, since the child begins life impelled by their own strong desires and instincts. According to Freud, childhood involves a struggle in which the child must learn to sublimate his or her desires in the face of the power of the real world:

**'To become civilized adults, children must move from their original, primitive and anarchic state, to a situation where strong desires can be held in check and aimed at socially sanctioned goals. Becoming human involves a conflict between two sets of forces – the child's drives and inhibitions which arise from interactions with parents and others, who act as representatives of society and the reality principle.'** (Edley and Wetherell 1995:41)

As quoted in Connel (1995) and Edley and Wetherell (1995), Freud argues that when children are born, they do not have an innate predisposition to behave in masculine

ways, or potential for a specific built-in form of gender-related behaviour. The instincts that children have in infancy are not particularly masculine or feminine; they are simply drives to satisfy hunger or needs for physical security or (more controversially) a set of sexual and aggressive drives. Masculine and feminine forms of drives towards sexual pleasure are mediated through relationships with parents, specific to male or female children. But he also argues that children are not clay that can be modeled easily into shape; they are active in their socialization.

Although Freud's theories have contributed greatly to our understanding of the possible links between sexual drives and the making of gendered identities, his psychoanalytic theory has been criticized for laying emphasis on an unconscious or psychic reality divorced from wider social conditions. Importantly, Freud's theories do not take full account of the ways in which social conditions may shape behaviour, including gendered differences. A further difficulty is that due to the focus on material at a subconscious level, psychoanalytic concepts can never be verified through empirical scientific enquiry, nor systematically tested or evaluated (Edley and Wetherell 1995).

#### **4.4 Social constructionist theories.**

A number of social constructionist theories have been employed in attempting to explain the construction of masculine identities. Prominent among these are the following theories:

#### **4.4.1 Sex Role Theory.**

Sex role theory is an established social scientific perspective (Edley and Wetherell 1995). The theory is positioned at the interface between psychology and sociology and draws attention to the fact that most people, for the majority of their time, behave in ways that are 'socially prescribed', that is based on expectations which are socially acceptable. According to Joseph Pleck (1981) 'sex role theory', constituted the dominant paradigm in understanding the difference between men and women. The theory is based on the differences in social, productive, and reproductive roles and responsibilities that arise from natural characteristics, such as differences in physical strength between men and women. As the name suggests, this theory is founded upon a theatrical or dramaturgic metaphor, in which all social behaviour is viewed as a kind of performance.

Edley and Wetherell (1995) observe that sex role theory suggests that people are like actors on a stage playing out parts that have been assigned to them. Viewed in these terms, masculinity is seen as an act rather than an essence. It exists as a set of lines and stage direction, which all males have to learn in order to perform. This theoretical perspective conceives masculinity and femininity as two opposing types of personality, located on either end of a single bipolar dimension. Masculinity and femininity are seen as variable and flexible states. These differences are traced through a process akin to Darwin's theory of natural adaptation, explaining that from historical primitive times, men were responsible for hunting, fighting and protection of the territory, while women had responsibility for reproduction and domesticity.

This notion of the social arrangement in male/female social relationships has, according to Goldberg (1998), been passed on from generation to generation. Goldberg further suggests that in early cultures, marriage existed as an integral part of the human division of labour. If either man or woman failed to fulfill the expected roles or functions, there would be little chance of survival because of the hostile environment that existed. Thus, the expectation of strength, power and sexual competence forms the basis of male roles.

Although this theory is still commonly employed in analysing gender, it has been criticised for implying that gender represents fixed, static and mutually exclusive role containers (Kimmel 1987) and for assuming that women and men have innate psychological needs for gender stereotypical traits. It has further been described as being essentialistic and deterministic and inadequate in capturing the complexities, contradictions and contingencies of gender identities and relationships (Arnot and Weiner 1987). This is because the sex role socialisation theories foster the notion of a singular female and male personality, a notion that has been effectively disputed and obscures the various forms of femininity and masculinity that women and men can and do demonstrate.

A further criticism of sex role theory relates to the ambivalence inherent in the framework upon which this theory is grounded. According to Connel (2000), this notion of sex roles defines expectation, and attaches a biological status to oppression in the sex roles. This arises from the fact that the model explains gender inequality and hierarchy in terms of men's perceived natural superiority. Lindsley (1997) explains that

this ahistorical perception of gender relations masks or underplays the significance of socialisation in the making of men and women. At the same time, the deployment of 'nature' as a key category, common in scientific discourse and informing psychological concepts, has the effect of neutralizing questions of social justice in gender relations, suggesting that they are determined by an underlying natural force.

#### **4.4.2 Socialisation theory.**

Socialisation theory views the primary factors that shape and influence men's construction of their gender identity and social behaviour as learning and the social environment, and not biology or psychology (Kimmel 1987, Hearn 1998, Lindsley 1997, Connel 2000, Sabo and Gordon 1993, Brittan 2001, Edley and Wetherell 1995). This perspective proceeds from the assumption that people learn their appropriate roles and expectations through the process of socialization. In other words, values are mediated and reproduced through socialization. From this perspective, women and men think and act in the ways that they do, not because of their role identities or psychological traits, but because of concepts of masculinity and femininity that they learn from their peers, family and culture (Pleck et al 1993).

Lindsley (1997) describes socialisation as a lifelong process, through which individuals learn their culture, develop their potential and become members of a society. This socialisation process starts from an early age in childhood within the family and is reinforced by peer pressure, cultural expectations and the influence of the media, resulting in individuals adapting to a variety of socially and culturally determined social roles. This might mean that men are expected to have multiple sexual partners or that

violence is an acceptable means of asserting power and resolving conflicts (De Keijzer 1995, Sampath 1997). Women, too, learn the imprints of domestic and motherly roles from childhood through a process of socialisation (Obbo, 1980).

As a critical process in social life, socialisation requires social interaction as the norms of a particular society are learned, personality is also shaped, and gender roles and attributes are defined. Thus, gender roles are learnt and vary from culture to culture and from generation to generation and amongst individuals. In this same connection, Kimmel (1987), points out that gender is constructed from culture and subjective meanings that constantly shift and vary depending on time and place. Thus, gender can be described as *socially constructed* and the definition of masculinity and femininity as the interplay between a variety of social forces.

Against this background, De Keijzer (1995) and Sampath (1997) cite examples of how, in some cultural and historic contexts, men's promiscuity may be condoned as an expression of masculinity, and women perceived as passive recipients of male passion. Furthermore, De Keijzer (1995) and Sampath (1997) have recognised the connection between such social phenomenon and HIV/AIDS transmission. They have argued that learned ideological norms of masculine promiscuity create social pressure for men and boys to risk infection, and create barriers to their use of HIV/AIDS prevention, care or support services.

In a growing body of literature on HIV/AIDS sexual behaviour and attitudes, it has been noted that sexual relations at a young age have implications for both present and future sexual behaviour. It has been demonstrated that men who engage in early sexual activities are more likely to report extra marital sexual relationships than men

who initiate sexual activity later. Early sexual initiation and multiple premarital partners may establish a pattern of sexual conduct that persists into later sexual life (White et al 2000)

#### **4.4.3 Postmodern social constructionist perspectives: masculinities as fluid and context specific phenomena.**

##### **4.4.3.1 *Postmodern social constructionist perspectives***

Connell (1995) theorises masculinity from a postmodern social constructionist perspective. The postmodernist perspective defines social constructionism as a movement that has arisen from, and been influenced by, a variety of disciplines and intellectual traditions (Burr 2003). Its multi-disciplinary background means that it has drawn its ideas from a number of sources: French philosophers, notably Foucault and Derrida; wider sociological debates, and contemporary concerns in social psychology (Burr 2003).

Hoffman (2001) has similarly described a social constructionist approach as one based on the ideology that there is no such thing as objective, knowable 'truth'. This theoretical perspective from postmodernism argues that knowledge is never stable or certain. It is *constructed* through social interactions and inter-subjective influences, including language, family and culture. The basic contention in this theorisation is that reality is negotiated. That is, what we perceive as reality has been shaped through a series of social, cultural, interpretative and negotiated interactions and processes. Thus, the development of a concept is a social phenomenon, a fluid process that

evolves within communication (Hoffman 2001). It is further argued that it is only through the interaction of social/cultural processes, with the 'interpersonal self' i.e. ideas, beliefs, history, that the construction of knowledge is nurtured.

This conceptual underpinning argues against the privileging of a naturalised or essentialised position. In the postmodernist view, there is no notion of 'universal truth'. 'Reality' or the 'real' is constructed and reflects constraints of time, place, and prevailing notions concerning ethnicity, class, gender and sexuality. Consequently, attempts to establish transhistorical or transcultural validity for ideas or points of view are seen as futile (Burr 2003). Instead, postmodern thought emphasises a form of subjectivity that is fluid rather than static.

Subjectivity as used by postmodern thinkers does also refer to a subjective sense of self that includes agency – the capacity for thought and action arising from individual motivation (Connel 1995). This is as opposed to the idea of individual thought and activity being totally driven by concepts - or those in power - that are culturally dominant.

Applying this theoretical perspective to the social construction of masculinity produces the understanding that masculinity is not a universal, unchanging, biologically determined 'natural' state. Instead, unlike the biological state of 'maleness', masculinity constitutes a gendered identity constructed socially, historically and politically. It is also argued that both men and women are actively involved in constructing their own gendered identities, accepting, rejecting or modifying the various models and messages that society provides.

Like femininity, masculinity also represents a cultural interpretation of 'maleness' acquired through participation in societies, communities and institutions. As such it operates at different levels. At one level, it is a form of identity, a means of self-understanding that structures personal attitudes, power relations and behaviour. At another, distinct but related level, masculinity can be seen as a form of ideology, in that it represents a set of cultural ideals that define appropriate roles, values and expectations for and of men.

The diversity and plurality of the social and cultural character of masculinity is evidenced by cross-cultural variations in masculine styles and by historical changes in the dominant definitions of manhood (Leach 1994). Thus, the implication of a Postmodernist understanding of masculinity is that it rejects an essentialist and uni-dimensional conceptualization of masculinity as a coherent homogeneous group. Instead, it stresses the multiplicity of masculinities (Gilbert 1998, Mac an Ghail 1996, Connel 1995). It also locates masculinity as a gender construct, where an individual or 'subject' is not a passive recipient of specific gender roles and responsibilities imprinted upon or socialized by society but as a subject imbued with agency and self-knowledge even if this is fractured by conflicting identities and social pressures.

Further, this theorization of the gendering process has shifted attention from roles that males and females learn, to an understanding of the forming of gender identities as relational, multiple and processual; hence the re-conceptualisation of masculinities and femininities that are constructed in opposition to each other in social interactions.

Furthermore, Connel (1995) observes that gender identities are interwoven with power and can take on dominant, hegemonic, subordinate and marginalized forms, which are increasingly recognized as historically and culturally located. Kaufman (1995), Mac an Ghail (1996) allude to a similar description of multiple masculinities and attribute these to the existence of different forms of structural power and powerlessness among men.

#### **4.4.3.2 *The fluid nature of masculinities***

To this effect Connel (1995), in his highly influential text *Masculinities*, describes masculinity as a relational construct, within the context of gender relations. He argues that masculinity is not a matter of an unchanging male identity, but inherently an issue of power relations in gender relationships. For this reason, he defines masculinity as:

‘Simultaneously, a *place* in a given gender relationship, and a practice through which, men and women *engage* that place in gender and the effects of these practices in *bodily experience, personality and culture*’ (Connell, 1995:71).

Connel (1995) argues that as a relational concept masculinity is not static and is always shifting. This explanation means that men, like women are gendered beings and both contribute to and are affected by gendered power structures that are interwoven with other hierarchies. This definition warns that masculinity is not the property of men and reminds us to be wary of using the term as such. The notion of masculinity cannot be tied to a form of fixed gender identity, but is, rather, a floating ‘signifier’ i.e. it does not give credence to a fixed sexual identity in terms of masculine or feminine characteristics.

Masculinity in this context is not defined as a stereotypical sex or gender attribute, but more as a *fluid manifestation* of unequal power relationships. From this perspective, masculinity is both a product and a determinant of social relations that legitimise and sustain men's power over women. It is inherently about relations between women and men, as well as relations among groups of women and among groups of men and subject to change (Greg et al 2000). It exists in the context of relations of power not only between but also within the genders.

In this context, unlike a stereotypical sex role, social constructionist perspective, the postmodern social constructionist perspective, lays emphasis on how the social environment influences gender relations in a more fluid form. Emphasis is placed on the ongoing nature of the social construction of gender identities and relationships between men and women (Doyal 2000). From this perspective, gender is therefore not a static category but rather a set of socially constructed relationships, which are produced and reproduced through people's actions. Courtney (2000) further describes this perspective as derived from the view that both men and boys are not passive victims of a socially prescribed role, nor are they simply conditioned or socialised by their culture. Men and boys are active agents in constructing and reconstructing dominant norms of masculinity.

#### **4.4.3.3 Masculinities as context specific**

At the same time, because gender relations are shaped, performed and reproduced within a specific cultural, societal and individual context, there are bound to be a

variety of different context-bound forms of masculinity (Hearn 1998, Connel 2000, Brittan 2001). This means therefore, that the concept of masculinity will differ according to the social and cultural background in which it is defined and amongst individual men (Sampath 1997). As expressed by Sabo and Gordon (1993), all men are not alike: nor do all male groups share the same stakes in the gender order.

'At any given historical moment, there are competing masculinities – some hegemonic, some marginalized, and some stigmatized – each with their respective structural, psychosocial and cultural mooring' (Sabo and Gordon 1993: 10)

This, in essence, means that there is no single masculine identity, rather that there are several masculinities. As Kimmel (1987) states, 'it is more accurate to speak about masculinities and femininities than positing a monolithic gender construct' (Sabo and Gordon 1993). Just as men exercise varying degrees of power over women, so they exercise varying degrees of power among themselves. Thus, men stand vulnerable to violence by fellow men. As described by Courtney (2000):

"Masculinities are configurations of social practices and produced not only in relation to femininities but also in relation to one another. Dominant masculinities subordinate lower status marginalised masculinities such as those of gay, rural or lower class men' (Courtney 2000: 1391).

This position is also alluded to by Connel (2000), who states that to recognise more than one kind of masculinity is only a first step. It is also important to recognise the relations between the different kinds of masculinity (relations or alliances, dominance and subordination). These relations are constructed through practices that may exclude and include, that intimidate, exploit and take many roles.

#### **4.4.3.4 *The tension between structure and agency***

Although this study has chosen to draw on a social constructionist approach, there is a fundamental tension which this theoretical perspective needs to negotiate. This is the controversy concerning the degree to which it is 'society' or 'the individual' that influences and shapes what it means to be a human being, including knowledge and understanding (Burr 2003). To put the issue in more frequently used terms: in sociology long running debates have evolved concerning the tension between the influence of structure and agency in constructing knowledge. Both positions are potentially problematic for the theoretical resonance of social constructionism, leading on the one hand to the apparent denial of the influence of social context, on the other, to a social/discursive determinism which gives us as human beings no agency to shape our lives.

As highlighted in Chapter Two, Burr's (2003) very helpful discussion of this tension argues that the structure/agency opposition is never entirely resolved within the paradigm of social constructionism. Sampson, in Burr, (2003) also suggests that this dichotomy needs to be re-conceptualised so that we see individuals and the environment as an ecosystem rather than perceiving the environment as 'some extraneous set of factors which have an 'effect' upon a species' (Burr, 2003: 109). Burr points out that this attempt to overcome the structure/agency dichotomy leaves open the question of how we come to understand and explore Sampson's suggestion of an ecosystem. However, the idea of interpretive repertoires provided by Potter and Wetherall in Burr (2003) supports another promising possible way through the structure/agency difficulty inherent in social constructionism.

According to Potter and Wetherall we have available a number of 'interpretive repertoires' from which to construct meanings of our experiences. These repertoires are like a toolbox of possible explanatory frameworks. Some of these frameworks will be oppositional and critical of others. These repertoires give humans some freedom and flexibility to reflect, review, critique, mix and appropriate discourses rather than receive them passively. The appeal of this concept is that it emphasizes individuals' active role in the construction of their accounts, while not discounting the possible influence of social contexts. While people may shape their understandings from available language and discourse at the broadest level, interpretive repertoires draw on a variety of possible moves that can be made locally.

For instance as pointed out in Chapter Two in a critique of the social constructionist perspective, Connel (1987) one of the prominent authors on masculinity argues that masculinity, as a practice, cannot be isolated from its social and institutional context because people's experiences, attitudes, behavior, physical and psychological functioning are inextricably linked to the social environment and the social structures in which they live (Hess 1988). These dynamic social structures and lived experiences affect all human beings irrespective of sex age, social economic status and ethnicity. Thus one cannot be masculine in a particular way without being affected by the broad social conditions in which that form of masculinity arises, but from the social constructionist view, it is important to appreciate that this is expressed in the dynamics of local transactions between the sexes. There is no *one* version of masculinity, rather

there are multiple masculinities which are constructed out of local interpretations of experiences in the light of available language and discourses. The range of contextual, individual 'realities' implies that men experience their manhood very differently and that generalizations about men and masculinities need to be made with caution because local interpretations are likely to undermine them.

Thus as Haywood and Mac an Ghail (2003: 9) point out, while in *Gender and Power*, Connel (1987) 'identifies inequalities between males and females in relation to levels of income, levels of literacy, women's participation rates in government and their overwhelming experience of domestic violence', these broad structural factors are not held to shape gendered behaviour in easily definable ways because differentiated masculinities and femininities exist 'relationally at local levels' (Connel, 1987 in Haywood and Mac an Ghail, 2003:9). Such local gendered interpretations will include variations in the way in which masculinity and risk are locked into each other and this, of course, is a key concern for this thesis. Similarly, while domestic violence is a global phenomenon, key to the concerns of this thesis are the ways in which violent behaviour (which can be physical and/or symbolic) is locally and relationally defended and resisted by men and women in rural Zambia.

Given this background it may need to be conceded that social constructionism does not fully address the wider social economic dimensions that create this tension, but there are versions of social constructionism which do accept that 'discourses, social

structures and social practices are intimately bound up with one another' (Burr, 2003: 93) and it is upon these versions that this thesis relies.

#### **4.4.3.5 *Influence of hegemonic masculinity***

Under the Social Constructionist perspective, one of the factors that shape the social construction of masculinity is what Connel (1995) has described as the influence of hegemonic masculinity. Hegemonic masculinity is a sociological term describing the process which keeps dominant groups in power by ensuring that subordinate groups accept 'the way things are'. Thus hegemonic masculinity is the socially dominant form of masculinity in a particular culture, within a given historical period. Against this backdrop, Courtney (2000) describes hegemonic masculinity as a form of idealised masculinity, that occupies the hegemonic position and is culturally exalted at a given place and time. It is a socially constructed gender role that subordinates femininities as well as other forms of masculinity and shapes men's social relationships with women and other men; it represents supreme power and authority.

Courtney (2000) further observes that rejecting what is constructed as feminine is essential for demonstrating hegemonic masculinity in a sexist society. He explains the notion of hegemonic masculinity as:

"In exhibiting or enacting hegemonic masculinity ideals are within health behaviours; men reinforce strongly held cultural beliefs that men are more powerful and less vulnerable than women; that men's bodies are structurally more efficient than, and superior to, women's bodies; that asking for help and

caring for one's health are feminine; and that the most powerful men among men are those for whom health and safety are irrelevant" (Courtney 2000:1389)

Thus, although achieving hegemonic masculinity may carry serious health risks, men who achieve these ideals are compensated by social acceptance and diminished anxiety about their manhood (Connell 1995). As men must correspond to this hegemonic model of masculinity, those who cannot correspond are considered as inferior and subordinate to other stronger men. This subsequently leads to the domination, subordination and marginalisation of the perceived lower categories of masculinities. In Latin America for example, concepts of masculinity also called 'machismo' are generally equated with bravado, sexual prowess, protecting one's honour and willingness to face danger and violence against women (Association for Voluntary Surgical Contraception: AVSC International 1998).

This concept of the social construction of masculinity has several implications for this study. This is because the hegemonic masculinity behaviour adopted by, or aspired to, by some men could carry a significant cost (Connell 2000). This could be in terms of health, emotional state, violence, reckless sexual behaviour, alcoholism and the social and self imposed pressure to maintain a masculine image. As a result of the influence of hegemonic masculinity, promiscuity amongst men is often condoned and sometimes encouraged, while it is usually frowned upon in women. One of the consequences of this gender difference is that men expose themselves to an increased risk of infection by having multiple partners and in turn risk transmission of HIV to their partners, even if women themselves are not behaving promiscuously.

## **4.5 Social constructionist perspectives on specific, men's health behaviours**

### **4.5.1 'Invulnerability'**

Global demographic indicators show that men are consistently reported to have shorter lives than women. (Sabo and Gordon 1993). This is because, in many societies, the cultural construct of masculinity may socialise men to the notion that that 'real men' do not get sick (Courtney 2000, Doyal 2000). This may also be coupled with a tendency by men to be less concerned than women about health issues (Sabo and Gordon 1993). Such behaviour, attitudes and beliefs may increase men's exposure to ill health and premature death. It may also decrease men's ability to protect and preserve their health, with implications also for women's health. With regard to this issue, Doyal (2000) has further observed that men are less likely than women to visit a doctor regularly and many are reluctant to seek professional advice, even when they suspect they may have a problem. Some men may see themselves as invulnerable to illness or risk. When they actually fall ill, they may put up with the sickness or seek health care only as a last resort (Sabo and Gordon 1993). This reflects men's sense of themselves as self-reliant and not in need of help.

These attitudes and behaviours have had a severe negative effect upon the spread of the HIV/AIDS epidemic. For instance, a man who delays the treatment of a STI may be up to 6-10 times more likely to pass on or acquire HIV during sex. The risk becomes much higher in the presence of a genital ulcer, which may occur in cases of syphilis, chancroid or genital herpes (UNAIDS 2000a).

#### **4.5.2 Men and sexuality.**

Cross-cultural constructionist accounts of masculinity often identify male sexual potency as an important affirmation of masculinity (Francher and Kimmel 1987). Male sexuality is also associated with initiation into adulthood and achieving a socially recognised manhood (Barker and Ricardo 2005). The centrality of sexuality in affirming masculine identities has been argued from two different theoretical perspectives. As I have discussed above, these are located within the biological determinist, psychoanalytical and social constructionist perspective.

This thesis argues from the perspective, which locates human sexuality within the context of a social constructionist paradigm. This approach sees sexuality as the product of complex social arrangement and individual phenomenon influenced by social norms such as culture and personal experiences (Schwartz 1997, Fine 1993). For instance, human sexuality may be determined by a biological imperative towards reproduction, but how we are sexual, where, when, how often, with whom and why has to do with cultural learning with the meaning transmitted in a cultural setting (Francher and Kimmel 1987).

Foucault (1978) in his *History of Sexuality* alludes to the social constructionist perspective, arguing that there is no evidence that there is internal force or drive that manipulates sexuality. He goes on to say, that what can be manipulated are ideas and definitions, a potential regulator of the ways in which sexuality can be thought of, defined and expressed. Sexualities, he argues, are constantly produced, changed and

modified, and the nature of sexual discourse and experience changes accordingly. Given this account, this affects the way individuals define, feel and perceive their sexuality. Therefore, diverse sexualities exist, even within the same environment (Baber and Allen 1992).

Given this conceptual underpinning, Francher and Kimmel (1995) have shown that sexuality can be as much a site for experiencing power, as well as powerlessness. Thus, because of the centrality of strength in masculinities, sexuality may be used as a means to affirm men's masculinity. In this way, it can be said that sexual behaviour allows a man to accomplish masculinity and overcome experiences of powerlessness, when his power is in jeopardy. Against this background, sexuality can arguably be said to a *location* for the enactment of masculinity.

Baker and Ricardo (2005) have further observed that by adhering to these gender roles, by default, men often have a disproportionate share of power and voice in intimate relationships with women. This imbalance of power between men and women in marital relationships, has, in many societies, conferred on men the ability to influence and/or determine the reproductive health choices of women. In the face of this inequality, many women have little or no control over sexual decisions in marital relationships. Furthermore, for economic and cultural reasons, men tend to have the dominant position in decision-making regarding sexual relationships. In Zambia, this has led research to conclude that most heterosexual transmission has occurred within the context of unequal gender relations (Macwan'gi 1993, Bryne 1995, Baylies and Bujra 2000, Foreman 1999, Sulwe 2000).

Furthermore, evidence and lessons learnt from a number of both regional and international studies in addressing sexual violence and HIV, indicate that men are also frequently the decision-makers about whether and under what conditions women and girls have sex (Heise 1998, Baker 1999, Jewkes 2002a). It is usually men who decide on the number of and variety of sexual relationships (Foreman 1998, PANOS 2001, UNAIDS 2003). Men also tend to make decisions on the frequency of sexual activity, and it is often men who decide whether to use a condom or other means of protection against the risk of infection (IPPF 1998a, FHI 2001, UNAIDS 2003,).

In spite of these norms, men frequently often have little accurate information on these matters and fear admitting their ignorance, which may lead them to engage in unsafe behaviour that puts both them and their partners at risk (Rivers and Aggleton 1998).

As Baker and Ricardo (2005) observe:

“While on the surface many young men might display bravado, this may in fact, be compensation for insecurities or doubts about their sexuality. Often young men have misconceptions about what their partners want, which in the context of poor communication can have serious implications for HIV risk” Baker and Ricardo (2005: 19)

To the contrary, however, dominant constructions of femininity generally stipulate that women's sexuality should be invisible and that it needs to be controlled. This often leads to double standards, which also puts men at increased risk. When men do not take care of their sexual health, or do not believe it necessary to seek advice on such matters, they put themselves and their partners at risk. Furthermore, unequal parties are not in a position to negotiate when they have sex, how often and how they can protect themselves from STIs and HIV.

### **4.5.3 Men and risk taking.**

Studies have further identified men's attitude towards risk-taking as key common elements of masculine performance and scripts. Men often use risk-taking as one of the ways in which to construct their masculinities. Such behaviour may include the endorsement of promiscuity, heavy consumption of alcohol or domestic violence as the appropriate expression of male dominance (Dobash and Dobash 1989).

It has further been observed that these attitudes towards risk-taking are inculcated into men from childhood. This is because, in many cultures, a number of ideologies regarding the social representation of men's masculinities often include being strong, assertive, emotionally robust, daring, virile and willing to take risks (Sabo and Gordon 1993). In view of the centrality of risk-taking in the construction of masculine identities, some men and boys are prone to adopting risk-taking attitudes and behaviour as a means by which to validate their masculinity. To this effect, it has been found that a number of ideas and assumptions that feed into notions of masculine identity may socialise men towards risk-taking.

On balance, it has also been observed that many of the problematic behaviours associated with hegemonic masculine identity, such as unsafe sexual behaviour and participation in violence or local insurgencies, are often efforts by men to publicly define or affirm themselves as men (Baker and Ricardo 2005). For instance, some

men define the degree of their masculinity by defying positive health behaviour, and by engaging in risky sexual behaviour, in order to prove their masculinity. In this connection, studies have shown that men tend to have multiple sexual partners as a way of asserting their masculinity. As a consequence, of the influence of hegemonic masculinity, some men may see promiscuity and having multiple sexual relationships as a way of affirming their masculinity. This association between risky sexual activity, manhood and identity has a number of direct implications for HIV/AIDS prevention (Baker and Ricardo 2005). This is because some men may ignore precautions for AIDS risk reduction such as safe sex, abstinence or using a condom as this is seen to compromise their manhood (Levin 1998).

#### **4. 5.4 Men in Heterosexual marital relationships**

A number of cross-cultural studies have observed that heterosexual marital relationships in many societies are characterized by unequal gender relationships between men and women (Hearn 1998, Dobash and Dobash 1989). As we have seen, this is attributed to a number of social economic factors that combine and generally position men in a dominant position in social relationships with women. Underpinning these observations is evidence from a number of gender-based studies (discussed in detail below), which show that for economic and cultural reasons, men in many societies commonly hold a dominant position over women. This has often led to a culture of male domination. In contemporary terms, male dominance has been defined as a socially imposed and symbolic organization of the superiority and authority granted to the male status in both the private and public sphere (Hearn 1998, Dobash and Dobash 1989). This notion of gender relationships awards a higher value and

prestige to masculinity than to femininity. This structure of relationships in turn confers the belief in the Hearn (1998) and Connel (1995) have described male dominance as the institutionalization of unequal power relations to varying degrees between men and women in different sites, in both the private and public sphere (Goldberg 1998, Connel 1995, Hearn 1998). This combination of male dominance in societies' culture and social relations is also referred to as patriarchy (Hearn 1998).

Among the key attributes associated with the notion and practice of masculinity and the culture of male dominance, is that men are often considered as the breadwinners in families. In terms of gender roles, in most sub-Saharan Africa, most women are poor and powerless (Obbo 1980, Ankrah 1993, Mbizvo and Basset 1996, Heise 1998, Baylies and Bujra 2000). Many women lack the ability to support themselves or gain employment. As men are usually in control of productive resources in marital relationships, they often occupy a privileged position in the social and economic organization of heterosexual marital relationships (Heise 1998). This has, in turn, placed many women in a position of economic dependence in the home and weakened women's bargaining power within marriage. Women's dependence on men has often made it difficult and sometimes impossible for women to leave unsatisfactory marriages.

In many cultures, this imbalance in social relationships between men and women has further meant that men hold a dominant position in decision-making regarding sexual relationships (Macwan'gi 1993, Baylies and Bujra 2000, Foreman 1999, Sulwe 2000). For this reason, it has been found that men often assume an influential role and/or

determine the reproductive health choices of women. In the face of this inequality, many women have little or no control over sexual decisions in marital relationships. Without power, women are likely to experience little control over the terms of sexual relationships with men (Dobash and Dobash 1989, Hearn 1998). This subsequently has serious implications for women's ability to protect themselves from the risk of HIV infection (Heise 1998, IPPF 2000). This view is also shared and supported by Panos (2000) and Germain and Kyte (1995) who observe that because of the severe economic hardships that women in developing countries are confronted with, they often have trouble in negotiating safe sexual encounters for fear of losing an important source of livelihood.

Similarly, Watkins (1995) in the Oxfam report on poverty and sexual health decision-making, observe that women's lack of confidence in the future makes them dependant on their spouses, even though their relationships may portend the risk of HIV/AIDS infection. For instance, because of the migration of young adults to urban areas in search of employment opportunities, females outnumber men in many rural Zambian communities. This has led some women to enter into polygamous marriages or temporary unions in order to survive.

Having noted the difficulties that many women face, it is important to acknowledge the plurality of masculinities, which has meant that not *all* men in marital relationships can be considered the same. As Panos/UNAIDS (2000) observed, not all men behave arrogantly towards women, many respect their partners and demonstrate this respect in their sexual and other behaviour. It should also be noted here that women should

not be construed simply as victims of hegemonic masculinity. They also play their role in determining masculinity and behaviour. The making of gendered identities is always relational. As mothers, sisters and wives, women have some agency in determining their femininity, which in turn affects forms of masculinity, particularly through the parenting of boys.

For instance in many families the socializing of children is done through rendering support and approval to certain specific types of games. For instance, a parent may encourage a male child to play with toys mimicking fast cars, or war games while a girl child is usually encouraged to play with toys associated with domesticity and nurturing. These imprints form the basis upon which the children are socialized. The irony is that females are often the major socializing force in the family, usually reinforcing the traditional beliefs associated with being a man (Olawoye et al 2005). Deviance and resistance to the prescribed social expectations may often carry sanctions. In a situation where a young boy may be naturally timid and withdrawn he may be derided as being too feminine or other definable descriptions such as 'sissy boy' or 'wimp' (Imms, 2000).

In a study entitled '*Sons and Fathers/Boys to Men in the Time of AIDS: Learning Masculinity in Zambia*', Simpson (2005) suggests that the designation of chores in childhood similarly reveals explicit ideas about appropriate tasks. He notes that young children acted out the particular task of work associated with each sex. For example, in the Tonga tradition in Zambia, there is a game called *mantombo* – the boys build shelters and the girls prepare food. The fact these games emphasize the difference in

masculinity and femininity activities show how deeply that these gender roles are accepted as being what is right and wrong for a particular sex.

In relation to cultural practices, Jagdeo (1996) has observed that cultural practices and norms such as the payment of dowry may diminish a woman's reproductive autonomy by having her interest subordinated to the interest of the husband and indeed the family. The payment of a dowry, though intended to signify respect and legitimize a marital relationship has been used as a strategy to disadvantage women by denying them reproductive and health rights. This unequal balance of power between men and women has been found to confer on men the ability to influence and determine the reproductive health and risk of infection of women in marital relationships. In an analysis of the problem of domestic violence in many developing countries, Leye et al (2001) has identified the same unequal gender relationships between men and women in marital relationships as the underlying cause of domestic violence. This is the case, as men are perceived to hold an influential position in gender relations.

As a result, there are unequal power relations, which are often played-out in sexual encounters. This is further sustained by social support for men who perceive they must fulfill their sexual needs by making it difficult for women to negotiate safe sexual relationships.

#### **4.5.6 Domestic violence and the risk of HIV/AIDS**

In a number of cross-cultural studies, it has been observed that men's violence is a key determinant of the inequities of gender relations. Men tend to use violence as a means of structuring, negotiating and sustaining male dominance (Hearn 1998, Heise 1998, Courtney 2000) reports a summary of twenty studies, from a wide variety of countries, that one-quarter to over a half of women in many countries of the world, report having been physically abused by a present or former partner. She concludes that the endemic form of violence against women is wife abuse or more accurately abuse of women by an intimate partner. This is further extended to sexual health and reproductive rights, where such abuses diminishes women's capacity to express and enjoy their sexuality and control fertility, while increasing their risk of pregnancy complications and acquiring sexually transmitted infections including HIV/AIDS.

Domestic violence takes many forms. Extensive evidence shows that it comprises a combination of physical, emotional and sexual force by men to control their intimate partner (Dobash and Dobash 1989, Hearn 1998). Thus, men's actual use of violence or the threat of violence stands at the centre of patriarchal cultures keeping women in submission to male decision-making (Dobash and Dobash 1989).

Male violence has been implicated in the spread of the HIV/AIDS epidemic at two levels (IPPF 1998). These are acts of actual physical violence perpetuated through rape, forced, or coerced sex. There are also forms of non-physical violence that through fear, prevent women from questioning extra marital affairs or ensuring their husbands use condoms. For example, in a study of women from over ten countries undertaken by the International Centre for Research on Women (ICRW) the following was noted:

'Though many women expressed concern about the infidelities of their partners, they were resigned to their lack of control over the situation. Women from India, Jamaica, Papua New Guinea, Zimbabwe and Brazil report that raising the issue of their partners' infidelity can jeopardize their physical safety and family stability' (Gupta and Weiss 1993: 405).

The potential to reduce the risk of HIV in marital relationships in these situations is significant (Heise 1998, Bujra 2000a). Although patriarchal behaviour and subsequent male dominance can be seen as a universal phenomenon, Dobash and Dobash (1989) have observed that this varies considerably across cultures, depending on the belief systems, forms of organisation and traditional patterns. This is because of the differences in cultural and social perceptions of male dominance. What one culture may define as normal interaction between a man and woman might be defined quite differently in another culture in which such relations take place.

