Men, Masculinities and Sexual and Reproductive Health in Botswana

By

Serai Daniel Rakgoasi

A Thesis Submitted in fulfillment of the requirements of the Degree of Doctor of Philosophy

University of Witwatersrand

March 2010

DECLARATION

Except where indicated, this thesis is based upon original research conducted by the author as a scholar at the University of the Witwatersrand from November 2005 to November 2009

Serai Daniel Rakgoasi

September 30, 2010

SPONSORSHIP ACKNOWLEDGEMENT

I am deeply thankful to the University of Botswana for generously funding my studies, and for allowing me time off work to purse this degree. I will always be grateful for your support during the four years that was my leave.

I am also thankful to the Fogarty Foundation for the pre-doctoral award, which came at a time of great uncertainty about how I was going to finance the last stages of my thesis preparation. The award was timely and allowed me the space and peace of mind to complete my studies without undue worry about financial matters.

ACKNOWLEDGEMENTS

I thank God, the omnipresent, the unknowable, and unnamable for the life, guidance and protection and all the blessings in my life, and most of all for uplifting my spirit through numerous challenges.

Many people contributed towards this work and I owe mountains of gratitude each one of them. I would like to especially thank my supervisor Professor Clifford Obi Odimegwu for his constant support, encouragement and direction. I thank you Prof for your constant encouragement during many difficult moments when it would have been much easier to give up than to persevere. You were always there to nurture my belief and allowed me space to develop confidence in my abilities. Words cannot adequately express just how much you inspired me or the gratitude I feel for your mentoring.

My sincerest thanks go to the University of the Witwatersrand Research Ethics Board, for your inputs and advice on the ethical issues of this study. My thanks also go to the Human Research Ethics Committee of the Ministry of Health in Botswana for reviewing and advising on the study tools and methodology. To the staff of the Department of Demography and Population (Wits) and the Department of Population Studies (UB), thanks for allowing me the time and providing the resources necessary for this work.

I also wish to express gratitude to my colleagues at the University of Botswana who motivated and encouraged me through their insights and criticism to pursue this study. To my fellow PhD candidates at the University of the Witwatersrand, thanks for the camaraderie. To my colleagues and business partner, Joe Pitso, thanks for holding the fort during my absence, and for going through the difficulties that arose as a result of my prolonged absence. The only way I can pay you back is to ensure that ICRE sours and reaches the heights that we know it is going to reach soon! Thanks for the support and words of wisdom through the ages mate!

I wish to express the deepest and heartfelt gratitude to Rose, my wife, friend, confidante and companion, for holding the fort and keeping our family together during many challenging times when I was absent from home and the kids. Your dedication and resiliency in supporting my studies while at the same time taking care of the needs of the family made all the difference, and in the end, was the life line that allowed me to focus on my work. The challenges that we have experienced together will make us stronger. Thanks for 17 blissful years, it feels like 17days. I'd do it all over again! You are the rose in my life and I love you.

To all my children, Gomolemo, Lame and Leatile, thanks for being an inspiration in my life. To all of you, I recognize the sacrifice you made during the weeks and months that I was away from home and couldn't be there to help with your school work or play tennis, basketball or soccer together! To my siblings, Susan, Gatote, Pule and Happy – I love you all, and thanks for being there for my family during my absence. To my nieces and nephews, you are a blessing in my life and a constant source of inspiration.

To my parents, George and Lizzie - I couldn't ask for a better blessing than to have you two as my parents. You have inspired every aspect and stage of my life through your presence, patience and love. The peace and serenity that pervades your union even in the midst of life's challenges are a constant inspiration in my life, my marriage and as a father to my children. To my other three dads, Ramogolo Reuben (Chechi)[God bless his soul] and Keoreketswe (Socks BBX), to my aunts, Mamogolo Queen and Mmangwane Joyce thanks for your love, guidance and protection during those times when I didn't even know myself. I have a great balance in life because of the nurturing of my three dads and three moms. Who could ask for more? My paternal aunts Rakgadi Morwadi, Mma Bushy, MmaStokie, you are all truly special, thanks for your love and confidence in me. My maternal aunts MmaThandi and MmaDuu, I love you dearly.

ABSTRACT

This thesis investigates the role of masculinities on men's sexual and reproductive health in Botswana. Botswana is currently in the throes of a severe heterosexually driven HIV/AIDS epidemic that has eroded some of the developmental gains the country had achieved since independence. A unique feature of Botswana's HIV epidemic is the rapid and phenomenal increase in infection and prevalence rates in the face of good levels of knowledge of HIV prevention and an early and comprehensive HIV prevention strategy that guaranteed access to free HIV prevention and treatment services, including ARV treatment.

The lack of effectiveness of the country's HIV efforts and subsequent increase in infection rates have been blamed on men's risky sexual behavior and lack of support of their partners' decisions to utilize these services. In fact, quantitative studies on men's sexual behavior and HIV such as the Botswana AIDS Impact Surveys show that men are less likely to use VCT services and more likely to engage in risky sexual behavior that increases risk of HIV infection to themselves and their partners. While studies provide the evidence that implicates men in the rapid growth Botswana's HIV epidemic, the studies provide little or no explanation of factors that motivate men's behavior in reproductive health. This lack of insights on factors that motivate men's behavior leads to stereotypes about male promiscuity and may contribute to the lack of effectiveness of HIV prevention strategies.

The current HIV epidemic has thus thrust heterosexual masculinities at the centre of HIV prevention efforts and provides an opportunity for research to interrogate the role of heterosexual masculinities in reproductive health, especially HIV transmission and prevention. The thesis employs qualitative data to provide in-depth appreciation of the prevalent masculine norms and beliefs and to highlight contextual factors and processes that shape and give rise to various masculinities. It further uses quantitative data to provide measures of levels of men's masculine and gender role beliefs that may influence HIV prevention and transmission and to test the association between masculinities and men's sexual and reproductive health attitudes and practices.

The results show that men's sense of identity is socially constructed, and revolves around the notion of superiority to women, independence and having and being in control of the family. However, men face many challenges to the realization of this masculine ideal. Men's perceived difficulty or failure to live up to socially constructed

notions of masculinities affects their experience of sexual and reproductive health programs, especially women's empowerment and HIV prevention programs. By their nature, these programs tend to challenge men's dominance of women's decision on sexuality, and are therefore experienced as a threat to some men's sense of identity. Quantitative results indicate an association between masculinities and sexual and reproductive health. While men's sense of masculinities is not the overriding factor determining their sexual and reproductive health attitudes and practices, the results show a strong association traditional masculine beliefs and negative sexual and reproductive health beliefs and practices.

However, there is also strong evidence that men and masculinities are responding to contextual factors, such as the HIV epidemic, which has become a specific stress on the local construction of masculinities. In focus group discussions, many men challenged traditional masculine norms, beliefs and practices that increase their vulnerability to HIV infection and those that either encourage or condone violence within intimate relationships. Significantly high proportions of men had positive attitudes towards HIV prevention programs. It is evident that now more than ever (and thanks to the HIV/AIDS epidemic) many men are ready to question the predominant masculine norms, beliefs and practices that increase their vulnerability to infection and disease. These voices of change represent a window of opportunity for research and programs can meaningfully engage with men and masculinities on issues of sexuality, gender roles, sexual and reproductive health and HIV/AIDS prevention and transmission.

There is need for future research and interventions to move away from focusing exclusively on individual models of preventive health behaviors to more multilevel, cultural and contextual explanations. Taking account of multilevel, cultural and contextual factors that shape masculinities and men's sense of identity will ensure increased effectiveness of sexual and reproductive health programs, especially HIV/AIDS prevention programs. On the other hand, failure to account for cultural and contextual factors that shape individuals' behavior will only ensure that the shortcomings of such intervention program will continue to be blamed on the individual.

Key Words

Botswana; Masculinities; Men; Sexual and Reproductive Health; HIV/AIDS

Table of Contents

List of Tables

List of Abbreviations & Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BAIS	Botswana AIDS Impact Survey
BFHS	Botswana Family Health Survey
BWP	Botswana Pula (currency)
CEDAW	Convention on the Elimination of Discrimination against Women
CHBC	Community Home-Based Care
CSO	Central Statistics Office
EA	Enumeration Area
FGD	Focus Group Discussion
GAD	Gender and Development
GDP	Gross Domestic Product
GoB	Government of Botswana
HAART	HIV/AIDS Anti-Retroviral Therapy
HIES	Household Income and Expenditure Surveys
HIV	Human Immuno-Deficiency Virus
HSRC	Human Science Research Council
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federations
MDGs	Millennium Development Goals
MIS	Multiple Indicator Survey
MoH	Ministry of Health
MSM	Men who have Sex with Men
NACA	National AIDS Coordinating Agency
NSRHP	National Sexual and Reproductive Health Policy
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission

PPS	Probability Proportionate to Size
PSU	Primary Sampling Unit
REC	Research Ethics Committee
RHT	Routine HIV Testing
S&RH	Sexual and Reproductive Health
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UB	University of Botswana
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children Educational Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WID	Women in Development
WITS	University of the Witwatersrand

Chapter 1 Introduction and Background

It is common knowledge that in most parts of the developing world, men contribute to and influence women's sexual and reproductive health decisions. Thus, men in the developing world make important contributions to fertility and sexual and reproductive health. However, Demographic studies of fertility and family planning programs have historically focused almost exclusively on women. Under such programs, men were either not considered at all or were considered indirectly. According to Greene & Biddlecom (2000), the origins of the discipline of demography in the west, and its development and the subsequent assumptions and research on fertility heavily reflected social norms that were in place in western countries where the field was first developed. These norms emphasized women's exclusive involvement in childbearing based largely on the concept of single unsupported mother (Greene & Biddlecom, 2000).

Family planning programs tended to focus on ways in which women's contraceptive use can be increased, and paid very little attention to local social realities that differed from or challenged the western norm. Fertility and fertility regulation was therefore assumed to be the domain of women; and men were assumed to be uninterested in fertility regulation and were considered important only economically as providers. In this context, men were problematic from the outset because they maintained sexual relationships with women that often departed from the western norm (Greene & Biddlecom, 2000). Thus, by adopting strategies that sought to control population growth by directly controlling the fertility of women, the family planning movement and funding organizations have historically facilitated, sponsored and subsidized the exclusion of men from the family planning and reproductive health discourse.

The result of this almost exclusive focus on women was a void in men's perspective in sexual and reproductive health, and an "over-emphasis on male involvement in women's reproductive health [and] an oversight of men's health needs" (Odimegwu &

Okemgbo, 2005). The focus on girls and women's sexual behaviour therefore overemphasized women's responsibility for contraceptive use, pregnancy and child bearing, while the resulting lack of information on males contributed to stereotypes about male promiscuity (Greene & Biddlecom, 2000). It is now clear however, that in order to understand fertility and reproductive decision making requires information on couple communication, negotiation and the degree of men's influence on women's choices and outcomes.

For many years, the demographic transition theory, which points to a path of mortality and fertility transition that every country should eventually take towards development, has driven demographic research and interventions. The theory was used to drive and support global interventionist perspectives that targeted women's fertility as a way to achieve population control, and justified financial support to women oriented fertility control. Such an approach excluded a focus on men, even in the face of evidence that showed that in most developing parts of the world, men have a significant influence on women's fertility decision. This focus on women's fertility and exclusion of men and other contextual factors that influence women's fertility increasingly rendered the theory incapable of explaining fertility changes across a range of settings, especially developing countries where fertility and reproduction norms are unlikely to mirror those from the west. Greene & Biddlecom (2000) observe that the conceptual shortcomings of the demographic transition theory helped to generate increased interest in men's roles in fertility and a quest to understand the mechanisms and processes through which men influence women's fertility and reproductive outcomes.

The conceptual shortcomings of the demographic transition theory therefore pointed to the need for new methodologies that incorporate and are sensitive to local and contextual factors that influence fertility. According to Greene & Biddlecom (2000), methodological developments in economics, anthropology and sociology and the use of both quantitative and qualitative ethnographic data greatly influenced demographers' interest in studying men. For example, the development of econometric models of

fertility that include conflict / bargaining; power and negotiation greatly enhanced demographers' study of men's roles in fertility and reproduction (Greene & Biddlecom, 2000). This made possible, smaller, more in-depth and cultural specific studies of men's behaviour and the processes through which they influenced women's fertility and reproductive health. Such methodological developments helped to identify the varied roles of men and women in different context.

Demographic research on men's roles in reproduction has grown since the 1990s, due in part to the work of feminist scholars and women's health movement. Feminist studies on health and population policy have highlighted the importance of gender as an analytic category in studies of fertility and reproduction. By highlighting the social meanings of women's child bearing roles, the gendered nature of reproduction as well as a host of social power and gender relations that situate women differently from men in fertility and reproduction, feminist thinking has impacted the way demographers think about men. For example, feminist have shown that historically, demographic and population research on fertility has been geared towards achieving specific population control targets through increase in women's contraceptive use and lowering their fertility, without paying much attention to their social wellbeing.

In fact, the women's movement helped to shape the resolutions of the 1994 International Conference on Population and Development (ICPD1994). By shifting focus from family planning and narrow fertility regulation to reproductive health, the conference re-directed attention to the role of men in reproductive health, and thus helped to situate men's sexual and reproductive health at the centre stage of efforts to achieve better sexual and reproductive health outcomes for men, women and children.

The feminist movement also showed that gender is inextricably implicated in the development process because culturally and economically, men and women are situated differently, with unequal relationships to the provision and consumption of material goods, and different and unequal access to the political processes that guide

the development process (Kimmel 2001) Thus, development is an uneven process not only within and between nations, but between the sexes (Kimmel, 2002: xi). The paradigm shift from Women in Development (WID) to Gender and Development (GAD) represented a shift towards recognizing the need to analyze social relationships between men and women and to be aware of factors such as class, age and personal agency (Cleaver, 2001). The former approach was found to be failing to address women's strategic needs by not addressing the culturally entrenched and unequal gender and power relations. Thus, in most cases projects designed to improve women's economic situation were found to increase women's already high workload, without improving their social standing.

Gender analysis thus helped to highlight the different ways in which women are disadvantaged by certain feminine ideologies, and unequal gender and power relations. It is therefore not surprising that most efforts to address gender in development have tended to focus on addressing the situation of women. Thus, current interest in men and masculinities is in part, an offshoot of the feminist movement's interrogation of social asymmetries based on sexual differentiation between men and women. In the developed countries, the gay rights movement's demand for a re-consideration of the social construction of sexualities and sexual identities also contributed to the interest in the study of men and masculinities.

While men currently feature in demographic research, they are nevertheless usually studied as accessories to women health, rather than as objects of study on their own. The different approaches aimed at promoting men's involvement in reproductive health reflect the fact that men are seen primarily as a problem, or a means to an end, and this over-simplistic view of men makes them averse to participation in these programs (Odimegwu & Okemgbo 2005).With a few exceptions, men are rarely explicitly mentioned in the gender policy documents, and where they are considered, they are generally seen as obstacles to women's development' (Cleaver, 2001:1). Cleaver (2001) notes that where men are considered in gender policy, the motivation for doing so is to

secure benefits to women, and argues that the assumption that a focus on men is justified in terms of securing benefits to women is linked to simplified ideas about power and gender relations. This simplified approach pays little consideration to the mechanism for equalizing the power relations between men and women; or incentives that will prompt men to participate in women focused projects or how men's participation in such projects will impact men and gender relations (Cleaver, 2001).

Men's behaviour, just like that of women, is constrained by traditional expectations about gender; and dominant versions of masculinity exert a powerful effect on boys and men to conform to sometimes destructive ideas about what it means to be a man (WHO 2000). However, while it is generally acknowledged that gender based customs and ideas promote and influence men's (and women's) sexual and reproductive behaviour, there is a lack a notable lack of research on men's understanding of these gender based issues and how they impact on men's health, especially in sub-Saharan context (Eschen 1999 in Odimegwu et al., 2005).

There currently exist a growing body of literature and research on the relationship between gender and gender role ideologies and sexual and reproductive health (Courtenay 1998; 2000; 2003; Dixon-Mueller 1993; Sternberg, 2000; Sternberg & Hubley 2004**;** Inhorn 2004) Less numerous however, are studies that relate to the experience of men in developing countries, especially in Southern Africa. The bulk of studies theorizing masculinities focus on the experience of men in northern industrialized countries, and with a few notable exceptions, studies of men in the south are predominantly exotically ethnographic or historical accounts (Cleaver, 2001).

In Botswana, the HIV/AIDS epidemic has placed male involvement at the centre of policy and programmatic efforts to control the spread of the epidemic. Interest in men's participation in health and men's reproductive rights in Botswana came about as a result of increased feminist activism following the ICPD 1994 and Beijing 1995 conferences. One of the issues coming out of these conferences was the necessity of

greater male participation in the promotion of sexual and reproductive health rights. Thus, the need to control the spread of the HIV epidemic has crystallized the importance of men's sustainable involvement prevention, treatment and care efforts, and the need to understand male behaviour and motivation.

HIV/AIDS intervention efforts, by their nature, present a challenge some of the ideological foundations of masculinities, which include men's control of sexuality and determining terms under which sex occurs. By advocating for and empowering women to negotiate safe sex and to refuse sex if their partner is unwilling to use a condom, and by publicly discussing issues which were hitherto decided in the private and largely patriarchal domain of the family, it can be argued that HIV presents a challenge to a masculine sphere of control. However, attention to men's reproductive health has tended to be indirect, and focused on how men facilitate or impede attainment of better health outcomes for women and children, and less on understanding men's motivation in sexual and reproductive health, or men's conception of themselves.

In Botswana, a number of nationally representative surveys1 have documented important sex differentials in health practices, attitudes and outcomes between men and women in Botswana. Findings from these studies have provided important insights into risk and disease vulnerability patterns between men and women and helped to guide and shape the country's public health policy. However, such studies are also notable for their lack of gender analysis and lack of elaboration of the impact of social and power relations on some of the observed sex differentials in health outcomes between men and women. Reproductive health problems cannot be precisely defined universally without elaboration of meaning within a particular cultural context and the experience of individuals as they negotiate healthy sexual outcomes (Dudgeon & Inhorn, 2004). These studies have thus provided sex-disaggregated data, without elaborating the gender and power relations that underpin gendered reproduction. While it is useful and convenient

[1] ***Botswana Family Health Survey I (1984, 1988); Botswana Multiple Indicator Survey (2000), Botswana AIDS Impact Survey I (2001, 2004)***

to look at differences between men and women's health in terms of differences in biologic sex, it has become clear that the most insightful investigations are those that consider gender (Brooks 2001).

Thus, while quantitative studies have managed to identify the places where men are present or absent, conditions under which they feature or do not feature in the reproductive health discourse, and how they influence women's sexual and reproductive health outcomes (Figuerora-Parea, 2003). For example, in Botswana, demographic and other surveys have documented men's high risk sexual practices and outcomes lack and demonstrated how men's risky sexual practices leads to negative health outcomes not only of men, but also for women and children. However, because these studies are quantitative, they do not offer adequate insights and explanations into the socio-cultural context within which such outcomes are achieved. For example, the studies do not explore the socio-cultural factors that govern the relationship between men and women in reproductive health or men's motivation in sexual and reproductive health.

Failing to examine the socio-cultural and other contextual factors that influence men's sexual and reproductive health is to fail to give "*due weight to the fact that men and women's lives are relational in process and outcome and that the health of each sex is influenced by socio cultural synergies between the sexes*" (Sabo, 2000). As a consequence, the socio-cultural factors that motivate men's sexual and reproductive health practices and behaviour in Botswana, specifically the role of masculinities, gender and power imbalances on men and women's sexual and reproductive health, have not been subjected to vigorous research.

Botswana's low uptake and utilization of certain sexual and reproductive health services, especially HIV Voluntary Counseling and Testing (VCT) and Prevention of Mother-to-Child Transmission of HIV (PMTCT), has been blamed in part on lack of male involvement and support for these programs. However, there is a serious dearth

of studies geared towards understanding men's motivation in sexual and reproductive health, or how norms and practices of masculinity impact sexual and reproductive health service utilization, especially HIV/AIDS prevention and care services. Thus, while the interplay between masculinities and sexual and reproductive health is critical to efforts to contain the spread of HIV, this area remains un-researched and therefore poorly understood. The HIV epidemic presents a good opportunity for the study and discussion of the impact of heterosexual masculinities on sexual and reproductive health of both men and women in Botswana. It presents good opportunity to understand men's conception of themselves and their motivation in sexual and reproductive health, and the likely impact on HIV prevention efforts in the country.

Dudgeon & Inhorn (2004) note that in order to understand a range of meanings of reproductive behaviors and beliefs within particular social and cultural contexts, there is need to focus on meaning and lived experience of reproductive health within particular local, cultural contexts. This appreciation of contextual factors is important for programs and policies that seek to attain male involvement in sexual and reproductive health and provide culturally appropriate interventions. Walter et al. (2004) documented the importance of understanding men's lived experience in understanding men's experience of injury. They found that the cultural construction of patriarchal masculinity shapes men's sense of worth and defined their experience of poverty and social marginalization.

This research will fill this gap in knowledge by examining the relationship between masculinity norms and practices and sexual and reproductive health in Botswana. The research first seeks to foster an understanding of cultural and other norms that shape men's sense of masculinities, and then explores how men's sense of masculinity mediates their sexual and reproductive health attitudes, beliefs and practices.

1.1 Background to the research

Botswana is currently experiencing an HIV epidemic that is unprecedented. In 2001, a United Nations report in estimated HIV prevalence to be as high as 38.8% of the population 15-49 years. Between 1992 and 2002 the HIV prevalence rate among women attending antenatal care aged 15 - 49 years increased from 13.8 to 35.4 percent (NACA, 2003), and reached 37.4 percent in 2003 (GoB, 2003). Recent statistics suggest that HIV prevalence rate is lower than previously estimated. Data from the most recent demographic survey indicate that national HIV prevalence of 17 percent (NACA, 2003). However the rate remains high by any standard, with certain population groups having prevalence rates that are more than twice the national rate. In all districts, HIV prevalence rates among pregnant women remains over 20 per cent, with some districts exceeding 50 per cent (NACA, 2003). The HIV/AIDS epidemic has already stated to erode gains in life expectancy and quality of life that the country had achieved since independence. Mortality across all age groups is on the rise and life expectancy has declined, and could be as low as 29 years by 2010 according to some United Nations estimates. Owing to increased HIV/AIDS related morbidity and mortality, Botswana's human development index has declined from 71 to 122 in 1999/2000 (NACA, 2003).

Botswana's HIV/AIDS epidemic is heterosexually driven. In Botswana, as it is true for most developing countries, men have a significant role in women's sexual and reproductive behavior. The epidemic has therefore thrust men at the centre of policy and programmatic efforts to control the spread of the epidemic. The need to control the spread of the HIV epidemic has crystallized the importance of the need to understand men's behavior and motivation as a means to achieve their sustainable involvement prevention, treatment and care efforts. Research all over the world points to a link between gender role ideologies generally and masculinities in particular, and poor health practices and outcomes (Sabo, 2000; Courtenay, 2002 & 2003). It is also understood that despite these generalizations, masculinities are context specific and can only be understood within a particular context (Dudgeon & Inhorn, 2004). So far no

research has explored the relationship between masculinities and men's sexual practices and health in Botswana.

1.2 Geography and Politics

Botswana is a landlocked country located in Southern Africa, and occupies a land area of 585,000km². Botswana borders South Africa to the south and south east; Namibia to the west and northwest and Zimbabwe in the north and Zambia. Most of the population and developments are found concentrated on a narrow strip along the eastern part of the country. Botswana gained political independence from Britain in 1966, and has held regular multiparty democratic elections since then.

1.3 Population size and growth

Historically Botswana has experienced rapid population growth, owing largely to high fertility and declining mortality. According to official statistics from the country's four post independence population and housing censuses, Botswana's population has grown from 574,094 in 1971 to 941,027; 1,326,796 and 1,680,863 in 1981; 1991 and 2001 respectively (CSO, 2000). These figures imply an annual population growth rate of 4.7 percent between 1971 and 1981, and 3.5 percent between 1981 and 1991 (CSO, 2000), and declines further to 2.4 percent between 1991 and 2001 (CSO, 2004). In 2008, the population was estimated at 1,921,000 people (UNICEF, 2008). Botswana's rapid population growth was a result of a combination of high fertility and fast declining mortality. For example, total fertility declined from 6.5 to 4.3 births per woman between 1971 and 1996 (CSO, 2000) and is currently estimated at 2.6 births per woman (UNICEF, 2008).

During the twenty years between 1971 and 1981, infant mortality rate declined from 97.1 to 48.0 infant deaths per 1,000 live births, and life expectancy at birth increased from 55.5 to 65.3 years during the same period (CSO, 2000). The infant mortality rate has since crept upwards, owing largely to the impact of the country's HIV/AIDS epidemic. Under-5-years mortality followed a similar pattern of decline to that of infant

mortality rate, declining from 152 to 74 deaths per 1,000 between 1971 and 2001. The combination of high fertility and fast declining mortality resulted in a young population structure, with over 40 percent of the population aged 15 years or less (CSO, 2000).

1.4.1 Health

Botswana has a modern, decentralized and highly accessible primary healthcare system, comprising an extensive network of hospitals, clinics, health posts and mobile stops. As early as 1995, 83 percent of rural population and 98 percent of urban population was within a radius of 15 kilometers from a health facility (CSO, 2000). Currently over 95 percent of pregnant women attend antenatal care and deliver in a modern health facility, attended to by qualified medical personnel (UNICEF, 2008). Botswana's HIV/AIDS epidemic represents a challenge of unprecedented magnitude and has reversed some of the gains to the country had achieved through effective health care delivery (CSO, 2000).

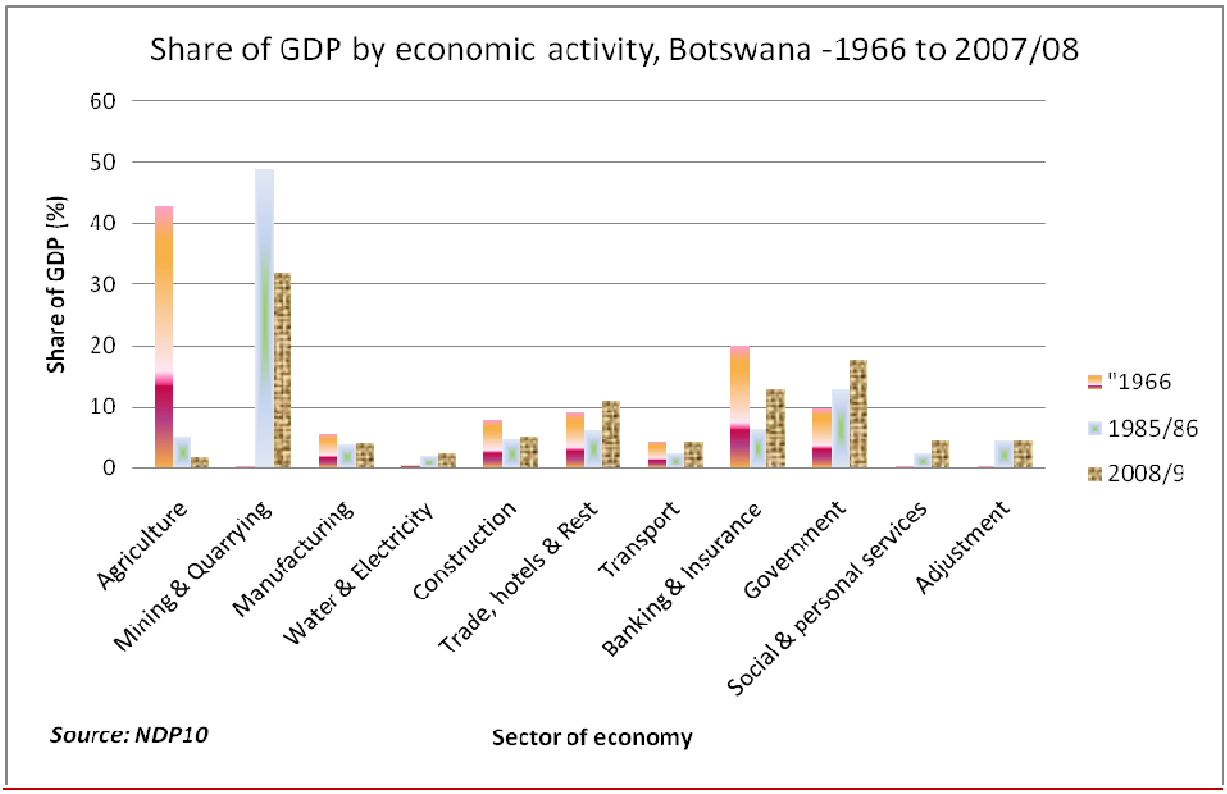
1.4 Urbanization and urban growth

Botswana has experienced rapid urbanization resulting mainly from a combination of rapid rural-urban migration and area reclassification. In 1971, less than a tenth (9%) of the population was classified as urban. This proportion increased to 17.7% in 1981 and 45.7% in 1991. As of 2001, just over half (54.2%) of the population was urban. It is currently estimated that half of the population lives within 100km of the country's capital city of Gaborone (UNICEF, 2008).

1.5 Economy

Botswana has experienced rapid economic growth since independence, especially since around the mid 1980's. In the 42 years to 2007/08, the real growth of GDP averaged 8.7 percent per year, with diamond mining, which fueled much of the growth, currently accounting for more than one-third of GDP and for 70–80% of export earnings (NDP10). The sustained economic growth has resulted in an improvement in most social indicators, and earned

the country the distinction of being one of Africa's economic successes. It is estimated that 97 percent of the population has access to safe drinking water; over 90 percent of children under one are immunized; 84 percent of children of primary school going age are enrolled in school (UNICEF, 2008).



The chart above is derived from statistics contained in the National Development Plan 10 (NDP10) shows the remarkable decline in the contribution of agriculture to GDP from 43 percent in 1966 to less than two percent in 2008. The decline in the share of agriculture's contribution to GDP was in part a result of significant growth of the mining sector. The contribution to mining to GDP increased from 0 percent in 1966 to 49 percent in 1985/6, and currently stands at 32 percent (NDP10). The decline in mining's contribution to GDP is a result of growth of other sectors rather than a decline in mining revenues per se.

1.6 Poverty

Despite Botswana's economic achievements over the last 40 years, the country still faces serious challenges of poverty compared to countries of similar economic stature. According to the Botswana Household and Income Survey (HIES) the percentage of households living below the poverty datum line has declined from 49 percent in 1985/6 to 38 and 22 percent in 1993/4 and 2002/3 respectively. During the same period, the percentage of individuals living under the poverty datum line declined from 59 percent in 1985/6 to 47 and 30 percent in 1993/4 and 2002/3 respectively (GoB 2004). The country's 2004 Millennium Development Goals Status Report identifies Botswana's poverty as a structural problem resulting from a combination factors, namely a narrow economic base, which limits opportunities for gainful employment; poor endowment of agro resources a small and sparsely distributed population. The Botswana Institute for Development Policy Analysis (BIDPA) identified a number of factors that contribute to the country's dire poverty statistic, among which are unemployment and underemployment, which are primarily determined by lack of skills; ill health, in particular HIV/AIDS, which takes people out of work (both those who are sick, and their carers), destroys accumulated wealth and creates new (BIDPA 1996).

1.7 Gender; Culture & Household Headship

Botswana has been subjected to a small but dynamic women's empowerment movement, spearheaded "*Emang Basadi*"[2]. This movement was formed in 1986 with the aim of lobbying against laws that discriminated against women and gender based inequalities. Its formation was catalyzed by the enactment in 1982 of the Citizenship Act, a law that sought to deny citizenship to children of women who are married to non-citizens (while according the opposite to those children whose fathers are Batswana while their mothers are foreign).

Despite severe criticism from mainly patriarchal structures, the movement has become a serious force for gender equity and women's rights. Partly as a result of such activism,

[2] Literally translated "Wake up / Get up Women"!

the government of Botswana adopted or amended a number of laws with the aim of promoting gender equality. For example, in 1996 the Government adopted the National Policy on Women in Development, whose aim was to promote gender awareness in development planning and the elimination of all forms of inequalities and inequities between men and women. During the same year, the government signed the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Southern African Development Community (SADC) declaration on Gender and Development.

In addition, a number of national laws that affect the right of women were also amended. These include the Public Service Act (2000); Penal Code (1998); the Criminal Procedure and Evidence Act (1997); the Deeds Registry Act (1996); Employment Act (1996) and Citizenship Act (1995). Some of the changes in these acts facilitated the inclusion of sexual harassment as a misconduct; to re-define rape to make is gender's neutral; to enable women, whether married in or out of community of property, to execute deeds and other documents without their husbands' consent, and to allow children whose mothers are citizens but whose fathers are non citizens to acquire citizenship. Previously one could only acquire citizenship by birth if the child's father was a citizen of Botswana. Despite these amendments, the dual nature of Botswana's legal system continues to present problems in the areas of gender equality. While the constitution guarantees everyone equal treatment before the law and the fact that government acceded to the UN CEDAW, customary law, which operates alongside statutory law, still bestows more power on men than women. Thus, despite the amendments to laws and statutes, gender inequality still exists.

1.8 Research problem

1.8.1 Problem Situation

Botswana is currently experiencing a heterosexually driven HIV/AIDS epidemic that is unprecedented in magnitude. In response, Botswana has put together a comprehensive multisectoral HIV/AIDS strategy whose central pillars are information provision, prevention, and free access to treatment and care for all who need it. Most HIV/AIDS services are delivered through the country's health care infrastructure, which is modern and highly accessible. This has contributed to improved knowledge and awareness of HIV transmission and prevention.

However, despite the early and comprehensive HIV response strategy, HIV infection rates have continued to grow for most of the time during which the strategy was in place. For example, between 1992 and 2002 the HIV prevalence rate among women aged 15 - 49 years attending antenatal care increased from 13.8 to 35.4 percent and further increased to 37.4 percent in 2003 (GoB, 2003). In 2001, a United Nations report estimated a national HIV prevalence to be as high as 38.8% of the population 15-49 years. However, data from Botswana's most recent demographic survey however suggests that the national HIV prevalence is not as high as initially estimated.

According to the Botswana AIDS Impact Survey, the national HIV prevalence in 2004 was 17 percent (GoB, 2003), and remained almost unchanged four years later at 17.6 percent (GoB, 2008). Despite the downward revision of the national HIV prevalence rate, the rate nevertheless remains high by any standard. With almost a fifth of the population infected with HIV, most of whom are in the productive and reproductive ages, the epidemic presents the single most serious development challenge the country is facing. For example, in all districts, HIV prevalence rates among pregnant women remains over 20 per cent, while some districts have prevalence rates exceeding 50 per cent (GoB, 2003). Explanations of Botswana high HIV prevalence tend to center on men's

sexual and reproductive health risk practices and how these practices increase both men and women's vulnerability to infection and thus facilitates the spread of HIV.

1.8.2 Discrepancy

It is to be expected that in a high HIV prevalence setting such as Botswana, the combination of free and accessible HIV prevention and treatment services and good knowledge of HIV prevention and transmission will translate into high levels of utilization of these services. However, in the case of Botswana, such conventional wisdom has not held as HIV infection rates continued to increase during the 1990s and early 2000's despite the early and comprehensive HIV strategy (see GoB, 2003). The level of utilization of these services has failed to reflect the severity of the epidemic or the fact that HIV prevention and treatment services are offered free of charge to all who require them. A pertinent question is '*Why* has the free and highly accessible HIV prevention, treatment and care services failed to generate a higher turnout of people seeking HIV services, given the high HIV infection?'

While Botswana has a modern and widely accessible modern health care infrastructure that is used to deliver sexual and reproductive health service, such services are not designed in ways that make them easily accessible to all target groups especially men. Historically, Botswana's family planning and reproductive health services were designed largely to benefit women and children through the maternal and child health care services. This focus on women and children was driven by the erroneous assumption that reproductive decisions were the exclusive domain of women. Such assumptions about female autonomy in reproductive health were used to drive sexual and reproductive health interventions even in the face of contradictory evidence that men also make important contributions to women's decisions on pregnancy, child bearing and child rearing.

The adoption of the 1994 International Conference on Population and Development (ICPD) programme of action inspired a paradigm shift from the narrow focus on family

planning and women's fertility regulation to a broader and rights based approach to sexual and reproductive health. This new paradigm included the recognition of men's sexual and reproductive health rights as an integral part of reproductive health. However, despite the recognition of men's sexual and reproductive health rights, most reproductive health programs and settings, including HIV prevention and care programs, have retained their female focus. In such circumstances, male involvement in reproductive health is pursued as a means to an end (the end being safer reproductive health outcomes for women) rather than an end in itself (to address men's sexual; and reproductive needs). As Mookodi (2005) observes, this focus on women is couched in gender discourses and policy interventions that have failed to make the paradigm leap to incorporate males and masculinities.

For example, a 2004 National Workshop on Male Involvement in Sexual and Reproductive Health in Botswana noted that "*the obvious benefit of involving men in reproductive health is that they would most likely be supportive of their partners' decision making on contraceptive use and family planning. This is critical if women are to practice safer sex or avoid unwanted pregnancies*".

Such a pronouncement illustrates how, a decade after the 1994 ICPD program of action, reproductive health was still conventionally understood and pursued as a female issue, and male involvement as no more than a means to women's health rather than an end in itself. The result of this focus on women is that reproductive health programs were regarded as women's programs and men became not only passive partners, but obstacles to the attainment of specific program goals. For example, the reason for the low utilization of VCT services among women has often been cited as fear of their partner's (men's) reaction (especially to a positive HIV test) (Gaillard et al. 2002) fear of abandonment by partner (Langeni 2003); men's lack of support for their partner's decision to test; (Nyblade & Field-Nguer, 2001). The 2004 National Workshop on Male Involvement in Sexual and Reproductive Health in Botswana observed the following about the role of men in the Prevention of Mother to Child Transmission (PMTCT):

> *Presently a major lesson learnt from the implementation of the prevention of mother to child transmission program is that the program uptake is generally low and is attributable to the fact that men generally prevent their spouses and partners from enrolling in the program.*

A 2002 Report on the National Response to the UNGASS Declaration of Commitment to HIV/AIDS (2002) identified as a major challenge, the need to increase the involvement of men in HIV/AIDS programs such as the PMTCT program. The report notes "*inadequate support of male partners*" and *fear of negative reaction from their partners* as the reasons why "*a significant portion of women do not want to enroll for PMTCT*". Thus, the current discourse on the subject of men and HIV is negative and portrays men as obstacles; uncooperative or resistant to HIV prevention programs and therefore responsible for fueling the spread of HIV.

Quantitative studies point to men's propensity towards high risk behavior, such as multiple sexual partnerships and lack of condom use, all of which increases risk of infection for men and their partners. An analysis of data from the Botswana AIDS Impact Survey (BAIS III) the found that male youth were more likely to report having had two or more sexual partners and to engage in multiple concurrent sexual partnerships. The study found that almost a third (29%) of males 18-25 years had one or more sexual partners during the year leading to the survey (compared to 12% of women); and almost a fifth (18%) of men were involved in multiple concurrent sexual partnerships, compared to 6.6 percent of women in the same age range. (Pitso & Rakgoasi, 2003).

So while quantitative studies point to the '*what*' and '*how*' of men's sexual and reproductive health practices in the spread of the epidemic, such studies do not shed light on the '*why*' of men's sexual and reproductive health. By not exploring the '*why*' of men's sexual and reproductive health practices, the quantitative studies have only served to entrench the stereotypical view of men as uncooperative and resistant to

sexual and reproductive health, including HIV prevention programs and therefore responsible for fueling the epidemic.

Thus in as far as the subject of Men and HIV in Botswana is concerned, there is absence of research on men's motivation in sexual; and reproductive health. There is absence of research to explain '*why*' men behave the way they do; or whether and how men's sense of masculinity might mediate men's experience of sexual and reproductive health, including HIV/AIDS prevention and care programs. This absence of the male perspective implies that programs and services that seek to address men's sexual and reproductive health and reduce the spread of HIV, are designed and implemented without the benefit of in-depth and evidence based understanding of men's motivation in sexual and reproductive health.

For a country with such a serious heterosexually driven HIV epidemic in which men are so clearly implicated, the absence of research on men's perspective or motivation in sexual and reproductive constitutes a programmatic '*blind spot*' for programs that seek to modify male behavior to attain specific reproductive health goals for men, women and children. Such a '*blind spot*' might contribute to the apparent lack of effectiveness of some of the interventions geared towards reducing the spread of the epidemic.

1.8.3 Problem questions

What is the social construction of masculinity among men in Botswana? How does men's sense of masculinity and gender role identity influence their sexual and reproductive health attitudes and practices?

1.9 Objectives

The objective of this thesis is to explore the relationship between masculinities and men's sexual and reproductive health attitudes and practices in Botswana. It seeks to provide a thorough understanding of the significance that certain masculine identities holds in the lives of men in Botswana, and the extent to which men's masculine and gender identities are likely to influence their internalization of sexual and reproductive health messages; their sexual and reproductive health attitudes and practices, especially those that have implications for HIV/AIDS prevention and treatment.

Specifically, the research will:

1. Elicit, explore and clarify norms; ideals; socio-cultural and other factors relating to masculinities and gender roles among men through focus group discussions and in-depth interviews

2. Analyze and present levels and patterns of men's masculine and sexual and reproductive health beliefs, attitudes and practices in Botswana.

3. Explore the relationship between men's masculine beliefs and their sexual and reproductive health attitudes and practices.

    a. Investigate whether men's masculine beliefs influence their sexual and reproductive health attitudes and practices.

    b. Investigate other factors that are associated with men's sexual and reproductive health attitudes and practices

1.9.1 Hypothesis

This study investigated two hypotheses relating to men's sense of masculinities and the relationship between masculinities and men's sexual and reproductive health attitudes and practices. The first hypothesis is that:

1. There exist certain conceptions of masculinities among men in Botswana, some of which are hegemonic and others subordinate within the current context and historical setting. These conceptions of masculinity are likely to vary over time and from context to context. Thus while certain masculinities may achieve and enjoy hegemony within a specific context and historical setting, this hegemony is always being renegotiated and challenged by emerging new ways of doing masculinities. This hypothesis is in line with the postulation that gender and hence masculinity is a social construct (Connell 2005); and that hegemonic masculinity does not refer to a specific pre-defined type of masculinity, but *whatever type is dominant at a given time* (Connell, 1987).

2. Keeping all other things constant, men's sense of masculinities is likely to have an influence in the way men experience and interpret sexual and reproductive health program messages and interventions, especially HIV/AIDS prevention and women's empowerment programs. Men who have negative masculinities are likely to experience sexual and reproductive health program messages and interventions as threat to their sense of identity and gender roles.

1.9.2 Justification for research

HIV/AIDS is one of the most serious development challenges currently facing Botswana. Ever since the first cases of HIV were diagnosed in the early 1980's, Botswana's HIV prevalence has increased dramatically since. HIV prevalence among pregnant women aged 15-49 attending antenatal care in Botswana increased from 18.1 percent in 1990, to 32 percent in 1995, and continued to increase during the 1990s, reaching 35.2 percent in 1997 and 38.5 percent in 2000 and declined slightly to 36.2 and 35.4 in 2001 and 2002 respectfully (NACA, 2003).

In 2004, the population based HIV prevalence was estimated at 17.1 percent (CSO, 2004), and this rate increased marginally to 17.6 percent in 2008 (CSO, 2008). This level of prevalence, established through the Botswana AIDS Impact Surveys, was contended by some United Nations bodies, whose previous estimates were more than twice this figure. However, despite the downward revision of the national HIV prevalence rate, the rate remains high and hides some serious variations in HIV prevalence among certain population groups. For example, HIV prevalence among those aged 30-34 was 40.2 percent, and was highest among those aged 25-44 years (CSO, 2004). The largely heterosexually driven epidemic has eroded some of the development gains that the country had achieved since independence in 1966.

Like most countries in the developing world, men in Botswana have significant influence over women's sexual and reproductive health (S&RH) decisions. Whether a woman utilizes S&RH programs might depend on their partner's approval (Pettifor et al., 2004; Gupta, 2000). The low utilization of PMTCT[3] services in Botswana has in part been attributed to the ambivalent role of men in the program. It has been found that a significant portion of women who refuse to enroll into the PMTCT program cite fear of negative reaction from their partners (NACA, 2003). Most men on the other hand, tend

- [3] Prevention of Mother-to-Child Transmission of HIV

to view the PMTCT and other programs as 'women's programs', thus they remain largely uninvolved and fail to perceive any meaningful role for themselves.

Sexual and reproductive health programs, especially those aimed at containing the rapid spread of HIV/AIDS can benefit immensely from meaningful male involvement and support. However, this requires an understanding of masculinities and how ideas about masculinity influences both men and women's use and perception of sexual and reproductive health services. Botswana provides a good setting for the study of the interplay between heterosexual masculinities and HIV/AIDS. Despite good access to HIV information and relatively good knowledge about how HIV is spread and can be prevented, the HIV epidemic continues to spread, mainly through heterosexual intercourse. While there has been an improvement in VCT utilization rates (NACA, 2007) due mainly to intensified HIV education and improved access to services, these rates are still modest, and don't reflect neither the severity of the epidemic nor the fact that all HIV/AIDS services are offered free of charge.

The HIV epidemic therefore presents a good opportunity for the discussion of the impact of heterosexual masculinities on sexual and reproductive health of both men and women in Botswana. The world over, but especially in developed countries, the HIV epidemic has been a site for intense struggles over gender, sexuality and race, and posed a challenge to some of the ideological foundations upon which hegemonic heterosexual masculinities are based (Redman, 1996).

Some of these challenges to heterosexual masculinities are also likely to be felt in developing countries, where the epidemic is more severe and generalized. For example, one of the ideological foundations of masculinities include controlling women's sexuality and determining the terms (when, how, with who) under which sex occurs. By empowering women to negotiate safe sex, or to refuse to have sex if the man refuses to use condoms, and discussing sexuality in the public domain instead of within the household or family, where masculinities are entrenched, the HIV epidemic, [through

HIV/AIDS interventions programs] is helping to undermine what has historically been a stronghold of masculinity.

In addition to the HIV epidemic, a significant number of Sub Saharan African countries face serious challenges relating to slow economic growth, poverty and conflict. The resulting economic decline traps significant proportions of these countries' population in poverty. Barker & Ricardo (2005) give an account of how masculinities are implicated in conflicts on the continents, but also shows how men's sense of masculinities are affected by the economic marginalization that has characterized most of post independence Sub-Saharan African economies.

This research investigates the role of men and masculinities in SRH and HIV/AIDS in Botswana. First it explores the social construction of masculinities among men in Botswana. Then it examines patterns of men's masculinities and sexual and reproductive health beliefs, attitudes and practices. Finally the research investigates the association between masculinities and men's sexual and reproductive health attitudes, beliefs and practices.

1.10 Outline of report

Chapter 1 presents the introduction and background to the research; the research questions, research problem, objectives; justification of research and definitions of key concepts. The literature review and theoretical and conceptual framework are presented in Chapter 2. Chapter 3 presents and discusses the study data sources and methodology. The study sampling and sample design, justification for the selected methods and analytical methods and procedures utilized to answer each research objective. This chapter also presents study ethical review mechanism and process; fieldwork preparations and execution and data handling procedures.

Chapters 4, 5 and 6 present study results. Chapter 4 presents a description of the study population followed a presentation of results relating to men's sense of identity and ascription to selected gender and masculine and gender beliefs. Chapter 5 presents

further results relating to men's sexual and reproductive health beliefs and practices by selected men's background and other characteristics. Some qualitative data are also presented in this chapter to provide grounded understanding of some of the gender and masculine beliefs that affect men's sexual and reproductive health practices and belief, especially those relating to violence and HIV/AIDS transmission, prevention and care. Chapter 6 presents the results of the investigation of the association between masculinities and men's sexual and reproductive health beliefs and practices, while Chapter 7 presents a summary of the main findings, discussions; conclusions and recommendations.

1.11 CONCLUSIONS

This chapter has introduced the field of men's health and provided a brief overview of previous research in this area, as well as the major conclusions regarding men's health and sexual and reproductive health. Then thesis has briefly identified the research problem statement, by highlighting the gap in our knowledge concerning men's roles and motivation in sexual and reproductive health. The thesis sought to understand men's roles, not from the point of view of the physical and behavioral patterns that puts men at risk of unfavorable health outcomes as previous research has done, but it focuses on understanding men's lived experiences of masculinities and men's motivation in sexual and reproductive health and HIV prevention and transmission in Botswana. The chapter has provided a justification for the research, and provided a brief account of the research methodologies to be employed in this analysis

Chapter 2 Literature Review

2.0 Introduction

The purpose of this section is to provide a summary of the current state of research and knowledge on masculinity and gender role ideologies and their impact the sexual and reproductive behavior and outcomes. Such a review of literature cannot be done without positioning it within the broader debate on gender inequality and its influence on relationships with women, and the various frameworks within which the subject is usually discussed. Prior to the 1994 International Conference on Population and Development (ICPD1994), very scant attention was paid to reproductive health needs of men. Over thirty years of demographic health surveys had produced very little information or insights on the reproductive health needs of men compared to those of women. The 1994 ICPD was instrumental in placing the right and reproductive health needs of men on the centre stage of the process of attaining the goal of better reproductive health outcomes worldwide. Currently, there is unprecedented attention being paid to the sexual and reproductive rights, responsibilities and needs of men. This focus on men was borne out of the realization during the family planning movement that studying the fertility of women to the exclusion of men can never give a complete picture of fertility dynamics in developing societies.

If this need to include men in family planning was ever in doubt, it was crystallized post ICPD sexual and reproductive health rights movement and the emergence of the HIV/AIDS epidemic. The need to take reproductive health rights and needs of men and their involvement in sexual and reproductive health is now generally well understood. In most countries around the world there have been attempts to reflect and address sexual and reproductive health needs of men, as a way to attain meaningful male involvement in S&RH programs. However, the way in which countries and programs have gone about trying to involve men in S&RH programs have been varied, reflecting

varied levels of understanding of men's reproductive health issues and what form men's involvement should take.

To a large extent many programs care about men simply because of their association with women, and less because they are clients with real reproductive health needs. Thus, even post ICPD 1994, efforts to involve men in sexual and reproductive health have largely focused on finding ways of getting men to be involved in existing reproductive health programs that are designed for women, without paying much attention to the specific needs of men or factors that motivate and influence their sexual and reproductive behavior.

However, the role of gender identities and norms that dictate what is appropriate or expected behavior for men [and women] in the sphere of sexual and reproductive health, as well as role of socialization in promoting inequitable resource and power relations between men and women is taking centre stage in the debate over men's involvement in sexual and reproductive health. Related to this realization, is the need and indeed the significant challenge of promoting gender norms and identities that promote more gender equity. Figueroa-Perea (2003) note that while one way of analyzing the role of men in the reproductive process is to identify the circumstances under which [men] are considered in the reproductive health discourse; the places they are absent and present and how they condition favorable consequences for women and children's health, such an approach while valid to some extent, ignores the existence of socially constructed gender role identities and how such identities shape the reproductive behavior of men. Figueroa-Perea (2003) argues that studies of family planning, maternal and child health have often ignored the gender relational dimension of sexuality, as well as the characteristics of men's sexual and reproductive behavior. [… and reproduction] He notes that it is not enough to consider the participation of men within the health of women, and recommends that men should be thought of as actors with sexuality; health and reproductive health needs that should be considered in their interaction with women and in their own right.

Masculinity and gender ideologies are being recognized as a potent force in shaping the sexual and reproductive health of both men and women throughout the world as evidenced by the growing number of studies on the subject (O'Brien et al., 2005; Levinson et al., 2004; Shears 2004; Davies et al., 2000; Courtenay 1998; Horwitz & White, 1987). A number of these studies have focused on how masculinity and gender role identities, ideologies and stereotypes impact the sexual and reproductive behavior of men and expose them to the risk of poor health outcomes even when such men have knowledge and means to avoid such outcomes.

2.1 Global Studies

Literature review by the International Planned Parenthood Foundation on Male Participation in Sexual and Reproductive Health revealed growing concern about negative consequences for both men and women, of a traditional and pervasive paradigm of masculinity and its socio cultural mandates. While the review focused on research and programs in Latin America, it provided some of the pioneering frameworks for understanding different types of masculinities and their relationship to gender; male and adolescent sexuality; men's knowledge and attitudes and their impact on their sexual and reproductive health including STDs and HIV/AIDS; violence and fatherhood. The review shows how adherence to certain types of masculine stereotypes increases men's chances of experiencing negative health outcomes. The review documented the evolution and emergence of new and different types of masculinities that challenge the popular hegemonic model (AVSC International & IPPF, 1998). Hegemonic masculinity refers to a prevailing, most lauded and idealized form of masculinity in a historical setting (Connell, 1987 in Sabo 2000); ideological constructions of masculinity that serve the material interests of dominant groups…that reflects support and actively cultivates men's dominance of women and lesser status males in various inter-male dominance hierarchies (Sabo & London, 1992, in Sabo et al. 1995)

A study of Brazilian adolescent males in the United States associated gender role ideologies and stereotypes, and adherence to certain masculinity ideals with increased risk of poor reproductive health outcomes (Levinson et al., 2004). This study found that despite having adequate knowledge of the risks of unprotected sex, adolescents indulged in risky sexual behavior to fulfill culturally defined gender roles and expectations. Such expectations associated masculinity with having many sexual encounters and being less concerned about sexually transmitted infections, pregnancy or condom use. The study casts doubt on how successful interventions aimed at modifying the sexual risk behavior of adolescents if they don't address gender role dynamics. Levinson et al. (2004) observed that a part of the Brazilian *macho* involves being protective of women (mothers, daughters and wives). He therefore notes the need to promote and reinforce those aspects of masculine and gender role identities that facilitate the attainment of safe sexual practices while discouraging those that increase the propensity for risky poor health outcomes. Sabo (1999:5) makes a similar argument for the promotion of what he terms *positive gendered health synergies*.

A study on men's accounts of masculinity found that ascription to certain traditional masculine identities that portray men as strong and silent, and associates manhood with ability to endure pain and suffering predisposed men to poor health seeking behavior (O'Brien; Hunt & Hart, 2005). According to O'Brien at al. (2005) ascription to traditional masculine stereotypes that associate manhood with ability to endure pain makes men reluctant to seek help in time. Thus the need for early help seeking presents a challenge to such men's perceived sense of manhood. The study found that men were especially less likely to consult for psychological and mental problems because these conditions are associated with women than men.

However the study found significant variations in men's perception of masculinity. For example, while younger and healthy men were more likely to ascribe to the masculine model that emphasizes ability to endure pain and slowness to seek help or consult, older men and those with experience of serious medical conditions were exceptions to

this norm. The advent of serious medical conditions presented a challenge to men's masculinity and forced them to critically examine and negotiate their departure from the dictates of the masculine model that other men abide by. The study found that in cases where health seeking is perceived to enhance rather than threaten men's masculine identity, men were prepared to consult regularly, even for what might be perceived minor ailments. O'Brien et al. (2005) found that where non-help seeking would likely compromise men's sexual performance, men were ready to risk their masculine identity by seeking help for ailments. That is, men were ready to risk their "public" image among peers by consulting early and regularly, for as long as doing that has the effect of enhancing or maintaining their actual sexual performance.

According to Forrest (2001) increased media coverage of men's sexual health and the resultant shift in public policy that emphasized men's responsibility in child welfare and support resulting from increased interest in men's health in the 1990s helped to pressure the US health system to identify and address men's needs. In a study of college men's reproductive and sexual health, Forrest (2001) notes that some of the challenges to addressing men's sexual and reproductive health in the United States include men's unfamiliarity with and discomfort in seeking health services; health providers' unfamiliarity with men's sexual and reproductive health needs as well as failure of programs and services to address the social context within which men lead their lives.

Davies et al., (2000) found that male socialization and gender role stereotypes that portray men as strong, self reliant and aggressive tend to restrict college men's emotional openness, willingness to seek help and perception of vulnerability to disease. Young men were found to have distinctive health threats, and were more likely than young women to engage in risk taking behavior. The study argues that socialization and gender stereotypes that portray men to be strong and independent, contributes to men's low perception of vulnerability to diseases. College men were particularly averse to seeking help before the condition for which they are seeking help became dire enough. Men expressed a fear of being judged unfavorably by their peers, or being

accused of making a "*fuss*" or not acting like men. Even men with a family history of heart disease had low risk perception of vulnerability to heart diseases. The study also revealed that men had doubts about the technical and personal competence of health services to meet or understand men's health and counseling needs. Many had serious misconceptions about the health services, while other groups of men, such as gay and bisexual and men of colour had concerns about not being accepted or understood by the health establishment.

