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'Men usually say that HIV testing is for women': Gender dynamics & perceptions of HIV testing in Lesotho

Abby L. DiCarlo, M.A., M.P.H.*,

Department of Sociomedical Sciences, Columbia University, New York, NY, 10032, and HIV Center for Clinical and Behavioral Studies, NY State Psychiatric Institute & Columbia University, 1051 Riverside Dr. - Unit 15, New York, NY 10032, New York, New York, United States, Tel: 914-582-2701, Fax: 212-543-5620

Joanne E. Mantell, M.S., MSPH, Ph.D.,

HIV Center for Clinical and Behavioral Studies, NY State Psychiatric Institute & Columbia University, Department of Psychiatry, 1051 Riverside Dr. - Unit 15, New York, NY 10032, New York, New York, United States, Tel: 212-543-5975, Fax: 212-543-5620

Robert H. Remien, Ph.D.,

HIV Center for Clinical and Behavioral Studies, NY State Psychiatric Institute & Columbia University, Department of Psychiatry, 1051 Riverside Dr. - Unit 15, New York, NY 10032, New York, New York, United States, Tel: 212-543-5375, Fax: 212-568-4385

Allison Zerbe, M.P.H.,

ICAP, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY, USA, Tel: 212-342-0505, Fax: 212-342-1824

Danielle Morris, M.P.H.,

ICAP, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY, USA, Tel: 212-342-0505, Fax: 212-342-1824

Blanche Pitt, M.D.,

ICAP, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY, USA, Tel: 212-342-0505, Fax: 212-342-1824

Elaine J. Abrams, M.D., and

ICAP, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY, USA, Tel: 212-342-0505, Fax: 212-342-1824

Wafaa El-Sadr, M.D., M.P.H., M.P.A.

ICAP, Columbia University, Mailman School of Public Health, 722 W. 168th Street, New York, NY, USA, Tel: 212-342-0505, Fax: 212-342-1824

Abby L. DiCarlo: ald2163@columbia.edu; Joanne E. Mantell: jem57@columbia.edu; Robert H. Remien: rhr1@columbia.edu; Allison Zerbe: az2258@columbia.edu; Danielle Morris: morrisd@icap.org.ls; Blanche Pitt: pittb@icap.org.ls; Elaine J. Abrams: eja1@columbia.edu; Wafaa El-Sadr: wme1@columbia.edu

Abstract

*Corresponding author. ald2163@columbia.edu.

In Lesotho, men have lower HIV testing rates, less contact with HIV clinical settings, and less knowledge of HIV prevention than women. However, women's HIV prevalence has consistently remained higher than men's. This paper explores gender norms, sexual decision-making, and perceptions of HIV among a sample of Basotho men and women in order to understand how these factors influence HIV testing and prevention. Two hundred women and 30 men were interviewed in Lesotho between April–July 2011. Participants reported reluctance among women to share information about HIV prevention and testing with men, and resistance of men to engage with testing and/or prevention services. Findings demonstrate a critical need for educational initiatives for men, among other strategies to engage men with HIV testing and prevention. This study highlights how gender issues shape perceptions of HIV and sexual decision-making and underlines the importance of engaging men *along with* women in HIV prevention efforts. More studies are needed to determine the most effective strategies to inform and engage men.

Keywords

HIV/AIDS; gender; Lesotho; men; HIV prevention

Introduction

Lesotho has one of the world's most severe HIV epidemics, with a 23% adult HIV prevalence and pronounced gender differences (Lesotho Ministry of Health and Social Welfare 2009). Among Basotho adults ages 18–49, women have higher levels of comprehensive HIV/AIDS knowledge (38% vs. 29%), are more likely to have ever tested for HIV (68.6% vs. 39.3%), and to have been offered an HIV test than men (46% vs. 20%) (Lesotho Ministry of Health and Social Welfare 2009). However, HIV prevalence is significantly higher among women than men ages 15–49 (26.7% vs. 18.0%), with these rates relatively unchanged since 2004 (Lesotho Ministry of Health and Social Welfare 2009). The disproportionate burden of HIV for Basotho women reflects a persistent trend in sub-Saharan Africa, where 58% of people living with HIV/AIDS are women (UNAIDS 2012). There is an urgent need to further understand the factors underlying these gender disparities and to develop interventions to address them.