#### **4.6 Implications of a social constructionist perspective for working with men**

In many countries, civil society organizations and reproductive health programs have initiated a number of programs on HIV/AIDS prevention using a variety of strategies. Many of these strategies are located within a social constructionist paradigm. Greg et al (2000) observed that the underlying conceptual underpinning in these approaches has moved from a biological determinist to a cultural constructionist account of masculinity. As such, a number of programs have been able to work with men by helping them understand the ways that structural pressures, cultural messages and /or parenting practices, have contributed to their socialisation behaviour, which may include violence and HIV/ADS risky behaviour.

Deconstructing male perceptions in this way has helped some men to question their embedded beliefs and change their behaviours. Furthermore, in attempting to work with men, Baker and Ricardo (2005) point out that it is important to bear in mind that there is no such thing as the typical man. Versions of masculinity are socially constructed, fluid over time, in different settings and plural. The emergence of these programs is therefore aimed at changing dominant local sexual behaviour, related to the individual perception of manhood (or what constitutes a 'real man'), and this perspective is increasingly attracting the attention of reproductive health researchers and programme planners.

Given the centrality of male sexuality and its expression in the social affirmation of masculine identities, a number of programmes that have been initiated at both the international, regional and at country levels are focused at deconstructing harmful ideologies of 'what it means to be a man' and ways that this can enhance the risk of HIV/ infection and transmission. To this effect, and working within the context of the social constructionist paradigm, Rivers and Aggleton (1999) observe that programmes that work with men and which persuade them to change their HIV sexual risk-taking behaviour, have an enormous potential to change the course of the HIV epidemic and to improve men's lives and that of their partners' and families.

These programmes vary in content and programme focus because of the diversity in male behaviour and social circumstances. This is because while men might share a patriarchal view, the behavioural differences, and attitudes about men vary within and across societies and are different in every society. The diversity in the programme

scope and content is also necessitated by the recognition of the different social circumstances that contribute to shaping masculine behaviour. This is because attitudes such as beliefs and practices regarding 'what it means to be a man' are known to evolve over time and are determined, at least in part, by context-specific expectations as to how men should act. As Sampath (1997), and De Keijzer (1995) describe: concepts of masculinity will differ according to the social cultural background in which it is defined.

Thus, ideas about manhood differ from culture to culture and within cultures and amongst individuals. Factors such as education, age, upbringing, income all influence the role that men are expected to play. For this reason men are a highly diverse group, and generalizations about their behaviour must be attempted with caution. Moreover masculinity is only one aspect of personhood, and versions of masculinity are likely to be influenced by other factors such as religious formation, political beliefs and values. Some of these factors may be in tension with each other and programmes will need to be sensitive to this and indeed to the opportunities they may present for exposing contradictions in men's gendered assumptions.

Across the world in communities as disparate as Brazil, Nicaragua, a number of countries in Western Europe and sub-Saharan Africa, the interconnection between male power and dominance over women and its connection with the spread of the epidemic in their communities has been recognised. To this effect, many efforts are challenging the unequal gender relations between men and women as the root cause driving the epidemic.

In South Africa, one of the successful projects in working with men is called the 'Men as Partners' project. This project utilises a societal approach to address men's role in the spread of the epidemic and is based on a social constructionist approach. It was launched in South Africa in 1988 as a collaborative effort between Engenderhealth, an international NGO, and the Planned Parenthood Association of South Africa. The project strives to engage young adult men in challenging patriarch attitudes and beliefs to positively impact the health and well being of men, women and children - particularly in the context of the synergistic epidemic of gender-based violence and HIV/AIDS. The guidelines for this programme are comprised of three core and interrelated elements of constructive male involvement: -

- (i) The recognition that men are often the gatekeepers for women's sexual and reproductive health in that they have the ability to influence and determine the choices of their partners;
- (ii) That traditional masculine gender roles also have a negative effect on men, in that they promote risky behaviour as manly and health-seeking behaviour as frailty and
- (iii) That men have a personal investment in the promotion of gender equity, as it will lead to positive outcomes for both men and women.

Originally, the programme began working with young adults and men in small group workshops. The program realised that to ensure a sustained change it needed to adapt towards a more ecological approach, considering both individually focused solutions and strategies for contributing to an enabling environment. To this end, it has now expanded its activities to include more broad-reaching efforts in community level mobilisation.

Some of the fundamental concepts emerging from the analysis of male-focused programs are that masculinities are clearly changing in Africa, as they are in the rest of the world (Ndubani 1998). To this effect, there have been suggestions that the dimension of the AIDS epidemic in Africa and the devastation it brings to families is forcing men to question gender norms and attitudes that were once unquestionable (Baker and Ricardo 2005). Some men are taking care-giving roles and others are caring for their own health in new ways. The number of AIDS orphans has also led to changes in family arrangements, with young men taking on roles previously assigned to women.

#### **4.7 Conclusion**

In this chapter, I have presented a review of the definitions and uses of concepts of masculinity in order to deconstruct ideologies, male assumptions and behaviour in relation to the transmission of HIV/AIDS in heterosexual marital relationships. I began with an analysis of the various theories and ideological positions that inform the construction of male identity. In this analysis, I have described the different and divergent views and ideas concerning the complexity of factors that contribute to the making of masculinities. In summing up approaches that describe the construction of male identities, Leach (1994) observes that most theories which have attempted to produce a political understanding of masculinity have had difficulty producing a coherent analysis of power relationships within and between genders. For instance, a biological perspective to masculine identity attempts to account for masculine nature

and power with reference to biology and physiology. This approach cannot account for cultural differences or historical redefinition of masculinity. Similarly, the relatively more sophisticated sex role and socialization theories suffer from analogous theoretical shortcomings.

Against this background, this chapter then proceeded to analyse the construction of male identities drawing principally on postmodern social constructionist theories. Understanding the definition and discourses surrounding masculinity from this perspective and within the context of shifting power relationships implies that different versions of masculinities are socially constructed: that 'there are many ways to be a man'. This perspective on explaining masculine identities is given added impetus by exemplifying the diverse roles that men play in the economy, the community and the family – after all men can be husbands, fathers, brothers and sons. Masculine identities were also seen as mediated through cultural practices and patriarchal structures, which shape the roles rights and responsibilities associated with being a man, in contrast to being a woman.

At the same time, while much of the analysis in this thesis is focused on the role that men play in constructing masculine gender identities, it has been important to point out that women also play a role in socialising boys and men to their various roles and responsibilities. Baker and Ricardo (2005) caution that:

**"Whether as mothers, aunts, sisters, girlfriends, sexual partners or teachers, women come in direct contact with boys and directly and indirectly pass on messages regarding gender norms. Young men's behaviour related to sexuality for example is directly influenced by young women's expectations about negotiating sex and condom use." (Baker and Ricardo, 2005:13)**

Women directly influence the behaviour of boys, for example channeling them into activities they perceive to be 'appropriate' for boys and discouraging attitudes or behaviour they perceive to be associated with girls and women. At the family level, Simpson (2005), Olawoye et al (2005) have highlighted the influence of parenting of boys in the construction of male gender identities. They point out that social pressure exerted by parents might play a significant role in influencing masculinity. The key point in this analysis is that gender roles are constructed and reconstructed and must be questioned by both men and women.

As I have argued, since 'what it means to be a man' is socially constructed, it follows that sexual behaviour which exposes both men and women to the risk of HIV/AIDS is socially constructed. It also follows that this means it is theoretically possible to contest harmful ideologies which expose both men and women to the risk of infection. This has significant implications for health promotion practice. It provides an opportunity to work with institutions within the community to help socialize men by encouraging access and creating new models of, and identities for, men to support a social cause.

In the light of this theoretical underpinning, increasing attention is being paid to the connections between masculinity and public health. Courtney (2000) among others, has described the ways in which traditional masculine roles and ideas increase men's exposure to ill health and premature death, and decreases men's ability to protect and preserve their health. These notions of masculinity have often been concerned with risk-taking. Cultural constructionist accounts of masculinity often identify risk as a key element of masculine performance and scripts. This concept continues to influence

health promotion work with men, especially in the area of sexual health. As argued by the UNAIDS (2000a) efforts to challenge harmful concepts of masculinity and commonly held attitudes and behaviour including the ways adult men look at risk and sexuality and how boys are socialized to become men, must be part of the effort to curb the AIDS epidemic. Contemporary gender roles suggest that men are expected to be physically strong, emotionally robust, daring and virile. Some of these expectations translate into attitudes and behaviours that endanger the health and well being of men and their sexual partners with the advent of AIDS.

Greg et al (2000) observes that in a number of studies in HIV prevention work with both straight and gay men, and homosexual and heterosexual transmission, has addressed HIV risk-taking behaviour as a facet or demonstration of masculine identity. Deconstructing the need for this demonstration and highlighting the pressure on men to perform their masculinity through risk-taking has created a space for men to be more conscious of the reasons for and consequence of their own sexual behaviour (Barker and Ricardo 2005).

Similarly, placing men's violence in a historical and cultural context helps overcome the naturalization of men's violence. This is because men and women's relationship to violence is more complex than that men are intrinsically perpetrators and women, victims. As this analysis has shown, gender-based interpersonal violence needs to be contextualized within structures, cultures and histories of violence reproduced through male – and female – assumptions and behaviour. Therefore to address these issues it is useful to look at violence as embedded in the discourses of masculinity. Encouraging men to be more conscious of how gendered expectations and

responsibilities adversely affect their lives, as well as those of women, could be an important first step to reconstructing the stereotypically problematic behaviour such as violence and sexual risk-taking in marriage.

In concluding this discussion, it is evident that a social constructionist perspective permits an understanding of the ways in which dominant forms of masculinity interact with widespread features of gender relations and economic organization (Kimmel 1987, Hearn 1998, Connel 2000, Sabo and Gordon 1993, Brittan 2001, Edley and Wetherell 1995). In this regard, I argue that in order to achieve sustainable long-term behavioural change there is a need to challenge some of the societal and institutional structures that promote and reproduce gender inequalities and which in turn enhance the risk of HIV/AIDS transmission in marital relationships: such as cultural beliefs and practices and some of the harmful ideologies that enhance the risk of infection.

A detailed context specific analysis from a social constructionist perspective, of perceptions of masculinity and HIV/AIDS risk-taking behaviour, such as this thesis seeks to provide, might increase the efficiency of interventions aiming to enhance men's role and participation in HIV/AIDS prevention in marital relationships.

**Chapter Five:**  
**Men and HIV/AIDS Risk Prevention**  
**Intervention:**  
**A Review of Health Promotion**  
**Interventions**

## **5.0 Introduction**

In this chapter, I review the main health promotion strategies that have characterised HIV/AIDS risk reduction behaviour in the Petauke District of Zambia. The review is focused on ascertaining the extent to which current health promotion initiatives in the district address aspects of the social environment, interpersonal perceptions and interpersonal interactions that impact on men's sexual behaviour and subsequent risk of HIV/AIDS transmission in marital relationships.

On the basis of this review, I will identify and describe opportunities within existing health promotion practices, that can be utilised to inform health promotion practice that aims at promoting men's participation and involvement in HIV/AIDS risk reduction efforts in Zambian rural communities, and ways in which health promotion needs to move beyond current approaches.

I begin this chapter by describing the conceptual framework and theoretical underpinnings, which inform health promotion practice in Zambia and which are reflected in initiatives in Petauke district. I then describe three key national HIV/AIDS risk reduction strategies falling within the context of health promotion practice. The three approaches are health education, social marketing and community based strategies, respectively. In this review, I examine the extent to which these three approaches address a societal dimension to HIV/AIDS risk reduction. I further examine the extent to which current health promotion practice is addressing the interconnection between domestic violence and the risk of HIV/AIDS infection in

marital relationships. This includes efforts to promote condom use in marital relationships.

In concluding the chapter, I argue that efforts that seek to promote male involvement in HIV/AIDS prevention need to encompass programmes that address the influence of the social environment and the impact this has on male sexual behaviour in relation to the risk of HIV/AIDS transmission in marital relationships. Furthermore that such attempts must take into account a pluralistic vision of masculinity. This is from the standpoint that current health promotion efforts in Petauke District seem to be underpinned by an image of masculinity as a homogeneous and privileged entity. This does not adequately accommodate the complex range of masculinities in the various communities in the district. There is therefore the need to build an image of masculinity as constituted by processes of social interaction that are plural, fluid and time bound, with varied and varying complex values and beliefs that underlie men's perceptions and behaviour and not as a set of characteristics shared by all men. To this effect, health promotion should seek to engage with the community to promote positive role modeling of masculinity as a process to deconstruct harmful ideologies of masculinity that enhance the risk of HIV/AIDS. As argued in this thesis a strategy such as the use of positive role model peer educators and opinion leaders to deliver HIV/AIDS campaigns can contribute to influencing positive behaviour change.

This 'multiple masculinities' approach is I, believe, the seed from which much significant work aiming at male involvement will grow during the next decade.

## **5.1 An overview of health promotion in Petauke District**

Petauke district is one of the rural districts in Zambia. As in all other districts in the country, the Government's ministry of health and other stakeholders are making a number of pragmatic efforts to fight the spread of the HIV/AIDS epidemic (PPAZ 2000, Zambia National HIV/AIDS/STD/TB Council 2000). The institutional framework for implementing HIV/AIDS related programmes at the district level is that the Ministry of Health through the District Health Management Board is the lead agency spearheading the various HIV/AIDS risk reduction interventions in the district. These Boards are in turn assisted and supported by a number of stakeholders which include NGO's, community and faith based organizations.

This review found that there were a variety of primary health care strategies used to contain the spread of HIV/AIDS in the communities and that in the absence of a cure or vaccine against HIV, health promotion efforts are mainly being directed at prevention and creation of awareness (MoH 1999, Zambia National HIV/AIDS/STD/TB Council 2000, Sulwe 2000). The aim of these efforts is to raise awareness of the risk of infection and to change people's attitudes towards sexual practices that are likely to predispose them to infection. Furthermore, the review showed that many of these activities are being implemented in the context of Health Promotion and Primary Health Care practice.

For the purpose of providing a contextual background to this analysis it is important to explore the major theoretical perspectives that inform health practice in Zambia as a

whole and which have permeated through to Petauke District. These are respectively health education, social marketing and a 'community based' approach.

## **5.2 Definitions of Health Education in Health Promotion**

The operational framework for health promotion is defined in the Ottawa Charter on Health Promotion (WHO 1986). It has three basic strategies for health promotion practice: advocacy for health - which is aimed at creating the essential conditions for health; enabling all people to achieve their full health potential and mediating between the different interest groups in society in pursuit of health.

The aim in health promotion is to prevent disease by altering an individual's behaviour (Peate 2003). Fundamental to this, and as a first step to behavioural change, is the understanding that in order for an individual to have a reasonably accurate assessment of risk, they need to explore the risk factors in their own environment (Bunton and Macdonald 1992, Kerr 2000). Thus, having a correct perception of risk and knowing more about ways to reduce these risks can help to mitigate the risk factors in the environment that people live in.

To this effect, Tones et al (1985) have defined health promotion to include any measure designed to promote health. They state that:

**'The central feature [in health promotion] is its concern to build a system conducive to health through the development of healthy policy at local and national level' (Tones et al, 1985:48).**

Having identified key health promotion strategies at a national level in chapter 3, this chapter focuses on reviewing strategies at local level and the perspectives and practices concerning individual behaviours and the prevention of HIV/AIDS transmission which they seek to develop.

Stemming from this background, consistent health promotion practice consists of any combination of education and related legal, fiscal, economic, environmental and organizational interventions designed to facilitate the achievement of health and prevention of disease. These definitions stress that the aim of health education and promotion is to enable people to gain control over the determinants of health behaviour (Bunton and Macdonald 1992). In its broadest sense, health promotion promotes self-empowerment and recognizes what Green and Kreuter (1991), have called 'predisposing factors' – that is, enabling and reinforcing factors, which call for the need to work with policy makers, communities and individuals. These values are reflected in the Ottawa Charter of Health Promotion (WHO 1986), which emphasizes that health promotion works through concrete and effective community action, by setting priorities, making decisions, and planning strategies and implementing them to achieve better health. Information-giving, self-empowerment, and community action based advocacy and policy development are all ways to assist an individual with their assessment of risk.

There seems in this definition to be a movement; from the 'simple transmission of knowledge' about health threats, prevention and management of diseases - to an ecological approach taking into consideration the *external* as well as *personal factors* affecting health.

### **5.3 Health promotion approaches for HIV/AIDS awareness and prevention.**

Consistent with this universal operational framework, there are a variety of health promotion and health education activities that are being implemented in the Petauke district aimed at achieving sexual behavioural change. These health education activities are located within the overarching conception of health promotion which Baric (1991) has described as:-

‘.....being concerned with the need to influence health decisions’ (Baric 1991:15)

A joint Planned Parenthood Association of Zambia meeting with the Petauke District health management Board held on 24<sup>th</sup> May 2002 at the Petauke district hospital conference centre (PPAZ/PDHMB 2002) itemized a number of health educational activities implemented by various stakeholders. These organisations included community based organisations, faith based organization, NGO's and concerned private individuals and organisations. Some of the activities itemized in the reports were:-

#### **5.3.1 Community talks and meetings**

One of the main outreach activities for HIV/AIDS education involved community talks and meetings. These activities were organized by health educational officers from the local health center and agriculture extension workers trained to provide these services. The outreach activities brought together community members with the aim of sensitizing them on issues around the risk of HIV/AIDS, prevention and the nature of

illnesses that follow in the event of being infected. This included information on the impact of the infection in a family and available treatment.

In the absence of a cure and or vaccine for the infection, most of the talks centred on the necessity to prevent the risk of infection. These talks and meetings were held in large gatherings which brought together different population groups within the community. These included men and women and sexually active young people. Community members were encouraged to ask questions in order to provide clarification on any of the issues raised in the discussions.

### **5.3.2 Distribution of printed materials.**

Further, the same report (PPAZ/PDHMB 2002) indicated that various stake holders working in the community occasionally distributed printed materials providing information on various aspects of the problem of HIV/AIDS in a family and indeed in the community. These printed materials included brochures, posters, leaflets and handouts on HIV/AIDS prevention. The materials contained information on the risk of HIV/AIDS and how it is transmitted. Many of these materials were illustrated with symptomatic pictures of a person suffering from an HIV/AIDS related opportunistic infection such as TB, or wasted in weight to illustrate the nature of illness that one was at risk of suffering in the event of an infection.

Because most of the populations in rural areas are of a low literacy level, the range of materials distributed in the communities was deliberately developed to mainly rely on extensive use of pictures. This meant that most of these materials were expensive to

produce as they had to present an illustrated story line in order to convey information. Linney (1995) recommends mainly illustrated materials for groups with low literacy levels.

### **5.3.3 Mobile public address campaigns**

A further initiative to disseminate information in the community has involved the use of mobile public address campaigns. This is where a van installed with a public address system is driven around in the communities to make announcements on the risk of infection and the impact that HIV/AIDS has on the family and indeed the community.

This approach has however been criticized as it is seen as one way information dissemination which does not allow the recipient of the messages to ask questions in order to clarify their concerns.

### **5.3.4 Mobile cinema and video shows.**

Occasionally, the ministry of information (Moi) working in conjunction with other stake holders uses a mobile film van to conduct educational activities in the community. These outreach activities involve showing educational films on HIV/AIDS. Some films or video shows are based on real life experiences and show the difficulties that people are faced with living with HIV/AIDS on a day to day basis. The essence of all the outreach activities is to influence behavioural change so that people change their behaviour in connection with the risk of HIV/AIDS infection.

### **5.3.5 A community based outreach service**

One of the prominent service delivery strategies used in the communities has involved the use of community based service delivery agents popularly known as CBD agents. The CBD agents are individuals identified by the community and chosen in a participatory manner to provide reproductive health related services in the community (Philips and Green 1993). The agents are trained in counseling and the provision of education, materials and advice. They also conduct home visits and distribute condoms within the community.

This outreach strategy provides a level of confidentiality as the CBD agents conduct home visits where they talk to a couple or one of the partners in a relationship (PPAZ 2000).

### **5.4 Limitations of current health education campaigns.**

There is no doubt in Zambia that these health promotion and educational efforts have been instrumental in stemming the spread of the epidemic. A joint evaluations by Options Consultancy and PPAZ in 2000 (Options/PPAZ 2000) evaluation of the effectiveness of current HIV/AIDS prevention conducted in the district reports that combinations of various of these methods have contributed behavioural change among the population. This was reflected in increased condom use and many of the people that participated in the study indicated that the programmes that PPAZ was carrying out in the communities had improved their relationships with their partners in marriages. However, as research continues, the search for more effective

opportunities to arrest the tide of the epidemic has meant that many of these educational campaigns have come under criticism. Some of the criticisms associated with current educational campaigns are detailed below.

#### **5.5 Inability to address the contextual factors driving the epidemic.**

The review observed that there was a lack of current health promotion practice in the district engaging with the social contextual factors related to HIV transmission. Though numerous studies have shown that many of the problems associated with HIV/AIDS are linked to social conditions such as cultural practices, poverty, and lack of employment (see chapter 3) current health promotion activities in the district did not address these factors. Instead these educational outreach activities have relied on a number of psychological and social psychological theories and educational approaches such as the Health Belief model (Becker and Joseph 1974), Social Learning theory (Bandura 1977) and the theory of 'reasoned action' (Ajzen I and Fishbein M 1980, Fishbein and Middlestadt 1987).

Although the application of these theoretical concepts has achieved some significant results in behavioural change, these theories have tended to neglect the social context in which particular actions become meaningful and tend to make (Singer and Weeks 1996) assumptions about rationality (Aggleton 2000). For example, social norms, duties and obligations may structure and influence behaviour. Furthermore these models may be inadequate in explaining sexual risk-taking in contexts where decisions may be rooted in group processes (Aggleton 2000). For this reason, many social scientists therefore have moved from individual risk-taking approaches to

investigating behaviour as guided by cultural contexts (Schoepf 1995, Treicheler 1992). For example, notions of what it means to be a 'real man' in a particular social context can powerfully influence sexual behaviour.

#### **5.6 Addressing harmful ideologies of masculinity.**

In the context of this study, the review found that there was a lack of deliberate effort to address some of the harmful ideologies associated with the social construction of masculinity which enhance the risk of infection.

For instance, in many societies in Zambia notions of masculinity are associated with having multiple sexual partners (Foreman 1999, Ndubani 1998). Coupled with this notion is the belief associating masculinity with risk taking. From this perspective, health promotion needs to engage with some of the factors that influence such gendered ideologies and which influence sexual behaviour, beliefs and practices.

This concern is linked with the knowledge that human sexuality is a complex phenomenon. Within the social constructionist paradigm human sexuality is considered to develop through a variety of perceptions and interactions informed by and informing social conditions ranging from cultural practices, social norms, and beliefs as well as individual personal experiences. These interactive processes affect the way individuals define, and perceive and experience their sexuality (Fine 1993, Schwartz, 1997). Without addressing these issues it is doubtful that the full potential of HIV/AIDS prevention will be fully realized.

### **5.7 Lack of a clearly defined target group.**

The present review also found a lack of a clearly defined target audience for educational campaigns. Almost all of the initiatives carried out in the community were targeted at a mass community audience. The campaigns brought together mixed groups of men and women for HIV/AIDS awareness activities. It was also observed in relation to men that there was a tendency to categorize them as a single monolithic group. This arises from an image of masculinity as a homogeneous entity without taking into account the different circumstances and perspectives of those involved. For instance married men, divorced or widowed men and young men were often grouped together for HIV/AIDS education and information sharing. Given the plurality and fluid nature of what it means to be a man all these groups of men are bound to have different information needs. They may also require different strategies that make them feel comfortable to talk about their concerns. A further example is that sexuality is often considered as personal and private matter. This might make it difficult for a married person to share their risk of HIV/AIDS infection in a marital relationship in the presence of an unmarried man. This makes it even more necessary that health promotion should begin to explore multiple masculinities, both differences among men and the ways in which ideas of masculinity change according to time, the event and the perspectives of those involved.

### **5.8 Health Promotion activities.**

In addition to these health educational activities, there are two prominent approaches considered as the basis of the HIV/AIDS risk prevention efforts in Zambia which have

permeated through to the district level. These are a 'social marketing project' and a 'community-based' approach to HIV/AIDS risk prevention efforts. Each of these approaches has to varying degrees of success, made efforts to reach men with information on HIV/AIDS. While the larger volume of health promotion activities in the district utilize a community based approach for reasons which are explained later in the chapter, the district has also been subject to a national social marketing programme on HIV/AIDS prevention and it is to this that I now turn.

### **5.9 A social marketing approach**

The HIV/AIDS prevention coverage in Petauke District has included elements of the social marketing approach to risk prevention. The social marketing approach is the most prominent national HIV/AIDS strategy in the country. It uses a multi-media strategy, involving the use of poster billboards, printed media, electronic advertisements and commercial radio tunes that promote condom use and risk prevention behaviour.

Although this approach has limited coverage in rural communities, the concept of social marketing is based on the principle of applying commercial marketing techniques and principles to promote a social cause or idea. The principles underpinning the idea of winning of people's hearts and minds has a long history (Lefebvre 1992). In his description of social marketing Lefebvre (1992) points out that when we examine major religions and political leaders, artists, social advocates and philosophers, we are actually looking at people who were all 'social marketers'. This approach to promote a cause has been used effectively for a variety of health products

and ideas such as oral rehydration salts for the treatment of diarrhoea, anti-smoking campaigns and in the promotion of breast-feeding. Hastings et al (1994) describes the concept of social marketing as 'acting in the public interest and not for profit'. The principle involves using commercial marketing skills to increase public awareness regarding a health concern.

Social marketing programmes are a common feature in many developing countries and have mostly involved the selling of contraceptives at subsidised prices through commercial outlets. The approach has two aims: to make contraceptives, and more specifically in the case of HIV, condoms more widely available, and to recover programme costs. Social marketing campaigns may be managed by corporations set up for this purpose, or through non-governmental organisations, as is the case in Zambia or through a technical assistance programme contract.

A study of the social marketing literature by Kotler and Zaitman (1997) and the ongoing debates on the social marketing paradigm Buchanan et al (1994) and Hastings et al (1994) reveal a number of important principles for an effective marketing strategy. These are briefly outlined below:

#### **5.9.0 Consumer Orientation**

Commercial marketing is premised on the principle of satisfying consumer wants. This implies that effective marketing evolves in an environment where there is a need and demand for a product or service. In relation to health promotion, Lefebvre (1992) states that the objectives of social marketing programmes in health should be

identified public health needs. Successful social marketing is founded on the principle that the relationship between the client and the marketers is mutually beneficial. The relationship is voluntary. At its best, social marketing is a consumer-oriented approach that creates a win-win situation (Hastings et al 1994). Such social marketing is a voluntary exchange of resources between two or more parties and can include processes of information, dissemination, public relations, lobbying advocacy and fundraising. The consumer-orientation makes the marketing more likely to succeed (Lefebvre 1992).

### **5.9.1 Marketing Research**

The development of the marketing strategy in Zambia started with a process of social marketing research. Kotler and Roberto (1989) state that social marketing research requires knowledge of the target group including their social demographic, psychological and behavioural characteristics. Careful anthropological studies assessments are conducted to ensure that the interventions used in social marketing are sensitive to the culture of potential individuals. Both qualitative and quantitative research approaches are used to understand the target group (Epstein, 1988). This enables the health promoter to gain an insight and a better understanding of their 'consumers', so that the design of the social marketing strategy is relevant, culturally sensitive and politically correct. In addition to guiding the initial planning, market research can be used to monitor the short-term effects of the programme operations and to evaluate progress towards their long-term goals.

### **5.9.2 Market segmentation**

The impact of social marketing is enhanced by target segmentation. This involves grouping the population into specific homogeneous units. The groups can be segmented by demographic characteristics such as age, sex, social-economic status and place of residence (Lefebvre 1992, Kotler and Zaitman 1971). An informed judgment can then be taken as to which of the most appropriate groups to target, and which market strategies to use for each group.

In Zambia the key messages for HIV/AIDS prevention and condom promotion have been targeted at sexually active young people and adults in the reproductive age group. There is a plausible explanation for targeting these two population groups. Firstly that young people form the larger group within the population in Zambia. It was also assumed that it is much easier to influence behavioural change amongst the young people than in adults. A further consideration was that young people constitute the future of the country.

In the case of adults, the social marketing programme has targeted men and women in the reproductive and productive age groups. The reason is that there is widespread prevalence of the epidemic on this group is already having a devastating impact on all sectors of human development in the country. There is need therefore to minimize the spread of the infection amongst this group.

In this way the strategy can achieve optimal impact. The product or message of the marketing strategy is often 'packaged' using the principles of the 'marketing mix', which is summarized under the idea of the 'four P's'. These are Product, Price, Place

and Promotion. This is also operationalised as the 'marketing concept' (Kotler and Roberto 1989).

#### **5.10. Limitation of the social marketing strategy in rural communities**

Petauke district has, as is the case with many other rural communities, not fully benefited from social marketing strategies (PPAZ/PDHMB, 2002). This is because the social marketing programme in Zambia has relied heavily on mass media, involving the use of radio, television and newspapers. Often, the only people who have access to these types of media in Zambia are the elite classes, who are mainly based in urban areas. It is rare to find these media in the rural areas, for instance newspapers are rarely available as their usefulness is limited by high illiteracy rates. Radio and television reception in rural areas is often extremely poor, with television sets being out of reach of many poor families. As a result, most of the poorer people cannot be reached through these means, and ironically these are the very communities who are in most need.

In addition, the use of mass media is likely to be of less benefit to women. Most women in Zambia, particularly in the rural areas, have less time and access to listen to the radio than men, because of the demands of their customary household chores such as fetching firewood or water.

Furthermore, the use of a social marketing strategy has also been criticized for its reductionist approach to addressing complex issues involved in the spread of the epidemic (PPAZ 2000). For example, many health problems in Zambia including

sexual and reproductive health concerns are gender and poverty related (Mach'wangi, et al 1994). As I have already highlighted in previous chapters poor health is associated with wider crises of poverty and inequality (Latkin 1998, Kurschner 2001). This view of health is also endorsed in the Ottawa Charter on Health Promotion (WHO 1986), which states that the fundamental conditions and resources for health are peace, shelter, education, food income, social justice and equity. Improvements in health require a secure foundation in these basic prerequisites, which are beyond the means of a social marketing approach (WHO 1986)

Similarly, Wallack has argued that the focus of the public information campaigns which have used social marketing strategies may deflect attention away from social environmental factors that have shown to be major determinants of health beyond the control of individuals. For instance, as I have explained in earlier chapters, the spread of HIV in Zambia is, in part, a result of the economic and social pressures faced by young men and women, which make them vulnerable to the risk of infection. The social marketing approach ignores this fact and focuses its programme on the use of condoms as a panacea and solution for the spread of HIV. According to Brieger and Ramakrishna (1987) this also unfairly blames the victims for their health problems. Another aspect of the reductionist aspect of social marketing can be seen in the way it addresses general issues of health by condensing its determinants mechanistic responses to infection by micro-organisms (Laura 1990) Attempts to change sexual behaviour require great sensitivity and a thorough knowledge of individual behaviour patterns and attitudes in interaction with cultural and social norms, rather than simply a reductionist understanding of the importance of barriers to micro-organisms. For

instance, for individuals to use condoms, they require a supportive and encouraging environment (WHO 1995).

### **5.11 A Community-Based Approach**

In view of these limitations many grassroots organisations in the country including the Planned Parenthood Association of Zambia has laid emphasis on a 'community based approach' rather than a social marketing approach. This is to try to ensure that health promotion is informed by sensitivity to the specifics of social interaction and assumptions in a particular locality.

The notion of community participation is generally used to describe activities in which community members participate in the decision-making process and at every stage of the project's life-span (Chambers 1995, Macdonald et al 2000). This includes the planning, design, operation, monitoring and evaluation of the project, which is meant for the benefit of that community. It also refers to the community's ability to interact and negotiate its interests with the wider social environment.

This approach is derived from the long-term involvement of the community in their own development process. Historically, support for community participation had its genesis in the failure of the economic growth approach to development driven by the 'trickle-down theory' (Macdonald et al 2000). This approach to development was implemented through centralized planning; industrialisation, and technology transfer (through the diffusion of innovation) where populations were seen as 'passive recipients' of the

benefits of development. Kane (1995) explains that by the 1970's failure in development projects around the world made a number of facts clear, in summary:

- All the components of development, not just the economic and technical, but also the social and cultural have to be taken into account,
- Each of the partners in development - donors, national governments, development workers, technical experts and local people have a unique perspective to contribute, and
- Most research takes too long - the problem has changed by the time the answer is found.

This gave rise to an approach which went beyond the conventional anthropological and survey-style to an approach which is focused more on the need for developers to listen and observe rather than dictate rural development (Chambers 1995). Specifically in relation to reproductive health, Askew (1988) defined community participation as:

"An educational and empowering process in which people in partnership with those able to assist them, identify problems and needs and increasingly assume responsibility themselves to plan, manage, control and assert their collective actions that are proved necessary". (Cited in Askew et al 1988).

This definition places community participation in the context of a partnership, where external practitioners work with community members who assume a key role in the decision-making process and the implementation of project activities. This view is also

expressed in the Alma Ata declaration that 'people should be the main health resource and accept the community as the essential voice' (WHO 1978).

In order to succeed, most of the community-based activities that have been carried out in Zambia have brought together men and women from a local community to address a common concern. The review of project activities did not result in an account of activities which were specifically targeted at men. The specific accounts of a range of community-based approaches carried out in Zambia include the following.

#### **5.12 A People-centred Approach**

One of the prominent community-based approaches in Zambia is the use of a people-centred approach. These strategies include the use of Participatory Learning and Action (PLA) and the use of the 'Stepping Stone' process (described in detail below). In this context, health promotion is seen as a process of empowering communities to own and control their own destinies and to have a direct involvement in the process of change. Rice (1996) observes that in these efforts *people* rather than *problems*, become the focus of the intervention. She states firstly that this implies that people take greater control for, and become more involved in, their own health care and maintenance. Secondly, for the general public, as well as for service providers of all sorts, it means understanding reproductive health in the context of an individual's life-span and the surrounding culture, social economic and physical environments. And thirdly, to move away from vertical problem-specific interventions and "an integrated and comprehensive approach to reproductive health, it will be necessary to mobilise

decision-makers to create and sustain their political will and commitment” (Rice 1996).

This approach to addressing the risk of HIV is what the UNAIDS describe as value transformation Rice (1996). This is a process through which individuals and communities critically reflect on the content of their indigenous knowledge in relation to their human and sexual rights and transmission of HIV/AIDS. This process of intervention can provide opportunities for value transformation to occur when appropriate. Value transformation involves critical thinking. It is about problem-solving and conflict resolution and draws on the Freirian pedagogy of 'conscientisation'. This calls for the raising of the self-reflected awareness of the people rather than educating or indoctrinating them. According to this theory, action for social change requires an educational process in which participants develop a critical awareness of the circumstances influencing their lives, reflect on what this means in their individual and communal situation and decide what action would be most important and feasible to take. Freire's widespread influence on development is the notion that people living in marginalized and deprived positions need to develop a critical insight into the structures, ideas and practices in the society, in which they are placed and which maintains them in positions of inequality (Helman 2000). Freire further argues that people learn more successfully through critical thinking of their own situation, rather than 'soaking-up' the knowledge of 'experts'.

Werner (1977) shares a similar view, stating that 'the conscious aim of such programmes is to help strengthen the position and bargaining power of the poor'. In this approach, he argues that community participation should be seen as a devolution

of power from the powerful which, in the process empowers the less powerful to take charge of their own development. Given this premise, effective health education and health promotion should involve representatives of the target population at all the stages of project assessment, planning, implementation and evaluation. The reproductive behaviour and conditions that need to be targeted should be based upon the priorities and perspectives of the community.