Courtenay (1998) found that college men who ascribed to traditional gender role stereotypes were likely to experience anxiety and poor cardiovascular reactivity to stressful situations and higher depression levels. Courtenay notes that young men received confusing and often contradictory messages about health and violence from health workers, parents, peers and other adults. While health workers might encourage young men to seek help when there is a need to, parents, peers and other adults might ridicule or punish them for going against the dictates of masculinity by seeking help early. While young men might learn about the undesirability of violence or violent behavior, institutions like the military, business and sport might encourage the use of aggression. The media is also likely to give conflicting messages about manhood and the use of violence and aggression.

Courtenay notes that gender role stereotypes among health professionals influence their diagnosis and service provision for men and women. Studies have suggested that mental health clinicians are significantly less likely to diagnose depression in men than in women because of gender stereotypes about men's invulnerability to mental disorders (Brooks, 2001). Such gender stereotypes in service provision then results in more women being treated for mental disorders than men, and thus generating the "*evidence*" that shows that men are insusceptible to mental disorders, and thus keep the stereotype going.

A study among married couples in Israel investigated the gender role ideologies within the paradigm of self esteem and tolerance for ambiguity (Kulik, 2004). The study concluded that individuals with high self esteem are more likely to be tolerant of and feel less threatened by shifts and changes in gender roles occurring at home, at work or in society in general. These individuals were more likely to believe that tasks should be shared equally, compared to those with low self esteem, who, when faced with these changes, prefer to cling to familiar traditional gender role perspectives. The study identified a number of factors that predict gender role identities as well as how well these factors predict gender role identities differently among men and women. While the study found that men were more likely than women to ascribe to traditional gender roles, education and employment was associated with more egalitarian attitudes among women only. Among men, household size was the most important predictor of traditional gender role identities.

In a synthesis of surveys conducted between 1974 and 1994, Harris et al., (1998) detected significant shift of gender role identities from more traditional gender role identities to more egalitarian view among all racial groupings in the Unites States**.** In his analysis of surveys over time, he found that the year in which a particular survey was conducted account significantly for changes in gender role identities from traditional to more egalitarian views. The study found that individuals who have more years of formal education, those who are young and mothers' education increase the chance of more egalitarian gender roles, while stronger religious affiliation; having fundamentalist views and being foreign born were associated with traditional gender roles (Harris et al., 1998).

A study to investigate the relationship between traditional gender roles and styles of pathologies among adolescents in the US found that conformity to traditional gender role expectations was associated with gender specific pathologies, and that the influence of gender identities on styles of pathology increases over the course of adolescence and young adulthood. The study found that masculinity was linked with

negative pathologies while femininity was largely irrelevant in accounting for these problems (Horwitz & White, 1987). Another study found that men aged 15-24 years who least supported egalitarian gender attitudes were more likely to report violence against a partner and least likely to report condom use, while among 25-59 year olds, support for more equitable gender norms was associated with condom use (Shears, 2004)

Nicholas et al. (2004) documented cultural experience of occupation injury among undocumented Latino immigrants in the United States. The study demonstrated how migrants' cultural experience and masculine identities shape their experience of injury and the structured inequalities in the U.S. labor migrant system. The injuries and inequalities, and the inadequate emotional support were found to constitute an assault on migrant male laborers' identity as they were not able to live up to culturally expected roles. As a result, injured migrants were found to suffer from psychiatric illnesses, self destructive behavior such as substance abuse and interpersonal violence. The authors argue that treating illnesses and symptoms clinically without paying attention to gender role ideologies that influence migrant's gender worth, overlooks part of the trauma, suffering and lived experience of migrants that is associated with not being able to perform expected gender roles. The study however found that despite migrants' common motivation for migrating and endurance of common economic and cultural stresses while injured in the U.S., migrants never shared a monolithic masculine identity. Their masculine identity was found to be shaped and influenced by their ethnicity; age, geography; class and educational background.

A study on men's sexual health problems and health seeking behavior in Mumbai, India (Verma et al. 2001) documented serious limitations in men's knowledge about sexual health problems. This limitation in knowledge was found to influence men's health seeking behavior, both in terms of the timing and types of treatment sought. Men's experience of sexual health problems was found to be related to the age, socioeconomic status, types of sexual unions they were in and multiple sexual

partnerships, including extra marital sexual relations. The study also found an association between experience of sexual health problems and men's behavioral correlates such as excessive alcohol consumption and gambling.

While studies on gender roles and their impact on reproductive health have provided some understanding through which men's motivation in sexual and reproductive health can be conceptualized, these experiences, mainly generated from developing countries cannot be generalized wholesale to developing world experiences, or even to diverse groups of men within countries in which such studies were conducted. For developing countries, this deficit leaves the male perspective as the critical missing link of gender. Robinson (n.d.) writing on race and theories of masculinity in North America notes that masculinity can only be studied within a specific cultural and social context within which it manifests itself, and that the conclusions and discussions generated cannot be generalized to all societies and masculinities or all men.

Robinson notes further how even the results of studies on gender role ideologies carried out in western countries cannot be generalized to the various racial and ethnic groups residents in these countries. He notes that even in the United States, generalized masculine traits that are usually thought of as applying to all men are in fact usually culturally specific and therefore not applicable to other non-white groups of men. Thus, while such studies of gender role ideologies in different parts of the world (especially in the west) have provided some form of framework through which to view gender ideologies in other parts of the world, most of their experiences and findings do not provide an adequate and accurate framework through which gender role ideologies in other parts of the world can be understood. Thus, to fully understand gender role ideologies and the evolution of the male perspective on sexual and reproductive health in the developing world in general and Africa in particular, there is need for more studies that focus on this part of the world.

2.2 African studies

While the importance of gender role identities in influencing sexual and reproductive behavior is not in doubt, most studies on gender roles have tended to be concentrated in developed countries, with few studies conducted in developing regions, particularly sub Saharan Africa.

A study in social construction of manhood in Nigeria found that masculinity was generally associated with the social position in the family as well as the physical capability to satisfy the sexual needs of female partners and to produce children. The study found that parents, families, relatives and communities all play a significant role in socializing young men into predetermined gender roles. Gender socialization of boys that prepares them for the transition to manhood was found to be the responsibility of both the mother and father, and that society closely monitors young boys' enactment of socially expected adult male roles. The research notes that male dominance and its effect on reproductive health behavior and relationships with women are pervasive across socio-cultural differences between groups of men in the ethnic groups studied (Olawoye et al., 2004).

In South Africa, Varga (2003) found that traditional gender ideals are grounded in traits that reinforce poor sexual negotiation dynamics and behavioral double standards for male and female adolescents that places adolescent at risk of negative health outcomes. In a study of male sexual behavior in three states in Southwest Nigeria, Orubaloye et al.,(1998) concluded that while traditional beliefs about the polygynous nature of male sexuality are being changed by modernization, such change is slow because the beliefs arise from the nature of traditional society, which itself is unlikely to change radically in the short term. The authors conclude that given the slow change in the ordering and nature of traditional society, HIV/AIDS programs will likely achieve better outcomes focusing on high risk sexual relationships that focusing on changing traditional beliefs about the nature of male sexuality.

In a study of the Igbo people of South Eastern Nigeria, Odimegwu & Okemgbo (2005a) and Odimegwu et al. (2005b) document a range of social conceptions of manhood, as well as the social and institutional processes that perpetuate and sanction certain dominant masculine and gender role divisions and stereotypes from boyhood through adulthood. The study notes how children are socialized at family and community levels, into masculine roles that are considered important for attainment of manhood. The research also documents how departures from the socially expected masculinity norms are looked down upon and socially ostracized, ridiculed and shamed through name calling and being denied recognition. Gender roles are clear cut [and] males getting into areas meant for females, and vice-versa is regarded as an abomination (Odimegwu et al. 2005b), and a boy's father will do everything to ensure that there is no trace of feminine trait in his son (Achebe 1958, cited in Odimegwu et al. 2005b). Thus, being a man involves maximum differentiation from women or any traits that are traditionally considered feminine. Among the Igbo, manhood is a state that has to be achieved and proved through functional processes such as being able to marry; and having (many) children; being the primary decision maker; protector and provider for the needs of the family, contribution to community development (Odimegwu & Okemgbo 2005a; Odimegwu et al. 2005b). In addition, some of the socially expected and cherished aspects of manhood include acquisition of attributes that are seen as being unfeminine, such as physical strength, independence; rationality; emotional in-expressivity; aggression; competitiveness and sexual virility. The study finds that masculinity is so revered that it is considered natural and is viewed as involving certain spiritual roles of being a bridge between the family and external (spiritual) world; between the present and the future through continuation of the patriarchal lineage.

Odimegwu (2005b) found significant relationship between ascription to traditional masculine ideologies and risky sexual practices and health seeking behavior. For example, Igbo men who identified and lived according to traditional masculine stereotypes were more likely to have had more current and lifetime sexual partners; to

have had sexual intercourse with commercial sex workers (CSWs); compared to men who held less traditional and more egalitarian views of masculinity and gender roles. These men were also less likely to have used condoms when having sexual intercourse with CSWs compared to other men.

The study found that Igbo men were more likely to seek health care for minor illnesses from a range of care providers (modern and traditional) for as long as the condition for which they seek care is not stigmatized. This implies that if the condition is stigmatized (i.e. if it poses a challenge to their traditional masculine view of strength and invulnerability; or if the condition is traditionally perceived as feminine) the choice of type of health intervention sought, or the timing of health seeking might be affected. The study documents important differentials in health-care seeking behavior, risk taking and health status, associated with socioeconomic status, masculine identities, level of education and urban-rural residence. The study found that Igbo men who ascribe to traditional masculine beliefs are more likely to engage in risky behavior and to have experienced poor health outcomes (Odimegwu et al., 2005b). While the research notes the prevalence and reverence of masculine stereotypes that sets men apart from women, it also notes that the centrality of traditional masculine values are being eroded and modified mainly through urbanization, acquisition of formal education and migration. This has led to emergence of less traditional views of masculinity. Also, due to globalization and increasing exposure to technology, the role of parents and other adults in socialization and transfer of knowledge and values through folk tales is declining; and the media and workplace interactions are assuming an increasing role in transferring ideas and values about masculinity.

In a study of violence against women in the highly patriarchal region of Nkomazi in Mpumalanga[4] Sideris (2003) found that faced with socio-economic forces that upset or threaten to destabilize gender roles between men and women, tradition is often evoked to restore dominant notions of what it means to be a man. Sideris observes that what is

[4] Mpulamanga is one of the provinces of South Africa

often passed as "*tradition*" or the natural order of [doing] things, actually involves a process of selectively emphasizing certain meanings from past or present, while excluding other meanings and practices to entrench a particular hegemony. The study found that despite increasing awareness of legal rights, the growing willingness among women to pursue these rights has brought about a sense of insecurity among men. This feeling of frustration and insecurity among men regarding women's rights is associated with men's sense that the political transition in South Africa has failed to alter their socio-economic status from that which they experienced under the repressive race and class structures of the apartheid era.

Sideris (2003) found that while in the context of Nkomazi, the status of manhood is conferred by having a woman, child (ren) and being able to regulate family relations as head of household, large scale social, economic and political changes and women's responses have unsettled the authority of men in their stronghold, the family. According to Sideris, the family is one of the most conservative institutions, and a refuge for male hegemony, and she observes when they feel threatened, "*….efforts are made to attempt to retrieve conservative ideologies about families in which roles, duties and responsibilities are rigidly defined and rights and privileges are differentially allocated according to gender*" (Sideris, 2003).

Sideris notes that while men talked with relative ease about issues such as division of labour and distribution of household income, discussion that challenged views about household headship caused varying degrees of internal conflict, confusion and discomfort. However, the study finds that despite being brought up in a society with rigidly defined traditional gender roles and responsibilities, and in response to their experience of childhood violence, some men were attempting to re-negotiate rigid distinctions that define men and women's lives to develop a framework within which they can achieve stable families, and create possibilities of more equitable gender relations in the home.

A regional HIV/AIDS conference held in Pretoria, South Africa agreed on the need to reconstruct masculinities to reflect socio-economic and other realities such as unemployment, rural urban migration and HIV/AIDS (UN, 2001). The conference agreed that men and boys from different races and classes are disoriented by socio cultural changes occurring in the Southern African region and that the sense of displacement and irrelevance, coupled with unemployment and poverty undermines male self esteem. This loss in self esteem and a sense of manhood are then manifest in risky sexual behavior that puts men and their partners at risk of HIV/AIDS. The conference noted that while the last decade has seen many interventions aimed at slowing down the HIV epidemic, many such interventions are failing because they do not account for the male perspective and the social construction of male identities and masculine stereotypes that make the attainment of safe health outcomes difficult to attain. The conference also noted that male exclusion and not paying attention to the male perspective causes young men to withdraw from interventions and programs because they feel blamed, and that many men who do not engage in risky behavior are not visible in the current discourse that portray men as drivers of the epidemic.

Lindsay and Miescher (2003) noted that while studies on gender have tended to focus on women and portray men to be only concerned about material concerns and less about their masculinity, this view has changed and has resulted in a focus on men and masculinities in Africa. In a review of 12 studies and essays on men and masculinity in Africa, they show how masculinities have and continue to evolve in response to a number of challenges and circumstances such as colonialism, capitalist economic system and the domestic arena. The authors show how experiences like education, military enrolment and employment generated new masculine identities, which were often in conflict with traditional gender ideals, and resulted in widespread re-definition of masculinity. For example, in Namibia, Christianity, colonial rule and wage labour fostered new and competing notions of masculinity among Ovambo men by reducing their dependence on their fathers. Citing examples about pre-colonial Igbo ideas about

masculinity; returning military veterans in Mali; teachers in Ghana, railways and coal miners in Nigeria, and black policemen in apartheid South Africa, Lindsay & Miescher (2003) show how different groups and classes of men have been able to re-negotiate the prominent masculine identities to create new, multiple and at times conflicting identities that are concomitant to their experiences.

Morrell (2003) uses gender theories to show the connection between "silence" about HIV/AIDS and society-wide gender inequalities. Morrell argues that silence is a feature of gender relations that prevents negotiation of safe sex, the exploration of self and the expression of vulnerability and building of trust. He argues that much of South Africa's violent forms of masculinity resulting from colonialism and apartheid, are played out in the interpersonal realm where men use their power to affirm their masculinity. Beliefs about men's entitlement to women's bodies and misogyny, masculine gender stereotypes that emphasize conquest of women through sex and the patriarchal family structure that expects obedience and submission from women have contributed to the "*silence*" from women who are exposed to gender based violence.

Morrell notes that the process of constructing and enacting gender identities necessarily omits certain acts, expressions and gestures, just as it includes and exhibits others. Thus, in his view, gender identities contain "silence" because they are discursive and policed. For men, the hegemonic masculine identity of being able to control one's emotions and refusing to acknowledge emotions such as pain, loss or grief engender the legitimization of this "*silence*" or "*unsaying of feelings and emotions*" among men. Among women, this "*silence*" is symptomatic of unequal gender and power relations, and is exacerbated by the absence of discourses from which reconfigured feminine subjectivities can be constructed. Thus the breaking of this silence is critical to the reconstruction of new gender relations and identities, and the creation of new norms and identities that stresses mutuality, responsibility and equality.

2.3 Studies from Botswana

There are no studies on impact of masculinities and gender role identities on men's sexual and reproductive health in Botswana. While a number of studies have documented the sex differential in knowledge, attitudes, practices and disease patterns, these studies have not examined these phenomena from the context of gender role ideologies or masculinities. For example, major national surveys, such as the Botswana Family Health Survey I (1984); Botswana Family Health Survey II (1988); The Multiple Indicator Survey (2000); Botswana AIDS Impact Survey I (2001) and Botswana AIDS Impact Survey II (2004) have over the years collected important information on fertility, contraceptive use, sexual and reproductive health. These surveys have documented differentials between men and women in terms of their contraceptive use dynamics; sexual practices and health outcomes including HIV/AIDS. These findings have formed the basis for some important policy and programmatic interventions. However, these studies have essentially presented sex-disaggregated data, without expounding the socio-cultural context within which these outcomes are achieved.

A study on sexual practice of male and female adolescents in Botswana, found while female adolescents were more sexually active than male adolescents; the latter were more likely to engage in risky behavior such as early initiation of sexual intercourse; alcohol use; multiple sexual partnerships than female adolescents. Among male adolescents, early initiation of sexual intercourse was associated with increased likelihood of non condom use, which increased the risk of STD infection, including HIV. The study found while a high percentage of adolescents considered themselves at minimum or no risk of STD or HIV infection, this proportion is higher among males than female adolescents (Rakgoasi & Campbell, 2004). However, this provided a documentation of adolescent sexual behavior and did not investigate the influence of social constructs such as masculinity or femininity identities, or the social processes that shape and maintain gender relations between male and female adolescents

The Botswana National Sexual Reproductive Health Policy recognizes the need for male involvement in sexual and reproductive health. The policy, informed by the recommendations of the ICPD 1994 conference and in line with the UN's Millennium Development Goals, cites a commitment to provision of high quality, gender sensitive and welcoming environment for both men and women. The policy identifies male involvement in sexual and reproductive health as a challenge and ideal for attainment of health improved sexual and reproductive health for both men and women, and that social, structural and cultural factors continue to present serious challenges to the attainment of male involvement.

One of the weaknesses of the strategy is its biomedical motivation for male involvement. Male involvement is desired for the purpose of controlling the spread of diseases, especially STDs including HIV/AIDS, and not for the need to transform gender relations and social institutions that create gender imbalance in sexual and reproductive health, or understanding how gender roles impacts health. In fact, Ezeh (1993) attributes the limited success of family planning programs in Ghana and most of sub-Saharan Africa to continued neglect of men as equal targets of such programs. In the same way, failure of programs to make men equal targets for programs, rather than as proxies for attainment of other targets, compromises the success of these programs. This is because such programs are based on an incomplete understanding of factors underpinning male sexuality.

While the Botswana National Sexual Reproductive Health Policy (NSRHP) identifies several social and cultural challenges and hindrances to involvement of men in sexual and reproductive health, the policy lacks clear strategies to address these challenges, but rather stressed the need to... '*make men modify their behavior and be involved in current programs*'. According to the policy, this change in behavior can be attained through '…improved services; counseling, referral; information dissemination, education; skills and communication for behavior change'.

While NSRHP recognizes the need for a gender balance in program and service delivery, and the potential benefit to men, women and children that a reasonable level of men's involvement will bring, the strategy does not propose ways to address gender role ideologies, socialization and other socio-cultural factors that impact men's sexual and reproductive behavior. As such the policy is restricted to addressing only the symptoms of gender roles ideologies, and blaming men for being uninvolved, uninterested and resistant to change. The Botswana's National Sexual and Reproductive Health Policy stipulates that men should be reached with messages to '*….change [their] risky sexual behavior such as intergenerational sex; refusal to use condoms on a continuous basis; refusing women to use family planning methods; failure to seek [medical] help for STIs; ignorance in dealing with pregnant women; denying responsibility for abortion and its consequences; alcohol abuse; rape; incest; domestic violence; murder of partners; infecting others with [HIV] virus and multiple sexual partnerships*'.

Without alluding to the social and cultural context that creates and enforces some of the gender role stereotypes and negative health outcomes listed here, men can only be blamed for causing these problems. Consequently, as a result of failing to '*problematize*' the socio cultural context within which gender relations and identities are formed and maintained, programs and services aimed at addressing issues of male involvement continue to be designed, based on false assumptions about the male perspective and motivation in sexual and reproductive health. Research, polices and intervention programs are likely to make more impact and provide more insights if they consider the social context within which men [and women] live their gendered lives.

2.4 Theoretical framework

Gender analysis has spawned a number of theoretical and conceptual frameworks that differ in terms of their understanding of gender; their approach to development; the extent to which each framework gives insights into the different institutions through which gender relations are manifest and the level of intervention at which each frame seeks to operate.

2.4.1 Hegemonic Masculinity Framework

This research will use the hegemonic masculinity framework to understand the nature and role of masculinities in sexual and reproductive health utilization in Botswana. There is a general consensus that a patriarchal, "*hegemonic*" model of masculinity exists; one that is incorporated into the subjectivity of men and in some way constitute their masculine identity (AVSC International, 1998:4). Hegemonic masculinity refers to a prevailing, most lauded and idealized form of masculinity in a historical setting (Connell, 1987 in Sabo 2000); and involves "the maintenance of practices that institutionalize men's dominance over women" and is "constructed in relation to women and to subordinate masculinities" (Connell, 1987 in Bird 1996). Sabo (2000) notes that male gender identity is not only constructed in reference to the prevailing hegemonic masculinity model but also in relation to women and cultural definitions of femininity.

Masculinities vary across cultures, social class, ethnicity, sexuality and age, and while dominant versions of masculinities are tied to hierarchy and power relations, they not static (Rivers & Aggleton, 2002). It is now commonplace to view masculinities as multiple, contested, dynamic and socially constructed in both time and place (O'Brien et al., 2005). At any historical moment, there is competition between different types of masculinities, some of which may be hegemonic, some marginalized and other stigmatized (Sabo & Gordon, 1995). The experience of masculinity is not uniform across cultures or within the same culture over time and the interplay between hegemonic and subordinate masculinities ensures that the hegemonic forms never really achieves complete hegemony.

Hegemonic masculinity is often associated with the devaluation of roles that are viewed as feminine, such as care giving (Doucet, 2004). In the US, current hegemonic masculinity emphasizes male dominance over females; physical strength; proneness to violence; emotional *inexpressivity* and competitiveness (Sabo, 2000). Doucet (2004)

argues that fathers who trade their traditional masculine role of family provider for the more feminine one of care giving, are neither reproducing nor challenging hegemonic masculinity, but are creating new forms of masculinity that, while enacted against a weighty backdrop of hegemonic masculinity, nevertheless incorporate varied aspects of femininities. However other researchers (Hondagneu-Sotello & Messner, 1997; Brandth & Kvande, 1998) view such apparent shifts in men's gender roles as a subtle expression and mere extensions of hegemonic masculinity. Thus, rather than challenging hegemonic masculinity, contemporary men's adoption of traditionally female gender roles is seen as an extension and an attempt to reconstruct and reconfigure hegemonic masculinity. Hondagneu-Sotello & Messner (1997) dismisses the ideological class icon of the "*new man*" and its emergent fragment of "*mythopoetic man*[5]" as attempts to reconstruct hegemonic masculinity by entrenching the belief that poor working class and ethnic minority men are stuck in the traditional male role while white middle class men are forging a new and egalitarian male role. Hondagneu-Sotello & Messner argue that by not addressing men's structural positions of power and privilege over women, these shifts in gender displays of white, college educated middle class men towards models of a highly involved '*nurturant*' father who is in touch with and expressive of his feelings and egalitarian in his dealings with women, are at best, strategies to reconstruct hegemonic masculinity.

Bird (1996) uses the twin concepts of *homosociality and heterosociality* to examine the processes through which hegemonic masculinity is perpetuated. According to Lipman-Blumen (1976) cited by Bird (1996), homosociality refers to the nonsexual attraction held by men (or women) for members of their own sex. Heterosociality on the other hand is defined as the nonsexual attraction held by men (or women) for members of the other sex. Bird (1996) argues that homosociality promotes clear distinctions between

[5] A movement started by Robert Bly, which became popular among white, college educated men in the US. The main idea behind Bly's movement was to reconstruct masculine bonds by discussing and finding solutions to men's poor relationships with their fathers and other men in workplaces through some kind of male initiation process. Bly's has been criticized for creating a false symmetry between his movement and the feminist women's movement by ignoring the social power structure that benefits men and oppresses women; and for focusing on reconstructing masculine bonds that bear little or no relevance to men's relationships with women.

hegemonic masculinities and non-hegemonic masculinities by the segregation of social groups through promotion of *emotional detachment*; emphasizing *competitiveness* and *sexual objectification of women.* Bird argues that male homosocial heterosexual interactions inhibit change by suppressing contradictions that non-hegemonic masculinity potentially poses to dominant masculinity patterns. The persistence of hegemonic masculinity results from the fact that individual departures from dominant masculinity are experienced as private dissatisfactions rather than as reasons for contesting the social constructions of masculinity (Bird 1996).

Increasingly, scholars who use Connell's hegemonic masculinity concept tend to imply that hegemonic masculinity is substantively negative, and tend to associate it with domination or violence, or devaluation of roles that a viewed as feminine (see Doucet, 2004, Sabo et al., 1995). While it is true that hegemonic masculinity in a specific historical setting and environment might be dominant, violent and be associated with the devaluation of anything feminine, this does not mean any masculinity that is hegemonic at any given time, is negative. If indeed, as Connell argues, hegemonic masculinity is not a specific, pre-defined type of masculinity, but is whatever type is dominant in a given time (Connell 1987:p76-77), then it is clear that in certain contexts, hegemonic masculinities need not necessarily be associated with the devaluation of the feminine, and can be positive in content.

However, Connell's concept of hegemonic masculinity has been conflated with "*type*" (one that is largely negative) instead of being understood to mean "whatever type is dominant at a given time". This conflation of hegemonic masculinity with "*type*" means that researchers often get away with not having to document other masculinities that are dominant at different times within the same context. Also viewing hegemonic masculinity as a specific "type" goes against Connell's assertion that hegemonic masculinities are constantly being contested and challenged by subordinate and other marginalized forms. Thus, because they are constantly being challenged and contested, hegemonic forms of masculinity never achieve complete hegemony or dominance. It is

therefore possible for subordinate masculinities to achieve dominance and hence become the hegemonic type in a specific time and context.

This research is based on the premise that hegemonic masculinity is not a specific predefined "type" of masculinity, but it is whatever masculinity is dominant at a given time. The research seeks to avoid conflating hegemonic masculinity with a specific type of masculinity and therefore assuming that any hegemonic masculinity is negative. Given that hegemonic masculinities are constantly being contested, it will be possible to document different types of hegemonic masculinities in a specific context or time, as well as those subordinate forms that challenge the dominant form.

2.4.2 The social constructionist perspective

The social constructionist perspective posits that men (and women) think and act in the ways that they do not because of their role identities or psychological traits, but because of concepts about masculinity (and femininity) that they adopt from their culture (Pleck et al., 1994a). This perspective views masculinity and femininity not as fixed states or mutually exclusive positions, but rather as "a set of socially constructed relationships which are produced and reproduced through people's actions" (Gerson and Peiss, 1985). By viewing masculinities and femininities as fluid products of gendered social transactions, this theory transcends the criticism labeled against previous theories such as 'gender socialization theory' or the sex role theory of socialization. These theories have been roundly criticized for implying that gender represents "two fixed, static and mutually exclusive role containers" (Kimmel, 1986); for assuming that women and men have innate psychological needs for gender-stereotypic traits (Pleck, 1987) or for fostering the notion of a singular female or male personality(Connell, 1995).

Thus, in the constructionist perspective gender is viewed as a dynamic social construct, the structure of which is continuously being shaped by cultural concepts and notions about masculinity and femininity. The fact that these very same cultural concepts and notions about masculinity and femininity are themselves evolving, gender this makes

gender dynamic social construct that is a product of dynamic, dialectic relationships (Connell, 1995), and rather than something that is innate to men or women.

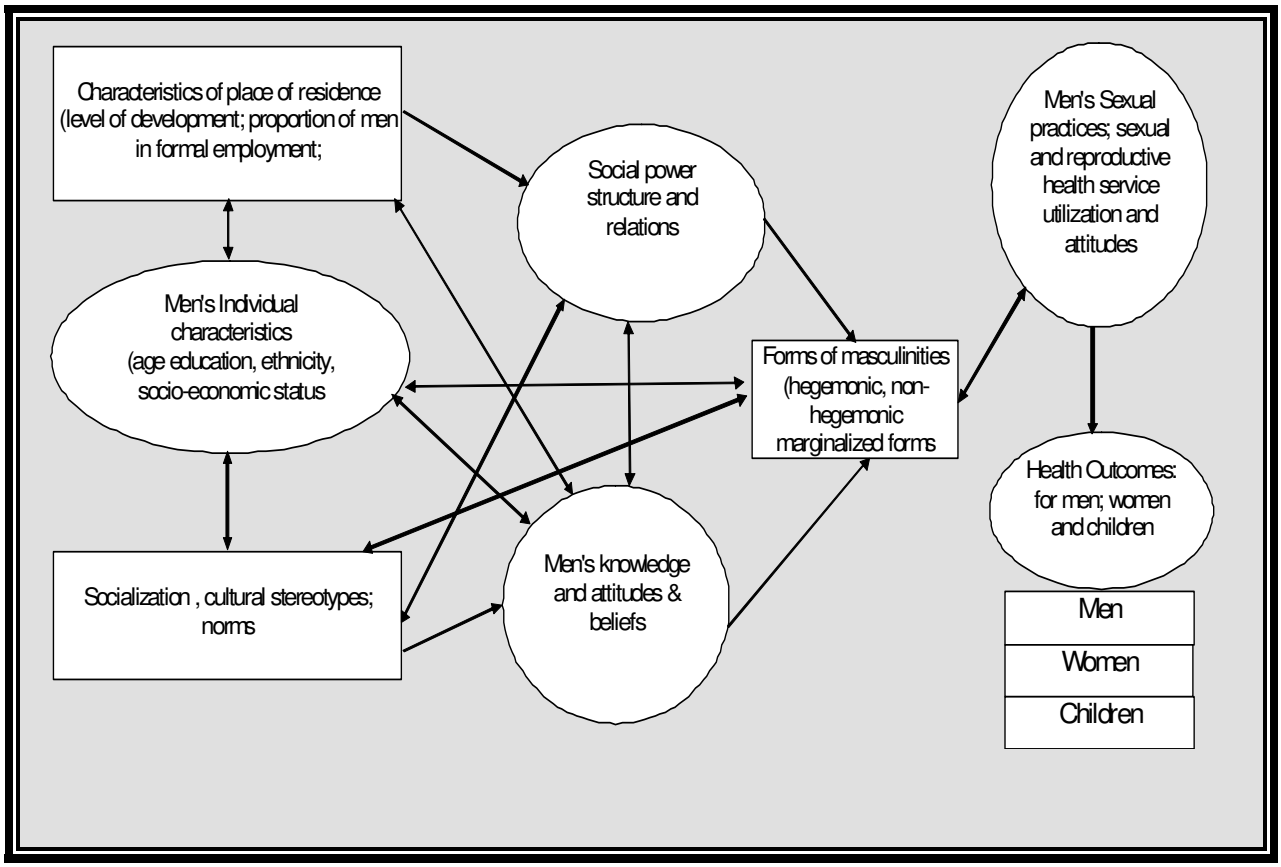
2.5 Study Conceptual framework

Masculinities are created, maintained, modified and expressed within specific context of social relations and relative to femininities and other subordinated masculinities. It therefore becomes important that a study of masculinity such as this one should also reflect the context within which masculinities and male gender identities are created and expressed, and how these contexts contribute to the creation and maintenance of certain forms of masculinity. The conceptual framework will highlight the role of gender social power relations within which masculinities are created and expressed.

While masculinities are not static, and are continuously subject to being proved and contested every time, it is expected that within the different socio-cultural and historical context in which men live, there will exist certain lauded and exalted forms of masculine stereotypes to which most men feel they are expected to conform and reproduce or justify their departure. As Bird (1996) notes, the social ideal for masculinity (which in itself is non static) may be internalized (such that it becomes a central to one's core self) or simply acknowledged by self, thus enabling individuals to understand the gender norms to which they are held accountable.

The following diagram shows the study's conceptual framework of relations between various social factors, masculinities and sexual and reproductive health.

Conceptual framework: Masculinities and Men's Reproductive Health Practices and Outcomes



2.5.1 Explanation of the Conceptual Framework

The above conceptual framework, perused from the literature review shows conceptual relationships between men's background and individual and men's sexual and reproductive health. It can be expected that men's individual characteristics such as age, level of education and socio-economic status have an influence on their sexual and reproductive health attitudes and practices. However, this impact is likely to be mediated by a number of other factors. Research is increasingly recognizing the impact of contextual factors on men's sexual; and reproductive health behaviour. The notion that sexual and reproductive health behaviour of men is subject to '*rational action*' Men's sexual and reproductive health might thus such as level of development and socio-cultural norms and beliefs that are prevalent in a particular context.

The framework shows men's adherence to socially constructed ideas about their manhood might lie at the intersection between men's individual characteristics and their sexual and reproductive health attitudes and practices. The latter has implications not only for men's sexual and reproductive health, but also that of their partners and children. These contextual factors sometimes influence the early childhood socialization, which may in turn influence the kind of identity he constructs for himself in later life - by either actively identifying with the cultural conditioning or challenging it.

This framework also recognizes that sexual and reproductive health is a gendered process and occurs within a web of social and structural power relations usually based on gender norms. These power relations usually position women in a lower position relative to men in socio-economic and personal relations. The social power structure between men and women; as well as between men and other men, is likely to be a significant influence on men's sexual and reproductive health attitudes and beliefs and ultimately their sexual and reproductive health practices.

The main thesis of this framework is that men's sense of masculinity is likely to influence men's sexual and reproductive health attitudes and practices both directly and through other variables. This framework incorporates men's knowledge of HIV/AIDS as one of the factors that influences men's sexual and reproductive health. The result of current HIV/AIDS information and education campaigns and programmatic interventions is that individual men acquire knowledge and information about HIV prevention and transmission. However, how that knowledge and attitudes are finally translated into practices might be acted through the '*lens*' of masculinities. So the confounding effect of masculinities on men's sexual and reproductive health will depend on the nature of one's masculine identity. Positive masculinities will most likely to lead to sexual practices that reduce the risk of negative health outcomes while negative masculinities will have the opposite effect.

In addition, men's sense of masculinity is also likely to mediate or confound their experience of sexual and reproductive health services and programs, as well as their experience of structural processes such as poverty or unemployment. For example, men who have negative masculinities that are deeply rooted in the control of women's sexuality might experience HIV messages that encourage women to take control of sexual decision making and negotiate condom use, in a different manner from men who have positive and non-dominant masculinities. For example, men's pain and perceived sense of loss of self worth arising from unemployment is likely to be seriously confounded by the ideas they have about what it means to be a man.

Chapter 3 Data and Methodology

3.0 Introduction

This chapter provides a detailed account of the data sources; methods; research procedures and terms that are used in the 2008 Study on Men, Masculinities and Sexual and Reproductive Health in Botswana. The data used in this study were collected in two phases, with the first phase consisting of qualitative data collection between April and August 2008, and the second phase covering quantitative data collection, between December 2008 and March 2009. The chapter provides a detailed description of the processes used to gather the qualitative and quantitative data, as well as specific methods and procedures that were employed to ensure and improve the quality of data. It also provides a justification for the choice of methods, and discusses the strengths and limitations of each data source and methodology in order to facilitate a rigorous understanding of the results and conclusions presented in this thesis.

Since independence, Botswana has conducted regular censuses and demographic and other surveys in order to facilitate planning and impact evaluation of development and other projects. The censuses and surveys provide important information that can be used to establish levels, patterns and trends of men's sexual and reproductive health practices and outcomes in Botswana. However censuses and surveys are by their nature limited in their ability to provide in-depth information on a single issue. This is because being quantitative undertakings, geared towards '*representativity*' and comparability; they aim to collect information from a large number of people, thus limiting their depth of inquiry into a single subject. While surveys and censuses have provided information on men and women's sexual and reproductive health practices; risk behaviors and outcomes, these are presented as sex-disaggregated averages that don't illuminate the socio-cultural and other contexts within which these practices and outcomes occur.

However, while the quantitative survey data has been useful for pointing out sex disaggregated trends and vulnerability patterns, there is a risk that without understanding the context within which these outcomes are achieved, these difference

tend to be regarded as behavioral norms or averages. This leads to stereotypical views of men's sexual and reproductive health behavior. O'Brien et al. (2005) note that in order to understand masculinities and men's behaviour, there is a need to focus on the processes and relationships through which men and women conduct their gendered lives.

> *Simplistic analysis of men's help seeking as presentation of sex disaggregated data runs the risk of reifying difference between men and women and treating the two gender groups as homogeneous* (O'Brien et al., 2005).

Thus, to understand the local cultural context of men's sexual and reproductive health practices, it was deemed appropriate to conduct a small scale qualitative survey, in order to provide an in-depth focus on the context, and highlight such factors as cultural construction of patriarchal masculinities, gender norms and power relations within a specific context.

3.0.1 Ethical Review Mechanism

This research underwent two ethical reviews and approval processes. The first review was conducted by the University of Witwatersrand Research Ethics Committee and the second one by the Human Research Science Council in Botswana, under the Ministry of Health.

The research protocol with copies of the research tools and copies of the informed consent form were submitted to the University of the Witwatersrand's Research Ethics Committee (Wits REC) for ethical evaluation on 24th April 2007. After receiving comments and revising the proposal and instruments, the Wits REC approved the research on July 2007.

The proposal was also submitted to the Human Science Research Council (HSRC) in the Ministry of Health in Botswana on 27th September, 2007. This was done in line with the requirements for securing research clearance for primary data collection in Botswana.

This committee scrutinized the research proposal and tools to ensure that all issues relating to research ethics are brought to the fore and adequately addressed in order to ensure that the rights of respondents are protected throughout the whole research process. After suggesting a number of revisions and clarifications, the HSRC granted research approval and permission on 1st February, 2008.

The process of seeking ethical clearance from the Botswana government took much longer was originally anticipated, due to the number of comments they raised and the fact that the committee meetings were far and apart. This increased the time between the revision of the proposal and tools and the committee meeting to consider the revised documents. Submitting the proposals and tools to two independent ethics review committees, and obtaining clearance from both of them ensured that the proposed study adequately reflected on and addressed most of the research ethics issues.

3.0.2 Informed consent

During the data collection, informed consent (verbal and written) of potential respondents was obtained before the interviews/discussions. The researcher ensured that the project team maintained high ethical standards and responsibility regarding confidentiality. For the focus group discussions and in-depth interviews, the code of ethics for research on human subjects as laid down in the University of the Witwatersrand document, Policy on Matters Sensitive and Confidential Research was followed. The informants were properly and fully informed about the nature of the project; that participation is voluntary and can be terminated at any point and that their anonymity and confidentiality of the information given are assured.

3.1 Data Sources

The following section gives a detailed account of the sources of data used in this analysis.

3.1.1 The 2008 Study on Men, Masculinities and Sexual and Reproductive Health in Botswana

A sample survey, titled "*Men, Masculinities and Sexual and Reproductive Health in Botswana*" was conducted between April 2008 and March 2009. The survey encompassed the collection of both qualitative and quantitative data on men, masculinities and sexual and reproductive health from a small sample of men. The first round of the survey, encompassing the collection of qualitative data, was conducted between April and August 2008. Qualitative data were collected first because of its utility in exploring topics that the researcher may not be completely familiar with. The absence of any significant study on masculinities in Botswana necessitated the use of qualitative data in order to understand the norms and ideas pertaining to masculinities in Botswana.

The second phase of the fieldwork entailed the collection of quantitative data, to measure the extent of men's identification with certain norms and values unveiled during the qualitative data collection and to investigate the possible association between masculinity norms and values and men's sexual and reproductive health practices. This phase of the study was conducted between December 2008 and March 2009.

3.1.2 Qualitative Survey on Men, Masculinities and Sexual and Reproductive Health

Botswana's national demographic surveys have provided data that can be used to account for men's roles in sexual and reproductive health and men's risk and vulnerability patterns. However, by their nature, these surveys are incapable of providing deeper meaning and understanding of the men's experiences of masculinities

and sexual and reproductive health. Qualitative data were therefore needed to provide fuller understanding of contextual and other factors relating to men's sense of identity, their sexual and reproductive health attitudes and practices, and to provide formative knowledge about a range of beliefs, ideas, or opinions regarding masculinity and men's sexual and reproductive health practices. Qualitative data were collected through focus group discussions and in-depth interviews with diverse groups of men in selected urban and rural locations in Botswana, in order to explore; explain and clarify the concepts and norms relating to masculinities and the context of men's sexual and reproductive health behavior.

3.1.3 Choice of discussants and respondents

Qualitative data are geared more towards explaining and clarifying issues and concepts, rather than for '*representativity*' and '*generalizability*' to a larger population. As a result, non-probability sampling techniques such as snowball and purposive sampling are used to target potential respondents for focus group discussions and in-depth interview. Using such non-probability methods such as snowball and purposive sampling also allowed the study to target information-rich sources such as people working with various groups of men in different capacities.

Participants for focus group discussions and in-depth interviews were chosen based on two criteria, as recommended by Weiss (1994). First, participants were chosen for their ability to provide unique insights into the subject matter. These are people who by virtue of their positions or experiences are able to provide unique insight into the subject of men and masculinities. These include people who are either experts in the area or are privileged to witness or experience a specific event. The second criteria involved the selection of people, who taken together, display what happens in a population or the behavior of interest.

Both focus group discussions and in-depth interviews used a semi-structured interview guides containing a set of topics to be explored. This is what Weiss (1994) terms a

'substantive frame'. The semi-structured nature of the substantive frame allowed respondents room to decide the saliency of topics, hence the order, time and emphasis they placed on each topic. The substantive frames were discussed with academic supervisors and readers, and vetted by two ethics committees.

3.1.4 Focus Group Discussions

Focus groups are useful for investigating normative behavior, but are not suitable for investigating the behavior of individuals in the group (Lundgren, 2000). Thus focus groups were conducted in order to provide a deeper understanding of socio cultural norms, ideas and beliefs relating to masculinities and how such norms and ideas might affect men's sexual and reproductive health. So, focus group discussions helped clarify normative and cultural beliefs relating to patriarchal masculinities, socialization of boys and how men negotiate their own performances of masculinity in their lives. This method therefore provided a vehicle for exploring the relationship between men's lived experience of masculinity and their lived expectations, and to offer possible explanations to observed patterns of men's sexual and reproductive health attitudes and practices.

3.1.5 Recruitment of discussants and key informants

Discussants were recruited through snowball sampling and referrals. The advantage of purposeful selection in a qualitative design is that it made it possible to select "*information rich*" individuals, from whom a great deal about the subject can be learnt. In each location, the researcher mapped out areas where it would be possible to get men. These areas included residential areas, sports and recreation areas such as sports fields and bars, church yards and workplaces. Once these areas were mapped out, research assistants were dispatched to recruit discussants according to set criteria and make appointments for group discussions. The criterion for recruiting discussants included maximizing intra group homogeneity around age, level of formal education; socio-economic status, while at the same time, maximizing inter group heterogeneity.

Once the appointments had been made, the researcher conducted all the focus group discussions and in-depth interviews.

Before the commencement of the interview, the objectives of the study, as well as the method that was going to be employed and the rights of the respondents were explicitly explained to all potential respondents, who were then asked to give informed consent about their participation in the study. Once consent was obtained, a second level of consent to record the interview was sought. Although many respondents tended to be a bit apprehensive about recording the interview, all potential participants eventually consented once the purpose of recording the interview was explained and respondents were assured that their rights as study subjects were protected. Throughout the interview, participants were asked if they wished to continue with the interview. Continuously asking for consent to continue the interview was necessary given that the subject of discussion was at times sensitive and invasive. However, once the initial consent was given, and the interview commenced, none of the participants opted to terminate the interview.

All the focus group discussions were facilitated by the researcher. It was imperative that the researcher should be the one conducting the interviews in person. Qualitative interviewing is a building process, whereby insights learnt from previous interviews become useful for subsequent interviews. By conducting the qualitative interviews in person, the researcher was able to use such insights and use probes that are informed by what transpired during previous interviews. While unspoken communication such as uneasy body language, physical gestures and eye contact cannot be captured on audiotape, such communication can speak volumes, sometimes as much as the verbalized communication, if not more, and can be important to the interpretation of the results. By its nature, qualitative data collection is hands-on, and requires one to be present and to be immersed in the data collection process in order to fully understand the issues and nuanced language.

3.2 Recruitment and training of research assistants

Following the research approval, a team of 4 research assistants was recruited and trained on the purpose of the study, its implementation plan and research ethical issues. The team was responsible for organizing focus group discussions and in-depth interviews. The other responsibility of the research assistants was to transcribe the interviews and conduct quality checks on the transcripts. Once these were organized, the researcher conducted the interviews, in person.

The qualitative instruments were *"piloted"* in order to identify and learn about cultural norms; prevailing and idealized masculinity stereotypes and gender identities that are prevalent among men in Botswana. This was followed by the consolidation of the qualitative instruments to reflect what has been learnt from the pilot. The qualitative data collection was conducted between august and October 2008.

3.2.1 Fieldwork

Fieldwork for this research was carried out in two phases between April and August 2008. The first phase of the fieldwork involved the collection of qualitative data in two preselected urban areas and a rural village. The two urban areas are Gaborone and Francistown, while the rural area is Gantsi. Qualitative data were collected through focus group discussions and in-depth and key informant interviews.

The second phase of data collection involved the collection of quantitative data in Gaborone and Francistown. Quantitative were collected through direct interview method using a structured household and individual questionnaire.

3.2.2 Transcription

All the interviews were electronically recorded and transcribed *verbatim* in the local language. Interviews were conducted in the local language in order to give participants freedom to express their views without hindrance of an unfamiliar language. The interviews were then translated into English, and then checked for quality.

3.2.3 Quality check

For quality purposes, a sample of transcribed interview transcripts was compared to the audio tape recordings of the same interviews in order to ensure that no critical information was lost during the transcription. A further quality check mechanism after translation was to compare a sample of the original (un-translated) transcripts with the translated versions. Again, this was necessary to minimize loss of information or insights that might result from the translation.

The quality check mechanism showed that for a majority of transcripts, very minimal information was lost during the transcription and translation processes. However two transcripts that showed significant distortion of content as a result of transcription were assigned to assistants for re-transcription. As a result of the quality check mechanism, certain parts of transcripts were left un-translated in order to preserve the original meaning of language and nuances that were otherwise compromised by the translation.

3.3 Constitution of focus groups

Focus group discussions constituted of seven to nine or ten men, of similar age and socio-economic characteristics. Focus group discussions were conducted in the local language to facilitate free expression of ideas. All the interviews were conducted in convenient locations where there was adequate privacy and little chance of interruption. These places included community halls, primary school classrooms, and other locations that were deemed appropriate at that time.

Intra-group homogeneity is a sought after ideal when organizing focus group discussions. While the extent to which one can achieve homogeneity within one group is always relative, it was endeavored as much as possible, to ensure that discussant shared common characteristics in order to facilitate free expression and ease of sharing of information. For this study, in as far as possible, homogeneity was pursued in terms of participants' age; social class; level of education and geographic location. On the other hand, inter group heterogeneity is also desirable because it facilitates the

discovery and exploration of patterns in behavior or attitudes that are unique to specific target groups, as well as those that cut across the different groups. Inter-group heterogeneity was achieved by maximizing the difference between the groups.

3.3.1 Number of focus group discussions

Twenty focus group discussions were conducted with various groups of men in selected urban and rural areas in Botswana. Participants of focus group discussions were selected based on a number of criteria, such as education, sex and socio-economic status. For as much as possible, the study attempted to maintain as much intra group homogeneity in terms of the above stipulated characteristics, while at the same time maximizing inter group heterogeneity.

There are no precise rules about ideal sample size for qualitative studies. In the case of focus group discussions, there are no universally agreed rules about how many focus groups constitute an adequate sample size. Lundgren (2000) notes that qualitative studies tend to use small sample sizes due to their time-consuming nature. She notes however that small sample sizes do not provide an adequate basis for generalization of findings. Clearly, it was desirable to balance the sample size requirements with time needed for analysis.

Characteristics of Focus groups Discussants

Group	Age range	Number of groups	Number of participants	Marital Status	Education
Young men students	17-23	2	9	Single	Tertiary
Young men working	25-35	1	7	Mixed	Primary & secondary
Young, unemployed	24-33	3	10	single	Secondary & tertiary
Middle aged unemployed	35-50	2	11	Mixed, mostly married	Secondary & Tertiary
Middle aged, vendors	30-45	2	8	Mixed	Primary
Middle aged, employed	33-47	2	9	Married	Secondary & Tertiary
Young men, church	18-27	1	7	Mixed, mostly single	Secondary & Tertiary
Middle age, university	34-42	2	10	Mixed	Tertiary
Young men, university	19-24	3	11	Single	Tertiary
Young men, vocational	19-29	2	8	single	Secondary & Tertiary

3.3.2 In-Depth and key informant Interviews

Respondents for in-depth interview were recruited through snowball sampling and referrals. Key informants were selected purposively for their ability to provide a unique perspective on the subject of men, masculinity and health. They included individuals who were members of organizations that address men's issues to local and traditional and community opinion leaders. Some discussants were identified from focus group

discussions, after demonstrating, through their contributions to the focus group discussions, that they might either have unique experience or knowledge of the subject of men and masculinities.

In-depth interviews provided information of men's normative beliefs as well as their actual experience of masculinity and sexual and reproductive health. Since they are semi-structured, in-depth interviews allowed respondents the space to determine the saliency of topics and issues and provided greater depth of detail and information. They provide an opportunity to share and understand viewpoints of respondents and how their beliefs, experience and vocabulary relate to wider issues and the possibility of discovering the unexpected (Lundgren, 2000).

3.3.3 Number of in-depth & key informants' interviews

Twelve in-depth and key informant interviews were conducted with selected participants who were deemed to be in a unique position to give valuable insight into the subject. A semi-structured interview guide was used to explore a range of topics and issues relating to masculinities and men's sexual and reproductive health. These included topics on the meaning of being a man; socialization; equality; multiple sexual practices; violence; homosexuality and HIV/AIDS.

Characteristics of In-depth and key informant interview respondents

Pseudonym	Age	Sex	Marital Status	Education	Children	Occupation
Kyle	41	F	M	Tertiary	2	Social Worker
Babusi	38	M	S	Tertiary	1	Nurse
Entaile	28	F	S	Secondary	0	Peer educator
Kgosi	56	M	M	Primary	3	Traditional leader
Mooki	47	M	M	Primary	3	Pastor
Ntwaetsile	44	M	M	Secondary	2	Men's Sector
Johan	39	M	S	Secondary	1	Soldier
Ndlovu	50	M	S	Tertiary	2	'RealMen'
Sebedi	27	F	S	Secondary	1	Police Officer
Tlhaodi	61	M	M	Tertiary	4	Councilor
Prince	35	M	S	Tertiary	1	DJ, Student
Kitso	75	M	M	Primary	5	Elder

3.4 Quantitative Survey on Men, Masculinities and Sexual and Reproductive Health

The quantitative survey on Men, Masculinities and Sexual and Reproductive Health in Botswana was conducted following the completion of fieldwork for the qualitative survey. Concepts and ideas learnt from the qualitative survey were incorporated into the quantitative survey in order to facilitate the objective measurement of some of these concepts and their association with men's selected measures of men's sexual and reproductive health practices and outcomes.

The quantitative survey utilized formal structured questionnaires. Two instruments were used to identify and interview eligible men. First, a household form was used to record both the individual and household characteristics of all members of the selected households. The completed household questionnaire was then used to identify men

who were eligible for individual interview. If more than two men from the same household were eligible, random methods were used to select two men who were to be interviewed. This randomization was achieved by writing the line numbers of all eligible respondents on small pieces of paper. These pieces of paper were then crumbled and put into a container. One of the household members was then asked to pick two pieces of paper, one at a time, without looking and without replacing them. Those household members whose line numbers in the household questionnaire corresponded with the 'picked' pieces of paper were selected for interview. Once the eligible respondents were identified, an enumerator administered the individual questionnaire to the respondents.

3.4.1 Sampling

Cost considerations precluded the utilization of a nationally representative quantitative sample of men. As a result, the sampling for the quantitative survey was purposive, and focused on two urban areas, namely Gaborone and Francistown. Between them, the two urban areas are home to almost half of the country's population, and probably three quarters of the urban population. Within each urban centre, three low income neighborhoods were further selected. In Gaborone, the three locations are Old Naledi and Bontleng were selected for inclusion. These neighborhoods are home to a significant proportion of the city's population. The latest census figures suggest that between them, the two locations are home to over 40 percent of the city's population. In Francistown, similar low to middle income neighborhoods were purposively selected. These neighborhoods are Somerset East, Bluetown and Monarch.

3.4.2 Sampling Frame

The sampling frame for this study was the Central Statistics Office (CSO) household listings by locality and Enumeration Areas obtained from the 2001 population and housing census. The CSO household listing comprises both localities and geographically defined units called Enumeration Areas (EAs) found in all cities and

towns; villages in Botswana. The listing provides information about the number of households and population size of each locality and EA.

3.4.3 Quantitative Sampling Design

The sampling design consisted of random methods, in multiple stages. First, a listing of all enumeration areas (EAs) in the selected localities was compiled and this constituted the study (secondary) sampling frame. The EAs were then randomly selected, with probability proportional to measure of population size (PPS) to ensure that larger enumeration had a proportionally greater probability of being included in the sample than smaller ones.

At the second stage, households6 were randomly selected from within the sampled EAs, and the final stage involved the random selection of individual respondents within households. Once a household has been chosen to be included in the sample, a list of all household members was compiled. The listing included all persons who were presently living in the household, including those who were not present at home but were to return to the household that evening. Eligible members of the household were then selected using an improvised randomization method. If the selected person was not at home, at least two return visits were made. If on the second visit the person was still not available they were excluded and replaced.

3.4.4 Sample size

The size of the sample is one of the most important parameters of any sample design. More than any other factor, sample size affects the precision, the cost and duration of the survey. For this survey, resource limitations precluded the selection of a nationally representative surveyi. So the sample size was pre-determined at 650 men from the five low incomes areas already identified.

[6] Household consists of one or more persons, related or unrelated "under the same roof" in the same *lolwapa* (dwelling), "eating together from the same pot", and making common provision for food and other living arrangements.

3.4.5 Stage One: Selection of primary sampling units (PSU)

The first stage of the sampling process involved the random selection of primary sampling units, in this case, census Enumeration Areas. Using the 2001 population and housing census' listing of EAs, twenty (20) EAs were randomly selected with probability proportional to population size (PPPS).

3.4.6 Stage two: random selection of households

The selected EAs were then listed, together with their population size and number of households. From the list of selected EAs, sixteen (16) households were randomly selected in each EA.

3.4.7 Stage three: Selection of respondents

The final stage involved random selection respondents from selected households. Two eligible respondents were randomly selected and interviewed in each household.

A total of 619 respondents were successfully interviewed, giving a completion rate of 97 percent. Of the 619 questionnaires brought in from the field, 9 questionnaires had not captured critical identifying information while the other 10 were highly incomplete. These were removed from the completed questionnaires, thus yielding a total of 600 completed interviews, which form the basis of the quantitative analysis in this study.

3.5 Justification of the methodology

This thesis triangulates quantitative and qualitative methods to gain an understanding of the role of men; masculinities and sexual and reproductive health in Botswana. Triangulating quantitative and qualitative data offers greater and more rigorous perspective and understanding of men's S&RH practices and outcomes that each method, on its own, could not provide.

Throughout years of prevention efforts, it has become increasingly clear that conventional public health awareness campaigns have been largely unsuccessful at

eliciting behavior change where sexuality is concerned, in part, because behavioral patterns are not only influenced by individual decisions but also deeply embedded within collective cultural norms (Somma et al., 2003). How well HIV prevention programs have accounted for the collective cultural norms relating to sexual and reproductive health and HIV prevention remains a big question, especially given the he limited success of these programs in eliciting sexual behavior change. A major of strength of qualitative data in this kind of research lies in its ability explore and to provide in-depth understating of norms, issues and concepts relating to masculinities in Botswana. Qualitative data lets the respondent determine the saliency of topics of interest, it is therefore ideal for exploring and clarifying issues and concepts relating to masculinities, and providing in-depth understanding of the traditional, cultural and other normative beliefs about masculinities.

Quantitative data are also used alongside qualitative data to provide objectively verifiable information on the levels and patterns of men's sexual and reproductive health attitudes, beliefs and practices. Despite more than a decade of work in the field of HIV/AIDS prevention, global estimates of HIV infections now stand at 40 million people (Somma et al., 2003). In Botswana, the number of new HIV infections has increased despite early initiation of free and highly accessible HIV prevention and treatment services and programs. Quantitative data are also used in order to test hypotheses about the association between masculinities and men's sexual and reproductive health attitudes, beliefs and practices.