Gender and the HIV epidemic

Gender has been conceptualized as the 'socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women' (World Health Organization 2013). Gender norms vary among different cultures and societies, but generally reflect the traditional gender dichotomy of male/female, wherein masculinity is equated with dominance, and femininity is typified by subordination to and accommodation of men. Gender norms are deeply ingrained in intrapersonal, interpersonal, and societal relationships, and also serve as a basis for discrimination and unequal economic opportunities, laws and policies, and access to other resources. Consequently, gender has been recognized as a social structure which is profoundly embedded in the individual, interactional, and institutional dimensions of society (Risman 2004), and established as a fundamental factor in the HIV/AIDS epidemic (Greig et al. 2008). HIV presents a specific risk to heterosexual women because of their biological vulnerability as well as the social,

political, and economic factors that fuel women's inequality (Susser and Stein 2000). While HIV prevention programmes targeted to women have increased in number, some have argued that they still do not adequately address gender as a social structure (Greig et al. 2008)).

Evidence suggests that men's adherence to models of hegemonic masculinity –the culturally idealized form of masculinity in which men are widely expected to be powerful, dominant, and controlling – is correlated with poor health outcomes for both men and women (Peacock et al. 2009). Characteristics associated with masculinity, e.g., power, self-reliance, and strength, may discourage health-promoting behaviours such as HIV testing or seeking help for health concerns (Mills et al. 2012). Men with traditional views about masculinity are more likely to have contracted STIs and less likely to use condoms (Peacock et al. 2009). Encouraging men to test for HIV has been recognized as a major challenge in HIV prevention; however, men's health-seeking behaviours are still poorly understood (Mills et al. 2012).

These gender effects highlight the crucial need for HIV prevention strategies to include the transformation of gender norms (Jewkes and Morrell 2010). This requires a multi-level understanding of gender – as an interpersonal factor within intimate relationships *and* a structural factor that shapes the lived experiences of both men and women – otherwise, interventions may overemphasize women's vulnerability and fail to attend to gendered experiences of men, thereby reinforcing hegemonic constructions of masculinity and perpetuating gender power inequities (Mindry 2010).

Therefore, in the present study, we explored how gender influences relationship dynamics, sexual communication and behaviour, and perceptions of HIV testing and prevention in Lesotho, a setting with high HIV prevalence.

Gender in Lesotho

Lesotho is a small mountainous country, landlocked by South Africa, with an estimated population of two million. It is characterized by high levels of domestic unemployment; half of the population lives below the poverty line (UN-INSTRAW and UNDP 2010). Driven by high poverty rates, Lesotho is one of the most migration-dependent countries in the world. In 2011, migrant remittances accounted for over 29% of the country's GDP (Nalane 2011). Men's migration to work in the South African gold mines is a significant part of Lesotho's labour history, with an estimated 60% of the total Lesotho workforce employed in these mines at some point within the past decade (Corno and de Walque 2007), and 240,000 Basotho people (80% are men) currently living outside the country (UN-INSTRAW and UNDP 2010).

A large body of research has identified migration as a contributing factor to the HIV/AIDS epidemic (Weine and Kashuba 2012), with higher population mobility linked to higher HIV rates (Corno and de Walque 2007). During Apartheid, migrant miners in South Africa often kept 'mine wives', and/or formed relationships with 'town women' and commercial sex workers (Moodie, Ndatshe, and Sibuyi 1988); today, migrant miners are more likely than non-migrant men to have casual sex partners, often at their migration destination (Lurie

2006). A culture of hegemonic masculinity in the mines, along with the physical demands and danger of mine work, loneliness and limited social support, and increased access to commercial sex workers may contribute to greater likelihood of multiple sexual partnerships (Weine and Kashuba 2012).

Economic factors are key drivers of gender inequalities in Lesotho. Historically, women's economic dependence on men was institutionally upheld, as women were prohibited from working in South African mines (Ferguson 1985). Until 2003, women were unable to legally refuse sex or demand condom use from partners, and until 2006, unable to own property, and dependent upon their father, husbands, or brothers to take out a loan, use contraceptives, or have surgery (Corno and de Walque 2007) due to customary policies that considered women to be legal minors (Braun 2010). However, as male labour migration peaked in the 1980s, women often became *de facto* heads of household (Braun 2010). While men sent home remittances to invest in livestock which strengthened social ties to the home community, women were often primary farmers, engaged in informal income-generation activities, and took lovers (Braun 2010; Ferguson 1985). With retrenchment in South Africa's mining sector in the mid-1990s, male migration decreased, and women, working in Lesotho's textile industry or as domestic workers in South Africa, were often the main breadwinners for their household (Braun 2010). Although women's contributions to the household economy have made joint decision-making more common among partners, this does not necessarily translate into greater equality (Francis 2002). Women's income and labour are often devalued, both socially and institutionally; contemporary development policies have reinforced existing gender inequalities through systematic devaluing of women's labour (Braun 2010). A 2006 bill provided equal status to married women; however, the economic and social effects of this law are unclear, and Lesotho remains a traditionally patriarchal society in which households and inheritances are still organized around men's lineage (Corno and de Walque 2007).