At the international level, the International Planned Parenthood Federation has highlighted a strong and growing movement towards the use of participatory approaches in the development and implementation of Sexual and Reproductive Health Programs (IPPF 2000). This approach has also been adopted and is being utilised by a growing number of organisations that are working in this sector. These methods include the use of focus group discussions, visualisation techniques, role-play and stories (IPPF 2000). In these approaches the community is involved from the beginning and believes that community members themselves have the best answers to their sexual and reproductive health concerns. The IPPF further points out that this requires a partnership between family planning services and the community where each takes on equal and complementary roles to share the responsibility for improving sexual and reproductive health.

### **5.13 Participatory Learning and Action.**

The Participatory Learning and Action approach is described as a growing family of approaches and methods to enable people to express, enhance, share and analyse their knowledge of life and conditions to plan and act (Chambers 1995). PLA is a

development process derived from Participatory Rural Appraisal (PRA), which in turn evolved from Rapid Rural Appraisal (RRA). RRA began as a response in the late 1970's and 1980's to biased perception derived from what Chambers has described as 'rural development tourism' where urban-based 'experts' visit rural communities and develop programmes *for* them rather *with them*.

PLA uses simple visualisation techniques to analyse problems and prioritise solutions and can be used in different circumstances. The UNDP Human Development Report (2004) acknowledges the use of the PRA approaches stating that:

"The great value of Participatory Rural Appraisal is in the way that it empowers communities and builds their capacity for self-help, solidarity and collective action. The methods used enable people to share information, and stimulate discussions and analysis. It essentially provides a voice to the poor enabling them to express their problems and priorities." (UNDP 2004:88)

The use of PLA and such participatory approaches to analyse sexual and reproductive health problems is a departure from the conventional needs assessment and development process carried out by teams from outside the community using questionnaires and instruments to gather data for project planning. In conventional needs assessment, the information collected is then analysed and interpreted by the program staff or external visitors who plan the program on the basis of the information. Edwards (1995) contends that this practice places values on the technical knowledge of the experts over the indigenous knowledge of the people being studied or helped where general solutions are offered and manufactured from outside the community for problems that are highly localised.

"The practice of development work teaches us that problems are usually specific in their complexity to a particular time and place. In addition, it is impossible to understand real-life problems, unless we grasp the multitudes of constraints, imperfections and emotions which shape the actions of real people". (Edwards 1996:78)

Edwards (1996) further points out that conventional research cannot do this because it divorces itself from the everyday context within which an understanding of these emotions can develop. He argues that researchers think that they perceive the reality of what is going on but do so through a series of biases which they carry with them from their training and other cultural experiences.

#### **5.14 Using Participatory learning and action methodologies.**

In some sections of the community, the Planned Parenthood Association of Zambia in connection with other stake holders have used simple drawings and visual techniques and drama techniques to discuss problems concerning HIV/AIDS and to identify priorities and solutions both in the short and long-term perspectives. Some of the methods used have included:

##### **5.14.0 Flow diagrams**

A DfID/Options (2000) evaluation report on the impact of PLA methodologies on HIV/AIDS prevention reports that flow diagrams are used to analyse the good things and bad things about cultural practices and behaviour such as polygamy and the implications it has for the risk of infection. They have also been used for critical analysis of the causes of problems and to suggest solutions. They provide an

opportunity to engage the creative as well as the analytical abilities of people leading to motivation to take action.

#### **5.15.1 Pairwise ranking**

The same report (DfiD/Options, 2000) describes pairwise ranking as a process where community based workers use sticks and bottle tops to identify the communities' immediate problems and prioritise reproductive health needs. In one session using this approach, women identified four problems. The problems in their order of priority were too many children, HIV/AIDS and STD's, drunken and lazy husbands. The discussions further covered linkages between problems and feasibility of solving them

#### **5.14.2 Seasonal calendars**

These methods are used to analyse how the season affects sexual and reproductive health practices in the community.

By using local materials, community members are able to draw and relate seasonal events to their lives. In terms of reproductive health programming, people identified that in the cold season couples slept together for warmth and therefore there were more conceptions and STD's. After harvest men have a lot of money. There are quarrels with wives over the use of money. There are more sexual partners among both women and men (men spending the money, women trying to access the money) and beer drinking in traditional ceremonies. All these events have implications for sexual and reproductive health programming.

### **5.14.3 Transect walk**

This involves mapping human and physical resources for sexual and reproductive health including Traditional Birth attendants (TBA's), Community Health Workers (CHW), traditional healers, clinics, source of condoms, as well as risky places, beer bars, places where one could meet different age groups and other resources which impact on reproductive behaviour.

### **5.14.4 The 'Stepping-Stones' process**

Within the context of a health promotion effort, another important community-based and participatory approach to reproductive health, gaining increasing momentum, is the use of a process called 'Stepping-Stones' (Welbourn 1995). This is a strategy that works with peer-groups grouped by gender and/or age to address sexual and reproductive health concerns. Welbourn (1995) has described Stepping-Stones as:

"[A] training package on HIV/AIDS, gender, communication and relationship skills, designed largely for sub-Saharan Africa but adaptable for use anywhere. It describes how to organise a series of workshops over several months to enable women and men of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face and to practice different ways of addressing their relationships. Workshop sessions include exercises involving role-plays and other participatory methods. They are held mostly with peer groups based on gender and age with occasional large meetings. There is a video filmed in Uganda which consists of 15 short clips designed to provide participants with a springboard for discussion during the workshop sessions" (Welbourne 1995).

This approach to tackling reproductive health issues goes beyond the conventional Information and Education Communication (IEC) approaches to HIV/AIDS prevention. This is achieved by encouraging the sharing of experiences within and between peer groups, building on-going support networks through peer-group activities and enabling these groups to articulate and make public the changes they would like to see.

The principle underlying this approach is that people work within and from their own realities and using their own modes of expression to explore real-life dilemmas. By engaging the analytical abilities of the local people, the use of 'Stepping-Stones' stimulates and sustains community participation in tackling their sexual and reproductive health concerns. This provides a valuable means of communication within and beyond the community that is, in itself, a process of empowerment.

In Uganda where this process was instigated by ACTIONAID in 1997, the process showed the capacity to bring about a number of important changes in communities in which it was used (Cornwall 1997).

#### **5.14.5 Advantage of community participation**

The advantage of community participatory approaches in a district is that such approaches foster and ensure democracy, accountability, and ownership of the project by the community. Slocum and Thomas-Sayer (1995) point out that the involvement of the local people further enhances significantly, the quality and effectiveness of programmes in such areas as problem definition, data collection, decision-making and implementation processes. They point out that such involvement encourages

community awareness, understanding and commitment, facilitates decision making, coalition formation, consensus building and promotes collaboration among outside researchers and development workers. This further assists the process of empowerment and sustainable development.

Similarly Green and Krueter (1991) have justified the involvement of the community by stating that this form of intervention provides the opportunity for ownership, which can lead to a sense of empowerment and self-determination. The Alma Ata declaration has also given community participation in health added impetus, pointing out that: 'People have the right and duty to participate individually and collectively in the planning and implementation of their health care' (WHO 1978). This declaration further established the key principal for primary health care, which has been established as "essential health care made accessible to individuals and families in the communities by means acceptable to them through their community participation and at a cost the community can afford (WHO 1978). But the World Health Organisation advocates the term community involvement in preference to community participation. This is because:

"It is not sufficient to merely participate, which may simply be a passive response; there should be a mechanism and processes to enable people to become actively involved and to take responsibility for some decisions and activities jointly with health professional" (WHO: 1981 in Shaeffer 1994: 16)

As a result of the central role that the involvement of the community played in primary health care, Rao (1995) explains that the concept rapidly emerged as a key component in recommendations for family planning and maternal and child health programs (MCH). This was further endorsed two years after the Alma Ata conference

in the Jakarta conference on Family planning. This conference stressed the importance of community participation in the design of family planning and reproductive health services so that people would find them culturally acceptable and responsive to their needs (UNFPA et al., 1981 cited by Askew and Khan 1990). They further added that the goals of encouraging community participation in the family planning programs appear to include:

".... more acceptable services that respond to expressed local needs; to increase the availability of services through expanding the service delivery system and to ensure more effective and efficient program implementation through community contribution of resources and decision making." (Askew and Khan 1990: 127)

#### **5.14. 6 Benefits of the range of activities to the community.**

Notwithstanding the various constraints which limit the effective coverage of the various health promotion approaches implemented within the context of a 'social marketing strategy' and a 'community based approach', a mid term evaluation of the community approach project activities in Eastern rural Zambia, covering Petauke district, under the auspices of the DfID and Options consultancy services Gordon (1998) shows that there are a number of benefits that have accrued to the communities through the implementation of these activities. Some of the benefits enumerated in the evaluation report are that:

- As a result of the variety of Information and educational activities carried out in the communities in this area, including Petauke the HIV/AIDS awareness level has increased to over 90 percent amongst young men and women and adults

of reproductive age. This same figure corresponds with the findings of the Zambia Demographic Health Survey (CSOZ 2003) which indicate wide spread awareness of HIV/AIDS through out the country. This means that almost all the sexually active young people and adults in the communities are aware of the risk of infection and how this can be averted.

- Men and women reported improved relationships as the use of contraceptives minimized the risk of unwanted pregnancies.
- Women reported that it is now easier for them to negotiate the use of contraceptive with their husbands because men have become aware of the benefits of family planning.
- The various projects have enabled the community to have access to HIV/AIDS information.
- There was a reduction in unwanted pregnancies because of the increased use of modern contraceptives.
- Once considered as taboo subject, it is now possible to openly discuss the use of condoms as a contraceptive as well as a measure of protection against sexually transmitted infections including the risk of HIV/AIDS.

- There was an increase in the uptake of condoms used as a precaution against the risk of STI and HIV infection and including for use as a contraceptive.
- There was a drop in incidences of STD's because of the use of condoms.
- Couples reported improved sexual relationships as they did not have to worry about the risk of an unwanted pregnancy
- Community members appreciated the manner in which the project activities were being implemented as they were involved in the decision making process.
- The availability of trained community based agents meant that community members had easy access to information and were able to raise and discuss their reproductive health concerns

### **5.15 Constraints on community participation**

Despite the many advantages associated with a community based approach, it has been found to have its own limitations. Rifkin (1990) and Helman (2000) point out that although the notion of community participation has been given a high profile, there is no standard definition given to the concept. This is because the process of community participation will be influenced by the political, cultural and social economic characteristics of the community and that the type and extent of participation may also vary depending on the programme. The influence of these factors yields a different and specific definition reflecting the context in which the participation is occurring.

At another level, while there is broad agreement on the outlines of content and importance of participation, unanimity has not yet been achieved in population and development programmes regarding the extent to which the community can participate in the design of the project. Askew and Khan (1990) point out that there are in fact some limitations to the extent in which community participation can be achieved in reproductive health programmes. They point out that most funding agencies support to varying degree areas of their own interest; this may preclude any need or opportunity for local level participation in setting objectives and determining service provision strategies.

For example, in reproductive health programmes, women may decide that their immediate needs are addressed in the provision of a community ambulance, which can take pregnant women with complications to a local hospital. However, this may not be within the area of support that an agency programme can provide. As a result,

this may lead to a situation in which the level of community participation in the programme activities remains minimal.

As implemented up to now, programmes adopting community approaches have also failed to focus on a series of issues, which this thesis argues are critical to health promotion initiatives having maximum effect on preventing HIV/AIDS transmission in heterosexual marital relationships. The programmes have failed to explore the problem of hierarchies within communities. For example they have not addressed the question of how domestic violence within marriage may both reflect and compound unequal relationships between men and women, contributing to risky sexual practices. They have also not taken into account how both specific traditional and current broader social conditions may provide a key context for risky male behaviour e.g. the association between enforced economic migration and multiple sexual partners; the dangers inherent in traditions of 'sexual cleansing', after the death of a spouse. Nor have they focused on addressing how the degree of variation in individual men's perceptions of desirable and appropriate male behaviour needs to be recognized as a crucial factor in targeting health promotion interventions.

#### **5.16 Men and HIV/AIDS health promotion interventions.**

While a number of gains have been made in raising awareness regarding a variety of sexual and reproductive health concerns, as shown here there is still a lack of a clear health promotion strategy to enhance male involvement in HIV/AIDS prevention, through addressing the specifics of men's perceptions and behaviour and in particular amongst men in heterosexual marital relationships which is the focus this study.

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This review indicates that due to the limited resources for HIV/AIDS reduction related activities, current and existing health promotion initiatives have targeted a general audience such as adult men or adult women without necessarily segmenting these populations further into groups with specific characteristics such as married men or unmarried divorced or widowers or further still, members of these groups who in turn will remain in the locality or who, for instance are due to move out of the area to work. The same situation applied to women and that interventions were focused on women as a general population.

The failure to segment the population into specific population groups has meant that current health promotion initiatives invariably assume that all the population groups are exposed and subjected to the same societal influences in constructing their sexual behaviour in relation to the risk of HIV/AIDS. Arising from this analysis, there is therefore a need for these approaches to evolve a process through which specific needs within local communities can be addressed. For instance men and indeed women in marital relationships have their own special needs and circumstances that require special attention e.g. the rationale for condom use within marriage.

It has also become clear that current and existing health promotion tended to neglect two key dimensions to the social-contextual factors that shaped and influenced the dominant ideologies of masculinity in the community. First, though there is ample evidence that HIV/AIDS risk behaviour *is* influenced by a variety of wider social conditions e.g. poverty most of the current and existing interventions being implemented in Petauke district are ignoring possible social determinants of risk

behaviour. As will be illustrated in this study, in interviews and focus group discussions men and women respectively observed that many problems of HIV transmission within the community were linked to conditions of poverty, limited access to employment and generally high levels demoralization amongst the local community.

Secondly, in relation to dominant ideologies of masculinity, current health promotion interventions seemed to be based on the contemporary understanding of masculinity. Although this has contributed greatly towards efforts for HIV/AIDS risk prevention, there appears to be a notable lack of engagement with the emerging theories on a pluralistic vision of masculinity. Current health promotion approaches appear to rely heavily on a universal interpretation of masculinity common to all men. As I have highlighted however, in chapter 4, postmodernist theories encourage the need to explore the relevance of multiple masculinities (Connel 1987, Mac an Ghail 1996, Hearn 1998). Diversity exists amongst men's behaviour, and concepts of masculinity change according to time, events and the perspectives of those involved.

#### **5.17 Conclusion: developing health promotion practice**

This present study analysed HIV/AIDS prevention literature, informational documents, education and communication (IEC) activity reports, project minutes of meetings guided by discussions with health promotion staff at Petauke district health management board and significant others in the community. This review has been focused on ascertaining the extent to which current health promotion initiatives in the district of Petauke, reflecting wider Zambian HIV/AIDS health promotion initiatives

address aspects of variations in interpersonal perspectives and interaction, together with features of the wider social environment that impact on men's sexual behaviour and subsequent risk of HIV/AIDS transmission in marital relationships.

It became obvious in this analysis that current HIV/AIDS interventions invariably assume that all the population groups are exposed and subjected to the same societal influences in constructing their sexual behaviour in relation to the risk of HIV/AIDS. Arising from this analysis, there is therefore a need for these approaches to evolve a process through which specific population needs can be addressed. For instance, as discussed earlier men and indeed women in marital relationships have their own special needs and circumstances that may require special attention.

Furthermore, there is an urgent need to begin to rethink the conceptual framework for health promotion intervention, focusing on male involvement. To assume that men exhibit identical gender characteristics is to create a monolithic stereotype that may only apply to few individuals. This gives reason to make a problem of the construction of masculinity and indeed the necessity to explore further its multilayered structure. Contemporary views of masculinity which inform current health promotion practice have tended to assume an ideal world, in which everyone is equal and free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality, both men and women face, and have to negotiate, a range of HIV-related risk factors and vulnerabilities that are embedded in the social relations and economic realities of their societies at national and local level. These factors are not easily conceptualized or addressed but until they are, health

promotion efforts to contain and reverse the AIDS epidemic are unlikely to develop further.

A useful starting point is to begin to promote the concept of the development of masculinity as a social process i.e. that masculinity is shaped and expressed through complex interpersonal perceptions and interpersonal interactions. Furthermore, masculinity is defined as a variety of complex values and beliefs which in turn inform men's behaviour. It is not one given set of characteristics shared by all men. By recognising this, health promotion can work towards deconstructing some of the harmful ideologies of masculinity that enhance the risk of HIV/AIDS e.g. that men are naturally promiscuous.

# **Chapter Six: Methodology**

## **6.0 Introduction.**

In this chapter, I describe the research methodology process for this study, beginning with a consideration of the definitions that inform a qualitative methodology, and the relevance of this approach. I will continue by describing the various data collection techniques and the debates that inform the suitability of each of these methods. The choice of the sample and the criteria used to select and recruit participants are also discussed. I then discuss the ethical issues that governed the study and the process of negotiating access into the communities. This was particularly relevant in conducting research on HIV, as sexuality and related issues such as domestic violence are highly personal and confidential matters. I conclude the chapter with a reflexive account on the practical experience in data collection during the fieldwork for the study and how the data was handled and managed.

### **6.1 Choice of a qualitative methodological approach.**

This study used a qualitative methodological approach to gather and process data from the field. The decision to locate the study within a qualitative paradigm was made at the conceptual stage of the study. This related to the 'fit' between the *interpretative* and *exploratory* nature of this study and the suitability of this methodological approach in exploring issues around beliefs, behaviour and practices (Burgess 1984). Furthermore, this approach was considered appropriate for this study because qualitative research methodology emphasises the importance of social context for

understanding the social world. In this regard, the meaning of a social action or statement is seen as dependent on the context in which it appears.

In connection with the decision to use a qualitative methodological approach, Cresswell (1994) has described this methodological paradigm as an enquiry process of understanding a social phenomenon or human problem based on building a complex, and holistic picture formed with words, and reporting the detailed views of informants conducted in a natural setting. For the purpose of this study, the term methodology is used to describe the methods of data gathering, forms of data analysis and the planning and execution of the study. A qualitative methodological approach has also been described by Evered and Lewes (1981) as an 'inquiry from the insight' stating that the aim of this methodological approach is to answer not only the 'what?' questions but also the 'why?' and 'how?'. These characteristics belong to an interpretative and phenomenological tradition, which requires the researcher to enter the field of study with an open mind, to explore, interpret and understand the nature of the world as perceived by the participants in the research.

This tradition of methodological approaches considers that social reality is a construct. It is constructed through interpretations of the actors. Furthermore, this approach is grounded in the perspective that life experiences vary significantly and that all meaning is socially constructed. This approach was therefore found to be particularly relevant in this study because it resonates with the theoretical and conceptual underpinnings which underlie a social constructionist approach used to inform the development of this study.

Furthermore this approach was found to be relevant to this study because the exploration inquired into aspects of human interaction and relationships such as human sexuality and domestic violence which are often considered private, personal and confidential matters. Renzetti and Curran (1992) include in their classification of sensitive subjects, topics which have the potential for being seen as an intrusion into the personal and private lives of participants such as sexuality. Similarly, since this study was to examine the interconnectedness between domestic violence and the risk of HIV/AIDS in marital relationships, Dobash and Dobash (1989) and Hearn (1998) classify studies about domestic violence as a sensitive topic for research.

Given this background, this study called for a research process that provided the flexibility to appropriately adapt the data collection process to accommodate the difficulties that participants may experience in talking about the various issues the study was to address. This consideration in addition took into account insights from Seiber (1993) who has previously pointed out the need to be culturally sensitive in the way that one designs and interacts with research participants when conducting studies in a sensitive area. Other considerations for this choice related to the flexibility that a qualitative methodological approach allowed in capturing local voices and the diversity of local knowledge in the research process. Darlington and Scott (2002) point out that a qualitative research approach takes seriously the notion that people are experts of their own experience and, as such, are best able to report how they experience a particular event or phenomenon. Because of this, they are therefore much better placed to offer solutions to problems affecting their life experiences.

While a qualitative approach is considered as an *ideal* approach for exploratory studies (Burgess 1984, Sarantakos 1996, Hammersley et al 1995, Punch 1998), I was, however, mindful throughout the research process of the problem of subjectivity that a qualitative approach presents. This is because qualitative research can be influenced by the moral and political values of the researcher. In this study, and particularly in view of the sensitive nature of the study area, this called for the need for reflexivity in order to reduce my moral and political values affecting the value of the information in the process of data collection. In section 6.4 I provide a background of my moral and political stand point so that the results of this study can be considered in that context.

## **6.2 Accommodation for reflexivity**

A key aspect underpinning a qualitative approach is its flexibility which accommodates opportunities for critical reflection and reflexivity in the way a study is conducted. Reflexivity in social research relates to the researchers need to understand how individual biases can contribute to shaping the data that is collected and ultimately, the research outcome (Pole and Lampard 2002). As I have explained above, the concept of reflexivity is centred on the notion of the researcher as a social actor and being an 'insider' or 'outsider'. Each of these positions influences the data collection and research outcome.

Central to this view is that we cannot directly present either the voices of participants or their direct experiences in the writing of research, based on a fixed account of participant's lives. This is because both the participants and researcher cannot be truly objective about the research process, but are an intrinsic part of the social world that

they seek to study. Consequently, those engaged in social research need to acknowledge that all research contains bias, but that the impact of the researcher and the extent of bias on their subjective understanding will vary, depending on the methodological approach. These issues are rarely acknowledged other than in qualitative studies (Denzin and Lincoln, 1994).

### **6.3 On being an insider or outsider**

According to Burgess (1984), there are both advantages and disadvantages in working in a familiar environment as an 'insider'. It has been argued that being an insider sometimes enables the researcher to blend-in well with those who share similar frames of reference. In such situations, the interaction between the researcher and those being researched is considered natural communication. For instance an insider is likely to share the same language and the same social-political context. In this circumstance, Burgess (1984) further argues that as an 'insider', a local researcher may be able to easily establish rapport and obtain a wider and deeper understanding of the issues, compared to that which might be achieved by an 'outsider'. Burgess (1984) further explains however, that there may be contrasting views that an 'insider' might have, as opposed to the 'outsider', this is because the 'outsider' may be more able to be detached in situations they experience. In this regard, it has been argued that the 'outsiders' experience is more conducive to a social research environment because the researcher is free from any commitment to those being studied and therefore more likely to be objective.

#### **6.4 My reflexive account as an insider**

My location in this research project is from a position that, I am male, heterosexual, married with four children, and native of Zambia. I am a Christian of the Roman Catholic faith. Although the Catholic Church has a position on the use of condoms, I have a liberal stand on their use as a measure of protection against the risk of HIV/AIDS infection. I further located my position in this study with an awareness a number of different perceptions that have been given to provide an explanation of the underlying factors associated with the spread of the HIV/AIDS epidemic in rural communities.

Since the outbreak of the epidemic in 1986, I have personally worked on a number of different programmes and projects in rural communities, aimed at mitigating the spread of the epidemic in the country. During these travels I have encountered first hand the tragic devastation that HIV/AIDS can bring onto a family. I have seen families disintegrate and children made homeless without hope for the future because of HIV/AIDS.

At a personal level I have been touched by the epidemic through the loss of three young brothers, Steve, O'Brien and more recently Joe who have passed on because of HIV/AIDS. Given this background I felt that I was familiar with the social impact and consequences that the HIV/AIDS epidemic is having on families. The possible bias that I may therefore bring to this study is that of a close attachment to the pain and trauma that HIV/AIDS is inflicting on families.

For this reason, I would to some extent be considered as an 'insider'. This, in a way, gave me an added advantage to easily interact with the study participants in the study communities.

However, even though I am a Zambian, my role as an 'insider' in the communities where the data was collected was contestable. This is because, coming from an urban setting and studying outside the country, I was to some extent, understandably viewed by many as an 'outsider'. Conscious of the double meaning that my representation as a researcher carried, my role therefore was to be as neutral and as passive a listener as possible throughout the data-collection research process. All through the research process, respondents were considered the 'experts' and were therefore provided with maximum opportunities to tell their stories.

Furthermore, my abilities for reflexivity as a social actor in the research process were enhanced by the fact that I was researching a subject on men in heterosexual relationships. As a married man, I shared the same frame of reference as the population group upon whom I was conducting the study. This enabled me to easily relate to their social realities and experiences in marital relationships.

#### **6.5 Data collection instruments.**

Two methods of data collection were used for the study. These were semi-structured in-depth individual interviews and focus group

The decision to use individual interviews with men and focus group discussions with women was made early at the onset of the field work. The use of individual interviews with men was based on past experience of working in rural communities with the Planned Parenthood Association of Zambia. I have worked with the Planned Parenthood Association of Zambia for over 15 years in typical rural communities on a variety of sexual and reproductive health projects with different population groups. As many of these communities are traditionally conservative societies, I have in my experience found that it is much easier as a man to talk to a fellow man on issues regarding sexuality. For this reason, I felt therefore that individual interviews would be a much more appropriate method for data collection with men. Furthermore, in the context of this study, as a married man, with children I found it easier to discuss issues regarding sexuality in a marital relationship because I shared the same frame with the men who participated in the study.

With regard to focus group discussions with women, the reasons taken for this decision were two fold. Firstly this was on account that both traditionally and culturally, it was going to be difficult for women to discuss such issues with me as a male researcher let alone that I was a stranger. Traditionally, it would not be acceptable for women to engage in a discussion with a man on issues surrounding sexual behaviour in a marital relationship. The other reason was to do with the fact this study was to explore issues on domestic violence. The WHO guidelines require providing a level of protection to the participants in such a study to do with domestic violence. Due to the limitation of resources to provide adequate protection for the study participants it was felt that it would be easier to obtain the participation of women in the study through the use of focus group discussion.

The additional consideration in using focus group discussions with women drew on the Planned Parenthood Association of Zambia experience of working with women on issues regarding domestic violence using the stepping stones package. Stepping stones is a strategy that works with peer-groups grouped by gender and/or age to address sexual and reproductive health concerns (Welbourn, 1995). It is a training package designed to facilitate community and family dialogue on HIV/AIDS, gender, communication and relationship skills. It is designed largely for sub-Saharan Africa but adaptable for use anywhere.

It has been used in selected communities in the Eastern province of Zambia through the hosting of a series of workshops over several months. The package enables women and men of all ages to explore their social, sexual and psychological needs, and to challenge the communication blocks they face and to practice different ways of addressing their relationships. Workshop sessions include exercises involving role-plays, focus group discussions and other participatory methods. They are held mostly with peer groups based on gender and age with occasional large meetings.

The principle underlying this approach is that people work within and from their own realities and using their own modes of expression to explore real-life dilemmas. By engaging the analytical abilities of the local people, the use of 'Stepping-Stones' stimulates and sustains community participation in tackling their sexual and reproductive health concerns. This provides a valuable means of communication within and beyond the community that is, in itself, a process of empowerment.

Much of this work has been achieved through women discussing these issues in focus group discussion and hence the decision to use this model of dialogue to explore issues related to this study topic, as it was likely to be acceptable to the women invited to participate.

#### **6.5.0 Using multiple methods of data collection.**

The purpose of using multiple methods for data collection for this study namely individual interviews and focus group discussions was in order to achieve a greater level of confidence of the accuracy of the targeted information (Burgess, 1982, Pope and Mays 1999, and Silverman 2000) state that researchers may in exploratory studies use multiple methods of data collection as a data collection strategy. This enhances the credibility of the information collected as it provides a means to crosscheck the consistency of information across the various research methods, Sarantakos (1996).

For the purpose of data collection, two sets of data collection instruments comprising a questionnaire for the semi-structured interviews and a question guide for the focus group discussions were developed prior to fieldwork (see Appendix 6, 7). Both the questionnaire and the focus group guide were developed while at the University of Warwick in the United Kingdom. The questionnaire for the semi-structured individual interviews comprised a number of open-ended questions based on the research questions for the study. A separate discussion guide for the focus group discussion based on the various themes reflected in the research questions to facilitate discussion with women was also developed (see Appendix 6, 7). Both the

questionnaire and focus group discussion guide underwent extensive review by colleagues prior to finalising the drafts for pre-testing.

The purpose for having developed the questionnaire and the discussion guide in advance was that this allows for the provision of a standard procedure for data collection and limits the extent of bias because without this, the information may not be collected in the same way (Singleton and Straits 1999). The initial data collection instruments were developed in English and later translated into the local language that was used during the data collection exercise. The purpose of using the local language was in order to achieve optimal verbal interaction with the study participants (Burgess 1984).

#### **6.5.1 Semi structured individual interviews.**

Semi structured in-depth individual interviews were selected to be use as a one-to-one discussion process for collecting data for the study. Thirty individual interviews were to be held with men that met the criteria of either being currently married, divorced, separated or widowed. This method of data collection was selected as it is known to be an effective way of accessing people's perceptions, meanings and definitions of situations (Punch, 1998). Researchers use semi-structured interviews in order to gain a detailed picture of a respondent's beliefs about, perception or account of a particular topic. It is a form of focused discussion between a respondent and the interviewer. Bryman and Burgess (1999) explain that semi-structured interviews enable flexibility for the respondents to reply in their own terms. It also enables the respondents to

elaborate on issues that they consider as important and relevant to both the interviewer and the respondent.

Central to this form of data collection is the advantage of working with the study participants in an intense and prolonged manner and within an environment that remains close to the everyday life of their families, groups, societies and organisations (Sarantakos 1996). Furthermore, it has been argued that the methodology allows for flexibility enabling the actual research process to elaborate on issues of relevance that may emerge.

Sarantakos (1996), Darlington and Scott (2002) further describe this method of data collection as being naturalistic, communicative and reflective. It is considered naturalistic as the process of research is carried out within the participant's natural environments and settings. This enables participants to describe their life experiences and events in their natural setting. It is also considered communicative as the method enables the researcher to operate in the context of the process of communication of which it is part. Furthermore the approach has been described as reflective as it allows the researcher and those being researched to reflect critically upon the aspects of reality on which the study is based. These considerations add a richness and depth to the gathered information (Sarantakos 1996).

Bailey (1996) has further described the approach as being suitable for a descriptive or an exploratory research study. This is because the approach provides an opportunity for detailed discussion and the quality of information can be enhanced through prompts in the course of the discussion. This, in turn, may reveal a detailed account of

what was experienced in the field. Additionally, this method of data collection was selected because interviews are known to be an effective way of accessing people's perception, meanings, and definitions of situations (Punch, 1998). An additional advantage with interviews is that this technique of data collection enables flexibility allowing the respondents to reply in their own terms (Burgess 1984).

Judd et al (1986) allude to a similar view, stating that interviews work well for exploratory studies. This is because the responses obtained during interviews are spontaneous rather than forced. The responses are, in addition self-revealing and personal rather than superficial. A further advantage of interviews is that it enables the researcher to prompt and probe around areas of significance to the topic. This is also used to remind the interviewee about vital points of the interview and to ask participants to relate further on a particular dimension of an issue that is brought up during the course of the interview.

'Probably the central value of the interviews as a research procedure is that it allows both parties to explore the meaning of the questions and answers involved. There is an implicit, or explicit sharing and/or negotiation of understanding in the interview situation, which is not so central and often not present, in other research procedures. Any misunderstanding on the part of the interviewer or the interviewee can be checked immediately in a way that is not possible when questionnaires are being completed or tests are being performed. (Hammersley et al 1995:149)

While considered an effective means of data collection, interviews also have drawbacks. In the case of researching sensitive issues, there is the danger that interviews result in therapeutic sessions for some respondents. Burgess further points out that another limitation is that interviews might be long-winded and require tact, empathy and skill on behalf of the researcher, to remain focused in bringing out the

needed information. Furthermore, there is a risk that interviewees may provide responses that seek to impress the researcher with what they think he or she expects to hear.

### **6.5.2 Focus Group Discussions**

Focus group discussions were chosen as technique for data collection. This is a research data collection method that involves bringing together a small group of about 8-12 participants to discuss the research questions (Krueger et al 1994). By using this method, respondents encourage each other to identify common experiences, which in turn, provide a means of gaining more in-depth information. This method is very effective if the aim of the study is to explore the complexities and dynamics of human relations. Focus Group discussions share many of the advantages of in-depth interviews as a means of data collection (Darlington and Scott 2002). This according to Krueger (1994) is because focus group discussions take the form of an open conversation, where each participant is given an opportunity to speak, ask questions and respond to the comments of others, including the facilitator. The facilitator moderates the discussion by asking questions that stimulate interactions among participants on various aspects of the study area. Some people prefer to participate in focus group discussions as they feel that there is less pressure on them as individuals and that they have more power to control their contribution in a discussion. Darlington and Scott (2002) point out that a group setting can make it easier for researchers to discuss taboo subjects as the less inhibited group members can assist to 'break the ice'.

Mindful that I was researching a sensitive subject, which had potential for embarrassment and as a result of which some participants may be reluctant to talk about personal experiences, the female research assistants started the focus group discussion with relatively safe issues and encouraged everyone in the group to speak early on. The discussion then moved on to more sensitive topics when there was evidence that the participants were ready to do so. This approach has been alluded to by Darlington and Scott (2002) saying that by starting off with relatively safe issues helps to build confidence among the participants. A similar approach to relatively safe issues is also recommended as being equally important in 'winding-down' the discussion.

## **6.6 Pilot Testing**

All the data collection instruments were pilot-tested prior to being used in the field. Pilot testing also known as pre-testing is a process of trying-out the instruments on a small but representative sample, similar to the intended sample for the main study (Singleton and Straits 1999). This ensures that the questions are clear and participants are able to communicate the essence that was intended. Furthermore, the process is also used to check if respondents have any difficulties understanding the questions, to measure how long it took to collect the data, to build competence in data collection, and uncover any problems in field procedures (Adamchak 2000). This procedure is highly recommended in order to discover and correct problems before data collection begins.

The piloting of the instruments was conducted in the Chongwe district of Zambia, (which lies on the outskirts of Lusaka) over a period of one week. Chongwe is a semi-urban and rural district and has similar characteristics to those where the main study was to be undertaken. It took the form of individual interviews and a focus group with a representative sample of participants. In addition to checking for consistency for the suitability of the data collection instruments, this pre-test exercise was used to ensure that the language and terms used in the study were culturally sensitive and respectful. The study was to gather information associated with human sexuality and domestic violence and these are classified as sensitive topics for research. As such, it was necessary to ensure that the language concepts used were culturally and socially acceptable. Strong cultural and traditional beliefs in Zambia make it difficult to openly discuss issues of sexuality (Gordon 1998). As such, it was imperative to respect the difficulty that the respondents may have with engaging in a detailed discussion, without being hindered by the use of the language terms that may be considered insulting or offensive.

With this background, a number of changes were made to the guidelines after the pretest exercise. Many of the changes were made to ensure that the questions asked were clear and did not carry a double meaning. Some of the questions were also re-arranged to ensure consistency in the logical sequence of thought. At this stage there were also some changes made in rephrasing the questions in order to ensure that they were not offensive. Some questions were at this stage discarded as they were found redundant. (interview and focus group guides are presented in Appendix 6, 7).

## **6.7 Additional study personnel and training**

Three female assistants were recruited to assist in facilitating the focus group discussions with women. All the three research assistants had previous training in conducting focus group discussion covering an HIV/AIDS topic. These were selected following a careful screening process of the skills that were available in the community. Most rural communities in Zambia face a critical lack of educated young men and women as they migrate to the urban areas. After careful screening, the research assistants selected for this study were the only three with the appropriate qualifications that were needed for this exercise.