Most of the countries seriously affected by the HIV/AIDS epidemic are already burdened by low economic growth, poverty; unemployment; and rapid urbanization. While the economy of Botswana has experienced rapid growth during the past twenty years, poverty is still deeply entrenched. Rapid urbanization and migration and the collapse of traditional mechanisms for regulating sexuality, have facilitated the evolution of a multiplicity of new cultural references relating to masculinities, which may challenge traditional norms and values and also have implications for the spread

of HIV/AIDS. Where cultural norms were considered within the formation of behavior change campaigns, they were often only considered obstacles to be overcome rather than fundamental determinants of behavior that could be resourced for not only local programs, but in the formation of larger health policies as well (Somma et al., 2003).

This research therefore aims to analyze and present men's sexual and reproductive health within the context of local cultural norms and practices of patriarchal masculinities. The research focuses on a range of meanings; beliefs and lived experiences of sexual and reproductive behavior because …*reproductive health problems cannot be precisely defined universally without elaboration of meaning within particular contexts and the experience of individuals as they negotiate healthy sexual and reproductive health outcomes* (Dudgeon et al., 2004). Such a focus on the context will provide valuable information to reproductive health programs and policies that seek to attain male involvement and provide culturally appropriate interventions (Dudgeon et al., 2004).

3.6 Analytical methods

3.6.1 Qualitative data analysis

All transcripts were typed into Microsoft Word and then read into ATLAS.ti, a text analysis software program, wherein they were coded and sorted into excerpt files according to the themes in the interview guide. The excerpt files were then further coded in accordance with new themes emergent from the data. An issue-focused approach was adopted in analyzing the qualitative data. This is an approach that describes what has been learned from all informants about a particular issue or situation. Data were coded according to concepts and categories used in the research, and from these coded data excerpt files that collected together material from both focus groups and interviews that dealt with the same issue were compiled. ATLAS.ti was used to analyze the qualitative data.

3.6.2 Quantitative data analysis

Initially, simple frequencies and cross tabulations were used to establish the levels and patterns of men's sexual and reproductive health practices and associated outcomes in Botswana. Beyond that, logistic regression is used to isolate significant factors associated with certain levels and patterns of men's sexual and reproductive behavior. The following section presents a list of independent and dependent variables that are used to explore the role of men in sexual and reproductive health in Botswana.

3.6.3 Dependent variables

The dependent variables are grouped into two, namely, (i) men's sexual and reproductive health attitudes and beliefs (ii) men's sexual and reproductive health practices. Quantitative analysis of levels and patterns of men's sexual and reproductive health knowledge, attitudes and practices yields objectively verifiable indicators of men's role and involvement in sexual and reproductive health and HIV/AIDS prevention and transmission in Botswana.

3.6.4 Men's Sexual and Reproductive Health Attitudes and Beliefs

It is important to establish the levels and patterns of men's knowledge of and attitudes towards sexual and reproductive health and HIV/AIDS. Many times, men's risky behavior has been blamed on inadequate knowledge resulting from men's lack of involvement with many S&RH and HIV/AIDS programs and services. Interrogating the levels and patterns of men's knowledge of and attitudes towards sexual and reproductive health, including knowledge and attitudes towards HIV prevention and transmission could help point to vulnerabilities patterns emanating from specific levels and patterns of knowledge, attitudes and contexts. Determinants of men's knowledge and attitudes towards HIV testing; Prevention of Mother to Child Transmission (PMTCT) and condoms will be examined.

Variables used in regression models

Dependent variables

Sexual and reproductive health attitudes and practices

Attitudes towards violence in relationships

(On a scale of 1 to 5, where 1 indicates "*complete agreement*" and 5 represents "*complete disagreement*"; rate your response to the following items)

It is okay for a boy/man to hit his partner if she

1. goes out without him
2. refuses to have sex with him
3. wants to terminate the affair
4. talks back at him during an argument
5. fails to take care of children

Attitudes towards Sexual coercion

(On a scale of 1 to 5, where 1 indicates "*complete agreement*" and 5 represents "*complete disagreement*"; rate your response to the following items)

1. Women find sexual coercion stimulating
2. Men are sexually stimulated by sexually coercing women
3. A woman can sometimes pretend she doesn't want to have sex, and expect the man to coerce her

Use of violence

I sometimes get so angry I slap my partner

1= yes
2= no

Slapped or used violence against partner in past 12 months

1= yes
2= no

Sexual practices

Current no. of sexual partners

1 =Two or more partners
0 =Zero or one partner

Number of life-time partners

1 =Two or more partners
0 =Zero or one partner

Number partners in past 12 months

1 =Two or more partners
0 =Zero or one partner

Times had casual sexual intercourse

1 =Two or times
0 =Zero or one time

Anticipated number of future sexual partners
1 =Two or more partners
0 =Zero or one partner

Anticipated number of future casual sexual partners
1 =One or more partners
0 =Zero

Independent variables

Masculinity — Ascription to masculinity stereotypes
1 = Negative
0= Positive
[*A composite variable made from answers to questions on respondent's ascription to certain masculinity stereotypes*]

Control variables

Age — Age groups (years)
17 – 21
22 – 25
26 – 30
31 – 35
36 – 45
46 – 69

Education — Respondent's level of education
Primary or less
Secondary
Tertiary

Employment — Is respondent is currently employed?
1= employed
2 = not employed

Marital status — Respondent's marital status
1=Married
2=Never married
3=Cohabiting
4=Widowed/ Divorced/separated

Type of place of childhood socialization
1=urban
2= rural

Type of family of orientation
1 = Both parents, married
2 =Mother only
3 =Father only
4= Both parents, unmarried
5= Extended

3.6.5 Men's Sexual and Reproductive Health Practices

Individual sexual practices and behavior is measured in terms of number of sexual partners; number of lifetime partners; multiple sexual partnerships and condom use; and HIV testing behavior.

3.6.6 Independent variable

The key independent variable is men's masculine identity. This variable is a composite variable encompassing men's responses to multiple questions on masculinities and gender role attitudes. Responses to these questions are dummy coded and added to produce an ordinal composite variable. This variable is then used as a rank variable, indicating the level of each respondent's ascription to a set of masculine norms.

3.6.7 Control Variables

Control variables are age of respondent, level of education; marital status, employment status; place of childhood orientation, type of family of childhood orientation and religion.

3.6.8 The model

Logistic regression is a predictive model that can be used when the dependent variable has two categories. Logistic regression does not assume that the relationship between the dependent and independent variables is linear; and does not assume that the dependent variable or the error terms are distributed normally. Preliminary data suggests that the relationship between the men's sexual and reproductive health knowledge, practice; outcomes and the independent variables is nonlinear, thus making logistic regression appropriate.

The logistic regression formula computes the probability of a selected response as a function of values of the predictor variables.

$P = 1 / (1+e^{(-(Bo + B1* X1 + B2*X2 + \ldots\ldots Bk*Xk))})$

Taking log transformation of the function yields:

$$\log(\frac{p}{1-p}) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \cdots + \beta_k X_k$$

Where p is the probability of the event happening

(1-p) is the probability of the event not happening

X_1; X_2; X_3…..X_k are the independent variables

ß$_0$, ß$_1$ ß$_2$ ß$_3$ .....**ß$_k$** are regression coefficients to be estimated from the data

Two sets of models were run to determine the association between masculinities and men's sexual and reproductive health knowledge, attitudes and practices. The first model investigated the association between masculinities and men's knowledge and attitudes towards sexual and reproductive health. Questions on knowledge of HIV prevention and transmission; attitudes towards HIV testing and condoms were used to *operationalize* men's knowledge and attitudes.

The second model investigated the association between masculinities and men's sexual and reproductive health practices. Sexual and reproductive health practices were measured by number of sexual partners; maintenance of multiple sexual partnerships; health seeking and condom use.

3.7 Meeting the objectives

The following section briefly outlines how each of the study objectives was addressed from the point of view of data collection and analysis.

3.7.1 Objective 1

Qualitative data from focus group discussions and in-depth interviews were used to explore men's sexual and reproductive health attitudes and beliefs, as well as to explore

and clarify socio cultural and other masculinities and gender role norms. The study explored men's attitudes, views and beliefs relating to the social construction manhood, childhood socialization; sexuality and multiple sexual partnerships, gender equality and social power relations, risk taking, violence and aggression and health seeking. Men's attitudes towards HIV programs were also explored.

3.7.2 Objective 2

The second objective of the study is to present levels and patterns of men's sexual and reproductive health attitudes and beliefs. Quantitative questions on men's views and attitudes towards gender roles; HIV/AIDS, equality, health seeking, sexual practices; power relations and other forms of masculinities were used to generate data on levels and patterns of men's sexual and reproductive health attitudes and beliefs. Data generated from these questions were presented in bi-variate tables against men's selected background characteristics such as age; education; marital status; family of childhood orientation and place of early childhood socialization. Chi-square was used to test the association between men's background characteristics and their sexual and reproductive health attitudes and beliefs.

3.7.3 Objective 3

The third objective investigates the relationship between men's masculine beliefs and their sexual and reproductive health attitudes and practices. Specifically, it investigates whether and the extent to which men's masculine and sexual and reproductive health beliefs are associated with their sexual and reproductive health attitudes and practices, as well as other factors that are associated with men's sexual and reproductive health attitudes and practices. Logistic regression analysis was used to examine the association between men's masculine beliefs and their sexual and reproductive health attitudes, beliefs and practices.

A number of variables on masculine and gender beliefs were used to derive a variable on '*masculinity*'. These variables were derived from responses to questions such as: *Men are better than women; It is okay for women to work outside the household, but men should always be heads of households; Boys / men should be tough and not show any emotions; It is unmanly to frequently seek medical and other professional services when you are not well.* Responses to these questions were 'dummy' coded, with "1" assigned of the respondent agreed with the statement or "0 if they disagreed with it. These dummy variables were summed to produce a rank index of men's masculine beliefs, with higher values representing 'negative' masculinity while lower values represent 'positive' masculinity. The rank index was further recoded to reduce the number of categories, and used as key independent variable in the regression models.

A number of dependent variables were used. These include variables that measure men's propensity to support the use of violence within intimate relationships; attitudes towards multiple sexual partnerships, number of sexual partners and anticipated number of sexual partnerships / encounters in future.

3.8 Conclusion

This chapter has provided an account of the data sources; methods; research procedures and terms and ethical issues of this study. The chapter has also provided a justification for the choice of methods used in this study, as well as the strengths and limitations of each method and data source. By explaining the research methods and procedures, the chapter aims to facilitate understanding of the research process and in-depth and insightful interpretation of the results and conclusions of this research.

Chapter 4 Sample Description; Men's Identity and Ascription to Masculine and Gender Ideals

4.0 Introduction

This chapter uses qualitative data to explore the socio-cultural construction of masculinities in Botswana, and to provide in-depth an understanding of masculine beliefs, attitudes and practices that have implications for men's sexual and reproductive health in Botswana. The chapter provides a description of traditional social and cultural construction of masculinities, and highlights some challenges to traditional masculinities resulting from modernization. It seeks to provide an understanding of the prevalent forms and practices of masculinities and the importance of various forms of masculinities to various groups of men.

In addition to qualitative data, some quantitative data are used to provide objective measures men's ascription to certain masculine sexual and reproductive health beliefs, attitudes and practices. Qualitative data therefore leads the exploration and clarification of issues surrounding masculinities, while quantitative data are used to provide an estimate of the extent to which men identify with these issues and beliefs. The advantage of triangulating qualitative and quantitative methods in the analysis of masculinities is that one is able to draw on the strengths of one method to compensate or complement for the weakness of the other method. Using both methods provides a more complete understanding of masculinities and fosters a more insightful interpretation of data than can be possible with each method individually.

4.1.1 Objective

The aim of this section is to explore and clarify social and cultural norms and ideals relating to masculinities and gender roles identify among men in Botswana. In addition this section will also employ quantitative data to determine the level and patterns of men's adherence ascription to certain masculine ideals and gender norms

4.1.2 Subjects

The qualitative results presented in this section are based on over 20 focus group discussions and 12 in-depth interviews with various groups of men and key informants while the quantitative results are based on a sample of 600 men interviewed in selected areas in Botswana.

4.2 Sample Characteristics

Six hundred (600) men in the age range 17-69 were interviewed, with a sample mean age of 29 years. Table 1 shows the percentage distribution of respondents according to selected background characteristics. Just under a fifth (17%) of the sample was less than 21 years of age; a quarter was 22-25 years, and 29 percent were 26-30 years of age. Just fewer than one in three men in the sample (29.5%) are 31 years or more. Most of the respondents had either secondary or tertiary education. Almost half (47%) of the sample had secondary education, while an almost similar proportion (46%) had tertiary education. Just fewer than seven percent (6.9%) had primary education or less.

Less than one in ten men were married, and 19% were in cohabiting relationships, while 6 percent were either divorced or widowed. The mean duration of marriage or cohabitation was 28.41 months. A majority of the sample (66%) was never married. Over three quarters (79%) of the sample belonged to the Christian denomination; ten percent belonged to the African traditional religions and a further 11 percent belonged to other denominations.

Over half of the sample (52%) was unemployed, with a mean length of employment of 23.3 months. Among those who were employed, six percent were earning less than BWP800 per month, 14 percent were earning between BWP8001 and BWP1, 000 per month. Almost half (45%) were earning between BWP 1,001 and BWP 3,000 per month, while just over a third were earning over BWP3,000 per month. Among those who were unemployed (48%), the average duration of unemployment was 16.6 months, while the mean duration of actively seeking employment was 20 months.

More than half the sample (52.6%) grew up in a rural area while 46.6 percent grew up in an urban area. A majority of men (43.5%) grew up in a family where both their parents were married while just under a fifth (18%) were raised by single mothers, and 1.9 percent were raised by single fathers. Slightly over one in ten men (12.4%) were raised by unmarried parents, while a further 16.8% were raised in extended family units.

The mean number of children ever fathered by men in this sample was 2.09 children, while the mean number of children fathered in men's current relationships was 1.69 children. Slightly over 3 out of every ten men (35.4%) had fathered one child, while 32 and 15 percent had fathered two and three children respectively. Only 5.4 percent of the men in the sample had never fathered a child, while 12 percent had fathered four or more children.

Table 1: Percent Distribution of Respondents by Background Characteristics

Variable	Number	Percent
Age		
17 – 21	96	16.6
22 – 25	143	24.7
26 – 30	169	29.2
31 – 35	78	13.5
36 – 45	57	9.9
46 – 69	35	6.1
Marital Status		
Married	53	9.2
Never Married	379	65.9
Cohabiting	109	19.0
Separated/widowed/divorced	34	5.9
Education		
Primary or less	39	6.9
Secondary	267	47.2
Tertiary	260	45.9
Employment		
Employed	276	48.1
Unemployed	298	51.9
Religion		
Christian	455	78.9
African traditional	60	10.4
Other	62	10.7
Income		
800 or less	16	6.0
801 – 1000	39	14.4
1001 – 3000	122	45.2
3001 – 5000	75	27.8
5001 or more	18	6.7
Place of childhood orientation		
Urban	274	46.6
Rural	309	52.6
Other	5	0.9
Family of orientation		
Both parents married	256	43.5
Mother only, married	29	4.9
Father only, married	9	1.5
Single mother	106	18.0
Single father	11	1.9
Both parents, unmarried	13	12.4
Extended family	99	16.8

N.B. Some of the figures in this table do not add up to the total sample because of cases missing information

Table 1a Means of Duration of Cohabitation, Children fathered & Employment

Variable	Mean	SE Mean
Duration of Marriage/cohabitation in months	28.41	4.210
Children fathered	2.09	0.103
Children fathered in current relationship	1.69	0.096
Length of Current employment in months	23.32	1.951
Duration of unemployment in months	16.62	1.441
How many months actively looking for a job	20.02	1.999

The following section presents qualitative results relating to men's views of their masculinity. Specifically the section focuses on respondents' definition and description of what it means to be a man; how one attains manhood as well as the challenges men face in aspiring to attain manhood.

4.3 The meaning of being man

According to most participants, the definition of manhood is tied to attainment of a certain status. These include getting married, taking care of one's dependants and being the head of household. To graduate to manhood is more than attaining a certain age and being considered an adult. Manhood is tied to being independent, having a family and being in control of the family as head of household.

> *A man is the head of the family, whether the woman enjoys higher social and economic status or not, when it comes to the family unit, a man is the head. This is because he initiates the family unit by getting married to the woman. It's the man who marries the woman, not the other way around. It may happen that the woman may have a higher*

> *position at work, but that doesn't change the fact that at home, the man is still head of household and family.* **[Men, Vendors 30-45 years]**

Apart from their assumed position as head of households, it is clear that attaining manhood is something that has to be attained rather than a stage that one simply attains by reaching a certain age. Attainment of manhood is based on the attainment of a certain socially approved status, a significant marker of which include being married and being able to provide for the family:

> *When you are labeled a man, it's not only because you wear pants, but there is a certain level of societal expectation and responsibility on your part. You have to be able to carry a lot of burdens, family problems, work and looking after cattle. Even when the woman is also employed, as a man, you carry a disproportionate amount of the burden. What makes you a man is your deeds and how you carry yourself.* **[Men, Rural, Unemployed 35-50 years]**

> *According to my culture from the north, in order to graduate to being a man, you should have a child, a woman, a home and have authority, that's how you become a man. Otherwise if you do not achieve these things, there is nothing that says you can call yourself a man. There is nothing socially that says you have moved from the current state (boyhood) into the next stage (manhood).* [Men, Vendors 30-45 years]

Once a man is married, he is expected to conduct himself in certain ways that distinguishes him from other men, especially those who are not married.

> *A man distinguishes himself by his acts, and wherever he is, there will be that aura that shows that here is someone worthy of respect. Even among other men, elders or women, it should be known that there is Mr. So and so. He should have respect that he earns through deeds, which everyone can see.* **[Men, University 32-42 years]**

To others, being a man is all about self sufficiency, to have command over resources. This self sufficiency and command over resources in turn shows that you are ready for the responsibility of getting married and caring adequately for your family.

> *As a man, you should have your own stuff and be self sufficient. A man has to work to achieve these things, in preparation for the fact that he should have his own place, a wife and children.* **[Young men, Church, 18-2 years]**

> *Even if the woman is also working, the man has to carry a disproportionate burden. : It seems like a man is defined in terms of all the difficult things and the easy things defines a woman* **[Men, Rural, Unemployed 35-50 years]**

Yet still, to others, a key feature that distinguishes one as a man is how they handle themselves in the face of adversity. Bravery is a highly cherished masculine trait because it suggests that you will be able to face any challenges and defend your family and all those who cannot defend themselves.

> *A man should be brave, if there is danger, he faces it. This is what we are therefore for. If you are a man, you should know that you have to face any problem or difficulty and find a solution. You have to be able to carry a lot of burdens; family problems; work; plowing; looking after cattle.* **[Young men, unemployed 24-33 years]**

An often cited aspect of masculinity among most men is that of being different from women. To be a man, you have to possess certain attributes that are commonly perceived to be missing in women. One such attribute is inexpressiveness. Some men referred to this as '*being able to keep secrets*', which basically means that to be a man, one should not be too quick to divulge their concerns in the form of complaints to other people, including other men, but more especially women. Women were generally viewed as '*talkative*' and were therefore more likely to divulge 'secrets' to their friends. This inexpressiveness was viewed as a foundation upon which family units are built, almost as if the absence of such inexpressiveness results in family units with weak foundations.

> *… it is important if you are a man to have secrets, or things that are only known to you and you won't share with others. We know that women cannot keep secrets. But if you are a man, and you decide that something is a secret, either family or personal secret, and*

you want to keep it that way, you can do that. But a woman cannot. **[Young men, Vocational 19-29 years]**

As a man, I believe that if you are someone worth his salt, everything of yours should not be known by everyone. You should have 'a secret'. There are things that cannot be kept secret, but there are others that, if they are family issues, they should stay there, at the family. To the extent that as a man, you may take some of these secrets to the grave, without having revealed them to anyone **[Men, unemployed 35-50 years]**

While most men identified the idealized form of masculinities, they nevertheless were aware of the challenges they face in attaining these forms, as well as some of the negative outcomes of trying to live up to these idealized forms. Men were especially aware of the fact that trying to be emotionally inexpressive can result in a bottling up of emotions, which may result in increased stress and dejection. Cherishing inexpressiveness closes a number of avenues that men could use to share and resolve issues.

These secrets of course can weigh down on us, but you know that when you decide to keep a secret. Of course others you may have to divulge or share with someone, in an orderly manner; so that people that you trust can help you. **[Young men, Vocational 19-29 years]**

The way I see things, things are not the way we expect them to be. There is a whole lot of confusion about what being a man entails or what is expected by society. For example, if I fall out with my partner, I would not be able to ask for advice from a friend or relative. The truth is that if I was able to do that, he might give me advice or encouragement that might prevent me from doing something adverse, like taking my own life. **[Young men, University, 19-24 years]**

4.3.1 Challenges to attainment of manhood

While men understood the socially constructed idealized forms of masculinities, they were of the view that the attainment of such idealized forms was a major challenge,

more so now, than in the past. Men feel that they face serious challenges to the attainment of socially expected status, most of which centered on men's reduced earning ability resulting from unemployment and poverty, as well as challenges posed by women's empowerment. Most men feel that modernization has resulted in their economic marginalization, as the main economic mode of production shifted from subsistence agriculture, which mainly featured cattle rearing, to the modern economy. In the subsistence economy, men controlled the means of survival through cattle rearing. The shift to the modern economy has resulted in an emphasis on jobs and access to formal education, while at the same time resulting in a marginalization of agriculture, which is mainly composed of cattle and small stock rearing and subsistence farming. One man summed men's perceived predicament by saying:

> *Men today are different from what men used to be; they are lesser men, in fact I'll dare say that there are no men left.* **[Kitso, 75 years, Village Elder]**

> *In the olden times people did not need education [to be men] as opposed to nowadays, where English is a necessity for someone to find a job or make a living. In the past a man could go to work at the mines and did not need English, he would leave a woman at home to take care of the cattle post and the lands, and the man would come back occasionally from the mines to check on the woman back home.* **[Kgosi, 56 years Traditional leader]**

Men identified lack of education as the main challenge that precludes their access to better paying jobs, and hence the ability to live up to socially expected roles.

> *According to me we fail to be "real men "because of lack of education. Due to lack of education… (Repeated) we fail to get good jobs, hence we would not be able to accomplish and maintain a good life for our families and meeting their every need as we desire. So the main problem is education.* **[Men, 35-50 years, Rural, Unemployed]**

> *It's tougher now, in those days it wasn't the end of the world if you were not educated. You could still work in the [South African], earn enough to buy cattle [to pay bride price], get married and support your children.* **[Tlhaodi, 61 years, Councilor]**

Within families and relationships, men's perceived disadvantage causes them to feel insecure, especially in cases where the woman has equal or more education than the man. Men were likely to feel less valued and vulnerable to being dumped for a better earning partner. Most men felt that in such a situation, the woman tends not to respect the man

> *It is harder nowadays than in the olden days because particularly when a man is not educated, and is in a relationship with an educated woman. In this case you find that often times the woman tends not to admire/desire the physical work or efforts that most of the un-educated men are good at. And it becomes hard for a man to force someone to admire what you do. Therefore, it means it becomes hard for people of such kind to live together. She ends up showing you the door!!* **[Men, 33-47 years, Employed]**

> *'Hei, it becomes difficult to maintain a relationship if you are not earning. She may disrespect you if you earn less than she does or do not have a job. She will leave you for another man if you lose your job or stop earning.* **[Young men, 17-23 years, Student]**

4.4 Men's Masculine and Gender Role Beliefs

Table 2 presents survey results of a number of questions on selected masculine and gender roles beliefs. Men were asked to '*agree*' or '*disagree*' with commonly held gender role and masculine attitudes and beliefs. The table presents proportions of men who agreed with the statements, according to men's background characteristics.

Table 2: Men's Masculine and Gender Role Beliefs by selected background variables

	Men are superior to women [%]	Men should always be Heads of Households [%]	Boys be tough, no emotions [%]	Not manly to seek help always [%]	Man be strong & self sufficient [%]	Man should be independent [%]
Age						
17 - 21	67.7***	49.0***	26.0	52.1	59.4	78.1***
22 - 25	67.1	60.1	33.6	54.2	58.7	61.5
26 - 30	69.8	71.6	34.3	45.6	59.8	73.4
31 - 35	62.8	66.7	47.4	46.2	57.7	57.7
36 - 45	43.9	61.4	38.6	54.4	52.6	50.9
46 - 69	74.3	80.0	37.1	48.6	62.9	74.3
Education						
Primary or less	59.0	82.1*	56.4***	56.4	41.0***	64.1
Secondary	65.9	63.3	37.1	52.4	53.6	65.2
Tertiary	66.5	63.1	30.8	45.0	66.2	69.6
Marital Status						
Married	62.3***	67.9***	39.6***	45.3***	50.9***	67.9***
Never Married	62.8	65.7	38.3	52.5	67.8	71.8
Cohabiting	70.6	63.3	21.1	38.5	45.0	54.1
Separated/wid/div	85.3	35.3	38.2	58.8	17.6	52.9
Employment						
Employed	65.6	62.7	35.9	52.2	55.8	63.4***
Unemployed	67.1	64.4	31.9	47.0	61.4	70.8
Religion						
Christian	64.6	64.2	32.7	46.4***	58.5***	66.2***
African traditional	71.7	66.7	41.7	56.7	73.3	85.0
Other	64.5	56.5	40.3	64.5	53.2	61.3
Family of orientation						
Both parents married	69.5	72.7***	33.2*	42.6***	58.6***	72.4***
Mother only	59.3	63.0	30.4	51.1	69.6	65.9
Father only	55.0	60.0	60.0	50.0	50.0	55.0
Both parents unmarried	64.4	57.5	41.1	52.1	49.3	64.4
Extended family	69.0 2.0	50.0	34.6	62.5	52.9	58.7
Place of childhood orientation						
Urban	67.9	69.3***	35.0	50.4	67.9***	73.7***
Rural	64.1	59.9	34.6	49.8	50.8	67.6
Number	***379***	***369***	***203***	***286***	***339***	***387***
Overall percent	***65.6***	***63.8***	***35.1***	***49.5***	***58.7***	***67.0***

*** Significant at 5% * Significant at 10%

Almost two-thirds (64%) of men believed that men should always be heads of households, regardless of whether their partner was also earning or contributing to the upkeep of the family. Twenty nine percent of men however did not agree that men necessarily should always be heads of households.

However, men tended not to overvalue emotional in-expressivity among boys as a way of preparing them for manhood. For example, just over a third of men (35%) felt that boys should be tough and not show emotions, while over half (53%) felt that this was not necessary. However, slightly over one in ten men were undecided about the importance or utility of portraying a tough exterior and emotional inexpressiveness in preparing young boys to the challenges of manhood.

Traits such as being strong, self sufficient and independent were valued by most men. These traits were viewed as necessary for man to be an effective head of household, and provider for the needs of the family. Six out of ten men felt that it was important for a man to be strong and self sufficient while seven out of ten felt that a man needs to be independent.

Most men appreciated the fact that women are now empowered to assume positions that were previously the domain of men, and the need for equal rights between men and women. However, exactly what such transformation meant in terms of power dynamics within relationships evoked strong emotions from many men. Most men see themselves as natural leaders within households and relationships, a role that comes naturally with that of provider for needs of their families. As a result, a majority of men felt that while women can work outside the home and contribute to family income, men should always be heads of households.

Table 2 shows that on a binary level, men's masculine beliefs are related to a number of individual and contextual variables. These include age, education marital status; family of orientation and place of childhood socialization. Close to two thirds of men held the belief that men are superior to women. The percentage of men who believe that men are

superior to women is highest among the oldest men (46-69 years) and men below thirty years. Seven out of every ten men in these age groups held the belief that men are superior to women, compared to four out of every five men aged 36-45 years. Also a higher percentage of men whose marriage has terminated either through divorce, widowhood or separation held the belief that men are superior to women compared to those who are never married or married. Close to nine out of every ten men who are either divorced, widowed or separated believe that men are superior to women, compared to seven out of every ten men who are cohabiting and six out of every ten who are either never married or married.

Most men believe that they are natural leaders within households and communities. As a result, close to two thirds of men (63.4%) held the belief that men should always be heads of households, even in situations where both partners are contributing to household income or even where only the woman is earning. This belief varied significantly by age; marital status; type of family and place of childhood orientation. The percentage of men who held this belief was lowest among the youngest men in the sample (17-21 years) tended to be higher among older men, especially those over the age of 46 years. Just under half (49%) of the men aged 17-21 years believe that men should always be heads of households while this proportion was 80 percent among men over 46 years of age. A higher percentage of married and never married men held this belief (66-68%) compared to those who are divorced, widowed or separated (35%).

Family of orientation also displayed significant relationship with the belief that *men should always be heads of households*. Almost three quarters (73%) of men raised in families where parents were married held the belief that *men should always be heads of households* compared to only half (50%) of those raised in extended families; or six out of every ten men raised in 'unmarried parent' families; or a similar proportion among those raised in either 'father only' or 'mother only' families. A higher percentage of men who were raised in urban areas (69%) believe that *men should always be heads of households* compared to those raised in rural areas.

Just over a third of men in the sample held the belief that boys should be tough and not show any emotions. This proportion did not vary significantly by most background characteristics except education and marital status. The percentage of men who held the belief that '*boys should be tough and not show any emotions*' decreases with increasing level of education, from 56 percent among men with primary and lower education, to 37 and 31 percent among men with secondary and tertiary education respectively.

Masculine and gender beliefs relating to health seeking showed significant variation according to a number of background characteristics. Only half of the men in the sample held the belief that *frequent help seeking is not manly*, however this proportion varied significantly according to marital status, religion and family of orientation. A higher percentage of never married (53%) and married (45%) men held the belief that *frequent help seeking is not manly* compared to cohabiting men (39%) or those who are either divorced , widowed or separated (39%).

The belief that a *man needs to be strong and self-sufficient* was held by close to six out of every ten men (59%). This proportion had significant variation by education; marital status; religion and place of childhood orientation. The percentage of men who held this belief increases with education; from 41 percent among men with primary education and less, to 54 and 66 percent among men with secondary and tertiary education, respectively. Over two thirds of never married men (68%) held this view, much higher than the corresponding proportion among married (51%) and cohabiting men (45%). Divorced, widowed and separated men had the lowest proportion of men who believe that in order to be a real man, one must *be strong and self sufficient*.

Religion also displayed a significant association with the belief that *a man should be strong and self sufficient*. A significantly higher proportion of men who identified themselves as belonging to traditional African religion held this belief compared to those who identified themselves as Christians and those who belong to 'Other' religions. Almost three quarters of traditional African religious men (73%) believe that a

man needs to be strong and self sufficient, compared to 59 and 53 percent among men who identified themselves as Christian and 'Other', respectively. In addition, a significantly higher percentage of men raised in 'mother only' households (70%) held this belief compared to men raised in other family setups. For example, half (50%) of men raised in 'father only' and 49 percent of men raised in 'both parents unmarried' households held the belief that a man needs to be strong and self sufficient. Place of childhood orientation also displays significant association with this particular belief. Two thirds of men raised in urban areas believe that men should be strong and self sufficient compared to those raised in rural areas (51%).

A majority of men (67%) believe in the notion that a *man needs to be independent*, and this belief varied significantly according to age; marital status; employment, religion; family of orientation and place of childhood socialization. The proportion of men who believe that a man should be strong and self sufficient tends to be high among younger men (78 % among 17-21 years; 62% among 22- 25 years and 73% among 26-30 years), reaching its lowest level among mid-age men (51% among 35-35 years) and increases among the older men in the sample (74% among 46-69 years).

4.5 Socialization and Gender Role Beliefs

The process of childhood socialization was identified as one of the factors through which gender roles are learnt and internalized, with specific regulatory mechanisms to ensure maximum differentiation between male and female roles. While children would often play together, there was always an attempt to ensure that each gender learnt specific roles in preparation for their roles as men and women. Men gave account of how parents, both their fathers and mothers, monitored their play activities, and would express concern if boys seem to play female games.

> *I was taught from an early age that as a boy you do not play with girls, or play their games, lest you become stupid.* **[Men, 34-42 years, University]**

There is a difference in the socialization of boys and girls. Boys are expected to learn male chores, while girls have to learn female chores from their mother and other females. If you played female games, you were reprimanded or assumed to be a bad omen if you did. **[Men 30-45 years, Vendors]**

One way in which parents ensure that boys are socialized into male roles is to introduce them to these roles from an early age. For example, fathers would bring their male children along when they go to the farm or cattle post, while the females would stay behind with their mothers. At the cattle post, they boy child is shown the livestock and informed that his task is to look after the farm and the animals.

When your father goes to the cattle post, he brings the boy child with him and the females are expected to accompany their mothers. There is also a certain code of behavior that is expected for boys and girls, which is different for the two. Boys are expected to behave in ways that prepare them for male roles. So they are not expected to perform female chores like sweeping the yard, but they are expected to for example, play with clay and mould toy animals (cattle). **[Kyle, 41 years, Social worker]**

If you played female games, you were reprimanded or assumed to be a bad omen if you did. When your father goes to the cattle post, he brings the boy child with him and the females are expected to accompany their mothers. There is also a certain code of behavior that is expected for boys and girls, which is different for the two. Boys are expected to behave in ways that prepare them for male roles. So they are not expected to perform female chores like sweeping the yard, but they are expected to for example, play with clay and mould toy animals (cattle). **[Men, 34-42 years, University]**

At times when boys play, they pretend they are animals (cattle) and they always want to be the 'male' one climbing on others. I don't know how that comes about (that they choose to play male not female animals). **[Young men, 24-33 years, Unemployed]**

Boys are expected to show that they are tough, they are told that they are men in the making and that they cannot be like women; that they have to be strong and be prepared

to shoulder problems and burdens without flinching. So there is emphasis that he should not be like a woman; that he should be different from women, that he will be ridiculed if he shows emotions like women do. The boy will be chastised for being like girls. **[Kitso, 75 years, Village elder]**

It is not only men who are interested in ensuring that boys learn female roles. Women also play an important role in the socialization of men into male roles. According to some discussants, women, mostly relatives, often played a significant role in their socialization into male gender roles.

In terms of instilling this discipline and insisting that boys play boys games, it is usually females who are more vigilant about that. In my case, it was my mother and other females who used to complain about boys playing girls' games and how doing that would make them grow up to be dumb /stupid. **[Young men, 19-24 years, University]**

I grew up at the lands, and I grew up among mostly females. There were very few males or boys. So as boys, we used to play separately from girls. But from time to time we would look over at the girls playing and at times it seemed like they were having more fun. Our games at times just appeared dull compared to theirs, so naturally we wanted to join them. We would end up playing with them. I remember my grandfather used to be concerned, he used to say we are going to grow up stupid because we play with girls or play girls games. So to prevent this interaction, we were made to herd goats, just to make sure that we stayed away from girls. **[Men, 34-42 years, University]**

A key informant had this to say:

As a woman in my household, if I have two girls and one boy, the way I raise them, or the way me and my husband would raise them, is such that the male child will always be reminded that the is 'the man' of the house, regardless of whether is the first or last born. He is his sisters' father / parent in a way. So he grows up with that mentality, that he is in charge, or that he has some influence and people have to respond to him. So when he enters adolescence, and starts having romantic relationships, he can't help himself but

want to be in control, to control the relationship; to have his own way; because he knows from his upbringing that he has to be in charge by virtue of being male, no matter what. **[Kyle, 41 years, Social worker]**

Gender roles relating to sexuality are also prescribed from an early age. When children reach adolescence and start being sexually active, parents tend to strictly monitor the girls' movements much more than they do the boys. According to some key informants, girls were monitored for fear that they may engage in sexual intercourse and fall pregnant. At the same time, male children were not closely monitored, even when there is evidence that they might have started being sexually active.

Our socialization is such that a lot of attention, in terms of discipline, is focused on women; from an early age, boys are given a lot of leeway. For example, if children went out to play after dusk, most of the time our parents would make the girls explain where they were and what they were doing and with whom. Boys were hardly ever interrogated in the same way that girls were. **[Men, 34-42 years, University]**

Boys were hardly ever asked to explain their whereabouts, it seemed like for them, it was natural that they could be away from the compound. In the evening to play boys were allowed to go out after dusk, and no one ever seemed to care where they were or when they came back home. It was not the case for us girls. Maybe because it was assumed that if girls went out they could end up having sex or doing some bad things. ***[Men, 35-50 years, Unemployed]***

Yes, boys might also do the same things, but it seemed not to be a serious problem if boys did those things (had sexual intercourse), maybe because for girls, if she falls pregnant, she has to bring the child home, but for boys, he might impregnate a girl, but the immediate results is that he does not bring the kid home. **[Entaile, 28 years, Peer Educator]**

It was also contended that while boys' movements were not subject to much scrutiny even when there was evidence that they may be engaging in sexual intercourse; boys

also received little if any information relating to puberty or how they should conduct themselves sexually. It was the view of most men that while women tend to give girls a lot of information about puberty and sexual conduct, boys are left to their own means because men hardly ever talked to them about sexuality.

> *What I have realized is that when boys grow up, there is very little by way of interface between boys and parents on issues of sex or sexuality. Girls were taught from an early age about their bodies, about how to sit properly (and not expose their private parts), but for the boy, he is left to his own means.* **[Men, 34-42 years, University]**

> *It seems like between boys and girls, its girls who are given more information about making important life decisions. There is usually not much said to boys, it is assumed they will figure things out; the little that may be said to them, it's done in such a way that they can easily ignore and not take serious heed of whatever they are being advised. Things like how to conduct themselves in sexual relationships; things like condom use etc. But a girl will be given information relating to puberty, body changes including menstruation and the fact that it signifies the fact that she may fall pregnant if she has unprotected sex. So condom use becomes something that they take quite seriously compared to boys.* **[Men, 30-45 years, Vendors]**

So boys are given free reign and very little information about how to behave; while girls are restricted but are better informed. This void in information sometimes results in confusion regarding puberty and body changes that accompany this stage of development.

> *When the adolescent stage comes, that's where the problems start. Because you have not been taught about your body or any changes that might occur, as a male child you are puzzled these changes. Apart from growing a beard or developing a deep voice, you might wake up in the morning and find that you had a wet dream. Because no one has ever taken time to talk to you about these things, you become confused; you might even think you are sick or feel ashamed. You only end up learning about these things from friends.*

But girls are taught about these things and how to make sense of these changes. **[Men, 34-42 years, University]**

I don't know if it happens naturally that boy s are so different from girls when it comes to expressing their emotions. Maybe because the girl spends most of her time in the company of the mother, and they talk a lot, they talk about how they feel, what makes them happy, what makes them sad, their wishes and hope. Women are naturally very expressive, so the girl learns from her mother. On the other hand, if the boy spends time with the father, they never talk about how they feel or things like that; they talk about impersonal stuff, like livestock / cattle; family assets, and how he should learn to control and manage them; they talk about material things. The girls (and even the mother) may not even know about some of the assets that the boy is being told about from time to time, she spends more in the company of her mother, doing household chores like cooking, cleaning. … **[Kgosi, 56 years, Traditional leader]**

The expectation that boys should learn male gender roles was also seen as a root for a lot of dysfunction in men's lives. The over valuation of emotional inexpressiveness, bravery and the expectation of being leaders and providers within families and relationships were cited as contributory factors to men's problems in later life. It was the contention of some that when boys are put through the paces in preparation for male gender roles; little attention is paid to the fact that they are just children or how they might misconstrue this socialization as some form of abuse rather than a process to prepare them for manhood.

Boys are not expected to show weakness or to cry when they are hurt. At times the boy is treated like a dog. The boy is expected to be strong because he is expected to grow to be man, so he has to show that he has those capabilities. However, at times such expectations over look the fact that this little boy is still a child, and he needs to show his emotions by crying if he feels hurt. **[Young men, 19-29 years, Vocational]**

Our socialization was such that if a boy injures himself, he is told and expected to pick himself up, dust himself and not cry, whereas if the same thing happens to the girl, there

will be concern about whether she is okay, she is attended to and soothed. So clearly there is a difference in the way that boys and girls are expected to behave. **[Men 35-50 years, Unemployed]**

I believe this differentiation is the root of a lot of problems. When you expect a child to prove that he is a man or will grow up to be a man, what registers in the child's mind is something else. The child might feel less loved. So you have to show him also that he is a child and treat him that way. Otherwise he will grow up feeling like he had a difficult upbringing. So what you as a parent may see as preparation for manhood (by expecting him not to show emotions) he may see as a difficult and uncaring upbringing, almost bordering on abuse. **[Men, 34-42 years, University]**

While some men saw the tough upbringing as a source of problems in later life, some men felt that the tough socialization was worth it as it was meant to prepare the boys for the challenges of manhood and the pressure that men feel to prove their masculinity:

*There is immense pressure on men to prove themselves. This is why the tough upbringing that we were discussing earlier and felt that it seems like abuse: all of that was meant to prepare you as a man, to build you for the kind of weight of expectations that you have to shoulder, so that you have the 'heart' to face problems. But it all depends on ones' personality. One person may later see this tough upbringing as something positive meant to help them be better men, someone else might see this upbringing as abuse or devoid of love***. [Men, 30-45 years, Vendors]**

Those days, if you had an injury, either wash it with water, if there is no water you wrap it with a cloth. If you don't have a cloth you'd just kick dirt into it and it will heal. Things have changed, nowadays if you do that you get an infection. **[Kitso, 75 years, Village elder]**

Some however pointed out that their socialization was gender equitable and there was not much differentiation between male and female gender roles. Most such men

indicated that they were brought up in families where there were either more female than male children or where there were no female children.

> *I was socialized differently from most men. I grew up knowing that I have to do all household chores; cooking, cleaning and washing clothes for my mum. Even today I can wash her clothes. I have a partner with whom I, we have two children and we are in the process of getting married. So, basically I do all activities that need to be done at home.* **[Ntwa, 44 years, Men's Sector]**

While most men pointed to their socialization as the reason for differentiated gender roles, most men in the focus group discussions were amenable to the idea of shared household roles with their partners. However, many men would rather do these roles within the safety and confines of the household, away from prying eyes of other men who might perceive them in a negative light. Men indicated that if they were to do traditionally female chores such as cleaning the house; bathing children; doing the laundry, they would rather perform these tasks in private, lest they be judged unfavorably by their peers and society. For example, one man indicated that if he were to do the laundry, he would insist that the woman be the one who hangs it out to dry, especially if such laundry contains women's clothes or nappies. A big fear among men who are willing to do these household chores is that their partner might brag to her friends about the fact that he is doing all these household chores. To some men, doing so would be an affront to their social status.

> *There are some things which can spoil relationship between partners which can then cause the man to stop performing some of those activities. For instance, if a woman boasts to another woman that her partner does such activities may not go well with the man hence he can be discouraged to continue doing them.* **[Men, 33-47 years, Rural, Unemployed]**

> *They will ask you whether you are mad (Laughter); your colleagues will tease you in front of others there that you are fool that is why you wash nappies. If you are a free*

person you can talk about it. To save face (if it got to be known they are doing female roles) some men may choose to make light of it, speak about it as if it were a joke, otherwise his colleagues would think that the woman has used some traditional medicine to 'pacify' them. **[Young men, 25-35 years, Urban, Employed]**

4.6 Men's Gender and Sex Beliefs

The following section presents results relating to men's gender and sex beliefs. Table 3 presents men's responses to selected gender and masculine beliefs.

Table 3: Percentage Distribution of Men according to Gender and Masculine Beliefs

Variable	Agree % (N)	Undecided % (N)	Disagree % (N)
1. Men need sex more than women do	43.5	21.3	35.2
2. Men have less self control than women when it comes to sex	48.1	17.6	34.3
3. Women find sexual coercion stimulating	54.2	15.6	30.2
4. Men are sexually stimulated by sexually coercing women	49.1	15.7	35.1
5. A woman sometimes pretends she Does not want sex expecting the man to coerce her	75.6	4.9	19.6
6. It is okay for a man to have multiple partners so that he can decide who he wants to marry	17.0	6.4	76.6
7. It is desirable to me for a woman to be strong and self sufficient	44.3	13.1	42.6

The results show that most men believe that men need sex more than women do (43.5%) and that they have less self control when it comes to sex (48.1%). At the same time, just over a third of men did not agree with the statement that men need sex more than women, or that men have less self control than women when it comes to sex.

The results further show that men generally believe in gender stereotypes that can facilitate use of coercion within relationships. For example, close to half (49.1%) of men believed that men are sexually stimulated by coercing women into sex, while over half

(54.2%) believe that women find sexual coercion stimulating. In fact, three quarters of men (75.6%) believe that sometimes a woman can pretend not to want sex, expecting the man to coerce her into having sex.

The practice of multiple sexual partnerships is understood to be one of the ways in which men tend to assert their masculinity and power over women. This practice also increases women's vulnerability to infection and facilitates the rapid spread of HIV. Beliefs that men need sex more than women, or that they have little self control in sexual matters have at times facilitated the maintenance of multiple sexual partnership. At times men would keep more than one partner with the idea that having multiple partners will allow him to compare and select the partner who is suitable for marriage.

Less than a fifth (17%) of men agreed that men need to maintain multiple sexual partners so that they can choose one partner to marry. In fact, over three quarters (76.6%) disagreed with this assertion about the need for multiple sexual partnership and choice of marital partner, while fewer than 7 percent were undecided.

Table 4: Percentage Distribution of Men by selected beliefs about socialization

Variable	Agree %	Undecided %	Disagree %
1. Girls should remain virgins until marriage	45.5	12.1	42.4
2. Boys should remain virgins until marriage	42.7	11.4	45.9
3. Only a bad girl shows that she likes sex a lot	18.8	11.2	70.0
4. A girl who initiates sex does so because she has other boyfriends	13.9	12.6	73.5
5. A woman who wants to have sex is failing to control herself	18.9	10.0	71.1

Table 4 summarizes men's gender roles and socialization beliefs. An examination of men's gender role beliefs indicates that most such beliefs are equitable and egalitarian. The equitable nature of some of these beliefs is likely to have been impacted by exposure to HIV messages, which tend to challenge common beliefs and misconception about sex and HIV. For example, close to half of the men interviewed believe that women should remain virgins until marriage (45.5%) while an almost similar proportion (42.7%) felt the same way about boys. In addition, relatively small proportions of men believe that only bad girls show that they like sex (18.8%); or that a girl who initiates sex does so because she has other boyfriends (13.9%) or that a woman who wants to have sex is failing to control herself (18.9%). Overall, seven out of every ten men disagreed with these gender role and sexual stereotypes.

Table 5 presents more gender role and socialization beliefs by selected men's background characteristics. The proportion of men who believe that boys or girls should remain virgins until marriage varies significantly by marital status; religion and family of orientation. A higher proportion of married (45-53%) and divorced, widowed

Table 5: Percentage Distribution of Men's Socialization beliefs by selected Background Characteristics

	Girls should be virgins until marriage	Boys should be virgins until marriage	Its good that women now havemore rights	Both have right to make decisions in relationhip	No one partner shouldhave more power than the other	Both should be free to say when they don't want sex	A woman should be as happy as man in relationshiop
Age	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**
17 - 21	50.5	54.2	80.2	78.9	76.0***	90.6	92.7
22 - 25	41.5	34.3	76.2	80.4	65.7	83.7	90.8
26 - 30	42.0	41.4	81.1	79.9	73.4	86.3	94.7
31 - 35	51.3	46.1	74.2	89.5	73.7	94.7	94.7
36 - 45	49.1	40.8	78.9	82.5	77.2	91.2	94.7
46 - 69	45.7	48.6	80.0	88.6	82.9	91.4	94.3
Education							
Primary or less	35.9***	41.0	92.3	87.2	84.6***	89.7	89.7
Secondary	51.3	44.9	96.2	82.3	72.5	89.4	92.0
Tertiary	38.8	39.6	77.3	81.5	71.9	87.3	95.0
Marital Status							
Married	45.3***	52.8***	83.0***	79.2***	75.5***	90.6	88.7
Never Married	42.6	38.6	79.9	87.5	72.2	88.5	94.1
Cohabiting	39.8	37.6	67.0	61.5	64.2	85.3	93.6
Separated/wid/div	73.5	70.6	82.4	88.2	88.2	91.2	91.2
Employment							
Employed	45.1	43.3	81.8*	85.1***	75.3	89.0	93.4
Unemployed	45.6	42.3	74.8	78.1	65.9	87.5	93.0
Religion							
Christian	44.2***	41.8***	77.3***	80.1***	71.6	88.0***	93.1
African traditional	45.0	31.7	73.3	83.3	80.0	78.3	88.3
Other	55.7	60.7	90.2	96.7	75.4	1.0	98.4
Family of orientation							
Both parents married	37.4***	34.8***	73.0***	72.3***	67.6***	84.6*	91.7
Mother only	48.1	47.4	77.8	88.1	71.1	91.1	92.6
Father only	40.0	40.0	75.0	85.0	80.0	95.0	95.0
Both parents unmarri	67.1	61.6	91.8	98.6	82.2	97.3	79.3
Extended family	46.6	52.7	82.5	85.3	77.7	86.3	95.1
Place of childhood orientation							
Urban	44.7	43.2	80.6	79.1***	69.2	90.1	94.1
Rural	45.6	41.7	78.2	84.1	75.7	87.1	93.2
	261	***246***	***451***	***463***	***412***	***504***	***534***
	45.5	***42.7***	***78.3***	***82.2***	***73.0***	***88.3***	***93.4***

*** *Significant at 1%* * *Significant at 5 %*

or separated (71-73%) men held the belief that boys and girls should remain virgins until marriage, compared to never married men (39-43%) and cohabiting (37-40%) men. The highest proportion of men who believe that boys and girls should remain virgins until marriage occurs among men who belong to 'Other' religions (56% for girls & 61

percent for boys) while between 42 and 44 percent of men who classified themselves as Christians held this view. Less than half (45%) of traditional African religious men held the belief that girls should be virgins until marriage and less than a third (32%) believed that boys should remain virgins until marriage.

Men's family of orientation also displays significant relationship to men's views about the need for boys and girls to remain virgins until marriage. A higher percentage of men raised in 'both parents unmarried' family setup (62-67%) supported the notion that boys and girls should remain virgins until marriage compared to men raised in 'both parents married' (35-37%) or 'father or mother only families (40-48%).

A majority of men (78.3%) felt that it was good that women now have more rights than was previously the case in the past. This proportion displays significant variation by marital status; employment status; religion and family of orientation. The percentage of men who feel it is good that women have more rights than before is highest among men who are married (83%) and those who are divorced or widowed (84%). This proportion is slightly lower among never married men (80%) but considerably lower among men in cohabiting relationships (67%).

The proportion of men who felt that it is good that women have more rights than before also significantly varied according to employment status and family of childhood orientation. This proportion was higher among employed men (82%) than those who were unemployed at the time of survey (75%). The proportion was also higher among men raised in families where both parents were unmarried parents (92%) and those raised in extended families (83%). This proportion is relatively lower among men raised in single mother families (78%) and even lower among men raised in families where both parents are married (73%).

A high proportion of men expressed attitudes that were supportive of their partners' rights to make decisions within the relationship. Over eight out of every ten men (82%) of men felt that both partners have a right to make decisions within relationships. This

proportion varies according to marital status; employment; religion; family of orientation and place of childhood orientation. A higher percentage of married (79%) and widowed or divorced men (88%) shared this view compared to men in cohabiting relationships (62%). A higher percentage of men who were employed at the time of study (85%) felt that both partners have a right to make decisions within relationships, compared to those who were unemployed (78%). In addition, slightly lower proportion of Christian men (80%) shared this view compared to African traditional (83%) and men belonging to other Non-Christian religions (97%).

The percentage of men who believe that both partners should have equal rights to decision making within a sexual relationship varies according to men's family and place of childhood orientation. A high percentage of men raised by unmarried parents (99%); single mothers (88%) and extended families (85%) supported this view compared to less than three quarters (72%) of men raised in families where both parents are married. In addition, a relatively higher proportion of men raised in rural areas (84%) believed that both partners have a right to make decisions within a relationship compared to men raised in urban areas (79%).

Most men were aware of the need to balance their power within the relationship with that of their partner. Almost three quarters (73%) of men felt that no partner should have more power than the other within a relationship. This percentage was highest among the oldest men (46-69 years) in the sample (83%) and lowest among men of ages 22-25 years (66%). The proportion of men who felt that no partner should have more power than the other within a relationship is inversely related to level of education. The proportion is highest among men with primary education (85%) and lower among men with secondary (73%) and tertiary education (72%).

Most men (88.3%) were also amenable to the idea that both partners should be free to initiate sex or to decline sex if they did not feel like it, and almost all men (93%) felt that

a woman should be as happy as a man in a relationship. These two proportions show the least variation by men's background characteristics compared to other variables.

4.7 Equality & women's empowerment

This section presents men's views and attitudes on social power relations, specifically women's empowerment and women's equality with men. Table 5a shows men's responses to a number of questions relating to equality and women's empowerment. The results show that men's attitudes were mainly positive and egalitarian. For example over three quarters of men (77.8%) felt that women's empowerment was a good thing. Most men were also aware of the desirability of equality within intimate relationships. For example, 72 percent of men felt that no one partner should have more power than the other in a relationship and 82 percent felt that both partners have a right participate in decision making within a relationship. Almost 9 out of every ten men (88.5%) felt that both partners should be free to decide if and when they want to have sexual intercourse.

Men's attitudes towards women's empowerment through affirmation and protection of women's rights were also examined. More than three quarters of men (78%) felt that it is a good thing that women now have more rights and powers than in the past. The percentage of men who held this view showed small but significant variation by marital status; religion and family of orientation. This proportion is slightly higher among men who are married (83%) and divorced, widowed and separated (82%) compared to those who are cohabiting (67%) or never married (80%). Religion also shows small but significant variation in attitudes towards women's empowerment. The highest proportion of men who believe that *it is a good thing for women to have more rights*, is highest among men belonging to 'Other' religion (90%), followed by Christians (77%) and traditional African (73%).

A significant percentage of men believe that both men and women should have equal right to make decisions within a relationship (82%). This proportion varies significantly by a number of factors, including marital status, employment status, religion; family of orientation and place of childhood socialization. The percentage of men who believe

that men and women should have equal rights within a relationship is highest among divorced, widowed and separated men as well as never married men (88%) while this proportion is lower for married men (79%) and cohabiting men (62%). A higher percentage of men who are employed expressed this belief (85%) compared to those who are unemployed (78%). Also, a smaller percentage of men raise in 'both parents married' families felt that men and women should have equal right to make decisions within a relationship (72%) compared to men raised in other family setups, where nine out of every ten men expressed this view. In addition, a higher percentage of men who were raised in rural areas indicated this belief (84%) compared to those who were raised in urban areas (79%).

Most discussants appreciative of the improvement in women's status arising from women's empowerment programs, as well as the need for men to play a positive role in affirming and protecting women's rights.

> *You see, the push for equality at home came at the right time, women were suffering. Unlike in the past where women stayed at home and tended to the household chores without men's help, women now have formal jobs, so men have to share household chores and accord the woman some respect.* **[Ntwa, 44 years, Men's Sector]**

However, there was also a strong view about the need for education on what equality within a relationship entails. The view was that men have to learn to exercise their authority with more diligence and consideration for their partner, while women also have to learn to exercise their new found rights without undermining the man's need for respect within the household. Many discussants felt that women's empowerment is being pursued at the cost of men's disempowerment. A key informant observed the following about men's need for respect:

> *You can undermine a man everywhere, at work, in the community, but if you undermine him at home, you have finished him. You will have hit him at the base, it's the most painful thing you can do to a man.* **[Kyle, 41 years, Social worker]**

A persistent view among some men was that women's empowerment is failing to result in improved relations between men and women due to a divergence between men and women's understanding of their roles and responsibilities within equitable relationships. This divergence in understanding results in lack of consultation and conflict:

> *My view is that men and women have the same basic rights, thus there should be proper consultation and respect within families and relationships; otherwise there will be conflicts in the relationship, which may affect children negatively. There should be consultation about everything, from household resources; when to have sex and whether or not to use condoms. We have to be careful as men not to want to impose our way in relationships every time. It doesn't work, it just creates conflicts and we end up in trouble.* **[Men, 34-42 years, University]**

Women's empowerment was seen as a mixed bag, on the one hand it has improved women's status and right, yet on the other hand it is seen as having resulted in disrespect for men within households and relationships. This apparently paradoxical view of women's empowerment and equality was summed by one respondent this way:

> *Hei, this equality…...(long pause)… if there is equality there is a lot of disrespect, a woman fails to respect her man, on the other hand, if there is no equality women get oppressed. Equality has had positive outcomes such as in addressing the plight of women within households, through violence and domestic abuse. But it has also bred disrespect for the man. Some (women) got derailed (by this 'empowerment) after learning how to drive a motor vehicle they (women) start to think that the man is a fool!* **[Men, 35-50 years, rural, unemployed]**

There was also evidence of varied understanding of what women's empowerment and equality were all about, resulting in the perception among some men that equality with men was not possible. A significant part of this variation in the understanding of

women's empowerment seems to have its basis on men's relative lack of information on what exactly equality and empowerment entails, and perhaps even more in their lack of certainty about their role in the transformation of gender relations. So while the desirability of improving women's social status through women's empowerment was generally well appreciated, some men faulted the way empowerment is being presented and pursued. They felt that strategies for attaining equality and empowerment tended to depicts all men as adversaries; uninterested, or obstacles to be overcome, rather than as partners to women's empowerment. They saw this as a key reason why women's empowerment has failed to transform and improve gender relations.

