

Masculine Identity and HIV Prevention among Male Youth in Rural South Africa

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ABSTRACT This article explores the construction of masculine identities in relation to sexual behaviours and HIV in the rural Ugu District, KwaZulu-Natal, South Africa. The research was conducted with groups of school-going male youth selected from three rural high schools and three urban high schools. In total, 12 focus group interviews were conducted in which 72 male youth participated. The objectives of the study were to investigate the relationship between health education on HIV and AIDS and sexual risk behaviours. Through the focus group interviews, the research sought to provide insights into the knowledge levels, attitudes, beliefs and behaviours of the participants and to ascertain how they positioned themselves in relation to the epidemic. More importantly, we sought to understand these attitudes and behaviours against a background of students having been exposed to lifeskills and HIV/AIDS educational programmes, both at school and through the media. The data was analyzed using thematic analysis, and the categories that were identified, form the basis for discussion in this article. The discourses of the participants pointed to the need to assert masculinity, largely through sexual intercourse with females being given priority over health and safety. The article concludes with suggestions to address gender inequities as one way to curb the spread of HIV.

INTRODUCTION

The association between HIV infection and gender power inequalities in heterosexual relationships has long been established in sub-Saharan Africa. Masculinity and masculine identity have been identified as factors that play a role in promoting and sustaining gender inequality and more recently, have been linked to the spread of HIV in South Africa. The high prevalence of HIV (15.3%) among young people, 15-24 years in KwaZulu-Natal, South Africa is well documented (Shisana et al. 2008). In many communities, despite the high HIV/AIDS prevalence, knowledge relating to prevention and treatment remains vague or is not taken seriously (Shisana et al. 2008). Authors such as Barnett and Whiteside (2006), Kwili and Shumba (2008) and Willig (1999) attribute this to the fact that knowledge alone does not necessarily lead to

behaviour change. Factors such as the fear of stigma and discrimination, relationship violence, the fear of being discarded by a partner and the need to prove manhood/womanhood may prevent many young people from seeking assistance and suggesting alternatives to prevent infection from risky sexual behaviour (Deacon et al. 2005).

This article reports research which investigated the relationship between education on HIV/AIDS and sexual risk behaviours among rural and urban secondary school male students. The study employed focus group interviews to engage the youth on issues related to sexuality and HIV/AIDS. The purpose of the article is to provide insights into the knowledge levels, attitudes, beliefs and behaviours of the male participants and to ascertain how they positioned themselves in relation to the epidemic. More importantly, we sought to understand these attitudes and behaviours against a background of students having been exposed to lifeskills and HIV/AIDS educational programmes, both at school and through the media.

We, as the researchers, chose to target adolescents for several reasons. Adolescence, being a phase of discovery and experiment, is accompanied by a range of personal and social issues,

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including that of establishing and asserting gender and sexual identities. Abdool-Karim (2005) emphasizes that although this phase is one in which the overall power imbalances between men and women become more pronounced, it has been largely ignored in terms of its dynamic importance in establishing a pattern of healthy communication and comfortable sexual relationships with intimate partners. Adolescents are particularly vulnerable to traditional gender role patterns and struggle to understand the meaning of their sexual feelings for others and their sexual orientation. This is particularly relevant in view of the tendency of many adolescents to seek immediate gratification with little or no consideration of the consequences. For Ramphele (2002), this situation is aggravated in economically deprived areas where adolescents often lack basic reproductive health information, skills in negotiating sexual relationships and access to confidential reproductive health services. An earlier study by Taylor et al. (2002), conducted in the same rural area of KwaZulu-Natal as the present study, found that although young people became sexually active at a very early age, little was known about how they viewed sex, sexuality and relationships. In an era of HIV/AIDS, it is crucial to explore what youth understand about their behaviour and the behaviour of others and how these may impact on sexual practices.

Under the broad umbrella relating to awareness of risk factors for HIV and responses to such awareness, the findings are discussed under sub-headings relating to sex and manhood, attitudes towards condom usage, and alcohol consumption as a risk factor for unsafe sex and HIV. The research reported in this article forms part of a broader study on HIV and AIDS and sexually transmitted diseases in rural KwaZulu-Natal.