One of the female assistants served as a moderator, one was responsible for taking notes, and the third female research assistant was recruited to coordinate the organisation of the focus group discussion and to serve as a coordinator within the community, during the period of data collection. The reason for utilising the services of female assistants was because of the anticipated difficulties that may have been experienced in discussing with women participants, in-depth issues to do with sexuality. In Zambian culture, issues of sexuality still remain a largely taboo topic, so women find it difficult to discuss such issues with a man and particularly that I was a stranger in the community.

This decision was also taken as it was hoped that the use of locally-known female research assistants could facilitate the discussions easily and would also provide an opportunity to collect richer data. This is because as the female assistants were

residents in the study sites, both the facilitator and moderator could be considered as 'insiders' and the participants were more likely to have a lot more confidence in speaking out and therefore fully participate in the discussions (as opposed to a male 'outsider' facilitating the discussion). Both the primary school teacher and the PPAZ reproductive health worker, who were recruited as research assistants, were well known in the communities for working in the reproductive health sector. This made it easier for the participants to relate to the researchers and thereby supplied the necessary confidence and legitimacy to the exercise.

In order to prove their competence and also for the purpose of refreshing their skill, I had an opportunity to role-play a mock focus group discussion with both the facilitator and the moderator prior to going in the field. As I have had previous experience of using focus group discussions as a data collection method, the role-play therefore confirmed the research assistants' skills and capability to facilitate a discussion. It also enabled them to familiarise themselves with the focus group guide and at the same time allowed them experience in using the recording equipment. This interaction was very useful and served as an opportunity for the two assistants to refresh their skills. It also gave me the opportunity to observe the two assistants, and rehearse the guide to be used in the discussions.

#### **6.8 Research governance and ethical issues.**

The study adhered to the ethical requirements of conducting a study on HIV/AIDS in Zambia. The process of undertaking this study started with the submission of a

concept paper on the research topic and the study instruments to the Ministry of Health Ethics Committee on HIV/AIDS Social Research. A covering letter, describing the general purpose of the study was also used to support my research status with an explanation of how the data was to be put into use (See Appendix 1-4). The documentation also explained the time frame for the field work and other relevant details. Singleton and Straits (1999) emphasise the need to follow this process in obtaining access to conduct research in a community.

The Ministry of Health Ethics Committee advised however, that because the operations of the Ministry had been decentralised, the proposal was to be submitted to the District Health Management Board in the area where the study was to be conducted. Subsequent to this advice the proposal was submitted to the Petauke District Health Management Board, who granted me the required permission and support to conduct the study within the province. The District Health Management Board further proved extremely helpful in that in addition to making suggestions of the possible areas for data collection, they also assigned the District Reproductive Health Officer to accompany me all throughout the study. The officer helped with the logistics and with making contacts with potential respondents at community level. The officer also represented formal approval for the study in the communities.

Upon obtaining permission from the Local Health Management Board, and in the company of the District Reproductive Health Specialist, at the village level, permission was obtained from either the chief and/or village headmen who served as community 'gatekeepers'. Burgess (1984:48) defines these gatekeepers:

'As those individuals in an organisation or community that have the power to grant or withhold access to people or situations for the purpose of research' (Burgess 1984:48).

During these contacts, the purpose of the study was explained and a copy of the letter from the Planned Parenthood Association of Zambia was given to the gatekeepers explaining the purpose of the study for record. Fortunately we did not experience any refusals from the gatekeepers (copies of these documents are included in Appendix 1-4).

## **6.9 Fieldwork**

The fieldwork for the study was conducted in Petauke district in Zambia over a period of six months, from November 2002 to May 2003. The first two months were spent researching local literature for the study, negotiating ethical approval and attending to various logistical supports. The remaining two months were spent in finalizing and pre-testing the study instruments and actual data collection in the field. Actual fieldwork involving data collection took two months. Burgess (1984) describes fieldwork as a stage in the research process when a researcher is expected to engage with a representative sample of the study group for the purpose of data collection. Singleton and Straits (1999) further explain that this aspect of the research process provides the researcher with an opportunity to obtain first-hand information and knowledge in the area of study. At this stage of the research process, the field researcher seeks to understand how the study participants perceive the world, without unduly influencing the shape and content of this view.

### **6.9.0 Sampling method**

A sampling strategy of 'simple convenience' was used for the selection of the participants. Dawson et al (1991), define properties of a 'simple convenience' sample as a selection process based on mutually exclusive segments, and where participants are as much as possible drawn from the same social economic and demographic background. In a relatively homogeneous community a convenience sample is appropriate to allow researchers in order to strengthen the comparability within the sample, and to permit the identification of major topics of interest and explore similarities and differences within the sample.

In this study, the selection process was deliberately aimed at achieving a level of homogeneity among the participants. For this reason, all the participants comprising thirty men and thirty women were selected on the basis of the following characteristics.

- (a) That the participants were residents in the community,
- (b) That participants were married or previously married, widow, widowed, or on separation or divorced.

This apparently was not difficult to achieve, as Zambian rural communities are characterised by small clusters of household belonging to one family. The lack of industry or commercial activity means that most inhabitants are peasant and small scale farmers. Thus almost all the participants in the study communities came from a similar socio-economic background.

Other considerations in the selection process were that both men and women participating in the study should have been resident in the community for over five years and should preferably have been born and raised within the district. A PPAZ community-based reproductive health worker helped to identify potential participants to the study. The PPAZ volunteer known by each community visited potential participants in their homes to interest them in participating in the interviews.

### **6.9.1 Recruitment strategy**

The recruitment strategy for this study started with a visit to the local headman by the research team comprising myself as the principle researcher, the reproductive health officer from the council and the three research assistants. On meeting with the local leadership, I explained the purpose and nature of the research project. Once permission was granted, we then proceeded either on recommendation of the local informants or on prior knowledge of the research team to visit the homes of prospective participants.

On contact we introduced ourselves and explained the nature of the study and the purpose for which the findings would be put to use. All prospective participants were encouraged to ask as many questions as they wished with regard to their role in the research process. At this same discussion issues regarding confidentiality of the information that they were to provide in the study were discussed. All the prospective participants were told that the discussion would be tape recorded. Where the prospective respondent agreed to participate in the study we arranged for their participation on a set date.

There was generally a very favorable response to the invitation to take part in the study. We think that this was because of the commitment of community members to participate in a study that was aiming to mitigate the further spread of the epidemic which had caused a lot of pain and suffering in the communities. As pointed out earlier HIV/AIDS is an issue of major concern in many households in Zambia. There is no family that has been spared the pain associated with the presence of HIV/AIDS. None of the participants objected to the taping of the interviews and the proceedings of the focus group discussions.

#### **6.9.2 Voluntary participation and confidentiality.**

On the day of the interviews and the focus group discussions the information shared during the initial visit to the participants' home was restated. Thus, participants' were informed that participation in the study was voluntary. That they were free to withdraw from participating in the study at any stage without giving any explanation (Krueger 1994). This ensured voluntary participation and that the participants did not feel coerced to participating in either the individual interviews or the focus group discussions. Singleton and Straits (1999) indicate that respondents for the interviews need to be informed that they have the right and can pull out of the interviews at any stage if they wish to do so.

In addition to voluntary participation, participants were informed that their participation and the information that they disclosed in the study would be confidential. To this effect, all the participants were assured that their personal details would not be written down and that they would not be referred to by their personal names in the course of the interviews. Admachak (2000) points out that this is essential in obtaining good data as some of the study participants may not answer questions honestly if they are concerned about who will see their answers or how the data will be utilized. Similarly, Singleton and Straits (1999) suggest removing the name and any identification details of the participants as a protection measure to ensure anonymity and confidentiality. They suggest the use of identification through a number or coded names.

In order to ensure anonymity of the transcripts, all records, tapes and transcriptions of participants in the study were only identified through a coded name. As an ethical requirement, participants were however informed that while their identity would be protected, if the information that they disclosed placed somebody else at risk of harm, I would be compelled to report the matter to the appropriate authorities.

The need to report to appropriate authorities where somebody else is placed at risk of harm is an ethical requirement in research (Singleton and Straits 1999). In this study this caution was clearly stated to be in relation to domestic violence. We did not raise this issue in connection with the sero status of the participant for fear that this would probably stop some participants admitting that they are HIV/AIDS positive. In the event that such information had emerged where a study participant was placing a sexual partner at the risk of infection, I would have strongly encouraged such a participant to

go for HIV/AIDS counselling, in order for the participant to be informed about the implications of their sexual behaviour.

### **6.9.3 Protection of the participants against harm**

One of the primary concerns in conducting research on a sensitive topic is the need to protect the participants from harm. Renzetti and Curran (1992) attribute harm to the participants through a violation of their trust in disclosing their identity and information to other persons. It is also necessary to ensure that the participants do not feel violated or leave the data collection exercise (i.e. interview or focus group discussion) with a sense of emotional loss or embarrassment. In all the data collection methodologies, a mechanism was put in place to ensure that at the conclusion of the interviews or focus group discussion, the participants were assured of the value and importance of the contribution that they had made to the research process.

A further concern in relation to the need for protecting the respondents from harm was particularly relevant for women who participated in the study. This could have been physical and psychological violence. In studies on domestic violence, Dobash and Dobash (1989) and Hearn (1998) point to the possibility of placing women at risk of violence from their partners for participating in a study to do with violence because of the notion of the need to protect the privacy of a family. In this study there was a risk of women being exposed to the risk of violence if they were known to have participated in the study.

Two strategies were utilised to counter this risk of violence. This was achieved by first, obtaining permission from the 'gatekeepers' in the community and secondly, by starting my fieldwork with interviews with men. This provided the men with the confidence that the interviews I was conducting were in the interests of the community. I believe this helped to reduce tensions and suspicion. Secondly, as described above, a female facilitator and moderator already well known to the community facilitated the focus group discussions with women.

#### **6.9.4 Procedures for data collection.**

Both the individual interviews and focus group discussions started with an introduction. Participants were thanked for finding time to attend either the individual interview or focus group sessions. A few minutes were provided to relax and review the nature of the study and to obtain willingness to participate in the study. Permission was also sought to record the interview. In both the individual and focus group discussions, it was stressed there was no right or wrong answer to the issues that were to be addressed in the data collection exercise.

In order to stimulate discussion during the individual interviews and also to enable the informants to become sufficiently relaxed and comfortable, participants were given the option of being seen either in their own home or at another location at their convenience.

#### **6.9.5 Experience with individual interviews.**

In this present study 30 individual interviews were held with men. These men met the criteria for study as they were currently married, divorced, separated or widowers. The interviews were relatively unstructured beginning with broad questions, whilst allowing the participant to guide the conversation. Since the interviews involved a sensitive subject, I started the interview with general discussion questions. This approach enables stimulating discussion and gradually builds on the momentum of the interview to ask questions of a more sensitive and difficult area (Bryman and Burgess 1999).

By using semi-structured interviews, I was able to follow-up particularly interesting avenues that emerged in the interviews and the respondent was able to give a fuller picture. In the course of the interviews tried to engage as much as possible the social world described by the respondent. The interviews for this study were tape recorded, each lasting 60-90 minutes in duration. None of the study participants refused to be tape recorded.

Because of the open-ended nature of the discussion, this provided considerable scope for informants to express their views in detail. As a result of this, there were instances in which the respondent gave answers to questions, which I was planning to ask much later in the interview process. In some instances, some of the questions became redundant and the interview ran to an abrupt end. I also discovered in the course of the interviews a need to reorder some of the questions to maintain consistency and logical sequence of thought. However, in spite of these difficulties, I always asked the main questions which I had intended to ask in the questionnaire, through constant probing, and the raising of questions on some of the topics that emerged during the

course of the discussion. Most of the interviews lasted for about one and a-half-hours, and in some instances, slightly more. All the interviews were of a person-to-person nature and took place in a secluded and private area, which ensured confidentiality and the Reproductive Health Officer from the District Health Management Board did not attend the interviews.

By the time the thirtieth participant was interviewed, the study had achieved saturation of the data. There were no new themes emerging from the individual interviews and no further data collection was necessary.

#### **6.9.6 Experience with focus group discussions**

Two focus group discussions were held with women. The focus group discussions with women generated new information that provided further insights to the study. As was the case with the male individual interviews, participation in these sessions was voluntary and all the participants were informed in advance of the purpose of the discussion and their informed consent was obtained. The research assistants reported no refusals to participate in the interviews.

At the beginning of the discussions, all the participants were asked their demographic details to ensure that they met the desired selection criteria, as originally intended in the sample frame. All the focus group discussions were held in a classroom, which offered a sufficient level of privacy, and allowed the participants to interact easily without disturbance from other people. The focus group guide encouraged natural

conversation about the themes to allow spontaneous emergence of subjective meaning.

When appropriate and necessary, further prompts were used to narrow the discussion to specifics. In order to ensure the full participation of all the study participants in the focus group discussion, both the moderator and the note-taker also observed the intra-group interactions, paying particular attention to the symbolic gestures reflecting consensus or disagreement. In order to respect privacy, and to avoid my presence having an influence on the data collection, I did not attend the study sites where the focus group discussions were held.

A second focus group discussion was held in order to help identify common themes amongst women and also to find out if there were any other new themes which were not covered in the first focus group discussion.

The interviews and the focus group discussions were concluded by offering an opportunity to the participants to ask any questions or raise any concerns that they may have had. This revealed a lot of information gaps and misconceptions, and these will be discussed later in the findings of this study (Chapter 7). I offered the best responses possible and made appropriate suggestions for specific concerns such as when one of the participants shared his anxiety that he may have already been infected with HIV.

Both the individual interviews and the focus group discussions were concluded by having a soft drink with the study participants. A small allowance was paid as a token

of appreciation for the time that the participants had spent during the data collection exercise. The participants had not been informed in advance that they would be paid an allowance and this gesture was appreciated.

#### **6.10 Triangulation.**

Though, strictly speaking, I did not triangulate my data from the interviews and focus group research, I gave respondents an opportunity to revisit their responses in a follow up discussion with them, thus providing a further iteration to the research process. I further felt confident with the quality of the data that was collected by means of data saturation. Through data saturation of the responses in both the individual interviews and focus group discussions it became apparent that the respondents were saying the same thing. This indicated to me that there was a degree of reliability to it.

#### **6.11 Study limitations**

As I also elaborate earlier, the interview data generated from the focus group research with the women has certain limitations. Because the thrust of this thesis has been an inquiry into men's perceptions and attitudes, much of the analysis has flowed from this emphasis. While the data from the women has been invaluable to my thesis because masculinity has to be understood as relational to femininity, I am aware that further research to draw out the specific conditions and perceptions of women would extend the findings of this thesis.

Furthermore, while this analysis of findings attempts to be as comprehensive as possible, this study has a number of limitations. Although the study is conceived as a

case study, and reflects significant features of rural communities in Zambia, the study findings can not be generalised to all aspects of all rural communities in Zambia. These limitations include the relatively small sample size from which the information for this study was obtained. The study only interviewed thirty men and held two focus group discussions with thirty women.

Zambia is a vast country, and almost all the rural communities are faced with different social, political, cultural, demographic, economic and historical circumstances. It has a population of over 10 million people. With over 61% of the total Zambian population living in rural areas, the number of people who participated in this study is not representative of the total population of people in the rural areas. Furthermore, the complexity and dynamics of social and human interaction, mean that each rural community in Zambia produces its own sets of obstacles and challenges in relation to the risk of HIV infections. Furthermore, these communities have been affected by the HIV epidemic differently and have been exposed to different scales of exposure, duration, histories and patterns of HIV information and awareness education.

In addition to these limitations, the study experienced a number of logistical and resource limitations, which made it difficult to provide the desired level of confidentiality to enable the women to talk with confidence about their **personal** experiences regarding domestic violence, sexual attitudes and practices in marital relationships. For example, the three women it was possible to recruit with appropriate skills to be research assistants, were health workers and teachers, so had pre-existing working contact with the women. While the study was faced a this range of limitations it did however, provide an opportunity for an intense and prolonged engagement with

the study participants and thereby provided an insight into a variety of issues in relation to the study area (Gilbert 1998).

#### **6.12 Exiting the field.**

Paradoxically, the process of exiting from the field proved the most difficult stage of my fieldwork. I had made friends, explored their private lives and enjoyed the friendship and hospitality of the communities. I had a sense of wanting to reciprocate the value of their hospitality. As an exit strategy, I firstly paid homage to the village 'gatekeepers' who had generously supported my fieldwork and I briefed them with some of my preliminary thoughts regarding the findings of the study. I thanked the community leaders for their support. I spent time with the family that had hosted me for five days when the vehicle I had used had broken down. I later met with a few of the respondents who had participated in the interviews, bid farewell and thanked them for their participation in the research process. Clearly there was a sense of expectations from both myself and the community of what next. Yet sadly it was time to say goodbye.

At the district council, I debriefed the Director of the District Health Management Board, and we discussed my preliminary ideas and suggestions in light of the findings of the research. I made a commitment that I would go back at the end of the study to disseminate my findings and possibly work with the community to design interventions based on the study.

### **6.13 Data Management**

The data from the field was managed by keeping all the audiotapes well secured and all the materials are still available. In order to protect the identity of the participants all the tapes have been given a code number.

### **6.14 Data Analysis Procedures**

The process of data analysis started with the translation and transcription of participants' stories gathered in the field. Since the participants' stories were recorded in Nsenga, a local language, all the information gathered through individual interviews and focus group discussions was translated into English.

I and the two research assistant together with the reproductive health officer from the Petauke District Health management team played back all the tapes and translated verbatim the responses from Nsenga to English. In some instances the responses were contextualized to give meaning in English. This was when what was said could not easily translate into English. The transcripts were then processed into word processing files. One of the challenges that were faced in the translation process was the loss of nuance and richness of what was said in the local language.

For instance, a literal adage in the local language such as 'walilamvula walila matope' carries a rich local meaning as a warning. The adage when literally translated in English means that when you cry for rain it means you are also crying for mud. In the context of HIV/AIDS it means that when you sleep around then you should also expect

consequences of either disease or pregnancy. The differences in the language concepts between the local language Nsenga and English meant that there was some loss of nuance resulting from the translation of the participant's stories.

A thematic analysis method was used to process and analyse the data for the research results. Thematic analysis is a search for themes that emerge as being important to the description of a phenomenon (Daly et al 1992). The process involves the identification of themes through careful reading and rereading of the data to identify recurrent statements emerging from the data (Ezzy, 2002).

This method of data analysis was initiated by reading through the first several transcripts when the translation was completed. The purpose of reading through the transcripts was to identify recurrent statements emerging from the data. This formed the basis upon which an initial list of codes was developed.

The NVivo qualitative data management programme formed the basis upon which the participants' stories were categorized into recurrent statements, patterns of responses and concepts. This in turn formed the basis for categorizing the data into broad thematic areas. These concepts provided a structure of coherence, a sense of order and also an explicit point of meaning to the data. The concepts and themes which emerged at this stage of the analysis were used in the analysis iteratively by going back to check these themes against the text.

My criteria for such themes relied largely on their recurrence in the many interviews conducted. Further themes were only found in low levels of recurrence, for example

the argument that the reason that men subordinate their wives in marital relationship was because of their biological endowments.

Some important themes which repeatedly occurred offer an opportunity for future research. For example, most men expressed remorse for their role in the spread of the infection. Men expressed concern for the plight of orphans and widows in the community and many took the view that the gravity and social impact of HIV/AIDS was much more severe than the pleasure derived from a sexual relationship. They felt guilty that this pain that the community was experiencing was as a result of irresponsible behaviour by a few men.

Data was then coded and categorised under each of the themes that was identified. All the interview data was incorporated within the formal analytical procedures.

The coding of the data in this way produced a 'data tree' consisting of four main branches:

- Participants' perspectives on constructing masculinities
- Participants' perspectives on Masculinity and HIV risk-taking sexual behaviour
- Participants' perspectives on the risk of HIV in marriages
- Participants' perspectives on Health promotion: Men and HIV/AIDS

These data 'branches' contained a description of views and values as induced from the thematic analysis. The data branches were then analysed to identify patterns of,

and associations with a phenomenon to form a theoretical rendition of the participant's reality. In the next chapter I present the findings of the study.

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# **Chapter Seven: Presentation of Findings**

## **7.0 Introduction**

In this chapter I present the study findings based on the study participants' stories about the ways in which they perceive aspects of the social environment influence and impact on men's sexual behaviour and subsequent risk of HIV/AIDS in heterosexual marital relationships. These findings are derived from a thematic analysis of the participants' stories. This process of analysis was achieved through careful reading and rereading of the transcripts to identify recurrent statements emerging from the data obtained during the fieldwork in selected sites in the Petauke District of Zambia data.

I begin the chapter by describing the demographic profile and characteristics of the study participants. I then move on to present the findings presented in four sections, reflecting a 'data tree' consisting of four main branches of recurrent statements which emerged from an analysis of participant's stories. These are: Participants' perspectives on the social construction of masculinity; Participants' perspectives on male HIV risk-taking sexual behaviour; Participants' perspectives on the risk of HIV/AIDS transmission in marriages; Participants' perspectives on Health promotion: men and HIV/AIDS. Section Five provides a summary of key findings derived from across the four sections.

In presenting these findings, each of the four sections begins with an introduction, describing the nature of the results being presented. This is then followed by a presentation of findings based on the transcripts of the information gathered during fieldwork. Verbatim transcripts have been used as much as possible to vivify and illustrate each substantial point. In order to maintain anonymity of the participant's identity in respect of the verbatim quotations presented in all the four sections of this analysis, participants have deliberately been identified by a code number.

Each section concludes with an overall summary discussion of the findings under the respective title heading and where I tie in and relate the study findings to postmodernist theories of the social construction of masculinity.

#### **7.0.0 Demographic characteristics of the study participants.**

The individual interviews and focus group discussions with men and women respectively commenced with the collection of demographic data and the following are the demographic characteristics of the study participants.

##### **7.0.1 Age**

The participants' ages in both the individual interviews and Focus Group Discussions ranged between twenty (20) and forty (40) years of age.

Among the women five (5) of the participants were below the age of twenty (20). The majority, constituting a total of twenty (23) participants, were between twenty (20) and thirty (30) years of age. The remaining two of the participants were in the range thirty one (31) to forty (40) years of age.

Amongst the men, two were below the age of twenty. The majority, constituting twenty three (23) participants, were between twenty (20) and thirty (30) years of age. The remaining five (5) were between the ages of thirty one (31) and forty (40) years.

##### **7.0.2 Marital Status**

In terms of marital status, eighteen (18) of the female participants were currently married. Two (2) of the participants were on separation; four (4) were divorcees, and six (6) of the women were widows.

Amongst the men, twenty (20) of the participants were married, none (0) of the participants were on separation, eight (8) were divorcees and two (2) participants were widowers.

### **7.0.3 Family size**

Amongst the female participants: five (5) of the participants had one (1) or two (2) children. Ten (10) participants had three (3) to five (5) children while thirteen (13) of the women who participated in the focus Group discussion had more than five (5) children.

One (1) of the men in the individual interviews had no children. Five (5) of the men had one (1) or two (2) children. The majority totalling eighteen (18) of the participants had three (3) to five (5) children. The remaining six (6) participants had more than five (5) children.

### **7.0.4 Education Levels**

The education levels among the participants showed variations on the basis of gender regarding educational achievement.

Seventeen (17) female participants had less than five (5) years of education. Eleven (11) of the participants had between five (5) and seven (7) years of education. The remaining two (2) had between eight (8) and twelve (12) years of education. Amongst the male participants only one (1) had below five years of education. Four of the participants (4) had between five (5) to seven (7) years of education. The majority representing twenty five (25) of the participants had between eight (8) and 12 years of education.

The variations in the levels of education in the villages roughly reflect a typical situation in many rural communities where young people with a higher educational level migrate to urban settings for employment and very few women compared to men have an opportunity of education.

### **7.0.5 Religion**

Participants were affiliated to five key religious groupings as follows:

One (1) female participant reported not being affiliated to any religious grouping. Fifteen (15) of the participants representing the majority were Christians of the Roman Catholic Faith. Five were protestants and nine (9) of the participants belonged to the seventh day Adventist church.

Amongst the men who participated in the individual interviews, eight (8) reported not being affiliated to any religion. The majority representing nine (9) of the participants were Christians belonging to the Roman Catholic faith. Three (3) belonged to the Jehovah's Witness faith and eight (8) belonged to the seventh day Adventist church.

## **7.1 Perspectives on the social construction of masculinity**

### **7.1.0 Introduction**

In this section I present the findings regarding participants' perspectives on how, in the local district, aspects of the social environment influence the construction of masculinity. I show how some participants did view male characteristics as innate. However, for the most part the themes generated from this data show that the study participants perceived social processes comprising early socialisation, peer pressure, kinship systems and influences from urban life to have a major influence on what it meant to be a man in Petauke district.

Two prominent and divergent perspectives emerged from participants concerning the origins of what it meant to be a man in this particular setting. Some male participants and a minority group of women in the focus group discussions held to the view that what it meant to be a man was a natural phenomenon determined by God. However, most participants, particularly men were of the view that masculinity was a result both of the socialisation process that male children went through and social conditions in adulthood.

A further salient theme emerging from this data is participants' awareness of the tension between traditional kinship structures and the influence of modernity, which corroborates findings in other studies of rural Zambia (see discussion in chapter 1). Participants held the view that set against the influence of traditional kinship systems; changes in social values deriving particularly from people's mobility between the urban

and rural areas, and the impact of the modern economy on the living conditions in rural areas have had a significant impact on the social construction of masculinity.

The following discussion and quotations illustrate these key themes.

### **7.1.1 Masculinity as a natural phenomenon**

Some participants were of the view that what it means to be a man i.e. male behaviour and attitudes represents a natural phenomenon and that men were from childhood 'born to be like that'. The following quotations reflect this perspective.

*"What it means to be a man is a creation of God and this how nature was mean to be" (R12).*

*"Men are naturally different from women. They are what they are because of nature." (Respondent identification number R5)*

*"Being a man is a natural process of growth" (R23).*

As we go on to discuss in some detail, this standpoint was far from representing the perspective of the majority of participants. Following on to this perspective, there was a sense of agreement among the participants in describing men as being naturally different from women. Men were also described as different from women because of their innate physical strength.

*"While there are many different types of men, one of the common similarities amongst them is that men tend to be generally stronger than women" (R4)*

*"The only difference between men and women is that men are much stronger than women other wise both men and women have the same potential and are capable of behaving in the same manner" (FGDP 7)*

### **7.1.2. Masculinity as a product of social processes**

A majority of both male and female participants observed that masculinity – or what it means to be a man – was constituted through a social process or processes.

*“Being a man in this community is a process which is molded by the social environment” (R9).*

*“The roles, responsibilities and expectations of what it means to be a man is determined by our tradition and culture” (R15).*

*“Pressure to adhere to social norms and responsibilities and the pressure on men for economic survival and social responsibility all play a role in determining what it means to be a man” (R10).*

*“There is no doubt that the different social circumstance, and social backgrounds in which men are brought up in influence men’s individual personalities, and character. That is why men are different” (R21).*

#### **7.1.2.1 Individual variations**

In identifying social processes as highly influential in the formation of masculine identity, participants did not subscribe to the view that this meant that men acquired uniform or monolithic identities. Instead they described the population of Petauke district as holding varied notions of manhood, and the experience of manhood as representing a highly complex state of being which was constantly changing.

*“I can say that there is not one version of men in this district. Men are different. Although men share certain similar characteristics such as aspects of male physical appearance they are in fact very different from each other” (FGDP 12)*

*“Men like women are complicated human beings behaving differently at different times” (FGDP 24)*

*“It is would be wrong to suggest that all the men are the same. This is because individual men have their own characteristics (R2)*

*“Although one is brought up in a particular community, it does not necessarily mean one is expected to be the same with everybody else. This is because men are influenced differently” (FGDP 3)*

Notwithstanding this appreciation of individual variations in views and experiences, participants' accounts also identified the following series of social processes as being generally influential in men acquiring masculine identities.

#### **7.1.2.2 Masculinity and the socialisation process**

The influence of social processes on men's identity was seen as including the process of socialisation that men underwent. Study participants, particularly women, commented that notions of masculinity were largely constructed through the socialization process. They said that the process of socialization was achieved through the influence of the family, peer pressure, the influence of the wider social economic context and cultural expectations.

*"Men and women are the same, and it is our upbringing which makes the difference between us." (FGD 8)*

*"The process of growing up to become a man is a life time journey. It starts from birth through childhood to adulthood. The parents in a family and the community at large shape a child's thinking distinguishing between being a male or a female. This is further reinforced by assigning to boys tasks and responsibilities that are associated with being a man and at the same time encouraging them (boys) to play with male friends so that they can learn what it means to be a boy". (R10)*

*"In this district, being a man is something which is developed early in childhood as boys identify with manhood" (R6)*

#### **7.1.2.3 Women as key players in the socialisation process**

While the above finding focuses on the participants' views of the key role of the socialisation of men in constructing masculine gender norms, they also pointed out that women play an important role in the socialisation of boys in two main ways.

As mothers, they considered that women directly influence the behaviour of their sons, for example by channeling them into activities they perceive to be appropriate for boys and men and by discouraging attitudes or behaviour they perceive to be associated with girls and women.

*"Mothers also play an important role in shaping male behaviour as they want their children to be seen to conform to what is considered as appropriate behaviour for boys in a particular community" (FGDP 24)*

*"Women expect to see a particular form of behaviour from boys and men alike" (FGDP 28)*

Women were also acknowledged by participants to be socialized from childhood in ways which tended to complement a relatively dominant role for men.

*"Women are socialised from childhood to be subordinate to their male counterparts." (FGDP 6)*

*"Women learn from early in childhood roles to do with cleaning the surrounds, housework and care for siblings and other members of the family" (FGDP 13)*

#### **7.1.2.4 Masculinity and the influence of peer pressure**

Alongside the influence of adult: child interactions, peer pressure was also identified by participants to having a strong influence in the construction of masculine identities. Participants explained that boys were influenced from childhood to adopt certain behavioral traits through the influence of peer pressure. This was done consciously and unconsciously as boys emulated male behaviour. The influence of parents and other elders of the community who sanctioned such behaviour as the norm additionally sustained this.

*“Peers have had a much stronger influence in shaping how boys and men relate with other people” (R1)*

*“Boys were expected to comply with notions of what it meant to be a male and if a boy did not act like other males he was mocked and called names” (R11)*

*“Boys are encouraged from childhood to play with male friends so that they can learn what it means to be a boy” (FGDP16)*

*“We parents play an important role in confirming what the correct behaviour is for girls. For instance, a girl child was taught from childhood to learn how to behave as a girl. Society prescribed certain norms and expectations of girl behaviour” (FGDP2)*

### **7.1.3 Male dominance: traditional kinship and culture**

The majority of both male and female participants observed that male dominance was very common in man/woman relationships.

*“One of the common factors in the relationship between men and women is that of male domination. This is a situation where men occupy a higher social position compared to that of women.” (R5)*

*“This behaviour where men dominate women starts from early in childhood. This is because as boys grow up they copy the behaviour of adults and learn to think that they occupy a higher position of authority and influence as compared to women. This has in turn perpetuated an attitude of male dominance in their relationship with women” (FGDP 17)*

There was also a consensus that such male dominance was deeply rooted in tradition and custom. Participants observed that male dominance was supported and legitimized by the kinship system, where men occupied an elevated position in decision-making with one consequence being their domination in the sphere of sexual activity.

*“The lower position that women occupy is also influenced by the kinship system which ensures that in order to be seen to be properly behaved a woman is expected to be submissive and respectful to her husband. This influence extends to include decisions regarding the issue of offering sexual favours to her husband.” (FGDP 28)*

*“Men are traditionally considered as heads of their families and as such have greater decision making power than females” (FGDP13)*

Some study participants also attributed a very influential role to local traditional culture and expectations in shaping masculinity:

*“Men’s social roles and responsibilities are shaped through cultural beliefs and practices and through the expectation of what it means to be a man. These beliefs and attitudes are inherited from parents and elders within the community”. (R8)*

*“Culture plays an important role in creating a male identity through the traditional and cultural expectation of what a man should be like.” (R13)*

*“Men are expected to be responsible for the welfare of their families. These are some of the attributes which have been passed on from generation to generation” (R10)*

*“Women are prepared through initiation ceremonies to take up roles of providing and caring for their families”. (FGDP 24)*

#### **7.1.3.1 Masculinity in marital relationships**

There was common consensus amongst all the study participants that men’s higher social status in both the private and public sphere of social life. This was also reflected in traditional marital relationships where men were considered as bread winners and heads of family. This concept of headship embraced other attributes such as dominance and decision making capability, as well as the ability to provide for the family and protect its members.

This was partly because men had control of productive resources in marital relationships. Although some of the participants testified that women are acquiring more access to resources and to work formerly felt to be men's domain, this invariably fostered unequal gender relationships.

*"Men enjoy a higher social status in marriages and the wife is expected to do what the husband wants (R15)*

*"My responsibilities in marriage are to provide for the family, ensuring that the family is properly provided for. I consider my wife as a partner who helps me to manage the household chores while I take responsibility for providing the requirements of the home. We are two sides of the same coin". (R5)*

*"Men are also expected to provide all the social welfare needs of the family such as the children's education, and health" (R23)*

*"It is better to be married, because life is very difficult without a man here (FGDP12)*

*"The fact that men are responsible for ensuring the economic and household security of the house means that men hold a very influential role in determining the use of resources available to the family. This in turn accords a man an influential position in decision making as the wife is seen to be dependent on the man". (FGDP8)*

#### **7.1.3.2 Masculinity and the traditional rural economy**

Participants' account of men's relatively powerful position vis a vis women and in marital relationships should not be read as meaning that that traditional male roles were devoid of hardship. Study participants described how the poor economic environment in rural areas could place heavy demands on men in discharging their roles as producers.

*"The poor economic climate in the district has meant that men are under constant pressure to make a living. Thus men have to be strong and creative to survive the pressure they experience" (FGDP 11)*

*"The lack of employment opportunities and poor agricultural yields has meant that men have to work very hard to sustain a livelihood." (R14)*

#### **7.1.4 Masculinity and the changing social environment**

As indicated, although Petauke district is traditionally a conservative society, study participants perceived that the district was undergoing a process of social transformation. Two major developments were highlighted. First, participants cited the advent of increased economic hardship as having led to the contraction of social institutions that fostered a kinship bond. Secondly, changes in the value systems and ideals were resulting from the increased mobility of people between the rural and urban areas. As a result of these changes participants saw Petauke district as moving from a typically rural and conservative community to a society in transition embracing social and cultural values more firmly associated with modernity. Participants viewed this transition as placing a lot of pressure on men to adopt a new way of life.

*"Because of the increase in the amount of travelling and the movement of people to and from urban areas most people were being exposed to different traditions and cultural values and this is beginning to influence the social relationships between men and women in rural communities such as ours." (R20)*

*"I also want to say that the influence of the media such as the radio and people marrying from other tribes is also having an influence on how both men and women relate to each other. (R8)*

*"Although men and women are traditionally supposed to lead separate social lives, the situation is changing because of the influence of modern life As a result of this there are no strict boundaries on what a man and a woman can and cannot do". (FGDP8)*

##### **7.1.4.1 Economic hardships and the kinship system**

Participants still described the Petauke district as a traditionally conservative society, where the kinship bonding remained a feature of life. In both the individual interviews and focus group discussions, there were also conflicting views about the continued importance of the kinship system.