From discussions with men it becomes clear than one of the grievances they have concerning equality is the unequal treatment before the law. The view among most men was that women's empowerment and equality has not translated into equal treatment of men and women before the law. There was a popular view that since men are generally viewed as perpetrators of violence within relationships, or as source or agents of women's inequality and disempowerment, when there is a conflict in the relationship, the law tends to over compensate for this imbalance in power within relationships by treating men more harshly than women, even before the full fact of the case are established. Men indicated that they were more likely to be detained or arrested whenever their partner lodges a complaint with the police. On the other hand, they were more likely to be scoffed at or ridiculed by police and authorities for not being '*real*' men if they were to lodge a complaint about their partner's violence or threat of violence.

> *I don't support equality 100%. There are instances when equality is good, but it fails us many times. For example, if a man and woman get into an argument and start trading profanities, enter the law, and the man will get a heavier sentence despite the fact that both the man and the woman were equally guilty, even in cases where the woman was worse. In the end you get the short end of the stick… why? Because you are a man, in their eyes, you don't deserve respect.* **[Men, 35-50 years, rural, unemployed]**

Coming to this issue of equality; I don't support it… (Pause) I do not support it … because if I commit a crime similar to one committed by a woman, we are not going to be sentenced the same way. When the police come for me, they will handcuff me while she does not get the same treatment, even if we committed the same crime together. **[Young men 25-35 years, urban, employed]**

When the police come to take both of you after committing a crime together, they will tend to be lenient with the woman while being harsh with the man. For example, if you both have to be detained, they can give the woman time to prepare and get her stuff together. As for the man, you are just bundled up as you are without being given any time to straighten yourself. **[Young men, 24-33 years, unemployed]**

The police are quick to lock you up if you have a conflict with your partner. But if you report a woman to the police, they take long to even investigate, and in many instances they are insensitive to your plight. They could even laugh at you, and ask you what kind of a man you are, for failing to control your woman. It's because while women have Emang Basadi, men have nothing of that sort to protect their rights. **[Tlhaodi, 61, Councilor]**

At times, when you report your partner, the police will insist that you go back to elders and try to resolve the dispute amicably. However, if the roles are reversed, the police are quick to take action against the man, and they will ensure that he spends the night in jail. In such instances equality oppresses us; we are neglected by the law. Out of frustration, the man might resort to violence. **[Young men, 19-29 years, vocational]**

Other men felt that equality has made them lose control over sexual matters within relationships. Men cited instances where now, it is possible for a woman to refuse to have sex with her partner, without having to offer any reasons for her unwillingness. The issue of marital rape was particularly a major cause for concern among many men, who saw it as a ploy to disempower men and punish men. Many men appreciated that even within a marital relationship, a woman has the right to refuse to have sex, but they felt that such refusal should be accompanied by credible reasons and proper

communication with their partner. They felt that most of the time, refusal to have sex is never an issue if there is proper communication and openness. However, they felt that problems usually start when the woman does not feel obliged to give any reasons for her unwillingness to have sexual intercourse.

> *It's okay, but it also oppresses us. For example, you may feel like having sex with your partner, and everything is there, time, opportunity, condoms, everything (slight pause) and she just tells you in no uncertain terms that she won't do it. That is where oppression sets in because when you are dismissed without any valid reasons, you may impose yourself on her and that where problems then start. You end up accused of raping her.* **[Men, 30-45 years, Vendors]**

> *Now [because of equality] your wife or girlfriend can accuse you of rape. If she does you end up being imprisoned because no one is willing to listen to you.* **[Men, 33-47 years, urban, employed]**

Many men felt that the equal status between men and women does not translate into equal treatment before the law, that they get harsher punishment than women for similar crimes. Some men argued that instances of violence in the home can be traced back to the fact that men have nowhere to turn for justice. According to some men, at times the police ridicule men for lodging a complaint about their partner,

> *…when I come back from the police and they did not listen to me, I may vent out my frustration and humiliation suffered at the hand of the police on her…if I find her at home, I may kill her and then take my own life… that is why nowadays there are many 'passion killings'.* **[Johan, 39 years, Soldier]**

Some men shared their experience of trying to lodge a complaint against their partners with the police.

> *They laugh at you and tell you are either crazy or not a real man. Three days ago I went to the police to report my partner for threatening to scald me with boiling oil. They told me to my face that I was crazy! Even if they were to follow up the case, I would have*

become the chief suspect and undergo interrogation which might result in my being locked up for the night to protect the woman. **[Men, 35-50 years, unemployed]**

That actually happened to me; I tried to report thinking the police would counsel us and help us get back together but instead I was told "why don't you look for another lady?" So I gave up, and went home. Later I went to for counseling from my mother. So, you see, if I was one of those men who lack self control, I could have resorted to violence, even killing her. The law must not sideline anyone. **[Babusi 38 years, male nurse***]*

It is them who oppress men. For instance, when you break up with a woman she would leave with most of the stuff you accumulated together while you get virtually nothing; they are not even prevented from robbing us. Even the government oppresses men; that is why there are a lot more men than women in prisons. Women now oppress us. **[Men 35-50 years, rural, unemployed]**

For instance, if have a child, you are supposed to take care of the child together. Every self respecting man want to look after his child and partner, but doing so becomes difficult when you are unemployed, regardless of whether you are a man or woman. However, if you are man, and are unemployed, your partner can still report you to the law and demand child maintenance. If you fail to pay you lend in deeper trouble and maybe imprisoned. The same treatment is not meted out to women who have children but fail to maintain them, and there are many such women. **[Men 35-50 years, rural, unemployed]**

Do you know how it is? Even though men make laws they love women more than their fellow men. Men make laws, but in cases where women are involved they tend to favor women, so that it would not look like they made laws to their own advantage. **[Men, 33-47 years, employed]**

While some men had a broad understanding of what equality with women entails, many had the view that equality is about men and women being required to perform similar types of tasks. In many men's view, the fact that most women cannot perform

physically demanding tasks to the same level and ability as most men was a clear sign not only that men are not equal to women, but that equality was not possible.

> *There is no way women can be equal with men! Starting from long-back, women could not go for battles/war. Even today the very same food the woman prepares at home is bought by money earned by a man including many possessions within the house.* **[Young men, 24-33 years, rural, unemployed]**

> *Even though we are said to be equal, a woman cannot go to fetch the cattle as far as a man would. She would even tell you that the borehole needs repair since she cannot do anything about it, she would not be able to even be able to milk cows. In things like that, even though we are 'equal' she is dependent on you as a man!* **[Men, 30-45 years, Vendors]**

> *No! There is nothing like. Equality can only be attributed to the Herero women who can milk cows, look after them and do all other things. If the whole country was like that, that is when we could have attained equality; not like what is happening among the other tribes [Bakgalagadi and Bakwena] whose women would rather to go nightclubs than get involved in such activities.* **[Kitso, 75 years, Village elder]**

> *Equality has been there long time back. We found it among our parents. Women used to ride donkeys, even to do manual work like treating leather, with men.* **[Tlhaodi, 61 years, Councilor]**

4.7.1 Equality within the household

A popular view among men was that while equality is a noble idea, it was more achievable and appropriate in the workplace rather than at home or within the household.

> *Equality has brought both good and bad outcomes; it just depends on how you take it. It's good because it makes consultation possible, and can ensure that the woman has a say in the way that their joint resources are used and deployed. At the same time, the woman*

might decide to stifle any decision that the man wants to make, just for the sake of doing so. **[Men, 35-50 years, Unemployed]**

To many men equality within the household was associated with loss of control; lack of order and instability. Some felt that equality within the household would compromise (men's) ability to make resolute decisions as heads of households, leading to many stalemates on important decisions if the woman has equal power to challenge her partner's decision.

Problems! It has caused problems, a man can no longer control his wife, if you say something; she counters, and reminds you about it (equality), that you are (now) equal. **[Men, 35-50 years, Unemployed]**

The term '50-50' was used repeatedly by men in focus group discussions to designate the perceived stalemate that would result if each partner had equal powers.

This 50:50 issue does not do any good to the families; there always has to be someone in control for progress to be achieved. Equality within the household will cause confusion.

[Young men, 18-27 years, Church]

Equality is applicable only at work not at home. For instance, to qualify for work should not have gender-bias; a woman can drive heavy-duty vehicles just as much as a man can. But at home equality does not apply. A man should be on top. **[Young men, 19-29 years, Vocational]**

So women tend to be perceived as incapable of making important decisions, or at least not able to make them as resolutely and promptly as the man, as head of household, would. So while many men saw the need to affirm women's rights within the family and communities, to many men, it's a question of finding the right balance. While men noted the need for women's rights in society and within families to be affirmed and protected, they nevertheless felt that such affirmation and protection of rights does not have to translate into lack of recognition for the male role within households. In the

view of others, for peace and order to reign within households, '*this equality*' has to leave the balance of power [even if it is just a semblance of it], tipped slightly in favor of the man. Men felt that this should be the case, if not for the fact that the man is the head of household, at least for the fact that in the traditional setup, '*it is the man who marries the woman, and starts the process of building the family*'. **[Mooki, 47 years, Pastor]**

As one discussant put it:

> *Otherwise the law has to be changed; let women marry men and pay bride (bridegroom)-price. They feel oppressed just because we pay bride-price? Let them also toil for resources to get married and raise a family, maybe then she can (feel justified to) also oppress me. In such case I will give-in to her oppression because she would have married me.* **[Men, 35-50 years, Unemployed]**

Chapter 5: Men, HIV/AIDS and Health Seeking Behavior

5.1 Sources of Information on HIV/AIDS

This section presents results relating to men's main sources of HIV/AIDS information. An important part of HIV prevention strategies is the provision of accurate and adequate information on HIV prevention and transmission. An examination of men's sources of HIV information is important for two related reasons. First, there is likely to be significant issues of access, reliability, adequacy and accuracy of HIV information depending on the source of such information. Thus an individual's main sources of HIV/AIDS information might have important implications for the quality of knowledge that an individual possesses and can acts on.

Second, Botswana's health care infrastructure forms an important delivery mechanism for sexual and reproductive health services and HIV/AIDS information and services. Generally information disseminated through health facilities is assumed to be more reliable compared to information disseminated through other sources such as the media, which might give conflicting images. However men tend to be uneasy about utilizing health services, which historically were geared towards maternal and child health. Despite efforts to make the services male-friendly, health services for male sexual health issues remain ill defined and health service providers not sufficiently prepared to provide services for males (MoH, 2007). Consequently, men are less likely to seek health care than women (MoH, 2007), so they tend to miss out on the information that is usually disseminated at health facilities. The fact that men are not likely to access this source of premium HIV information makes it critical to understand where men generally obtain their HIV information and the strengths and weaknesses of such sources of HIV information.

Table 6: Men's Sources of HIV/AIDS information and Knowledge of HIV/AIDS

Variable	Number	Percentage
Main source of knowledge on HIV		
Radio/TV	492	85.0
Newspapers / magazines	50	8.6
Friends	3	0.5
Wife / partner	1	0.2
School	4	0.7
Health facility	29	5.0
Second source of knowledge on HIV		
Radio/TV	11	3.5
Newspapers / magazines	226	71.1
Friends	40	12.6
Wife / partner	13	4.1
School	13	4.1
Health facility	15	4.7
Third source of knowledge on HIV		
Radio/TV	0	0
Newspapers / magazines	3	1.1
Friends	113	41.9
Wife / partner	13	4.8
School	25	9.3
Health facility	101	37.4
Other	15	5.6
Knowledge of HIV prevention		
Consistent condom use	436	97.8
Being faithful to one partner	225	93.4
Abstinence	212	89.8
HIV can be transmitted from one person to another through		
Unprotected sex	531	98.3
Blood	176	89.3
MTCT	141	84.9
HIV Misconceptions: HIV can be transmitted by		
Sharing meal with infected person	18	3.1
Sharing utensils	60	10.2
Witchcraft	40	6.8
Mosquitoes	79	13.5

Table 6 shows men's sources of information on HIV and AIDS, as well as their knowledge of HIV transmission, prevention and misconceptions. The results show that men's main sources of information on HIV are the media, specifically radio, television. Radio and television are the main sources of HIV/AIDS information for 85 percent of the men in the sample. Only 8.6 percent cited newspapers and magazines as their main source of HIV/AIDS information, while health facilities were the main source of information for only 5 percent of the sample.

The second most important source of information on HIV/AIDS was newspapers and magazines (71%). However, over a tenth men cited friends as their second most important source of HIV/AIDS information. Less than five percent of men indicated partners, schools and health facilities as their second most important source of HIV/AIDS information. The third most important source of HIV/AIDS information was friends (42%), closely followed by health facility (37%).

5.2 Men's Knowledge of HIV/AIDS

This section presents results relating to men's knowledge of HIV prevention, transmission and misconceptions (Lower half of table 6). Most men were aware of the three ways of preventing HIV infection and the various ways in which HIV can be transmitted from one person to another. For example, virtually all men knew that HIV can be transmitted through unprotected sexual intercourse with an infected person (98.3%); unsafe blood transfusion (89.3%) and mother to child transmission (84.9%). In addition, virtually all men knew that HIV transmission can be prevented by consistent condom use (97.8%); being faithful to one uninfected partner (93.4%) and abstinence from sexual intercourse (89.8%).

The high awareness of the means of HIV prevention and transmission was also reflected in the high percentage of men who were able to dismiss popular local HIV/AIDS misconceptions. Only a small proportion of men believed that HIV can be transmitted through sharing meals with an infected person (3%) or sharing utensils

with an HIV infected person (10%), witchcraft (7%) or mosquito bites (14%). The misconception that HIV can be transmitted through sharing utensils with HIV infected persons, or that HIV can be transmitted through mosquito bites is relatively more prevalent than the other misconceptions. The high awareness of HIV/AIDS prevention and transmission can be credited to increased and intensified HIV/AIDS information campaigns that form the core of the country's preventive efforts.

However, there are signs that despite men's awareness of specific aspects of the epidemic, such as transmission and prevention, men's overall knowledge of the epidemic may not be very deep. In the above results, men's knowledge of HIV is measured in terms of percentage of all men who know a specific individual method of HIV prevention or transmission e.g. the percentage of men who know that HIV can be transmitted through unprotected sexual intercourse; or the percentage who know that HIV can be prevented through consistent condom use. This foregoing approach focuses on knowledge or awareness of individual aspects of the epidemic. Despite the fact that this approach is simple and easy to understand, it may result in conflicting interpretations the overall level of knowledge if the percentages corresponding to each item vary significantly.

An alternative way to measure men's knowledge of HIV is to attempt to simultaneously assess an individual's knowledge of various aspects of the epidemic. The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) recommends that knowledge of HIV/AIDS should be measured as a composite variable based on knowledge of HIV various aspects of the epidemic, such as transmission, prevention and misconceptions, rather than using only one variable to determine level of knowledge. This approach compiles a score for each individual based on the number of correct responses to a number of questions on various aspects of the epidemic, which may include HIV transmission; HIV prevention and misconceptions.

In this analysis, a composite variable on men's knowledge of HIV was created. This variable was scored according to the number of HIV prevention methods that men correctly identified. It made it possible to rank men's knowledge of HIV, such that those who correctly identified all the three methods of HIV prevention obtained a higher score than those who identified only none, one or two out of three. The results *(table not shown)* indicate that not all men know all the three methods of preventing HIV infection either. In fact, only a fifth (21%) of men correctly identified three methods of HIV transmission, compared 68 who correctly identified only one method of preventing HIV transmission, and just over one in ten (11%) who correctly identified two such methods.

5.3 Attitudes towards HIV/AIDS Programs and Services

Attitudes towards HIV/AIDS programs are important because such attitudes might determine the likelihood of use or none use of these services not only by men, but their partners as well. The literature on men and HIV in Botswana generally paint men as unwilling, uncooperative and resistant to HIV/AIDS messages. (See Gaillard et al. 2002; Nyblade et al., 2001; Langeni, 2003; Kayembe 2006). However, the results of this analysis suggest that a significantly large majority of men are supportive of HIV programs and interventions. A significantly high percentage of men believe that current HIV programs have helped to reduce the spread of HIV, and also reduced risky sexual behavior. For example 90.6 percent of men believe that HIV programs have reduced the spread of HIV through reducing risky sexual behavior. However, a higher percentage of men believe that HIV programs have reduced women's risky sexual practices (83.2%) compared to men's risky sexual practices (65.5%).

Table 7 presents men's attitudes towards HIV/AIDS services in Botswana. Men tended to be unanimous in their assessment of the impact of HIV programs in reducing the spread of HIV.

Table 7: Men's Attitudes towards HIV/AIDS Programs and Services

	Have reduced spread of HIV	Have reduced women's risky sexual behavior	Have reduced men's risky sexual behavior	Have ensured equality between men and women	Have led to improvement in gender relations	Have given men more control over sex	Should address gender power imbalance
Age	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**	**[%]**
17 - 21	88.5*	83.3	66.7	68.4	66.7	33.3	23.9
22 - 25	85.3	78.6	57.9	69.3	69.1	36.0	24.3
26 - 30	92.9	82.1	63.7	68.5	69.6	40.5	27.8
31 - 35	93.4	86.7	76.3	78.9	76.0	26.3	26.7
36 - 45	93.0	86.0	68.4	71.9	63.6	43.9	21.4
46 - 69	97.1	94.3	74.3	75.8	72.7	18.9	20.6
Education							
Primary or less	100.0	97.4	82.1*	78.4	56.8	32.4*	44.7***
Secondary	87.4	80.5	63.4	70.9	67.4	40.1	22.7
Tertiary	92.7	84.6	67.4	68.0	72.3	30.6	23.6
Marital Status							
Married	93.4	86.8***	77.4***	68.6	70.6	17.6***	18.9***
Never Married	89.4	82.1	65.4	72.1	68.5	33.1	27.8
Cohabiting	91.6	81.3	51.9	62.3	71.0	49.5	22.5
Separated/wid/div	94.1	100.0	85.3	70.6	61.8	44.1	6.3
Employment							
Employed	94.1***	85.7*	67.3	73.3*	68.8	33.7	23.8
Unemployed	87.9	81.1	62.8	67.2	70.1	37.5	26.1
Religion							
Christian	91.4	84.9	64.1*	70.8	71.0	36.5	25.7
African traditional	86.7	85.0	78.3	70.0	60.3	25.0	23.7
Other	91.7	75.0	70.0	71.7	63.3	31.7	19.7
Family of orientation							
Both parents married	91.7	80.1*	60.6***	58.6***	61.7***	36.8	27.8
Mother only	85.9	80.7	61.5	69.6	67.9	63.6	21.4
Father only	100.0	95.0	70.0	60.0	70.0	25.0	35.0
Both parents unmarri	90.4	87.7	87.7	90.4	79.5	23.5	24.7
Extended family	93.2	90.3	66.0	87.4	80.4	39.8	21.2
Place of childhood orientation							
Urban	92.2	86.2	65.7	68.3	71.3	34.8	28.0
Rural	100.0	84.0	66.0	74.2	67.1	35.1	22.2
	518	***475***	***381***	***408***	***398***	***201***	***141***
	90.6	***83.2***	***65.5***	***70.8***	***69.4***	***35.3***	***25.0***

*** Significant at 5% * Significant at 10%

As a result, this proportion did not display any significant variation by most background characteristics, except employment status. A slightly higher proportion of employed men shared this view (94%) compared to those who are unemployed (88%). While a higher percentage of divorced, widowed or separated men (85%) and married

men (77%) felt that HIV programs have reduced men's risky sexual practices, just over half (52%) of cohabiting men and 65 percent of never married men shared this view.

A high proportion of men (70.8%) were of the view that HIV programs have helped to ensure equality between men and women and improved gender relations (69.4%), while only 35 percent of men believe that HIV programs have given men more control over sex and an even smaller percentage (25%) believe that HIV programs should address the fact that socially, men tend to have more power than women. Only 24 percent of men were of the view that their fellow men were utilizing HIV services to the level expected given the seriousness of the HIV epidemic.

The proportion of men who believe that HIV programs have helped to ensure equality between men and women does not vary significantly by most background characteristics, except men's family of orientation. A higher percentage of men raised in extended families (87%) or those raised by unmarried parents believe that HIV programs have helped to ensure equality between men and women, compared to those raised in married parents families (59%) or those raised in mother only (70%) or father only families (60%). A similar pattern is observed when it comes to the issue of whether HIV programs have improved gender relations between men and women. A smaller percentage of men raised in both parents married families (62%) tend to agree that HIV programs have resulted in improved gender relations compared to men raised in unmarried parent families and extended families (80%).

By their nature, HIV programs tend to challenge established social, gender and power relations between men. By empowering women to negotiate safe sex with their partners, these programs are likely to be perceived as a challenge to some of the common masculine stereotypes and beliefs, most of which are rooted in inequality between men and women, and control over women's sexuality. Slightly over a third of men felt that HIV programs have given men more control over sex. Thus a majority of men did not feel that men have more control over sex as a result of HIV information

and education programs. This view does not display any significant variation by men's characteristics except marital status. The smallest proportion of men who feel that HIV programs have given men more control over sex occurs among married men (18%), while the corresponding proportion among unmarried men is 33 percent. This percentage increases to 44 percent among divorced, widowed and separated men and increases further to 50 percent among cohabiting men.

Men were further asked to indicate if in their view, HIV programs need to address the gender power imbalance between men and women. Only a quarter (25%) of men felt that HIV programs need to address the gender power imbalance between men and women. This proportion varies significantly by men's level of education and marital status. The proportion of men who feel that HIV programs should address the gender power imbalance between men and women is highest among men with primary education or less (45%) and declines to just under a quarter among men with secondary education (23%) and those with tertiary education (24%).

5.4 Men and HIV testing

Voluntary HIV testing through population based voluntary counseling and testing and prevention of mother-to-child transmission forms an important part of Botswana's Abstain, Be faithful and Condom use (ABC) HIV strategy. Voluntary HIV testing provides the means through which individuals can learn of their HIV status and avoid infection if they are HIV negative, or adopt safer sexual practices to prevent further transmission if they are HIV positive. In Botswana, HIV testing is the gateway to free HIV treatment and care services.

Men in Botswana have largely been viewed as obstacles to the success of HIV prevention programs. Men's tendency for multiple sexual partnerships; reluctance to undergo voluntary HIV testing have been viewed as major challenges to the success of VCT programs. Since reproductive health have had an almost exclusively female focus, the discourse on the role of men in HIV prevention has mostly been negative and

focused on how men are obstacles to the attainment of safe reproductive health for women and children. For example, men are understood to contribute to women's vulnerability infection through 'lack of support for their partners' decision to test' (Nyblade & Field-Nguer 2001; Ministry of Health 2004); or reacting negatively to their partners' HIV test. Thus 'fear of partner's reaction (Gaillard et al. 2002, NACA 2003) fear of abandonment by partner (Langeni 2003); preventing their partners and spouses from enrolling for PMTCT (Ministry of Health, 2004) are pervasive aspects of the discourse on men and HIV prevention in Botswana.

Table 8 presents patterns of men's use of and attitudes towards HIV voluntary counseling and testing services. The results of this survey indicate that a significant majority of men (73%) in the sample have ever tested for HIV, and that a large majority (74%) tested during the 12 months prior to the survey. The percentage of men who have ever tested for HIV varies significantly by a number of men's characteristics. These include age; education religion family of orientation and place of childhood orientation. The percentage of men who ever tested for HIV is lowest among the youngest men (17-21; 52%) and oldest (46-69; 57%). Eight out of every ten men in the age range 22 to 45 have ever tested for HIV (76-80%). The percentage of men who ever tested also increases with men's level of education. This proportion increases from just over half (51%) among men with primary education; to 70 percent among those with secondary education and 81 percent among those with tertiary education.

A slightly higher percentage of men who were currently employed at the time of the survey had ever tested (78%) compared to those who were unemployed (70%). Just over three quarters (76%) of men who classified themselves as Christians have ever tested (76%) compared to just over half (57%) of those who belong to the traditional African religions. Family of orientation also displays significant variation in percentage of men who ever tested. For example, only half of men raised in father only families have ever tested, compared to between 7 and 8 out of every ten men raised in other types of

family setups. Additionally, a higher percentage of men who were raised in rural areas have ever tested (77%) compared to those raised in urban areas (69%).

Table 8: Men's Use of Voluntary HIV Testing and Attitudes towards Testing

	Ever tested for HIV [%]	Tested in the 12 months before survey [%]	Ever encouraged family member to use VCT [%]	Ever encouraged partner to use VCT [%]	Would like to learn more about HIV/AIDS [%]	Ever accompanied partner to Antenatal clinic [%]	Accompanies partner to Antenatal clinic always [%]	Accept if partner tested without infroming me [%]	Accept if partner tested HIV+ [%]	Accept if partner tested HIV+ and me HIV- [%]	Accept if partner tested HIV- and me HIV+ [%]
Age											
17 - 21	52.1***	58.5*	43.0***	57.4***	94.8	9.9*	10.0	77.7*	66.7	61.5	65.6
22 - 25	79.0	75.4	61.7	74.1	96.4	21.7	25.0	68.8	71.7	64.3	64.0
26 - 30	79.9	79.9	56.3	79.3	95.7	19.1	20.0	79.3	63.7	61.5	73.4
31 - 35	80.3	73.0	60.0	75.0	91.9	16.0	40.0	85.5	78.7	70.7	86.1
36 - 45	76.4	73.8	74.5	73.6	89.5	29.6	16.7	80.7	76.4	70.9	78.2
46 - 69	57.1	76.2	80.0	66.7	91.0	17.1	66.7	85.7	80.0	74.3	80.0
Education											
Primary or less	51.3***	61.9	71.8	60.5*	97.3***	30.8	30.8	87.2	79.8	38.5	28.2
Secondary	70.2	72.6	55.6	71.0	91.7	17.4	25.5	80.5	67.0	62.5	73.1
Tertiary	80.9	75.0	61.0	76.3	96.8	19.6	20.7	75.0	72.9	68.6	72.2
Marital Status											
Married	67.9	58.3***	81.1***	79.2***	96.2	45.3***	41.7***	94.3***	88.7***	84.9***	90.6***
Never Married	71.3	80.4	60.3	65.8	94.8	14.9	25.3	73.9	67.0	65.6	71.0
Cohabiting	80.7	64.0	52.3	90.6	92.3	21.2	13.6	83.2	69.7	56.0	86.7
Separated/wid/div	82.4	67.9	47.1	84.4	94.1	21.2	14.3	76.5	75.8	58.8	70.6
Employment											
Employed	77.5***	74.0	66.1***	76.7***	95.5	22.0*	24.2	83.2***	74.3***	69.5***	77.5***
Unemployed	70.1	73.2	53.1	68.3	94.1	17.1	26.7	73.3	66.1	61.7	67.8
Religion											
Christian	75.8***	72.2	57.3*	74.4***	95.7	18.8	22.5	80.4	72.1***	66.3***	72.9
African traditional	56.9	88.2	65.0	56.1	91.6	20.0	53.8	55.0	51.7	50.0	62.1
Other	71.2	69.0	71.2	72.4	100.0	15.8	0.0	82.0	75.4	70.5	72.1
Family of orientation											
Both parents married	74.0***	68.4	64.3***	74.1***	95.7	21.9	27.6	78.6	68.5	66.1*	70.5***
Mother only	68.1	79.3	57.7	68.9	91.6	19.1	38.5	78.5	74.8	72.6	76.7
Father only	50.0	75.0	35.0	72.2	100.0	15.8	0.0	85.0	75.0	55.0	60.0
Both parents unmarri	85.9	79.4	62.9	88.6	92.8	16.7	9.5	82.2	72.6	63.0	81.9
Extended family	75.7	76.3	53.0	66.2	96.0	13.9	26.3	70.9	64.7	54.9	64.4
Place of childhood orientation											
Urban	68.8***	74.9	53.0***	66.2***	93.7	17.2	20.4	74.4***	65.7***	63.7	74.5
Rural	77.0	72.3	65.1	77.2	95.3	20.5	28.8	81.0	73.4	66.0	69.8
Number	***421***	***317***	***405***	***327***	***532***	***104***	***31***	***445***	***399***	***371***	***409***
Overall percent	***73.3***	***74.2***	***72.5***	***59.2***	***94.8***	***18.7***	***24.9***	***77.8***	***70.6***	***65.1***	***72.3***

*** Significant at 5% * Significant at 10%

A significantly high percentage of men (95%) indicated that they are interested to learn more about HIV/AIDS. This percentage does not show any significant variation by most background characteristics except education, whereby the percentage of men who expressed an interest to learn more about HIV/AIDS is slightly higher among men with primary education as well as those with tertiary education (97%) than those with secondary education (92%).

Men were also asked about their role in encouraging their family members and partners to undergo voluntary counseling and testing. Almost three quarters of men (73%) indicated that they had encouraged a family member to undergo VCT, however a lower

proportion (59%) have ever encouraged their intimate partner to undergo VCT. The percentage of men who encouraged a family member to use VCT varies significantly by age; marital status, employment, family of orientation and place of childhood socialization. This proportion tends to increase with increasing age, from under half (43%) among men aged 17-21 to 60 percent among those aged 31-35 and 75 and 80 percent among those aged 36-45 and 46-69 years.

Men's marital status displayed significant relationship with likelihood of having ever encouraged a family member to use VCT services. A significantly higher percentage of married men (81%) have encouraged a family member to test compared to never married men (60%) or those who are cohabiting (52%) or divorced widowed and separated men (47%). In addition, a higher percentage of employed men (66%) had encouraged a family member to use VCT, compared to those who are unemployed (53%).

The percentage of men who ever encouraged a partner to test varied according to men's type of family of orientation. A Higher percentage of men raised in both parent families married and both parent unmarried families (64 and 64%, respectively) had ever encouraged a family member to use VCT compared to those raised in father only (35%) or extended family (53%). In addition, a higher percentage of men whose place of childhood orientation is rural had ever encouraged their partner to use VCT services.

While almost three quarters (73%) of men claim to have encouraged a family member to use VCT, the corresponding percentage of men who encouraged their partners to undergo VCT is relatively smaller (59%). This percentage shows statistically significant variation by age; marital status, employment, religion; family of orientation and place of childhood socialization. The percentage of men who encouraged their partner to undergo VCT increases with age from 57 percent among men aged 17-21, to 74 and 79 percent among those aged 22-25 and 26-30 years. This proportion then declines to three

quarters among those aged 31-35 and 74 and 67 percent among men aged 36-45 and 46-69 years.

However, less than a fifth (19%) of men had ever accompanied their partner to the antenatal clinic. Women's attendance of antenatal clinics in Botswana form a major point of contact with the health care system, which contact acts as an important interface through which women acquire information and knowledge on sexual and reproductive health, including HIV/AIDS. A large percentage of men indicated that they are willing to accompany their partners to the antenatal clinic. The percentage of men who have ever accompanied their partners to ANC shows significant variation by marital status. This percentage of married men who ever accompanied their partners to ANC is much higher (45%) than that of never married men (15%) or cohabiting or divorced, widowed and separated (21%).

One of the reasons for the lack of success of early VCT initiatives was men's reluctance or lack of support of their partners' decision to use S&RH services, especially VCT services. A number of studies on women's utilization of HIV prevention programs, especially the prevention of mother to child transmission of HIV (PMTCT) have cited women's fear of their partners' adverse reaction; fear of termination of relationship and loss of economic support as some of the main obstacles to their utilization of these programs (see Gaillard et al. 2002; Nyblade et al. 2001; Langeni 2003; Kayembe 2006), and reasons why women would not undergo HIV testing without their partner's consent and support. This study investigated men's attitudes towards HIV testing, specifically their attitudes towards their partners' utilization of VCT services. An important point when it comes to VCT is the issue of the couple's communication about VCT, specifically, their partner's consent to the test. Men were asked about what their reaction would be if their partner underwent HIV testing without their consent.

More than three quarters of men (77%) indicated that they would accept if their partner underwent VCT without having informed them of their decision to test. However, if

test result shows that their partner is HIV positive, a relatively smaller percentage (71%) would accept their partner's decision to test without their consent. So the acceptance of the decision to test without informing the man is conditioned upon the outcome of the test. An HIV negative result will improve the chance of acceptance of the decision to test without consent than an HIV positive result. An even smaller percentage (65%) of men would accept their partner's test result if the results were HIV positive for their partner and they themselves tested HIV negative. However, if the partners were to test HIV negative and the man HIV positive, the percentage who would accept their partner's decision to test increases slightly to 72%.

Men's attitudes towards HIV testing shows significant variation by marital and employment status. For example, consistently, a higher percentage of married men would accept their partner's decision to undergo HIV testing without informing them or obtaining their consent, regardless of the test outcome, compared to never married men or those in cohabiting relationships. In addition, a higher percentage of currently employed men would accept their partners decision to undergo HIV testing without informing them or obtaining their consent, regardless of the outcome of the test, than men who were unemployed at the time of the survey.

Despite the relatively high percentage of men who claim to have tested for HIV, as well as those expressing a willingness to participate in sexual and reproductive health programs, men generally recognized that as a group, men tended to find knowing their HIV status problematic for a number of reasons, including lack of information and men's masculine identities and attitudes. Men's lack of participation in S&RH was viewed as a vicious cycle between lack of participation and access to information. In the view of some, men don't participate because they lack information; and men lack information because they are not involved in these programs.

> *Men lag behind because most of the time they are not involved in many activities and programs, so they do not have ready access to information and education.* **[Ndlovu, 50 years, Real Men]**

Some men felt that their masculine identity required that they should not be overly concerned about health issues. These men perceived themselves to be physiologically stronger than women, hence they felt that the main reason why women participate in HIV programs is because they are weak, in their view, women have no choice because if they do not do it, their weak physiology will succumb to diseases very fast. Others saw men's apparent lack of concern for their well being as a sign of bravery':

> *It's is not a question of money or access to health facilities, men are like soldiers, they are soldiers, and they are not scared of pain.* **[Young men, 24-33 years, Unemployed]**

They argued that men's lack of concern for their HIV status, even though they know that being infected could result in a terminal illness and death, was a sign that they were brave.

> *Men would usually not rush to the clinic on the first signs of being unwell. Men believe in lying low for a while, almost ignoring the signs until he realizes their severity. Men don't want to make a fuss about illness, unlike women; they would not want to rush to the clinic on the first signs of a headache. It has to be something substantial, that everyone can 'see'.* **[Men, 34-42 years, University]**

> *Men are brave, they only respond when they see the severity of the [health] problem; he doesn't respond to signs and symptoms the first time. If the signs persist, he can still put off going to the clinic. Usually when you see a man going to the clinic first thing in the morning, you should know that he probably didn't sleep a wink at night, that the pain kept him up all night!* **[Men, 33-47 years, employed]**

> *It's the same approach with HIV testing; men just don't react immediately to messages, especially some of us who drink alcohol. Once he has his beer in hand, he looks at things different. You find that by the time he decided to seek help, when even the alcohol could not help him ignore the signs of the disease, he might find that had he not delayed; his condition could have been treated successfully.* **[Ntwa, 44 years, men's Sector]**

It's just a habit among men (not to seek help early), a man convinces himself that he is physically strong, and that he is not scared of death. A woman on the other hand, has to worry about the welfare of the kids if at all she is not concerned about hers. She has to think about who will take care of the children if she was to die. **[Kgosi, 56 years, Traditional leader]**

Other men however were quick to question the bravery hypothesis, suggesting instead that men are actually scared of knowing their HIV status, and that if indeed bravery can be measured by how willing one is to undergo HIV testing, then women were far braver than men.

Men are very reluctant to undergo HIV testing. You would hardly find them at testing centers; other even avoid walking past these centers, but you always find women there. I don't know, but I think men are scared, we are scared to know our HIV status. **[Babusi, 38 years, male nurse]**

It's true, when it comes to HIV prevention, especially testing; we are being led by women. It's funny because if a woman was being attacked by something, a person or animal, most of the time she will be glad to see a man close by because she knows that he will protect her. It's different when it comes to HIV testing; women cannot count on us to do the right thing, we have abdicated our leadership and responsibility; we are scared, we are scared to know. **[Kyle 41 years, Social worker]**

That is because when you think of testing… you think of how the virus might have got infected by the virus if it could be detected. Hence that makes it hard to go for testing. It can be easy for married men to go for testing since the blame will be among one of the two, but as for un-married men it would be difficult. **[Prince, 35 years, DJ, Student]**

No! (With a lower voice as if unsure) It's only that women… hey, I don't understand what they do with the fear or how they overcome it. What I know is that women do test more than men and they also participate in many programs than men. Maybe we should accompany women to health facilities and for HIV testing so that we can also overcome

our fear like they seem to have overcome theirs. Men are really scared [to know their HIV status] **[Men, 35-50, rural, unemployed]**

When you are in a relationship, and you really care about your partner, if she insists and stands her ground that unless you go for HIV testing, she won't have sex with you… what options do you have? If you really love her, you will have to do as she says; she may even direct you to the nearest testing center. There should be equality in decision making, instead of wanting to claim a superior positions as a man, rather be an equal partner. **[Men, 34-42 years, University]**

Some key informants, while being conversant with men's low participation in voluntary HIV testing, blamed men's lack of participation on their historical exclusion from family planning and sexual and reproductive health programs. This exclusion has conditioned men to view family planning and sexual and reproductive health, indeed health generally, as a women's domain, with many being unsure about their role in these programs.

The number one issue is that men have been left out from the start. You cannot address family issues in a family where there are boys and girls, and you neglect boys though they also are part of the family. Men were left out forgetting that the same man who impregnates a woman is the same man who provides for her, and can decide not to listen to that woman, and the same woman who has been taken to 'Beijing'' is not that I am bound to listen to what she says in China, because after all "I am the leader of this house". **[Ndlovu, 50 years, Real Men]**

Current programs that also seem to exclusively focus on the plight of women and girls were also blamed for alienating men and boys and thus leaving them uniformed and thus un-empowered to adapt to new gender roles.

They took 'Beijing' as the end of the world or heaven, forgetting that when they come back they will the same man they left back home. You know men are men and they say 'guys go back to where you come from'. So this exclusion has lead not only to lack of

> *information, but it has also ensured lack of interest and failure by men to transform and adapt to changing gender roles. As a result, their cultural conditioning becomes their only major reference point.* **[Men, 30-45 years, Vendors]**

However, recent efforts to engage men sexual and reproductive health programs were not lost to many men. It was the view of most men that while their participation rates in voluntary HIV testing have traditionally been very low, things have changed and more men are now participating. The only thing is that *it is now fashionable to blame men, and for nothing too!* **[Ndlovu, 50 years, Real Men]**

> *We have had positive results working with men at the mines. Men do avail themselves to our programs; some even volunteer as peer-educators. One thing we do know is that men need information. The problem is that men were not taken on board from the start. Therefore, we are missing here and there, so we need to see how turn around and see how to rectify where we went wrong.* **[Ndlovu, 50 years, Real Men]**

Some key informants indicated that while men are generally responsive to sexual and reproductive health messages, finding men was a major challenge. Most of the time men are absent from home either because they are at work or out looking for work. In most cases employers' concern with productivity makes targeting working men an issue. How much time employees can take away from work to attend or participate in sexual and reproductive health programs has proven to be an issue with employers. This key informant narrated his experience trying to run a peer education program for mine employees, most of whom are men:

> *Their time is always an issue [for peer educators], and the mine had concerns about productivity, so in the end we couldn't use mine workers as peer educators, we didn't want to compromise their productivity. So instead of training peer educators among mineworkers, we end up using our own workers, who we have trained and certified as peer-educators.* **[Ndlovu, 50 years, Real Men]**

> *They conduct 'clinics' at the mines, we have set up and office with tables, chairs and computers. The mines are very cooperative. The peer educators also target men at places that men tend to frequent, such as football matches and bars.* **[Babusi, 38 years, Male Nurse]**

From conversations with men, it becomes clear that many men understand the need to know their HIV status, or to seek medical and professional help when they have problems. They are aware too that increasingly many men are accessing sexual and reproductive health, including HIV/AIDS services. However, help and health seeking, especially early on when the signs and symptoms are '*not serious enough for all to see*' , still presented challenges to men's self image of being strong and in control. Seeking help, or even getting to know one has HIV tends to be an affront to most men's image of strength and independence.

> *Nowadays, it is a little better with respect to HIV testing; more men are testing, but men still feel guilty about showing concern for their health. They tend to associated concern for one's health with weakness, loss of control or even conceit!* **[Young men, 19-24 years, University]**

> *We hear from radios and television that more men are participating in HIV programs, they have committed themselves to that, despite many challenges such as social norms and excessive use of alcohol, which sometimes curtails their participation. But yeah, there are men who are setting a good example, made the commitment and taken responsibility for the improvement of their life situation.* **[Men, 35-50 years, Unemployed]**

> *Some in fact are trying. Most take it lightly and see participating in such programs as a waste of their time for work, they brush any talk of HIV aside, and others refer to such [HIV] talk as 'a national anthem'.* **[Men, 30-45 years, Vendors]**

There was also an undertone to men's discussion on HIV testing that suggested that men's willingness to undergo HIV testing is related to their socio economic status. Men, especially those who considered themselves poor, felt that testing and finding out that

they are HIV positive would be a bigger blow to their masculine identity than would be the case if they were wealthy and HIV positive. They felt that the mental stress induced by an HIV positive result would be too much for them to bear especially because they are already poor. They felt that if they were wealthy and HIV positive, they could take the strain because they would still be able to fulfill the socially expected masculine roles. As one man put it:

> *I'd rather be HIV positive and driving an X5*[7]*rather than be poor, HIV positive and failing to live up to expectations of being a man. You'd be finished as a man!* **[Young men, 24-33 years, Unemployed]**

> *Men do test, albeit in smaller numbers than women. However I have realized that it is mostly men of higher socio-economic status, those holding high and prestigious positions in society who test.* **[Kyle, 41 years, Social worker]**

However there were also narratives of how, despite challenges to the male image posed by HIV/AIDS and sickness, once men experience HIV infection and fall sick, some tend to soften their masculine identity, and negotiate a new identity that encompasses health seeking, or at least does not make help seeking problematic.

> *Once a man has accepted his (HIV) status, they take it easy, and try to make sense of their existence, which involves acceptance that they need help. The problem is when they have not tested and are not aware of their HIV status; they find it hard to go for testing. Once infected, some men become active in recruiting and advising others about HIV and the importance of knowing one's HIV status. For example, men [who are infected] refer to ARVs as 'airtime' and when they go to health centers for their supplies, they would often say 'I am going to re-charge' (laughter from audience). Unfortunately, for most men, until they get to that point, many do nothing, and appear uninterested; the concern about the perceived loss of status [if they are HIV positive] obscures everything!* **[Men, 34-42 years, University]**

[7] X5 is the name of BMW's Luxury Sports Utility Vehicle

HIV testing is about personal choice and taking responsibility for your life and health. There are men who don't want to face this responsibility, they would rather not know. There are others who test themselves indirectly through their partner. If their partners undergoes HIV testing and returns a negative result, the man concludes that he also must be HIV negative, and won't bother to test. **[Men, 33-47 years, employed]**

You know as men, we 'proxy test' using our partners; whatever the status of the woman you will always assume that you have the same. There is this entrenched belief among men that if she is negative, then I too must be negative...hence I may find no reason to go for testing. I think that, as men generally, we are scared that we would be demoralized should we test and find out that we are infected. **[Men, 34-42 years, University]**

Most men felt that there was no need for their partner to ask for their permission before testing for HIV. They felt that while there should be consultation, there was no need for their partner to await their consent, especially in cases where the man does not show enough interest in testing. Most men felt that women have a right to know their status, regardless of their partner's approval or disapproval. It transpired during the interviews that while most men would gladly welcome the news of an HIV negative test result from their partner, even if he was not initially consulted about the decision to test, they would not necessarily be so understanding if the test results indicated that the woman was infected. While some men indicated that under such circumstances they would think about undergoing HIV testing, the popular opinion among men was that such a situation would make them suspicious that their partner has not been faithful.

He would take it that the partner has been having another partner apart from himself and require that the partner should pack her belongings and go; since he cannot afford to stay with an infected person- forgetting that he may be the one who infected her. **[Young men, 24-33 years, unemployed]**

You would assume that you too are negative, nevertheless you would still have to go and consult with your other sexual partners and find out their status so that you are absolutely sure. **[Young men, 19-29 years, Vocational]**

The following exchange between two focus group discussants highlight the perceived role of consultation before HIV testing, and how, while lack of consultation may not result in any adverse consequences for the woman if she tests HIV negative, an HIV positive result could make it [lack of consultation] a major issue. The following excerpts concerning HIV testing are from a conversation with a group of middle aged men in a rural area:

***R1**: Both of you need to agree on when to go for testing, so that it becomes a decision that you both own, and will do it without having to be pushed.*

***R2**: But how about if she wants to go for testing at a time when you are not ready to go?*

***R1**: No in that case I let her to go alone.*

***R2**: But she has to consult you before going for testing?*

***R1**: Yea there must be consultation. There has to be a lot of change and adjustment in the relationship if she tested positive. I will be worried that I too might be infected. In addition, I will suspect that she got infected as a result of being unfaithful in the relationship.*

***Interviewer**: How about if she tested negative?*

***R1**: You would assume that you too are negative, nevertheless you would still have to go and consult with your other partner that you hide yourself with so that you may know her status too.*

While there were many reasons men gave for their lack of participation in HIV programs, some of the reasons given reflected lack of knowledge about the programs, and suspicions about lack of confidentiality based on gender beliefs about women. To

many men, the fact women make up most of the staff of health facilities and certain programs was viewed as problematic. One of the common masculine perceptions of women is that they are incapable of '*keeping secrets*'; that '*women talk too much*' and thus they would not be able to keep their results confidential.

> *Health facilities are staffed by women, and young women at that. So imagine if you have a disease (STI) and you have to show the nurse your private parts… we don't want to be insulted, women talk too much!* **[Men, 35-50 years, rural unemployed]**

To these men, their problem would be alleviated somehow if, depending on what conditions they present with, or what service they require, they could have a choice between being attended by a woman or a man.

> *Yes…it could be better especially considering the kind of the disease you suffer from or the service you need. As men, we would be much free to talk about other issues pertaining if we are sure of confidentiality.* **[Men, 35-50 years, rural unemployed]**

5.5 Beliefs about Violence and aggression

Table 9 presents men's attitudes and beliefs relating to violence, including intimate partner violence and sexual coercion. The percentage of men who support the use of violence or aggression is relatively small. For example, only 9.9 percent of men felt that the use of violence in a relationship is sometimes justifiable. One in ten men believed that the use of violence in a relationship is sometimes justified, depending on the circumstances that may prompt such violence. These circumstances include if the partner fails to take care of children; wants to terminate the relationship; refuses to have sex or talks back during an argument.

Table 9: Men's Beliefs and Attitudes towards Violence and Aggression

	It is justifiable to hit a partner is she goes out without me	It is justifiable to hit a partner is she refuses to have sex	It is justifiable to hit a partner is she wants to terminate relationship	It is justifiable to hit a partner is she tlks back during an argument	It is justifiable to hit a partner is she fails to take care of children	Sometimes the use of violence in a relationship is justifiable	Women find sexual coercion stimulating	Men are sexually stimulated by coercing women	Women sometimes pretend not to want sex, expecting to be coerced	If my partner was not home she would be in trouble	I sometomes get so angry I hit my partner	I have slapped by partner atleast once in past 12 months
Age	[%]	[%]	[%]	[%]	[%]	[%]	[%]	[%]	[%]	[%]	[%]	[%]
17 - 21	4.2	4.2	4.2	8.3	8.3	9.4	39.6	36.5	66.7	9.4	19.8	8.8***
22 - 25	6.3	2.8	7.7	9.1	11.2	11.9	55.9	46.2	74.1	12.6	28.0	26.7
26 - 30	7.7	5.3	5.9	11.2	10.7	8.3	53.8	48.5	78.1	10.1	16.6	28.4
31 - 35	17.9	9.0	9.0	11.5	16.7	15.4	50.0	51.3	73.1	19.2	26.9	52.9
36 - 45	7.0	3.5	3.5	21.1	5.3	8.8	52.6	45.6	64.9	8.8	24.6	32.7
46 - 69	5.7	11.4	11.4	8.6	11.4	1.0	62.9	65.7	80.0	14.3	17.1	27.3
Education												
Primary or less	7.7	2.6	2.6***	20.5***	15.4***	12.8	48.7	69.2***	66.7	5.1	25.6*	21.6
Secondary	9.7	6.4	9.0	12.7	12.4	10.5	55.4	47.2	72.7	13.7	26.2	31.0
Tertiary	6.2	3.5	4.2	7.7	6.5	10.0	47.3	45.0	72.7	11.5	18.5	25.0
Marital Status												
Married	11.3	7.5	3.8	11.3	3.8*	3.8	49.1***	45.3***	67.9	11.3	30.2***	26.4
Never Married	9.0	6.1	8.4	12.7	12.1	11.6	57.5	44.6	74.1	12.1	23.7	30.9
Cohabiting	5.5	2.8	2.8	6.4	5.5	6.4	33.9	46.8	68.8	11.0	12.8	21.0
Separated/wid/div	1.0	1.0	2.9	8.8	14.7	5.9	61.8	70.6	88.2	2.9	23.5	20.6
Employment												
Employed	5.8*	6.2	7.2	10.1	9.1	10.5	55.1	49.6	72.8	9.8*	20.3	35.4***
Unemployed	9.4	4.4	6.0	11.1	11.4	9.7	49.7	45.0	73.8	14.4	24.5	19.1
Religion												
Christian	7.0	4.0	5.9	7.5	7.5	9.2	49.5	43.3	71.2	11.6	18.2	25.7***
African traditional	8.3	11.7	18.3	28.3	30.0	13.3	63.3	56.7	81.7	18.3	46.7	49.1
Other	14.5	8.1	1.0	14.5	9.7	11.3	61.3	71.0	82.3	4.8	30.6	22.8
Family of orientation												
Both parents married	8.6	4.3	5.9	14.5	12.5	14.1	45.3	100.0	69.9	12.1	25.4	24.0
Mother only	3.7	6.7	7.4	9.6	9.6	6.7	51.9	37.0	71.1	15.6	22.2	29.7
Father only	25.0	10.0		10.0	10.0	5.0	45.0	65.0	70.0	10.0	15.0	38.9
Both parents unmarried	4.1	2.7	0.0	4.1	2.7	6.8	69.9	56.2	80.8	8.2	16.4	22.4
Extended family	10.6	5.8	10.6	8.7	12.5	8.7	58.7	51.9	79.8	10.6	21.2	36.0
Place of childhood orientation												
Urban	9.5	4.9	6.6	13.5	12.8	13.9	51.5	45.6	70.8	15.3	24.1	27.3
Rural	5.8	4.9	5.8	8.4	8.4	6.8	53.7	48.2	76.1	9.4	21.0	28.2
Number	***46***	***30***	***38***	***60***	***58***	***57***	***301***	***275***	***424***	***67***	***130***	***155***
Overall percent	***8.0***	***5.2***	***6.6***	***10.4***	***10.1***	***9.9***	***52.2***	***47.7***	***73.5***	***11.6***	***22.5***	***28.1***

*** Significant at 5% * Significant at 10%

For example, only 5 percent of men believe that the use of violence in a relationship is justified if the partner refuses to have sex, while ten percent would support such violence if their partner talks back during an argument or if she fails to take care of the children. Most of these proportions do not show any significant variation by men's background characteristics, except for education, which shows significant relationship with the belief in the use of violence if a woman wants to terminate the relationship; talks back during an argument; or fails to take care of children.

The percentage of men who believe that the use of violence is justified if the partner talks back during an argument declines with increasing levels of education, from 21 percent among men with primary education or less to 13 and 8 percent among men with secondary and tertiary education, respectively. A similar pattern is observed concerning the belief in the use of violence if the partner fails to take care of children. This proportion declines from 15 percent among men with primary education and less, to 12 and 7 percent among men with secondary and tertiary education, respectively. .

However, despite the high percentage of men who do not agree with the use of violence in intimate relationships under any circumstances, there was still a persistence of attitudes and beliefs about the use of coercion within relationships which may increase the likelihood of violence. Many men were surprisingly open to the idea that a certain amount of coercion within sexual relationships is necessary or even expected. There is a pervasive view among men that within relationships, women expect a certain amount of coercion from their partner before consenting to sexual intercourse. Some men even felt that men derive a certain amount of sexual stimulation from coercing their partners to have sex.

For example, over half the sampled men believe that women find sexual coercion stimulating (52%) and almost equally high proportion (48%) believe that men are stimulated by sexually coercing women. A significantly high percentage of men felt that

sometimes a woman pretends she does not want to have sex, expecting the man to coerce her to have sex (74%). As one man observed:

> *Women expect you to put some kind of pressure on them. She expects you to convince and coerce her, if you don't do that, or leave her she may conclude that you were not serious, that you are not a man.* **[Johan, 39 years, Soldier]**

The beliefs about the desirability of sexual coercion within relationships while prominent do not vary significantly by most background characteristics, except marital status and to a limited extent education. For example, 69 percent of men with primary education believe that men are stimulated by sexually coercing women, while the corresponding proportion among men with secondary and tertiary education were 47 and 45 percent, respectively.

Other men felt that in a new relationship, a woman tends to hold back on sex because she doesn't want to appear easy, and not want to create the impression that she is always ready for sex.

> *It happens like that most of the time, when it comes to having sex with someone for the first time, it is difficult (for the woman) to be free and expressive like she would otherwise be with someone she has been with for some time. So, in that context, if I do not initiate sex, or gently coerce her, she might be scared to do so herself, for fear of how you would react.* **[Men, 30-45, Vendors]**

However most discussant were also quick to point out that expecting and thinking that women always want and expect to be coerced can easily land them in trouble. It was the view of many discussants that many men sometimes overstep the boundaries and end up having inadvertently committed rape.

> *However, at times, we are too aggressive with our partners when it comes to sex, and end up over stepping our boundaries. We have to recognize and accept if a woman is not ready for sex. However, sometimes her resistance seems to stimulate us, [speaking*

emphatically] even if she tries to repel his advances by covering her private parts with her hands he becomes even more aggressive as if her resistance stimulates his aggression (laughs). So they assume that when she says 'no' it actually means 'yes'. **[Men, 34-42 years, University]**

Yes, there is a danger in assuming that when she says 'no' she actually means 'yes' because if indeed she is not ready or interested, you might end up having committed a crime (rape). **[Prince, 35 years, DJ / Student]**

Most men expressed the undesirability of violence within intimate relationships or against other men as a means to assert their masculinity.