The Social Construction of Masculinity

The research was guided by the perspective that gender is socially constructed, based on a growing body of evidence suggesting that masculinity and femininity are constructed differently according to the social conditions in which people are situated. The term 'gender' encompasses both masculinity and femininity. Gender identity refers to an individual's own feelings of whether he or she is a woman or man, a girl or a boy (Harris 1995). At an individual

level, a boy constructs his gender identity based upon his biology which influences messages he receives from his environment about how he ought to behave. The significance of gender as a social construction, particularly in the context of masculinities, is well established in the work of Mac an Ghail (1994), Connell (2002) and Kimmel (2004). Supporting the above authors, Ampofo and Boateng (2007) elaborate that masculinity is fluid and diverse across different times and contexts and is mediated by factors such as socio-economic position, race, religion, age and geographic location making it appropriate to refer to these as 'masculinities'. The definition by Whitehead and Barrett (2001: 15-16) lends itself to this study. They state that "masculinities are those behaviours, languages and practices existing in specific cultural and organizational locations, which are commonly associated with males and thus culturally defined as not feminine. So masculinities exist as both positive, inasmuch as they offer means of identity for males, and as negative, inasmuch as they are not the 'Other' (feminine)." These and other authors emphasize that masculinities reflect social and cultural expectations of male behaviour rather than biology.

In the same vein, Kimmel (2004) asserts that we actively and continuously define and redefine what it means to be men and women in our daily interactions with one another. Of relevance to this study is Ratele's (2003) assertion that we cannot talk of relationships without mentioning identities because intimacies and identities are closely related. Individuals need other people in relation to whom they define themselves, that is, they need other identities against which to 'fix' them-selves so as to be understood. In other words, a self is always established in relation to other selves.

METHODOLOGY

A qualitative approach was employed to enable us to explore and understand the social and cultural meanings and practices underlying the attitudes, beliefs and behaviour of the male participants. Guided by Henning et al. (2004), Ulin et al. (2002) and Patton (2002), we aimed to explore how the youth interacted with each other, how they perceived the world around them, and their patterns of shared understanding and variations in those patterns in the context of an HIV/AIDS epidemic.

KwaZulu-Natal is a centre of the AIDS epidemic in South Africa. It is the province with the largest population and is one of the poorest of the provinces in the country. Despite urbanization, more than half the population live in disadvantaged rural areas lacking access to resources such as electricity and health services. The Ugu District is typical of such rural areas and has an estimated population of 744 000 (Ugu IDP 2008/9). Umlazi, from where the urban school sample was drawn, is an urban township with an estimated population of 300 000 (eThekweni IDP 2007/8).

Using systematic sampling, groups of males from grade nine aged between 15-20 were selected from three high schools in the rural Ugu District referred to by the pseudonyms Langa, Njabulo, Phambili and from three high schools in an urban township, Umlazi, referred to by the pseudonyms Vuka, Mpumelelo and Qhubeka. Each of the schools has between 700 - 1000 students. The high schools are all co-educational, but our purposes were best served by focusing on exclusively male groups to enable the boys to freely discuss their attitudes, beliefs and behaviours relating to sexuality and HIV. We were also able to observe group dynamics, ascertain individual and group thinking and obtain some idea about normative behaviour of young men in this community. The focus groups were moderated by facilitators who had considerable experience in working at the selected schools and who were familiar with the environments. In addition, each group had an observer who documented group interactions and non-verbal responses. The groups, which consisted of 12 students each, were moderated in isiZulu by male facilitators and the responses were transcribed and translated by these moderators. Each group met twice with each session lasting about 60 minutes. In total, 12 focus group interviews were conducted and 72 young men participated in the study.

We considered focus group interviews to be an appropriate method of data collection for several reasons. Focus groups use interaction between research participants to generate data. As suggested by Parker and Tritter (2006) and Krueger and Casey (2000), the dynamic nature of interaction enables the generation of insights which provides understanding of how people perceive a situation. Kitzenger and Farquahar (2001) emphasize the use of focus groups to unpack the social construction of sensitive issues,

uncover layers of discourse and group taboos, and the routine silencing of certain views and experiences. An additional advantage mentioned by Bloor et al. (2001) and relevant to our objectives, is that focus groups afford the researcher privileged access to in-group conversations which often include everyday language and indigenous terms, thus enabling us to observe performances of masculinity and identity within the group. Following the stages of thematic analysis suggested by Gomm (2008), we identified patterns of similarities and differences in participant responses and categorized these into themes and sub-themes in keeping with the objectives of our study. These themes form the basis for discussion in this article. Ethical clearance for the study was granted by the University of KwaZulu-Natal Ethics Committee.