*“Although the kinship system is not as strong as it used to be, it continues to play an influential role in social relationships between men and women”.  
(FGDP1)*

However, increasing economic hardship was recognized as placing men under increased pressure for greater individual self-sufficiency and independence now entailing a form of masculinity that is in a position of greater self support. As the final following quotation shows, there was recognition that this reduction in the reliance on relatives had diminished the power of the kinship system:

*“In the past the kinship system used to provide a means through which families looked out for each other. However, because of the economic hardships that many families are experiencing it has become common for families to concentrate on looking after their own economic interests to the exclusion of the extended family or clan. This is leading to the collapse of the influence of the kinship system which has been a major bonding factor in the communities”  
(R11)*

Some participants also recognised that such a development might hold some advantages for equalising women's position:

*“The kinship system has traditionally granted men an enhanced social status as compared to the women.” (R30)*

*“While women are an important symbol of social activity and continuation of a family, the kinship system locates women at a lower social status when married” (R9)*

#### **7.1.4.2 Influential values from urban areas**

Study participants further observed that as a result of the increasing influence of urban values, the local belief system concerning the traditional values associated with being a man in the district were changing. The cultural construction of masculinity was now in competition with the values brought back by men returning from migrant labour in the urban areas. So, while the local culture was still considered to have a strong influence in shaping and influencing the social construction of masculinity, participants reported that in the Petauke district, like many other rural districts in Zambia, theirs had become a society characterised by a constant struggle between tradition, culture and the realities and values of modern life.

*'Although these cultural practices and expectations have been going on for a long time, we are now beginning to see changes on how people relate to each other. This is because some of the people who come from the urban areas bring with them new attitudes and behaviours. Sometimes, these new attitudes and behaviour are in conflict with traditional values held by the kinship system. As such, although the kinship system has a lot of influence on the people around here, the situation is beginning to change as people are taking to adopting what is considered as modern life'. (R 24)*

*"The long held traditional values regarding what it meant to be a man are changing because of some of the influences that are being imported from urban areas"(R 3)*

*"Because of the increase in the amount of travelling and the movement of people to and from urban areas most people were being exposed to different traditions and cultural values and this is beginning to influence the social relationships between men and women in rural communities such as ours." (FGDP 20)*

*"I also want to say that the influence of the media such as the radio and people marrying from other tribes is also having an influence on how both men and women relate to each other. (FGDP 8)*

#### **7.1.5 Urban values: a bad influence?**

From participants' reports, it would seem that men have tended to emulate an urban model of masculinity such as placing a higher value on material wealth. In doing so, some regarded themselves as achieving enhanced status. According to participants' accounts, unfortunately adopting such life styles has led to harmful and negative behaviour, which has directly impacted on the spread of HIV/AIDS such as the constant needs to travel in search of material wealth and which in the course has led some men to be exposed to the risk of HIV/AIDS infection as they tend to spend time in sexual encounters to fend off loneliness while away from their homes.

*"I see that one of the reasons that some men behave badly is because they try to copy the attitude and behavior of men from the city and those whom they considered to be successful and important in the community" (FGDP 16)*

*"Men who travelled to the city to look for employment on return displayed the behaviour that they had copied while in the city. Some of these attitudes and behaviours tend to be harmful." (R20)*

*"Some of the behaviour that men copy from the people they consider successful tend to be harmful to their well being" (R4)*

#### **7.1.6 Summary**

In this section I have presented key themes emerging from study participants' feedback on how men acquire their identity. These both reflect their perspectives and their experience. For some participants male identity, and the behaviour and assumptions proceeding from it was innate or 'natural', not a matter of social construction. It is important for health promotion workers to be aware of this continuing perspective as they try to address the question of men's role in HIV/AIDS transmission. For the majority of participants the development of masculinity reflected complex interactions between men and women's perspectives, interpersonal relations and wider – and changing - social norms. The analysis set out salient features of this. These constitute vital intelligence for health promotion workers, setting out to engage

with the connections between how masculinity is defined and enacted in relation to HIV/AIDS transmission in marital relationships, in rural Zambian communities such as Petauke district.

The themes generated from this data show that the study participants perceive socialisation processes, peer pressure, kinship systems and urban life as major influences on the social construction of masculinity in Petauke. On the basis of these findings, the notion of masculinity in Petauke district cannot be considered as a single variable. Because it is influenced by different factors it is a highly complex state of being. To this effect, participants' feedback 'what it means to be a man' indicates that it can be more accurately described as reflecting processes of social construction, prevailing socio-economic conditions, plural and fluid overtime and in different settings.

Furthermore, these findings suggest that as complex gendered subjects, men, and women, are engaged in constructing and reconstructing both rigid and changing views about manhood. With this in mind, study participants observed that there was no one version of masculinity in the district. Rather that there multiple masculinities influenced by a host of different factors and histories. Thus the range of contextual individual 'realities' put forward by the participants implies that different men experience their manhood very differently and that generalisations be made with caution about men and masculinities in Petauke district.

One salient factor highlighted by both men and women who participated in the study was that there was a level of tension between traditional kinship structures and

emergent features of modernity in rural Zambia. This tension was said to have led to changes in social values deriving particularly from people's mobility between the urban and rural areas and the impact of the modern economy on the living conditions in rural areas. These factors were said to have had a significant impact on the social construction of masculinity. Participants' perspective here suggests that men's social identity and behaviour cannot therefore be generalised through a traditional model of masculinity.

It is evident from the interview data, that a model of masculinity which has emanated from urban areas and which, at the same time, has exploited the some of the advantages of traditional kinship values, has emerged as very influential. From participants' reports, it would seem that men have tended to emulate elements of a more urbanized model of masculinity in order to attain desired social status in the community. In particular, men espousing urban lifestyles was said to have led to the adoption of harmful and negative behaviour, which has directly impacted on the spread of HIV/AIDS. Feedback from both male and female participants therefore provides us with an understanding of the significant influences of ideals of masculinity, from beyond Petauke in shaping men's identities and behaviour in Petauke District.

Secondly, feedback confirmed that, although some of the participants testified that women are acquiring more access to resources and to work formerly felt to be men's domain in marital relationships, men were considered as heads of their families. Men also had control of productive resources in marital relationships. Participants to the study observed that this invariably fostered unequal gender relationships.

Within the context of HIV/AIDS risk prevention efforts; these findings highlight the importance of understanding divergences and commonalities in how male and female members of local communities perceive and act on notions and ideologies of masculinity, and how prevailing social circumstances are influential. This is a necessary prerequisite to developing programmes that seek to enlist their participation and involvement in the fight against HIV/AIDS

## **7.2. Perspectives on Male HIV risk taking sexual behaviour**

### **7.2.0 Introduction**

In this section, I present the findings from participants' perspectives on how male attitudes and aspects of the social environment shape men's risk of HIV/AIDS infection in Petauke District.

I begin the presentation with a description of the study participants' accounts of what they considered to be the main factors that influenced male sexual behaviour. In presenting these findings, it must be noted that there are undoubtedly many different factors and social circumstances that are antecedent to any sexual encounter that may affect the risk of a HIV/AIDS infection and/or transmission. In this analysis, I have for the purpose of this study limited myself to focus attention only on five recurrent themes that emerged from an analysis of the transcripts of the participants' stories.

These five aspects concern: participants' perception of:

- The degree to which male sexuality and sexual behaviour are socially constructed.
- The risk of infection arising from having multiple sexual partners.
- The risk of infection through local sexual networks.
- The influence of alcohol on risky sexual behaviour.
- The risk of infection through the outcomes of migration.

The section concludes with a summary of the highlights of the study findings and an analysis of their implications for health promotion practice for HIV/AIDS prevention in the district.

## **7.2.1 Social construction of male sexuality and sexual behaviour**

Study participants in both the individual interviews and focus group discussion described male sexual behaviour as a complex phenomenon which was determined by a combination of a number of biological and social factors. The following findings provide insights derived from participants' accounts of these factors.

### **7.2.1.1. *Male sexuality as a biologically determined drive***

Some participants in both the individual interviews and focus group discussions described male sexuality as being biologically determined. This also reflects a view that male sexuality is naturally uncontrollable. Men were further perceived to have a much stronger sexual drive than women and hence stronger motivation to seek out sexual partners. It was also thought that it was consistent with this position that men are allowed sexual freedom while women are generally not. They are not allowed and even expected to have sexual relationships outside their stable union or relationships.

*“Biologically men tend to have a much stronger sexual drive and that is why they tend to be more sexually active than women. (R8).*

*“I believe that male sexuality is biological. Men find it difficult to control their sexuality and that is why they have a much stronger motivation to seek out female partners for sex” (FGDP 8)*

### **7.2.1.2. *Male sexuality as a socially constructed phenomenon***

The majority of participants also observed that male sexuality was a complex phenomenon and was influenced by a variety of social factors. These included factors such as individual beliefs, histories and preferences, cultural influences and social expectations of how a man is expected to behave. For this reason men and women were said to make sexually related decisions for many different reasons – this could

be for romance, financial gain, procreation and sometimes in circumstances of abuse. This was epitomised in the following comment:

*"It is difficult to say precisely why men have sex and as human sexuality is driven by a variety of factors not easy to itemise." (R10).*

### **7.2.1.3 Sexuality as a means of affirming masculinity**

Both men and women in the individual interviews and focus group discussions described male sexuality as an important means of affirming masculinity. The data indicates that traditionally, men were expected to become sexually active from their late stages of adolescence. As boys grew up they were expected at some stage in their lives to begin to take an interest in women. Thus a man who is unable to take an interest in women was considered to be an object of shame and 'not worth his salt'. As a result of this negative opinion associated with the lack of demonstrated interest in women and particularly sexual interest, males from an adolescent age were said to have a strong motivation to show that they were normal by seeking out female partners for a possible sexual relationship. Therefore the ability to initiate a sexual relationship with women was a sign of masculinity.

*"To be a man is associated with certain expectations in this community. For instance, as a man one will be expected to have a much stronger motivation for a relation with women and that is why girls are socialised to be careful in their friendships with men" (R 2).*

### **7.2.1.4. Sexuality and cultural expectations.**

Participants also mentioned the influence of the social cultural and economic context in determining men's sexual behaviour. To this effect participants observed that in poor communities without a social safety network for security in old age, children were

viewed as insurance in old age. This underscored the importance for marriage and procreation. Some cultural practices such as polygamy were said to encourage men to have multiple sexual partners.

*“Male sexuality is also related to the cultural expectation for men to raise a family. In our communities families want to have children to provide security in old age.” (R12)*

*“Cultural practices which allow men to have a polygamous marriage also expose the risk of infection in a family if one of the partner is having an extra marital relationship”(R2)*

#### **7.2.1.5. Variations of sexual behaviour between individuals**

Study participants observed that sexual behaviour varied between individuals and that all the men behaved differently and that it was not possible to generalise this behaviour. This was because men's sexual behaviour was determined and influenced by a variety of social factors. Both men and women who participated in the study said that there were many men in the community who displayed positive and good behaviour. Yet there were also some who were known to behave badly towards their partners. They explained that men who displayed positive and good behaviour could be used as positive role models to change the behaviour of those men who displayed what were defined as bad attitudes.

#### **7.2.2 Risk of infection arising from having multiple sexual partners.**

Study participants identified a number of male attitudes and social circumstances that put men at the risk of infection. This included risks resulting from sexual relations with multiple partners.

Although mutual monogamy in marriages was seen as a social ideal in the Petauke district, this study revealed that some men in heterosexual marital relationships engaged in casual sex encounters with partners other than their wives. This enhanced their risk of HIV/AIDS infection. To this same effect, study participants observed that it was common for men to have multiple relationships. They said that men engaged in this type of behaviour either for fun and adventure or as a source of prestige. Participants further observed that some men sought multiple sexual partners as a means of proving sexual prowess. As discussed in chapters 4 assumptions concerning men's sexuality have been found to enhance the risk of infection.

*"It is common for men in the community to have multiple sexual partners." (R8)*

*"Some men feel important when they have many female sexual partners" (FGDP 17)*

*"Although married men are expected to be faithful to their spouses some of them still engage in sexual relationship outside marriage." (R5)*

#### **7.2.2.1. Evidence of sexual behavioural change among men,**

Notwithstanding this finding, a further significant observation emerging from participants this study was that while some men in the community engaged in sexual relationships with multiple sexual partners, men increasingly described how they were restraining themselves from engaging in casual sexual relationships because of their fear of infection. Most male participants indeed did express worries regarding the risk of infection and passing on the infection to their partners. This fear of infection was identified by respondents as a strong motivation for behavioural change.

*"Since the out break of the epidemic incidences of having multiple sexual partners are beginning to reduce." (R14)*

*"Men are restraining themselves from having multiple sexual partners because of the fear of being infected with HIV." (R13)*

### **7.2.3. The risk of infection through local sexual networks.**

Participants identified a number of specific types of local sexual networks that exposed both men and women in the community to the risk of HIV/AIDS. These networks involved both men and women having sexual relationships either for fun or adventure and or romance with persons from within and outside the local communities. This included businessmen who came to the local communities to purchase agricultural produce for sale in the urban areas. It was further observed that men have more networking than women and that participation in these networks was much lower amongst adult married men and much higher amongst single males.

*"I find that men tend to have more sexual networks than women and that this is more common among young people as opposed to older men"(R23)*

*"Married women's sexual networking was far much less than that of men. This is because women's mobility and propriety was traditionally under greater social view and control than that of men." (FGDP 7)*

#### **7.2.3.1 Risk of infection from sexual contact with sugar daddies**

In this same category of having sex for commercial gain was the risk of infection that local girls had by being infected by 'sugar daddies'. These were older men with a lot of money who enticed and lured young girls into sexual relationships. Participants pointed out that most sugar daddies came from the urban areas. There were no sugar daddies within the local communities because most people resident in these communities were poor peasant farmers.

*".....it is much like a chain connection, a local young girl gets an infection from a sugar daddy from the city. When the Sugar Daddy is gone, she sleeps with her local boyfriend and passes on the infection. The local boy friend then sleeps with another person and he also passes on the infection to another person. (R28)*

### **7.2.3.2 Influence of urban models of masculinity on sexual behaviour**

In describing the significance of specific networks of sexual activity, participants highlighted the growing influence of urban lifestyle on male sexual behaviour most male participants said that local men would have liked to emulate men who came from outside the community to purchase agricultural produce such as maize for sale to millers in the urban areas. Such people usually carried with them a lot of money and it was easy for them to entice young women into a sexual relationship.

*“Local men want to emulate other men who come from city by having several girl friends” (R8).*

*“Some men particularly sugar daddies use their economic muscle to lure young girls into a sexual relationship.” (FGDP16)*

### **7.2.4 Alcohol and risky sexual behaviour**

Excessive beer drinking and use of common drugs such as marijuana was repeatedly said to influence men's behaviour and enhanced their risk of infection. Most participants said that they knew of a number of their peers who engaged in sex with casual sexual partners and commercial sex workers when they got drunk. Many female participants in the study worried that men usually engaged in extra marital sexual relationships when they went to bars to drink with their friends, indeed some men admitted that they sometimes ended up having a sexual relationship with their girlfriends after drinking excessively. Furthermore participants described how foreknowledge of alcohol's disinhibitory effects propels some individuals to consume alcohol in order for them to engage in behaviour they would not normally participate in.

*“Excessive use of alcohol is one of the main causes of why people get infected with HIV/AIDS. This is because when a person gets drunk, this reduces their moral sense of judgment and as such both men and women easily ended up having unprotected sex.” (R18)*

*“It is very common for men to get excited and get involved with a commercial sex worker when drunk as opposed to when one is sober.” (FGDP8)*

#### **7.2.4.1      *Alcohol and neglect of use of condoms***

Excessive alcohol abuse was also associated with the lack of proper use of condoms. Study participants talked of the failure by men to use a condom when they were drunk. This was said to be because of the lowered sense of judgement to the risk of infection. They also talked of incorrect use of condoms and that some men even forgot under the influence of alcohol that they had a condom which they had intended to use in a casual sex encounter.

*“Some men even forget that they have a condom when they get drunk.”*  
(FGDP8)

#### **7.2.4.2      *Lack of recreation facilities***

Participants also identified the lack of recreation facilities, sports and social amenities within the district as a contributory factor to why men engaged in drinking alcohol. Study participants pointed out that the relatively poor social economic environment in the rural areas characterised by the lack of industrial and commercial development has meant that most of the rural areas do not have developed infrastructure for recreation. Apart from games such as football and netball where local men and women improvise on the playing field, rural areas critically lack a well developed recreational and sporting infrastructure. According to participants this has meant that some men have tended to spend more time with their friends in drinking alcohol. In the course of doing so some men also tend to pursue girls for a sexual relationship.

*“The lack of recreation facilities, sports and social amenities cause men to pursue girls for company and to engage in early marriages”* (R14)

#### **7.2.5. Migration and sexual risk taking.**

Men explained that due to droughts that resulted in poor crop harvests coupled with a poor economic environment, men were compelled to travel outside their villages to sell their animals to raise money to support their families. Some travelled to urban areas in search of opportunities for employment. During these errands it was thought that men would tend to have multiple sexual partners. It was also observed that high-risk behaviour such as sex with multiple sexual partners is not simply the result of migration but may be the result of alienation, of loneliness, of being separated from family and regular partners and the breakdown of traditional family units and the freedom to throw off norms of behaviour.

*"Some men go into a relationship while away from home because of loneliness and desire for company" (R22).*

*'Men normally take on other sexual partners when away from home for long intervals for the need of company because they are lonely in strange places while they are away from their homes where they are known" (R15).*

*"While in different communities men took advantage of their anonymity and lack of social restriction to develop sexual relationships with other women." (R12).*

#### **7.2.5.1. Negative opinion of men that engage in casual sex encounters**

Women in the focus group discussions (FGD's) did not favour this movement of men going to the city for long intervals. They pointed out that although migration brought with it material prospects to improve the quality of life it also brought with it the risk of infection.

*"While in the city men end up sleeping with town women who give them diseases and only returned to the village to infect their wives and to die." (FGDP6)*

A number of both men and women participants described married men engaged in casual sex encounters as being selfish. They observed that it was such men who were spreading the HIV infections. Without having multiple sexual partners the HIV/AIDS epidemic would not have spread. This perspective is reflected in one of the statements from the individual interviews saying that

*“Men who sleep around with other women are selfish and are not considerate of their families as they stand to bring an infection in a relationship” (FGDP23)*

### **7.2.6 Summary**

This analysis has shown that some participants in the study to some degree perceived male sexuality as an innate phenomenon. However, most participants concurrently saw it as influenced by different aspects of the social environment. In view of the diversity of ways in which men experienced and viewed the social environment, men's sexual behaviour and attitude was said to vary from one individual to another. These findings highlight the plural nature of masculinity or masculinities and the complexity of linking manhood to HIV/AIDS sexual risk taking behaviour.

Male sexuality was further described as being an important element in the affirmation of masculinity. It was perceived to be an essential element for procreation as well as ensuring 'social reproduction' for the community. While the value of male sexuality was acknowledged participants also highlighted some negative aspects to male sexuality such as attitudes and behaviour reflected in sexual prowess and conquest and a propensity for multiple sexual partners. Such attitudes and behaviour were seen to expose men to a greater risk of infection and in the transmission of the virus that causes AIDS. This is because the more sexual partners an individual has, especially if a condom is not used, the more likely it is that they become infected with HIV/AIDS and pass on the virus to women. Furthermore it was noted that while many men live in monogamous relationships, other men may have multiple partners or have casual sex with other women. Study participants in both individual interviews and focus group discussions observed that such, men who have multiple partners stand a much higher chance of bringing an infection into a marital relationship.

Other social influences such as the lack of recreation facilities resulting in excessive abuse of alcohol and migration were cited as social factors that exposed men to the risk of infection. When men were under the influence of alcohol some of them were known to lose their sense of moral judgment and ended up in casual sexual encounters. Similarly when men traveled outside their communities to either sell

agricultural produce or migrate into the city for employment, they were known to establish temporary sexual relationships. This was said to expose men to the risk of infection. Women participants were particularly censorious about the likelihood of men having multiple sexual partners during the course of economic migration.

A further finding emerging from this study is that in the Petauke District men are changing predominant concepts and beliefs about masculinity. As in the rest of the world the devastation that the epidemic is having on families and the traumatising experience of HIV/AIDS orphans are forcing men to question some of the long-held ideologies of 'what it means to be a man' and hence their sexual risk taking behaviour.

Male and female participants' accounts of assumptions and behaviours informing and expressing masculinity, which they held or encountered indicate that these are highly influential in shaping men's sexual practices and behaviour. Their accounts also indicate the complex nature of the factors involved, including associations between men's social and economic pre-eminence and 'risk taking behaviour', whether involving alcohol consumption or multiple partners in the course of economic migration. However, accounts also show that men's and women's perspectives on acceptable male behaviour are not uniform and are changing.

These findings provide a complex, but helpful picture for health promotion workers seeking to gain an understanding of the relationship between masculinity and the underlying determinants of sexual behaviour. In doing so it contributes to the basis for initiating a process of change which involves understanding and challenging male sexual behaviour that exposes men and women to the risk of infection in marital relationships in rural Zambian settings such as Petauke

### **7.3. Perspectives on the risk of HIV/AIDS transmission in marriages.**

#### **7.3.0 Introduction**

In the previous section (Section 7.2), I presented the study participants' perspectives on how social perceptions, social interactions and broader social conditions (influenced by aspects of the social environment) were perceived to influence men's risk of HIV/AIDS infection.

In this section, I present the findings on how participants perceived the social environment structured gender relationships within marriage relationships and how these interacted with sexual decision-making and the risk of HIV/AIDS transmission in marital relationships. This is followed by accounts of participants' views on unequal gendered relationships concerning domestic violence and the association with HIV/AIDS transmission, and men's use and non use of condoms as a measure of protection against the risk of HIV/AIDS in marital relationships.

The section concludes with a summary of the highlights of the study findings and an analysis of the implication of these finding (on) for health promotion practice for HIV/AIDS prevention in the district.

### **7.3.1 The place of marriage in social relations**

The data from the transcripts indicate that participants perceived marriage and family life as one of the most important and basic social units for ensuring social reproduction and that most men and women aspired and looked forward to being married in adulthood.

#### **7.3.1.1 *The ideal of marriage in Petauke district***

The ideal marriage in Petauke district was described as a stable and long lasting intimate relationship between a man and woman. Participants further observed that marriage ensured a sense of social security, and respect and legitimised sexual relationships and having children.

*“Marriage is an important event in the social life of both men and women and this provides a mark of social acceptance and respect as a responsible adult in society.” (R8)*

*“Marriage is a long-lasting partnership involving an intimate emotional and sexual relationship”. (FGDP 18)*

*“The importance of marriage is that it accords respect to the married person because he or she doesn’t have to perform tasks that are designated for a particular sex. For instance there are certain occupations such as building a residential dwelling house or roofing a thatched house. These tasks are meant for a man. Tasks such as drawing water or collecting fire wood are meant for women. Marriage therefore confers respect as both men and women stand only perform those tasks which they are expected to perform.”(FGDP 26)”*

*“Marriage confers a level of respect and maturity to the people that get married as this is seen as a very important stage in life” (FGDP 24)*

*“Marriage legitimises having a sexual relationship and having children. The tendency in this community is that children who are born out of wedlock are ridiculed and stigmatised as illegitimate children” (FGDP 8)*

### **7.3.1.2 Marriage and Parenthood.**

Marriage was also considered as a necessary step towards parenthood and in conferring legitimacy in having children. At another level, marriage and family was also perceived to be essential for socializing the next generation. It was not only seen as a means of ensuring community survival but also individual and social fulfillment. Some of the additional responses made by the respondents were as follows:

*“I think that one of the reasons that people want to marry is because of the wish to have children. Every family desires to have children. This is not only because children bring happiness but it is also because children are seen as insurance in old age”(R3)*

*“Parenthood is an ultimate desire for any person getting into marriage this is because parenthood ensures the continuity of the human race and our culture”(R16)*

*“It is different if a person has a child out of a recognised marriage. Children born in marriage are better recognised as opposed to children that are born out of marriage” (FGDP 4)*

### **7.3.1.3 Preparing for marriage.**

From a very early age boys and girls are socialised to prepare for specific gender roles, tasks and responsibilities associated with marriage. Participants cited the preparation of boys as responsible parents. This involved preparing boys for tasks

associated with providing for a home while girls were socialised in activities to do with reproduction and domesticity.

*“The importance of marriage in our social life is seen by the fact that both males and females are socialised towards a life of marriage from a very early age. Boys are taught skills that are tailored towards providing for the family such as agriculture and fishing while girls are taught skill to do with the proper keeping of the home” (R10)*

*“It is important that boys are prepared to be responsible husbands whenever the opportunity arises. This ensures that when they get married they are adequately prepared for this role. Similarly there are also some specific initiation ceremonies that aim at preparing girls for marriage so that they become good wives” (FGDP 14)*

#### **7.3.1.4 Men’s entry into marriage.**

Establishing a family is considered as an important step in life. In Petauke, the standard for entering into marriage was based on a man’s ability to provide enough food through farming. When a man is able to provide for a wife and family, he is considered ready for marriage. The only requirement for a woman is biological maturity. Both must seek the approval of their parents before they marry. A mature but unmarried man is viewed with suspicion and that he might be impotent.

#### **7.3.1.5 Male dominance in marriage.**

While marriage was described as a partnership between men and women most marriages in the district were said to be characterised by unequal gender relationships. This was said to be common in the community as men occupied a higher social status than women and this was said to form the basis for gender relations.

Participants perceived male domination to be a result of the social responsibilities that men had in providing for the family. Thus men in marriages were considered as breadwinners and generally referred to as the head of the household. Furthermore men's enhanced social status was a result of the nature of the responsibilities that they had for providing for the family. With limited technology in the rural area most of the means for economic production were labour intensive. This favoured men because they were much stronger compared to women and this usually resulted in men being in control of productive resources for the family.

*"Although marriage is a partnership between a man and a woman, men are traditionally the providers and heads of the family while women were largely associated with household work." (FGDP10)*

*"The situation that we live in requires men to be bread winners. This is because men are strong and they are able to carry out tasks that women can not do. Because of this men, have tended to have control of the means to support the family. This has in turn fostered male domination" (FGDP 13)*

*The nature of life in these communities is that many activities to support the family are labour intensive. This means that men are able to survive. In order to avoid the difficulties of life, that is why women accept to have a lower position to men in a marriage" (R8)*

### **7.3.2. Gendered sexual decision making power in marriages.**

Women participants highlighted gendered power differentials as highly significant in sexual decision making. These socially determined roles were seen as having a significant effect upon the responsibilities for decision making with men having a greater influential role in decision making including on sexual decision-making in marital relationships. This has, in turn, limited women's opportunities and required them to be under the protection and control of their husbands.

*“Men generally have a much greater decision making power in marriages and this includes making decision to do with sexuality such as when to have a baby” (FGDP 18)*

*It is common in marriage that men decide when to have sex. With such power men determine the sexual health of family including having the power to decide when to have a child.” (FGDP 24)*

*Although women can suggest having sex, it is often men who decide when to have sex” (FGDP 2)*

### **7.3.2.1      *The payment of dowry and male domination.***

Participants in the focus group discussion also pointed out that tradition of paying dowry as a requirement to legitimise a marriage diminished womens' say in sexual decision making as some men took it that they had bought the woman's sexual rights. With this background of subordination women had a social responsibility to provide sexual favours to their husbands considered as a basis for a marriage and a man could demand sex at will. As one woman described:

*“Since the man pays lobola (dowry) for a woman to enter into marriage, it means that the man has authority over the woman in a marriage” (FGDP 10)*

*“The payment of a dowry also makes some men believe that they own a woman that they can demand to have sex as and when they need” (FGDP 18)*

*“Although bride price is meant to solemnise the marriage and show of respect in many marriages, this has resulted in women having a subordinate role in sexual decisions as men are seen to have paid for women's sexual rights.” (FGDP9)*

*“The payment of a dowry to take a woman into marriage brings many problems in a marriage because the woman has to comply with the demands made by the husband including having sex as and when he wants. If a woman does not*

*agree to the husbands sexual advances he has the right to complain to the relatives of the woman” (FGDP 7)*

### **7.3.2.2 Risk of HIV/AIDS transmission in marriages**

The combination of men’s power to shape sexual decision making in marriage and relatively promiscuous behaviour beyond marriage were seen by participants as significant in HIV/AIDS transmission. Study participants acknowledged that HIV/AIDS infections in the communities were common. Participants described men as having a much higher possibility of bringing an infection in an intimate relationship. This was because men were seen to be more likely to have a sexual relationship outside marriage than women. This might be because while many men live in monogamous relationships other men might have sex with multiple partners or occasionally without a condom. This enhanced men’s risk of infection. Similarly men who indulged in excessive beer drinking and those who returned from the city where they might have had a relationship with other sexual partners could not be denied sexual favours from their wives.

*“Men are more prone to bring an infection into a marriage because of their social mobility and that they have more opportunities and motivation for extra marital partners than women” (R6)*

*“Men determine our reproductive health welfare. If a man is unfaithful this enhances a woman’s chance of getting an infection” (FGDP5)*

*“Traditionally, women are dependent on the man in marriages and this accords women a lower bargaining power to influence their husband’s sexual affairs within and outside marriage”. (FGDP13)*

### **7.3.2.3 Men: Women and sexual decision making**

Participants described the risk of infection in a marital relationship as occurring in the process of performing “marital duty” where the wife provides unprotected sexual favours to the husband. They observed that this was because men had a greater influence on sexual decision making and as such women can not refuse to have sex even when they knew that their partners were having sex with other women. They also said that women had little opportunity to bring the infection in a home because women’s social interactions were closely watched in the community.

*“Men have a greater sexual making power n marriage and a woman cannot refuse to have sex even when she knows that the husband is having a sexual relationship with another women”(R5)*

*“One of the expectations in marriage is that of a husband and wife having a sexual relationship. Since marriage is founded on the spirit to remain faithful to each other, an insincere partner who brings the infection and this is usually men may infect the partner in the course of having a normal sexual relationship in a home” (FGDP 14)*

*“We live (on)in hope that our husbands have been faithful to the marriage whenever they demand sex” (FGDP 22)*

### **7.3.3 Domestic violence and the risk of HIV/AIDS infection**

Domestic violence was reported as a common occurrence in the communities. Contradictory accounts from women and men on this issue validated the importance of separate data gathering strategies for male and female participants. .Most significant to this study, there appeared to have been a problem of under-reporting by men of incidences of domestic violence. The following summaries and quotations provide an(d) indication of the responses derived from respectively male and female participants’ accounts.

#### **7.3.3.1 Men’s reports of domestic violence.**

Generally, both men and women viewed domestic violence negatively. Most male participants in the study also denied being involved in domestic violence.

*"I personally find it is inappropriate to beat a wife as this is demeaning to her social status and erodes her respect both within the family and in the society."* (R6)

*"I never beat my wife because I consider her as my partner and (it is) as such it is wrong to subject her to domestic violence"*(R13)

*I now get angry when I hear of a man that beats his wife. I always ask what if it was the wife that beat the husband how would he feel"*(R14)

Nevertheless where male participants did describe inflicting violence on their partners they echoed a theme that this was as an appropriate means of men exerting their authority.

*"Men beat up their wives in order to instill discipline and as a way of asserting their authority."* (R18)

*In the early stage of our marriage I used to beat my wife as a way to instil discipline. I later realise that this was considered shameful and I have since stopped".*(R20)

### **7.3.3.2 Women's reports of domestic violence**

I became aware of the possibility of under reporting of the incidence of domestic violence in a home. This was because of the contradiction which emerged from the statements the women made in the focus group discussion. Most women participants complained that they had been physically beaten at least once in their life. This contradicted the reports from most men who participated in the study, who said that they had *never* physically assaulted their wives.

*"It is common for men to beat their wives and I wish this could stop" ( FGDP 16)*

*"My friend is always being beaten over very petty and small issues such as delaying in serving a meal when the husband comes back from drinking"(FGDP 23)*

Women in Focus Group discussions also lamented that without economic leverage it was impossible for women to leave relationships, even if they perceive it to be risky. This was because of the lack of bargaining power and fear of abandonment and destitution. Again this echoed a common theme in wider literature on domestic violence in Zambia, and internationally as discussed in Chapters 1 and 2.

### **7.3.3.3      *The connection between domestic violence and the transmission of HIV/AIDS***

Female participants highlighted the connection between domestic violence and the risk of HIV/AIDS in marital relationships as coming about when women were afraid to negotiate safe sex even when they knew that their partners were having an extra marital sexual relationship. The fear of domestic violence and sexual coercion were mentioned as making women in marital relationships vulnerable to the risk of infection.

*"I know of a friend who was often intimidated by the husband for refusing to have sex. She was so scared of the husband that even when she knew that he had another relationship which put him at risk of an infection she still could not refuse his advances for fear of being beaten" (FGDP21)*

*"The fear of domestic violence makes it difficult for women to refuse having unprotected sex with their husbands." (FGDP8)*

*"Sometimes these men coerce us into having sex by intimidating us that they will take on another sexual partner if we refuse to have sex with them." (FGDP10)*

### **7.3.4    Condom use and the risk of infection in marital relationships.**

Most study participants (both male and female) reported that they had heard about and seen a condom. Participants said condom use was widespread. Almost all the male participants had used a condom. All men acknowledged that condoms provided the most effective protection against HIV and other STIs.

*"These days condoms are easily available, and I have used some and they are good for protecting against the risk of infection"(R4)*

*"Yes I use condoms and I don't find anything wrong with that"(R10)*

*"I have found condoms in my husbands pocket one and I think this was good because he was protecting himself against the risk of infection" (FGDP 26)*

#### **7.3.4.1 Condom use in marriages**

However, both male and female participants observed that male use of condoms in marital relationships was minimal and was fraught with a number of limitations. The two major reasons cited for this were as follows. First, men described how they did not use condoms in marital relationships because of the association between condoms and multiple partners/prostitution. As such, a suggestion to use one, could be interpreted as evidence that a man had been unfaithful, or thought that his wife was involved in other sexual liaisons. It is notable in this context that, participants' accounts confirm wider findings (Jackson 2004) that men are more likely to use condoms with commercial sex-workers, where there is no emotional relationship and where condoms imply a lack of commitment and trust.

*"I fail to gather enough courage to suggest to my wife to use condom because she would become suspicious that I was having sex elsewhere (R12)*

*"Condoms introduce mistrust in a marriage because it means that the person suggesting to use a condom has been unfaithful or does not trust the other partner." (FGDP6)*

*“Condoms are not very popular because they are associated with promiscuous behaviour.” (FGDP18)*

Secondly, participants described the following reason for condom use being problematic in marital relationships. The use of condoms conflicted with the desire to have children. Participants’ feedback again echoed findings from wider studies (discussed in chapter 1 and 2). In many Zambian rural communities, children are highly valued partly because they provide a level of social support for parents in old age. Since condoms are a barrier method and prevent conception this has presented difficulties for their use.

*“Using condoms in a marriage is difficult because it conflicts with the desire to have children” (FGDP12)*

A further conflict for condom use was the teaching of the church that condoms were not permitted. A high number of people in Petauke district are members of the Roman Catholic church which opposes the use of condoms.