Aggression or violence in the home doesn't help. The biggest and most important thing is to have genuine discussions about problems. If things are not going well, either the children did something wrong, you should sit down with your partner and discuss your concerns in a non-threatening or non violent manner. If you still find it difficult to do that, inform your relatives and involve them in finding the solution to your problems. **[Young men, 25-35 years, employed]**

Within intimate relationships, men use violence to assert their authority over women and children. One man, referring to the use of violence to assert authority, summed it this way:

They have to know their boundaries, lest they go beyond them. At times you have to show by facial expression …and in that way that is when some women will stop what they are doing against you. **[Men, 33-47 years, employed]**

There is a Setswana saying that goes 'se nkganang se nthola morwalo'[8], Most of us are aware of this saying but we don't apply it in our lives. For example, if your partner is no longer interested in you, rather than feel hard done by the materials things that you have worked so hard to provide her with, rather walk away, you can always start all over

[8] Literally translated: Don't be sad when you are ditched, for this act, although painful, might save you a whole lot of trouble in future

again. To recount all your expenses will result in drastic reaction and you might end up killing her. Your life becomes messed up, when you could have walked away. Is that really worth it? **[Young men, 19-29 years, Vocational]**

When jilted, most of us think about all the expenses we have incurred in looking after the woman, and end up really upset. Men are prone emotional outbursts under such a situation and may fail to deal with the experience and end-up killing her. **[Young men, 17-23 years, employed]**

Women nowadays are like parasites, most women are after money, so they get into relationships to better their lot. They just want money from men, for groceries, airtime, gas, etc. While the man might be interested in a long term relationship and looking forwards to settling down, she may not be willing to do that yet because she wants to have more than one partner so that she can get more money. That is why infidelity is high, leading to high rates of passion killings. **[Johan, 39 years, Soldier]**

5.6 Use of violence in intimate relationships

While most men did not support or justify the use of violence, a considerable proportion of men in the sample indicated that they sometimes use violence against their partners, or that they have used violence against their partner during the year leading to the survey. Almost a quarter (23%) of the men indicated that they sometimes get so angry that they hit their partner and 28 percent of men had used violence against their partners in the past. A higher percentage of married men (30%) indicated that they sometimes get so angry they hit their partner, followed by the never married and divorced, widowed and separated (24%) and those who are cohabiting (13%).

Almost a third of men (28%) had slapped their partner during the year leading to the survey. A higher percentage of men who were currently employed (35%) had slapped their partner during the 12 months leading to the survey compared to those who are unemployed (19%), while a higher percentage of African traditional religious men

(49%) had slapped their partner during the year leading to the survey compared to Christian men (26%) or those who identified with 'Other' religions (23%).

From discussions with men, there was also a perception that a certain amount of violence might be necessary in order for a man to assert his control and authority within the family. For example, some men spoke of the use of violence to '*correct wayward behavior*' especially among women and children within families. Such violence is perceived as normal if the intention was to '*correct*' what is perceived as wrong behavior, and not excessive, but is proportional to the task.

> *There are certain circumstances where the use of violence may be justified, but there are others where is absolutely uncalled for. It has to be managed and controlled, just to prevent yourself from being trampled under other people's feet, so that people might know that you are also there, staking your claim to life.* **[Men, 34-42 years, Vendors]**

Men indicated that while there is a perception that they have a propensity to resort violence to deal with situations in their relationships and families, they are aware of the undesirability of violence within relationships. They note that the use of violence is mostly not an explicit strategy that men design and implement in order to keep women and children under control, but that it something that just happens out of a sense of frustration and perceived helplessness. They noted that every man desires to have cordial and mutually beneficial and trusting relationships with their partners and children. However, sometimes they feel '*pushed*' to act violently when they feel they do not have a choice, such as when they feel their authority undermined, or the need to protect their family or reputation:

> *Violence is not something that you keep in your heart and remind yourself that you have to be violent, like a strategy. No! You want to be sociable, people should not be scared to socialize or be in your company. At the same time, there has to be limits, and these have to be very clear, so that people can understand that they can meddle with you up to a*

certain point, beyond which you would react, and may use aggression or even violence. **[Men 33-47 years, employed]**

However, to some men, the use of violence is clearly a strategy for control over the family and other people. For example, many men did not see anything wrong with the use of physical violence, if it is moderate and used as a means to a '*positive*' end, such as when such violence is meant to keep the family together; to correct what is perceived as wayward behaviour or indeed as an act of '*territory demarcation*' so that other men (people) are left in no doubt about '*who is in charge here*'.

Take the example of a man in his home. It has to be clear to everyone what they can and cannot do. They (wife, children relatives) should know that they can do such and such, but not such & such, and that if we go beyond our limits, the man has to impose order and punishment where appropriate. The danger is that if you are quiet about these things, you will lose control of your family; even children will do as they please. **[Men, 34-42 years, Vendors]**

Violence was viewed as a way to deal with what was perceived as women's '*incessant and unrelenting verbal assault*' that many men reported experiencing from their partners. Some men indicated that one can either leave such a woman, and in the process breakup the family, or use some form of limited violence, such as a cane to '*keep her from losing direction*'.

It's inevitable, some form of force of violence might be necessary to set things right if she losing direction. However, you do not have to do that every day she does wrong. It is only vital after having tried all the possible ways of letting her know of your disapproval have failed. You know sometimes women can make you angry by verbally assaulting you about an issue that is in the past. You may end up slapping her to shut her up, or using a cane. **[Men, 35-50 years, rural unemployed]**

Many men indicated that they are not proud to use violence, especially against their partners. So, if it has to be done, it has be moderate, appropriate and done in private, away from the prying eyes of neighbors

> *If you join her shouting match, the neighbors might here that you are having a fight, so it's much more expedient to get her inside the house, away from the prying eyes of neighbors and give her a quick slap to shut her up* . **[Men, 34-42 years, University]**

5.7 Men's Sexual and Reproductive Health Practices

Southern Africa's heterosexually driven HIV epidemic has thrust heterosexual masculinities at the centre of HIV prevention efforts. While research has been slow to explicitly engage the role of men and masculinities in Southern Africa's HIV epidemic, there is an intuitive realization of the role that men and masculinities play in reproductive health and HIV transmission. There is also a realization of the potential role that certain aspects of masculinities can be harnessed and contribute to the effectiveness of HIV prevention efforts. However, for HIV prevention programs and interventions to be effective there is need for culturally relevant and context specific research to provide evidence based understanding of masculinities and gender role identities that influence men's sexual and reproductive health practices.

Table 10: Men's Sexual and Reproductive Health Practices

Variable	Yes (%)	No (%)
1. Have you ever had sex?	90.2	9.8
2. Do you have a girlfriend/partner?	82.8	17.2
3. Have you had sexual intercourse in past 12 months?	85.5	14.5
4. Have you had more than one sexual Partner?	47.6	52.4
5. Have you ever had casual sex?	39.7	60.3
6. Did you use a condom with all casual Sex partners?	82.5	17.5
7. Did you regret having casual sex?	39.3	60.7
8. Have you ever had sex when you were drunk?	37.3	62.7
9. Have you ever paid someone to have sex with you?	13.1	86.9
10. Did you use a condom every time you paid for sex?	88.2	11.8

Table 10 presents selected men's sexual and reproductive health practices. A majority (90%) of men had ever had sexual intercourse, with a large proportion (83%) of men having a sexual partner at the time of survey, and most men (86%) had sexual intercourse within the 12 months leading to the survey. Almost half of the men (48%)

have ever had more than one sexual partner at a time, and four in every ten men (39%) had ever had casual sexual intercourse.

Eight out of every ten men (83%) who had casual sexual intercourse used a condom every time with their casual sexual partners and over a third (39%) of men who reported having had casual sexual intercourse regretted doing so afterwards. Close to four out of every ten men (37%) have ever had sexual intercourse while drunk. Just over a tenth of men (13%) had ever paid for sex, and a high percentage (88%) reported using a condom every time they engaged in paid sexual intercourse.

Table 11: Mean Number of Regular and Casual Sexual Partners

Variable	Mean % (N)	STD Error % (N)
1. Number of partners in past 12 months	2.40	0.202
2. Number of current partners	2.23	0.496
3. Number of lifetime partners	8.01	0.816
4. Number of partners in future	6.44	0.966
5. Number of times had casual sex	4.56	0.715
6. Number of lifetime casual sex partners	9.96	1.818
7. Number of casual sex partners in future	7.37	1.246
8. Number of times paid for sex	4.11	0.702
9. Number of times paid for sex in past 12 months	3.49	1.066

Table 11 presents means relating to men's sexual and reproductive health practices. The mean number of current partners was 2.2 while the average number of partners during the 12 months before the survey was 2.4. Men were also asked about the total number of sexual partners they have ever had in their lives and to also look forward into the future and estimate the number of partners that they think they will have in future, before they are finally settled into a permanent relationship or marriage. The average number of life time partners was 8.01, while the average number of anticipated future partners is 6.44.

5.7.1 Casual sexual intercourse

Men provided information on the number of times they have engaged in various sexual and reproductive health behaviors and practices. On average, men had casual sex 4.56 times in the 12 months before the survey, while the average number of lifetime casual sexual contacts was 9.96. The average number of casual sexual partners that men felt they are likely to have in the future was 7.37 partners. On average, men paid for sex 4.11 times in the past, and 3.49 times during the 12 months leading to the survey.

Table 12 shows bi-variate patterns of men's sexual practices by selected background characteristics. Almost four out of every ten men had two or more sexual partners during the 12 months prior to the survey, while over three quarters (79%) had two or more partners during their life time. Almost a fifth (18%) had two or more current sexual partners. The proportion of men who had two or more partners during the twelve months leading to the survey varies significantly by marital status; religion and family of orientation. The highest percentage of men who had two or more partners during the twelve months leading to the survey is highest among never married men (46%), followed by divorced, widowed or separated men (29%) and cohabiting men (23%). This proportion is lowest among married men (14%).

The percentage of men who had two or more partners during the twelve months leading to the survey also varies significantly by religion, with Christian men having the lowest proportion (32%) compared to African traditional religious men (67%) and men who belong to 'Other' religions (50%). More than half (56%) of men raised in extended families and 44 percent of those raised in mother only families had two or more partners during the twelve months leading to the survey. The proportion of men who had two or more partners during the twelve months leading to the survey is lowest among men raised in both parents married families (29%), and slightly higher among men raised in father only families (32%) and those raised in both parents unmarried families (35%).

Table 12: Regular and Casual Sexual Partnerships by Background Characteristics

	Two or more sexual partners in past 12 months [%]	Had two or more sexual partners lifetime [%]	Has two or more sexual partners currently [%]	Expects two or more sexual partners in future [%]	Had casual sex two or more times [%]	Has ever had two or more casaul partners [%]	Anticipates 2 or more casaul partners in future [%]
Age							
17 - 21	40.0	54.8***	12.2	28.4	42.9	48.3	31.6
22 - 25	39.1	76.6	26.3	29.0	68.2	51.1	35.1
26 - 30	44.4	84.5	16.2	35.7	60.0	62.9	34.8
31 - 35	37.7	90.9	15.3	35.3	65.4	58.6	51.5
36 - 45	24.4	94.1	6.8	35.4	57.1	60.9	39.5
46 - 69	23.3	80.0	31.0	54.8	100.0	66.7	52.4
Education							
Primary or less	22.9	86.1	14.7	51.4***	100.0***	100.0***	59.3***
Secondary	39.2	76.0	17.8	26.4	55.3	45.2	30.1
Tertiary	38.9	79.0	16.2	38.4	61.7	63.5	40.4
Marital Status							
Married	13.7***	79.6*	5.8	27.5***	30.0***	50.0***	37.5***
Never Married	45.8	81.2	20.2	40.4	69.6	59.6	42.0
Cohabiting	23.1	70.0	12.7	15.5	32.4	60.0	14.7
Separated/wid/div	28.6	69.0	18.5	6.5	83.3	50.0	66.7
Employment							
Employed	36.6	84.8***	17.6	33.2	59.3	67.0***	42.9***
Unemployed	37.9	73.3	16.3	31.5	61.5	50.4	28.7
Religion							
Christian	32.2***	77.0***	14.1***	28.5***	54.3***	52.9***	31.4***
African traditional	67.3	84.0	31.9	56.9	90.3	75.0	60.0
Other	50.0	92.0	23.1	40.0	72.2	77.8	68.2
Family of orientation							
Both parents marrie	28.8***	73.4*	12.1*	33.9	61.0	64.8	37.4
Mother only	43.7	85.4	23.4	39.6	50.9	56.1	39.0
Father only	31.6	70.6	21.1	27.8	66.7	44.4	55.6
Both parents unmar	35.1	83.9	23.8	31.7	81.3	61.1	32.4
Extended family	56.1	82.6	18.2	23.6	67.6	40.6	30.0
Place of childhood orientation							
Urban	38.8	80.4***	17.4	40.4***	66.7*	56.9	39.9*
Rural	36.5	78.8	17.3	27.1	55.1	58.2	32.6
Number	***178***	***390***	***86***	***162***	***119***	***119***	***127***
Overall percent	***38.3***	***79.4***	***17.6***	***32.9***	***61.0***	***57.5***	***36.7***

*** Significant at 5% * Significant at 10%

Most men in the sample (79%) have had two or more sexual partners during their lifetime. This proportion varies significantly by age; employment status; religion and place of childhood socialization. As can be expected, the proportion of men who had two or more partners during the twelve months leading to the survey increases with age, from just over half (55%) among men aged 17-21 to over 8 in every ten men among those who are 26 years and over. A higher percentage of men who were currently employed at the time of survey (85%) had two or more partners during the twelve months leading to the survey compared to those were unemployed (73%). Christian men (77%) had the lowest proportion of men who had two or more partners during the twelve months leading to the survey compared to African traditional religious men (84%) and men who belong to '*Other*' non-Christian religions (92%). A slightly higher proportion of men raised in urban areas (80%) had two or more sexual partners in the year leading to the survey compared to men raised in rural areas.

Almost a fifth (17%) of the men in the sample had two or more current sexual partners. The proportion of men practicing multiple concurrent sexual partnerships did not vary significantly according to men's background characteristics, except religion. Almost a third (32%) of African traditional religious men had two or more current sexual partners compared to less than half that proportion (14%) among Christian men and almost a quarter (23%) of men of 'Other' religions.

Men were also asked to provide information concerning their involvement in casual sexual intercourse, and the number of sexual partners they expect to have in future. A third (33%) of men in the sample anticipated having two or more regular sexual partners in future. This percentage however displayed significant variation by level of education; marital status; religion and place of childhood orientation. Just over half of men with primary education (51%) and 38 percent of those with tertiary education expected to have two or more sexual partners in future, compared to just over a quarter (26%) among men with secondary education.

The percentage of men who expect to have two or more partners in future displays statistically significant variation by marital status. For example, never married men had the highest proportion of men who expect to have two or more partners in future (40%) followed by over a quarter of married men (28%). The lowest proportion of men who expect to have two or more partners in future occurs among cohabiting men (16%) and divorced, widowed and separated men (7%). A significantly high percentage of men raised in urban areas (40%) compared to those raised in rural areas (27%) expected to have two or more sexual partners in future.

A significant percentage of men (61%) had ever engaged in casual sexual intercourse, and this proportion shows significant variation by education, marital status and religion. A higher percentage of men with primary education (100%) and those with tertiary education (62%) had engaged in casual sexual intercourse compared to those with secondary education (55%). Married men had the lowest proportion of men who reported having casual sexual intercourse two or three times during the year leading to the survey (30%) followed by men in cohabiting relationships (32%). Divorced, widowed and separated men and never married men reported the highest proportion of men who had casual sexual intercourse at least twice during the twelve months leading to the survey (83 and 70 percent, respectively). The proportion of Christian men who reported having casual sexual intercourse at least twice during the year leading to the survey (54%) is significantly lower than that of African traditional religious men (90%) or that of men belonging to '*Other*' non-Christian religions (72%) reporting the same.

In addition to the number of times they have had casual sexual intercourse; men also reported on the number of casual sexual partners that they have ever had. Half of the married men and 60 percent of never married and cohabiting men had had two or more casual sexual partners in the past. In addition, two thirds of employed men (67%) have had two or more casual sexual partners in the past compared to half (50%) of the unemployed men. While slightly over half (53%) of Christian men reported having had

two or more casual sexual partners in the past, this proportion is significantly larger among African traditional religious men (75%) and men belonging to '*Other*' non-Christian religions (78%).

Looking forward, men were asked to provide information about the anticipated number of casual sexual partners they expect to have in future. Over a third of the men (37%) indicated that they expect to have two or more casual sexual partners or encounters in the future. This proportion displayed significant variation by education; marital status; employment and religion. A significantly higher proportion of men with primary education (59%) compared to those with secondary (30%) or tertiary education (40%) expected to have two or more casual sexual partners in the future. While the percentage of men in cohabiting relationships who expect to have two or more casual sexual partners in future is low (15%), this proportion is relatively higher among never married men (42%), married men (38%) and divorced, widowed and separated men (67%).

Men's current employment status also displayed significant association with the number of casual sexual partners expected in the future. A higher proportion of men who were employed at the time of survey (43%) expected to have two or more casual sexual partners compared to men who were unemployed at the time of survey (29%). The number of future casual sexual partners expected also varies significantly by age. Christian men have the lower proportion of men who expect to have two or more casual sexual partners in future compared to African traditional religious men (60%) and men belonging to '*Other*' non-Christian religions (68%).

5.7.2 Perception of Multiple Sexual Partnerships

The practice of sexual networking through multiple sexual partnerships by men has long been recognized as one of the various ways that facilitate rapid heterosexual HIV transmission. Studies have shown that men are more likely to have multiple sexual partners than women, and condom use within such multiple sexual partnerships is low

and inconsistent. Binson et al. (1993) found that almost a quarter (24%) of 18-25 year old men in the United States had more than one sexual partner during the year leading to the survey. The study found strong evidence of low and inconsistent condom use within such multiple sexual unions. Forty (40) percent of men engaged in multiple sexual never used condoms either with their primary or secondary partners; while condom use decreased with increasing number of partners (Binson et al., 1993). Younger and unmarried men were more likely to report multiple sexual partners than women or married men and (Binson et al., 1993).

According to Halperin (2006), Southern Africa displays a unique pattern of multiple sexual partnerships, which can overlap for months or even years, thus greatly facilitating HIV transmission (Halperin 2006). Halperin (2006) presents evidence that implicates the overlapping nature of these multiple sexual partnerships as the driving force behind Southern Africa's HIV epidemic. Gender inequality has been identified as a central feature of the Southern African HIV epidemic. In Botswana, unequal gender and power relations disadvantages women and results in male domination of women's reproductive health decisions through maintenance of multiple sexual partnerships and lack of consistent condom use and thus contribute to women's vulnerability to infection. Pitso & Rakgoasi (2003) found that almost a fifth (18%) male youths of aged 18-25 years in Botswana were involved in multiple concurrent sexual partnerships (compared to only 6.6% among females youths of the same age) while almost a third (29%) of males had two or more sexual partners during the 12 months leading to the survey (compared to 12 percent of females in the same age range).

However, cultural contexts that shape and sustain gender relations have not received much attention in HIV/AIDS research (Ntseane, 2004). It is clear that multiple sexual partnerships increase the risk of HIV infection, especially in contexts of low and inconsistent condom use. However, except for pointing out vulnerability patterns resulting from multiple sexual partnerships, research has not directly engaged the role of masculinities and other socio-cultural norms and practices on men's sexual and

reproductive practices. For example, the social acceptance of sexual networking by men has been identified as one of the key socio-cultural determinants of the current HIV epidemic in the country (NACA, 2003).

The study examined men's perceptions and attitudes towards multiple sexual partnerships. The quantitative results of this study show that just under a fifth (18%) of men reported having multiple concurrent sexual partnerships. This figure compares with the findings from the Botswana AIDS Impact survey that suggest that 13 percent of men reported having more than one sexual partner (NACA, 2004). While many men were aware of the dangers inherent in multiple sexual partnerships, especially the elevated risk of HIV infection and disruption of relationships, many men still felt that there are reasons that sometimes compel them to have and maintain multiple sexual partnerships. Also, while men generally seemed sympathetic to reasons why some men may engage in multiple sexual partnerships, they tended to take a dim view of women, who for whatever reason might maintain similar type of relationship. This reflected a *double standard* where this practice is shunned among women, but tolerated among men.

According to most discussants, men often have multiple sexual relationships because of '*lack of sexual satisfaction*' within their current relationships. Many men indicated that usually, at the beginning of their relationship, their partners are sexually exciting, spontaneous and willing to go to lengths to ensure that they are satisfied sexually. However, with time, the spontaneity dies off, and the woman may not be as sexually adventurous as they used to be. According to some men, it is at this time that they may opt to get the satisfaction that is missing from their relationships from outside.

> *In most cases it starts with someone living well with a partner and later when one begins to reduce or stop doing some things he/she usually does for the other that is when the problem starts; therefore a man starts feeling he is no longer loved and goes outside. But [we try to inform them that] having multiple partners does not help because it is simply going out to bring 'the disease' [HIV/AIDS] home and at the end of the day children will be left as orphans while it was not supposed to be so.* **[Ntwa, 44 years, Men's Sector]**

> *….when you are not satisfied, you find another on the side to satisfy yourself, thus end up maintaining two relationships. One is your permanent partner, with who you stay and the other you keep secret and have sex with whenever the chance to do so presents itself. I still wonder what makes us do that… is it just 'greed?'* **[Young men, 19-29 years, Vocational]**

Some men felt that it was the nature of men to have more than one partner. Others advance the argument that in their view, 'a man's desire for a woman / sex is infinite' and almost uncontrollable. As one discussant put it:

> *A man's desire for a woman does not finish, it is boundless. A man can propose love to a woman and pursue her for a long time. When he is successful, it seems the excitement dies because if he sees another more attractive woman, he will pursue her also.* **[Men, 30-45 years, Vendors]**

> *There is a desire [among men] to have a 'sugar-baby' even if you have someone you call a real-partner. Even at Junior and senior school, we used to have 'sugar-babies', it was part of the culture, and when everyone seems to be doing it, the temptation becomes too much (group laughs). There was a belief that 'sugar babies' help to relieve the stress associated with a regular relationship.* **[Ndlovu, 50 years, Real Men]**

> *Isn't that [multiple sexual partnerships] natural? We hear in some countries of kings having many wives! In the past, men used to have polygamous families, but nowadays things are different due to some common diseases now.* **[Men, 35-50 years, rural, unemployed]**

> *Men can't help themselves, they are not to blame; there are just too many beautiful girls around. A man can sleep with a lady even if he does not love her; he will do it just to fulfill his lust and curiosity of what it feels like to have sex with her.* **[Johan, 39 years, Soldier]**

The seemingly perennial conflicts within intimate relationship were also cited as a reason why men maintain multiple sexual relationships.

At times that is caused by women especially if they are quarrelsome type, the type who wakes up from sleep if she wants to have a fight. You would have tried all you can to speak with her but in vain, so you end-up getting relief from outside. **[Men, 33-47 years, employed]**

Men also felt that at times they cannot help maintaining multiple sexual relationships if their partners refuse to have sex with them, especially in cases where the reasons for their partner's reluctance to have sex are not clear to them. To many men, they then engage in multiple sexual partnerships in order to 'relief' their desire for sex.

The withholding of conjugal rights, either by the man or the woman is what causes multiple sexual partnerships, especially among men. Remember that if one partner is not willing to have sex today, tomorrow when she feels like having sex, I might not be interested. This means that the couple can go for a long time without sex and in the end another person ends up being covertly brought into the relationship. **[Men, 33-47 years, employed]**

Women's refusal to have sex causes suspicion of infidelity. When a woman refuses to have sex with you, as their partner, you start to suspect that they are unfaithful, that they are not interested in having sex with you because they are getting it somewhere else. It has happened to many men, it has happened to me personally, whereby my partner continually refused to get intimate with me, only to find out later that she was having an affair. **[Men, 34-42 years, University]**

If you have a partner who does not refuse you your conjugal right, and gives you sound reasons why she may not be ready or willing to have sex at a particular time, you understand, and sleep right beside her without harboring any grievance or resentment. **[Men, 33-47 years, employed]**

At times when you have been away from your partner for a long time, you expect that when you meet you will get intimate. But when she refuses and doesn't give you any

reasons, you have to be suspicious. At times men indulge in multiple sexual partnerships as a form of revenge for his partner's infidelity. **[Men, 35-50 years, unemployed]**

Some men blamed their tendency to have multiple sexual partners on what they saw as their partner's ineptitude in bed. Some men felt that once some women are in a stable union, either a marital or cohabiting union, they no longer try to spice up their sex life. In addition to refusing to have sex, they also may show lack of interest during sex, and thus fail to stimulate the man.

There are some women who are like logs in bed, they remain passive, she could as well start reading a book while you busy at it! **[Young men, 19-24 years, University]**

Other men felt that multiple sexual partnerships add variety and spices their sex life. One man posed the question:

Can you eat the same type of food, served the same way, every day? Of course not, if you do, you soon lose interest, so you need variety. **[Men, 35-50 years, urban, unemployed]**

Some men felt that lack of sexual satisfaction within a relationship that was satisfying is caused by women's infidelity. Discussants in one group were adamant that once a woman has sex with another man, who is not her regular partner, she will fail to satisfy her regular partner, arguing that it is easy for a man to detect if the woman has had sex with someone else. The main argument was that some men have large penises, and if a woman has sex with one of these men, her female organ becomes stretched and therefore might fail to stimulate her regular partner, who might have a smaller penis. To these men, sexual satisfaction was equated to '*friction*' during sex, so that the loss of this '*friction*' equates to loss of sexual satisfaction.

We are not equal, she might have found herself an 'extra-heavy duty' [large penis] (laughter); the result if that you may fail to satisfy her, and you may not get satisfied yourself. There must be 'friction'. This friction and tightness during sex is what

strengthens relationships and keeps families intact, it keeps you within the relationship. **[Men, 35-50 years, rural, unemployed]**

While many men seemed to be sympathetic to the reasons why men usually engage in multiple sexual partnerships, they were nevertheless aware of the negative consequences of these relationships, such as increased vulnerability to HIV infection, instability and loss of trust in relationships, and violence. Men argued currently, just like men, women are increasingly having multiple sexual relationships either because they enjoy it, or at times they do it for economic reasons. Men cited this tendency towards maintenance of multiple sexual relationships as the main reason behind '*passion killings*' in Botswana. In addition, men were also aware of the contribution of excessive alcohol consumption towards multiples sexual partnerships and relationship violence.

Infidelity is the root cause of violence in intimate relationships. You might have a partner and work hard to provide for her, but she might start getting out of control, having intimate affairs with other men and now using the same resources you provide her with to maintain the secret relationship. This causes a lot of conflict and fighting within relationships, which ends up in serious instance of violence and murder. **[[Men, 35-50 years, urban, unemployed]**

5.8 Risk Perception

Research points to a poignant association between masculinities and risk perception among men (see Sabo et al., 1995; Helgeson, 1995). Men's need to be strong and independent is generally understood to contribute to men's low risk perception of their vulnerability to diseases and unwillingness to seek help. The need to be a '*sturdy oak*' and thus avoid semblances of feminine dependency (Helgeson, 1995) is probably at the centre of men low risk perception of their vulnerability and unwillingness to seek help.

Men were asked to provide an evaluation of their perceived risk of HIV infection, as well as their attitudes towards the use of condoms. Table 13 shows men's evaluation of HIV as a risk to their communities and their own HIV risk perception. Over nine out of every ten men (91%) characterized HIV/AIDS either a serious or very serious problem within their respective communities. However, over half the men (53%) considered themselves to be either at no or low risk of contracting HIV. As a means to ensure that they remain uninfected and also protect their partners, most men indicated that they are '*faithful*' to their sexual partners (41%) while others indicated that they ensure their partners' protection from infection through use of condoms (43%). Almost one in ten men indicated that they are abstaining (9.9%) while 6.3 percent underwent HIV testing just for the sole purpose of ensuring that they knew their HIV status.

Men's perception of the seriousness of HIV within their communities did not show any significant variation by men's background and other characteristics. However, men's place of childhood orientation showed a small but statistically significant association with men's perceived seriousness of the HIV epidemic in their respective communities. A slightly higher percentage of men who were oriented in rural areas (93%) perceived HIV as a serious problem in their respective communities compared to men whose place of childhood orientation is urban (91%).

Men's risk perception of HIV infection varies significantly by age, marital status and family of orientation. The percentage of men who do not perceive themselves at risk of HIV infection tends to be relatively higher among older men compared to younger men.

While 43 percent of men aged 17-21 considered themselves to be a low or no risk of HIV infection, this proportion increases to 59 percent among men aged 22-25 years, declines somewhat among those aged 26-30 years before increasing to 51 percent among men aged 31-35 years. This proportion reaches its peak among men aged 36-45 years (75%) before declining slightly among the oldest men in the sample (62%).

Table 13: Men's HIV Risk Perception and Health Seeking

	HIV is a serious problem in the community	I am at low or no risk of HIV infection	Ever had a physical examination	Had physical exam during past year
Age	[%]	[%]	[%]	[%]
17 - 21	87.5	46.3***	21.9***	21.1
22 - 25	91.6	58.7	41.1	35
26 - 30	93.5	46.7	35.1	31.7
31 - 35	89.7	50.7	41.6	19.4
36 - 45	94.7	74.5	48.2	23.3
46 - 69	85.7	61.8	46.9	33.3
Education				
Primary or less	92.3	66.7	18.4***	18.2
Secondary	89.5	52.1	32.6	31.4
Tertiary	93.8	54.1	45.2	28.7
Marital Status				
Married	88.7	73.6***	47.1***	39.4***
Never Married	92.1	52.8	34.8	23.2
Cohabiting	89.9	58.3	38.3	36.2
Separated/wid/div	97.1	26.5	55.9	56.7
Employment				
Employed	91.7	56.3	42.2***	31.8
Unemployed	90.3	53.7	33.6	26.2
Religion				
Christian	90.8	56.1	35	27.6
African traditional	93.3	63.3	61.7	34
Other	91.9	34.4	36.1	33.3
Family of orientation				
Both parents marrie	91.8	66.1***	33.5***	25.5***
Mother only	92.6	55.7	36.6	28.7
Father only	85	50	20	23.1
Both parents unmai	87.7	30.1	40	30.5
Extended family	91.3	41.2	51.5	34.1
Place of childhood orientation				
Urban	90.5***	55.1	30.3***	23.3
Rural	92.9	52.9	44.4	32.9
Number	**527**	**306**	**212**	**110**
Overall percent	***91.2***	***53.8***	***37.2***	***28.2***

*** Significant at 5% * Significant at 10%

The highest proportion of men who considered themselves at low or no risk of HIV infection occurs among married men (74%) and is lowest among divorced, widowed and separated men (27%). This proportion remains just slightly over half for never married (53%) and cohabiting men (58%). Men's family of childhood orientation also displays significant association with men's HIV risk perception. Almost two thirds of men raised in both parents married families (66%) consider themselves at low or no risk of HIV infection compared to men raised in extended families (41%); both parents unmarried families (30%) and mother and father only families (56 and 50 percent, respectively).

5.9 Health Seeking

The results of the quantitative analysis show that 38 percent of men have ever had a physical examination (Table 13), and that of those who did, only 28 percent had the physical examination during the 12 months leading to the survey. The percentage of men who ever had a physical examination varies significantly by age; education; marital status; employment status; family of orientation and place of childhood orientation. The proportion of men who ever had a physical examination tends to increase with age, from just over a fifth (22%) among men aged 17-21 years to between 4 and 5 out of every ten men for ages beyond 22 years.

Men's level of formal education also shows significant leverage on men's use of the physical examination. The proportion of men who ever had a physical examination increases with level of education, from under a fifth (18%) among men with primary education or less, to a third (33%) among men with secondary education and 45 percent among men with tertiary education. Men's use of physical examination also varies significantly by marital status, with the highest proportion of men who ever underwent physical examination occurring among married men (47%) as well as men who were previously married but are divorced, widowed or separated (56%). Just over a third of

never married men (35%) and 38 of cohabiting men have ever had a physical examination.

The proportion of men who ever had a physical examination is also higher among men who were currently employed at time of the survey (42%) compared to those who were unemployed (34%), as well as men whose place of childhood orientation is rural (44%) compared to those who place of childhood orientation is urban (30%).

5.9.1 Men's Health and Help Seeking for Sexually Transmitted Infections (STI's)

Table 14 shows men's health seeking behaviour, including health seeking for sexually transmitted infections. Just over half the men in the sample rated their health as good (51.9%) while a third rates their health very good (38.1%). Only 1.5 percent of men rated their health as poor while 8.4 percent rated it as fair. Less than a fifth (17.2%) had experienced either illness, injury or both during the 12 months prior to the survey and significant majority (79.8%) sought medical or professional help for their injury or illness. On average, men sought help for their illness or injury after 3.5 days. Over a third (38%) of the men who experienced illness or injury sought help within a day of experiencing the injury or illness, just under a fifth (18%) sought help after two days. A quarter of men who experienced injury or illness sought help after 3 to 5 days, while a fifth (20%) sought help after six or more days.

One in ten men (10.5%) reported experiencing signs and symptoms of an STI during the year prior to the survey. On average, those who reported signs of STIs experienced these signs 10.21 days prior to the survey. These symptoms include blisters, burning sensation when urinating, penile discharge or sores. Over a third (34.4%) of the men who experienced signs of STD did not disclose their symptoms to their partners, and 36.5 percent of men who experienced signs and symptoms of STD had sexual intercourse with their partners during the time they were experiencing these signs and symptoms and 13.3 percent of these men did not use a condom.

Table 14: Men's Health and Help Seeking for Sexually Transmitted Infections

	%
How would you rate your health?	
Very Good	38.1
Good	51.9
Fair	8.4
Poor	1.5
During the past 12 months have you suffered any illness or injury?	
Yes, illness only	6.5
Yes, injury only	9.2
Yes, both	0.5
No	83.8
Did you seek medical or professional help for your illness or injury?	
Yes	79.8
No	20.2
After how many days did you seek help?	
1 day	37.5
2 days	17.9
3-5 days	25.0
6 days or more	19.6
Experience of STI during the past 12 months	
Yes	10.5
No	89.5
How long ago did you experience these symptoms?	
1 day	17.5
2-3 days	15.8
4-8 days	42.1
9-14 days	8.8
15 days or more	15.8
Did you inform your partner about the symptoms?	
Yes	65.6
No	34.4
Did you have sexual intercourse while experiencing the symptoms?	
Yes	36.5
No	63.5
Did you use a condom while having sex with symptoms of STI?	
Yes	86.7
No	13.3

Table 15 presents men's health and help seeking by selected background characteristics.

Table 15: Men's Health and Help Seeking by Background Characteristics

Variable	Rate your heatlh:Good	Didn't Experience illness/injury prev year	Sought help for injury / illnes	Experienced STI in prev year	Informed partner of STI	Ever felt depressed / psychological distress	Did not seek help for depression/distress	Have you ever felt suicidal
Age								
17 - 21	**95.8*** **	78.9	78.9	1.1***	100.0	37.0	82.4	18.1
22 - 25	94.4	81.1	98.5	10.9	73.3	37.9	78.8	12.8
26 - 30	87.6	86.7	77.8	14.4	50.0	49.7	66.3	17.1
31 - 35	83.1	82.9	90.0	7.9	83.3	40.0	67.7	9.5
36 - 45	93.0	87.7	71.4	7.0	100.0	45.3	54.2	20.0
46 - 69	80.0	82.9	66.7	25.7	55.6	40.0	50.0	14.3
Marital Status								
Married	86.8	88.5	80.0	15.1	100.0***	42.3	54.2	11.3
Never Married	90.5	82.9	78.7	9.0	57.6***	42.5	72.7	15.1
Cohabiting	93.6	89.0	88.9	10.1	54.5	39.4	74.4	11.7
Separated/wid/div	85.3	82.4	83.3	14.7	100.0	48.5	53.3	26.5
Education								
Primary or less	92.3	89.7	100.0***	15.4	66.7	33.3	63.6	8.1
Secondary	88.7	83.3	93.0	9.6	73.9	42.6	67.6	14.4
Tertiary	93.1	84.0	63.9	9.1	64.0	42.0	72.9	156.0
Employment								
Employed	87.8***	86.8***	90.0*	10.7	70.4	47.6***	68.3	14.8
Unemployed	92.6	80.7	73.7	10.3	59.4	36.3	71.3	13.8
Religion								
Christian	91.6***	82.7	81.9	9.3	65.1	41.4	66.5	12.6***
African traditional	80.0	86.2	62.5	16.7	60.0	40.0	73.9	32.8
Other	90.3	87.1	75.0	13.3	66.7	49.2	82.8	18.0
Family of orientation								
Both parents married	93.4*	86.7	80.6	10.4	66.7	41.3	66.3	13.0***
Mother only	88.1	81.1	78.3	10.8	50.0	44.6	72.2	28.4
Father only	85.0	85.0	66.7	15.0	66.7	55.0	70.0	22.2
Both parents, unwed	83.6	75.3	68.4	5.6	66.7	38.2	56.7	6.8
Extended family	91.3	86.4	100.0	11.5	75.0	39.8	84.6	6.8
Place of childhood orientation								
Urban	89.4	81.8	73.9	11.2	60.0	40.3	67.6	18.4***
Rural	91.1	85.7	85.7	9.1	67.9	42.9	71.0	12.1
	520	***95***	***69***	***59***	***38***	***238***	***163***	***86***
	90.1	***16.6***	***79.3***	***10.4***	***64.4***	***42.3***	***69.4***	***15.3***

*** Significant at 5% * Significant at 10%

The percentage of men who rate their health as '*good*' varies significantly by age, employment status and religion. The percentage of men who rate their health as 'good' is highest among younger men (96% among 17-21year old men) and is lowest among men aged 31-35 (83%) and those aged 46-69 years (80%). A higher percentage of Christian men (92%) rated their health as '*good*' compared to African traditional religious men (80%) or those of 'Other' non-Christian religions (90%). In addition, a higher percentage of unemployed men (93%) rated their health as '*good*' compared to

employed men (88%). Most men (83%) did not experience any injury or illness during the year leading to the survey. The percentage of men who did not experience any injury or illness during the year leading to the survey is lowest among unemployed men (81%) compared to employed men (87%). Just over three quarters (79%) percent of men who experienced injury or illness during the year leading to the survey sought medical or professional help for their injury or illness. This proportion varies significantly by age, declining from 100 percent among men with primary education or less, to 93 and 4 percent among men with secondary and tertiary education respectively.

One tenth of the men in the sample had ever experienced a sexually transmitted infection. This proportion shows significantly variation by age only, increasing from just over one percent (1.1%) among men aged 17-21 years, to 11 and 14 percent among those aged 22-25 and 26-30 years respectively. This proportion then declines to 8 and 7 percent among men aged31-35 and 36-45 years respectively, before increasing to over a quarter (26%) among men aged 46-69 years. Slightly under two thirds (64%) of men who experienced an STI informed their partner of the STI. The percentage of men who informed their partners of STI infection is highest among married men (100%), followed by never married men (58%) and then cohabiting men (56%).

A significant portion of men (42%) reported having experienced depression or psychological distress in the past. However this proportion varies significantly by employment status only. Almost half (48%) of men who were currently employed at the time of survey indicated that they have experience stress and psychological distress compare to men who are unemployed at the time of survey (36%). Despite the significant percentage of men who reported experiencing depression or psychological distress, just over two thirds (69%) of these men did not seek for their condition. The proportion of men who did not seek any help for depression or psychological distress does not vary significantly according to mean background characteristics.

Just under a fifth (15%) of men reported that they have felt suicidal in the past. This proportion shows significant variation according to religion, family of orientation and residence. For example, just over one tenth (13%) of Christian men reported having felt suicidal compared to 18 percent among 'Other' non Christian men and 33 percent of African traditional religious men. Family of childhood orientation also shows significant association with the likelihood of feeling suicidal. For example, the lowest percentage of men who felt suicidal occurs among men raised in extended families or both parent unwed families (7 percent each) followed by those raised in both parents married families (13%). The percentage of men who felt suicidal is highest among men raised in either mother only families (28%) or father only families (22%).

It is apparent from qualitative interviews with men on the subject of health seeking, that most discussants felt that generally men are slow or reluctant to seek help, including health, due to the perception that they are physically stronger [than women] and therefore less vulnerable to disease, or that health seeking was '*unmanly*'.

> *Men are not overwhelmed by illness at the same rate as women. Women are easily overcome by illness; they are more vulnerable to pain so they have to seek help.* **[Men, 35-50 years, unemployed]**
>
> *It is not that men are reluctant to seek help for health related problems, men are stronger and don't fall ill easily. This is why it is much harder to detect the HIV virus in men than in women.* **[Men, 33-47 years employed]**
>
> *I know men whose partners were attending ante-natal care and receiving anti-retroviral drugs (ARVs). It is common that when the man presents for HIV testing, he find that he is HIV negative, or they just can't find the virus in his body. This is an indication that often times it takes long before a man's HIV status is detected.* **[Men, 30-45 years, Vendors]**

The feeling that they have to be strong and in control makes seeking help to feel like an indictment on their masculinity, or an admission of weakness, vulnerability and not being in control.

> *Sometimes you may feel very sick at night as a man but in the morning you would a bit hesitant to go to the clinic. You ask yourself if really there is a need to ask for help or even tell someone or ask for help from someone. [***Men, 35-50 years, unemployed]**

> *The main problem with men is that they are reluctance to seek help. This makes them delay consulting medical professionals on the onset of signs and symptoms of an illness or disease; which makes treatment ineffective or long and expensive.* **[Kyle, 41, years, Social Worker]**

> *Yes, it is true that it can be hard for men to go and seek for medical help. At times you just become sluggish to go to the hospital so you simply try to keep your sickness a secret until you die not even knowing the cause of the disease; whether you have been infected through your careless ways or by an unfaithful partner. Women get infected, but we die!* **[Kitso, 75 years, Village elder]**

> *Women are bold…and brave, even braver than men because when it comes to health, they face the issues and problems head-on. Sometimes a man can go to the hospital to ask for help [when he is really sick] and when he arrives there he changes his initial plan of seeking help, and might change his story, and now claim that he has a headache or back pain. Anything other than what he came to the hospital for.* **[Men, 30-45 years, Vendors]**

5.9.2 Attitudes towards use of condoms in intimate relationships

The consistent use of condoms is one of the three pillars of most national HIV prevention strategies in Botswana and most of Southern Africa, which encompass Abstinence, Being faithful to one uninfected partner and Consistent condom use (ABC). Despite the centrality of condom use in HIV prevention, most research on condom use for HIV prevention point to men's reluctance or unwillingness to use condoms. The limited condom use is not a result of lack of information (MacPhail, 2003). Evidence from a number of demographic surveys suggests that the sex differential in knowledge of HIV prevention and transmission among men and women is not significant. An analysis of levels knowledge of HIV among adolescents in Botswana did not reveal any significant sex differentials knowledge between male and female adolescents (Pitso & Rakgoasi, 2003). According to Varga (1999), men have knowledge and awareness of the benefits of condom use but they have difficulty in personalizing the use of condoms in their own relationships.

Most men in this study were aware of the necessity of using condoms, especially if they are engaged in multiple sexual partnerships. This awareness of the importance of using condoms can be attributed to intensified HIV prevention education occasioned by the prevailing HIV/AIDS epidemic in the country. While many discussants felt that consistent condom use was necessary for protection against HIV infection, the idea of using a condom every time with a steady sexual partner did not take hold with many men. However, consistent condom use was sometimes perceived as unnecessary within a relationship that is perceived as to be '*permanent*', '*steady*', or '*serious*' or where there is '*love*' in a relationship.

There was a view that consistent condom use would be unnecessary, even disruptive in a relationship where a certain level of 'trust' is established, regardless of whether the two partners have undergone testing to establish their HIV status. Thus there is an implied view among men that condoms are used with casual partners, or in transient

relationships, because '*if she insist on condom use every time, you may end-up giving up on her, because does not love you'*. **[Young men, 24-33 years, rural, unemployed]**

A discussant offered the following narrative concerning consistent condom use within intimate relationships:

> *As a man you give-up [if your partner insists on condom use every time] and allow the use of the condom, after all, sexual intercourse lasts few minutes then it's done. But you would still prefer to have unprotected sex with her because she is your partner. The heightened sensation of unprotected sex makes it more enjoyable, and you also feel like you are bonding.* **[Young men, 25-35 years, employed]**

At times men prefer to have unprotected sex rather than use a condom. The popular view was that while condoms are necessary for HIV prevention, they also reduce sexual pleasure and dulls the sensation associated with '*live' sex*', as some men put it. In one rural area, men observed that high unemployment rates were driving women into form of sex work, whereby the women deliberately maintain multiple sexual relationships with different men for financial gain. This practice was not considered to be commercial sex work since the women do not have sex with any man who is willing to pay, but rather have a closed circle of boyfriends who provide financial assistance in exchange for sexual favors. In such an environment, men's reluctance to use a condom was a big problem because the dependence of women on their boyfriends' financial assistance limits the women's ability to negotiate safe sex, let alone to take a firm stance if she felt she was in danger of infection.

> *In this area most ladies are not working hence they are dependent on men. Sometimes men insist on unprotected sex, arguing that since he gives the woman his money without any preconceptions, he also needs to have unprotected sex. Because the lady would be desperately in need of money she ends up agreeing to have sex without using a condom, exposing herself to risk of HIV infection or transmission in the process.* **[Men, 33-47 years, employed]**

Most discussants were doubtful about whether they would be able to control their sexual urges if they discovered right at the moment that they were about to have sex, that they do not have a condom.

> *Indeed it is hard. Many men would try to persuade the lady [to have unprotected sex]; he may end up using force and even raping her now that he will now be 'heated-up' (laughter). He would only start to worry about the possibility that he could have gotten infected after the sexual act.* **[Men, 35-50 years, unemployed]**

In one rural community, a key informant from the local men's organization indicated that there was concern among most men, who feel that the condoms that were being supplied through government clinics were too small.

> *Some men complain that the size of the condom is small. We were glad last year to hear that a company which makes condoms is coming to Botswana and thought that by now it would already be here and would help address the issue and other concerns. There is need for a condom survey to understand the problem and issues with condom use.* **[Ntwa, 44 years, Men's Sector]**

> *When condoms were introduced and men used to complain that they are small while others said they're too big. We thought they were just making excuses for not using condoms, but now it is clear that there are issues and concerns. In the mean-time, we hope the female condom will make up for the deficit.* **[Ntwa, 44 years, Men's Sector]**

> *Condoms are available in government health facilities, which men do not visit. If men are scared to go to health facilities even when they are sick, how can he go there just to obtain condoms? Even if the condoms were placed in areas that are frequented by men, such as bars and sports facilities, men would still have a difficult time getting them because he constantly would have to look over his shoulder to ensure that no one sees him taking them.* **Men, 35-50 years, unemployed]**

Table 15: Men's Experience of and Help Seeking for Psychological Distress

	%
Have you ever felt depressed or experienced psychological distress?	
Yes	42.3
No	57.7
Have you ever sought medical or professional help for this condition?	
Yes	30.1
No	69.9
How many days after experiencing the psychological condition did you seek help?	
1 day	31.6
2 days	28.9
3-4 days	23.7
5 days or more	15.8
Where did you seek help from?	
Clinic hospital	27.2
Counselor	51.9
Psychologist	9.9
Other	11.1
Have you ever felt suicidal or entertained thoughts of suicide?	
Yes	15.3
No	84.7
In your view, what should a man do if he is experiencing psychological distress?	
Seek help immediately	91.6
Try deal with it first before seeking help	8.2
Other	0.2

5.9.3 Help Seeking for Psychological Distress

Table 15 presents results relating to men's experience of and help-seeking for psychological distress. A significant proportion of men (42%) reported having experienced depression or some other forms of psychological distress during the year before the survey, while 15 percent have felt suicidal or entertained thoughts of suicide. However a significant portion of who experienced psychological distress never sought any help for their condition (69.9%). Those who sought help did so, on average, after 13.08 days. Most men who sought help did so from counselors (51.9%), from medical

facilities (27.2%) or private psychologist (9.9%), while 11 percent sought help from other sources that include friends and relatives.

5.10 Alcohol Consumption and Sexual and Reproductive Health Practices

Table 16 shows men's alcohol consumption patterns as well as their self reported sexual behavior and practices after consuming alcohol. Close to six out of every ten men (57.8%) had ever drank alcohol, with over three quarters (76.2%) indicating that they usually drink alcohol. Just under a third of the men (31.5%) drank alcohol once a week while a slightly higher proportion (34.4%) did so twice a week. A further fifth (19.6%) of the men consume alcohol three to five times a week while 14.5 percent did so six times or more per week. On average, those who drink alcohol did so 3.14 times per week, and drank an average of 13 drinks or beers per typical drinking session.

Almost four in every ten men (37%) had ever had sexual intercourse while drunk, or under the influence of alcohol. While more than two thirds (67.9%) of the men who had sex while drunk did so with their regular partners, almost a fifth (17.2%) had sex with a non- regular partner while drunk and 14.8% reported doing so with both their regular and non-regular partners. A quarter (25%) of the men who had sex under the influence of alcohol reported that their partner was also drunk. A large percentage of men who had drunk sex (88%) used a condom every time they had sex drunk.

Table 16: Men's Alcohol Consumption and Sexual and Reproductive Health Practices

	Percent
Have you ever taken alcohol?	
YES	57.8
NO	42.2
Do you usually drink alcohol?	
YES	76.2
NO	23.8
On average, how frequently do you drink alcohol?	
Once a week	31.5
Twice a week	34.4
Thrice a week	19.6
Four or more times a week	14.5
How many drinks do you usually take per session?	
1-5	14.2
6-11	33.7
12-18	29.4
19 + drinks	22.7
Have you ever had sex when you were drunk?	
YES	37.3
NO	62.7
The last time you had sex when you were drunk; who did you have sex with?	
Regular partner	67.9
Both regular and non regular partners	32.1
The last time you had sex when you were drunk, was your partner also drunk?	
YES	25.1
NO	74.9
Did you use a condom when you had drunk sex?	
YES	86.6
NO	13.4

5.11 Attitudes towards homosexuality and men-who-have –sex-with men [MSM]

This research sought men views on homosexuality in Botswana, including whether they feel that homosexuals are different from heterosexual men and on the desirability of legalization of homosexuality. Eight out of every ten men (84.9%) felt that homosexuality should not be legalized. Only 11 percent of the men felt that homosexuality should be made legal, with 3.5 percent being undecided about the desirability of legalization of homosexuality. Men who were against legalization of homosexuality described it as '*undesirable*'; '*unnatural*'; '*a sin*' or '*uncultured*'. Those who felt that homosexuality should be legalized cited an individual's right to make decision about their sexuality.

Men expressed a range of views towards homosexuality and men who have sex with men (MSM), from outright rejection of this lifestyle to views that expressed a certain level of compassion.

> *I don't agree with the lifestyle, but we should consider that some of them are born like that, with those desires for other men, so there is not much that can be done to change them.* **[Men, 30-45 years, Vendors]**

> *In my view, there is no problem with homosexuals. If that is what they want, and they feel satisfied and fulfilled with that life, so be it.* **[Young men, 1-24 years, University]**

> *We are free in this country, so everyone should be allowed to live the way they want to live. Those people (homosexuals) have chosen to live that way and they are comfortable with it. It is us who are not comfortable with them!* **[Men, 33-47 years, employed]**

However, views that accept or show compassion for homosexuality were rare and far in between. Most views however were overly negative and tended to view homosexuality as '*unnatural*'; *undesirable*'; '*a sin*'; '*uncultured*'; '*foreign' or 'diseased*'. Other men, while accepting that homosexuality is a reality, tended to think that it is a condition that can be corrected through a number of ways. A majority of men felt that people '*change*

themselves' and choose be homosexual, as a result they saw homosexuality as condition that can be fixed through counseling or being reprimanded.

> *They are just normal people, but when they grow up they start changing themselves, desiring to something other than what they are, just turning themselves into animals.* **[Young men, 1-29 years, Vocational]**

> *They should be counseled and made to see the need to change their situation by changing their behavior. That is the only way they can be assisted.* **[Ntwa, 44 years, Men's Sector]**

To some, men might choose to be gay because of past failed relationships with women, and *'hence resorted to relationship with another man.* So to these men, homosexuality can be '*cured*' by introducing women to these men's lives.

> *They (homosexuals) should be isolated and put into an enclosure. Once they are in the enclosure, throw some women inside, and then watch what happens!! (Laughter)*

Homosexuality was seen as foreign and therefore contrary to culture. A popular view was that homosexuality is copied from western media, especially films and television; *they just copy these things from other countries, especially our neighbor… South Africa.* **[Young men, 24-33 years, unemployed]**

> *Television shows various lifestyles that some of us get interested in and may start to emulate. It's no different from the current youth culture where young people wear low riding trousers that expose their underwear. So, while some of us want to live just the way we are, others want to change into something else just because they see that thing being practiced in America, just because of television.* **[Young men, 19-29 years, Vocational]**

> *They opt to be homosexual and deliberately. It's like someone who decides to be a prostitute. They get most of these things from foreign countries and popularized through television.* **[Young men, 18-27 years, Church]**

In addition to the influence of western media and modernization, many men saw prisons as a source of homosexual tendencies. They felt that since men in prison don't have access to women, they tend release their sexual energy by having sex with other men. The popular view was that many men who undergo imprisonment come back either as homosexuals or if they may maintain a straight lifestyle but occasionally would desire or even have sex with other men. Once they get out of prison, they tend to want to maintain that practice.

> *I had a friend of mine who was in prison and he learnt that from prison. Then after leaving prison he had an urge to carry on with men.* **[Men, 35-50 years, rural, unemployed]**

> *It's a big problem, they learn these things from prison; we hear that homosexuality is rife behind bars. There is need to investigate this issue. It seems like people reach a stage whereby even after being released from prison, they want to continue with homosexuality. Some even rape other men if they cannot find a suitable partner. Once released, others deliberately commit offences in order to get arrested and sent back to prison so that they can continue with their homosexual life.* **[Men, 34-42 years, University]**

> *It happens a lot in prison where men miss their partners. It really does happen and there are actually other men in there who behave like women and even walk like them. If I was to be imprisoned today, I will be proposed by over 20 men, today!* **[Men, 30-45 years, Vendors]**

Men attributed the perceived increase in homosexuality to the fact that many men cannot find gainful employment and end up in poverty and increased likelihood of committing crimes and being sent to prison. So the perceived decline in the social status of men not only makes them struggle to live up to socially expected roles through poverty and unemployment, but also increases their chance of involvement in crime and law breaking. This in turn increases their chances of imprisonment, and exposure to

homosexuality. One discussant was adamant that homosexuality is rampant in prison, and related the increased risk of sexual transmission of HIV resulting from sexual acts among men in prison.

> *I learnt from a workshop [of government ministers' and prison officials'] that men do actually have sex with men, and that such sex results in a lot of friction and bruising. Since prisoners don't have access to condoms, this significantly increases their risk of infection.* **[Men, 33-47 years, employed]**

Botswana's HIV epidemic is generalized, and has seriously affected many population groups. While homosexuality is illegal in Botswana, there can be no doubt that there are homosexuals, and that given the nature of the epidemic, they are most likely to be as affected by HIV as other population groups. Homosexual men may also maintain heterosexual relationships with women, either out of preference or as a cover for their true sexual orientation. So the question of identifying and addressing the sexual and reproductive health needs of homosexuals and men who have sex with men (MSM) becomes important. If the sexual and reproductive health needs of some of the minority population groups, such as homosexuals, are not addressed, they may act as a link for the transmission of HIV to the rest of the population.

This thesis elicited men's views on the need to provide sexual and reproductive health education, information and resources to address the needs homosexuals and men who have sex with men. Some realized the need for government to provide certain services to reduce the chance of HIV transmission among homosexual men and men who have sex with men. Most of the men who men who saw the need for provision of sexual and reproductive health services to homosexuals gave qualified support for any efforts in that direction:

> *In spite our initial resistance, we now provide condoms to youth [in recognition of the danger of infection], so perhaps, even though we might be against homosexuality, government can also provide services to homosexuals if indeed their lifestyle increases*

their vulnerability to HIV infection. Failing to do so would amount to discrimination. And in the end, would affect everyone. I would still add a word of caution though; that we should not accept certain things just because they are practiced and accepted in other countries. **[Ntwa, 44 years, Men's Sector]**

There is need for education to address the needs of homosexuals and men who have sex with men. There is no way around it, it will be difficult to make people change their sexual orientation, so maybe making their sexual practices safe through proper education and services is the only way to go. Personally, I think that rather than decriminalizing homosexuality, we should rather address their needs. Let us look at their needs and problems, understand and address them, without legalizing it. **[Ndlovu, 50 years, Real Men]**

Yea, some things though not acceptable, if they are prevalent they need to be to be attended to. Such services can ultimately be provided to try to alleviate the spread of the infection. There is nothing that can be done. **[Young men, 25-35 years, employed]**

A far stronger view was that government should not provide such services.

They might have needs, but the government should turn a deaf ear to those things…not even resources…. The government has outlawed homosexuality, I see no need to provide services for an outlawed lifestyle or educate people about it. **[Men, 35-50 years, rural, unemployed]**

Government should not provide condoms to prisoners; to do that will amount to condoning and encouraging the practice. If anything, the law needs to be tightened to prevent such practices. **[Young men, 19-29 years, Vocational]**

Most men saw homosexuality as a big problem and a threat to the natural order of things. They felt that there was need for tougher laws against homosexuality in order to control and ultimately eliminate it. There were also views that while laws that protect individual rights and freedoms are welcome, the very same laws implicitly permit some men to choose lifestyles that are considered '*unnatural*'. To some men, issues relating to

the protection of human and individual rights make it difficult for government to take decisive action against homosexuality.