FINDINGS AND DISCUSSION

All the students in this study have participated in HIV/AIDS educational programmes although the extent of participation of each student was difficult to ascertain. The South African Department of Education has encouraged HIV prevention messages through the lifeskills programmes implemented by teachers during the life orientation lessons at schools. Programmes, for example, Soul City use media such as television and radio to raise awareness about HIV/AIDS. In addition to these programmes, some of the participating schools were exposed to programmes such as Lovelife, a non-governmental organization which has specific goals in relation to HIV prevention. The Lovelife programme provides educational material on HIV/AIDS and engages students using discussions and exercises which focus on aspects such as relationships, sexual negotiation and safe sex. However, Saleh-Onoya et al. (2008) maintain that only a few behavioural interventions targeted to vulnerable populations have been tested, and very few have shown efficacy in reducing the incidence of HIV.

We report on the participant's awareness of risk factors for HIV and AIDS, the responses to such awareness and the extent to which these are determined, particularly by male identity issues. Our overall observations were that both the urban and rural groups engaged with the topics easily. We attributed this to the fact that since the moderators and observers had previously undertaken lifeskills training at these

schools, the participants were familiar with them and felt comfortable to participate. Furthermore, having young African moderators and observers may have contributed to the ease of participation.

Without Sex, You Are Not a Real Man

In exploring risk factors for HIV, our research revealed that for many of the male students, having sex was equated with manhood. The pressure to prove manhood took precedence over the need to protect them from, or to prevent the spread of a sexually transmitted disease.

Contrary to findings from an earlier study with rural youth in the Ugu District by Sathiparsad and Taylor (2006), where females were considered by males to be the carriers of HIV and AIDS, the students in this study acknowledged the role played by males. This section presents examples of common themes that emerged across the groups as to whether males or females were largely responsible for the spread of HIV:

Vuka School (urban):

It's the guys – they are so used to it (sex) they can't live without it.

Yah, the guys want it flesh on flesh - the condom is a disturbance.

(Some laughter from other participants)

Langa School (rural):

Hey, the boys – they are the ones who are playing with the girls and sleep with them all at once – that is how they spread this virus.

Mpumelelo School (urban):

It's the guys – they are the ones who have many girlfriends in one area – then he spreads the virus. It's all about boasting.

(Other males laugh in agreement)

Clearly, these quotes show that participants believe that male sexual behaviour does indeed contribute to the spread of HIV. Their belief that they cannot live without sex, together with condoms being viewed as an obstacle to sexual enjoyment, presents much cause for concern. The phrase “*playing with the girls*” positions boys as having the power to manipulate girls to satisfy their own sexual needs. Similar to findings by researchers such as Dunne et al. (2006), Ampofo and Boateng (2007) and Sathiparsad (2007), the comments highlight the notion of unrestrainable male sexuality and the need for multiple sexual partners. The comments suggest that the identity of males is defined through sexual ability and accomplishment, a conclusion confirmed by

Pattman (2007) who, in his study of young men in South Africa and Zimbabwe, stressed that within the collective peer identity of male students, part of striving for masculinity included boasting about sexual performance. This may be reinforced, as pointed out by Silberschmidt (2004) from her studies in rural and urban East Africa and Leclerc-Madlala (1999) from her South African study, by the belief that a man who cannot handle several women is not a real man. In the light of the above findings, it is worth noting that The South African National Study by Shisana et al. (2008) documented that among 15-24 year olds 30.8% of males reported that they had multiple partners as compared to 6% of the females.

While women's subordination to men increases their risk of HIV infection, researchers such as Peacock et al. (2009) draw attention to the fact that men also suffer from harmful gender norms as manhood almost requires that they behave in ways that heighten their risk of HIV infection. A major concern, according to Peacock et al. (2009:120) is that “studies repeatedly show that men who adhere to rigid notions of manhood, who equate masculinity with risk-taking, dominance and sexual conquest, and who view health-seeking behaviours as a sign of weakness experienced a range of poor health outcomes.” A further observation by Larkin et al. (2006) is that young people tend to overlook the fact that unhealthy attitudes and behaviours on the part of males, as reflected by the participants in this study, affect both them and their female partners. A male student at Mpumelelo School (urban) explained:

There is a tendency of saying to each other that if you don't have sex with your girlfriend, then you are not a real man, and you will find that someone else will have sex with the very same girl and come to tell you that he has done it without a condom and then you will get angry and want to do it without a condom like your friend has said and you will also get HIV.