Methods

Overview

Data were collected as part of the 'Enhanced Prevention for Couples' (EPIC) study in Lesotho, under ICAP at the Mailman School of Public Health, Columbia University. ICAP has been developing, implementing, and supporting TB and HIV treatment and prevention programmes in Lesotho since 2006. EPIC aims to engage pregnant and postpartum women in antenatal clinics – venues where women learn their HIV status and receive Prevention of Mother-to-Child Transmission (PMTCT) services.

EPIC is comprised of multiple feasibility/acceptability studies intended to inform the development of a combination HIV prevention intervention for HIV-serodiscordant couples. The study described here was conducted between April and July 2011 in two districts — Mafeteng and Mohale's Hoek.

Sampling and recruitment

Using convenience sampling, we recruited 200 women from four antenatal clinics. Thirty men were recruited as key informants to offer broader understandings of men's perceptions of HIV. To recruit men, we asked women to approach men they knew that might be interested in study participation and obtain permission for male study staff to call and explain the study and determine eligibility.

Eligibility criteria for all participants included being 18 years of age or older. Women had to be pregnant or within six months postpartum and receiving antenatal care at one of the study hospitals. Men had to live or work in one of the study districts. In-depth interview and focus group participants had to be willing to be audio-recorded.

Procedures

Quantitative cross-sectional surveys were conducted with all participants. The women's survey included 62 questions, addressing demographic and relationship information, HIV testing and treatment history, opinions regarding HIV testing, sexual partnerships, and sexual behaviour. The men's survey included 36 questions covering similar domains as the women's survey; however, while men were asked to characterize their current sexual partnerships, questions regarding sexual behaviour were not as extensive as those in the women's survey. Surveys were conducted in English or Sesotho, depending on the participant's preference.

In-depth interviews and focus groups addressed relationship norms and decision-making, sexual behaviours, HIV testing experiences, and knowledge and attitudes about various HIV prevention and treatment strategies. All 30 men completed in-depth interviews. All women who participated in the survey were invited to participate in a subsequent focus group. Eight focus groups, each with 7–8 women, were conducted with the 62 women who chose to participate. Survey administration lasted 20 minutes, focus groups approximately two hours, and in-depth interviews, one hour. Focus groups were conducted at one of the four antenatal clinics and in-depth interviews were conducted at a location of the participant's choosing. All focus groups and interviews were conducted in Sesotho, audio-recorded, transcribed, and translated into English. All participants received travel reimbursements of 100 Maloti (\$12) at the end of their interview or focus group.

Ethical considerations

The study protocol, instruments, and consent forms were approved by the Institutional Review Board at Columbia University Medical Center and the Lesotho Ministry of Health and Social Welfare. Participants completed written informed consent prior to study participation. All study staff completed training in Good Clinical Practices.

Data analysis

Descriptive data analyses were conducted using Stata Data Analysis and Statistical Software (Version 9). Qualitative data management and analysis were conducted with NVivo9. Focus group and interview transcripts were reviewed and read repeatedly by the qualitative team (ALD, JEM, & RHR). A coding framework was developed by identifying major themes

using applied thematic analysis (Boyatzis 1998; Braun and Clarke 2006). Transcripts were reviewed and an initial list of themes, structured along the pre-conceived domains of the focus group and in-depth interview guides, was developed. Transcripts were re-read and coded broadly, searching for relevant themes or patterns in the data. Initial codes were collected, analysed, and considered for intersections and relationships. A set of candidate themes was produced, discussed, and refined. Transcripts were re-read and re-coded to ensure all relevant text was properly coded and all codes accurately reflected the data. Relevant text was excerpted broadly to retain interview context, and copied into coded sets. From this process, a structured coding framework was developed, wherein each code was identified, defined, and illustrated through selected interview excerpts. Codes were summarized, discussed, analysed, and verified for consensus by the entire qualitative team.

Though gender was not a preconceived domain, it was identified as a significant theme throughout the data. Sub-themes included (1) *gender norms* – references to perceived natural or social differences between personalities, behaviours, or qualities of men and women; (2) *gender and power* – references to how men and women negotiate power in different ways; (3) *gender performance* – references to how men and women perform roles in relationships; and (4) *perceptions of HIV* – references to how men and women perceive HIV. These codes were analysed and interpretations were triangulated based on extant literature.