*“I do not use condoms because my church does not allow us to use them”(R26)*

### **7.3.5 Summary.**

These findings, drawn from male and female participants’ perceptions and experience have highlighted the association between the ways in which masculinity is configured in Petauke district and the risk of HIV/AIDS transmission in a marital relationship. Participants perceived the unequal balance of power between men and women to have a strong influence on defining men and women’s reproductive health and the risk of infection of women in marital relationships.

In terms of gender roles, the status of many women in the district was said to be low. It was observed that most women were poor and powerless and as a result, there were unequal power relationships that were played out in sexual encounters. This was sustained by social support for men to fulfil their sexual needs and desires as they wished. This was said to make it difficult for women to negotiate sexual relationships. This often led to a situation in which women were often unable to take full control of their sexual and reproductive lives in such areas as choosing a partner, how and when to have sex, using contraceptives, protecting themselves against STD's/HIV and avoiding coercion.

These findings illustrate how collecting information from key stakeholders, as achieved in this study, to better understand human sexual behaviour and gender relations is of vital importance to improving reproductive health and to achieving reproductive rights.

At another level, study participants observed that poverty caused many women in the district to compromise their sexual and reproductive rights. This was said to be particularly evident in situations where women lacked the ability for economic self-support. Furthermore study participants perceived the severe economic hardships women were faced with led to their lack of capacity to effectively negotiate their desire in sexual relationships or insist on safe sex, for fear of losing an important source of financial support. In this same connection study participants observed that the low status of women meant that they had little power to control their sexual and reproductive decisions.

It was also observed that the dangers of economic dependence were more acute for women who have never had a chance to develop skills needed to earn a living, including many who marry early and later face breakdowns in their marriages. This is also associated with the lack of education among the female population (identified in section 7.0). Many women in the district have little or no education. The lack of education denies women the necessary knowledge, means and confidence for individual self-support. In terms of sex education, some traditional initiation ceremonies encourage young women to be submissive to their husband's sexual demands.

Furthermore, participants' accounts, notably those from the women in focus group discussions, highlighted how violence and coercive practices limit an individual's capacity for autonomous action and self protection against unwanted sexual intercourse, pregnancy and HIV/AIDS.

Participants' accounts also revealed how the same unequal gender relationships affected the use of condoms in marital relationships. Although, the correct and consistent use of latex condoms has been promoted globally as one of the most effective strategies for containing the spread of the epidemic their use in marital relationships still remains problematic. This study has shown that both men and women experienced difficulties in suggesting the use of condoms as it suggests mistrust of the other partner. Despite the evident advantages for protecting against infection, and the context of men's reported greater tendency to have multiple sexual partners, some men felt that using a condom was unmasculine.

Participants' feedback on masculinity and HIV/AIDS transmission in marriages underlines a number of important factors for health promotion workers to take account of in addressing the spread of the epidemic in a district such as Petauke. These include issues arising from male dominance in marriage, notably the connection between domestic violence and sexual coercion and HIV/AIDS transmission; women's disadvantaged economic position and associated vulnerability; and paradoxically, the problematic nature of condom use in marriage. Participants' feedback also indicated that whether or not male conduct was consistent with this, the issue of the unacceptability of male violence was at least present in public debate, and therefore could be referred to as a starting point in health promotion discourse.

## **7.4. Health promotion: Men and HIV/AIDS.**

### **7.4.0 Introduction**

In this section, I present findings from participants' accounts of the various health promotion activities carried out in the community. The findings presented in this analysis are focused on efforts to reach men in marital relationships with information and education on HIV/AIDS.

I begin the section by presenting participants' accounts of the various health promotion activities. This is then followed by a presentation of findings in relation to participants' knowledge and awareness of the risks of HIV/AIDS within marital relationships.

### **7.4.1 HIV/AIDS awareness and educational activities**

The data from the transcripts indicate that there are a number of HIV prevention health promotion activities carried out by a number of different organisations such as government ministries, the church and non-governmental organisations. These activities include public meetings, drama and a limited coverage of home visits by the PPAZ community-based workers. These initiatives are further focused on encouraging sexually active individuals to abstain, be faithful and/or use a condom (i.e. the ABC Approach, described in chapter 5).

#### **7.4.1.1 *Organisations carrying out HIV/AIDS educational activities.***

Study participants mentioned a number of organisations as providing HIV/AIDS educational activities in the communities. These services included the Planned Parenthood Association of Zambia (PPAZ), the Zambia Red Cross, the Government Ministry of Health, and the Ministry of Agriculture Department of field extension services. The faith based organisations identified as providing HIV/AIDS prevention related activities were the World Vision a predominantly protestant led organisation and a project supported by the Seventh Day Adventist Church called ADRIA. The following quotations provide the data for this summary.

*“Mabvuto’s project (Mabvuto is a fictitious name for one of the PPAZ Community-based agents working in the community. The name has been changed to render the worker anonymous) is the most well known project providing HIV/AIDS prevention and awareness education in the communities. Although other organisations have been providing information regarding these activities it is easier to talk to Elias and obtain services such as condoms because he lives with us here in this community” (R5)*

*The Ministry of Agriculture has been providing an Agricultural and HIV/AIDS education outreach service. This is where agricultural extension service workers provide HIV/AIDS education when they visit us to provide an agricultural extension service” (R10)*

*“The church has also been instrumental in providing these services. Some of the organisations that we have seen from the church are the world vision and ADRIA.” (FGDP 16)*

#### **7.4.1.2 Nature and type of services offered**

Study participants observed that there were a variety of types of information and educational activities aiming at preventing the spread of HIV/AIDS which are being carried out in the communities. These activities included distribution of educational materials, holding public meetings and a limited range of home visits.

*“There are people from different organisations that come here to provide us with information on AIDS. Some of these people come from the hospital at the*

*Boma and they conduct public meetings and distribute materials with information on AIDS". (R12)*

*"The PPAZ has been distributing pamphlets and brochures and they also use posters with information on AIDS which are put at Market places and in bars". (R10)*

*"The types of activities carried out are tailored to meet different information needs such as information for young people and information for the adults" (FGDP 18)*

*"I am aware that the various organisations distribute a variety of print materials which provide information on different aspects of the HI/AIDS epidemic. (R16)*

*"I have also seen the PPAZ conduct home visits where they visit homes and talk to families regarding HIV/AIDS". (R15)*

#### **7.4.2 Impact of current programmes on knowledge of HIV/AIDS**

Participants described the current range of activities to have managed to create a level of awareness on HIV/AIDS the risk of infection and on how this can be prevented. At the same time most of the participants appeared to be well informed about the spread and risks of infection as well as major features of treatment regarding sexually transmitted diseases and HIV/AIDS.

##### **7.4.2.1 Incidence of HIV/AIDS**

Participants described the problem of HIV/AIDS as widespread and common in the communities where they lived. This knowledge was of course largely gained from direct personal experience. All the respondents reported that they knew of somebody within the community and either or a close friend or relative suffering from HIV/AIDS.

*"HIV/AIDS is a fatal disease which always results in death" (R8)*

*"Anybody who is sexually active stands the risk of infection". (R4)*

*"There is no day that passes without discussing HIV/AIDS. Either there is somebody ill or a death in the community because of HIV/AIDS (R13)*

*"Many people in this community have lost a relative or friend through AIDS" (FGDP15)*

*"A person infected by HIV/AIDS often suffers from sores or rashes on the body especially affecting the genitalia, boils and herpes Zoster on any part of the body. Skin changes in texture and colour such as dry skin, red and or chipped lips" (FGDP12)*

*"When one is infected they also develop a problem which results in hair loss". (FGDP2)*

*"I have had AIDS in my family and know many people in the community struggling to cope with the infection in their families" (FGDP 24)*

#### **7.4.2.2. Views on populations at risk**

Respondents described all sexually active individuals including married couples as being at risk of infection. Young people were considered more at risk because they tended to have more multiple sexual partners. Commercial sex workers and people who slept with prostitutes were considered as being at high risk of infection.

*"Any person with multiple sexual partners has a higher chance of getting an infection" (R1)*

*"Older men who have sexual relationships with younger girls known as 'sugar daddies' contribute to the spread of HIV/AIDS infections in communities" (R12)*

*"Cultural beliefs and practices such as sexual cleansing and having sex with a woman who has just had an abortion increase the risk of infection" (FGDP11)*

*"Skin piercing, blood transfusion, use of infected instruments such as needles and razors contribute to the risk of infection" (FGDP10)*

#### **7.4.2.3 Reasons for the spread of HIV/AIDS.**

There were a number of reasons given for the spread of the HIVAIDS infections in the community. These ranged from having unprotected sex, increased casual sex encounters, male sexual behaviour and that due to lowering of the traditional values many people were getting involved in sexual relationships at a young age. They also cited the problems for sex for money.

*"Although people are aware of the risk of infection it seems that many people are still engaging in unprotected sex encounters"(FGDP1)*

*"These days' young people have lost respect for sex and they drink too much alcohol and that is why there are so many diseases" (FGDP16)*

*"Most young people have lost the lost respect for sexuality and this is why there are so many infections" (R13)*

*"There is also the problem of people having sex for money. Because of poverty many young people and particularly women who can not easily survive the harsh realities and life in rural communities tend to exchange sex for money" (FGDP 30)*

#### **7.4.2.4. Prevention and cure**

Most participants were aware that there was no known cure for HIV and that the risk of infection could be avoided. Behaviour modification and adoption of safe sex behaviour such as abstaining from sex, and use of condoms were considered as an effective means of avoiding infection.

*"There is presently no cure for HIVAIDS" (FGDP 24)*

*"I know that some traditional healers can provide medicine some of the illnesses associated with HIVAIDS for instance they can cure illnesses such as persistent cough, or a skin rash but they can not cure the actual HIVAIDS infection" (FGDP 19)*

*"The various programmes carried out in the communities have been very successful in influencing sexual behaviour change, although much still needs to be done"(R3)*

*"AIDS is a killer disease. Once it catches you, finish. It is a death sentence because there is presently no cure to protect against infection"(R20)*

*"It is a curse from God for a punishment for those people who sleep around"(R13)*

#### **7.4.2.6. Concern for the risk of infection**

All the study participants expressed concern for the fear of being infected with the virus that caused AIDS. Men worried the most for the fear of infecting their wives and the negative impact that this would have on the entire family. The following quotations relate to this summary.

*"I worry about the welfare of my children in the event of death from AIDS". (R13)*

*"I am also concerned of the risk of infecting my wife" (R28)*

*"I am scared of HIV/AIDS because I have seen how people suffer when they are infected". (R16)*

#### **7.4.2.7 Myths and beliefs**

Although most of the respondents had correct and accurate information on the risk of infection and a fairly good idea on some of the general symptoms of infections, some of the respondents located the spread of infection within the context of the local belief system. This could be attributed to the low literacy levels in the community (See section 7.0.).

*"AIDS can be thrown at you by a person who hates you such as a witch" (R20)*

*"AIDS is as a result of a bad omen or mysterious powers". (FGDP12)*

### **7.4.3 Limitations of current outreach activities**

Although participants showed a level of awareness on the risks of infection and some of the symptoms associated with the infection, study participants in both the individual interviews and focus group discussions indicated that there were a number of limitations to the effectiveness of current education and awareness activities. These comprised both limitations in the format of health promotion interventions, and that most of the information provided was too general and did not target specific groups in the population

#### **7.4.3.1 Drawbacks of public presentations**

Participants complained that since most of the educational activities were provided in public gatherings it was difficult for most of the people particularly women to ask questions and seek clarifications on their concerns. This was largely because sexuality in rural areas of Zambia still remains a taboo subject and women found it difficult to discuss this subject in public. To this effect there was a preference for a home based strategy since this offered a level of privacy. The following statements highlight some of the issues raised in respect of the limitations of service.

*"The current information offered is too general and does not address many of the concerns that we have. It is even worse for women because they can not discuss issues regarding sex which is the main mode for HIV/AIDS transmission in public."(R15)*

*"We are restricted in asking intimate questions in large gatherings because most of the people that attend such meetings are related to each other through the kinship system and it would be offensive and insulting to discuss sexuality in such a gathering." (FGDP12).*

*"I would rather that programmes focused more on home visits. Mabvuto's project (Mabvuto is a fictitious name for one of the PPAZ Community-based agents working in the community. The name has been changed to render the worker anonymous) has been very successful in providing family planning services using home visits and I think this can also help in HIV/AIDS education as home visits ensure privacy and confidentiality" (FGDP 24)*

*"It is easier to talk to the community-based agents on a person-to-person basis in a privacy of a home on issues regarding sexuality and sexual behaviour" (FGDP8)*

#### **7.4.3.2 Information on Men and HIV/AIDS**

Study participants indicated that there was a critical lack of specific information on men and HIV/AIDS. They observed that male sexual behaviour was a subject of concern in the community and there was need to address the problem of HIV/AIDS in families yet there seemed to be no strategy in the current HIV/AIDS prevention strategy that addressed the information needs of men in marital relationships

*"The current information programmes being carried out in the community do not specifically target men Although the information provided is meant for men and women who are sexually active it would be useful to have information for men only"(R20)*

*"There is a lot of AIDS in marriages yet there are no programmes to stop men from bringing AIDS into families"(R16)*

*"Married men have been left out in the campaign against HIV/AIDS" (FGDP 23)*

*"We have seen programmes for young people and women considered being vulnerable groups to HIV/AIDS yet these activities leave out married men who carry the risk of bringing an infection into a home and which is resulting in an immense problem of orphans" (FGDP 24)*

Participants observed that there were no programmes which were currently addressing some of the harmful ideologies associated with what it meant to be a man, in the district. They pointed out that the current range of activities were focussed on

promoting condom use amongst men without addressing what they saw as more fundamental issues that caused men to be more at risk of infection.

*“Instead of just encouraging the distribution and use of condoms health promotion needs to go a step further and begin to address men’s sexual behaviour and attitudes”(R23)*

*“My worry is that most of the current programmes appear to be focussed more on promoting the use of condoms and not addressing the real issues of why men put them selves at risk”(R18)*

*“There are certain attitudes that men hold such as the idea of having too any sexual partners which is spreading the infections. If each man only had one partner the infection would not spread. This is a challenge for Health promotion”(R11)*

#### **7.4.3.3 HIV/AIDS and domestic violence.**

Strikingly, both male and female respondents complained that there were no health promotion activities or materials which addressed the connection between domestic violence and HIV/AIDS. They pointed out that some NGO’s and church organisations working on gender equality programmes have carried out programmes on the impact of domestic violence. These programmes did not, however, address the problem of domestic violence and the risk of HIV/AIDS.

*“There is an evident lack of programmes targeting the problem of domestic violence and its association with HIV/AIDS” (FGDP 24)*

*“People do not want to talk about domestic violence in their home, and it is likely to be more difficult to talk about the risk of HIV/AIDS infection in marital relationships. This is because sexuality is generally considered as a taboo subject. For instance it is disrespectful for a woman to say that she was forced to have a sexual relationship in a marital relationship or accuse her husband of rape” (R1)*

*“Some men become violent and involved in domestic violence when they drink excessively. In this condition men are more likely to adopt risky sexual behaviour practices”. (FGDP2)*

*"When men come home drunk it is sometimes difficult to challenge them and impossible to even suggest the use of a condom" (FGDP11)*

*There are no programs addressing the problem of domestic violence and risk of infection". (FGDP13)*

#### **7.4.3.4 HIV/AIDS and condom use**

Participants described condoms as providing a level of protection against the risk of infection when they are properly used.

*"One has to use condoms in order to prevent the risk of infection"(R4)*

Participants also described widespread initiatives to make condoms more generally available. They mentioned the Ministry of Health and the Planned Parenthood Association of Zambia as the main providers of condoms in the communities. The condoms were distributed in the communities by community based agents. Study participants said that more and more people were taking to the use of condoms to avoid the risk of infection.

*"There are condoms available in this community. They are usually made available by the PPAZ and the Ministry of Health. They normally give these condoms to their community based workers for distribution in the communities"(R29)*

*"Condoms are usually given out free of charge by community based workers" (FGDP 24)*

*"I purchase my condoms from tu themba (roadside retail vendors)"(R20)*

However, participants criticised the absence of initiatives specifically undertaken to address the issue of the use of condoms in marital relationships. They said that although there was a high incidence of infections in families, health promotion efforts were not addressing this segment of the population. They urged programmes to

seriously consider intensifying programmes for HIV/AIDS prevention in families in order to avert the risk of infection and the creation.

*"It seems organisations providing HIV/AIDS prevention service are focusing ore on the young people and women only yet there is a huge problem of HIV/AIDS in families and nobody is making an effort to promote the use of condoms in couples at the risk of infection" (FGDP 14)*

*"There is a strong resistance to use condoms in marriages and health promotion should take up this change in order to protect against the risk of infection (FGDP 28)*

*"Since condoms are the only means of offering protection against the risk of infection, we need to encourage the use of condos if we are to protect against the continued out pouring of orphans from families ravaged by the epidemic"(R30)*

#### **7.4.4 Summary**

The findings emerging here show that there were a number of organisations which include government departments, NGO's and faith based organisations that were providing HIV/AIDS awareness and education services in a rural community such as Petauke. The main preventive methods being promoted (is) were the use of condoms, abstinence and being faithful in a sexual relationship. As a result of the range of activities being carried out and bitter personal experience, the study further found there was a high level of awareness of HIV/AIDS risk perception in the community.

Feedback from participants indicated that there were however a number of limitations to the current range of programmes that were being carried out in Petauke, as a rural community. Some of the limitations that were cited by the study participants were that the information being disseminated in the communities was too general. Participants

also observed that the range of activities being carried out did not address the specific information needs of a number of population groups. The current programme did not, for example, address the information needs of men particularly those in marital relationships. There were no programmes that were addressing the association between masculinity and the risk of HIV/AIDS in marital relationships. This is in spite of a background that men's risk of infection and likelihood of bringing an infection into a marital relationship are influenced by gendered perspectives and expectations, that are also shaped by societal factors and influences.

To this effect feedback from participants also revealed that there were no activities that were addressing the connection between the social construction of masculinity and how this is reflected in domestic violence and the risk of HIV/AIDS. This lack of health promotion intervention also extends to the lack of a strategic framework for promoting the use of condoms in marital relationships.

These findings therefore highlight the urgent need for health promotion interventions that deconstruct some harmful aspects of what it means to be a man in the district. It further underscores the point that while condoms provide a level of protection against the risk of infection, it is important that the same zeal and interest in promoting the use of condoms in the general population should be extended to focus attention on men in marital relationships. Moreover, the evidence from both male and female participants' comments in our study indicates that at least some members of the community already recognize the importance of such initiatives being developed in districts like Petauke.

## **7.5. Summary of key findings**

### **7.5.1 Introduction**

This chapter has identified the key themes emerging from the demographic profile of male and female participants in the rural Petauke district of Zambia, and from their perspectives and experience concerning the following issues:

- How the concept of masculinity is socially constructed.
- Male HIV risk taking behaviour.
- The risk of HIV/AIDS in marriage
- Health promotion in relation to men and HIV/AIDS

These themes are now summarised in relation to the thesis' four research questions. The chapter then concludes by also highlighting certain cross-cutting themes from participants' feedback, which present important issues for developing health promotion practice.

### **7.5.2 Empirical contribution to the Research Questions**

I present a summary of the contributions of the empirical data collected and analysed, to the answers of the research questions, before relating them to the wider literature and further consideration in the Discussion in Chapter 8.

### **7.5.2.1 Research Question 1**

**What are the stakeholder perceptions of the ways in which aspects of the social environment influence notions of masculinity and how these impact on men's risk of infection and HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?**

- Petauke district like many rural districts in Zambia, is gradually becoming a complex society, in which numerous factors are responsible for shaping male perceptions and attitudes. The district is on a 'cultural crossroads', characterized by social transformation. The influence of the media, education, intermarriages and social mobility has given birth to new social values which all have an influence on the social construction of masculinity.
- This study suggests that specific versions of manhood in the Petauke district are socially constructed, fluid, plural and in differ in other settings and over time. As such, there is no typical version of masculinity in the Petuke district.
- Contemporary notions of masculinity are, however, rooted in traditional culture and custom. There is evidence to suggest that men's social behaviour is defined more through the influence of hegemonic forms of masculinity. Furthermore, men in the Petauke district tended to emulate other men whom they consider to be successful.
- Some of the behavioural and attitude traits adopted through the influence of hegemonic forms of masculinity have led to the disregard of traditional social values and to problems of excessive alcohol abuse and having multiple sexual partners' - all which increase men's risk for STD's including HIV transmission.
- The poor social economic environment in the district has led to a large exodus of young adult men to migrate to the urban areas in search of employment and

economic opportunities. Men separated from their families for a long time find new sexual partners for company and to quell loneliness while away from home and some men form new families. Consequently, some women may seek out new sexual partners as a strategy of economic survival.

- Poverty and the lack of economic opportunity make it more likely that both men and women will migrate in search of income and employment which will disrupt stable, social and familial relationships and expose both men and women to increased risk of infection (UNAIDS 1999).
- AIDS is still highly stigmatised in most of the district. Pointing at witchcraft or a bad omen is used as a form of scapegoat and denial. In rural communities such as those found in Petauke, people would win sympathy from their communities if a witch was perceived to be the cause of their suffering. This therefore emphasises the important influence of the belief system in the spread of the epidemic.
- These findings challenge the explanation that HIV/AIDS is largely spread through cultural practices. While there *are some* cultural practices that increase the spread of the infection, this often affects only a few people in the community and is not relative to the spread of the epidemic.
- These study findings suggest that there are several factors, including the influence of the wider social economic conditions which have an impact on the social construction of masculinity and the tendency toward HIV/AIDS sexual risk taking.

#### **7.5.2.2 Research Question 2**

**What are the perceptions of local men and women on the interconnections between notions of masculinity and gender based violence as a risk factor in HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?**

- The study found that the use of domestic violence against women, and unsafe sexual behaviour were often efforts by young men to publicly define or affirm themselves as men. In marital relationships, the incidence of domestic violence was also associated with the elevated position that men occupied and because men controlled the productive resources for the family.
- Men were commonly seen as heads of households and the ultimate decision-makers. These decisions included issues around sexuality in marital relationships.
- Women feared to challenge their husbands because of the obligation to provide sexual favours to their husbands. Some feared the breakdown of their marriages and loss of husband, as men would find it easier to find another sexual partner.
- Violence against women occurs because culture and habit feed into patriarchal attitudes of male dominance and power over women. Reviving the customary institutions of marriage advice and counselling given by elders was mentioned as a possible means to deal with domestic problems.

#### **7.5.2.3 Research Question 3**

**What are local men and women's perceptions in rural Zambia of the social and individual behavioural factors which influence men's decisions on whether or not to use condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marital relationships?**

- Feedback from participants showed that young men and unmarried men were more likely than older men and married (or formerly married) men to use condoms.
- Consistent condom use is not widely practised by men in marital relationships. Where condoms are used, this is usually for the purpose of contraception. The reasons for failure to use condoms range from embarrassment at buying them, to a belief that they reduce sensitivity and pleasure.
- Men are also less likely to use condoms with a steady girlfriend or their wives because they believe those partners are unlikely to pass an infection to them. This contrasts with the men's lack of consideration that a condom might protect them from infection from their partner. The reason for not using condoms in marital relationships lies mostly in the association of condom use with multiple partners and prostitution. A request to use a condom in a marital relationship can thus be interpreted as unfaithfulness or fear of having acquired an STI or HIV/AIDS.
- Additionally, condoms are more strongly associated with non-committed relationships. It is notable in this context that commercial sex-workers are often more able to insist on condom use with clients where an emotional relationship is not involved, than they are with male partners where condoms imply a lack of commitment and trust.
- It is very hard for married women using other means of contraception to introduce condoms at home solely to prevent infection, but potentially easier if they need condoms for contraception.
- Health promotion efforts need to convince policy-makers and programmes workers to seriously consider a strategy to promote the wider use of condoms, which takes account of these issues in marriage.
- Women's influence on condom use in a marital relationship is much lower than men's. Although she may want to use a condom this is dependent on agreement from their partner.

#### **7.5.2.4 Research Question 4**

**How can current HIV/AIDS risk prevention strategies be revised and developed to enhance men's participation and involvement in reducing the risk of HIV transmission in heterosexual marital relationships in rural Zambia?**

- There are a variety of approaches being used to provide education and awareness about the risk of HIV/AIDS infection and transmission in the Petauke District. One of the prominent approaches has been through a nationwide social marketing project which utilizes both print and electronic media to disseminate information on the risk of HIV/AIDS infection and transmission.
- At an interpersonal level, a series of outreach activities involving educational talks, meetings, and a limited number of drama activities have been carried out to sensitise communities to various aspects of HIV/AIDS.
- There was a lack of health promotion interventions addressing some of the societal factors that influence the spread of the epidemic. For instance, while some families still maintained the practice of sexual cleansing upon the death of a spouse, feedback from participants showed there are no concerted efforts from a community level to ban such practices. Sexual cleansing is a traditional practice where a widow is made to have sexual intercourse with a relative of a deceased in order to avoid the spirit deceased person haunt the surviving spouse.
- Further, while the study indicates the possible association between domestic violence and the risk of HIV/AIDS, there was a lack of clear program activities that specifically addressed this issue. Since gender-based violence is predominantly perpetrated by men, there is a fundamental requirement to increase awareness amongst men on the interconnections between domestic violence and the risk of HIV/AIDS.

### **7.5.3 Cross cutting themes**

Having set out the range of specific issues that emerged from my fieldwork, it is also important to highlight some cross-cutting themes that informed or emerged from participants' feedback. First, while both male and female participants gave full accounts of the complex ways in which the concept of masculinity is socially constructed, there was a substantial minority among participants who held that male characteristics were innate. This is an important consideration to be born in mind in elaborating any proposals for developing health promotion initiatives, which are seeking to be more sensitive to stakeholders' awareness of the social processes involved in masculinity and its association with HIV/AIDS transmission in marriage.

Secondly, the following research strategies proved very productive: separating male and female participants, and taking great pains to ensure that the women concerned felt safe enough to comment on the most intimate issues, which were also issues that they might have otherwise felt intimidated to comment on, because of possible reprisals from male partners. Women commented extensively on pressures they were under within marriage in relation to male promiscuity, sexual coercion and domestic violence and the implications for HIV/AIDS transmission. The high incidence of personal experience of domestic violence reported by women contrasted strikingly to the picture presented by male respondents. This pointed to the importance of health promotion workers finding ways through the possible under-reporting of an issue which both women and male participants considered was germane to the spread of HIV/AIDS in marriage.

Third, participants' feedback confirmed the significance for the association between masculinity and HIV/AIDS transmission, of relatively low educational levels both for the population as a whole and for women in particular, that had emerged from participants' demographic profile. This was therefore not only an important issue for the form that health promotion information should take, but given its apparent consequences for HIV/AIDS transmission, an important issue for health promotion workers to raise beyond their field.

Fourth, there was considerable recognition among both male and female participants of the need for forms of health promotion which took more account of the complex ways in which 'what it meant to be a man', was associated with HIV/AIDS transmission in marriage. These included health promotion addressing more specific issues e.g. men's condom use in marriage; and health promotion which considered more varied means of engaging with such a community: e.g. less reliance on standard public meetings, in recognition of the constraining unequal power relations that women experienced. In such ways feedback from participants suggested that there would be a greater degree of responsiveness to health promotion initiatives.

Finally, participants testified to the diversity of individual male behaviour and perspectives (as discussed in earlier chapters (see specifically chapters 2 and 4). Some male participants as well as female participants argued for ending various health – threatening forms of dominating male behaviour. However, participants' accounts also brought out the pervasive and extensive ways in which the social construction of masculinity continued to represent forms of male dominance, inimical to the prevention of HIV/AIDS in marital relations in rural Zambia. These included the

persistence of certain traditional kinship and cultural assumptions and practices. While the influence of more modern/urban lifestyles was growing, it also fostered risky behaviours. Further, endemic poverty, experienced in gendered ways, was problematic for sustaining safe sex practices.

#### **7.5.4 Conclusion**

The case study informing this chapter has been grounded in the perceptions and experience of local men and women in Petauke district. Through sharing their considered views they have provided an informed, nuanced and penetrating account of the significance of the social construction of masculinity in relation to marital relationships and HIV/AIDS transmission in rural Zambia. In doing so they have also raised a series of important issues concerning how health promotion may be able to engage more effectively with male behaviour relating to this issue. The following, final chapter draws overall conclusions distilled from these empirical findings and the thesis' analysis of relevant secondary sources.

**Chapter Eight**

**Discussion  
and  
Implications for Health Promotion  
Policy and Practice**

## **8.0 Introduction**

This study has set out to examine the perceptions of both local men and women about the ways in which aspects of the social environment in Petauke District in Zambia have influenced notions of masculinity, and the interconnection between masculinity and the risk of HIV/AIDS in marital relationships.

Using Petauke District as a case study, the study further explored participants' perceptions about the interconnections between masculinity and gender based violence as a factor in the risk of infection. The study in addition examined how dominant ideologies of masculinity have shaped both men and women's views' and behaviour relating to use of condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marriages.

Finally, drawing on these findings the study has reviewed current and existing HIV/AIDS prevention strategies in Petauke District. This is with a view to identifying opportunities for developing health promotion strategies that promote male involvement in HIV/AIDS risk prevention in marital relationships.

In this final chapter, I discuss the value of the study based on the results of the findings presented in the preceding chapter, and setting these findings in the context of previous studies. In doing so I highlight the contribution this study makes by providing new insights into the interconnections between the social construction of

masculinity and the risk of HIV/AIDS in marital relationships in rural communities in Zambia.

The discussion of the findings is presented in six main sections. The first three sections of the chapter address the thesis' first three Research Questions:

**1. What are stakeholder perceptions of the ways in which aspects of the social environment influence notions of masculinity and how these impact on men's risk of infection and HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?**

**2. What are the perceptions of local men and women on the interconnections between notions of masculinity and gender based violence as a risk factor in HIV/AIDS transmission in heterosexual marital relationships in rural Zambia?**

**3. What are local men's and women's perceptions in rural Zambia of the social and individual behavioural factors which influence men's decisions on whether or not to use condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marital relationships?**

First, I discuss the significance of the findings in relation to the major factors that influence the social construction of masculinities in the Petauke District. Secondly, I discuss the study's findings concerning the social construction of masculinity and HIV risk-taking sexual behaviour. Thirdly, I discuss the connections between gendered power relations and the risk of HIV/AIDS in marital relationships, incorporating discussion of domestic violence, and condom use.

The remaining three sections address the fourth Research Question informing the thesis;

#### **4. How can current HIV/AIDS risk prevention strategies be revised and developed to enhance men's participation and involvement in reducing the risk of HIV transmission in heterosexual marital relationships in rural Zambia?**

In the fourth section I examine the relevance of the study's findings to current health promotion practice in an effort to tackle male attitudes and behaviour in relation to HIV/AIDS transmission in heterosexual marital relationships in rural Zambia. I conclude the chapter by drawing out in section five, the implications of these findings for health promotion policy and practice, and then finally in section six, the implications for future research.

#### **8.1 Constructing masculinities.**

Drawing on the study participants' perspectives, this study revealed that there is no single typical form of masculine identity in Petauke district. Instead, that there are multiple versions of masculinities. There is a form of indigenous masculine identity based on the traditional cultural constructions of appropriate male attitudes, behaviours, beliefs and practices. However, the study showed that notions of what it meant to be a man varied and were seen to be shaped by a range of different social factors such as the influence of wider contemporary social cultural contexts, socialisation processes, peer pressure, religion and modernity. All of these combined in varying degrees in reflecting how society and individuals constructed their ideologies of masculinity.

It must also be noted that Zambia is a nominally Christian nation. The predominance of the Christian faith has meant that many people, particularly in rural communities, as evidenced in the demographic profile of the study participants, hold strong Christian values and beliefs. This in turn has a profound influence on moralities and on what it means to be a man. Most Christian religious beliefs propagate patriarchal social relations and also have strong restrictions on non marital sexual relationships. However, while men may hold these values in earnest, feedback from male and female participants indicated considerable individual variations in adhering to these values.

These empirical findings on the plurality of men's masculinities were in keeping with postmodernist conceptions of masculinities, which as the thesis highlighted, argue that there are differences among men and the ways in which ideas of masculinity change according to time, events and the perspectives of those involved (Connel 1987, 1995; Mac an Ghail 1996; Hearn 1998). Hence notions of masculinity are not limited to unitary homogeneous concepts, but are seen as plural, fluid and negotiated in a particular space and time. Thus the thesis' theoretical standpoint and empirical findings suggest that there is no typical man in the Petauke district. because there is no one version of masculinity. Male gender is personified through social interactions and is signified by beliefs and behaviour, like being 'hard and strong' and notions of what it means to be a man vary across cultures and between individuals. Gender is not something we are, but something we 'do' in social interactions and is influenced by historical, social, and cultural factors, rather than determined by anatomical factors (Connel 1987, 1995; Mac an Ghail 1996; Hearn 1998). It is not part of a person's

essential, 'natural' or 'true' self; it combines many different, even contradictory, theories of 'what it means to be male'.

The thesis also set out how a postmodernist social constructionist perspective questions the rules of fixed categories of sex and gender, replacing them by 'floating signifiers'. Floating signifiers give no credence to "masculine" or "feminine" characteristics stereotypically assigned to sex or gender. Such a theoretical position is in opposition to the positivist view that the male sex is signified by male anatomy. In the biological approach, sexual anatomy equates with sexual destiny. A biological approach equates sexual anatomy with sexual destiny. Anatomy is proof of being a man and being a man takes on a universal status, generalisable and immutable. Aggression, reason, a need for control, competitiveness, and emotional reticence are thought to be 'natural' attributes for a man; and ambiguity is anathema to him.

Within a social constructionist perspective, this study also argued that the creation of masculine identities is not a passive process which locates the individual as a passive recipient imprinted upon or socialized by society - but recognizes the individual as a subject imbued with agency and knowledge. In doing so it drew on a number of studies which have long critiqued the essentialist and deterministic nature of sex role socialization theories as being conceptually inadequate in capturing the complexity, contradictions and contingencies of masculine identities (Arnot and Weiner 1987, Connel 1987). This more complex theorization of gender has shifted discussion from a focus simply on the roles that males exhibit, to an understanding of the formation of gender identities as relational, multiple and processual. Furthermore, it argues that masculine identities are associated with power and can take on dominant, hegemonic,

subordinate and marginalized forms, as well as being historically and culturally located.

Male and female participants' feedback highlighted how hegemonic or dominant forms of masculinity in Petauke district comprised both traditional and contemporary elements, both of which were problematic for safe sex behaviour. In this way the study moved beyond the emphasis in much health promotion work in rural Zambia, that has focused on the role of traditional cultural practices in the spread of HIV/AIDS. This finding challenged the long held explanation that HIV/AIDS is largely spread as a result of traditional cultural practices (MoH 2002). As revealed by this analysis, the hegemonic form of masculinity was defined by a combination of traditional and contemporary notions of physical strength, bravado, independence, authority over women and other subordinate men and being able to adequately provide for the family as a breadwinner (Connell 1987). Thus hegemonic masculinity is the socially dominant form of masculinity in a particular culture within a given historic period.

Participants reported how traditionally men were naturally considered to be different from women because of their physical and natural endowments. This concept of masculinity was equally important as men utilised this physical advantage to control and carryout tasks such as the manual tilling of the land for agricultural purposes and/or herding farm animals for the family. Therefore, the ability to carry out physically demanding tasks in the light of limited technologies was an essential affirmation of masculinity, and women had to be dependent on men for most labour-intensive tasks. This has, in turn, supplied men with authority over the productive resources for the families. The combination of men's physical advantage, control of productive

resources, coupled with the influence of the kinship system has historically directly and indirectly combined to perpetuate male dominance and inequality in gender relations. The kinship system legitimizes men's elevated position in decision-making including sexual decision-making also (Macwan'gi 1993, Baylies 1995, Wallman 1998).