This reaction represents the views of the majority of males in the sample whose comments suggest that sex often occurred in an emotional vacuum, and is not linked to intimacy, between the male and female. The competition amongst young males to demonstrate sexual prowess exceeded their fear of HIV infection, demonstrating that risky behaviour is indeed a hallmark of masculinity. Pattman's (2007: 42) study of South African youth found that young men feel defeated

“not only in failing to ‘win’ a girl, but also in failing as a man”. Further evidence of this trend was highlighted by Sathiparsad and Taylor (2006) whose earlier study of rural male students in the Ugu District found that the need to present as physically, sexually and emotionally tough took precedence over taking heed of the risks associated with unsafe sexual practices.

Some mixed responses were also noted, for example, the following responses during the discussion at Langa School (rural) points to both girls and boys and girls being responsible for the spread of the disease.

C: They are the same - you can't say it's the boys or the girls because when it comes to us as guys, we want to prove a point to each other that we're real men, and there are girls who are like that, who just sleep with anyone they see and find interesting. As we are doing this, this thing is growing.

D: The other thing is that girls also have many boyfriends and also sleep around and spread this thing (HIV).

Although abstinence emerged as a possible way to prevent infection, the comments made suggested that this was not easy, especially for the males. The following responses were noted amongst the male group at Phambili School (rural):

Moderator: What do you think of abstaining from sex (as a way of protecting yourself from infection)?

N: Hey, it will be a hard thing

O: Why have a girl friend if you do not have sex with her?

P: It will be hard, because as a guy there will be things that really tempt you... and you will want that thing...

N: It is hard because the girls will say that you know nothing about this (sex).

This interaction brings to the fore several aspects regarding male identity. First, the purpose of having a girlfriend was to have sex. Second, men find it hard to resist sex and immediate sexual gratification is important. Third, sexual performance is a significant marker of masculine success and male peer group positioning. Such comments may be viewed against Ampofo's (2007) suggestion that viewing women as sexual objects and viewing sex from a performance-oriented perspective often begins in adolescence and may continue into adulthood. On the other hand, Lindegger and Maxwell (2007) and Pattman (2007) caution that in groups, boys may perform

masculinity by talking outrageously about girls as objects used primarily for sexual gratification and showing no element of commitment. However, as individuals, they may display a deeper sense of care and commitment to their relationships with girls.

In this regard, Godia (2008) reminds us that sexuality is influenced by a complex set of actions, emotions and relationships nested with certain social and cultural realities. She emphasizes that levels of sexual coercion and male domination in sexual relationships ensure that many women are not in a position to abstain. However, she maintains that abstinence is meaningless as sexual desire is natural and abstinence should be a choice among many other options. Larkin et al. (2006) acknowledge that turning around sexual and gender stereotypes that promote high risk behaviours are crucial but difficult to achieve. What was interesting in our study was the assumption by males that girls expected sex and that sexual negotiation was hardly a consideration.

Loving Sex and Hating the Condom

In the groups, some of the boys asserted their masculine rights to enjoy sex. We provide some quotes that illustrate that while the majority of the males supported unprotected sexual practices despite knowledge of the associated risks, some spoke in favour of condom use. There was some consensus that ‘*They (boys) love unprotected sex*’ (Vuka School), indicating knowledge of protected and unprotected sex and a choice regarding sexual behaviour.

The following interaction at Mpumelelo School (urban) illustrates some attitudes towards condoms and condom usage:

K: I like girls and I hate the condom.

L: Me and my friends are not in danger because since the “Love life” programme people came to the school, we were tested, we know our status and our lives are safe, so we are making sure that whatever we do, we do with care.

K: ... the condom just kills all your feelings, so the best way is to do without it.

M: Yah - once you start romancing without thinking of the condom then just forget about it because there is no time to take it out.