> *So laws should be changed. However even if that was to be the case, they can still appeal on grounds of discrimination or oppression, or cite violation of some other human right they may claim to have. So in that sense, the human rights are a problem because it handicaps any decisive action.* **[Prince, 35 years, DJ/Student]**

> *The government should enact tougher laws against homosexuality and men who have sex with men; a woman was made for a man. It's shocking, what kind of life is that?* **[Mooki, 47 years, Pastor]**

> *Human rights allow people to choose the kind of lifestyle, including sexual orientation, but the law needs to be amended to address this problem.* **[Ndlovu, 50 years, Men's Sector]**

During the focus group discussion, some men became aware of the futility of advocating for stricter laws and harsher punishment in the form of jail terms for homosexuality. For as long as they were convinced that prisons were a source of homosexual tendencies, sending men to prison for being homosexual will actually intensify this tendency among men.

> *Indeed it is hard. Even if you may try to jail them still they will continue. That is what they want. Nowadays, some people say they have some rights, they would claim they are discriminated against.* **[Men, 34-42 years, University]**

Most men viewed homosexuals as different from heterosexual men. Half the respondents (50.6%) felt that homosexual men are not '*real*' men.

> *They are less worthy than us (heterosexual men), but better than women!* **[Men, 30-45 years, Vendors]**

However a significantly high and almost similar proportion (48.0%) felt that homosexual men are not different from heterosexual men. The perceived difference was

also a source of mistrust of homosexuals by heterosexual men. One of the things that tended to make some men uncomfortable about homosexual men is the fact that another man might find them sexually attractive. This is a thought that tended to unsettle many discussants, who felt that they could not trust such men.

> *They are men alright, but they are different; they are not like us. You can't trust them. The way they behave is different; they tend to behave in girlishly!* **[Johan, 39 years, Soldier]**

Homosexual men were also considered a kind of safety risk at the workplace, especially when performing work that is dangerous and requires alert attention. There was a view that since men tend to perform strenuous and difficult jobs that sometimes require a lot of attention to safety, working with homosexual men might be a distraction. Some men felt that homosexuals may be attracted to some of the men they are working with; they might start day dreaming or fantasizing about their colleague and not pay attention to what they are doing, and end up compromising everyone's safety. In their view, the appearance of a woman in an area where men only are working sometimes causes a big distraction as men look, whistle and make sexually explicit innuendos towards her. They reasoned that homosexuals may experience the similar distraction while working with other men.

> *He may have sexual thoughts and that can distract his attention, especially if you are doing some dangerous (manly) job. No, you cannot trust them to stay focused under such circumstances!* **[Men, 35-50 years, rural, unemployed].**

Chapter 6: Masculinities on Men's Sexual and Reproductive Health

6.0 Introduction

This chapter investigates the association between masculinities and men's sexual and reproductive health attitudes and practices. Chapter 5 examined and presented levels and patterns of men's sexual and reproductive health attitudes, masculine beliefs and practices. The chapter also tested the association between men's sexual and reproductive health attitudes, beliefs and practices and men's selected background characteristics. This chapter examines the association between men's masculine and gender role beliefs and their sexual and reproductive health attitudes and practices. It uses logistic regression analysis to determine the impact of masculine and gender role beliefs and a number of other variables on men's sexual and reproductive health attitudes and practices.

6.1 Computation of Masculinities variable

The following section provides an explanation of how the variable on '*masculinities*' was computed. Men were asked to agree or disagree with six statements on masculinities and gender role beliefs. The responses to these statements were classified into five categories, namely 1='*Completely Disagree*'; 2='*Disagree*'; 3='*Undecided*'; 4='*Agree*'; 5='*Completely Agree*'. During data analysis, the '*Completely Disagree*' and the '*Disagree*' (categories 1 and 2) were merged and named "Disagree", while the '*Agree*' and '*Completely Agree*' (categories 4 and 5) were also merged to create a category named "Agree". This initially reduced the number of categories to three, namely *Agree, Disagree and Undecided*.

Table 17 shows the number and percentage of men who agreed with each of the six masculine and gender role statements[9].

[9] These patterns are presented in Table 2

Table 17: Percentage of men who agreed with Masculine and Gender Role Beliefs

Masculine / Gender role statement	Number	Percent
Men are superior to women	393	65.8
Men should always be heads of households	384	64.2
Boys should be tough and not show emotions easily	210	35.2
It is unmanly to seek help for minor problems and ailments	252	50.3
It is important for a man to be strong and self sufficient	353	60.0
It is important for a man to be independent	402	68.7

Responses to each of the six questions were 'dummy' coded, with the value '1' assigned to respondents who '*agreed*' with the statement, and '0' for those who thought otherwise. This latter category includes those who '*disagreed*' with the respective statements, as well as those who were '*undecided*'[10]. The resulting six dummy variables were then summed to produce a composite rank index of men's masculine beliefs, ranging from 0 (zero) for those respondents who consistently disagreed with all the six statements, to 6 (six) representing only those who consistently agreed with all the six statements. The intermediate values that lie between the minimum value of the index (0) and the maximum value (6) represents combinations of instances where a respondent agreed with one or some of the statements and disagreed with one or others. (See Table 18)

This rank index variable was further recoded in order to reduce the number of categories. Those who agreed with statements about the superiority of men over women, or about the desirability of men to be strong and independent relative to women, clearly display masculine beliefs and attitudes that are not equitable, hence can be classified as having '*Negative masculinities*'. In the same way, men who explicitly disagreed with such statements have relatively equitable beliefs and are therefore

[10] See section 5.1.1 for justification for including 'undecided' with 'positive'

classified as '*Positive masculinities*'. Respondents who agreed with between four and six items (those with a score between 4 and 6) were coded as having '*negative masculinities*'. These were given a code of '1'. Those respondents who agreed with the least number of items (0 to 3) were coded as having '*positive masculinities*', and assigned a code of '0'.

Table 18: Masculinities Rank Index of the number negative masculine and gender to role beliefs that men identified with

# Negative Masculine/ Gender Beliefs Identified With	Number	Percent
0/6	19	3.2
1/6	58	9.7
2/6	74	12.3
3/6	141	23.5
4/6	160	26.7
5/6	115	19.2
6/6	33	5.5
	600	**100**

6.2 Impact of masculinities on men's sexual and reproductive health beliefs and attitudes

The following section presents logistic regression results showing the influence of men's masculine beliefs on their sexual and reproductive health attitudes and beliefs. Table 19 presents logistic regression gross effects model of the association between negative masculinities and negative sexual and reproductive health beliefs and attitudes.

Table 19: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Men's Beliefs about Violence and Sexual Coercion

		GROSS EFFECTS MODEL		
Variable		**Odds**	**Significance**	**95% C.I [L - H]**
It is justifiable to use violence if partner:				
Went out without me	Disagree	1.000		
	Agree	2.302	0.012	1.202 - 4.409
Refused to have sex	Disagree	1.000		
	Agree	1.448	0.332	0.685 - 3.062
Wants to terminate relationship	Disagree	1.000		
	Agree	1.490	0.244	0.762 - 2.916
Talks back during an argument	Disagree	1.000		
	Agree	2.741	0.001	1.552 - 4.843
Fails to take care of the child	Disagree	1.000		
	Agree	3.029	0.000	1.673 - 5.482
Is the use of violence ever justitied	Disagree	1.000		
	Agree	1.727	0.052	0.995 - 2.998
Women enjoy being sexually coerced	Disagree	1.000		
	Agree	2.372	0.000	1.709 - 3.293
Men are stimulated by coercing women	Disagree	1.000		
	Agree	1.613	0.004	1.168 - 2.229
Women pretend not to want sex, expecting coercion	Disagree	1.000		
	Agree	3.570	0.000	2.424 - 5.257
If I found my partner not home, trouble	Disagree	1.000		
	Agree	1.875	0.017	1.119-3.141
I sometimes get so angry I hit my partner	Disagree	1.000		
	Agree	2.052	0.000	1.327 - 3.057

6.3 Beliefs about violence in intimate relationships

Gross effects logistic regression odds ratios of the association between negative masculinities and men's beliefs about violence and sexual coercion are presented in table 19. The results suggest that masculinities are related to men's sexual and reproductive health beliefs and attitudes. Specifically, having negative masculinities significantly increases the odds of having negative sexual and reproductive health beliefs and attitudes.

For example, men who had negative masculine beliefs were twice as likely to support the use of violence if a partner went out without him (Odds= 2.302 $p<0.05$); or for talking back during an argument (Odds= 2.741 $p<0.05$) or for failing to take care of children (Odds=3.029 $p<0.05$) compared to men who have positive masculinity. In fact, men with negative masculinities were almost twice as likely as men who have positive masculinities to feel justified to use violence if they didn't find their partner at home (Odds=1.875 $p<0.05$). Actually, men with negative masculinities were twice as likely to agree to the statement that '*sometimes I get so angry I hit my partner*' (Odds=2.052, $p<0.05$) compared to men with positive masculinities.

Masculinities also show a strong bi-variate association with attitudes towards sexual coercion in intimate relationships. Men with negative masculinities were more than twice as likely as those with positive masculinities to believe that women enjoy being coerced into sex (Odds=2.372, $p<0.05$); and almost four times as likely to believe that sometimes a woman pretends not to want to have sex, expecting that the man to coerce her (Odds=3.570, $p<0.05$). Also, having negative masculinities increases the odds of believing that men are stimulated by sexually coercing men to have sex (Odds=1.613, $p<0.05$).

Tables 22-29 (appendix) present the net-effects models of the impact of masculinities on men's attitudes towards violence, after controlling for selected background

characteristics. The results show that masculinities have a mixed effect on men's attitudes towards violence in sexual relationships. In some models, masculinities don't show any significant effect on attitudes towards violence in sexual relationships, whereas in models where such effect is there, it is always negative. Uni-variate results have already shown that the percentage of men who support the use of violence within intimate relationships is small. As such, for some models, once other background variables are controlled for, the effect of masculinities dissipates. But there are specific contexts where a relatively large percentage of men seemed open to the idea of using violence, especially if they feel that the use of such violence is towards a worthy cause, such as taking care of children or when their partner shows disrespect by talking back during an argument.

Logistic regression odds ratios of the likelihood that men with negative masculinities will express an attitude that is supportive of the use of violence if their partner left home without saying where they are going are presented in table 22. While negative masculinities increases the odds of supporting the use of violence by 60 percent in the case where the partner leaves home without consultation or without saying where they are going, this effect is not significant statistically. The belief in the use of violence if the partner leaves the home without saying where they are going is related to men's employment status, place of childhood socialization and type of family of orientation. For example, men who were currently unemployed were two and half times (Odds=2.518, $p<0.05$) more likely to support the use of violence in the context where the partner leaves the home without consultation, while having a rural place of orientation reduced such odds by 54 percent (Odds=0.461, $p<0.05$) men who were brought up in rural areas were only 46 percent as likely as those brought up in urban areas, to support the use of violence. While there was no significant difference in the odds of supporting the use of violence in the context where the partner leaves the home without consultation between men who were brought up in unmarried or extended families compared to those who were brought up in married parents families, such significant

difference exists for men brought up in single parent families. For example, men brought up in single mother families were only 25 percent as likely to support the use of violence in the context where the partner leaves the home without consultation, compared to those brought up in married parents families, while being brought up in father only family increases such odds over eight times (Odds=8.397, $p<0.05$) compared to men brought up in married parents families.

There was also very little support for use of violence if the woman refuses to have sexual intercourse (table 23), and the variation according to men's characteristics is limited. However, the belief in the use of violence if the woman refuses to have sex varies significantly by men's religion, where by African traditional religious men four times (Odds=4.150, $p<0.05$) more likely to support the use of violence if the partner refuses to have sexual intercourse than Christian men.

The use of violence if a woman want to terminate the relationship (table 24) also does not show any significant variation with masculinities or most other background characteristics, except, to a limited extend, age and religion. For example, being in the oldest age group (46-69years) increases the odds of supporting the use of violence in the case where the woman wants to terminate the relationships (Odds=7.144, $p<0.05$) compared to men aged 17-21 years of age, by being African traditional religious increases such odds almost four fold (Odds=3.909, $p<0.05$) compared to Christian men.

While the use of violence within contexts such as when the woman leaves the household without permission or without saying where she was going, or refusing to have sexual intercourse, didn't enjoy much support from men, there were contexts that men were likely to feel that the use of limited violence is justified. One such a context is using violence if the woman fails to take care of children (table 25). Within this context, negative masculinities clearly increased the odds of supporting the use of violence. Age, marital status, religion and family of childhood orientation also show mixed effects on

the likelihood of supporting the use of violence if the woman fails to take care of children.

Men with negative masculinities were more than three times as likely as those with positive masculinities to support the use of violence for failing to take care of children (Odds=3.442, $p<0.05$). While most age groups did not show any significant relationship with support for violence for failing to take care of children, men in the age group 31-35 years were significantly more likely to support the use of violence (Odds=9.028, $p<0.05$) compared to those aged 17-21 years, while being raised in a single mother and extended families reduced the odds of supporting the use of violence for failing to take care of children by 71 (Odds=0.293, $p<0.05$) and 83 percent (Odds=0.176, $p<0.05$), respectively.

Whether a partner talks back during an argument is perceived by a relatively large proportion of men as something that can justify the use of violence, probably because a woman who 'talks back' to her partner during an argument is culturally constructed as a sign of a lack of respect for the partner. Table 26 presents logistic regression odds ratios of the likelihood that a man with negative masculinities will express support for use of violence if their partner talks back during an argument. The results show that men who have negative masculinities were almost three times (Odds=2.610, $p<0.05$) more likely to support the use of violence if the woman talks back during an argument compared to men with positive masculinities, while being African traditional religious increases such odds seven fold (Odds=7.064, $p<0.05$). Being raised in a rural area decreases such odds by 52 percent (Odds=0.485, $p<0.05$) compared to being raised in an urban area, while being raised mother only or unmarried parents family decreased such odds by 74 percent (Odds=0.268, $p<0.05$) and 71 percent (Odds=0.289, $p<0.05$), respectively.

Men were also asked about their likelihood of resorting to violence if they didn't find their partner at home when they expect her to be there; and about whether they sometimes hit their partner in anger (tables 31 & 32). Masculinity is the only variable

that displays a significant association with the men's attitudes towards use of violence if the partner is not at home when they are expected to be there. In such a circumstances, negative masculinities increases the chance of using violence by 80 percent (Odds=1.893, $p<0.05$) compared to men who have positive masculinities. Negative masculinities also increases the chance that a man will indicate that he sometimes gets so angry that he hits his partner, by 90 percent (Odds=1.907, $p<0.05$) over positive masculinities. Only men in the age range 22-25 years were twice as likely to confess to hitting their partner in anger (Odds=2.276, $p<0.05$) compared to those aged 17-21 years while being never married; being in a cohabiting relationship or being divorced, widowed or separated decreased the likelihood of owning to the use of violence in anger, by 76, 80 and 74 percent respectively. Being African traditional religious or 'Other' non-Christian religious was associated with increased odds of confessing to hitting their partner in anger. For example, African traditional religious men were almost five times more likely than Christian religious men to indicate that they sometimes hit their partner in anger (Odds=4.982, $p<0.05$). Being 'Other' non-Christian religious doubles the odds of confessing to hitting a partner in anger compared to Christian religious men (Odds=2.041, $p<0.05$). Men raised in female were only 45 percent as likely as men raised in both parents married families to confess to hitting their partner in anger.

6.4 Attitudes towards sexual coercion

While a large proportion was generally not supportive of the use of violence within intimate relationships, the results show that a significant proportion of men still hold beliefs and attitudes that could not only condone the use of violence, but can also facilitate or even encourage such violence. One such belief, which seemed common among men, is that women find sexual coercion stimulating.

Logistic regression odds rations of the association between negative masculinities and men's support for coercion in sexual and intimate relationships are presented in tables

28-30. Table 28 shows that men with negative masculinities were almost three times as likely to believe that women find sexual coercion stimulating, compared to those with positive masculinities. In addition, men in the age range 31-35 (Odds=2.130, $p<0.05$) years as well as those 46-69 years (Odds=4.499, $p<0.05$) were more likely to believe that women are stimulated by sexual coercion compared to their younger (17-21 years) compatriots. Being brought up in unmarried parents (Odds=4.732, $p<0.05$) and extended family (Odds=1.751, $p<0.05$) setups significantly increase the odds of having the belief that women are stimulated by sexual coercion.

An almost complementary belief to the one that women are stimulated by sexual coercion is that men are (sexually) stimulated by sexually coercing women. Table 29 shows that having negative masculinities doubles the odds of believing that men are sexually stimulated by coercing women to have sex (Odds=2.099, $p<0.05$) compared to men who have positive masculinities. In addition, being over the age of 35 years was associated with increased odds of having such a belief. In fact the odds of believing that men are sexually stimulated by coercing women to have sex increases with age. For example being 26-30 years is associated with a 60 percent increase in the odds of believing that men are sexually stimulated by coercing women (Odds=1.607, $p<0.05$) while being 31-35 years was associated with more than doubling of such odds (Odds=2.481, & 2.231, $p<0.05$) compared to men aged 17-21 years. The odds of believing that men are sexually stimulated by coercing women to have sex are even higher among the oldest men in the sample (46-69 years) (Odds=7.180, $p<0.05$).

While men whose marriage has ended in either divorce, widowhood or separation were three times more likely to have this belief compared to married men (Odds=3.416, $p<0.05$), such was not the case among never married or cohabiting men, compared to men who are married. Compared to Christian men, men belonging to 'Other' non-Christian denominations were almost four times more likely to believe the men are sexually stimulated by coercing women to have sex (Odds=3.697, $p<0.05$), while having been raised in a father only (Odds=4.401, $p<0.05$), unmarried parents (Odds=2.120,

p<0.05) or extended families (Odds=1.366, p<0.05) significantly increased the odds of having this belief, compared to men raised in both parents married families.

Even more entrenched than the beliefs that women find sexual coercion stimulating, or that men are sexually stimulated by coercing women to have sex, is the belief that women expect men to coerce them before they can have sexual intercourse. Table 31 shows that having negative masculinities was associated with an almost fivefold increase in the likelihood of believing that women expect to be coerced before consenting to sexual relations (Odds=4.878, p<0.05) compared to men with positive masculinities. The odds of believing that women expect to be sexually coerced before consenting to sex are almost three times as high (Odds=2.698, p<0,5) among men aged 31-35 years compared to men aged 17-21 years, and higher among divorced, widowed or separated men.

Men's level of education shows limited effect on the likelihood of believing that women expect men to coerce them before consenting to sexual intercourse. While there is no significant difference in the odds of believing that women expect men to coerce them to have sex among men with secondary education compared to those with primary education, such odds are almost three times as high among men with tertiary education (Odds=2.960, p<0.05). Compared to men raised in both parents married families, those raised in families where both parents are unmarried were significantly more likely to believe that women expect men to coerce them before consenting to sexual intercourse (Odds=2.761, p<0.05).

6.5 Beliefs about sex and sexuality

The following section explores the relationship between masculinities and men's beliefs about sex and sexuality. Table 20 presents logistic regression gross effects odds ratios of the association between masculinities and beliefs about sex and sexuality. The results show that negative masculinities are related to the belief that men have less control when it comes to sex; or that men need to have multiple partners in order for them to

choose the partner they deem most suitable for marriage. Negative masculinities are also related to men's belief sexuality. For example, men who have negative masculinities were twice as likely as those with positive masculinities to believe that if a girl shows that she wants sex, it's a sign that she has other boyfriends (Odds=2.003, $p<0.05$). Having negative masculinities increases the odds of believing that a woman who shows that she wants to have sex is failing to control herself (Odds=1.526, $p<0.05$).

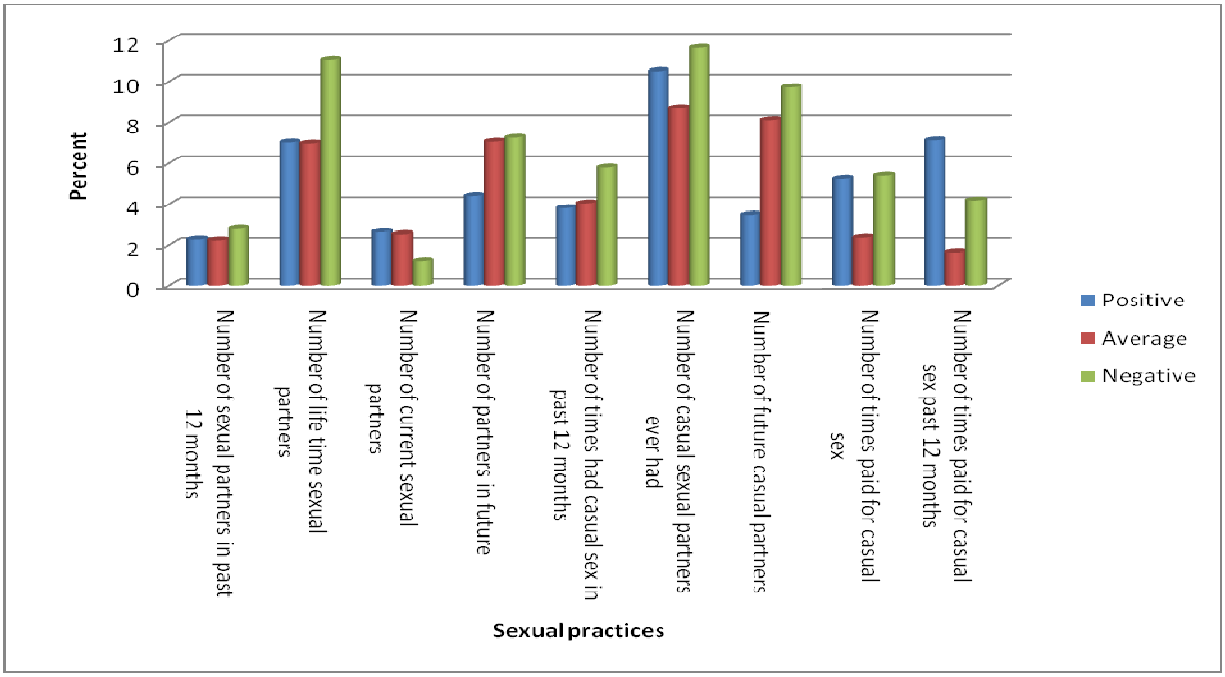
Table 20: Logistic Regression Odds of the association between Negative Masculinities and Men's Sex and Gender Beliefs

		GROSS EFFECTS MODEL		
Variable		**Odds**	**Significance**	**95% C.I [L - H]**
Men need sex more than women	Disagree	1.000		
	Agree	1.249	0.179	0.903 - 1.729
Men have less self control in sex	Disagree	1.000		
	Agree	1.980	0.000	1.429 - 2.742
A boy/man many partners to prove manhood	Disagree	1.000		
	Agree	1.023	0.936	0.585 - 1.790
A man needs multi partners from who to choose for marr	Disagree	1.000		
	Agree	2.003	0.000	1.282 - 3.128
Only a bad girl shows she likes sex	Disagree	**1.000**		
	Agree	1.497	0.059	0.985 - 2.275
A girls who wants to have sex has other boyfriends	Disagree	1.000		
	Agree	2.004	0.005	1.231 - 3.265
A woman who wants to have sex failing to control herself	Disagree	1.000		
	Agree	1.526	0.047	1.005 - 2.316
Men who have sex with men are not real men	Disagree	1.000		
	Agree	1.001	0.997	0.727 - 1.378
Homosexuality should be de-criminalized	Disagree	1.000		
	Agree	**1.008**	0.975	0.604 - 1.682
Government to provide services for homosexuals	Disagree	1.000		
	Agree	0.822	0.287	0.573 - 1.179

However, negative masculinities did not show any significant relationships with men's views and attitudes towards other forms of masculinities, such as homosexuality. For example, the odds that a man will perceive homosexuals as not real men or support the de-criminalization of homosexuality in Botswana are not significantly different between men with negative and those with positive masculinities.

6.6 Men's Masculine Beliefs and sexual practices

Figure 1: Masculinities and Men's Sexual and Reproductive Health



Logistic regression odds ratios of the association between masculinities and men's sexual practices are presented in tables 33-36. Table 33 shows logistic regression odds ratios of the likelihood of having had two or more sexual partners in the 12 months prior to the survey. While negative masculinities increases the odds of having had two or more sexual partners in the year leading to the survey by almost 50 percent compared to men with positive masculinities, such an increase is not statistically significant at 5 percent level (Odds=1.471, $p>0.05$), but at 10 percent level of significance. However, religion and men's family of childhood orientation shows significant influence on the number of sexual partners in the year leading to the survey. For example, African traditional religious men and men belonging to 'Other' non-Christian religions were between three and four times as likely to have had two or more sexual partners during the year leading to the survey, compared to Christian men. On the other hand, having been raised in a mother only family doubles the odds of having had two or more partners in the year leading to the survey (Odds=2.093, $p<0.05$) , while

having been raised in an extended family almost triples such odds (Odds=2.926, p<0.05) compared to men raised in both parents married family. Being never married was also associated with a large but marginally significant increase in the odds of having had two or more sexual partners in the year preceding the survey (Odds=2.586, p=0.058).

Logistic regression odds ratios of the association between masculinities and of current sexual partners are presented in table 35. The number of current sexual partners did not show any significant association with masculinities, however the likelihood of having more than one current sexual partner varies significantly by age, marital status, religion, and to a limited extent, type of family of childhood orientation. The odds of having two or more current sexual partners 3 times as high among men aged 22-25 years compared to those aged 17-21 years. Such odds are also significantly higher among never married men (Odds=15.096, p<0.05); cohabiting men (Odds=11.413, p<0.05) and those who are divorced, widowed or separated (Odds=18.082, p>0.05), as well as those raised in mother only families (Odds=2.298, p<0.05).

A measure of the rate of change of sexual partners is the number of partners that an individual has ever had in their lifetime. Logistic regression results (table 34) shows that while having negative masculinities increases the odds of having had two or more sexual partners in the past, such difference in odds is not statistically significant at 5 percent level of significance. However, as can be expected, this variable displays strong association with men's age and to a limited extent, religion and type of family of childhood orientation. The odds of having ever had a total of two or more lifetime sexual partners increase with increasing age. The odds of having ever had two or more sexual partners in the past increases from three to four times among men aged between 22 and 30 years to between 13 and 17 times among men aged 31-35 and 36 and 46 years respectively, compared to men aged 17-21 years. On the other hand, men belonging to 'Other' non-Christian denominations were almost six times more likely than Christian men to have had two or partners in the past (Odds=5.573, p<0.05) while men raised in

mother only families were almost three times as likely to have had two or more sexual partners in their lifetime (Odds=2.696, $p<0.05$).

Logistic regression odds ratios of the association between masculinities and anticipated number of future sexual partners are presented in table 36. Masculinity displays a significant effect on men's anticipated sexual and reproductive health practices in future. Having negative masculinities was associated with an almost threefold increase in the odds of expecting to have two or more regular sexual partners in future compared to men who have positive masculinities (Odds=2.796, $p<0.05$). In addition, men aged 46-69 years were almost eight times more likely to expect to have two or more sexual partners in future compared to those aged 17-21 years (Odds=7.709, $p<0.05$) while being never married was associated with a threefold increase in the odds of expecting to have two or more partners in future compared to married men.

Men's religious affiliation also displays significant association with the likelihood of expecting to have two or more future sexual partners. Compared to Christian men, those who belong to African traditional and 'Other' non-Christian denominations were between two and three more likely to expect to have two or more sexual partners in future (Odds=2.188 & 2.564, $p<0.05$, respectively).

Men also provided information relating to their involvement in casual sexual partnerships during the year leading to the survey. Logistic regression odds of the association between masculinities and men's involvement in casual sexual partnerships are presented in Tables 37-39. A significant proportion of men (40%) indicated that they have had casual sexual intercourse at least once in their life time. Men with negative masculinities were three times more likely to have ever had casual sexual intercourse at least two or more times during the year leading to the survey compared to men with positive masculinities. While men's age; marital status and education did not display any statistically significant association (at 5 percent level of confidence) with the likelihood of having had two or more casual sexual encounters in the 12 months before

the survey, religion and place of childhood orientation does displays statistically significant with the likelihood of having had two or more casual sexual encounters during the year leading to the survey. African traditional religious men and men belonging to 'Other' non-Christian denominations were almost eight and five times more likely to report having had two or more casual sexual encounters, respectively (Odds=7.539 & 4.557, $p<0.05$) compared to Christian men. Having a rural place of childhood orientation significantly reduces the odds of reporting two or more casual sexual encounters in the year preceding the survey by 63 percent (Odds=0.369, $p<0.05$) compared to men whose place of childhood orientation is urban.

While the likelihood of reporting two or more casual sexual encounters varies significantly by masculinities, religion and place of childhood orientation, the likelihood of maintaining a casual sexual relationship with one or more individuals only varies only by religion, with African traditional religious men and those belonging to 'Other' non-Christian denominations being more likely to have ever maintain a casual sexual relationship with two or more casual sexual partners in the past.

Men's anticipation of their involvement in casual sexual intercourse in the future is also examined here. Men were asked to indicate the number of times they expect to have casual sexual intercourse in the future. The results show that men's expectation of casual sexual intercourse in the future is related to their sense of masculinities, religion and employment status. Having negative masculinities elevated the odds of expecting to have at least two or more casual sexual encounters threefold (Odds=3.141, $p<0.05$) compared to men with positive masculinities, while being unemployed at the time of the survey decreased such odds by 52 percent (Odds=0.480, $p<0.05$) compared to men who were currently employed. Being classified as African traditional religious or 'Other' non-Christian religious were associated with a three (Odds=2.548, $p<0.05$) and nine fold (Odds=9.246, $p<0.05$) increase in the odds of expecting to have two or more casual sexual partners in future, respectively.

6.7 Conclusion

This chapter has investigated the association between masculinities and men sexual and reproductive health attitudes and practices. It presented logistic regression gross effects model results showing the association between masculinities and men's sexual and reproductive health attitudes and practices. The results of the net effects model, which include control variables, were presented following those of the gross effects model. The results show that at a binary level, there is strong association between masculinities and men's sexual and reproductive health attitudes, beliefs and practices. Specifically, negative masculinities was consistently associated with increased likelihood of having sexual and reproductive health beliefs, attitudes and practices that are negative, and can increase the men's risk of HIV infection.

Chapter 7: Summary and Conclusions

7.1 Summary of major findings

The HIV/AIDS epidemic that is currently ravaging Southern Africa is largely a heterosexually driven epidemic. Unlike in the west and in other parts of the world where the epidemic has traditionally been associated with marginalized groups and population minorities, such as gays and homosexuals, or groups that engage in high risk behavior such as injecting drug users, the Southern African epidemic is unique in the sense that it is generalized and requires quite a different approach from those that are generic to concentrated epidemics. The heterosexual nature of HIV epidemic in Southern Africa has put men at the centre of efforts to control the spread of the epidemic. However, the absence of research on masculinities and HIV/AIDS prevention and the subsequent failure of HIV prevention programs to engage masculinities are clear shortcomings of the country prevention strategy.

In Botswana, the government's early comprehensive and multisectoral response to the epidemic has not produced the kind of results that were expected, given the highly accessible healthcare infrastructure, free services and high prevalence rates. While many commentators blame the slow progress of HIV prevention programs on men as well as masculine and other gender beliefs that subordinate women and facilitate multiple sexual partnerships, there has been a serious absence of scientific research on the role of masculinities in HIV transmission in Botswana. Differences in sexual and reproductive health patterns between men and women can easily be gleaned from nationally representative quantitative surveys, such as the Botswana AIDS Impact Survey (BAIS), however such surveys do not provide any basis for understanding masculinities, or how men's sense of identity might influence their experience of sexual and reproductive health programs, especially those relating to the spread of HIV or their sexual and reproductive health practices.

Despite and probably as a result of the absence of research on masculinities and HIV, there has been an increase in stereotypical statements that blame men for fueling the spread of HIV through what is seen by many as '*irresponsible behavior*' or apparent '*resistance to common sense programs*' without any appreciation of the socio-cultural and contextual factors that form the basis for such behavior. However the recognition of the need to engage masculinities is becoming more apparent and increasingly more research is being devoted to the nexus between masculinities and HIV. However most such research is generated and focuses on the understanding masculinities in the context of the west. Most research emerging from Southern Africa tends to be at a regional level, or utilize national quantitative datasets that by their nature are not effective in unearthing contextual and other factors that might influence masculinities.

In his work on young men and construction of masculinities in Sub-Saharan Africa, Barker & Ricardo (2005) argue for a gendered analysis of young men in Africa that takes into account the plurality of masculinities in Africa. Since masculinities are socially constructed, plural, fluid and differs between settings and can vary over time in the same setting, there is need for local and in-depth studies to understand the social cultural and other contextual factors that give rise to and sustain certain forms of masculinities. It is only through such in-depth understanding that HIV programs can address and challenge the negatives aspects of masculinities, while at the same time, tapping on to the positive aspects.

7.1.1 Men's sense identity

Masculinities and gender role beliefs are socially constructed, so the types and forms of masculinities that become prevalent in a specific area at a certain time are likely to reflect and be influenced by context specific. The results of this thesis show that men's primary sense of identity is tied to '*achievement*' of a certain status, rather than the act of biologically qualifying by virtue of attainment of a certain age. Manhood is a social construct '*attained*' by economic independence, marriage and childbearing; caring for

and being in control of the family and being a responsible and respected member of society. Barker & Ricardo (2005) from their work with young men and masculinities in Sub-Saharan Africa notes that a primary mandate of achieving manhood in Africa is the achievement of some level of financial independence, employment or income and subsequently starting a family (2005). Studies show that contextual factors such as low levels of social and economic development, unemployment and conflict do give rise to specific forms of masculinities that reflect the context in which men live (Barker & Ricardo, 2005; SilberSchmidt 2004; Jobson, 2009).

In addition to being married, one of the perceived universal roles of being a man is that of being head of household, and being in control of the household and members thereof. Being seen to be able not only to provide for the family needs, but also being in charge and in control of the family and household members was seen as an important virtue. Failing to be in control of the family and household was seen a serious affront to the authority of any man, even if he has met other social expectations of manhood. Since they perceive themselves as natural leaders, more rational, unemotional and decisive than women, failing to be in control of the family, which constitute mainly women and children was seen as failure to triumph over '*minors*' in the household, any may be experienced as feelings of diminished and frustration which in turn might increase the propensity towards violence.

It is clear from focus group discussions that men don't consciously and actively pursue violence as an explicit strategy to maintain power and control within relationships. However, the view that sometimes it is unavoidable or even necessary for a man to use violence to assert his authority; to show who is in charge or to correct wayward behavior was prevalent. Failure to use such violence when (in the eyes of many) it is called for leads to one being perceived as a weak or failing to control and impose discipline on the family. More prevalent though is the belief that sexual coercion within relationship is normal and at times expected or even desirable.

While most men welcome the idea of equality with women, there is also evidence that men's support for equality is qualified. While recognizing the need to accord women equal status in the work place, many discussants were also in agreement with the idea that women' status within households needs to improved. However, the perception of women as '*minors*' not much different from children, made it problematic for many men to conceptualize themselves being completely equal to women. Many discussants either questioned or were uncomfortable with the idea that they can be completely equal to their partners (women) within relationships and households. These men felt that there was need for one person to be in charge in a relationship or household, and that the man should be in charge. Thus being equal to their partner within a household would mean that there is no one person in charge of decision making, a situation that many men called "*50-50*" to designate a perceived stalemate in decision making that would result if both partners are truly equal.

Thus, according to some discussants' interpretation, equality within the household is a relative rather than absolute reality; it is a question of improving and affirming women's position and rights within households but not necessarily elevating them to the point where the gulf between the man and the woman disappears. So, while a real man is fair, compassionate and caring with his partner and members of his household, he also possesses latent power which allows him to have the last say in household decisions, should there be a stalemate.

The belief that they have to be in charge also means that men may experience women's empowerment as a threat or encroachment into their sphere of control. This attitude and belief that they should be in charge makes men feel insecure in relationships where they are not either the primary providers or do not feel in charge in some way. As more and more women get empowered and earn their living without depending on men, it is likely that their expectations of their intimate partner may shift, from that of being provider to that of being an emotional companion. This is a shift that many discussants were aware of, and most unsettled by. Women's empowerment means that men within

relationships also have to undergo change, and many men are unsure of what their role within relationship is, if they are not provider or head of household, roles that seem to have been scripted into their minds from an early age and reinforced with time. As one man noted, '*women have changed so much that we can hardly recognize them or what they want*' **(Men, 34-42 years, University).**

As a group, men appear to be poorly informed about what their role in women's empowerment is, or indeed what equality between the sexes is. Equality was often perceived as a state where both men and women do perform all tasks equally. As a result, it was common for men to cite instances where women could not do the same physically demanding chores as themselves, as an indication that '*equality is a panacea*'. Women's empowerment is perceived to be tantamount to men's disempowerment; a zero sum game where the power that is apportioned to women is somehow siphoned from men. The suspicion that most discussants held of the women's empowerment movement generally, emanates partly from men's perceived loss of power, but also partly from the approach that the movement has taken towards men, where instead of being treated as partners, men are most often seen as obstacles or adversaries.

From men's narratives, it is clear that men's sense of masculinities was also influenced by social and economic change. Discussants were of the view that it is currently more difficult to live up to the socially expected roles of manhood, compared to the past. Discussants cited the socio, cultural and economic changes that have occurred over the decades, especially the marginalization they have experienced as a result of the shift from agrarian to modern economy, as one significant factor that makes it more difficult now for them to live up to socially and culturally expected roles. To many men, the shift from agricultural based production to industry, poor education and the lack of good quality jobs makes it difficult for them to be '*independent*'. The process of acquiring resources with which they need to fulfill socially expected roles and the realities of men's lived experience of their masculinity was a source of pain for many men.

The gulf between men's lived experiences and social expectation of manhood is experienced as dissatisfaction; feeling of being less worthy, or feeling unimportant. The result is that some men act out this dissatisfaction in a number of ways, which may include violence against their partner, or sexually risky behavior such as multiple sexual partnerships and unprotected sex. In her work on Masculinities and HIV/AIDS in East Africa, SilberSchmidt (2004), in an exploration of the gendered effects of socio-economic change, notes that men's experience of social structural changes, especially unemployment, has a negative effect on their sense of masculinity and self worth, which then leads to masculinities that are expressed in the form of aggressive sexual practices such as multiple sexual partnerships. She concludes that men's experience of socio-economic change, which is mediated by their gender and masculine beliefs, makes up for what she terms '*the less stereotyped reasons why men now seem to be driving the HIV epidemic*', as the real reason why men seem to be driving the HIV epidemic

While most discussants did not support the use of violence, they identified this gap between their life experiences and the socially expected roles, and the accompanying feelings of being '*less than worthy*' as being responsible for men's propensity towards violence in intimate relationships. When they cannot assert their role economically through being a provider and head of household, they try to do so through violence, or other forms of risky sexual expression such as multiple sexual partnerships, rape or casual sex. This resort to violence and sexually aggressive forms of sexuality as a result of not being able to fulfill socially expected roles is also noted by other researchers who examined the relationship between masculinities and HIV/AIDS (see SilberSchmidt, 2004; Hunter, 2005).

The impact of social and economic change on men's sense of identity is also noted by Hunter (2005) in an examination of historical perspective of multiple partnerships in KwaZulu Nata, an area with the highest HIV prevalence in South Africa. Hunter notes the effect of capitalism, migrant labour and Christianity on masculinities, and how men's experience of structural changes occasioned by high unemployment

compromised their ability to live up to the socially expected roles of getting married, setting up independent households and being heads of households. These structural changes not only made it a challenge to live up to socially expected roles, but also give rise sexually aggressive forms of masculinity that cherished multiple sexual partnerships (see SilberSchmidt, 2004).

Sometimes stakeholders such as health professionals and law enforcement officers also tend to reflect their gender role beliefs and stereotypes when dealing with issues that involve men and women, especially if those issues arose from within intimate relationships. The stereotype of men as primary perpetrators of violence was problematic for many men, who felt that most of the time they are usually apportioned a disproportionate part of the blame when there are problems within intimate relationships, even before all fact are established.

Law enforcement was also seen as part of the emasculation of masculinity through enforcement practices that were generally perceived as harsher on men and lenient on women. There was a feeling among men that police officers tend to show a willingness to use force or extreme methods such as summary detention when dealing with men in domestic disputes, rather than when the woman is the perpetrator. In traditional and customary law, men tend to draw harsher sentences, such as corporal punishment, while such punishment cannot be meted out to women because of the existence of a law that bars corporal punishment on women. To some men, this demonstrates lack of equality before the law, while others take it as proof that women and men's bodies are weaker than that of men. In their view, if equality means that women get to do and experience everything that men experience and do, then equality is not possible.

While most discussants were supportive of HIV/AIDS programs, it is clear from focus group discussions that HIV presents a major challenge to men' sense of identity. For many men, getting tested for HIV was perceived as a big gamble because the implications should one find out that they are HIV positive. Being HIV positive was

problematic because it implies that over time, one will get sick and depend on other people for care, quite an affront to the image of being strong and independent. However, there was also evidence that once they fall sick, men are sometimes able to go against some of the masculine stereotypes that prevent them from seeking help in time, and actually incorporate health seeking as part of their masculinity. The example of men at an ARV clinic, referring to the act of coming for their ARV supplies as '*recharging air time*' clearly illustrates this point. There were many narrations of how men put a positive spin on their health seeking and at times even become activists, recruiting other men and actively challenging norms and beliefs that used to prevent them from seeking help. Illness thus does have the impact of either softening masculinities or prompting the individual to negotiate a new identity or a version of the old one in which help and health seeking are prominent.

7.2 Levels and patterns of men's sexual and reproductive health beliefs, attitudes and practices

7.2.1 Men's attitudes towards gender roles and socialization

This section discusses quantitative results of patterns and levels of men's sexual and reproductive health attitudes and beliefs. The results show that while a significant majority of men ascribe to traditional gender and masculine attitudes based on lack of equality between men and women, a significant portion of men are also beginning to challenge some of the established masculine beliefs, especially those that increases the chance of HIV infection.

While men tended to generally ascribe to gender role and masculine beliefs that are based on the notion of men's superiority over women, there was a propensity among men to actively challenge those beliefs that seek to express this perceived superiority through sexual risk taking and multiple sexual partnerships. White (1997) notes that need to examine men's '*private stories*' and how men's accounts and experiences support or contradict the ideologies promulgated by more hegemonic masculinities. Compared

to other beliefs, a relatively small proportion of men believed in the need for a man to be *emotionally inexpressive,* or to have multiple sexual partners so that they can choose the one partner who is deemed suitable for marriage. In fact many men identified '*emotional inexpressivity*' as the cause of men's '*bottling up*' of emotions which then sometimes erupts in bouts of violence, while multiple sexual partnerships were associated with increased risk of HIV infection. Thus, some men expressed '*private dissatisfaction*' with some aspects of their socially constructed identity. This finding reflects Jobson (2009)'s observation that while context specific factors such as unemployment, poverty and HIV puts stress on the local construction of masculinities and may serve to undermine men's sense of identity and ability to live up to socially expected roles, such stresses nevertheless provide an entry point for work with men on gender equality. Jobson (2009) observes that as the construction of masculinities becomes under stress from the various contextual factors, it may force some men to negotiate less rigid and adaptable forms of masculinities that may be egalitarian, or at least open to the idea of equality with women.

Barker & Ricardo (2005)'s analysis of programs applying a gender perspective to work with young men, make reference to representations of young men whose private stories and experiences of masculinities question and counter the prevailing norms. Odimegwu et al, (2008) presents such representations of men questioning prevailing masculine and gender role ideologies, especially those that encourage multiple sexual partnerships and heighten susceptibility to HIV infection. Working with such positive aspects of traditional masculinities can lead to a shift towards gender –equal behaviour and masculinities (Jobson, 2009).

Notwithstanding their disapproval of '*emotional inexpressivity*' however, the ability of a man to '*play his cards close to his chest*' or '*keep things to himself*', or '*to have things that are only known to him and no one else*' was a virtue that in the view of many men, sets men apart from women. These '*things*' or '*secrets*' ranged from important decisions concerning family welfare, to personal matters. Women were generally portrayed as

incapable of '*keeping secrets*'. In a study of socio-cultural factors that place men at risk of HIV infection in Botswana, Maundeni & Mookodi (2009) observes that males tendency to learn about sex and sexuality mainly from peers and the media and the fact that the family has virtually no role in the education of boys about sex and sexuality as well as the absence of community based socialization agents gives rise to men's views and beliefs about sex that encourage sexual conquest of women. This conclusion is congruent with the view of most focus group discussants that when it comes to learning about sex and sexuality, boys and young men are left to their own means.

7.2.2 Men's attitudes towards violence

Literature on men and masculinities points to the poignant association between men; masculinities and violence (Messner, 1990; Campbell 1992; Barker & Ricardo 2005; Kenway et al., 1997; Connell 2001; Miedzian 2002). There is very little contention to the well established fact that in most instances, men generally predominate as both perpetrators and victims of violence at both the interpersonal and organized levels. At the interpersonal level, men are overrepresented as perpetrators of domestic and intimate partner violence, including rape, defilement and other forms of sexual abuse. In an extensive literature review of programs working with young men in Africa, Barker & Ricardo (2005) give an account of how masculinities are implicated in a number of conflicts at national, community and interpersonal level on the continent. Campbell (1992) argues that much of the political violence that characterized South Africa was driven by a crisis in working class African masculinities, and that violence is compensatory mechanism by which men try to reassert their masculinity (Campbell 1992).

A large proportion of men in this study (90% or more) were generally not supportive of the use of violence within relationships or households under different contexts. For example, the proportion of men who supported the use of violence if the partner refuses to have sex; leaves the home without saying where they were going or want to

terminate the relationship, is small (8% or less) and didn't show any significant variation by men's background and other characteristics. While the percentage that supports the use of violence is generally small, there were certain contexts where a slightly higher proportion of men seem to feel the use of violence would be justified. These contexts include the case where the partner is neglecting or failing to take care of children (10%); or where the partner talks back during an argument (10%), the latter which is generally equated to lack of respect for the man.

Most focus group discussants felt gender role stereotypes among police officers influences the quality of services they render to men. Men complained that in cases where they report their partner for either violence or threat of violence, police officers may fail take the case seriously because they believe that there is something wrong with a man who feels threatened by a woman. Men gave personal accounts of being lightly dismissed or laughed by police officers, and labeled '*unmanly*' for reporting a woman. This leaves the aggrieved man feeling like he cannot access justice and may resort to desperate measures, such as physical violence. This finding mirrors Courtenay (1998)'s conclusions concerning the influence of gender stereotypes among on health service providers' diagnosis and treatment of patients. Courtenay (1998) observed that at times health service providers' diagnosis and treatment of patients can be influenced by the provider's own gender role stereotypes and prejudices. In a country where there are strong gender role stereotypes and beliefs, it is not surprising that law enforcers' service to men (and women) will reflect or be influenced by their own prejudices and deeply entrenched beliefs.

Men generally displayed significant awareness of the undesirability of violence within relationships. Part of the men's awareness of the undesirability of violence can be credited to HIV prevention messages that have sought to address the main practices and beliefs that heighten women's vulnerability to HIV infection, such as forced sex, women's lack of leverage in negotiating safe sex, multiple sexual partnerships and domestic violence. These are issues that the HIV prevention campaigns have focused

on and issues in which men displayed the greatest awareness. However, other gender role beliefs and attitudes, such as the belief in the '*superiority*' of men over women or the belief that men are natural leaders and should therefore always be heads of households even when the woman is the main earner in the household, have not been equally challenged by HIV prevention campaigns. In fact, some of the HIV campaigns have tapped into some of these masculine beliefs in order to make men respond favorably. For example, in order to get men to use VCT services, HIV prevention programs have tapped onto men's self perceived role of leader, provider and protector for their family. Such programs create the image of a '*real man*' as one who shows leadership and vision by taking steps to protect and secure the welfare of the family.

Some HIV prevention messages targeting men in the country's disciplined forces portray '*safe sex*' as a battle or a competitive game, suggesting that a real man is one who always '*wins*' at this game or is '*ready for battle*' . This portrays women as nothing more than pawns in a game that men play. Thus, HIV programs may reinforce or trump up certain masculine stereotypes that may be problematic to the prevention of HIV infection. Hawkins (1996) observes that programs designed to meet women's immediate sexual and reproductive health needs, including those designed to promote condom use, may inadvertently reinforce inequalities in gender and sexuality by using stereotypical and '*macho*' images to promote these programs.

At times HIV prevention programs may seek to promote certain aspects of masculinities that are viewed as positive. However men's failure to live up to these socially constructed images of manhood may negatively affect their sense of self worth. For example, the image of a '*real man*' as a provider for their family may result in a diminished sense of self-worth among men who are not able to live up to that socially constructed image.

7.2.3 Men's beliefs about sexual coercion

Men generally tend to be in control of sexual decision making. However most men were aware that with women's empowerment, equality and HIV prevention messages and strategies, such control is no longer absolute. Most men are aware either through education or experience, that increasingly, women are taking more and more responsibility for negotiating sexual decisions, including safe sex. In qualitative interviews, men were clearly aware of the danger of adhering to a long held belief that in sexual matters, '*when a woman's says no, she actually means yes*' or that women expect men to pressurize them before consenting to a relationship or sexual intercourse.

However one striking finding [from the quantitative survey] is the strong and persistent belief among men that sexual coercion within relationships or between a man and a woman is expected or even desirable. According to Rivers et al. (1999), in many cultures, coercive sex and sexual violence are not unusual. Quantitative data from this study indicates that quite a significant portion of men (52-74%) believe that women expect to be coerced before consenting to sexual intercourse; or that women sometimes pretend not to want to have sexual intercourse, expecting that the man (if he is a real man!!) will be persistent and coerce her to have sex. In the view of some men, failure to be persistent and to apply pressure on the woman might be interpreted by the woman as a sign that you are either *not a real man* or that you were *not serious* in the first place. Even when this belief about sexual coercion is turned inwardly (to suggest that men are stimulated by sexually coercing women) it still found popular expression among men. Half of men in the sample believed that men find sexually coercing women enjoyable or stimulating.

7.3 Men and HIV/AIDS

7.3.1 Sources of information on HIV/AIDS

In Botswana, health facilities are a primary source of sexual and reproductive health information for women. Health facilities are generally more reliable source of accurate

information on HIV/AIDS compared to the media (radio or newspapers) and friends, all of which make up men's three main source of information on HIV/AIDS. This is because such information is likely to be disseminated by trained and qualified professionals who can provide clarification if necessary, whereas messages from the media are oftentimes in appropriate, inadequate or even contradictory.

Men generally don't frequent health facilities either to seek health or as part of the ante and post natal care, so they do not benefit from HIV/AIDS information that is routinely disseminated at these facilities. Hence health facilities did not feature among men's three main sources of HIV information. The three primary sources of HIV information for men were, in order of importance, radio or television; newspapers and magazines and thirdly, friends. In fact the health facilities were cited by 6 percent of men or fewer, as their first, second or even third main source of HIV information.

7.3.2 Knowledge of HIV/AIDS

According to the Botswana AIDS Impact Survey (BAISII), 93 percent of men in Botswana have heard about HIV and 82 percent knew At least one method of preventing HIV infection. However, while knowledge of individual aspects of the epidemic, such as prevention and transmission was high, the percentage of men who know all the three methods of HIV prevention was very low by comparison. For example, according to BAISII only 13 percent of men knew the three methods of HIV prevention, with almost a fifth (19%) not knowing any methods of HIV prevention (CSO, 2004). The results of the Botswana AIDS impact survey further show that while 88 percent of men knew at least one popular local HIV misconception, only 36 percent could dismiss all the three popular local HIV misconceptions.

The results of this study show that awareness of HIV transmission and prevention among men is generally good. This may not be surprising given the sustained HIV prevention and education campaigns that form part of Botswana's HIV preventions strategy. For example, nine out of every ten men were aware of at least one of the three

ways in which HIV can be transmitted from one person to the other, or the methods for preventing HIV infection. While most men were also aware of and therefore could dismiss popular local HIV misconceptions, quite a sizeable proportion of men could not dismiss such misconceptions. One in every ten men or more had misconceptions concerning the transmission of HIV through sharing household utensils with an HIV infected person or through mosquito bites.

If HIV knowledge is to have an empowering effect on an individual, it is desirable that such an individual should not only be conversant with how HIV can be transmitted, but also how HIV transmission can be prevented, and be able to dismiss popular HIV/AIDS misconceptions that might increase vulnerability to HIV infection. The results of this analysis have shown that while awareness of individual aspects of the epidemic is high, men overall knowledge of the epidemic is not deep. Only a fifth of men were able to correctly identify all three ways of preventing HIV infection, while a majority (68%) correctly identified only one method. This proportion would be even lower if knowledge of other aspects of the epidemic such as transmission and misconceptions were factored into the calculation. The results of this analysis suggest that while men's awareness of individual aspects of the HIV/AIDS epidemic is widespread, the quality and depth of their knowledge might be superficial and thus may not be deep enough to have a protective or transformative effect on men's sexual behavior. Varga (1999) makes a similar observation concerning condom use among men in South Africa. He observes that while men have knowledge and awareness of the benefits of condom use, they have difficulty in personalizing the use of condoms in their own relationships.

This analysis has shown that men tend to rely on friends and the media for information on sexuality and HIV/AIDS. Whiles these sources maybe accessible to men, they are nevertheless less reliable; are bound to carry self contradictory messages and provide little opportunity for interaction and reinforcement of messages compared to established sources such as health facilities, which constitute a major source of

HIV/AIDS information for women. This finding is in line with Maundeni & Mookodi (2009)'s observations that men tend to learn about sex and sexuality mainly from peers and the media.

7.3.3 Attitudes towards HIV programs and services

Generally, men's attitudes towards HIV/AIDS programs and services were positive. Quite a high proportion of men indicated a willingness to learn more about HIV/AIDS. Most credited the programs with reducing the spread of HIV and curtailing women and men's risky sexual behavior patterns. However, while they believe that HIV programs have reduced women's sexual behavior, a slightly higher percentage of men remain skeptical whether HIV/AIDS prevention programs have managed to achieve the same effect among men. A relatively smaller percentage of men were convinced that HIV programs have reduced men's risky sexual practices more than it has reduced those of women.

Most men felt that HIV programs have encouraged openness and communication between partners and thus facilitated the emergence of a better equilibrium between men and women in sexual relationships. These programs were generally viewed to have contributed to improved gender relations within sexual relationships and households, by encouraging discussion and sharing of sexual and reproductive health decisions.

Men were also aware that HIV programs have challenged the control that men have traditionally had over sex and sexuality, or at least that HIV prevention messages have not given men more power in sexual decision making. For example almost two thirds of men disagreed with the statement that '*HIV programs have given men control over sex*'. However, while acknowledging that social power relations between men and women are relevant to the way in which men and women experience sexual and reproductive health, only a quarter of the men felt that HIV programs should seek to address the gender and power imbalance between men and women. Thus, while men

acknowledged the need to empower women, most men felt that there was no need to for HIV programs to further challenge the semblance of social power than men enjoy over women, no matter how small or illusory.

7.3.4 HIV testing

Close to three quarters of men had undergone HIV testing at least once in their lifetime, and almost similar proportion had done so during the 12 months leading to the survey. Less than six out of every ten men (59%) reported ever having encouraged their partners to use VCT and less than fifth (18%) had ever accompanied their partners to the antenatal clinic. However, almost three quarters (73%) of men reported having encouraged a family member to use VCT services.

While men are stereotypically characterized as formidable barriers to women's decision making, research has shown consistent exceptions to these generalizations (Dudgeon, 2004). The reason for the low utilization of VCT services among women has often been cited as fear of their partner's reaction to a positive HIV test (Gaillard et al. 2002; Langeni 2003); or lack of support for their partner's decision to test; (Nyblade et al., 2001). However, data from this study indicates that a high proportion of men would accept their partner's decision to undergo HIV testing. For example, while only 59 percent of men had encouraged their partner to use VCT services, a significantly higher proportion (78%) would *'accept it'* if their partner underwent HIV testing without informing them of their intention to do so.