Results

Socio-demographic characteristics

Demographic characteristics of participants are presented in Table I. Female survey participants (n=200) ranged in age from 18–45 years and 94.5% had tested for HIV and received the results; female focus group participants (n=62) ranged in age from 18–41 years, and 100% had tested for HIV and received the results. Two significant differences were noted between female survey and focus group participants: (1) HIV+ status (41.8% of survey vs. 29% of focus group participants; and (2) male partners employed outside Lesotho (28.5% of married/cohabitating survey participants vs. 47.6% of those in focus groups) Male participants (n=30) ranged in age from 24–57 years; 76.6% had tested for HIV and received the results. While not asked directly about sexual partner concurrency, 12% of female survey participants and 26.7% of male participants reported having more than one sexual partner in the last 12 months.

Characteristics of women's sexual relationships

Of the female survey participants who provided information about their most recent sexual relationships, 92.4% reported having older partners, and 44.1% reported having partners who were older by 5 years or more. Female focus group participants reported similar findings: 88.5% reported having older partners and 45.9% reported having partners who were older by 5 years or more. 37.1% of female survey participants and 27.9% of female focus group participants reported using a condom during their last sexual encounter

Overview of themes

Four broad themes emerged from qualitative data analysis relating to gender dynamics and perceptions of HIV: (1) relationships; (2) gender dynamics within relationships; (3) perceptions of HIV testing; and (4) strategies for engaging men in HIV prevention and testing.

Relationships

Participants reported that multiple concurrent relationships were common among both men and women and primarily attributed this to men's labour migration and sexual desire, and women's financial needs. Women described the financial benefits of extramarital relationships, while men primarily described the emotional support and sexual fulfilment of such relationships.

'Something that might happen is if... you live with a partner that does not work. At times you end up falling for someone else so as to get money. Really money is the source of *bonyatsi's* [extra partner's] occurrence.' (Woman)

'People have needs and a man gets lonely out there by himself. He needs someone to keep him company and take care of his needs.' (Man)

Men also spoke of cultural expectations that men seek multiple concurrent relationships.

'I have seen that [multiple concurrent relationships are] a very common thing, as you know a *mosotho* [Basotho person] will say *monna ke mokopu oa nama* [a man is a pumpkin plant that spreads, meaning that men are supposed to have a lot of sexual partners].' (Man)

Women and men characterised men's sexual desire as 'greed' – expressing beliefs that men are inherently 'greedy' – unable to stop themselves from the temptation of women and prospect of multiple partners.

'[Multiple relationships] are very common because... females are the ones who entice us to the things we do not intend to do.' (Man)

Men were aware of the transactional nature of these relationships – and explained the essential role money plays in the initiation of such relationships.

'Money is also the source of all these [extra relationships] because if you have money, everyone is willing to take you.' (Man)

Participants distinguished primary relationships (marriage or long-term partnerships) from secondary or extra relationships by level of commitment. Primary partners were perceived as willing to remain committed and supportive in spite of hardships, while secondary partners were seen as opportunistic and self-interested.

'The main partner is the one who will rise and fall with you. Maybe when you are sick or when she is working and you are not working or maybe both of you are not working, but she will rise and fall with you. That one is the main partner. The one who is not the [main] partner will leave you immediately when your money is gone

and she will say she is going to look for a job. You will find her somewhere not even where she said she was going. She is now doing her other businesses.’ (Man)

Gender dynamics

Participants often described relationship dynamics in terms of gender roles/norms. Hegemonic masculinity was commonly characterised as a central feature of heterosexual relationships, particularly male dominance.

Male dominance

Men and women frequently described men as heads of household. While many participants viewed household decision-making as a joint endeavour (e.g., health care, child care, employment, and finances), most conceded that male partners have ‘final say’ over household decisions.

‘Truly speaking, my husband and I always reach a consensus together. [But] sometimes you may find that [even though] we can discuss an issue, he will coerce me and end up making his own decision. There is nothing you can do, you will just agree with him.’ (Woman)

‘...in my house every main decision has to be made by me because I am the head of my house. She only assists me in making the decisions, but at the end of the day, I say what goes.’ (Man)

Sexual decision-making was uniformly typified by male dominance; men and women agreed that men primarily make sexual decisions, such as when and how sex would occur.

‘In our culture a man is the head in a relationship. If you look at cocks, for example, a cock always has sex with a hen without asking.’ (Man)

‘Normally men are the ones that propose sex and when he wants to, you will just have to agree and if you just tell him that you are tired, he will not accept.’ (Woman)

Participants often attributed male dominance to the ‘nature’ of men and women. Men were described as naturally sexual creatures, with more urgent physical needs than women.

‘...men tend to get intimate with women when their manhood is ready to act. I would again say the minute men see women, their manhood becomes very active ...so the decision is still made by men, especially since Basotho women are even shy to demand sex from their partners. That is why a final say is always reached by men.’ (Woman)

Codes of female sexuality

Participants also conveyed explicit codes of female sexuality that prohibit women from actively engaging in sexual communication and negotiation. Autonomous female sexuality is often equated with promiscuity; men may view women with suspicion if they know or say ‘too much.’ Therefore, women spoke of being unable to discuss sex openly with their partners.