A similar response was noted amongst the males at Phambili School (rural)

O: “... We really love the girls a lot and we even like to do sex and we hate condoms.”

P: "Yah, condoms stops us from enjoying sex"

A major point echoed by these participants is that condoms act as a barrier to sexual pleasure. As in previous interactions, the message underlying the boys' comments at both the urban and rural schools is that sexual pleasure takes priority over risk of HIV infection. Such responses may be attributed to the belief in myths regarding condoms reducing sensitivity and pleasure or, as suggested by Saleh-Onoya et al (2008), issues such as negotiating condom use may not be adequately covered by health education programmes. The issue is aggravated by the fact that negotiation of condom use is complex, limited by gendered power relations and may be seen as a barrier to male sexual dominance (Larkin et al. 2006). Although a minority response, L's explanation is encouraging, providing evidence that an educational programme does have the potential to create awareness and to reduce risk behaviour.

However, many students in our study admitted that knowledge related to the risks of infection did not usually result in behaviour change. In the words of a student at Vuka School (urban): *'To be honest, since I started school, people were being taught about HIV/AIDS, but there is no change at all, and people are still doing things which cause them to have HIV'*. Another student at Njabulo School explained: *As youth, we are not educated that much about this. Yes, we have had some lessons, but we need more. Some of us don't know how you can get infected and can't see if they have it and what to do.* For this reason, Peacock et al. (2009) question aspects such as the language used, style of delivery, and content of educational programmes in targeting specific needs of individuals and groups. Further exploration with our participants revealed that students, especially the males, did not take the content of the lessons seriously, and often *'just gave time to the teachers.'*

The following excerpts from the male group at rural Phambili School suggest that some boys are open to positive and healthier living:

T: *The thing that we must do is to protect ourselves when we do sex. It is not safe to have sex without a condom.*

U: *Yah, those that are free are not good. Just use your money and buy a good condom that can be trusted.*

The male group at the urban Mpumelele School offered similar comments:

V: *I have learnt a lot about sexually transmitted infections and HIV. I am not in danger because I'm careful. We must take care of ourselves.'*

W: *Me too. I know my status. After I got tested for HIV, that's when I began to do things in a different way like someone who knows what he wants in his life.*

Similar comments were expressed by youth in Canada and South Africa (Larkin et al. 2006: 216) where it was acknowledged that some males thought it crucial to know one's HIV status and wouldn't have sex without wearing a condom. The statements made by our participants suggest that some young males have put into practice what they have learnt - either from the educational programmes, the media or elsewhere. Engaging in behaviour change for self care - *doing things in a different way* - offers hope that there is some space for behavioural interventions.

Alcohol: A Major Factor in Risky Sexual Behaviour

Alcohol was mentioned at two of the urban schools, Vuka and Qhubeka. At both schools, boys agreed that going to parties and consuming alcohol were strong factors influencing unsafe sexual practices, as is evidenced in the following interaction at Vuka School:

X: *Mostly girls go to parties without any cash and they know guys will buy them drinks. Men don't feed a horse they won't ride.*

Y: *No, never*

Z: *I can't be buying you stuff and yet you give me nothing back.*

Moderator: *Why is it that at a party you are likely to get infected?*

A1: *They get drunk.*

A2: *Once you get drunk you lose your mind.*

A3: *When drunk, it does down on you and you get turned on.*

A1: *You can have sex with anyone.*

A3: *You end up not knowing whom you slept with.*

A4: *With us men, if we see freebies we don't waste time we go ahead.*

Some agreement on the above responses were noted by a boy at Qhubeka:

Sex is associated with having a nice time or parties. That's why it's hard to abstain...the reason being that people don't think clearly because of alcohol and the girls will wear

something to seduce the guys. Once you are seduced as a guy, you cannot control your feelings.