The percentage of men who would accept their partner undergoing HIV testing without informing them is high and varies slightly depending on the results of the partner's HIV test. The percentage accepting their partner's decision to test is relatively lower if the partner tests HIV positive (71%) and even lower if the partner tests HIV positive and the man tests HIV negative (65%). Thus, a significantly large percentage of men would accept their partner's decision to undergo HIV testing results, and the accompanying test results, even if the partner tested without their consent. However,

there is also evidence that while a majority of men would accept the test results of their partners; their acceptance is influenced by the outcome of the test results. A smaller percentage of men would accept their partner's decision to test for HIV if such a test returns an HIV positive result.

7.4 Men's attitudes towards equality

Quantitatively a large majority of men in the sample are supportive of the notion of gender equality and women's empowerment. For example, quite a high proportion of men felt that it was a good thing that now women have more rights and power than before; or that both partners have a right to make decisions within a relationship or to decide when or when not to have sex. However, it is clear from qualitative data that while men do support the equality in principle, their support for equality is qualified, with many having misgivings about the way equality is being pursued. There was a clear feeling among many discussants that the pursuit of equality and women's empowerment has tended to portray men as adversaries or as obstacles to be overcome or bypassed, but not engaged. It is the conclusion of this study that men's experience of sexual and reproductive health programs, including women's empowerment and HIV prevention, is often filtered through a veil of masculinities. Thus in the absence of programs to address men's needs, men with negative masculinities may experience and interpret such programs as a threat to male hegemony. This conclusion is consistent with recent evidence emerging from a study on male involvement in prevention of violence and femicide in Botswana. This study concluded that in Botswana, men experience women's empowerment programs and initiatives as a challenge to their masculinity (Kgwatalala 2009). The study identifies the historically exclusion of services to men by organizations addressing violence and the subsequent limited services for male victims of violence as giving rise to this perception of women's empowerment (Kgwatalala 2009).

Men also reported that sometimes service providers are influenced by their own gender role beliefs and prejudices when dealing with men and thus fail to provide the kind of service needed. The lack of appropriateness of current programs to address the needs of men is an emergent issue in research on male involvement in sexual and reproductive health. For example, Mmonadibe (2009) notes that men in Botswana are generally excluded from most activities relating to pre and post natal care activities, and that health service provision is such that men often feel out of place at health facilities. The author concludes that while some of these limitations maybe a result of infrastructure challenges, most of the time the limitations are simply a reflection of gender bias and condition of health professionals. This is in line with observations from other research that shows that gender role stereotypes can and do influence health service providers' interaction, diagnosis and treatment of patients (Courtenay, 1998; Odimegwu, 2005).

7.5 Men's attitudes towards health and help seeking

Gender role beliefs form an integral part in the process of constructing masculinities and femininities. Existing literature suggests that men's strict adherence and belief in traditional gender role stereotypes is associated with a number of negative outcomes. Stereotypes that portray men as strong, self reliant, stoic, and aggressive and socialization to conceal vulnerability, appear to restrict men's emotional openness and willingness to seek help (Davies et al., 2000).

Most men in this study were aware of the need to seek health early in order to avoid negative health consequences. However, men's belief that they are physically stronger than women and can withstand disease and illness better than women tends to present an obstacle to some men's health seeking. This was especially true when help is to be sought for conditions that are deemed to be '*minor*' or '*not tangible for everyone to see*' such as psychological stress and depression. Seeking help for '*minor*' ailments was socially constructed as a feminine role while men would persevere and only seek help when the condition is serious beyond dispute. Seeking counseling was viewed as a sign

of failure to cope with life's problems, something that men felt they should be able to do by virtue of being a man and what they believe. Actually, as Davies (2005) observes, seeking counseling carries more stigma than seeking medical services. While noting the significant variation in men's perception of masculinity and health seeking behavior, O'Brien et al. (2005), observes that sometimes men might trivialize their illness in order to avoid appearing to be over consulting for '*minor*' illnesses. These findings tally with Robertson & Fitzgerald's observation of an association between strict adherence to traditional notions of masculinities and negative attitudes towards personal counseling. Men who held traditional masculine beliefs were also found to prefer alternative sources of help over traditional ones (Robertson & Fitzgerald, 1992). Good et al. (1989) also found an association between traditional attitudes about the male role and negative attitudes towards seeking psychological help. Having traditional attitudes about the male role also predicted decreased past help seeking behaviour as well as decreased likelihood of seeking help in future (Good et al., 1989)

However some men's experience of illness sometimes forces them to give up the façade of a strong, independent male, and actually incorporate health seeking as part of his new identity. There were narrations of men who, once diagnosed with HIV, became activists, rallying men to challenge and critically evaluate their beliefs and stereotypes that make it difficult for them to seek help early or at all. This finding is in line with Obrien (2005)'s finding that while the experience of chronic or terminal illness presents a challenge to their masculinity, such an experience sometimes forces men to critically examine and question the model of masculinity they abide by. In fact, there was a realization among men that once infected; seeking medical help is probably the best way to preserve whatever is left of their image. Research on men's health seeking behavior suggests that men are capable of seeking health early if health seeking is seen as a way of preserving masculinity and men would risk their masculine credentials (by seeking health) if it is clear that non health seeking would jeopardize sexual performance (O'Brien, 2005). So, in the case of men infected with HIV and facing the

prospect of rapid progress to developing AIDS, health seeking among men infected with HIV can be viewed as a way to preserve masculinity. Under such circumstances, men negotiate a variant of their masculinities that incorporates health seeking.

7.6 Men's attitude towards multiple sexual partnerships

Multiple sexual partnerships have emerged as a possible explanation for Southern Africa's high HIV prevalence. Halperin et al., (2006) provides evidence that multiple concurrent partnerships are responsible for Southern Africa's high HIV prevalence than any other factor. He notes that while the association between lack of male circumcision and HIV might be responsible for Southern Africa's high HIV prevalence relative to West Africa where circumcision is prevalent, the association between lack of male circumcision and HIV risk does not explain why HIV prevalence is higher Southern Africa than in other settings where circumcision is equally uncommon such as India or Europe.

Also discredited as an explanation for Southern Africa's high HIV prevalence; is the belief that men in Southern Africa have more lifetime sexual partners than men in other parts of the world. Evidence from demographic surveys (Careal, 1995; Pettifor et al., 2004, Morris, 2002) suggests that men in Southern Africa do not have more sexual partners than men elsewhere. Halperin notes that Southern Africa seems to display a pattern of multiple concurrent sexual partnerships that is not common to other areas with comparable characteristics in terms of the practice of circumcision or number of lifetime partnerships, and might be an explanation for Southern Africa's high HIV prevalence. A unique feature of these multiple sexual partnerships is the fact that these partnership sometimes can overlap for months or even years, thus greatly facilitating HIV transmission.

The results of this analysis show that a significant portion of men realize the danger of multiple concurrent sexual partnerships and express views that reflect this understanding. For example, most men dismissed the notion that a man needs to have

multiple partners in order to be able to choose the one partner who is suitable for a long term stable relationship or marriage. However, the quantitative results show that quite a significant portion of men have more than one current sexual partner, and many engage in casual sexual intercourse and paid sex.

In addition, while men felt that multiple sexual partnerships were not only harmful to their relationships, but also increased the risk of HIV infection, many nevertheless felt that sometimes they have no choice but to have more than one partner. Conflicts within relationships were often cited as a reason why a man would have more than one partner. According to statistics from Botswana's latest demographic survey, 39 percent of 15-24 year olds reported having sexual intercourse with a non-marital, non-cohabiting and non-regular partner in the 12 months prior to survey (CSO, 2008).

7.7 Men's attitudes towards other forms of masculinities

Men's attitudes towards homosexuality and men-who-have-sex-with-men [MSM] were generally negative. Men tended to view homosexuality as unnatural, uncultured and an affront to masculinities. While some discussants indicated their disapproval of homosexuality as a masculine way of being, some nevertheless were of the view that if homosexuals were born with the desire to have sex with other men, then there is nothing anyone can do to change that. However the main thrust of the views were negative and acrimonious, and tended to perceive homosexuality and homosexuals as '*unnatural*'; '*lacking something*' compared to heterosexual men.

Homosexuality was thought to result from men's extended period of abstinence from heterosexual sex. This abstinence could either be forced, as in the case of men in prison, or a result of men's failure to attract a sexual female partner. A pervasive view among men was to see the apparent increase in homosexual tendencies as a result of the incarceration of an increasing number of men. The explanation is that due to unemployment and poverty, men feel marginalized, and turn to crime or violence, and end up in prison. Once in prison men may have sex with other men as a way to release

their sexual energy and end up developing '*a taste*' for sex with men. The perceived marginalization was also thought to make it difficult for men to attract female sexual partners and so end up having sex with other men. So, homosexuality was viewed as an acquired condition, which, as one discussant put it, '*can be cured simply by the introduction of women*' (heterosexual sexual intercourse). A large majority of men were against the decriminalization of homosexuality in Botswana or the provision of services and sex education geared towards homosexual men.

However, some men were willing to entertain the idea that it might be beneficial for sexual and reproductive programs, including HIV prevention and transmission, to begin to find ways to address the information and service needs of homosexuals and MSM. This willingness to entertain the idea of providing services to homosexual men was based on the understanding failure to address these men's information and service needs might increase their vulnerability to HIV infection. Since some of these men are likely to also maintain heterosexual relationships with women, thus providing a '*bridge*' for transferring infection from this group, which would have become a high risk group to the rest of the population. Thus, most men's support for provision of services to homosexual and MSM was based on the perceived increased risk to heterosexuals that can result from homosexuals and MSM's increased HIV vulnerability resulting from failure to address their information and service needs. But many discussants warned that in addressing the needs of homosexuals and MSM, the government should not go overboard and inadvertently end up advertising homosexuality as an alternative masculine lifestyle. Men's disapproval of homosexuality, decriminalization and provision of services to homosexuals and MSM, did not vary significantly across all background characteristics.

7.8 Impact of masculinities and sexual and reproductive health attitudes

This section discusses the findings relating to the analysis of association between masculinities and men's sexual and reproductive health beliefs and practices. The

association between masculinities and men's beliefs and attitudes are discussed first, followed by the discussion of the association between masculinities and men's sexual and reproductive health practices.

7.9 Influence of masculinities on men's sexual and reproductive health practices

The need to involve men in sexual and reproductive health has gained momentum, especially in Southern African where efforts to control the spread of HIV/AIDS have so far faltered. This interest in men is partly a result of the impetus of the 1994 International Conference on Population and Development, held in Cairo, which articulated the need for a broader and more comprehensive approach to sexual and reproductive health that entails increased male participation and addresses the needs of men, for their own benefit [instead of addressing men's needs only as a strategy to improve women's health].

Southern Africa's heterosexually driven HIV/AIDS epidemic has crystallized the need to involve men in sexual and reproductive health, and thus added to the impetus to study men sexual and reproductive health behaviors, attitudes and practices, especially as these relate to HIV prevention and transmission. However, despite such increased attention to men in this area (S&RH), most of what is known about sexual and reproductive health comes from work amongst women (Varga, 2001). Such a focus on women is partly a result of the historical exclusion of men from the family planning and other sexual and reproductive health initiatives based on certain assumptions about the roles of gender in reproductive health and the primacy of women's needs and their involvement in health service utilization, contraceptive use and childbearing (Varga, 2001).

Sexual and reproductive health rights in most of Southern Africa and the developing world exist at the confluence of group, rather than individual interests. As a gendered process, reproductive health decisions of women are also influenced not only by their partners' decisions but also decisions of other relatives within the often extended

kinship structure. While the reproductive health rights framework assumes and implies individual rights to make choices and decisions regarding reproductive health, in traditional and marginal communities reproduction rights lie at the intersection of group interests such as family, households, religions and states (Dudgeon et al., 2004). As Dudgeon (2005) notes, since culturally men in most traditional societies and the developing world have implicit and at times explicit rights to women's sexuality and reproduction, it makes sense for sexual and reproductive health programs to address the reproductive health rights of men and women in relationship to each other.

Men's attitudes towards sexual and reproductive health are very important because they can act as an indication of the likely action that one will take, if they have to make a decision concerning not only their sexuality or health, but that of their partners too. This thesis examined the association between masculinities and men's attitudes towards sexual and reproductive health. The results of this research shows that masculinities have an influence on a number of men's sexual and reproductive health attitudes, beliefs and practices. While in some cases masculinities did not display any statistically significant association with specific S&RH attitudes and practices, where such an association existed, it was always consistently negative.

Having negative masculine beliefs was associated with increased likelihood of having S&RH attitudes, beliefs and practices that could facilitate the spread of HIV/AIDS. Other variables that tended to have an influence on men's S&RH attitudes, beliefs and practices include age, marital status, education, employment, type of family of orientation and place of childhood orientation.

7.10 Impact of masculinities and beliefs about violence

Indeed logistic regression results points to an association between masculinities and beliefs about violence. Despite the fact that a majority of men did not support the use of violence within relationships or families as a means of control or to get what one wants, there were certain contexts where men displayed a worrying propensity to support or

justify the use of violence under certain circumstances. For example the use of limited violence was deemed appropriate, even desirable if the aim of such violence was to achieve a certain '*good*' such as keeping the family or relationship together, or taking care of children. Men with negative masculinities were significantly more likely to feel that the use of violence is justified if the partner fails to take care of children; talks back during an argument or want to terminate the relationship.

7.11 Masculinities and beliefs about sexual coercion

Most men were generally against the use of violence within relationship or in their interaction with other men. However there was a pervasive view regarding the desirability of a certain level of coercion within intimate and sexual relationships to '*show that one is indeed not playing*'. While evidence from focus group discussions suggest that men are generally aware of the danger of assuming that women need or want to be coerced to have sex, a high proportion of men in the quantitative survey had the belief that women expect the man to be coercive, if only to show that he is serious.

7.12 Masculinities and sexual and reproductive health practices

7.12.1 Masculinities and sexual partnerships

Most men recognized the danger of multiple sexual partnerships. Despite the stated awareness of the undesirability of multiple sexual partnerships, a significant proportion of men had two or more current sexual partners; or was occasionally involved in casual sexual relationships. Masculinities did not display a significant effect on a number of variables on men's sexual practices, however, masculinities tended to have a significant influence on men's intentions and anticipated number and nature of future sexual partnerships.

7.12.2 Masculinities and use of violence

Masculinities displayed a significant association with men's actual use of violence within relationships. Having negative masculinities was associated with significantly

higher odds of reporting actual violence within a relationship. Men who had negative masculinities were at significantly higher odds of reporting ever having ever used physical violence against their current or former partner, or having slapped their partner at least once during the year preceding the survey.

7.13 Conclusions about research problem

Botswana is currently in the throes of trying to contain a debilitating HIV/AIDS epidemic that has already started to reverse some of the gains in quality of life that the country had achieved in the decades prior to the epidemic. While the country has won international acclaim for its adoption of an early and comprehensive HIV response strategy, the HIV prevalence rates have remained stubbornly high, while incidence rates have remained high. The most recent statistics show a national general population prevalence rate of 17.6 percent; HIV prevalence is highest (40 percent) among the productive and reproductive sectors of the population aged between 30 and 44 years (see CSO, 2008). In addition, over most age ranges, HIV prevalence rates among women are higher than those of men. The current official national HIV prevalence rate of 17 percent is much lower than the estimated figure provided by the United Nations and Botswana's development partners. However the figure remains high and hides significant variations in prevalence between groups. Currently the country's HIV incidence rate of 2.9 percent (CSO, 2008) shows a sex differential, with more females (female incidence = 3.5 %) than males (male incidence rate= 2.3%) acquiring new HIV infections.

Botswana has a highly accessible health care infrastructure that is being used to deliver HIV/AIDS services free of charge. Despite this, the rate of utilization of these services has nevertheless struggled to reach levels that reflect the severity of the HIV epidemic ravaging the country, or the fact that these services are free of charge. Unequal gender, power and social relations between men and women have been blamed for failure to utilize VCT services. Key among factors widely believed to influence the HIV epidemic

are systems and structures of gender that keep women in a subservient position to men in sexual decision making. On the other hand, men are understood to be fuelling the epidemic through risky sexual behavior that includes multiple concurrent sexual partnerships, unwillingness to use condoms and violence. In fact data from the country's demographic survey suggest that men have a higher risk profile than women (see CSO, 2004). So, more programmatic attention has focused on the position of women within the epidemic, and efforts have been largely channeled towards addressing factors that increase their susceptibility to HIV infection.

While this approach is understandable given the vulnerability of women to infection, it has nevertheless resulted in the neglect of men, specifically, in a dearth of information and research to understand men's perspective in sexual and reproductive health and HIV prevention; especially the socio-cultural factors that drive men's sexual and reproductive health behavior. Thus, while there is general understanding and appreciation of how gender roles and beliefs have historically disadvantaged women in sexual and reproductive health, such wisdom does not seem to come naturally when it men's sexual and reproductive health risks and practices is the issue. Perhaps this is partly so because men, as '*perpetrators*' of most of women's problems or as *obstacles* to attainment of safe sexual and reproductive health outcomes, are assumed to enjoy a '*patriarchal dividend*'. However, while an almost exclusive focus on women has produced its dividends, it is proving inadequate and incapable of achieving the desired HIV prevention goals in the face of an HIV epidemic that is heterosexually driven. The necessity of a balanced understanding of gender as a set of socio-culturally created and conditioned behavior patterns, created and affecting both men and women (Mane & Aggleton, 2001) has become all too apparent. Apart from stereotypical reasons and explanation of how or why men seem to be driving the epidemic, there is a dearth of research on masculinities and their impact on Botswana's HIV/AIDS epidemic.

Research points to the need to involve men in HIV prevention efforts and other programs that seek to address the negative impact of inequalities on sexual and

reproductive health (Wood and Jewkes, 1997), however such an undertaking requires an understanding of masculinities and the socio-cultural and contextual factors that give rise to and sustains certain types of masculinities. However, one of the most important gaps in the work for improved sexual and reproductive health is the absence of clear information about men's attitudes towards sex and sexuality (Rivers et al., 1999). In Botswana, the absence of relevant research on masculinities and HIV has left HIV prevention programs working with a '*blind spot*' in as far as understanding men's motivation in sexual and reproductive health, including HIV prevention, is concerned. Despite the fact that men are held responsible for the dramatic increase in the spread of HIV/AIDS in Botswana, very little has been done to research male sexuality or the context within which males express their sexuality (Maundeni & Mookodi, 2009). The result is that HIV prevention programs targeting behavior change in men are being designed and implemented, without adequate knowledge and information about the very same group whose behavior they seek to modify.

The UNAIDS Framework for Communicating HIV/AIDS messages notes that individuals' decisions about HIV/AIDS prevention are often based on emotion rather than on rational volition as assumed by many frameworks. This framework, which arose out of a consensus at an international AIDS conference posit that HIV/AIDS communication frameworks that assume rationality and volition in HIV prevention do not serve Africa and most of the developing world's HIV communication needs because they usually focus fail to address contextual factors which shape individuals and their decisions, such as culture, socio-economic status, gender and power relations, government and policy (UNAIDS, 1997).

While understanding of global masculinities is essential to understanding some of the key tenets of masculinities everywhere, it is never adequate without interrogating contextual factors that are unique to each setting because masculinities encompass a collection of meanings that are influenced by contextual factors and change over time. Thus, in addition to personal characteristics, an individual's response to the HIV/AIDS

will be strongly influenced by societal and gender, socio-economic status, religions and other faith beliefs, as well as governmental and HIV/AIDS policy environment (see UNAIDS, 1997).

This research, while limited in scope and magnitude, is an attempt to articulate the need to understand and engage the role of masculinities in the country's HIV/AIDS epidemic. It represents an effort and a call to the desirability of understanding contextual and other factors that motivate men's sexual and reproductive health, especially in HIV prevention in Botswana, and to incorporate such insights into HIV prevention strategies for maximum effectiveness. The results suggest that while masculinities are not the one and only overriding factor influencing men's sexual and reproductive health attitudes and practices, masculinities are nevertheless important to the way men perceive, interpret and experience sexual and reproductive health, including HIV/AIDS prevention programs.

Masculinities and gender role stereotypes act as a filter through which men (and women) experience sexual and reproductive health and HIV prevention messages, and may also mediate men's experience of socio and economic structural changes such as unemployment, marginalization and poverty that are so characteristic of most Sub-Saharan African countries and economies. It is therefore necessary for sexual and reproductive health programs, including HIV prevention programs, to pay attention not only to masculinities in their various forms or their influence on men's sexual and reproductive health attitudes and practices, but also gain a deeper understanding of the social, cultural and other factors that produce and sustain certain masculine and gender role norms and stereotypes.

HIV prevention programs need to move away from prevailing models of preventive health care and explanation that focuses on the individual, to more multilevel, cultural and contextual explanations and interventions. Failure to do so only ensures that in HIV

and other preventive programs targeting men will continue to be blamed on the individual, disregarding the context that shapes the individual.

7.14 Limitations of the study

This study has a number of limitations that are worth acknowledging. First, the study utilized a sample design that is not nationally representative of all men in Botswana. As a result, while the conclusions derived from the study are insightful, they cannot be generalized to the whole male population of Botswana. However, probability sampling procedures were employed to select the sample within the urban localities in which quantitative data were collected. So while the data are not nationally representative, the sample constitutes a fair representation of the target population in the sampled localities.

In addition, the quantitative sample on which objective measures of men's attitudes and practices are based is limited. Resource limitations played an important role in the choice of an unrepresentative study design and a relatively small quantitative sample size than was originally envisaged. The limited sample restricted the depth and rigor of analysis of certain quantitative data. Despite the foregoing limitations, the results of this study point to important dynamics between masculinities and men's sexual and reproductive health attitudes and practices.

7.15 Frontiers for further research

This type of research could never provide all the answers on the subject of men, masculinities and sexual and reproductive health. However, it raises a number of questions that highlight the need for further research to inform our collective understanding of men's motivation in sexual and reproductive health, including HIV prevention in Botswana.

The limitations of this study point to the need for more comprehensive and perhaps nationally representative studies to understand the role of men and masculinities in

sexual and reproductive health in Botswana. In this way, this study can only point beyond itself, to the need for a fuller understanding of the '*why*' of men's sexual and reproductive health in Botswana.

Appendix 1 Tables

Table 21: Masculinities and Men's S&RH Practices, Violence and Alcohol Consumption

Masculinities and Men's Sexual Practices
Statistics=Mean

		MASCULINITIES			
	Variable	**Positive**	**Average**	**Negative**	**Total**
1	Number of sexual partners in past 12 months	2.28	2.23	2.82	2.4
2	Number of life time sexual partners	7.02	6.96	11.09	8.01
3	Number of current sexual partners	2.65	2.52	1.21	2.23
4	Number of partners in future	4.42	7.06	7.27	6.44
5	Number of times had casual sex in past 12 months	3.8	4.04	5.79	4.56
6	Number of casual sexual partners ever had	10.51	8.69	11.65	9.96
7	Number of future casual partners	3.48	8.11	9.71	7.37
8	Number of times paid for casual sex	5.27	2.37	5.43	4.11
9	Number of times paid for casual sex past 12 months	7.13	1.65	4.19	3.49

	Masculinities and Men's Involvement in Violence	**Positive**	**Average**	**Negative**	**Total**
1	Number of times got into a FIGHT in past 12 months	2.08	2.06	2.53	2.16
2	Number of times got into a THREATENED a fight in past 12 mo	1.93	2.11	2.4	2.04
3	Number of times made VERBAL threat in past 12 months	1.94	2.12	2.72	2.21

	Masculinities and Men's Alcohol Consumption	**Positive**	**Average**	**Negative**	**Total**
4	Number of alcoholic beverages taken per drinking session	11.59	12.72	14.88	13.03

Table 22: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_1

	Sometimes it is justifiable to hit a partner if she goes out without me			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.601	0.227	0.746	3.433
Age				
17 - 21	1.000	----	----	----
22 - 25	3.233	0.156	0.640	16.344
26 - 30	5.297	0.041	1.067	26.302
31 - 35	16.388	0.001	3.164	84.879
36 - 45	5.067	0.111	0.689	37.255
46 - 69	5.194	0.164	0.510	52.928
Marital Status				
Married	1.000	----	----	----
Never married	0.403	0.144	0.119	1.364
Cohabiting	0.269	0.079	0.062	1.162
Sep/Div/Wid	0.000	0.998	0.000	.
Education				
Primary or less	1.000	----	----	----
Secondary	2.229	0.312	0.472	10.534
Tertiary	1.249	0.779	0.264	5.914
Religion				
Christian	1.000	----	----	----
African traditional	1.584	0.429	0.506	4.956
Other Non Christian	1.831	0.269	0.626	5.355
Employment				
Employed	1.000	----	----	----
Unemployed	2.518	0.022	1.144	5.543
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.461	0.039	0.220	0.963
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	0.253	0.036	0.070	0.912
Father only	8.397	0.002	2.131	33.085
Both parents umarried	0.827	0.782	0.215	3.181
Extended	1.858	0.172	0.764	4.514

Table 23: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of Violence_2

	Sometimes it is justifiable to hit a partner if she refuses to have sex			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.603	0.299	0.658	3.905
Age				
17 - 21	1.000	----	----	----
22 - 25	0.368	0.197	0.081	1.681
26 - 30	0.896	0.874	0.231	3.477
31 - 35	1.852	0.391	0.454	7.56
36 - 45	0.347	0.398	0.03	4.026
46 - 69	1.773	0.589	0.222	14.169
Marital Status				
Married	1.000	----	----	----
Never married	1.293	0.769	0.234	7.156
Cohabiting	0.706	0.734	0.095	5.254
Sep/Div/Wid	0	0.998	0	.
Education				
Primary or less	1.000	----	----	----
Secondary	4.572	0.202	0.442	47.304
Tertiary	2.284	0.496	0.212	24.598
Religion				
Christian	1.000	----	----	----
African traditional	4.15	0.01	1.414	12.184
Other Non Christian	2.698	0.111	0.795	9.158
Employment				
Employed	1.000	----	----	----
Unemployed	1.089	0.845	0.463	2.565
Place of Childhood Orientation		0.253		
Urban	1.000	----	----	----
Rural	5.135	0.075	0.848	31.074
Family of Childhood Orientation	0.736	0.719	0.138	3.915
Both parents married	1.000	----	----	----
Mother only	0.007	0.002		
Father only				
Both parents umarried				
Extended				

Table 24: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_3

Sometimes it is justifiable to hit a partner if she wants to terminate the relationship

				95% C.I.for EXP(B)	
		Exp(B)	Sig.	Lower	Upper
Masculinity					
	Positive	1.000	----	----	----
	Negative	1.293	0.515	0.596	2.805
Age					
	17 - 21	1.000	----	----	----
	22 - 25	1.254	0.728	0.350	4.496
	26 - 30	0.856	0.821	0.223	3.290
	31 - 35	2.516	0.203	0.608	10.405
	36 - 45	0.268	0.277	0.025	2.869
	46 - 69	7.144	0.044	1.052	48.498
Marital Status					
	Married	1.000	----	----	----
	Never married	3.743	0.146	0.633	22.135
	Cohabiting	1.173	0.876	0.158	8.695
	Div/Wid/Sep	1.299	0.852	0.083	20.405
Education					
	Primary or less	1.000	----	----	----
	Secondary	7.456	0.087	0.749	74.224
	Tertiary	2.432	0.455	0.236	25.092
Religion					
	Christian	1.000	----	----	----
	African Traditional	3.909	0.003	1.582	9.659
	Other non- Christian	0.000	0.997	0.000	.
Employment					
	Employed	1.000	----	----	----
	Unemployed	0.692		0.297	1.612
Place of Childhood orientation					
	Urban	1.000	----	----	----
	Rural	0.979	0.956	0.454	2.108
Type of family of orientation					
	Both parents married	1.000	----	----	----
	Mother only	0.945	0.904	0.378	2.364
	Father only	1.211	0.866	0.131	11.145
	Both parents unmarried	0.000	0.997	0.000	.
	Extended	1.551	0.357	0.610	3.945

Table 25: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_4

Sometimes it is justifiable to hit a partner if she fails to take care of children

				95% C.I.for EXP(B)	
		Exp(B)	Sig.	Lower	Upper
Masculinity					
	Positive	1.000	----	----	----
	Negative	3.442	0.002	1.594	7.433
Age					
	17 - 21	1.000	----	----	----
	22 - 25	2.857	0.135	0.723	11.294
	26 - 30	2.484	0.192	0.633	9.745
	31 - 35	9.028	0.003	2.156	37.805
	36 - 45	0.367	0.389	0.037	3.592
	46 - 69	2.198	0.473	0.256	18.896
Marital Status					
	Married	1.000	----	----	----
	Never married	2.767	0.255	0.480	15.935
	Cohabiting	1.279	0.807	0.178	9.164
	Div/Wid/Sep	12.727	0.022	1.447	111.909
Education					
	Primary or less	1.000	----	----	----
	Secondary	1.112	0.878	0.288	4.297
	Tertiary	0.424	0.226	0.106	1.700
Religion					
	Christian	1.000	----	----	----
	African Traditional	4.910	0.000	2.132	11.309
	Other non- Christian	0.546	0.356	0.151	1.975
Employment					
	Employed	1.000	----	----	----
	Unemployed	0.979		0.479	2.002
Place of Childhood orientation					
	Urban	1.000	----	----	----
	Rural	0.532	0.086	0.259	1.093
Type of family of orientation					
	Both parents married	1.000	----	----	----
	Mother only	0.293	0.015	0.109	0.785
	Father only	0.730	0.749	0.106	5.030
	Both parents unmarried	0.176	0.031	0.036	0.855
	Extended	0.714	0.451	0.296	1.718

Table 26: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_5

Sometimes it is justifiable to hit a partner if she talks back during an argument

				95% C.I.for EXP(B)	
		Exp(B)	Sig.	Lower	Upper
Masculinity					
	Positive	1.000	----	----	----
	Negative	2.610	0.007	1.300	5.241
Age					
	17 - 21	1.000	----	----	----
	22 - 25	1.785	0.369	0.504	6.313
	26 - 30	1.930	0.295	0.564	6.599
	31 - 35	2.430	0.194	0.636	9.285
	36 - 45	2.699	0.180	0.632	11.521
	46 - 69	1.001	0.999	0.147	6.804
Marital Status					
	Married	1.000	----	----	----
	Never married	0.549	0.332	0.163	1.845
	Cohabiting	0.267	0.093	0.057	1.244
	Div/Wid/Sep	0.412	0.382	0.057	3.007
Education					
	Primary or less	1.000	----	----	----
	Secondary	0.757	0.624	0.248	2.305
	Tertiary	0.406	0.120	0.130	1.264
Religion					
	Christian	1.000	----	----	----
	African Traditional	7.064	0.000	3.161	15.785
	Other non- Christian	2.555	0.079	0.897	7.274
Employment					
	Employed	1.000	----	----	----
	Unemployed	0.914		0.464	1.799
Place of Childhood orientation					
	Urban	1.000	----	----	----
	Rural	0.485	0.039	0.244	0.964
Type of family of orientation					
	Both parents married	1.000	----	----	----
	Mother only	0.268	0.007	0.103	0.696
	Father only	0.298	0.325	0.027	3.327
	Both parents unmarried	0.289	0.065	0.077	1.081
	Extended	0.615	0.278	0.256	1.480

Table 27: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_6

	Sometimes it is justifiable to use violence in a relationship			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.356	0.370	0.697	2.637
Age				
17 - 21	1.000	----	----	----
22 - 25	2.807	0.092	0.845	9.328
26 - 30	1.387	0.604	0.402	4.782
31 - 35	2.983	0.102	0.806	11.034
36 - 45	0.673	0.640	0.127	3.550
46 - 69	0.000	0.998	0.000	.
Marital Status				
Married	1.000	----	----	----
Never married	1.836	0.471	0.351	9.596
Cohabiting	0.955	0.961	0.147	6.185
Div/Wid/Sep	1.955	0.574	0.189	20.256
Education				
Primary or less	1.000	----	----	----
Secondary	0.493	0.279	0.137	1.772
Tertiary	0.367	0.128	0.101	1.335
Religion				
Christian	1.000	----	----	----
African Traditional	1.552	0.353	0.614	3.926
Other non- Christian	0.700	0.605	0.182	2.697
Employment				
Employed	1.000	----	----	----
Unemployed	0.527		0.269	1.035
Place of Childhood orientation				
Urban	1.000	----	----	----
Rural	0.443	0.024	0.219	0.897
Type of family of orientation				
Both parents married	1.000	----	----	----
Mother only	0.205	0.002	0.075	0.565
Father only	0.289	0.264	0.033	2.551
Both parents unmarried	0.077	0.014	0.010	0.591
Extended	0.467	0.098	0.189	1.152

Table 28: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_7

	Women find sexual coercion stimulating			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	2.898	0.000	1.944	4.320
Age				
17 - 21	1.000	----	----	----
22 - 25	1.684	0.096	0.911	3.113
26 - 30	1.558	0.171	0.826	2.940
31 - 35	2.130	0.048	1.007	4.504
36 - 45	2.072	0.098	0.874	4.908
46 - 69	4.499	0.014	1.360	14.888
Marital Status				
Married	1.000	----	----	----
Never married	1.979	0.099	0.879	4.457
Cohabiting	0.815	0.648	0.338	1.964
Div/Wid/Sep	2.244	0.149	0.748	6.735
Education				
Primary or less	1.000	----	----	----
Secondary	2.219	0.063	0.957	5.146
Tertiary	1.632	0.253	0.705	3.780
Religion				
Christian	1.000	----	----	----
African Traditional	1.379	0.336	0.717	2.652
Other non- Christian	1.456	0.277	0.740	2.865
Employment				
Employed	1.000	----	----	----
Unemployed	0.908		0.589	1.400
Place of Childhood orientation				
Urban	1.000	----	----	----
Rural	1.061	0.776	0.705	1.598
Type of family of orientation				
Both parents married	1.000	----	----	----
Mother only	1.270	0.337	0.780	2.070
Father only	1.030	0.958	0.344	3.080
Both parents unmarried	4.732	0.000	2.284	9.800
Extended	1.751	0.039	1.028	2.981

Table 29: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_8

	Men are stimulated by coercing women into sex			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	2.099	0.000	1.418	3.106
Age				
17 - 21	1.000	----	----	----
22 - 25	1.310	0.386	0.711	2.414
26 - 30	1.607	0.140	0.856	3.019
31 - 35	2.481	0.016	1.182	5.209
36 - 45	2.231	0.064	0.956	5.209
46 - 69	7.180	0.002	2.058	25.045
Marital Status				
Married	1.000	----	----	----
Never married	1.472	0.353	0.651	3.328
Cohabiting	1.990	0.124	0.829	4.780
Div/Wid/Sep	3.416	0.034	1.099	10.618
Education				
Primary or less	1.000	----	----	----
Secondary	0.582	0.215	0.248	1.369
Tertiary	0.628	0.285	0.268	1.472
Religion				
Christian	1.000	----	----	----
African Traditional	1.503	0.208	0.797	2.835
Other non- Christian	3.697	0.000	1.816	7.530
Employment				
Employed	1.000	----	----	----
Unemployed	1.066		0.694	1.638
Place of Childhood orientation				
Urban	1.000	----	----	----
Rural	0.981	0.924	0.657	1.463
Type of family of orientation				
Both parents married	1.000	----	----	----
Mother only	0.807	0.392	0.493	1.319
Father only	4.401	0.017	1.298	14.920
Both parents unmarried	2.120	0.024	1.103	4.077
Extended	1.366	0.239	0.813	2.295

Table 30: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_9

Sometimes women pretend not to want sex expecting the man to coerce them

				95% C.I.for EXP(B)	
		Exp(B)	Sig.	Lower	Upper
Masculinity					
	Positive	1.000	----	----	----
	Negative	4.878	0.000	3.035	7.839
Age					
	17 - 21	1.000	----	----	----
	22 - 25	1.292	0.451	0.663	2.519
	26 - 30	1.718	0.143	0.832	3.548
	31 - 35	2.698	0.024	1.136	6.407
	36 - 45	1.696	0.262	0.673	4.272
	46 - 69	3.081	0.102	0.800	11.856
Marital Status					
	Married	1.000	----	----	----
	Never married	1.850	0.173	0.764	4.481
	Cohabiting	1.391	0.486	0.550	3.523
	Div/Wid/Sep	5.140	0.020	1.297	20.364
Education					
	Primary or less	1.000	----	----	----
	Secondary	2.253	0.082	0.902	5.627
	Tertiary	2.960	0.021	1.181	7.417
Religion					
	Christian	1.000	----	----	----
	African Traditional	1.360	0.446	0.617	2.995
	Other non- Christian	1.755	0.200	0.742	4.150
Employment					
	Employed	1.000	----	----	----
	Unemployed	1.430		0.863	2.369
Place of Childhood orientation					
	Urban	1.000	----	----	----
	Rural	1.374	0.187	0.857	2.202
Type of family of orientation					
	Both parents married	1.000	----	----	----
	Mother only	1.008	0.978	0.586	1.733
	Father only	2.440	0.206	0.612	9.733
	Both parents unmarried	2.761	0.021	1.163	6.555
	Extended	1.609	0.136	0.861	3.005

Table 31: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Support of violence_10

	If my partner was not home when I got there she would be in trouble			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.893	0.038	1.035	3.462
Age				
17 - 21	1.000	----	----	----
22 - 25	1.248	0.643	0.489	3.183
26 - 30	0.942	0.905	0.356	2.496
31 - 35	2.355	0.105	0.836	6.637
36 - 45	0.699	0.638	0.157	3.110
46 - 69	1.422	0.679	0.268	7.530
Marital Status				
Married	1.000	----	----	----
Never married	0.779	0.662	0.254	2.389
Cohabiting	0.788	0.710	0.226	2.754
Div/Wid/Sep	0.298	0.308	0.029	3.055
Education				
Primary or less	1.000	----	----	----
Secondary	3.251	0.149	0.656	16.100
Tertiary	2.815	0.206	0.567	13.977
Religion				
Christian	1.000	----	----	----
African Traditional	1.809	0.166	0.782	4.188
Other non- Christian	0.457	0.232	0.126	1.651
Employment				
Employed	1.000	----	----	----
Unemployed	1.334		0.703	2.532
Place of Childhood orientation				
Urban	1.000	----	----	----
Rural	0.735	0.305	0.408	1.324
Type of family of orientation				
Both parents married	1.000	----	----	----
Mother only	0.810	0.569	0.392	1.674
Father only	1.211	0.815	0.244	5.996
Both parents unmarried	0.456	0.223	0.129	1.612
Extended	1.011	0.978	0.466	2.195

Table 32: Logistic Regression Odds Ratios of the Association between Negative Masculinities and Use of violence

	I sometimes get so angry that I hit my partner			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.907	0.007	1.189	3.059
Age				
17 - 21	1.000	----	----	----
22 - 25	2.276	0.034	1.062	4.876
26 - 30	1.068	0.873	0.476	2.393
31 - 35	2.016	0.124	0.825	4.925
36 - 45	1.148	0.797	0.400	3.298
46 - 69	0.289	0.114	0.062	1.347
Marital Status				
Married	1.000	----	----	----
Never married	0.238	0.002	0.097	0.580
Cohabiting	0.117	0.000	0.040	0.346
Div/Wid/Sep	0.259	0.037	0.073	0.920
Education				
Primary or less	1.000	----	----	----
Secondary	1.051	0.918	0.406	2.720
Tertiary	0.587	0.276	0.225	1.532
Religion				
Christian	1.000	----	----	----
African Traditional	4.982	0.000	2.562	9.691
Other non- Christian	2.041	0.053	0.990	4.205
Employment				
Employed	1.000	----	----	----
Unemployed	1.176		0.710	1.950
Place of Childhood orientation				
Urban	1.000	----	----	----
Rural	0.778	0.310	0.478	1.264
Type of family of orientation				
Both parents married	1.000	----	----	----
Mother only	0.446	0.012	0.237	0.837
Father only	0.528	0.374	0.130	2.155
Both parents unmarried	0.588	0.189	0.266	1.299
Extended	0.702	0.276	0.372	1.327

Table 33: Logistic Regression Odds Ratios of the Association between Masculinities and Men's Sexual Practices: Number of partners in past 12 months

	Two or more sexual partners in past 12months			
			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.471	0.090	0.941	2.301
Age				
17 - 21	1.000	----	----	----
22 - 25	0.797	0.556	0.374	1.697
26 - 30	0.843	0.655	0.398	1.783
31 - 35	0.770	0.553	0.325	1.825
36 - 45	0.559	0.291	0.190	1.646
46 - 69	0.482	0.316	0.116	2.006
Marital Status				
Married	1.000	----	----	----
Never married	2.586	0.058	0.968	6.909
Cohabiting	1.267	0.671	0.425	3.780
Sep/Div/Wid	0.869	0.843	0.215	3.505
Education				
Primary or less	1.000	----	----	----
Secondary	1.893	0.219	0.684	5.235
Tertiary	1.995	0.184	0.721	5.521
Religion				
Christian	1.000	----	----	----
African traditional	3.823	0.000	1.848	7.908
Other Non Christian	3.052	0.003	1.455	6.403
Employment				
Employed	1.000	----	----	----
Unemployed	0.806	0.386	0.496	1.312
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.850	0.489	0.537	1.346
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	2.093	0.010	1.195	3.666
Father only	0.791	0.721	0.220	2.852
Both parents umarried	1.345	0.426	0.649	2.790
Extended	2.926	0.000	1.614	5.305

Table 34: Logistic Regression Odds Ratios of the Association between Masculinities and Men's Sexual Practices: Lifetime Sexual partners

Has ever had two or more of sexual partners in their lifetime

		95% C.I.for EXP(B)		
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	1.359	0.262	0.795	2.321
Age				
17 - 21	1.000	----	----	----
22 - 25	3.364	0.001	1.617	6.998
26 - 30	4.238	0.000	1.932	9.297
31 - 35	13.151	0.000	3.719	46.513
36 - 45	16.774	0.000	3.675	76.556
46 - 69	2.891	0.200	0.571	14.644
Marital Status				
Married	1.000	----	----	----
Never married	2.827	0.123	0.755	10.582
Cohabiting	1.741	0.416	0.457	6.624
Sep/Div/Wid	1.007	0.993	0.207	4.906
Education				
Primary or less	1.000	----	----	----
Secondary	0.284	0.098	0.064	1.263
Tertiary	0.345	0.163	0.077	1.539
Religion				
Christian	1.000	----	----	----
African traditional	0.829	0.693	0.327	2.101
Other Non Christian	5.573	0.006	1.655	18.761
Employment				
Employed	1.000	----	----	----
Unemployed	0.665	0.195	0.359	1.233
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.815	0.464	0.471	1.410
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	2.696	0.010	1.264	5.752
Father only	1.063	0.931	0.272	4.153
Both parents umarried	1.711	0.248	0.688	4.254
Extended	1.839	0.102	0.886	3.819

Table 35: Logistic Regression Odds Ratios of the Association between Masculinities and Sexual Practices: Number of Current Sexual Partners

Currently has two or more sexual partners

			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	0.885	0.676	0.497	1.574
Age				
17 - 21	1.000	----	----	----
22 - 25	2.962	0.024	1.152	7.617
26 - 30	1.002	0.997	0.360	2.787
31 - 35	1.039	0.949	0.320	3.374
36 - 45	0.470	0.409	0.078	2.825
46 - 69	5.223	0.076	0.839	32.509
Marital Status				
Married	1.000	----	----	----
Never married	15.096	0.025	1.401	162.668
Cohabiting	11.413	0.050	1.002	130.049
Sep/Div/Wid	18.082	0.032	1.278	255.909
Education				
Primary or less	1.000	----	----	----
Secondary	0.697	0.592	0.186	2.609
Tertiary	0.906	0.883	0.244	3.365
Religion				
Christian	1.000	----	----	----
African traditional	2.400	0.032	1.078	5.343
Other Non Christian	1.806	0.188	0.749	4.358
Employment				
Employed	1.000	----	----	----
Unemployed	0.531	0.043	0.288	0.979
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.860	0.620	0.472	1.564
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	2.298	0.021	1.135	4.654
Father only	0.321	0.289	0.039	2.628
Both parents umarried	1.285	0.574	0.536	3.083
Extended	1.372	0.442	0.613	3.074

Table 36: Logistic Regression Odds Ratios of the Association between Masculinities and Sexual Practices: Number of Future Sexual Partners

Anticipates to have two or more sexual partners in future

			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	2.796	0.000	1.724	4.533
Age				
17 - 21	1.000	----	----	----
22 - 25	1.339	0.486	0.589	3.043
26 - 30	1.410	0.406	0.626	3.175
31 - 35	1.582	0.327	0.632	3.965
36 - 45	2.460	0.118	0.795	7.617
46 - 69	7.709	0.006	1.802	32.974
Marital Status				
Married	1.000	----	----	----
Never married	3.092	0.031	1.112	8.599
Cohabiting	0.984	0.977	0.320	3.018
Sep/Div/Wid	0.000	0.998	0.000	.
Education				
Primary or less	1.000	----	----	----
Secondary	0.482	0.127	0.189	1.230
Tertiary	0.977	0.961	0.387	2.469
Religion				
Christian	1.000	----	----	----
African traditional	2.188	0.038	1.044	4.582
Other Non Christian	2.564	0.029	1.099	5.983
Employment				
Employed	1.000	----	----	----
Unemployed	0.880	0.621	0.531	1.459
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.693	0.129	0.431	1.113
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	1.284	0.407	0.712	2.316
Father only	0.719	0.681	0.149	3.465
Both parents umarried	0.895	0.784	0.404	1.981
Extended	0.753	0.403	0.387	1.465

Table 37: Logistic Regression Odds Ratios of the Association between Masculinities and Sexual Practices: Casual Sexual Intercourse

Has had casual sexual intercourse two or more times in the past

			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	3.041	0.010	1.299	7.120
Age				
17 - 21	1.000	----	----	----
22 - 25	3.203	0.058	0.961	10.678
26 - 30	1.229	0.736	0.371	4.071
31 - 35	1.243	0.760	0.308	5.018
36 - 45	2.190	0.423	0.322	14.917
46 - 69	2.220	0.999	0.000	.
Marital Status				
Married	1.000	----	----	----
Never married	10.057	0.082	0.746	135.514
Cohabiting	5.110	0.245	0.327	79.960
Sep/Div/Wid	15.742	0.178	0.286	865.324
Education				
Primary or less	1.000	----	----	----
Secondary	0.000	0.999	0.000	.
Tertiary	0.000	0.999	0.000	.
Religion				
Christian	1.000	----	----	----
African traditional	7.539	0.006	1.788	31.783
Other Non Christian	4.557	0.049	1.010	20.564
Employment				
Employed	1.000	----	----	----
Unemployed	1.168	0.726	0.489	2.792
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.369	0.023	0.156	0.870
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	1.182	0.741	0.439	3.182
Father only	0.856	0.881	0.112	6.540
Both parents umarried	2.294	0.343	0.412	12.771
Extended	2.346	0.137	0.762	7.222

Table 38: Logistic Regression Odds Ratios of the Association between Masculinities and Sexual Practices: Lifetime casual sex partners

Has had two or more casual sexual partners ever

			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	0.626	0.220	0.296	1.324
Age				
17 - 21	1.000	----	----	----
22 - 25	1.597	0.415	0.518	4.924
26 - 30	1.750	0.326	0.573	5.342
31 - 35	0.999	0.998	0.287	3.479
36 - 45	2.380	0.292	0.474	11.946
46 - 69	15.303	0.084	0.695	336.738
Marital Status				
Married	1.000	----	----	----
Never married	3.544	0.156	0.617	20.361
Cohabiting	4.645	0.120	0.669	32.274
Sep/Div/Wid	0.227	0.369	0.009	5.746
Education				
Primary or less	1.000	----	----	----
Secondary	0.000	0.998	0.000	.
Tertiary	0.000	0.998	0.000	.
Religion				
Christian	1.000	----	----	----
African traditional	2.817	0.074	0.903	8.787
Other Non Christian	15.613	0.001	3.062	79.593
Employment				
Employed	1.000	----	----	----
Unemployed	0.478	0.074	0.213	1.073
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	1.097	0.818	0.498	2.415
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	1.014	0.975	0.420	2.452
Father only	0.055	0.052	0.003	1.026
Both parents umarried	1.032	0.966	0.240	4.434
Extended	0.409	0.090	0.146	1.150

Table 39: Masculinities and Sexual Practices: Anticipated future casual sexual partners

Anticipates to have two or more casual sexual partners in future

			95% C.I.for EXP(B)	
	Exp(B)	Sig.	Lower	Upper
Masculinity				
Positive	1.000	----	----	----
Negative	3.141	0.000	1.765	5.592
Age				
17 - 21	1.000	----	----	----
22 - 25	0.853	0.741	0.332	2.194
26 - 30	0.793	0.618	0.319	1.973
31 - 35	0.896	0.844	0.301	2.669
36 - 45	1.482	0.538	0.424	5.180
46 - 69	1.730	0.528	0.315	9.496
Marital Status				
Married	1.000	----	----	----
Never married	1.801	0.293	0.602	5.390
Cohabiting	0.447	0.218	0.124	1.608
Sep/Div/Wid	2.984	0.352	0.299	29.761
Education				
Primary or less	1.000	----	----	----
Secondary	0.429	0.123	0.147	1.258
Tertiary	0.806	0.694	0.274	2.369
Religion				
Christian	1.000	----	----	----
African traditional	2.548	0.023	1.138	5.704
Other Non Christian	9.246	0.001	2.511	34.045
Employment				
Employed	1.000	----	----	----
Unemployed	0.480	0.023	0.255	0.903
Place of Childhood Orientation				
Urban	1.000	----	----	----
Rural	0.647	0.138	0.364	1.150
Family of Childhood Orientation				
Both parents married	1.000	----	----	----
Mother only	1.008	0.982	0.485	2.097
Father only	3.544	0.285	0.349	35.954
Both parents umarried	0.594	0.318	0.213	1.651
Extended	0.642	0.256	0.299	1.380

8.0 References

AVSC International; International Planned Parenthood Federation, 1998, Literature Review for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms, Oaxaca Mexico.

Barker G & Ricardo C, 2005, Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict ad Violence

Barnett H, 1998 Introduction to Feminist Jurisprudence, Cavendish Publishing Limited, London.

Barter C., & Reynold E., 1999, The Use of Vignettes in Qualitative Research, Social Research Update, Issue 25, Summer 1999, accessed at http://www.soc.surrey.ac.uk/sru/SRU25.html on February 6th 2006

Binson D, Dolcini M.M; Pollark L.M. & Catania J.A. Multiple Sexual Partners Among Young Adults in High-Risk Cities, *Family Planning Perspectives*, Vol. 25, No. 6 Nov. – Dec., 1993, Guttmacher Institute

Bird S.R. 1996, 'Welcome to the Men's Club: Homosociality and Maintenance of Hegemonic Masculinity', *Gender and Society*, Volume 10 no. 2, pp120-132, accessed on JSTOR at http://www.jstor.org on 2005-12-07

Botswana, Government of, 2002 National Sexual and Reproductive Health Program Framework, Ministry of Health, Gaborone, Botswana

Botswana, Government of, 2003 Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS, National AIDS Coordinating Agency (NACA) Ministry of State President, Gaborone, Botswana

Botswana, Government of, 2003, Botswana National Strategic Framework for HIV/AIDS 2003-2009, National AIDS Coordinating Agency, Ministry of State

Botswana, Government of, 2003 Adolescent Sexual and Reproductive Health Implementation Strategy, Ministry of Health, Gaborone, Botswana.

Botswana, Government of, 2008 Stats Brief, Botswana AIDS Impact Survey – Preliminary Results, Ministry of Health, Gaborone, Botswana.

Botswana, Government of, 2004 Botswana Household Income and Expenditure Survey (HIES) 2002/03, Central Statistics Office, Gaborone Botswana

Brandth, B., & Kvande, 1998, E. 'Masculinity and child care: The reconstruction of fathering', *Sociological Review*, vol. 46 no. 2, pp293-313.

Brooks G.R., 2001, 'Masculinity and Mental Health', *Journal of American College Health*, Washington, vol. 49 pp285-306

Caldwell J.C. & Caldwell P, 1996 'Toward an Epidemiological Model of AIDS in sub-Saharan Africa', *Social Science History*, vol. 20 no.4 pp559-591

Campbell C. 1992, Learning to Kill? Masculinity, the Family and Violence in Natal, *Journal of Southern African Studies*, volume 18 no. 3 Special Issue: Political Violence in Southern Africa accessed online at: http://www.jstor.org/stable/2637301 on 11/02/2010

Careal M., 1995 Sexual Behavior, in JG Cleland & B. Ferry, (eds) Sexual Behavior and AIDS in the Developing World, Taylor and Francis, London.

Central Statistic Office, 2001, *Statistical Bulletin*, Volume 26 Number 1, Government Printer, Gaborone, Botswana.

Central Statistic Office, 2004, Botswana AIDS Impact Survey II, preliminary findings, Government Printer, Gaborone, Botswana.

Central Statistic Office, 2009, Botswana AIDS Impact Survey III (2008), Results Stats Brief, Government Printer, Gaborone, Botswana.

Cleaver F., 2001 Men and Masculinities: New Directions in Gender and Development, in *Masculinities Matter! Men, Gender and Development ed. F. Cleaver (pp1-27)* Zed Books, London

Connell R.W. The Social Organization of Masculinity accessed online at http://scholar.google.com/scholar?cites=11533269078471493656&hl=en&as_sdt=2000 on 17/02/2010

Connell, R.W., 1995. . Masculinities University of California Press, Berkeley, CA.

Courtenay W.H. 1998, 'College Men's Health: An Overview and Call to Action', *Journal of American College Health*, Washington, vol. 46 no. 6 pp279-299

Courtenay W.H., 2003, 'Key Determinants of Health and Wellbeing of Men and Boys', *International Journal of Men's Health*, accessed at www.findarticles.com on 2005-11-06

Courtenay W.H., 2000, 'Constructions of Masculinity and their influence on Men's Well-being: A theory of gender and health', *Social Science and Medicine*, Volume 50, no. 10, pp1385-1401

Davies J., McRae B.P., Frank J. & Dochnahl A., 20000, 'Identifying male college students' perceived needs, barriers to seeking help and recommendations to help them adopt healthier lifestyles', *Journal of American College Health*, Washington, vol. 48 no. 6 pp259-273.

Dixon-Mueller R. 1993 The Sexuality Connection in Reproductive Health, *Studies in Family Planning*, Vol. 24, accessed online at http://www.jstor.org/stable/2939221 on 15 January 2010

Dolan C, 2001 Collapsing Masculinities and Weak States in *Masculinities Matter! Men, Gender and Development ed. F. Cleaver (pp57-83)* Zed Books, London

Doucet A., 2004 " It's Almost Like I Have a Job, but I Don't Get Paid": Fathers at Home Reconfiguring Work, Care, and Masculinity, *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers*, Volume 2, # 3

Dudgeon M.D. & Inhorn M.C., 2004, 'Men's Influence on Women's Reproductive Health: anthropological Perspectives', *Social Science and Medicine* volume 59 no. 7, pp1379-1395.

Figueroa-Parea J. G., 2003, 'Gendered Perspectives on Men's Reproductive Health', *International Journal of Men's Health*, accessed from www.findarticles.com on 2005-10-15

Forrest K.A., 2001, 'Men's Reproductive and Sexual Health', *Journal of American College Health*, Washington, vol. 49 no. 6 pp253-275.

Gerschick T.J. & Miller A.S. 1995, Coming to Terms – Masculinity and Physical Disability in *Men's Health and Illness – Gender, Power and the Body* eds. D. Sabo & D.F. Gordon (pp 183-204), Sage Publications, London

Gerson, J.M. & Peiss, K., 1985. Boundaries, negotiation & consciousness: Reconceptualising gender relations. *Social Problems* 32 4, pp. 317–331.

Green M.E., 1998, Male Involvement in Reproductive Health: Translating Good Intentions into Gender Sensitive Programs, accessed at www.europrofem.org on 2005-10-10.

Gaillard et al, 2002 Vulnerability of Women in an African setting: Lessons for Mother-to-Child HIV transmission prevention programs, *AIDS*, Volume 16 #16, 12 April 2002

Good G.E., Dell D.M., & Mintz L.B. 1989 Male Role and Gender Role Conflict: Relations to help seeking in men, *Journal of Counseling Psychology*, Vol. 36 (3)

Good G.E. & Wood P.K. 1995 Male Gender Role Conflict, Depression and help seeking: Do College men face double jeopardy? *Journal of Counseling and Development*, Vol. 74 (1)

Green M.E. & A.E. Biddlecom, Absent and Problematic men: Accounts of Male Reproductive Roles, Population and Development Review volume 26 number 1, March 2000 p81-115.