‘If a woman talks about sex and maybe how she wants it done, her man might start having doubts and ask her where she learnt all those things.’ (Woman)

Women’s feelings of being unable to discuss sex with their partners or request sex were compounded by feelings of futility in negotiating condom use.

‘You will end up making it [having sex] without using a condom. As a woman, you will understand that if you refuse this, family will be destroyed. Or he will be angry with you day and night, and it will just be silence in the house....’ (Woman)

These gender norms also affected women’s discussion of HIV testing with their partners.

‘Maybe you want to talk about HIV with him. He will get cross and say you already have it -- that’s why you want him to test. It’s not very easy to convince a male person to go for a test.’ (Woman)

Therefore, gender norms within relationships were implicitly seen as impeding sexual communication and decision-making, and HIV prevention for women.

Perceptions of HIV testing and testing behaviours

Unlike women, who may have regular access to HIV information and testing through antenatal clinics, and/or incentive to test for their children’s well-being, men have neither regular contact with clinics nor direct incentive to test. Men and women unanimously characterised men as fearful of and resistant to HIV testing. Although most men reported having tested and received the result, the consensus was that most Basotho men avoid HIV testing.

HIV testing & gender

Men reported few opportunities for regular contact with health clinics or HIV testing sites, and commonly receive information about HIV from television, radio, or friends. Because women have more opportunities for contact with health services and HIV prevention, and may test for HIV during antenatal care, participants reported that men commonly perceive HIV testing to be something that women do. Consequently, HIV itself has come to be seen as a disease that women bring into the relationship and are responsible for managing.

‘Men usually say that HIV testing is for women.’ (Woman)

‘In most cases, men perceive their partners to be the ones that brought infection in the family...just because she is female.’ (Man)

Additionally, men and women explained the phenomenon of men using their wives’ HIV status as a proxy for their own, which allows men to avoid HIV testing while still feeling they have some indication of their HIV status.

‘What [men] like to say is that once I have tested, he had already tested, too.’ (Woman)

Barriers to HIV testing for men

Both men and women reported that a positive HIV test may be seen as confirmation of infidelity, and that men may avoid testing because they do not want their wives to know

about their extramarital activities. Furthermore, men discussed how testing for HIV is often perceived as a life-changing event that will directly impact their relationships and behaviour, regardless of the test result. Men reported feeling (or expecting to feel) obligated to change their behaviour once they learned their status, whether positive or negative, suggesting that men may consider HIV testing to be incongruous with their current lifestyles or may alter their lifestyle in undesirable ways.

‘[Some men] know that they are not faithful to their wives so they don’t want to be exposed.’ (Woman)

‘I think that after a person gets their test results they become more careful, whether they are negative or positive, knowing their status would influence them to be more careful.’ (Man)

Fear and lack of knowledge were the most commonly cited reasons for men’s avoidance of HIV testing. Community-based HIV stigma and conflict within personal relationships were viewed as significant barriers to testing. Most importantly, many men described HIV as a ‘death sentence’, or people with HIV as ‘already dead’, indicating a strong basis for not only fear, but also feelings of futility regarding HIV testing.

‘[Men testing for HIV] is something not common, because once you get HIV tested and your friends discover that you are HIV-positive, you will feel isolated and it is something disappointing in life.’ (Man)

‘Basotho men are afraid to test because when we test and we are told that we are HIV-positive, that sounds like a death sentence to us.’ (Man)

Additionally, both men and women believed that because men are acutely aware of how their sexual behaviour may contribute to their HIV risk, they fear they are already infected, and consequently avoid HIV testing.

‘Our own actions tend to prevent us from [HIV testing] because you know what you have been doing outside and now you know that for you to have this thing, I could very well have it. I think you get frightened of knowing you have it...’ (Man)

Participants suggested men’s fears stem from a lack of education and information about HIV prevention and treatment – in particular, there seemed to be a dearth of reliable narratives conveying the possibility of surviving and living well with HIV. While a few participants knew of a person living well with HIV, many others reported distressing stories about men with HIV who lost friends, were stigmatized by the community, committed suicide after learning their status, were abandoned by spouses, who purposefully spread HIV to exact revenge, and who suffered early, inevitable death. While the majority of these stories were at best second- or third-hand accounts, perhaps based on rumour, they indicate a lack of information about living positively with HIV and the benefits of antiretroviral therapy.