These responses indicate that the boys do realize that alcohol is likely to cloud judgment. Despite this knowledge, it appeared that alcohol was used by males as a tool to secure sexual achievement, again constructing themselves as being manipulators of female sexual behaviour. The observers noted that the tone during this part of the focus group interviews was quite relaxed and light-hearted. The association of alcohol and sexual temptation, as well as the assumption that men have an enormous sex drive over which they have little control after drinking (Pattman and Chege 2003), was confirmed by the boys in our study who agreed that *'they (boys) are at risk (for HIV) because they go to parties, they get drunk and want to have fun.'* While the students maintained that males and females consume alcohol, Pattman's (2005) study of Ugandan men found that male drinking is construed as being a defining part of male culture, while females who drink are perceived to be 'loose' and engage freely in sexual relationships. The suggestion by a participant that *"girls wear something to seduce the guys"* places blame on the girl for the guy not being able to control his feelings. The significance of alcohol in constructing their masculinities as sexually powerful and uncontrollable, along with the objectification of women as sexual providers in exchange for material gain – *feed a horse they won't ride; give me nothing back; we see freebies we don't waste time* – make boys vulnerable to infection. This, according to Peacock et al. (2009) is another way in which norms about manhood harm both women's and men's health.

On a broader level, Barnett and Whiteside (2006: 88) argue that HIV and AIDS is a symptom of the way in which we organize our social and economic relations, and medical issues and individual behaviour change must be viewed against the backdrop of structural factors which result in those behaviours. The economic context, social and cultural prescriptions and gender power inequalities all intersect to create barriers for women in sexual negotiation and women being involved in sexual relationships for economic gain has been illustrated (Shefer 2003). Likewise, for Larkin et al. (2006) poverty, hopelessness and a lack of recreational facilities may lead young people to alcohol and drugs as a form of recreation

with little concern for health consequences. These authors suggest that unsafe sexual practices may be viewed within a risk context by considering broader structural factors such as poor socio-economic conditions, limited access to health care and prevention education that can influence decision-making on sexuality.

IMPLICATIONS OF THE FINDINGS FOR HIV PREVENTION

In exploring the relationship between HIV and AIDS education and sexual risk behaviours among rural and urban secondary school students, this article has focused on the relationship between health education on HIV and AIDS and sexual risk behaviours among rural and urban secondary school male students. The findings contribute to the understanding of the intersection between masculinity, gender inequality and HIV. The majority response in the focus groups demonstrated the youth constructing themselves as being dominant and in control of sexual relationships, objectifying women and using sexual performance as a benchmark for proving manhood. We also noted minority responses challenging dominant notions of masculinity and offering suggestions to promote safer sex practices. These responses are significant as we believe that the actions of individual men in changing behaviour, as well as the social space where individual men and women can negotiate identity, offers hope for broader social change.

A possible limitation is that this article reports only on focus group responses which represent the groups' thinking and perhaps included a performance for effect by some of the participants. Furthermore, some participants may have felt restrained to reveal their real fears, concerns and experiences in a group context. Further research incorporating individual perspectives on the issues discussed is therefore suggested, as well as the inclusion of females in the sample to investigate how females construct their sexual identities in relation to males. Despite the contention of Yahaya (2008) that HIV/AIDS awareness is lower among rural youth than among urban colleagues, the study presented did not reveal significant differences between the rural and urban samples. Research incorporating larger rural and urban samples may throw light on comparative responses and guide interventions in these different contexts.

Despite being exposed to lifeskills and HIV/AIDS preventive programmes, there was little by way of changes in attitudes, beliefs and behaviour to prevent transmission of the disease among the participants giving credence to Cornwall and Wellbourn's (2002) assertion that changing what people know may have little or no impact on what they do. In this regard, Shefer (2003) points to the pervasiveness of the traditional double standard where men are encouraged to actively pursue sexuality and take multiple partners, while women may be punished for being sexually active and are constructed as loose and promiscuous. Shifting these traditional constructs of gender roles pose a major challenge and suggest a need to review educational programmes and approaches used. A further aspect requiring attention is alcohol consumption, sexuality and risk for HIV which was mentioned at two of the urban schools. The impact of alcohol on behaviour, particularly sexual behaviour, must be interrogated. However, Kwili and Shumba (2008) argue that single interventions do not change deeply entrenched individual and community perceptions and suggest multi-sectoral and holistic approaches to HIV, integrating programmes based in schools, families and communities.

As mentioned previously, adolescence is an experimental phase and young people are likely to be open to reflections on issues such as gender, relationships, health and sexuality. In this regard, the school, which brings together diverse groups of students, teachers and parents, offers an ideal site within which such reflection and learning can occur. We support Pattman's (2006) suggestion that HIV/AIDS educational initiatives must involve training teachers to be gender sensitive, with HIV/life skills education focusing not on sex but more generally on the lives, cultures and identities of young people. Such an approach may encourage young people to protect themselves. In the same vein, Larkin et al. (2006) suggest that HIV prevention programmes may provide opportunities to interrogate students' definitions of sex and thereby allow for fuller sexual expression and safer sexual practices. An approach that provides positive messages about sexuality rather than messages that instill fear and danger is likely to be more effective in promoting desired behaviour change.