Gupta G. R., 2000, Approaches for Empowering Women in the HIV/AIDS Pandemic – A Gender Perspective, paper presented at the Expert group meeting of the United Nations Program On HIV/AIDS Pandemic and Its Gender Implications, Windhoek, Namibia, 13-17 November 2000 EGM/HIV-AIDS/2000/EP 4 - 1 No 2000 accessed from http://www.findArticles.com on 6th December, 2005

Halperin D.T. and H. Epstein, 2006 Concurrent Sexual Partnerships help to explain Africa's high HIV prevalence: Implications for prevention, downloaded on 18 October 2009 at http://www.sceincedirect.com/sceince

Harris R.J. & J. M. Firestone, 1998 Changes in Predictors of Gender Role Ideologies Among Women: A Multivariate Analysis, *Sex Roles*, Volume 38, Numbers 3-4, 239-252

Hawkins 1996 Resources in Social Development Practice Volume 1: Participatory Design and Monitoring of Reproductive Health Projects, Swansea: University of Wales, Center for Development Studies, Swansea

Helgeson V.S, 1995, Masculinity, Men's Roles and Coronary Heart Disease in *Men's Health and Illness – Gender, Power and the Body, eds.* D. Sabo & D.F. Gordon (pp 68-104) Sage Publications, London

Hondagneu-Sotello P. & Messner M.A., 1997, Gender Displays and Men's Power – The New man and the Mexican Immigrant Man, in *Gender Through the Prizm of Difference,* eds. M.B Zinn; P Hondagneu-Sotello & M.A. Messner, (2nd ed., Pp63-74), Allyn and Baconand, Boston.

Horwitz A.V. & White H.R., 1987, 'Gender Role Orientations and Styles of Pathology among Adolescents' *Journal of Health and Social Behaviour*, Volume 28 No. 2 pp158-170.

Hunter, M. 2005 Cultural Politics and Masculinities: Multiple-partners in historical perspective in KwaZulu Natal, Culture, Health and Sexuality, volume 7 (4), July-August 2005.

Inhorn M 2004 Middle Eastern Masculinities in the Era of New Reproductive Health Technologies: Male Infertility and Stigma in Egypt and Lebanon, *Medical Anthropology Quarterly*, Volume 18 Issue 2 accessed online on 15 February 2010

Jobson G. 2009 Changing Masculinities: Land use, family communication and prospects for working with older men towards gender equality in a livelihoods intervention, Culture, Health & Sexuality Vol. (http://www.informaworld.com/smpp/title~db=all~content=t713693164~tab=issueslist~branches=12 - v1212) 3

Kenway J. & L Fritzclarence, 1997 Masculinity, Violence and Schooling: Challenging Poisoned Pedagogues, *Gender and Education*, volume 9 #1

Kgwatalala D.L., 2009 Male Involvement in the Prevention of Intimate Femicide in Botswana, in Maundeni, Osei-Hwedie, Mukamaambo & Ntseane (eds) 2009 *Male Involvement in Sexual and Reproductive Health: Prevention of Violence and HIV/AIDS in Botswana*, Made Plain Communications, Cape Town 7700.

Kimmel, M.S., 1986. Introduction: toward men's studies. American Behavioural Scientist 29 5, pp. 517–529

Kimmel M.S., 2001 Global Masculinities: Restoration and Resistance, in *A Man's World? Changing Men's Practices in a Globalized World eds. B. Pease & K Pringle (pp21-37)* Zed Books, London

Klein A.M. 1995, Life is Too Short to Die Small – Steroid Use among Male Bodybuilders in *Men's Health and Illness – Gender, Power and the Body, eds.* D. Sabo & D.F. Gordon,(pp 105-120) Sage Publications, London .

Kulik L. 2004, 'Predicting Gender role identities among husbands and wives in Israel', *Journal of Sex Roles Research,* accessed from www.findarticles.com on 2005-07-08

Langeni TT, 2003 Ramifications of Ostracism as a Consequence of HIV positive status: Its Effect on Individuals and Families in Botswana, *Canadian Studies in Population*, Volume 30 #1, 2003

Levinson R.A., Sadigursky C. & G. M. Erchak 2004 The impact of cultural context on Brazilian adolescents' sexual practices, *Adolescence*, Summer, 2004 accessed online at **http://findarticles.com/p/articles/mi_m2248/is_154_39/ai_n6364172/pg_2/?tag=content;col1** On 15 March 2006

Lindsay L. & Stephan F. Miescher 2003, (abstract) Men and Masculinities in modern Africa, Portsmouth, New Hempshire, Heinemann, 2003, in *African Studies Quarterly*, Volume 8 Issue 2.

Lindsay L., 1990, Men and Masculinity, in *Gender Roles: A Sociological Perspective, ed.* L. Lindsay, Prentice-Hall Incorporated, NJ. USA.

Lundgren, 2000, Research Protocol to Study Sexual and Reproductive Health of Male Adolescents and Young Adults in Latin America, Division of Health Promotion and Protection, Family Health and Population Program, January 2000.

MacPhail C. 2003 Challenging dominant norms of masculinity for HIV prevention, *Journal of AIDS Research*, volume (2) number (2), South Africa.

Mane P & P Aggleton, 2001 Gender and HIV/AIDS: What Do Men have to Do with it? *Current Sociology* Nov 2001 vol. 49 no. 6 23-37

Maundeni T. & Mookodi B.M. (2009) Socio-Cultural Factors that Place Males at Risk of HIV Infection in Botswana – Implications for Sexual and Reproductive Health Strategies in Maundeni, Osei-Hwedie, Mukamaambo & Ntseane (eds) 2009 *Male Involvement in Sexual and Reproductive Health: Prevention of Violence and HIV/AIDS in Botswana*, Made Plain Communications, Cape Town 7700.

Messner M. 1990, When Bodies are Weapons: Masculinity and Violence in Sport, *International Review of the Sociology of Sport*, volume 25#3

Miedzian M. 2002, Boys will be Boys: Breaking the link between Masculinity and Violence, Lantern Books, one Union Square West, Suite 201, NY, NY 10003

Mmonadibe P.N. (2009): Couples Counseling- A tool for promoting male involvement in HIV and AIDS Management in Botswana, in Maundeni, Osei-Hwedie, Mukamaambo & Ntseane (eds) 2009 *Male Involvement in Sexual and Reproductive Health: Prevention of Violence and HIV/AIDS in Botswana*, Made Plain Communications, Cape Town 7700.

Mobley C., 2001, 'The Impact of Community Colleges on the School-to-Work Transition: A multilevel Analysis', *Community College Review*, Spring, accessed from www.findarticles.com on 2005-07-08

Mookodi G. 2005 Understanding Male Sexuality: The Weak Link in Sexual and Reproductive H Health and HIV Interventions in Botswana, *Botswana Review of Ethics and Law* Volume 1 No. 1

Morrell R., 2003 Silence, Sexuality and HIV/AIDS in South African Schools, *The Australian Educational Researcher*, Volume 30 Number 1, accessed at http://www.aare.edu.au/aer/online/30010e.pdf on 2005-11-05

Morrell R. (2001), Changing Men in Southern Africa (an abstract) ed. R. Morrel, Zed Books

Morris M.A., 2002 A Comparative Study of Concurrent Sexual Partnerships in the United States, Thailand and Uganda, American Sociology Association Meeting published abstracts, Anaheim, California August 18-21, 20032, Session 409

Mvududu S. & McFadden P, (no year), Reconceptualizing the Family in a Changing Southern African Environment, Women in Law in Southern Africa Research Trust.

Nicholas W., Phillippe Bourgois & Margarita Loanaz, 2004, 'Masculinity and Undocumented Labour Migration: Injured Latino Day Labourers in San Francisco', *Social Science and Medicine*, Volume 59 no. 6, pp1150-1168.

Ntseane P. 2004 Cultural Dimensions of Sexuality: Empowerment Challenge for HIV/AIDS Prevention in Botswana, accessed online at http://www.unesco.org/education/uie/pdf/Ntseane.pdf On 12-05-2006

Nyblade L & Field-Nguer ML., 2001, Women, Communities and the Prevention of Mother-to Child Transmission of HIV, International Center for Research on Women &, The Population Council.

O'Brien R., Hunt K., & G. Hart, 2005 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking; *Social Science & Medicine* Volume 61, Issue 3, Pp 503-516

Odimegwu C. & Okemgbo C. 2005, Our Culture; Our Behavior and Our Health: Conspiracy of Indifference, a paper presented at the XXVth IUSSP Conference, Tours, France 18-23 July.

Odimegwu C.; Okemgbo C. & Pallikadavath S., 2005, What is the Cost of Being a Man? An Analysis of Social and Health Consequences of Masculinity in Nigeria; paper presented at the XXVth IUSSP Conference, Tours, France 18-23 July.

Odimegwu C. & C. Okemgbo 2008 Men's perceptions of masculinities and sexual risks in Igboland, Nigeria, *International Journal of Men's Health*, Spring 2008, accessed online at http://findarticles.com/articles/mi_1_7/ai_n25378703

Olawoye J.E. Omololu F.O. Adrinto Y; Adeyefa I & Adeyemo D; 2004, Social Construction of Manhood in Nigeria: Implications for male Responsibility in Reproductive Health; *African Population Studies*, October 2004 volume 19 No. 2, accessed from www.uaps.org/journal on 2005-09-08

Orubuloye I. O., Caldwell J.C. & P. Caldwell 1998 Perceived Male Sexual Needs and Male Sexual Behaviour in Southwest Nigeria accessed online at www.sciencedirect.com/science? July, 2006

Pettifor A.E., 2005, 'Sexual Power and HIV Risk in South Africa', *Emerging Infectious Diseases*, accessed from http://www.findArticles.com on 6th December, 2005

Pettifor A.E., Rees H.V. and A. Steffenson, 2004 HIV and Sexual Behavior among Young South Africans, A National Survey of 15-24 year olds, University of the Witwatersrand, Johannesburg, accessed on September 2009 (http://www.rhru.co.za/site/publications.asp

Pitso JMN & Rakgoasi SD. 2003 Knowledge of HIV/AIDS and Sexual Practices of Youths in Botswana: Does sufficient knowledge of HIV/AIDS translate into safer sexual practices? Botswana AIDS Impact Survey Dissemination Report 2004, Central Statistics Office, Gaborone, Botswana.

Pleck J.H. 1987, The Theory of Male sex-Role Identity: Its Rise and Fall, 1936 to the Present, in *The Making of Masculinities* ed. H Brod, (pp21-38) Allen and Unwin Inc, Boston.

Pleck, J.H., 1987. The Myth of Masculinity (3rd ed. ed.), M.I.T. Press, Cambridge, MA.

Pleck, J.H., Sonenstein, F.L. and Ku, L.C., 1994. Problem behaviours and masculinity ideology in adolescent males, in: Ketterlinus, R.D. & Lamb, M.E. (Eds), 1994. Adolescent Problem Behaviours: Issues and Research Lawrence Erlbaum, Hillsdale, NJ, pp. 165–186.

Prasad P., 2005, Measurement of gender-role attitudes, beliefs and principles, accessed at www.sas.upenn.edu on 2005-11-12

Rakgoasi S.D., & Campbell E.C., 2004, Botswana Adolescent Sexual and Practice and Health, Study Report, UAPS Small Grant Programme, *Union of African Population Studies*, no. 54.

Redman P, 1996 'Empowering men to disempower themselves': heterosexual masculinities, HIV and the contradictions of anti-oppressive education, in Understanding Masculinities, in Ghaill, M. Mac an (ed) (pp168-179) Open University Press, Buckingham.

Rivers K. and Aggleton P., 2002, Working with Young Men to Promote Sexual and Reproductive Health, Thomas Coram Research Unit, Institute of Education, University of London

Robertson J.M. & Fitzgerald L.F.. 1992 Overcoming the masculine mystique: Preferences for alternative forms of assistance among men who avoid counseling, *Journal of Counseling Psychology* Vol. 39(2)

Robinson P. Race and Theories of Masculinities (n.d.) Race, Ethnicity and Class in Contemporary Societies, paper originally written to fulfill requirement of 53.544 class Race, Ethnicity and Class in Contemporary Societies, Carleton University, accessed from www.europrofem.org on 2005-08-16

Sabo D., 1999, 'Understanding Men's Health: A relational and gender sensitive approach', *Harvard School of Public Health Working Paper Series* no. 99 no.14.

Sabo D. & Gordon D.F., 1995 Rethinking Men's Health and Illness – Relevance of Gender Studies, in *Men's Health and Illness – Gender, Power and the Body*, eds. D. Sabo & D.F. Gordon (pp 1-21) Sage Publications, London

Sabo D., 2000, 'Men's Health Studies: Origins and Trends', *Journal of American Colleges Health*, Washington, vol. 49, no.3 pp133-149

Selolwane, O.D. 2004, The Emang Basadi Women's Association. website, accessed on 04/21/2006

Shears K.H. 2004 Assessing Men's attitudes about gender roles, *Network* 2004, Vol. 23 No. 3: p31

Sideris T. 2003 Non-Violent Men in Violent Communities: Negotiating the Head and the Neck accessed from www.findarticles.com on 2005-11-12

SilberSchmidt M. 2004 Men, male sexuality and HIV/AIDS: Reflections from studies in rural and urban East Africa, *Transformation: Critical Perspectives on Southern Africa* 54, 2004, pp. 42-58

Somma D B and Bodiang C (2003) The Cultural Approach to HIV/AIDS Prevention, Swiss Agency for Development and Cooperation/Swiss Centre for International Health, Swiss Tropical Institute, Geneva accessed at: http://www.sdc-health.ch/priorities_in_health/communicable_diseases/hiv_aids/cultural_approach_to_hvi_aids_prevention on 23 March 2007

Sternberg P. 2000 Challenging Machismo: Promoting Sexual and Reproductive Health with Nicaraguan Men, *Gender and Development*, Vol. 8, No. 1, [Globalization and Diversity] (Mar., 2000)

Sternberg P. & J. Hubley 2004, Evaluating men's involvement as a strategy in sexual and reproductive health promotion, *Health Promotion International* Vol. 19. No. 3

Tierney H. ed. 1991 Women's Encyclopedia

United Nations, 2001, 'Re-defining Masculinity in the Era of HIV/AIDS' – Regional HIV/AIDS Conference on Men and HIV/AIDS, *United Nations Integrated Regional Information Networks (IRIN)*, Regional AIDS Initiative of Southern Africa of Voluntary Services Overseas (RAISA/VSO), Pretoria, South Africa.

UNFPA, Government of Botswana, Country Report 2003, International Conference on Population and Development, Gaborone, Botswana.

UNAIDS, 1997 Communications Framework for HIV/AIDS, A New Direction, accessed online at http://data.unaids.org/publicatons/IRC-pub01/JC335-CommFramew_en on 10/12/2009

Varga C.A., 2001 The Forgotten Fifty Percent: A Review of Sexual and Reproductive Health Research and Program focused on Boys and young men in Sub-Saharan Africa, *African Journal of Reproductive Health*, December 2001 Vol. 5 No.3 Women's Health and Action Research Centre

Varga C.A., 2003, 'How Gender Roles Influence sexual and Reproductive health among South African Adolescents', *Studies in Family Planning*, Vol. 34 no. 3 pp160-172.

Varga C. 1999, South African young people's sexual dynamics: Implications for behavioral responses to HIV/AIDS, in Caldwell J, Caldwell P. Anarfi J. Awusabo-Asare K. Nozi J. Orubuloye I. March J. Cosford W. Colombo R & Hollings E, eds *Resistance to Behavior Change to Reduce HIV/AIDS Infections in Predominantly Heterosexual Epidemics in Third World Countries*, Canberra, Health Transitions Centre.

Verma R.K; Sharma S.; Singh R. Rangaiyan G & P.J. Pelto, 2001, Beliefs Concerning Sexual Health Problems and Treatment Seeking Among Men in an Indian Slum Community, paper presented at the 3rd IASSCS Conference, Melbourne, Australia.

Walter N, Bourgois P & H Margarita Loinaz, 2004 Masculinity and Undocumented Labor Migration: Injured Latino Day Laborers in San Francisco, *Social Science & Medicine*, accessed online at: Social Science & Medicine, Volume 59, Issue 6, pp 1159-1168

Weiss 1994 Learning from Strangers: The Art and Method of Qualitative Interview Studies, Simon & Schuster Inc New York, NY

White, S.C. 1997 Men, Masculinities and the Politics of Development, in C. Sweetman (editor), Men and Masculinity, Oxford: Oxfam

WHO 2000. What about boys? A Literature Review in the Health and Development of Adolescent Boys, WHO, Geneva, Switzerland

Wood K & Jewkes R, 1997 Violence, rape and sexual coercion: everyday love in a South African township. *Gender and Development* 1997 Vol 5:41-46.

Appendix 2 Tools – Study Consent form

INFORMED CONSENT FORM & SUBJECT INFORMATION SHEET

Sponsor: University of Botswana.

Principal Investigator: Serai Daniel RAKGOASI

(267) 72467284

(+27) 072 020 6919

E-mail: sdrakgoasi@yahoo.co.uk

rakgoasi@mopipi.ub.bw

Introduction

This Consent Form contains information about this research. In order to be sure you are informed about being in this research, we are asking you to read (or have read to you) this Consent Form. I will ask you to say out loud in front of two persons whether you agree to be part of this study or not. You may chose to given written consent, by signing this form or give verbal consent.

I will give you a copy of this form, please feel free to ask me to explain anything you may not understand.

Sponsor

This research is sponsored by the University of Botswana. The research is carried out as part of the principal researcher's fulfillment of requirements for a PhD. The University of Botswana is a government sponsored institution of higher learning in Botswana.

Reason for the Research

I humbly invite you to take part in this research to help us understand how ideas about masculinity might influence men's health as well as utilization of HIV/AIDS services. Your taking part in this research will help us to understand important issues relating to men, their attitudes towards health and HIV/AIDS as well as how ideas about manhood influences the use of HIV/AIDS and related services in Botswana.

Botswana is currently inundated by a multiplicity of poor health outcomes resulting mainly from the HIV/AIDS epidemic. At the same time, men play very important multiple roles that may influence the extent of utilization of HIV/AIDS related services. Men are mostly policy makers; policy implementers; partners / husbands; heads of households; civic leaders and consumers of sexual and reproductive health services. It is very clear that in most cases, men influence women's use of sexual and reproductive health services, including HIV/AIDS services. However, except for a few cursory referrals to men, many family planning and reproductive health studies have not dedicated much attention to understanding men's views, problems; perceptions and motivation in sexual and reproductive health.

What is involved in the study?

If you agree to be part of the study, you will be asked some questions relating to men, masculinities, health and HIV/AIDS generally. The interview should last between 45 minutes and 1 hour. If you choose to participate, I will ask you tell me about your views and personal experiences regarding the subject. Please remember that you are the expert and I am here to learn from you. Please don't tell me what you think I might want to hear. Tell me what you really think. Tell me your views no matter what they are and remember that I am not looking for right or wrong answers. Not everyone in the community will be included in this study. You were chosen as random from a list of households in this area.

Your Part in the Research

If you agree to be involved in this research, I will invite you to discuss a number of issues or provide answers to specific questions. The interview is expected to last anything between 45 to 60 minutes.

Participation is voluntary

Your participation in this research is completely voluntary, and you may opt out of the interview at any time. If you choose not to participate, your refusal will involve no penalty or loss of any benefits that you might be entitled to. I will not view you in any negative light if you exercise your right not to be part of the study.

Possible risks

Some questions in the study may make you feel uncomfortable or embarrassed. Some of the questions may require you to recall certain events in the past that may cause you discomfort. You do not have to answer any questions that you do not want to. We can skip any questions that you feel uncomfortable answering. You can also stop the interview at any time.

Possible Benefits

There are no direct benefits of participating in this study, either to you or members of your family. The information you provide however, will help us understand men's views and how their attitudes affect the use of health services, especially HIV/AIDS related services. Such information will also help us understand men's problems and issues and help in designing new programs or upgrading existing ones to make them more inclusive and responsive to men's needs.

If You Decide Not to Be in the Research

You are free to decide if you want to be in this research. Your decision will not affect you in any way.

Confidentiality

We will protect information about you and your taking part in this research to the best of our ability. Your full name will not be recorded anywhere. All records of your interviews will be kept in a safe place under lock and key protection. The information that you provide will be analyzed and the results presented in a manner that will not link you to your responses However, absolute confidentiality cannot be guaranteed. Personal information maybe disclosed if required by law, especially in cases where the interview process unearths evidence of serious infringement of the law.

Compensation

There is no monetary compensation associated with your participation in this research. However, you can be reimbursed for out of pocket expenses, such as transport cost associated with your participation in this research. This is no way constitutes reimbursement for participating in the research.

In case of adverse response to methods of study

The study project will assist with transportation and the initial consultation and evaluation costs by a specialist in cases where the study methods trigger an adverse reaction that requires such intervention. However, budgetary limitations preclude the payment of long term and continuing professional care from this project

Alternatives to Participation

You do not have to participate in the research. Your decision not to participate in the research will not affect you in any negative way. The research team will not hold any negative views or any grudge should you decide not to participate in the research.

Leaving the Research

If you choose to take part, you can change your mind at any time and stop the interview.

If You Have a Problem or Have Other Questions

VOLUNTEER AGREEMENT

The above document describing the purpose; benefits, risks and procedures for the research study has been read and explained to the volunteer. I am convinced he/she understands the activities that will occur. S/he agrees to participate as a volunteer.
I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual. He/she has not been coerced and given his/her oral consent to participate in this study.

Printed Name of Person who Obtained Consent

_____ _____

Signature of Person who Obtained Consent **Date**

I was present throughout the entire informed consent process with the volunteer. All questions from the volunteer were answered and the volunteer has agreed to take part in the research.

_____

Printed Name of Witness

Signature of Witness **Date**

Appendix 3 Tools - Household Questionnaire

TIME BEGUN: _____ HOUSEHOLD ROSTER AND SELECTION OF INDIVIDUALS

[IF NO, END THE INTERVIEW. IF YES, CONTINUE. INTERVIEWER SIGN HERE TO ACKNOWLDEGE THAT CONSENT WAS GIVEN _____].

Identification information				
Town / Village _____				
Locality _____				
Enumeration Area _____				
Plot / Dwelling no. _____				
Household number _____				
Household Headship ……*Male* _____ *Female* _____				
Age of head of household _____ *years*				
Interviewer's identification and record of visits				
Visit no.	**1**	**2**	**3**	
Date	Date _____	Date _____	Date _____	Date _____
Interviewer's name	_____	_____	_____	_____
Identification code				
Result	_____	_____	_____	_____
Result codes 1. Completed 2. Present but not at home 3. Refused 4. Postponed 5. Partly completed 6. Other (specify)_____				

First, please give me the names of the persons who usually live in your household, starting with the head of the household.

FIRST RECORD ALL NAMES STARTING WITH THE HEAD. PROBE FOR EVERYONE IN THE HOUSEHOLD NOT JUST FAMILY MEMBERS, E.G SERVANTS, LODGERS ETC.

Line number Usual members	Relation to head of house-hold	Age	Sex 1= M 2= F	Does [name] attend school? 1= Yes 2= No	Employment [Under 17]; Is [NAME] employed? 1= Yes 2= No	Is [NAME} illegible for interview? 1= Eligible 2= Not eligible	Transfer line number to individual questionnaire	Notes
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[9]	

Q.2 CODES FOR RELATIONSHIP TO HEAD OF HOUSEHOLD

01= HEAD 05= GRANDCHILD 10= OTHER RELATIVE Record 00 if parent is not a member of the household

02= WIFE/HUSBAND/SPOUSE 06= PARENT 11= ADOPTED/FOSTER/STEP CHILD

03= SON/DAUGHTER 07= PARENT-IN-LAW 12= NOT RELATED

04= SON-IN-LAW OR DAUGHTER-IN-LAW 08= BROTHER OR SISTER 09=GRANDPARENT 98= DON'T KNOW

N.B. Please use additional form in cases where there are more than ten members of household

Household facilities

Type of house [main house]	Number of rooms	Source of Water Supply	Source of energy for:		Toilet facilities	Access to media	Transport facilities
Lolwapa Detached house Semi detached house Town house Flat Rooms Servant's quarters Part of commercial building Shack 10.Other _____	In main house ____ In household ____	Piped indoors Stand pipe in plot Stand pipe outside plot Borehole / well River Dam / lake	**Cooking** Electr mains Electr solar Gas Paraffin Wood charcoal / coal Other _____	**Lighting** Electr mains Electr solar Gas Paraffin Wood charcoal / coal Other _____	Own flush Own pit latrine Neighbour's Communal flush Communal pit Bush Other _____	Does any member of this household have access to the following Working radio Working TV Telephone Cell phone Printed media Electronic media	Does any member of this household have access to the following Motor vehicle Tractor Motor cycle Bicycle Donkey cart Donkeys / horses Camels

Instructions

Circle the number corresponding to the appropriate response. Where more than one answer is applicable, probe for the most important.

Household poverty assessment

Over the last year, how often have you or your household gone without :						
	Never	Once or twice	Several times	Often	Always	DK
Enough food	1	2	3	4	5	6
Enough clean water	1	2	3	4	5	6
Medicines	1	2	3	4	5	6
Enough fuel for cooking	1	2	3	4	5	6
Cash income	1	2	3	4	5	6
Money for school fees & other expenses	1	2	3	4	5	6
Circle the number corresponding to the correct answer						

Health & Health seeking

Below please list any member of this household who has experienced some sickness or death in the past 12 months						
	For how many days was [name] sick	How long after falling sick did [name] seek treatment?	Did [name] need to seek permission to go for treatment	Was [name] eager to go for treatment?	Is [name] still alive?	Sex
	_____days	_____wks	Yes No	Yes No	Yes No	1.M 2.F
	_____days	_____wks	Yes No	Yes No	Yes No	1.M 2.F
***NB**: Remember to transfer the line number of the eligible person to the individual questionnaire,*						

Appendix 4 Tools - Individual Questionnaire

IDENTIFICATION

Serial Number				

Town / Village _____

Locality name _____

E.A. no. _____

Plot / dwelling no. _____

Household no. _____

Respondent's line no. [from household questionnaire] _____

Interviewer's identification and visits record

Visit no.	1	2	3	Final visit
Date	Date _____	Date _____	Date _____	Day _____
Interviewer's name	_____	_____	_____	Month Year
Interviewer's ID	_____	_____	_____	_____ Interviewer ID
Result	_____	_____	_____	_____ Result _____

Results codes
Completed
Present but not found home
Refused
Postponed
Partly completed
Other

If found please Send to:
Serai D. Rakgoasi,
Department of Demography & Population Studies
Wits University
Tel: +27 078 311 8079

Supervisor	Field Editor	Office Control	Keyed by:
Name:_____ Date: _____	Name:_____ Date: _____		

Section 1: Masculinities; Gender and Relationship norms

In the following section, on a scale of 1 to 5, where 1 indicates "*complete agreement*" and 5 represents "*complete disagreement*", rate your response to the following items			
	Men are generally superior to women	1 2 3 4 5	
	It is okay for women to work outside the household, but men should always be heads of households	1 2 3 4 5	
	Boys / men should be tough and not show any emotions	1 2 3 4 5	
	It is unmanly to frequently seek medical and other professional services for minor illnesses	1 2 3 4 5	
	Men need sex more than women do	1 2 3 4 5	
19	Men have less self control than women when it comes to sex	1 2 3 4 5	
	It is okay for a man / boy to hit his girlfriend / partner if she: goes out without him refuses to have sex with him wants to terminate the affair talks back at him during an argument fails to take care of children	 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	
	It is sometimes justifiable to use violence against your partner	1 2 3 4 5	
	On a scale of 1 to 5, where 1 indicates that you agree and 5 that you disagree the following statement about sexual relations between men and women: Women find sexual coercion stimulating Men are sexually stimulated by sexually coercing women A woman can sometimes pretend she doesn't want to have sex, and expect the man to coerce her	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	
	It is important for a man to be (a) Strong and self sufficient	 1 2 3 4 5	

	(b) Be aggressive (c) Independent	1 2 3 4 5 1 2 3 4 5	
	Men who have sex with men are not real men	1 2 3 4 5	
	Homosexuality should be legalized in Botswana	1 2 3 4 5	
	A man or boy needs to have a number of sexual partners to prove their manhood	1 2 3 4 5	
	Girls should remain virgins until marriage	1 2 3 4 5	
	Boys should remain virgins until marriage	1 2 3 4 5	
	It is okay for a man to have multiple partners so that he can decide who he wants to marry / stay with	1 2 3 4 5	
	It is desirable to me for a woman to be strong and self sufficient	1 2 3 4 5	
	If I went to my partner's home and she was not there, she would be I trouble	1 2 3 4 5	
	I sometimes get angry in such a way that I hit my partner	1 2 3 4 5	
	Both partners have a right to a say making decisions in a relationship	1 2 3 4 5	
	It is a good thing that women now have more rights than ever before	1 2 3 4 5	
	No one partner should have more power than the other in a relationship	1 2 3 4 5	
	We are both free to say if we don't want sex	1 2 3 4 5	
	It is very important that woman be as happy as a man in a relationship	1 2 3 4 5	
	Only a bad girl shows that she likes sex a lot	1 2 3 4 5	
	If a girl initiates sex, its because she has other boyfriends	1 2 3 4 5	
	A woman who want to have sex is failing to control herself	1 2 3 4 5	
	If I did not have partner at all, I would not feel like a real person	1 2 3 4 5	
	I don't think a person can survive without having someone to love	1 2 3 4 5	
	I would die for my love	1 2 3 4 5	

Section 2: Sexual practices

	Do you have a girlfriend / partner / wife?	Yes……1 No……2	If NO go to 32
	What is the gender of your partner	Male ……1 Female …… 2 Refused to say……..3	
	Have you ever had sex?	Yes……1 No……2	If NO go to 35
	Have you had sexual intercourse in the past 12 months?	Yes……1 No……2	
	During the past 12 months, how many sexual partners have you had in total?	_____	
	Have you ever had more than one sexual partner at a time?	Yes……1 No……2	
	How many girlfriends / sexual partners have you ever had in your life?	_____	
	How many girlfriends / partners / sexual partners do you currently have?	_____	
	How many sexual partners do you think you will ever have in your life in total, (excluding those you have already had?)	_____	
	Have you ever had casual sexual intercourse with someone who is not your partner?	Yes……1 No……2	If No go to 43
	If yes, how many times has this happened in the past 12 months?	Times _____	
	How many casual sexual partners have you ever had in your life?	Number _____	
	Did you use a condom then?	Yes, with all ……1 Yes, with some …2	

		No……3	
	Looking ahead, how many casual sexual encounters do you think you will ever have in your life (excluding those you have already had)	_____	
	Have you ever had sex when you were drunk?	Yes……1 No……2	If NO go to 49
	The last time you had sex when you were drunk; who did you have sex with? (partner)	Regular……1 Non regular……..2 Both……3	
	The last time you had sex when you were drunk, was your partner also drunk?	Yes, partner was drunk…… 1 Yes, both drunk …..2 No ……..3	
	Did you regret / or have any feeling of remorse after having casual sex?	Yes……1 No……2	
	Did you use a condom then?	Yes……1 No……2	
	Have you ever had to pay someone to have sexual intercourse with you?	Yes……1 No……2	If NO go to 53
	How many times have you paid someone to have sex with you?	_____	
	In the past 12 months, how many times have you paid someone for sex?	_____	
	When you paid someone to have sex, did you use a condom?	Yes, always……1 Yes, sometimes…..2 No, never…… ...3	
	During the last 12 months, have you done any of the following: (with a man or a woman) Been in a physical /fist fight?	Times Yes....1 ___ No…..2 Yes....1 ___ No…..2	

	Threatened someone /fist/knife? Verbally threatened someone? If yes to anyone of these, indicate the number of times this happened	Yes....1 ___ No.....2 _____	
	Have you ever slapped your partner or used violence against her?	No, never Yes, previous Yes, current	
	Have you ever taken alcohol	Yes……1 No……2	If NO go to 59
	Do you usually drink alcohol?	Yes……1 No……2	
	On average, how frequently do you drink alcohol?	_____per week	
	How many drinks do you usually take per session? [beers / Chibukus]	_____/ session	

Section 3: HIV/AIDS

	What are the different ways of preventing HIV infection? [Ask for more than one / three main ways]	Consistent condom use Being faithful to 1 uninfected partner Abstinence Other_____ _____ _____	
	How can HIV be transmitted from one person to the other? [Multiple answers]	Unprotected sex Blood /needles Mother to child Other _____	
	Can HIV be transmitted through: Sharing a meal with an infected person? Sharing utensil / toilet facilities Witchcraft Mosquito bites	 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No	
	How serious a problem is HIV in your community?	Very serious……1 Serious……..…2 Not serious……3	
	How much do you consider yourself to be at risk of infection of HIV?	Highly at risk……..1 At risk…..……2 Low risk……..3 Not at risk……..4	
	In your view, what are the main factors behind the current HIV/AIDS epidemic in your community?	1_____ 2_____	

		3_____	
	What are you currently doing to protect your partner / family from HIV infection?	Being faithful Using condoms VCT Other (explain) _____	
	What HIV/AIDS programs and services in your community are you aware of?	VCT[11] PMTCT OVC HBC Prevention & Treatment of TB STDs Other (explain) _____	
	Have you ever tested for HIV	1. Yes 2. No	If NO go to 69
	If yes, did you test in the past 12 months?	1. Yes 2. No	
	Have you encouraged /advised any member of your family to use any of the HIV/AIDS prevention; treatment or care services?	1. Yes 2. No	If NO go to 71
	Which family member did you encourage / advice to use VCT services?	_____ _____	
	Have you ever encouraged your partner to take an HIV test?	1. Yes 2. No	
	In your view, have the current HIV/AIDS programs helped to:		

[11] Enumerators will be provided with an attachment that explains the abbreviations used here, together with their interpretation into Setswana.

	Reduce the spread of HIV Reduce risky sexual behaviour among women Reduce risk sexual behaviour among men? Ensure equality between men and women in negotiating for safe sex? Improved gender relations within marriage / cohabiting unions? Given men more control over sexual relations	1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No	
	Are you interested in learning more about HIV/AIDS?	1. Yes 2. No	
	Have you ever accompanied your partner to the ante natal clinic?	1. Yes 2. No	If NO go to 76
	How frequently do you accompany your wife / partner to ANC?	1. Always 2. Sometimes 3. Hardly ever 4. Never	
	How do you feel about accompanying your partner to the ante-natal clinic if she was pregnant? [If you have never done it...How would you feel about accompanying your partner?]	_____ _____ _____	
	What would you do if your partner: a) Underwent HIV testing without informing you?	**Accept** **Not accept** 1 2	

	b) Tested HIV positive? c) Tested HIV positive and you are negative? Tested HIV negative and you are positive?	1 2 1 2 1 2	
	Do you think HIV/AIDS programs should also try to address the fact that men have far greater power and privilege over women?	1. Yes 2. No	
	In your view, are men utilizing HIV/AIDS services at the level expected?	1. Yes 2. No	
	In your view, what are the main reasons why men might not use these services as much as expected?	1. Men are too busy 2. Men are unwilling /stubborn 3. Culture dictates so 4. Afraid 5. Men feel left out 6. Other (specify) _____	
	What changes to current HIV/AIDS programs would you suggest in order to increase men's participation in these programs?	_____ _____	
	What are your three main sources of information on HIV/AIDS? [Try to identify the MAIN source]	Radio / TV Newspapers/ magazines Friends Wife/partner School Health facility / clinic Other _____ Specify	
	In your view are men motivated to use VCT services?	Yes……1 No……2_Explain	

		_____ _____	
	Do you think homosexuality should be legalized?	Yes……..……1 No…….……2	
	Please explain your answer above	_____ _____	

Section 4: Health & Help Seeking

	How would you rate your overall health?	Very good……..1 Good……..2 Fair……..3 Poor……..4	
	During the last 12 months, have you had a serious illness or injury?	Yes, illness……..1 Yes, injury……..2 Yes, both ……..3 No……..4	If NO go to 91
	Did you seek medical / professional help for the illness / injury?	Yes……..1 No ……..2	
	How many days after the injury / onset of illness did you seek medical / professional help	_____Days	
	What was the reason for seeking help in the time you did?	_____ _____	
	Have you ever had physical exam?	1. Yes 2. No	
	If yes, did you have the physical exam during the last 12 months?	1. Yes 2. No	
	During the last 12 months, have you ever experienced Burning sensation when urinating /blisters / sore on your penis or penile discharge?	1. Yes 2. No	If NO, go to 98
	How long ago did you experience these conditions:	___months ____days	
	When you experienced these symptoms, did you inform your girlfriend / partner?	Yes……..1 No……..2	
	Did you have sexual intercourse while you were experiencing these symptoms?	Yes……..1 No……..2	If NO, go to 98
	If yes, did you use a condom?	Yes……..1	

		No……2	
	Have you ever felt depressed or experienced any psychological distress?	Yes……1 No……2	If NO go to 103
	Have ever sought any medical / professional help for this condition?	Yes……1 No……2	
	If yes, after how many days did you seek help?	_____ days	
	Who did you seek help from?	1.Clinic / hospital 2. Counsellor 3.Psychologist 4. Other (specify)	
	Why did you not seek medical / professional help?	_____ _____	
	Have you ever felt suicidal or entertained thoughts of suicide?	Yes……1 No……2	
	In your view, what should a man do if he is experiencing mental / psychological problems?	Seek help immediately ……1 Try to deal with it on his own first, seek help later……..2 Other ……..3 Specify _____	
	Should government provide sexual and reproductive health services that target men who have sex with men?	Yes……1 No……2	
	Please briefly explain your answer to the above question / Why or why not?	_____ _____	

Section 5: Socialization

In this section, I am going to ask you questions about your early childhood upbringing; who brought you up; the place you were brought up, as well as things that you learnt during the first 15 years of your life.			
	Where did you spend most of your early childhood years, up to age fifteen?	1. Town 2. Rural area 3. Other specify _____	
	Which of these best describes the type of family within which you were raised?	1.Both parents, married 2. Mother only, married 3. Father only, married 4. Single mother 5. Single father 6. Both parents, unmarried 7.Extended family 8. Other (describe)	
	Where did you spend the most part of the last five years?	1. In this town 2. Other town 3. This rural area 4. Other rural area 5. Other country urban 6. Other country, rural	
	What important lessons did you learn about relating to women that you never learnt during your upbringing?	_____ _____ _____	
	With the benefit of hindsight, are there any aspects of social interaction with women that you wish you had learnt during your	1.Yes 2. No	If NO go to 113

	upbringing?		
	What aspect of social interaction (esp. with women) would you wish you had learnt during your upbringing?	_____ _____ _____	
	Looking at your family, who was the most important influence in your life when you were growing up?	Father……..1 Mother……2 Brother……..3 Sister ……..4 Others, explain _____	
	Is it important for boys and girls to be raised and socialized differently from each other?	Yes……1 No……2 Explain _____ _____ _____	
	Does one's childhood socialization influence the type of man he turns out to be?	Yes……1 No……2 Explain _____	
	Where / how did you learn about being a man?	1. School 2. Friends 3. Church 4. Relatives 5. Traditional rites/initiation 6 Other _____	
	Looking back, would you have changed any aspect of your upbringing / socialization? If yes, explain	Yes……1 No……2	
	Have you ever attended traditional initiation school / ceremonies?	Yes……1	If NO go to 120

		No……..2	
	If yes, what important lessons did you learn about being a man?	_____ _____ _____	
	Have you been circumcised?	Yes……..1 No……..2	
	What meaning do you attach to being circumcised?	_____ _____ _____	

Section 6: Demographics & Employment			
	Age (age in completed years / as of last birthday)	_____ years	
	What is your current marital status?	1. Married 2. Never married 3. Cohabiting (NM) 4. Separated 5. Divorced	
	If married or cohabiting, how long have you been married / cohabiting?	_____months	
	How many children have you fathered in total?	_____ children	
	How many children have you fathered in this current relationship?	_____ children	
	Can you read and understand a letter / newspaper / bible (written in Setswana or English) easily, with difficulty or not at all?	1. Easily 2. With difficulty 3. Not at all	
	Have you ever attended school?	Yes……1 No……2	If NO go to 131
	What is the highest level of education you have attained?	Non formal……1 Primary…….2 Secondary…….3 Higher……..4	
	How many years in total have you lived in this locality?	_____ years	
	What is your religious affiliation	1. Christian 2.African traditional 3. Other non-Christian	
	How important is religion in your life?	1. Very important	

		2. Important 3. Somehow important 4. Not important	
	How many times do you go to church / take part in religious activities?	1. Regularly 2. Sometimes 3. Rarely 4. Not at all	
	Are you currently employed?	Yes……1 No……..……..2	If NO skip to 138
	What is your current occupation?	Code _____ Specify	
	If yes, how many months have you been employed in the current position?	_____ Months	
	What is your current monthly salary?	_____ Monthly salary Range 1.< P200 2.P201 – 400 3.P401 – 600 4.P601 – 800 5.P801 – 1000 6.P1000 – 3000 7.P3001 - 5000 8.P5001 +	
	[If not employed] How many months have you been unemployed?	_____Months	
	How many months have you been actively trying to find a job?	_____ months Not looking …99	

	Have you ever gone for days / weeks without enough food?	Yes……1 No……..2	
	Have you ever gone for days / weeks without enough money to seek medical attention?	Yes……1 No……..2	

Thank the respondent and record the time of the end of interview.

Go through the questionnaire and ensure that all necessary field are entered, starting with the cover page.

Keep the questionnaire safe and intact.

Appendix 5 Tools – Focus Group Discussion Guide

Topic	Core questions	Prompts & expansion material
Meaning of manhood	How does your society define being a man? Apart from age, what makes one a man? When I mention the word "man" what comes to your mind? How does one achieve manhood?	*Old and new roles; household headship;* *Bride price; breadwinner* What distinguishes successful men from those who are not? Are all men able to live up to these expectations?
Socialization	Early childhood socialization Rules learnt about how boys and girls are supposed to behave Story or significant incident(s) from which you learned one or more of these rules	How were these taught? Taught / Enforcement /Tasks Rewards / penalties Language Role of religion; Culture Relationship / view of women

Topic	Core questions	Prompts & expansion material
Desirability of certain masculine traits	Desirability of certain masculine traits: Lived expectations What are some of the most desirable masculine traits in your community? Lived experiences Are men generally able to live up to the society's expatiations of their masculinity? Which factors facilitate / compromise their achievement of these? Which of these traits are suitable for both men and women?	Independence; cattle Aggression /Competitiveness Emotional in-expressivity/ able to keep secrets Family provider? Household head; leader To be unlike women? To marry & have children (feel complete?)/ control Sexual virility / Social potency "***Monna ke nku, o swela mo teng***" (literally translated means a man is a sheep, he never cries / shows vulnerability). What do you understand about this saying? ….. ***Monna ke selepe, oa adimanwa*** (Literal translation: A man is a tool /axe, meant to be shared) *Unemployment; Poverty; failure to pay bride price; headship*

Topic	Core questions	Prompts & expansion material
Social / power relations	In any society, there is a power structure, and gender and power relations determine the position than men and women occupy in this structure. What is the nature of the power structure between men and women? Are men and women equal in society? Can men and women be equal?	Advantage one gender over the other? Workplace; Family / home; Relationships Who determines these positions? How? Importance / significance *Unemployment; Poverty; failure to pay bride price; headship*
Women's empowerment	What major changes have occurred to men and women's positions in society? *Old and New Roles: Household headship; breadwinner; family provider;* What is your understanding of women's empowerment? In Botswana, the government has enacted a number of laws to address gender issues. One such law is the Abolition of Marital Power Act. What do you [as men] understand about this law? What is your feeling towards it? What does this law do to the position of men and women? What is your understanding of the objectives of Emang Basadi?	Voluntary / legislation; what needs to be done to accelerate / reverse changes? Sharing power with women; Good or bad? Threat or enhancement to men's authority Reaction to women's empowerment What do they seek to achieve? What are views of Emang Basadi Past, current and future role of men,

Topic	Core questions	Prompts & expansion material
Gender roles	How important is it for men and women to have different roles in society? How do you feel about men and women swapping roles *Unemployment; Poverty; failure to pay bride price; headship*	Providing for the family Childcare; Nursing Hard labour Cooking; Cleaning the house Rewards / penalties
Sex and sexual satisfaction	Proposing love Love and sex Sexual satisfaction Men vs. women's need for sex Sexual behaviour; Extramarital / multiple sexual partnerships	Who determines where, when; how to have sex Old and new roles *Unemployment; Poverty; failure to pay bride price; headship*
Multiple sexual partnerships	Multiple sexual relationships Causes Why do men have these relationships? Do men need to be in-love with someone before they can have sex with them?	Social value / potency from having multiple sexual partnerships? Why? What causes this? Condom use Married? Instability in relationship? Do men need more sex more often than women? Are men able to control their sexual urges?

Topic	Core questions	Prompts & expansion material
Risk perception & Health seeking	Men's health seeking and help seeking Are there aspects of masculinity that makes it easy / difficult for men to seek help?	Where, When How Risks & rewards
	Risk perception: HIV, STIs Injury; Mental distress Importance of risk taking important to men? Extent to which HIV/AIDS is perceived as a risk	Condoms Multiple sexual partnerships STI HIV/AIDS Emotional risks Reputation risks Others
Condoms	What do men think about condoms? Some people would say that they would rather not have sex than use a condom… - What do you think women / men of your age think about that? Attitude towards the female condom?	What are their advantages and disadvantages? What do men feel when a woman insists on condom use? What if she won t have sex unless a condom is used? As a contraceptive method? As a means of empowerment for women to negotiate sex? Men/women carrying condoms around

Topic	Core questions	Prompts & expansion material
Violence / Aggression	Use of force or violence Is coercion ever justified within a relationship? Botswana has recently experienced a spate of 'passion killings' where men kill their girlfriends / partners [Explain what it is; give statistics, show pictures / video] In your understanding, what happens /causes the man to react that way?	When is use of violence / aggression justified? Towards women; other men? Women? Children? To get what you want? To prove you are a man? In a sexual relationship? (infidelity, withholding sex) Marriage? (for failure to perform household chores) Sport / competition? What alternative ways could be adopted to passion killings? What makes some men kill their partners when others don't? Guilt ;Shame; Pride
Awareness of health services	Which places can men to visit to talk and learn about sex, contraception, STIs? Do men and women of your age visit the local services for contraception and sexual health advice? What HIV/AIDS messages are you aware of? What do they say about men? Women? How do men view these programs?	Acceptability Triggers and reasons for attending services Barriers to attendance Acceptability of services Masculinity Men's views / attitudes to these services
HIV/AIDS Services	What is your view of how HIV/AIDS is perceived in your community?	Factors that contribute to the spread of the epidemic

Topic	Core questions	Prompts & expansion material
HIV/AIDS & men's control of sexuality	Practices of masculinity that increase / reduce spread of HIV Main HIV/AIDS services available in the community Are there certain masculine practices that contribute affect the way HIV is spreading? Do gender and power relations influence the spread of HIV? HIV/AIDS interventions effect on men's control over women's sexuality? Which of the above aspects do men have control or a final say in?	Groups most affected Available services Utilization: men's use of these services vs. women Orphan hood programs; Treatment programs [ARV program; treatment of opportunistic infections? Those that increase vulnerability Those that reduces vulnerability Is this view [of factors that contribute to the VCT; PMTCT; shared by other stakeholders? Have they helped men maintain control? Decisions (sex, fertility, contraception;
HIV/AIDS messages	Is it important for a man /woman to ask for his partner's permission before they can use HIV/AIDS services? Awareness of HIV/AIDS messages Men's reaction to HIV/AIDS program messages Are men supportive of HIV/AIDS services and messages? How has HIV/AIDS affected relations between men and women? What aspects of these campaigns would men like changed to get (more) support from men?	VCT, PMTCT, ARV) Support of partner decisions Permission to use services How do they depict men and women VCT / PMTCT; Home Based Care; Orphan programs; Condom use
Masculinity & Sickness	What is it that they would do which they are not doing now? How do men facilitate / hinder use of these services? Is there a way that men or ideas about being a man contribute to this situation? Do men have power / privilege to affect use of VCT and HIV/AIDS services?	Men and women's depiction Changes that need to be made How? How does a man's value of himself change if he learns he has HIV?

Topic	Core questions	Prompts & expansion material
	Many people have been affected by HIV, including men. Does sickness have an impact on how men perceive themselves?	Compromised ability to live up to social expectations Household headship; breadwinner; sexual virility
Homosexuality	Who are homosexuals What are your views on homosexuality? Are homosexuals different from other men? How would you feel if your friend was homosexual? What about if it was your son?	Good / Bad; Why or why not? Its prevalence? Origins? Do they have a right to choose their sexual orientation What are some of the main views about it? Threats /rewards Would you be friends with a homosexual? Public health services to homosexuals Legislation

Appendix 6 Tools – In-depth Interview and Key Informant Guide

Topic	Core questions	Prompts & expansion material
Meaning of manhood	How do you define yourself as a man? Apart from age, what makes one a man? When I mention the word "man" what comes to your mind? How does one achieve manhood?	*Roles - Old and new; household headship;* *Bride price; breadwinner*
Socialization	What about your early childhood socialization would you say prepared you for being a man? Recall a story / event about your early childhood from which you learnt something about being a man. What was your reaction? Did this shape your subsequent relationship?	From whom did you learn this? Taught / Enforcement /Tasks Rewards / penalties; Language; Relationship / view of women

Topic	Core questions	Prompts & expansion material
Desirability of certain masculine traits	How important to you is it to be able to live up to the socially expected roles of being a man? Do you worry when you don't conform to expectations? Lived experiences Looking at your life, would you say you have been able to live up to the society's expatiations of their masculinity? Which factors facilitate / compromise their achievement of these?	Independence; Aggression /Competitiveness Emotional in-expressivity/ able to keep secrets Family provider? Household head; leader To be unlike women? To marry & have children (feel complete?)/ control; Sexual virility / Social potency "***Monna ke nku, o swela mo teng***" (literally translated means a man is a sheep, he never cries / shows vulnerability). What do you understand about this saying? ….. ***Monna ke selepe, oa adimanwa*** (Literal translation: A man is a tool /axe, meant to be shared) *Unemployment; Poverty; failure to pay bride price; headship*

Topic	Core questions	Prompts & expansion material
Social / power relations	*In any society, there is a power structure, and gender and power relations determine the position than men and women occupy in this structure.*	Explain
	Do you consider yourself equal to other men?	
	Do you consider yourself equal to women?	Is it necessary? How has it worked out so far?
		How is affecting your relationship with women in your family? Siblings? Relationships?
Women's empowerment	What is you view of women's empowerment?	
	What major changes have occurred to men and women's positions in society?	
	Old and New Roles: Household headship; breadwinner; family provider;	
		Voluntary / legislation; what needs to be done to accelerate / reverse changes?
	In Botswana, the government has enacted a number of laws to address gender issues. One such law is the Abolition of Marital Power Act.	Sharing power with women; Good or bad?
		Threat or enhancement to men's authority
	What do you understand about this law?	What are your fears, concerns?
	What is your feeling towards it? What does this law do to the position of men and women? How has the laws affected you?	What do they seek to achieve?
		What are views of Emang Basadi
	What is your understanding of the objectives of Emang Basadi?	Past, current and future role of men,

Topic	Core questions	Prompts & expansion material
Gender roles	Think about your life and how you relate to member of the opposite sex in your family, community, work or relationships. Would you say there are certain roles that you can not / are supposed not to do because they are not meant for a man? Under what circumstances would you go against this rule?	Providing for the family Childcare; Nursing Hard labour Cooking; Cleaning the house Rewards / penalties Give examples
Multiple sexual partnerships	Have you ever had more than one partner at a time? Why did you have multiple relationships? Do men need to be in-love with someone before they can have sex with them?	Social value / potency from having multiple sexual partnerships? How often Why? What causes this? Condom use; Married? Instability in relationship?
Health seeking & Risk perception	Risk perception: HIV, STIs Injury; Mental distress Do you consider yourself at risk of HIV/AIDS? STDs? Mental Illness	What makes health seeking easier / tougher? Where, When How Risks & rewards
	Men's health seeking and help seeking When you fall sick, how easy is it for you to seek help at the clinic / hospital? Are there aspects of how you feel, as a man, which makes it easy / difficult for men to seek help? Explain	Condoms Multiple sexual partnerships STI HIV/AIDS Emotional risks Reputation risks Others

Topic	Core questions	Prompts & expansion material
Condoms	What are your views / attitudes towards condoms - Male and female condoms? Have you ever had sex without a condom because you couldn't find one?	What are their advantages and disadvantages? What do men feel when a woman insists on condom use? Won't have sex unless a condom is used Why / why not?

Topic	Core questions	Prompts & expansion material
Violence / Aggression	Have you ever used force / violence or threat of violence to get what you want? Botswana has recently experienced a spate of 'passion killings' where men kill their girlfriends / partners In your understanding, what happens /causes the man to react that way? Have you ever been in a situation, where you considered killing or hurting your partner?	When is use of violence / aggression justified? Towards women; other men? Women? Children? To get what you want? To prove you are a man? In a sexual relationship? (infidelity, withholding sex) Marriage? (for failure to perform household chores) Sport / competition? What alternative ways could be adopted to passion killings? What makes some men kill their partners when others don't? Guilt ;Shame; Pride Why? What happened? How did you resolve it? How were you able to move on?

Awareness of health services	How /where do you learn about sex, relationships, contraception, STIs? What HIV/AIDS messages are you aware of? What do they say about men? Women? How do you view these programs? Which ones have you used?	Acceptability Triggers and reasons for attending services Barriers to attendance Acceptability of services Masculinity Men's views / attitudes to these services
HIV/AIDS Services **HIV/AIDS & men's control of sexuality** **HIV/AIDS messages**	What is your view of how HIV/AIDS is perceived in your community? What practices of masculinity that increase / reduce spread of HIV? What are some of your practices / beliefs about being a man might affect your / partner's use of HIV/AIDS services? Main HIV/AIDS services available in the community? Do you usually accompany your partner to the clinic? Are there certain masculine practices / beliefs that you identify with which might influence your chance of HIV infection? HIV/AIDS interventions effect on men's control over women's sexuality? Which of the above aspects do men have control or a final say in? Is it important for your partner to ask for your permission before they can use HIV/AIDS services?	Orphan hood programs; Treatment programs [VCT; PMTCT; ARV program; treatment of opportunistic infections] Factors that contribute to the spread of the epidemic Groups most affected; Available services Utilization: your use of these services Those that facilitate utilization of these services Those that hinders utilization of these services Why? Why not? Support of partner decisions Permission to use services How do they depict men and women VCT / PMTCT; Home Based Care; Orphan programs; Condom use

Topic	Core questions	Prompts & expansion material
Masculinity & Sickness	Men's reaction to HIV/AIDS program messages What is you view of current HIV/AIDS services and messages? How do they depict you as a man? Has HIV/AIDS affected relations between men and women? What aspects of these campaigns would men like changed to get (more) support from men? What is it that they would do which they are not doing now? How do men facilitate / hinder use of these services? Many people have been affected by HIV, including men. Does sickness have an impact on how men perceive themselves?	Why/ Why not? Totally supportive / partially supportive? Men and women's depiction – victims and perpetrators Facilitated or reduced men's control over women? Changes that need to be made How? How does a man's value of himself change if he learns he has HIV? Compromised ability to live up to social expectations Household headship; breadwinner; sexual virility
Homosexuality	Who are homosexuals What are your views on homosexuality? Are homosexuals different from other men? How would you feel if your friend was homosexual? What about if it was your son?	Good / Bad; Why or why not? Its prevalence? Origins? Do they have a right to choose their sexual orientation What are some of the main views about it? Threats /rewards Would you be friends with a homosexual? Public health services

[i] Since the study was using a mix of qualitative and quantitative techniques, with the former driving the study, it was deemed after the qualitative data field work that despite the resources limitations, the inclusion of a sample quantitative sample, no matter how small, with a detailed questionnaire, especially on the subject of masculinities, will be a good addition to the study. The quantitative sample was made all the more necessary by the fact that the researcher was unaware of any existing quantitative data that touched even in the least, on the subject of masculinities, men's gender roles or male sexuality.