‘[Men believe that a positive HIV test] means I am now useless. That’s why you find one selling his cattle and sheep, claiming he is dying – even though there is still help – leaving the place empty and [he] ends up being killed by depression because all he [understands] is that he is infected by this thing [that] is not curable. Therefore, he is going to die. He destroys whatever wealth he might have from the

mines and spends his finances on beer and everything. Others just spread it on purpose...so that when he dies, he may die with others...I've had one friend of mine say that if he was told he is infected, he would spread it a lot....' (Man)

Strategies for engaging men in HIV prevention and testing

All participants were asked: *What do you think could be done to encourage more men to get tested?* Some men and women suggested legal mandates for men to get tested.

'There should be laws to force them...to get tested. HIV is a deadly disease [and] if we wait for them to initiate to go get tested, people will be put in danger intentionally.' (Man)

Many women suggested incentives for men, such as money, food, calling cards, or t-shirts.

'They would all [test] [if there was financial incentive]. My husband wanted to come after seeing R100.00 incentive I got last week [from a testing initiative]. Truly everyone would come because of the money.' (Woman)

Men rarely discussed material incentives, and were more likely to suggest strategies to increase knowledge, raise awareness, and make HIV testing more accessible and acceptable for men. These suggestions are outlined below.

Interventions for men

Both men and women indicated that increasing men's knowledge of HIV might increase their testing rates. Men spoke about insufficient educational initiatives for men.

'Basotho should [make] huge *pitsos* [village meetings] in the country so they may understand... the experts that work with [HIV], they must go out and clarify things to people in ways that are very clear, other than once in a blue moon when a person is from town in their home town will come up and say, "hey do you know this pamphlet". Our people are illiterate. We are from the mines. We don't know what is being said ... here in Lesotho we want clear things.' (Man)

Additionally, men and women asserted that HIV interventions *among men* could successfully engage men in HIV testing.

'I think it's needed for men only to have their own meeting where discussions about HIV can be held and us as men should be advised to go for HIV tests...the chief should call a *pitso* and tell [us] he wants men only so when we are there at *khotla* [a place where meetings are held by men only], he may tell us what to do.' (Man)

Testing together and home-based testing

Men and women were asked about couples testing and home-based testing as strategies to increase testing rates. Many men and women were receptive to counselling and testing couples together as a component of HIV prevention, and thought that home-based testing could increase testing rates among men. Men, in particular, saw home-based testing as

preferable to clinic-based testing because they would not be stigmatised due to being seen at an HIV testing site.

‘[Testing for HIV is] still a terrifying thought to me. I think it is the whole thing about me going to the clinic. I wish they could come here in the village to test us. It is a bit scary to do it at the clinic.’ (Man)

Men also noted that the comfort of home might be an ideal environment to engage men in testing, discussion, and support.

‘I think men definitely would [home]-test ... because there is no place like home. It is where I know I can get all the support’ (Man).

Home-based testing was also perceived as a potentially more equitable method of testing for couples, as both men and women asserted that testing together at home could facilitate disclosure and support among couples.

‘Again, as a woman, you will come to the clinic alone, and if you are told that you are HIV-positive, it won’t be easy for you to tell your husband that you are positive. But if you both come, you will be told at the same time. So that you can both be counselled.’ (Woman)

However, a minority of men expressed concerns about home-based testing, including men’s willingness to discuss HIV prevention with their wives, and potential negative effects of home-based testing on family dynamics.

‘I think [home-based testing] is necessary...but given our tradition, it not easy for men to openly talk about such issues in the presence of their wives and children.’ (Man)

Discussion

In this paper, we describe how Basotho men and women in this study characterised gender dynamics within intimate relationships, as well as how perceptions of HIV testing and HIV prevention strategies are inherently gendered. Men and women reported gender dynamics that were consistent with hegemonic masculinity: men as dominant, heads of household, entitled to and easily tempted by sex with women; women as deferential to their husband’s decisions and sexually subservient. Numerous studies have identified traditional gender and power dynamics as a barrier to open sexual communication and increased HIV risk in sub-Saharan Africa (Kaufman et al. 2008; Jewkes and Morrell 2010, 2012). Our findings contribute to this research, as both men and women in our study characterised gender dynamics as impeding sexual communication, and women described feeling unable to discuss sex or HIV testing openly with their partners, or play a collaborative role in sexual decision-making. Gender and power dynamics also contributed to the formation and prevalence of multiple concurrent partnerships, as men reported gendered expectations to engage in extramarital relationships, and women felt economic pressure to maintain extramarital relationships while their partners were away. These findings support a growing body of literature examining the role of gender norms and masculinity in multiple

concurrent partnerships, as well as the transactional nature of such relationships (Carter et al. 2007; Leclerc-Madlala 2009).