Of concern to us was our observation that, despite the identified need, none of the schools involved in the study had access to supportive

services such as those provided by social workers or counsellors. Students were required to seek services outside, usually from clinics or hospitals. Especially in the rural area, the clinics were not easily accessible and there was no privacy. To this end, we suggest that the Department of Education make regular social work services available to these schools. Furthermore, well-trained, sensitive and supportive counselling is recommended at public health facilities in which confidentiality, privacy and respect for people are paramount.

The findings of our study support the contention of Cornwall and Wellbourn (2002) that HIV/AIDS is increasingly being recognized as a gendered disease, impacting disproportionately on women but requiring an understanding of the role played by men and the construction and performance of masculinity in driving the epidemic. HIV risk reduction interventions must therefore consider the role of gender in their content, design and implementation. HIV prevention educators could provide counter narratives to challenge a hegemonic masculinity that positions females as submissive and sexual providers, and male sexual behaviour as biologically driven. Condom promotion must be accompanied by knowledge regarding prevailing power relationships, sexual patterns and the context within which sexual and reproductive decisions are made. A supportive approach is advocated where men and women have opportunities to dialogue, in addition to HIV transmission, issues such as self confidence, intimacy, respect, mutual fidelity, and alcoholism (Sathiparsad and Taylor 2006).

There is emerging consensus on the need to incorporate men more adequately into sexual and reproductive health issues and initiatives related to HIV and AIDS. Work with boys on issues of gender and gender inequality requires a focus on the ways in which domination and oppression are implicated in the construction of idealized masculinity and how these affect male-female relationships, including sexual relationships. In engaging men, Peacock et al. (2009:120) caution against treating men as "the problem," suggesting that men and boys should be seen as agents of change and whose actions would serve to benefit men and women. Programmes in KwaZulu-Natal which target men include Men as Partners (MAP), Mobilizing Young Men to Care Project (MYMTCP), and Stepping Stones, which integrate gender, gender-based violence, sexual and reproductive health and HIV/AIDS. Although

some of these programmes have not been systematically evaluated, informal evaluations indicate positive attitude change amongst both males and females and indicate that some men are open to change. Such efforts should be expanded and the outreach to young people in all areas encouraged. It was noted that programmes such as Lovelife do not reach many rural areas. We maintain that preventive interventions that are ongoing are likely to be more effective in bringing about and sustaining desired attitudinal and behavioural change than once-off programmes. Saleh-Onoya et al. (2008) make two points that we endorse: first, that HIV behavioural interventions must have a skills training component and second, that interventions must be tested to demonstrate short and long-term successful outcomes.

Changing the risk environment is an important part of prevention and requires moving beyond behaviour change to approaches that tackle contextual factors such as poverty and discrimination. Given that HIV transmission and infection are inextricably bound to social and economic relations of class, race, gender and sexuality, it is essential to focus on issues such as these which place women at risk for HIV. To this end, Barnett and Whiteside (2006) emphasize the significance of political leadership in prioritizing specific objectives, target groups and programme components to successfully curb the epidemic.

CONCLUSION

Our research aimed to draw attention to some of the factors that contributed to the difficulty in translating HIV preventive education into practice. We highlighted, from a male youth perspective, some of the feelings, attitudes and beliefs underlying risky behaviour. The study revealed that while adolescents had sound knowledge on some aspects of HIV/STI transmission, gaps in understanding and misconceptions were still evident. For many participants in our sample, the life skills and HIV educational programmes have failed to bridge these gaps and to promote healthier behaviour among young people. The socio-cultural constructs of gender, particularly dominant masculinities and submissive femininities continue to pose a challenge to promoting gender equitable relationships and healthier interactions between young people. To

this end, we suggest the evaluation of existing programmes, creative educational strategies and advocacy aimed at creating new norms that stress mutuality, responsibility and equality. Both men and women will benefit from interventions that question skewed gender roles and relations.

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