These gender roles have invariably fostered unequal gender relationships and sustained historically patriarchal social relationships that restrict women's opportunities and require them to be under the protection and control of a man. This traditional custom of patriarchy has implications for HIV/AIDS risk prevention programmes. This is because, as discussed above, unequal gender relationships place women in a weaker position regarding sexual decision-making. As such, it is usually men, not women who determine when and how often to have sex and whether a condom is used. This, in turn, determines both men and women's vulnerability to the risk of infection.

It also became evident from analysis of feedback from male and female participants that while the local traditional cultural customs were considered to still have a strong influence in shaping and influencing the social construction of masculinity, Petauke district like many other rural communities in Zambia, has become a complex society characterised by a constant struggle between tradition and the realities and values of modern life. The district is at a cultural 'crossroads', characterized by rapid social transformation. As such, a number of social factors, such as the influence of the media, education, intermarriages and social mobility have given birth to a set of new social values. These social values are further characterized by a lack of social cohesion and a weakening of traditional forms of community moral control.

Therefore, in spite of the considerable influence of the local culture on how men constructed their masculinity, the study found that the demand and stresses from the poor economic environment and the contraction of the kinship system combined with the influence of other contemporary developments and peer pressure have had a significant influence in defining 'what it means to be a man' in the Petauke district. For instance, the advent of a monetary economy, has led to a contraction of the social institutions that fostered a kinship bond that in common with many sub-Saharan communities had served as a form of social capital through which men and the local tribal communities supported each other.

Participants' accounts revealed that this has placed men under increased pressure for greater individual self-support, self-sufficiency and independence. The emerging culture arising from these social changes was that manliness is closely associated with individual or personal achievement.

Based on accounts of participants' perceptions and experience, the form of hegemonic masculinity that was aspired to in the Petauke District was currently closely associated with the identity of men who migrated to the urban areas in search of employment and other economic opportunities. Men who returned from the urban areas with items of value were considered as being successful and this influenced the hegemonic perceptions and notions of masculinity.

Participants' accounts also highlighted how these contemporary aspirations have also led to some men adopting harmful and negative attitudes and behaviours, including alcohol abuse and the pursuit of multiple sexual partners. These attitudes have, in

some instances, also led to the domination of women, while simultaneously encouraging men to view health-seeking behaviour as a sign of weakness. These findings parallel those of other studies, such as De Keijzer's work in Latin America, which found that certain contemporary models of hegemonic masculinity have led to early deaths among men (De Keijzer 1995).

In this regard, it becomes necessary for health promotion initiatives to recognize the importance of trying to increase men's awareness that they pay a high price for trying to live according to the hegemonic model of masculinity, which may not only generate uncertainty, and frustration but also health problems.

Nevertheless, derived from its social constructionist perspective and participants' feedback, the thesis also concurs with other studies which have argued that as a social construct, the macho culture, associated with masculinities, can be challenged and changed. Feedback from participants provided evidence that ideologies of masculinity, held by adult men, which place men at the risk of HIV/AIDS infection, can be deconstructed. There was a clear indication that, as in evidence from wider sub-Saharan Africa (Baker and Ricardo 2005), hegemonic notions of masculinity were changing in the Petauke district. The dimensions of the AIDS epidemic in Africa, and the devastation of families are forcing some men to question gender norms and attitudes that were once unquestionable, and have also led some men to question elements of masculinity, which include sexual risk taking.

The study's theoretical standpoint and evidence from participants in Petauke district therefore combine to support the proposition that in rural Zambia challenging

traditional and contemporary elements of the hegemonic model of masculinity should be one of the main tools of health promotion.

## **8.2 Masculinity and HIV risky sexual behaviour**

Through analyzing a wide range of further studies, this study has provided evidence of a consistent association between the social construction of masculinity and risky sexual behaviour. The studies in question have shown that men are frequently the decision-makers about whether, and under what conditions women and girls have sex (Heise 1999, Jewkes 2002a, Baker and Ricardo 2005). Studies by Foreman (1999), PANOS (2001), UNAIDS (2003), have shown that it is usually men who decide on the number of and variety of sexual relationships. Men also tend to make decisions on the frequency of sexual activity and it is often men who decide whether to use a condom or other means of protection against the risk of infection. Although men's sexuality and intimate relationships vary from culture to culture, it is common that all over the world, men generally have more sexual partners than women. This is in part because of the patriarchal advantage that men utilize in both the public and private spheres of life. As men's sexuality and relationships may also be associated with power, men may have multiple sexual partners as a means to enhance their masculine identity. This phenomenon is combined with a further attribute associated with the social construction of masculinity: risk-taking. (IPPF 1998, UNAIDS 2003).

Feedback from both male and female participants in the Petauke district, confirmed that, as in other societies, men have tended to have multiple sexual partners out of the desire for fun, adventure, as a reflection of manliness or merely a tendency towards risk-taking.

This image of male sexuality has exposed many men to a greater risk of infection and the transmission of the virus that causes AIDS. This is because, as argued in chapter 3, the more sexual partners an individual has, especially if a condom is not used, the more likely it is that they become infected with HIV/AIDS and pass on the virus to women. As such, men who have multiple partners stand a much higher chance of bringing an infection into a marital relationship. Furthermore, the thesis provided evidence that in many locations in Zambia contemporary notions of masculinity ensure that men occupy an elevated status in gender relations and sexual decision-making within marital relationships.

In relation to male risk of HIV/AIDS infection, this study found that men having multiple sexual partners played a significant role in enhancing the likelihood of HIV/AIDS infection and transmission. While sexual networking was reported to be much lower amongst older adult married men, it was reported to be much higher amongst single males. Participants in this study described the risk of infection associated with local sexual networks as involving both men and women having a sexual relationship with persons from areas which had higher HIV/AIDS prevalence rates. In particular, young women in Petauke were said to be lured into a sexual relationship by business men from the urban areas. In Zambia, urban areas are known to have a higher HIV/AIDS

prevalence rate. Once infected, these young women passed on the infection to their local sexual partners and boyfriends, who in turn passed on the infection to other sexual partners. This parallels Bujra's work (2000b) in rural Tanzania where local girls were exposed to the risk of infection by having sexual relationships with truck drivers and businessmen who had the potential for having multiple sexual partners and thus a higher risk of infection. These young women in turn had a sexual relationship with their local boyfriends some of whom were married and thus these sexual networks had the high potential of spreading the HIV/AIDS infection within a local community. At another level, in Petauke the lack of recreational facilities, sports and social amenities within the district was identified as leading men to spending time with their friends in different social settings where they engaged in drinking alcohol.

This study has further revealed that male attitudes towards risk-taking extends to the use of condoms. Participants' experience in Petauke district is consistent with the pattern reported in other studies, cited in the thesis that it is often men who decide when and with whom to have sex and whether to use condoms. This leaves many women with little or no control over their potential exposure to HIV. Some men may consider using condoms as 'unmasculine'. In some settings, the notion of masculinity is also associated with an ideal of unprotected sex as more pleasurable, often with numerous partners. (McPhail and Campbell 2001). This finding has also been associated with older men seeking-out young women and girls as sexual partners, where they do not use condoms because they believe that young women are less likely to be infected. However, this perpetuates the chain of transmission of HIV from older men to younger women, who in turn, may infect younger men and reinforce

norms of women as sexual objects to satisfy male desire (Baker and Ricardo 2005). The Zambian Sexual and Behaviour Survey (2002), which found that men tended to have more sexual partners than women. In relation to HIV/AIDS research Foreman (1999), in an overview of men and HIV/AIDS in Zambia, found that the importance of male sexuality in affirming their masculinity was inculcated into men as they grew up. In this study, this point was specifically evidenced by boys who boasted about their sexual conquests. Similarly, in a study amongst the Goba people in the Southern Province of Zambia, Ndubani (1998) found that young men attached great importance to their sexuality, as an essential affirmation of masculinity.

For this reason, outreach and educational efforts need to take into account the multiple and complex perspectives on condoms use, as well as an analysis of how situational realities determine knowledge, understanding and practice of various prevention methods.

This study has further highlighted how one of the factors associated with male sexual risk-taking behaviour is male abuse of alcohol. Feedback on this issue from participants concurred with findings from more extensive studies on this specific issue. For example, Avins (1994) observed that a history of heavy alcohol use is also correlated with a lifetime tendency toward high-risk sexual behaviours, including multiple sex partners, unprotected intercourse, sex with high-risk partners (e.g., commercial sex workers), and the exchange of sex for money. There may be many reasons for this association. For example, it has been observed that alcohol can act directly on the brain to reduce inhibitions and diminish risk perception (MacDonald et al 2000, Cooper. 2002). However, Cooper (2002) has argued that people who strongly

believe that alcohol enhances sexual arousal and performance are more likely to practice risky sex after drinking. Indeed, some male participants in this study reported that after excessive drinking they engaged in casual sexual relationships with commercial sex-workers. Some participants went on to explain that this was because of a lowered sense of judgement about their potential risk. Understandably therefore, Petry (1999) has observed that people with alcohol problems are more likely than the general population to contract HIV.

Dermen et al (1998) has similarly observed that some people report deliberately using alcohol during a sexual encounter to provide an excuse for socially unacceptable behaviour, or to reduce their conscious awareness of risk. Furthermore, a study by Gordon and Gordon (1996) found that participants from an experimental study on the effects of alcohol on perceptions of sexual risk-reduction showed that men who took alcohol tended to report more negative attitudes towards condoms and lower self efficacy in initiating condom use.

Finally, participants from Petauke emphasised the close connection between migration and risky behaviours increasing the chances of HIV/AIDS infection. Many men travel far from their home in Petauke either to sell agricultural produce or migrate into urban areas in search of employment. While away from home some men engaged in sex with multiple sexual partners. Some attributed this to the need for company and companionship. The problem of migration as a catalyst in the spread of HIV/AIDS in rural areas has long been established in many countries (Brummer 2002). This observation is consistent with an acknowledged concern in sub-Saharan African countries where population mobility, specifically, the movement of people from the rural areas into the urban areas and vice versa, has long been established as a

significant contributory factor in the spread of the HIV/AIDS epidemic (Boogarts and May 1989, Brummer 2002). Another observation made by Brummer (2002), is that migrants experience many problems living in new environments, which may influence their mental and physical health. High-risk behaviour such as sex with multiple sexual partners may be a result of alienation, loneliness and being separated from family and regular partners and the breakdown of traditional family units. The significance of this finding is that, while this study reveals highlights how migration is considered to play an important role in the spread of the epidemic in rural communities, there have been very few well-designed epidemiological studies documenting the relationships between migration and the transmission of HIV/AIDS. More importantly, even at this late stage of the HIV/AIDS epidemic in Zambia, there is a lack of interventions, which attempt specifically to reduce transmission among migrants and their rural or urban partners.

Notwithstanding male risk taking sexual behaviour, this thesis clearly suggests that notions of appropriate masculinities are changing in Petauke district and that there is the potential for changes in sexual behaviour amongst men. This is because of high levels of awareness and perception of the personal risk of infection and the impact that the epidemic is having on families. These concerns are coupled with the trauma that many orphaned children suffer because of the epidemic and the possibility that HIV/AIDS may wipe-out an entire generation in small rural communities. As this study has shown, this is forcing some men to question gender role norms and attitudes that encourage HIV/AIDS risk-taking behaviour.

These findings provide evidence that it is important for health promotion efforts to encourage men to engage in open discussion about their views of risk-taking behaviour, sexuality and their sexual health, as well as their overall emotional and physical well being, and that growing numbers of men may be amenable to this. Men must also be encouraged to be supportive of one another and of their loved ones. All men, especially men at risk of HIV, need the support of their families as they challenge their own sexual attitudes and risk-taking behaviours. This is also necessary because, as discussed earlier, men are often reluctant to acknowledge a health problem and seek help. Men often see themselves as invulnerable to illness or risks and may ignore or delay seeking help when ill. Moreover, some men believe it is not "manly" to worry about risky behaviours or to use condoms.

I conclude therefore that a further important health promotion strategy for reducing male sexual risk taking behaviour is that health promotion messages and initiatives endeavour to deconstruct the harmful ideologies and values associated with masculinity that sustain sexual risk taking behaviour.

### **8.3 HIV/AIDS in marriages.**

Evidence from secondary studies analysed in this thesis, together with its empirical findings from Petauke district converge to show that the risk of HIV/AIDS in marriages is associated with unequal gender relationships where men have a more influential role in sexual decision-making. Participants' accounts suggested that men were more likely to bring an infection into a marital relationship and transmit the infection to women through acts of unprotected intercourse than vice versa. This was because

men were more likely to engage in risky sexual practices through having multiple sex partners and not using condoms. This finding is similar to that found in studies of several different locations in Zambia, and is against the backdrop that men are ideally seen as heads of household and the ultimate decision-makers in marital relationships (Macwan'gi et al 1994, Sulwe 2002). Men are also seen, in traditional, rural communities to have control over productive resources and breadwinners in families. This has, in turn, limited women's opportunities and required them to be under the protection and control of a man. As discussed in chapter 5, this finding can also be generalised to many societies at sub-Saharan Africa level, where for reasons of economy and custom, men occupy an enhanced social position in both the public and private spheres. In many sub-Saharan African countries the social factors that sustain unequal gender relations span a whole spectrum from cultural practices, and beliefs, to political and low legal, economic and educational status.

Philips and Green (1993) argue that in most sub-Saharan African countries cultural norms may be the main determinant which influences sexual and reproductive health intentions. These cultural norms are expressed through the influence of the family and kinship as pressure on women to adhere to cultural standards. Cultural practices such as dowry may further diminish the sexual and reproductive health autonomy of the woman by having her preferences subordinated to the interests of the family. The thesis set out how it is customary and common, in many typically traditional societies in sub-Saharan Africa, that women be subservient to their husbands (Obbo 1980, Ankrah 1993, Caldwell 2000, Jewkes 2002b). The same male dominance when applied in marriages has been found to inhibit girls and women's ability for sexual negotiation. This has led to men having a greater influence on sexual decision-making

in marital relationships. Researchers such as Baylies (1995), Fleischman (2002) in Zambia have reported unequal gender relations in marital relations which grant men an influential position in sexual decision-making in marriages. For example, a wife is traditionally expected to submit to her husband's sexual demands. Culturally, a married woman is deemed to have consented to sex, for instance, depending on local culture when a man pays a dowry for his bride, it may be assumed that he has paid for the sexual rights over his wife (CAFS 2004).

In terms of gender roles, the status of many women in developing countries is low. Most women are poor and powerless and as a result, there are unequal power relationships that are played out in sexual encounters. This is sustained by social support for men to fulfill their sexual needs and desires as they wish. This was not only reflected in wider studies discussed in detail in chapter 3, but in the detailed accounts of participants in our study. This makes it difficult for women to negotiate sexual relationships. This often leads to a situation in which women are unable to take full control of their sexual and reproductive lives in such areas as choosing a partner, how and when to have sex, using contraceptives, protecting themselves against STD's/HIV and avoiding coercion.

This thesis has also highlighted how poverty causes many women in developing countries to compromise their sexual and reproductive rights. This is particularly evident in situations where women lack the ability for economic self-support. Germain and Kyte (1995) has pointed out that poverty has a strong influence on sexual and reproductive motives, and this makes poor people prone to high-risk sexual and reproductive behaviour. This view has, for instance, also been supported by Panos

(2000) who observed that because of the severe economic hardship that women in developing countries are confronted with; they cannot effectively negotiate their desire in sexual relationships or insist on safe sex for fear of losing an important source of financial support. Watts et al (1995) report that the low status of women means that they have little power to take control over their sexual and reproductive decisions. The lack of confidence in the future and control over circumstances makes them dependent on their spouses. This was played out in Petauke district, where because of male economic migration to urban areas, women out-numbered men. This has compelled some women to enter into polygamous marriage or temporary unions and to bear children in order to increase the bond with their male partners.

This thesis has further highlighted how the dangers of economic dependence are more acute for women who have never had a chance to develop skills needed to earn a living, including many who marry early and later face breakdowns in their marriages. This is also associated with the lack of education among the female population. The educational profile of female participants in Petauke reflected the wider situation in Zambia and developing countries more generally that there are large numbers of women with little or no education. The lack of education denies women the necessary knowledge and confidence for individual self-support. In terms of sex education, some traditional initiation ceremonies encourage young women to be submissive to their husband's sexual demands.

### **8.3.1 Masculinity, gender based violence and HIV/AIDS.**

This study adopted the definition of gender-based violence as defined by the United Nations Population Fund, "Violence involving men and women in which the female is usually the victim and which is derived from unequal power relations between men and women" (IPPF 2000). As in many societies, men emerged as predominantly the perpetrators of the violence in a marital relationship.

It found that domestic violence was a common phenomenon in many marital relationships in the Petauke district. While most male participants acknowledged that it was not appropriate to use violence against female partners, its occurrence was said to be frequent. Many male and female participants reported that the occurrence of violence was associated with anger and alcohol use (as discussed above). At the same time, echoing a theme in studies worldwide, many male participants in the study justified their violence by holding women accountable for provoking it, due to women's infidelity and pestering.

In this study, men tended to report the incidence of domestic violence as occurring less frequently than women did. One explanation for this could be that its incidence was seen as a sign of male weakness. However, women indicated that it was common in many households. Another significant observation on both individual interviews with male participants, and focus group discussions with women was that virtually none of the participants spoke about their personal experience with domestic violence. This suggests that powerful taboos still surround the subject.

The situation in Petauke reflected the nature of domestic violence as a universal phenomenon. In almost all societies, men are the main perpetrators of violence (World Bank 2000). As set out in this thesis, there is now evidence that domestic violence can be associated with the risk of HIV/AIDS infection. The international conference of Population and Development (ICPD 1995) has argued that violence against women and more specifically, rape and sexual coercion are widespread, and a rising number of women are at the risk of AIDS and sexually transmitted diseases as a result of this.

It is reasonable to consider that there are interconnections between domestic violence and the risk of HIV/AIDS in marital relationships. This is because women may be unable to negotiate safe sex, even when they know that their partners are/were having an extra marital sexual relationship, for fear of violence. Previous studies, in South Africa (e.g. Jewkes 2003) have specifically focused attention on the interconnections between domestic violence in intimate partner relationships and have found that domestic violence can have a major impact on the reproductive and sexual health of women often resulting in ill health. This is because female victims of domestic violence are less likely to negotiate safe sex and this might result in forced or coercive sexual relationships. Men who were violent and abusive towards women were more likely to be infected with HIV because of other aspects of their behaviour such as having multiple sexual partners. In addition observed that women who had experienced intimate partner violence were also more likely to report several forms of HIV risk behaviour.

Hence collecting information to better understand the connection between domestic violence and human sexual behaviour and gender relations is considered to be of vital

importance to improving reproductive health and to achieving reproductive rights. In more specific terms sexual violence in the form of forced or coercive sexual intercourse with an infected partner may increase a woman's risk of HIV/AIDS STD infection (Maman et al 2000)

Furthermore, as discussed in this thesis, violence and coercive practices limit an individual's capacity for autonomous action and self protection against unwanted sexual intercourse, pregnancy and HIV/AIDS (Wood and Jewkes 1987) Rape and coercive sex can lead to unwanted pregnancy, HIV/AIDS, chronic pelvic pain, infertility and several severe sexual problems (Jewkes 2000b). Domestic violence during pregnancy is detrimental for the health of the mother and fetus. It may lead to pregnancy loss, infant mortality, maternal mortality, smoking and substance abuse in pregnancy, urinary tract infections (Satin et al 1992), low birth weight and delayed entry into prenatal care (Parker 2000). In some settings, the use of violence to discipline women is reinforced by local traditions such as bride price. Leye (2001) has identified that in many cultures in sub-Saharan Africa, bride price is usually a source of violence in marital relationships. This is presumably due to the social norm of male ownership of the woman and the female duty that it perpetuates.

Analysis of domestic violence in Petauke District in marital relationships, drawn from male and female participants' accounts revealed that one of the key reasons for domestic violence was the dominant roles that men occupied in marital relationships. For instance, the relatively poor current social economic environment, together with cultural practices and norms, sustained by a kinship system, favoured men controlling productive resources for the family in marital relationships. This fostered an unequal

balance of power, which in turn supplied men with the ability to influence and determine the reproductive health and risk of infection of women in marital relationships, through having a much stronger influence on sexual decision-making.

In turn, women feared challenging their husbands because the breakdown of the marriage could lead to social and economic losses. In the face of this inequality, many women had little or no control over sexual decisions in marital relationships.

Due to methodological limitations, and reluctance of participants to be specific, empirical findings from this study were unable to provide direct evidence of a correlation between domestic violence and the risk of HIV/AIDS. However, based on the substantial incidence of domestic violence reported by women in Petauke, in the context of evidence from secondary studies, it is reasonable to infer that women in marital relationships in Petauke face a high risk of HIV/AIDS transmission from their husbands. It is therefore important to include a focus on this subject in HIV/AIDS risk prevention efforts in rural communities. Moreover, while the study indicates a possible association between domestic violence and the risk of HIV/AIDS, there was a distinct lack of health promotion programme activities addressing this mode of transmission. Further, since men predominantly perpetrate gender-based violence, there is a fundamental requirement to increase awareness amongst men themselves on the interconnections between domestic violence and the risk of HIV/AIDS.

### **8.3.2 Condom use in marriages.**

A social constructionist perspective has facilitated a comprehensive reading in the thesis, of the complex male and female assumptions and interactions informing the subject of condom use in marriage. As participants' responses have shown, the question of condom use in marriage cannot be divorced from unequal gendered marital relations and the constraints women experience as a result of domestic violence. Nevertheless, analysis of secondary studies, together with accounts of individual male and female experience in Petauke, show how a series of further constraints characterize or rather, thwart, condom use in marriage.

Findings from secondary studies and fieldwork in Petauke indicate that male use of condoms in marital relationships is minimal and fraught with a number of limitations in rural Zambia. While the use of condoms has generally been on the increase in Zambia among single, sexually active population groups, marriage remains the relationship with the least-documented condom use. Men have been found not to use condoms in marital relationships because of the association that condoms have with multiple partners and prostitution. A Sexual and Behaviour Study (CSOZ 2000) found that men in Zambia are more willing to use condoms with sex-workers or with casual girlfriends, an attitude that often makes sense in terms of reducing their risk of infection. Men are also less likely to use condoms with a steady girlfriend because they trust that these partners will not pass on infection to them.

The study also found that women may want to use condoms, but this is dependent on their partner's willingness. A number of women also think that in a long-term relationship they can stop using a condom because they perceive they are not at risk. The desire to have children also militates against the use of a condom within a long-term partnership. This difficulty is further compounded by the fact that female condoms

are much less available than male ones, but even if women can access them their consistent use may still depend on the man's consent. It found too, that a woman may even be assaulted if she demanded the use of a condom even in the context of her husband's HIV/STI status.

Denominational influences also have a bearing on the issue. Some men and women are also restricted in using the condom because of their belonging to the Roman Catholic Church. The church has a policy restricting the use of condoms as sexual relations in marital relations are perceived to be for procreation only. The use of a condom is thus considered as being counter to the church doctrine.

This thesis found that participants' feedback suggested that young and unmarried men were more likely than older men and married men to use condoms. The stated reasons for failure to use condoms range from embarrassment at buying them to a belief that they reduce sensitivity and pleasure. Moreover, condoms were associated not only with the prevention of sexually transmitted disease but also with contraception, and accounts indicated that many heterosexual men believe that condoms are unnecessary if their partner is using a contraceptive such as the pill. In addition to this, many men who do use condoms regularly have sex without one on some occasions. Male resistance to condom use also lies in the association with multiple partners and prostitution. A request to use a condom in a marital relationship can be interpreted as indicating that a man has been unfaithful or had acquired an STI or HIV/AIDS infection.

Furthermore, as reported in this thesis, the use of condoms in rural communities has been found to conflict with the desirability of having children. In many Zambian rural communities children are valued because they provide a level of social support for parents in old age. Since condoms are a barrier method and prevent conception this has presented difficulties for their use.

These findings, specifically on condom use present a complex challenge to health promotion for HIV/AIDS risk-prevention. Enlisting the desire to use condoms effectively in marriage remains elusive. The most practical solution might be to promote methods such as virucides, employed by women, which allow conception whilst destroying HIV and other agents of sexually transmitted diseases (STD's) (Elise and Heise 1993). However since these methods remain difficult to obtain, emphasis still needs to be placed on strategies for condom use. This study shows that such a strategy needs to address complex socially constructed factors inhibiting both male and female motivation, to have a greater chance of success.

#### **8.4 Health promotion: Men and HIV/AIDS.**

This study found that there were a variety of approaches being used to provide education and awareness of the risk of HIV/AIDS infection and transmission in Petauke district. These include public address meetings, drama and a limited coverage of home visits by the PPAZ community-based workers. It also reported in both the individual interviews and focus group discussions that a number of Government departments, church organisations and NGO's are working in the

communities, providing HIV/AIDS awareness and education. The efforts place emphasis on promotion of condom use, abstinence and being faithful to a sexual partner. This approach has had a universal appeal and constitutes the main strategy for risk prevention in many sub-Saharan African countries. However, this study has shown that this approach to HIV/AIDS risk prevention has been criticised because it reduces the risk of infection to a question of individual action alone. This study's empirical findings also endorse the position of analysts such as Freudenthal (2001) who argue that sexual behaviour and the risk of HIV/AIDS is more complex and cannot entirely be attributed to individual action; and Shelton et al (2004), who discuss how the 'ABC' approach to reducing the risk of infection is debatable because many women are unable to negotiate relationships based on abstinence, faithfulness or condom use. Shelton et al further point out that the enduring contribution of gender inequalities, including economic inequality and gender violence, play a critical role in enhancing women's vulnerability to the risk of infection.

In relation to the social construction of masculinity and the risk of HIV/AIDS infection /transmission, this study found that the participants' accounts indicated that the spread of HIV through sexual intercourse in the Petauke district was determined by a complex interplay of a variety of social factors. As discussed above, these included the influence of the wider social economic context, cultural beliefs, attitudes and practices. The analysis further highlights the finding that male sexual behaviour is inextricably tied up with male social and cultural expectations and the influence of hegemonic masculinity.

In the light of this complexity, the best option to reduce the risk of infection could be through the distribution of a vaccine or availability of a cure for HIV/AIDS, but because a vaccine or a cure for HIV/AIDS is not expected to be available in the near future, efforts to reduce the spread of infection and impact of HIV/AIDS continue to rely on changing high risk sexual behaviour.

Notwithstanding the difficulty of achieving this, there is no doubt that current and existing health promotion initiatives have achieved significant results in containing the spread of the epidemic. However, this study has argued that In order to further enhance these efforts, health promotion aiming at male involvement and participation in HIV/AIDS risk prevention needs to incorporate strategies that take into account emerging theories concerning the social construction of masculinity.

As this study has shown, currently there is a risk that health promotion efforts may be concentrated on restrictive definitions of masculinity which do not take into account the complexities and plurality of masculinities. This is seen in the community-based efforts, which have relied on a mass mobilisation of community members for social change (PPAZ 2000). These efforts have seldom recognised the complex social issues of gender and the power relationships instilled in gender relationships. This approach takes a stereotypical view of the expectations of male behaviour, without taking into account the diversity and heterogeneity of masculine identities and the power structures that imbue male: female relationships. Taking such issues into account into account will enable health promotion practitioners to see more clearly context-specific risk factors and how best to address them. To this effect health promotion efforts should be based on a thorough contextual analysis of sexuality and

behaviour and how this affects specific groups of men, as reflected in the case study of Petauke district..

Seeking to understand the complexities of gender and how masculinities are socially constructed, can help health promotion initiatives to understand how interactions between individuals and their wider social environment contribute to HIV/AIDS sexual risk-taking. In so doing, this can provide an opportunity for men to reflect upon the gendered nature of their social relationships with women and can further offer opportunities to promote change that can be closely linked to the specific social contexts. This approach further offers the possibility of creating new models and identities for men that will enable and encourage greater participation in HIV/AIDS risk prevention.

As Greg et al (2000) have argued, quoting from a UNAIDS report::

“Challenging harmful concepts of masculinity and changing many commonly held attitudes and behaviours, including the way adult men look at risk and sexuality and how boys are socialised to become men, must be part of the efforts to curb the AIDS epidemic. Broadly speaking, men are expected to be physically strong, emotionally robust, daring and virile. Some of these expectations translate into attitudes and behaviour that endanger the health and well being of men and their sexual partners with the advent of AIDS” (Greg et al 2000:23)

In this context, and in line with a number of social scientists, this thesis has highlighted how in order for HIV/AIDS risk prevention efforts to be effective, it is imperative to investigate individual behaviour as guided by shared cultures and the social, political and economic contexts within which the AIDS epidemic is occurring (Ankrah 1993, Schoepf 1995, Farmer 1997). However, in relation to the social construction of

masculinity and the risk of HIV/AIDS transmission in marital relationships, this study found that there were no specific health promotion activities being carried out in Zambia to address the social factors that enhance men's risk of infection or HIV/AIDS transmission in marital relationships. At the same time, even though specific aspects of men's sexual behaviour have been identified as enhancing the risk of HIV transmission, programmes to date have not attempted to challenge any of the contextual determinants of this behaviour. Instead, the emphasis of many programmes has been primarily on simply emphasizing condom use and education on the biology of HIV/AIDS (Gupta, 2000a).

The thesis has also set out evidence that men and women who are economically disadvantaged are less likely to have information about HIV/AIDS than those from higher income levels and are therefore more vulnerable to infection. Similarly, women and men who are economically vulnerable are less able to negotiate the use of a condom or fidelity with a non monogamous partner and less likely to leave relationships that they perceive to be risky because they lack the bargaining power and fear abandonment and destitution (Gupta 2000a, 2000b; Heise 1998).

In the light of these findings, for health promotion to effectively address the rapid spread of infections in rural Zambian districts, this thesis argues for a more holistic approach to the societal factors that contribute to the spread of the epidemic. Noting the poor social and economic situation in Zambia, the ability to address some of the societal factors that shape and influence men's sexual behaviour and the risk of HIV/AIDS will remain daunting. This is because interventions to address some of these factors will be outside the traditional sphere of public health and will require

investment in infrastructure development and collaboration across multiple sectors of society (Sumartojo 2000a, 2000b). For instance, reducing the levels of poverty in areas of the country which have been associated with the spread of the epidemic requires massive investment in all sectors of human development (Kelly 2005). At another level, this might require the involvement of the Government, including changes in laws and policies, increased health and education services for populations at risk and changes in funding priorities. This will also require the involvement and participation of service organisations, business, and workforce organisations.

Although the best option for reducing the risk of infection would be a vaccine or cure for HIV/AIDS, this is not expected to be available in the near future, efforts to reduce the spread of and impact of HIV/AIDS still need to be geared towards changing high risk behaviour. Based on this analysis, this might be best achieved through health promotion efforts that are supported by a contextual analysis of sexual behaviour hence the need for a community-based approach.

The following three project initiatives constitute examples of approaches that embody awareness of such issues. The relative economy of resources they require, and the pre-existence of health promotion networks in rural Zambian communities suggest that it is feasible to translate similar projects to Zambia.

- 1) The Mexican affiliate to the International Planned Parenthood Federation has started focusing on publicizing possible attributes of new forms of masculinity as a response to macho hegemonic models of masculinity. Materials concerning new perspectives about 'what it means be a man' are being created and disseminated,

which incorporate the expression of affection and emotionality in men and participation in activities that are traditionally viewed as women's domain, for example child and household responsibilities.

In relation to domestic violence and the risk of HIV infection, there are a number of programmes internationally that are working directly with men, while most initiatives addressing domestic violence have previously targeted women. Wood and Jewkes (1987) have argued that the focus should be widened to consider male involvement in raising awareness of the negative impact of domestic violence. They continue by saying that by neglecting to work with men and concentrating solely on providing crisis support for female victims through counselling, giving shelter or help with court interdicts, programmes thereby unwittingly promote the idea that violence is only a women's issue.

In an analysis of project interventions Leye (2001), describes the '5 in 6' project, in Cape Town, South Africa, as aiming to prevent violence against women and which has the innovative approach of helping women and involving men. The starting point is the assumption that although 1 in 6 women are victims of violence in South Africa, the majority of men do not abuse their partners. Hence the '5 in 6' project decided to work with these men, instead of focusing resources on programmes that target perpetrators of violence. The '5 in 6' project involves both men and women from the community in fighting domestic violence or other community problems, through a grassroots social movement that consists of the Daily Saving System (DSS) and an initiative called the Rolling Mass Action. The cornerstone of this double approach is that '5 in 6' believe

that women stay in abusive relationships mainly for economic reasons. These women's lives are characterised by fear due to abuse in their homes and in the wider communities.

2) The DSS collects money from the community in order to give small loans to the same community: every day seven days a week, women leaders collect money from the women in each community. The women give what they can on a voluntary basis. The amounts are then recorded in a ledger system, for each individual and for each community. Women have direct and immediate access to the money on a daily basis: they can use it for finding alternative housing, for starting a small business, for accessing a course of skills development, for their children's education or simply for buying food. The loans give women a chance to leave abusive relationships. As the leaders collect money they can speak with all the people in the community on a daily basis. This brings many private issues and secrets like domestic violence and rape out into the open. Later, when the leaders meet to record the savings, they often sit and speak to one another. This helps to identify common problems and to work together to develop effective solutions. In this way, the shared savings unite women and the community for a more effective approach to problem-solving as opposed to waiting for government intervention, police and court and protection.

3) The 'Rolling Mass Action' focuses on men who are not abusing their partners, also through a workshop programme. The goal of the workshop is to raise awareness and to mobilise men to take action and solve the problems they face at home and in the wider community, by small projects and short-term action plans. These problems can be domestic violence, rape, HIV/AIDS and crime. In the workshop, attitudes and

beliefs that support current ideas about manhood are challenged. After the workshop, the men who attended continue to gather with friends or men who live in the same community and they either repeat the workshop process or implement solutions identified by the groups. This process creates a multiplier effect by identifying and involving other 'good' men in the community. 'Good' men are personally identified, starting with one good man in the community, who then identifies other 'good' men in the neighborhood. Records are kept of men who want to get involved which allows building a network and that enables the '5 in 6' to mobilise these men in community events, petitions and matches. The 5 in 6 project has grown to a point where it now has a database of 50,000 men all over South Africa. This database allows 5 in 6 to collect baseline information upon which the intervention initiatives are based. Once this 'Rolling Mass Action' has started the women are then encouraged to start their daily saving scheme. In this way, men and women at grassroots level work together and a social movement is created to address some of the problems that both men and women are faced with Leye (2001).

According to Leye (2001), these project initiatives have given women power and confidence and together with men's involvement in the mass enrolment, it has changed whole communities and reduced the levels of violence in the communities. These examples show how community based interventions that embody the possibility of deconstructing dominant features of masculinity, in line with this thesis' core analysis can draw on the effective participation of both men and women.