Men and women in our study indicated that the most significant barriers to HIV testing for men are fear and lack of education. Men described feeling that HIV testing was incongruent with their current lifestyles, which included having multiple concurrent partnerships. Additionally, men and women indicated that community-based HIV/AIDS stigma deters men from HIV testing, as well as fear of disrupted relationships and early death. These findings implicitly demonstrate how men's adherence to models of hegemonic masculinity may adversely influence men's willingness to test for HIV. Our findings are supported by other studies which have shown how masculinity affects willingness to engage in HIV prevention strategies, such as HIV testing and disclosure (Dageid, Govender, and Gordon 2012), and how uptake of HIV testing and treatment may be associated with weakness and thus incompatible with men's perceptions of their own masculinities (Siu, Seeley, and Wight 2013). Our study contributes to this research by demonstrating the vital role fear plays as a barrier to HIV testing for men.

Men and women indicated that HIV has come to be seen as a disease that women are responsible for managing, and consequently, that women bring into the relationship. This prevents women from feeling they can ask their partner to test for HIV, and causes conflict within relationships. These findings illustrate the imperative for HIV interventions to specifically target men and couples in HIV prevention and testing programmes. We assert that targeting men is a necessary strategy not only to increase testing rates and improve health outcomes in men, but also to address women's HIV vulnerability and enhance overall health outcomes in women. This assertion is supported by prior research that calls for a more balanced approach to HIV prevention, both globally and within sub-Saharan Africa (Pulerwitz et al. 2010; Mills et al. 2012). Interventions that seek to increase knowledge of HIV/AIDS among men are needed to increase HIV testing rates and improve sexual communication and negotiation with their female partners (Peacock et al. 2009). Our findings suggest that such educational interventions are lacking in Lesotho, and indicate that including local chiefs and/or utilising community-based outreach methods specifically run by and targeted to men may be potential strategies for implementing educational interventions in Lesotho.

Engaging with men also provides the opportunity to implement 'gender transformative' programmes – interventions which seek to actively transform underlying gender norms such as male power, control, and violence (Peacock et al. 2009; Dunkle and Jewkes 2007; Gupta 2000). Our findings demonstrate the necessity of gender transformative programmes; men and women in our study described hegemonic masculinity and gender as factors underlying relationship formation and dynamics, sexual decision-making, knowledge of HIV/AIDS, and willingness to test for HIV and/or engage in HIV prevention strategies. The Men as Partners programme in South Africa, designed to engage men in reducing gender-based violence and promote men's constructive role in sexual and reproductive health, has resulted in constructive changes in men's knowledge of HIV prevention, attitudes regarding HIV prevention and sexual relationships, and practice related to gender equity within relationships (Peacock and Levack 2004). Other similar programmes have demonstrated the

feasibility of interventions seeking to transform hegemonic construction of masculinity, and engage men constructively in gender equality and sexual health (Greig et al. 2008). A recent review suggests gender transformative programmes can play an important role in preventing partner violence, increasing protective sexual behaviours, and reducing HIV/STIs (Dworkin, Treves-Kagan, and Lippman 2013).

Additionally, increased access to testing sites and incentives to test are needed for men in order to normalize and expand testing. In our study, home-based testing was perceived as a potential strategy to engage men and couples in testing and counselling. Lesotho's National HIV/AIDS Strategic Plan cites home-based testing as a potential strategy to increase HIV testing rates and expand male involvement and partner communication (Lesotho National AIDS Commission 2011). Our findings support this approach, indicating that home-based testing may be effective in increasing uptake of HIV testing among men, as well as facilitating a more mutually supportive testing environment for couples. However, our findings also indicated potential problem areas in home-based testing, including men's dominance over household decisions, which could prevent home-testing from occurring, as well as men's uneasiness with discussing sex and/or HIV with their female partners. Further research on home-based testing is necessary to address implementation issues such as potential conflict within the family, confidentiality and privacy concerns, where to provide counselling following home-testing, and other practical issues such as cost and sustainability.

Incentivising HIV testing monetarily, suggested by the women in our sample, is a strategy that warrants more discussion and research. While conditional cash transfers have been used in prevention trials to promote safer sex and health behaviours (Medlin and de Walque 2008) as well as uptake of voluntary testing and counselling services (Thornton 2008) in sub-Saharan Africa, study findings have been mixed and more research is required to assess the potential ethical concerns of such programmes (Kohler and Thornton 2011).

While some participants expressed the need for HIV testing to be required by law, this topic is highly debated among public health researchers, due to concerns regarding privacy, coercion, and human rights as well as issues of social stigmatisation and institutional discrimination, and questions regarding cost, sustainability, and enforcement (Durojaye and Balogun 2010). Both UNAIDS and the WHO have affirmed opposition to mandatory HIV testing based on public health grounds (World Health Organization 2012).

This study has a number of limitations. Qualitative studies aim to gain in-depth insights and their variations from small samples and therefore are not generalisable to the overall population in these two districts or to other regions in Lesotho. Convenience sampling and self-selection bias limit the ability to draw inferences to broader populations. In a country with high HIV-related stigma and low rates of HIV testing, we chose to recruit women who had previously tested for HIV at PMTCT clinics and the men they referred in order to increase the likelihood of recruiting receptive participants who could provide rich qualitative data. Consequently, study participants may have had more favourable attitudes about HIV testing than non-participants. For example, the rate of HIV testing among the 62 female focus group participants was 100% (compared to the national rate for women of 68.6%), and

among the 30 male in-depth interview participants, the rate was 73.9% (compared to the national rate for men of 39.3%). Finally, group dynamics in the focus groups may have led to over-representation of the views of certain participants and underrepresentation of others. In spite of these limitations, this study provides valuable findings that contribute to a more comprehensive understanding of the ways in which relationship dynamics and perceptions of HIV are influenced by gender in Lesotho.

Conclusion

This study demonstrated the vital importance of understanding and addressing gender as a structural factor in HIV prevention programmes. More studies are needed to determine the most effective strategies to inform and engage men, increase women's negotiation skills, and involve couples in testing and counselling. Even as we move forward with HIV prevention programmes that target individual and couples' behaviour, women's sociopolitical and economic inequalities will continue to affect their vulnerability to HIV. To reduce new HIV infections, these factors must also be addressed via structural changes at the social, political, and economic level.

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Table 1

Sociodemographic characteristics of samples.

	Female Survey (n=200) No. of participants (%)	Female Focus Groups (n=62) No. of participants (%)	Male Survey (n=30) No. of participants (%)
Age	Range: 18–45 Mean: 26.2 SD: 5.9	Range: 18–41 Mean: 25.1 SD: 5.6	Range: 24–57 Mean: 32.6 SD: 8.6
Has tested for HIV and received results	189 (94.5)	62 (100.0)	22 (73.3)
HIV status of those tested who received results			
Positive	79 (41.8)	18 (28.5)	3 (10.0)
Negative	108 (57.1)	44 (69.8)	16 (53.3)
Undisclosed	2 (1.0)	0 (0)	3 (10.0)
Married or cohabitating	159 (79.5)	48 (77.4)	21 (70.0)
Where male partner or men are employed			
Same village	46 (23.0)	12 (28.5)	15 (50.0)
Other village	32 (16.0)	10 (23.8)	13 (43.3)
Out of country	57 (28.5)	20 (47.6)	0 (0)
Number of sexual partners in last 12 months			
0 sexual partners	3 (1.5)	1 (1.6)	0 (0)
1 sexual partners	173 (86.5)	56 (90.3)	22 (73.3)
2 sexual partners	21 (10.5)	4 (6.5)	7 (23.3)
3 sexual partners	3 (1.5)	1 (1.6)	1 (3.3)
Had sex with someone other than primary partner in last 12 months ¹	21 (13.2)	5 (10.4)	7 (33.3)

¹ Of those married or cohabitating with partner

Table 2

Characteristics of women’s sexual relationships.

	Female survey (n=170) ¹ No. of participants (%)	Female focus group discussions (n=61) ² No. of participants (%)
Age of most recent sexual partner		
<i>1–5 years younger</i>	2 (1.2)	1 (1.6)
<i>Same age</i>	10 (5.9)	6 (9.8)
<i>1–5 years older</i>	82 (48.2)	26 (42.6)
<i>5–10 years older</i>	52 (30.6)	18 (29.5)
<i>>10 years older</i>	23 (13.5)	10 (16.4)
<i>Not sure</i>	1 (0.6)	0 (0)
Relationship with most recent sexual partner		
<i>Husband</i>	131 (77.1)	45 (73.8)
<i>Cohabiting partner</i>	1 (0.6)	1 (1.6)
<i>Steady partner</i>	16 (9.4)	8 (13.1)
<i>Casual partner</i>	20 (11.8)	6 (9.8)
<i>One night stand</i>	2 (1.2)	1 (1.6)
Use of condom at last sexual encounter		
<i>Yes</i>	63 (37.1)	17 (27.9)
<i>No</i>	107 (62.9)	44 (72.1)

¹ 170 of 197 women who reported having sex within the last 12 months; data for 27 women is missing for these questions due to interviewer error

² 61 of 62 women who reported having sex within the last 12 months; data for 1 woman is missing for these questions due to interviewer error