## **8.5 Implications for health promotion policy and practice.**

### **8.5.1. Antiretroviral drugs: as yet a partial solution**

In the absence of a cure and or vaccine against HIV/AIDS and in view of the tragic severity of the epidemic of many households, the Zambian Government in 2002 embarked on a programme to provide Antiretroviral drugs to people living with HIV/AIDS (Zambia National HIV/AIDS/STD/TB Council 2000). Antiretroviral drugs also commonly known as (ARVs) significantly delay the progression of HIV to AIDS and allow people living with HIV to live relatively normal, healthy lives (Hubley 2002, Jackson 2002, and Panos 2001).

The Government's national antiretroviral therapy programme began in 2002 with two pilot sites at the University Teaching Hospital and Ndola Central Hospital. By July 2004, 74 health facilities in Zambia were offering antiretroviral therapy including central, provincial and district hospitals, health centers and private clinics. These were expected to increase to 397 by the end of 2005 encompassing all central and provincial district hospitals and a third of all health centers. By end of 2009, it is proposed that all hospitals and health centers in Zambia will be providing antiretroviral therapy (WHO 2004).

While the Government has demonstrated its commitment to provisioning these medicines, there are still a number of impediments to this provision of ARVs. This is largely because distributing these drugs requires money, a well structured health system and a sufficient supply of healthcare workers (Banda et al 2004, Ginwalla et al 2004). Zambia is lacking in these areas and the health care system is already overwhelmed with the increasing number of people requiring treatment. Already many thousands of people in the country are not receiving treatment for opportunistic

infections which affect people whose immune systems have been weakened by HIV infection.

At the district level there is evidence that the antiretroviral drug programme has greatly enhanced the quality of life of many people receiving treatment (Banda 2002, IMF 2005). The large scale distribution of these drugs is however hampered at the district level by the poor healthcare infrastructure and a shortage of medical professionals that are able to administer the drugs (Ginwalla et al 2004). Another major challenge is ensuring that drugs are continuously supplied to these areas. This is particularly important because once a person starts to take ARV's they have to take them for the rest of their life. If for instance, their local hospital runs out of ARV's, the interruption that this causes in their treatment could result in them becoming resistant to the drugs (Banda, 2002).

In view of the limitations that the Antiretroviral drugs programme is faced with in mitigating the social and health impact of the HIV/AIDS epidemic, Health promotion activities suggested there still remains a key opportunity for behaviour change in minimizing the risk of infection spread.

#### **8.5.2 Approaches based on study findings**

This study has recognized that there are many different strategic approaches that can be utilised to promote and foster male participation in HIV/AIDS risk prevention efforts. Nevertheless, drawing together the main theoretical and empirical strands of its analysis it proposes that health promotion policy and practice needs, on a community basis, to be characterised by the following stadpoints if it is to raise men's critical

consciousness concerning their role in the HIV/AIDS equation, and address HIV/AIDS transmission in marriage in rural Zambia, more effectively..

- 1) Recognition that masculinity comprises a complex process of social construction, resulting in varied values and beliefs that underlie men's behaviour. It is not an homogenous set of characteristics shared by all men.
- 2) The assemblage of meanings and behaviours which constitute masculinity are derived from values, norms and prescriptions current within a particular culture and locality.
- 3) Awareness that masculinity results from such a socially constructed process means that health promotion can work towards deconstructing some of the harmful notions of masculinity that enhance the risk of HIV/AIDS. For such an approach emphasizes that the sexual behaviour available to both men and women can, in the light of the tragic consequences of the epidemic be re-evaluated and diversified. Of course such a process would take time to happen, but social constructionist perspectives open up opportunities for and possibilities of transformation, and the issue of men and women's responsibility for their own sexuality.

As pointed out in Chapter five this approach to addressing the risk of HIV is what the UNAIDS describe as value transformation (Rice 1996). This is a process through which individuals and communities critically reflect on the content of their indigenous knowledge in relation to their human and sexual rights and transmission of HIV/AIDS. This process of intervention will entail bringing together groups of married men and

women in the community to critically analyse the process of the risk of infection and the impact of HIV/AIDS on a family.

It draws on problem-solving and conflict resolution reflecting – as discussed earlier - Freirian pedagogy of 'conscientisation' (Helman 2000), which calls for raising self-reflecting awareness rather than educating or indoctrinating people. According to this theory, action for social change requires an educational process in which participants develop a critical awareness of the circumstances influencing their lives, reflect on what this means in their individual and communal situation and decide what action would be most important and feasible to take. The considered, and informed nature of the feedback from participants in Petauke, together with their numerous comments challenging traditional and contemporary social norms indicates that such an approach has real potential.

In order to set this process in motion there are a number of implications for health promotion policy and practice.

- 1) As a starting point, health promotion programmes need to develop a strategic framework, which specifically addresses the role of men in relation to the risk of HIV/AIDS transmission in heterosexual marital relationships. This thesis endorses the viewpoint of several authors who believe that involving men in this task is an ideal starting point. It helps men begin to question concepts of masculinity and the influence this has on their daily lives and those of women, for example concepts that breed violence against women (Cornwall 1997).
- 2) In order to carry forward these initiatives, service providers need to be trained in greater awareness of the social construction of masculinity and how it

interconnects with male behaviour and unequal gender relationships. The purpose of the training would be to help the service providers better understand gender roles, gender equity, and healthy relationships. Training opportunities would also highlight the effect of gender issues on reproductive health, sexual and domestic violence, and HIV/AIDS. This would emphasize in turn, the need to foster constructive male involvement in reproductive health by addressing certain attitudes and behaviours.

Engenderhealth and the Planned Parenthood Association of South Africa (PPASA) have found that addressing gender issues and violence against women were critical to improving the reproductive health of both men and women in South Africa. For example, both organizations found that in order to help men prevent HIV transmission, dialogues about gender relations, partner communication, relationships, power, and violence were essential. Simply providing reproductive health information to men in isolation from the social contexts in which men and women interact has proved to be ineffective.

- 3) Outreach activities should consider enhancing couple counselling, separate male and female counselling and groupwork activities in districts such as Petauke. This is key to greater male involvement – alongside women's involvement - in reproductive health issues, including domestic violence and condom use. These initiatives may include using teams of male/female field workers, training service providers to counsel couples, holding community

activities that attract both men and women or men and women in separate groups. The programme interventions should also consider the importance of ensuring that both men and women can be provided with services individually, or separately if either men or women so require. Becker and Joseph (1974) have previously observed that given the predominance of unequal gender relations, programmes that use a couple approach must be carefully designed so as not to jeopardize woman's decision-making and self-determination when they do not agree with the male partner. Since the concept of male involvement is new, especially in the developing countries, careful planning is necessary to underpin making the case in the community concerning its vital importance.

To translate these programme activities into rural Zambia, they require support, the necessary resources and a political commitment from the Government, as well as from both the civic and community leaders. At the same time, in order for health promotion activities to effectively undertake these suggested programme initiatives, there is a need for the project initiators to develop strategic partnerships with community-based organizations that can collectively work together to mobilize men for behaviour change.

Running throughout these strategies, emphasis needs to be placed on enhancing male awareness that they pay a high price for trying to live according to the

hegemonic model of masculinity that represses their feelings and generates insecurity, frustration and health problems.

## **8.6 Implications for further research**

This study has taken one step in understanding and providing an explanation of the interconnection between the social construction of masculinity and its impact on male HIV/AIDS related sexual behaviour. It has also examined more specifically the association between the social construction of masculinity and domestic violence as a risk factor in HIV/AIDS transmission, as well as the use and neglect of use of condoms as a measure of protection against the risk of HIV/AIDS in marital relationships in rural Zambia.

While, as has been reflected in the thesis, there is no doubt that male HIV/AIDS risk-taking behaviour is at the centre of the spread of the epidemic, it is equally important to recognize that there are a number of other aspects of Zambian rural life to which the spread of the HIV/AIDS epidemic can be attributed. The problem of HIV/AIDS is not only a social, medical or health issue, it is a development problem requiring a multi-sectoral approach, including e.g. economic initiatives, for an effective and sustainable response.

For example, in Zambia as in many other sub-Saharan countries, the spread of the HIV/AIDS epidemic has been closely associated with the widespread poverty that

many people are faced with. Most Zambian rural communities are inhabited by the poorest of the poor. In many of the rural areas, there are a number of socio-economic factors almost entirely outside the control of most people in rural communities that makes them vulnerable to infection. These include:

- Prior to HIV infection the poor may have their immunity depressed because of poor health and nutrition status
- Poor sanitation
- Limited access to healthcare; inability to pay for or access healthcare services
- Increased exposure to other health hazards such as Malaria, TB or gastrointestinal problems
- A greater likelihood of untreated STI's
- An absence of information about their own HIV status or that of their sexual partner
- An increased possibility of high-risk behaviour because of limited ability to access and store condoms correctly (in addition to major constraints on opportunities to use them properly)
- Economic pressure to resort to the sale of sex to generate household income.

In addition, the poor constitute the majority of those who migrate from place to place in search of economic opportunities and better living conditions. In this way, the poor carry the burden of their HIV vulnerability with them. As Cohen (1999), and Kurschner (2001) have further argued, poor people are more vulnerable to HIV/AIDS because of the conditions of their lives. Poor people have less access to health care and if they

have AIDS, they experience less access to antiretroviral therapy. AIDS makes the poor poorer. Attempts at solving the spread of the epidemic must also be grounded in addressing factors associated with poverty.

Against this background, attempts to address the spread of the epidemic therefore need to embrace a much broader spectrum of issues and a requirement to broaden our horizons to begin to deal with prevention, treatment and mitigation of HIV/AIDS in ways that take into account the roles played by poverty, poor education, and poor health facilities. For this reason, the epidemic transcends many different disciplines. This study has presented many valuable points, drawn from its process, evidence and analysis. However, it is important to emphasize in this conclusion, that this study only provides a partial understanding of the multiple social factors involved in the spread of the epidemic in rural Zambia and Petauke district in particular.

In order to have a more detailed understanding of the variations in attitudes and behaviours that expose both men and women to the risk of infection, research needs to address the issues identified in this study, but also needs to go beyond these.

## **8.7 Conclusion**

Through a detailed case study of Petauke district and analysis of wider literature, this study indicates that one key factor in the risk of HIV infection through marital

heterosexual intercourse in rural Zambia is how masculinity is socially constructed. A complex interplay of individual and interpersonal perspectives and behaviours informs the power dynamics and the sexual behaviour of both men and women in relation to the risk of HIV infection in marital relationships. These also reflect traditional and contemporary ideals and are also specific to current times and local contexts, while being enacted against harsh and unequal wider socio-economic conditions.

To change sexual behaviour influenced by such a complex variety of social factors is more than a matter of straightforward behaviour change and the distribution of knowledge. It requires health promotion to work towards challenging some of the harmful ideologies associated with being a man, that expose men to the risk of infection, as well as men and women to the risk of HIV/AIDS transmission in marital relationships.

In order to achieve this, a variety of factors that promote and foster unequal gender relationships, and notions about what constitutes a real man that encourage risky behaviours, must be targeted. Since notions of what it means to a man and or a woman are social processes which are socially constructed within a particular historical and social context, health messages directed at men must go beyond merely looking at the individual and his ability to act autonomously. These messages must attempt to deconstruct stereotyped perceptions and values that promote HIV/AIDS risk taking sexual behaviour, while at the same time impeding the use of condoms. Actively involving men in implementing these strategies may enhance their uptake and effectiveness.

This study acknowledges that social change cannot be achieved easily or quickly. neither can it be imposed upon an unwilling populace. It proposes that through intensive locality based campaigns, involving both men and women as active participants, the social construction of ideas and behaviours concerning male responsibility can be modified, and changes result in a healthier way of life for both men and women in heterosexual marital relationships in rural Zambia.

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## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti retroviral drugs
AVSC	Association for Voluntary Surgical Contraception
CBoH	Central Board of Health
CSO	Central Statistics Office
DFID	Department for International Development (United Kingdom)
FGD	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
IEC	Information Education and Communication
MCH	Maternal and child health
MoH	Ministry of Finance
MoFED	Ministry of Finance and Economic Development
NGO	Non Governmental Organisation
MoCA	Ministry of Agriculture and Co-operatives
MTCT	Mother to Child Transmission
PPAZ	Planned Parenthood Association of Zambia
SAFAIDS	Southern Africa AIDS Information Dissemination Service
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nation Development Programme
UNFPA	United Nations Fund For population Activities
VCT	Voluntary Counseling and testing
WHO	World Health Organisation
YWCA	Young Women Christian Association
ZDHS	Zambia Demographic Health Survey
ZSBS	Zambia Sexual Behaviour Study

THE UNIVERSITY OF  
**WARWICK**

**TO WHOM IT MAY CONCERN:**

Dear Sir, Madam,

**RE: INTRODUCTION LETTER.**

This letter serves to introduce Mr. Clement Lumuel Sakala a research student in the School of Health and Social Studies at the University of Warwick, where he is studying for a PhD in Primary Health Care and Management. Clement works for the Planned Parenthood Association of Zambia and is in the country to conduct fieldwork for his research study. The conducting and writing up of his research topic is part of the requirement in fulfillment of the PhD programme.

The topic for his research project is **“Men and HIV/AIDS in heterosexual Marital relationships in rural Zambia:** the study will be conducted as a case study in selected study sites in Petauke District in the Eastern province of Zambia.

The aim of the study is to explore the Association between the social construction of masculinity and the risk of HIV/AIDS in heterosexual marital relationships in rural Zambia. It is focused on examining the connection between the wider social economic conditions and cultural context in rural communities and on how this intersects with the risk of HIV/AIDS in heterosexual marital relationships. Further, the study specifically explores the interconnections between domestic violence and HIV/AIDS transmission in marital relationships. In addition the study goes on to examine how dominant ideologies of masculinity are reflected in men’s use of condoms as a measure of protection against the risk of HIV/AIDS transmission in heterosexual marriages.

While primarily focused on men, the study will also seek information from married women on men’s attitudes HIV/AIDS risk taking behaviour amongst men in heterosexual marital relationships. It is expected that the outcome of this study will contribute towards other efforts in Zambia in mitigating the further spread of the epidemic in Zambian rural communities.

We will gratefully appreciate any assistance that you can provide to Clement in carrying out his fieldwork for the research project.

Yours sincerely, Dr Hilary Hearnshaw

## Appendix 3

There follows a letter from the Petuake Health Board

Telephone: 063 71075  
Teletax: 063 71029



In reply please quote

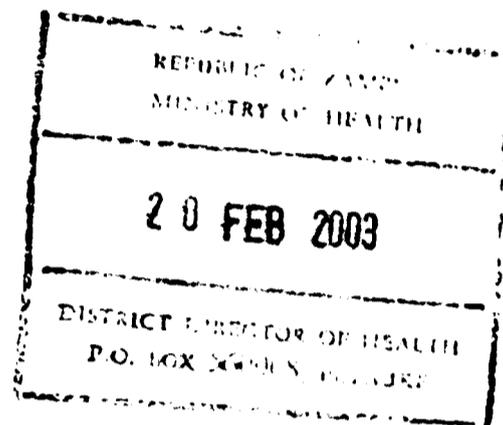
No. \_\_\_\_\_

REPUBLIC OF ZAMBIA - MINISTRY OF HEALTH  
**PETAUKE DISTRICT HEALTH BOARD**

OFFICE OF THE DIRECTOR

P.O. BOX 560008

Petauke



20<sup>th</sup> February 2003.

Dr Hilary Hearnshaw,  
School of Health and Social studies  
University of Warwick,  
Coventry,  
United Kingdom

Dear Dr Hearnshaw,

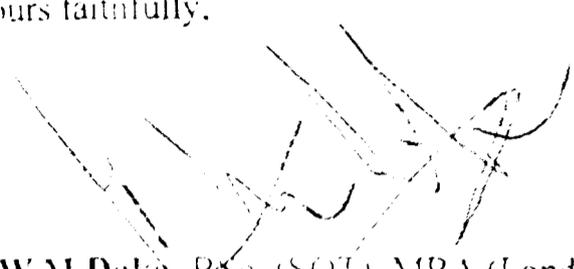
This letter serves to confirm that Mr. Clement Sakala a Doctoral Research Student in the School of Health and Social Studies at the University of Warwick, Coventry, United Kingdom visited Petauke District for the purpose of Data collection for his research topic **'Men and the risk of HIV infection in Heterosexual Marital Relationships'**

During the period of his stay, Mr Sakala interviewed a total of thirty married male respondents from four different sites. These were Mumbi, Phamba/Zuze and Muzuma Villages. He in addition held focus group discussions with two groups of women at Kaulu Primary School at Chief Kalindawalo's palace and Kavumbe Primary School. Two local female assistants assisted him to conduct the focus Group Discussions.

Mr Sakala was accompanied all throughout the data collection exercise by Mr Victor Kamulaza the District Reproductive Health and Family planning supervisor who assisted him in coordinating the research logistics and in gaining entry into the communities

Mr Sakala had a successful data collection exercise and we wish him success in his studies.

Yours faithfully,

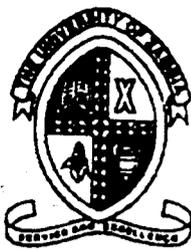


**E. W. M. Daka, BSc. (SOT), MBA (London)**  
**DISTRICT DIRECTOR OF HEALTH**

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## Appendix 4

There follows a letter from the University of Zambia



THE UNIVERSITY OF ZAMBIA  
**INSTITUTE OF ECONOMIC AND SOCIAL RESEARCH**

P.O. Box 30900

Lusaka

Tel: 294131/294673

Fax: 294291/253952

E-Mail: [INESOR@Zamnet.zm](mailto:INESOR@Zamnet.zm)

3rd October 2002

The University of Warwick  
School of Health and Social Studies  
Centre for Primary Health Care Studies  
Coventry  
United Kingdom

**Att: Dr Hilary Hearnshaw**

Dear Dr Hearnshaw

**RE: MR CLEMENT LUMUEL SAKALA**

This letter is meant to confirm that we received Mr. Clement Lumuel Sakala, your PhD student in Primary Health Care Management, who was conducting research for his study project on **'Men and the risk of HIV infection in heterosexual marital relationships in rural Zambia.'**

Mr. Sakala spent quite a lot of time in our Documentation and Information Centre, collecting data on various aspects related to his area of study.

Our Centre stocks numerous research materials in the field of HIV/AIDS in addition to information in other areas of study. These documents provide a very good source for background data for undergraduate and post-graduate students as well as researchers.

During his frequent visits, Mr. Sakala managed to access many of these documents from which he was able to acquire the necessary data.

You may be interested to know that on all occasions that he utilised the Centre, Mr. Sakala displayed an admirably high sense of respect, enthusiasm and seriousness. It was a source of much inspiration that we were able to work with him.

We wish Mr. Sakala success in his academic pursuits and look forward to being of further assistance in future.

Yours Sincerely

*Stephen M. ...*

*M. ...*

**Head**

**Documentation and Information Centre**

## Appendix 5: Photos from the fieldwork



This is the view of communities where I conducted my field work for the study



Sometimes the roads were impassable and the bridges were washed away



Sometimes this required contributing to local community work to repair the roads.



Sometimes it all seemed too impossible to continue with the field work as the roads were impassable



The family which hosted me during the field work



An interview in progress



Some of the research assistants from the local district health management board who helped facilitate focus group discussions with women.



Focus group discussion in progress



Community members who met with me after the focus group discussion to express concern for HIV/AIDS in the community



The research assistants found time to answer questions from women on HIV/AIDS in a relaxed environment after the focus group discussions



A community leader explains the impact of HIV on the community



Community members who helped me to find my way during the data collection exercise.

**University of Warwick  
School of Health and Social Studies**

**INTERVIEW GUIDE FOR THE RESEARCH STUDY ON**

**'MEN AND HIV/AIDS IN HETEROSEXUAL MARITAL RELATIONSHIPS IN  
RURAL ZAMBIA: A CASE STUDY OF PETAUKE DISTRICT'**

01 QUESTIONNAIRE IDENTIFICATION NUMBER

02 DISTRICT \_\_\_\_\_

03 VILLAGE \_\_\_\_\_

04 SITE \_\_\_\_\_

**Introduction:** My name is Clement Sakala, I work for the Planned Parenthood Association of Zambia. I am presently studying at the University of Warwick, in Coventry in the United Kingdom where I am reading for a research Degree in Primary Health Care Management. The topic for my research is **'Men and HIV/AIDS in heterosexual marital relationships in rural Zambia: a case study of Petauke district'**

The aim of the study is to explore the association between the social construction of masculinity and the risk of HIV in heterosexual marital relationships in rural Zambia. It is further concerned with exploring issues around gender, power relations, and men's sexual behaviour with the view to understanding some of the dominant factors and influences that enhance and hinder some men from protecting themselves and their partners from the risk of HIV infection.

While primarily focused on men, I will also be collecting information from two mixed group of married and divorced women and those separated (in and from heterosexual marital relationships) on their perceptions and experiences of men's attitude and sexual health behaviour with regard to the risk of HIV in heterosexual marital relationships.

I am glad that you have spared your time from your other commitments to attend this exercise. Please be assured that your presence here is very important and every thing you say will be treated in confidence.

In this interview, I will be interested in all ideas, comments and suggestions that you can offer. There are no right or wrong answers in this interview. All comments are welcome and will be greatly appreciated. The information that I am collecting is intended to help better understand men's sexual health and behaviour in order to design and develop better programs aimed at addressing the problem of HIV AIDS in heterosexual marital relationships.

**Confidentiality and consent:**

I am going to ask you some very personal questions that some people may find difficult to answer. Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any information that you tell me. You do not have to answer any questions that you do not want to answer and you may end the interview at any time that you want to. However, your honest answers will help me to better understand what men think, say and do in regard to their health and sexual behaviour. I am in this discussion only talking to women in heterosexual marital relationships, those who are separated or divorced. Do you qualify?

The interview will take about two hours and I will record the interviews using a tape recorder for a detailed analysis at a later stage. Would you be willing to participate?

---

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

**Interviewer Visit**

	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Result			

Result codes: Completed 1; Respondent not available 2; Refused 3; Partially completed 4; Not completed due to Language 5; Other 6;

05 INTERVIEWER NAME \_\_\_\_\_

06 DATE INTERVIEW     /     /

07 LANGUAGE USED \_\_\_\_\_

**(All information will be explained in the local language)**

**SECTION 1: SCREENER****1. SOCIAL DEMOGRAPHIC PARAMETERS**

The questions in this section will be used as a screener to ensure that the participants to the focus group discussions qualify and conform to the desired characteristics.

**1.1 Occupation.**

- a) What type of job do you do?

- 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....

**1.2 Education**

- 1. Have you ever attended formal school
- 1.2 Yes if No skip question 1.3
- 1.3 What highest level of education did you complete?

- a) Primary
- b) Secondary
- c) College
- d) University

**1.3 Marital Status**

- 1.3.1 What is your marital status, are you married, widowed, divorced or separated.

- a) Married
- b) Widowed
- c) Divorced
- d) Separated

**1.3.2 For how long have you been :**

**Married?**

- a) One - two years
- b) Two - three years
- c) Three - Four Years
- d) Four - Five years
- e) Five - Six years

**Widowed ?**

- a) One - two years
- b) Two - three years
- c) Three - Four Years
- d) Four - Five years
- e) Five - Six years

**Divorced ?**

- a) One - two years
- b) Two – three years
- c) Three - Four Years
- d) Four - Five years
- e) Five – Six years

**Separated ?**

- a) One - two years
- b) Two – three years
- c) Three - Four Years
- d) Four - Five years
- e) Five – Six years

**1.4 Religion**

**1.4.1 What is your religion?**

- a) Church of God
- b) Apostolic
- c) Muslim
- d) Seventh Watchtower
- e) Catholic
- f) Church of Day Adventist
- g) No religion
- h) Other (specify.....)

**1.4.2 How old are you?**

- a) .....
- b) Don't know
- c) If year of birth is not known, can you tell me any important event/famous event that occurred during the year you were born
- d) List events:
  - I. ....
  - II. ....
  - III. ....

**1. The next questions ask about individual, societal and institutional factors which influence the social construction of masculinity in heterosexual marital relationships**

- a) How would you describe a man and what are the factors that influence male behaviour and attitudes in this community.
- b) What role and responsibilities do men play in heterosexual marital relationships?.....  
 .....  
 .....

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.....

c) What are the reasons that cause men to assume this role in heterosexual marital relationships?

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d) What do you think are the individual reasons that cause men to play this role?

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e) What are some of the societal reasons that influence men to play this role?

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f) What are some of the institutional factors the influence men to play this role

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g) Do you think that poverty that many people in marital relationships experience has an influence on men's sexual health and behaviour in marital relationships and how does this occur?

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h) What is the community opinion of a man who does not meet the expectations of the perceived role that you described in the first question?.....

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i) Do you in your opinion think that this is a proper role that men should play in heterosexual marital relationships and why?

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**2. The next questions aim to explore the association between the social construction of masculinity and the risk of HIV transmission in heterosexual marital relationships?**

a) Would you know if some men in this community have a sexual relationship with other women other than their marital partner.....

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b) With whom do they usually have a sexual relationship with.....

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- .....  
.....
- c) Why do they have a sexual relationship
  - d) How many sexual partners do men normally have in this community.....  
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.....
  - e) What do other men think of a man that does not have a sexual relationship with another sexual partner other the wife.....  
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.....

**3. The next questions aim at ascertaining married men's men knowledge and perceived risk of HIV infection in heterosexual marital relationships.**

- a) Have you ever heard of HIV infection and what do you understand by the term.....  
.....  
.....  
.....  
.....
- b) Have you ever heard of AIDS and what do you understand by the term ?.....  
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- c) What is the difference between being infected by HIV and having AIDS ?.....  
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.....

d) Do men know that they can catch an infection from an infected sexual partner

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.....

e) Do men know that they can pass on the HIV infection to their wives and partner

?.....  
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.....

f) What do men do to avoid catching the HIV infection from their sexual partners

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g) What are the local beliefs associated with having HIV/AIDS?

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.....

h) Do you know of any safe practices that a man can use in preventing HIV infection in a marital relationship?

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.....

i) Do men use condoms in a marital relationship YES NO

- i. If yes, why do they use condoms in a marital relationship and what is the difficulty in using them?.....  
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.....  
.....
  
- ii. If no, why do men not use condoms in a marital relationship.....  
.....  
.....  
.....  
.....
  
- iii. Do married men use condoms with their other sexual partners?
  
- iv. If yes, why do they use condoms in a marital relationship and what is the difficulty in using them?.....  
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- v. If no why do men not use condoms in a marital relationship?.....  
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- vi. If Condoms were to be used in a marital relationship who has the stronger influence in introducing their use in a marital relationship and why?.....  
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**4. The next questions are intended to obtain information on the various health promotions interventions and practices being carried out in addressing some of the gender and sexual health concerns in relation to the risk of HIV infection in heterosexual marital relationships?**

I. What are some of the current health promotion activities being carried out to address the problem of HIV infection in the community?.....  
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II. Are there any programmes that target men?  
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III. What is the level of men's involvement in programmes aiming at creating awareness in preventing the spread of HIV infection in the community.....  
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IV. Are there any problems in involving men in health promotion activities aiming at preventing the spread of HIV infection in the community?  
?.....  
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V. What are some of the health promotion activities that you think should be undertaken in order to engage men in HIV/AIDS risk prevention.

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.....

**CONCLUSION**

Thank you very much for the time that you have spent with me and in discussing the issues, which were raised in this discussion. Do you have any other information pertaining to the subject of this discussion which you feel is important that I should know about?

**University of Warwick  
School of Health and Social Studies**

**FOCUS GROUP GUIDE  
FOR WOMEN**

**RESEARCH TOPIC**

‘MEN AND HIV/AIDS IN HETEROSEXUAL MARITAL RELATIONSHIPS IN  
RURAL ZAMBIA: A CASESTUDY OF PETAUE DISTRICT’

- 01 DISTRICT \_\_\_\_\_
- 02 VILLAGE \_\_\_\_\_
- 03 SITE \_\_\_\_\_
- 04 DATE FOCUS GROUP DISCUSSION HELD \_\_\_\_\_
- 05 NUMBER OF PARTICIPANTS \_\_\_\_\_
- 06 DESCRIPTION OF GROUP \_\_\_\_\_

**Introduction:** My name is ....., I and my colleague’s is .....and she will be taking notes in the course of the discussion. We are both research assistants working with Mr Clement Sakala who works for the Planned Parenthood Association of Zambia and is conducting a study in this community to explore the association between the social construction of masculinity and the risk of HIV in heterosexual marital relationships in rural Zambia. The study is further concerned with exploring issues around gender and power relations, men’s sexual behaviour and factors that influence to be at risk of catching AIDS and passing it on to their marital partners in heterosexual marital relations.

The topic for which the data is being collected is ‘**Men and HIV/AIDS in Heterosexual Marital relationships in Rural Zambia**’. The study is being carried out in selected study sites in Petauke district.

All through out the study we shall be interested in obtaining information that will help to understand some of the dominant factors and influences that enhance and hinder some men from protecting themselves and their partners in marriage from the risk of HIV infection.

We are glad that you have spared your time from your other commitments to attend this exercise. Please be assured that your presence here is very important and every thing you say will be treated in confidence.

During this discussion we shall be interested in all ideas, comments and suggestions that you can offer. There are no right or wrong answers in this interview. All comments are welcome and will be greatly appreciated.

**Confidentiality and consent:**

I am going to ask you some very personal questions that some people may find difficult to answer. Your answers will be kept completely confidential. Your name will not be written on this form and will never be used in connection with any information that you tell me. You do not have to answer any questions that you do not want to answer and you may end the interview at any time that you want to. However, your honest answers will help us to better understand what men think, say and do in regard to their health and HIV/AIDS risk taking sexual behaviour.

The interview will take about two hours to ask question and I will record the interviews using a tape recorder for a detailed analysis at a later stage. Would you be willing to participate?

---

(Signature of interviewer certifying that informed  
Consent has been given verbally by respondent)

07 FACILITATORS NAME \_\_\_\_\_

08 RECORDERS NAME \_\_\_\_\_

09 LANGUAGE USED \_\_\_\_\_

**(All information will be explained in the local Language)**

**SECTION 1: SCREENER**

**1. SOCIAL DEMOGRAPHIC PARAMETERS**

**The questions in this section will be used as a screener to ensure that the participants to the focus group discussions qualify and conform to the desired characteristics.**

**1.1 Occupation.**

a) What is your occupation?

1. ....
2. ....
3. ....
4. ....
5. ....

## 1.2 Education

1. Have you ever attended formal school
- 1.2 Yes if No skip question 1.3
- 1.3 What highest level of education did you complete?
  - a) Primary
  - b) Secondary
  - c) College
  - d) University

## 1.3 Marital Status

### 1.3.1 What is your marital status, are you married, widowed, divorced or separated.

- a) Married
- b) Widowed
- c) Divorced
- d) Separated

### 1.3.2 For how long have you been :

#### Married?

- a) One - two years
- b) Two - three years
- c) Three - Four Years
- d) Four - Five years
- e) Five - Six years

#### Widowed?

- a) One - two years
- b) Two - three years
- c) Three - Four Years
- d) Four - Five years
- e) Five - Six years

#### Divorced?

- a) One - two years
- b) Two - three years
- c) Three - Four Years
- d) Four - Five years
- e) Five - Six years

**Separated?**

- a) One - two years
- b) Two – three years
- c) Three - Four Years
- d) Four - Five years
- e) Five – Six years

**1.4 Religion**

**1.4.1 What is your religion?**

- a) Church of God
- b) Apostolic
- c) Muslim
- d) Seventh Watchtower
- e) Catholic
- f) Church of Day Adventist
- g) No religion
- h) Other (specify.....)

**1.4.2 How old are you?**

- a) .....
- b) Don't know
- c) If year of birth is not known, can you tell me any important event/famous event that occurred during the year you were born
- d) List events:
  - I. ....
  - II. ....
  - III. ....

**SECTION TWO: Question Guide**

**(The following questions will not necessary be asked in the order of the progression of the Focus Group Discussion. The questions listed here are intended to provide as a guideline for the focus group discussion and the flow of the discussion will be determined by the response. Thus the questions listed below will serve as a reminder of the issues to be raised and all the questions will be followed by a series of probing questions to exhaust the direction of enquiry)**

- 1. The next series of questions are intended to enlist responses on the social construction of masculinity and gender relationship.**

- a. What would you describe to be some of the attributes associated with being a man in this community?
- b. What do you think influences and shapes male attitudes and behaviour?

**2. The next series of questions are intended to enlist responses on participant knowledge and awareness levels of the risk of HIV/AIDS infection.**

- a. What do you know about HIV/AIDS and How it is spread
- b. Are there anyways you might be personally at risk
- c. Why do you think you are at risk and what measures do you take to protect yourself

**2.2 Risk of catching HIV/AIDS**

- a. Have you ever considered that your marital partner was at risk of catching AIDS?
- b. What would be your response to such a risk?
- c. Do you discuss the risk of HIV in your marital relationship and what is the response of your husband?

**3. The next series of questions are aimed at obtaining information regarding Husbands sexual behaviour in heterosexual marital relationships**

- a) Some husbands may have (had) more than one sexual relationship; it would be very helpful if you could share some of your experience of this with me.
- b) Could I just ask if you have had this sort of experience?
- c) What are the reason do you think that your husband has had more than one sexual relationship?
- d) With whom do you think that he has had an extra marital sexual relationship (commercial sex worker, girl friend etc)

**6. The next series of questions are aimed at obtaining information on some of the dominant social cultural factors that cause men to have sex outside marriage which places them at a risk of catching HIV and in turn pass it on to their regular partners in a heterosexual marital relationship.**

- a. Would you know of any dominant social cultural factors that cause men in this community to have another sexual partner outside marriage?
  - b. What do you think can be done for men to appreciate the risks involved in having sex outside marriage which might lead to passing on the infection to their marital partners?
- 3. The next series of questions are intended to enlist responses on the experience of domestic violence in marital relationships and on how this intersects with the risk of HIV/AIDS.**

- a. How common are the incidences of domestic violence in this community?
- b. How many amongst us (study participants in the focus group discussions) have ever experienced domestic violence.
- c. How often has this happened?
- d. What are the common causes of domestic violence?

**2.3 Experience of sexual violence as a risk factor**

- a. Have you ever experienced the threat of violence or actual violence which has caused you to participate in a sexual relationship which you thought exposed you to the risk of HIV

- 4. The next series of questions are intended to explore information about the use of condoms in addressing the risk of HIV infection in heterosexual marital relationships.**

- a) We know that using a condom is not necessarily straightforward. It would be very helpful if you could share with me what you think about using condoms and also what it was like in your experience if you have ever tried
- b) Have you ever discussed the use of a condom with your husband
- c) What was the reason for having discussed the use of a condom
- d) Do you use a condom in your marital relationship and if yes why and if not why not.

- 4 The next series of question are intended to enlist information regarding current Health promotion activities and the extent to**

**which the activities are focussed on promoting male involvement and participation in HIV/AIDS prevention.**

- a) Many programmes are carried out to educate or sensitise people on the risk of HIV/AIDS, what is your opinion of such programmes?
- b) Do you think that these programmes are effective
- c) Do the programmes give information about the risk for men and the risks for women and for married couples
- d) How do you feel about such programmes?

## **1.2 Behavioural change**

- a) Do you think you or your husband has changed your behaviour or his sexual behaviour because of the various educational programmes on HIV/AIDS and understanding the risks

## **CONCLUSION**

Thank you very much for the time that you have spent with me and in discussing the issues, which were raised in this discussion. Do you have any other information pertaining to the subject of this discussion which you feel is important that I should know about?

---