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Avoiding Truth in a Time of Knowledge: Male Youth Refusing to Test for HIV



DECLARATION BY STUDENT

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Acknowledgements

I am thankful to my God and ancestors for relentlessly being the light in all I do.

I dedicate this report to Mrs. Nurse Ramadimetja Baloyi, my mother. Mom, I know this has been a very tough and demanding journey, but through your unwavering and endless love, encouragement, support and sacrifices, I made it. I am thankful to you mother for believing in me and giving your all for me to study for this degree.

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List of acronyms

AIDS:	Acquired immune deficiency syndrome
ART:	Anti-retroviral treatment
HCT:	HIV counselling and testing
HIV:	Human immune virus
LGTB:	Lesbian, gay, transgender, and bisexual
MSM:	Men who have sex with men
NDOH:	National department of health
NGO:	Non-Governmental Organisation
NHS:	National health survey
NSP:	National Strategic Plan for HIV, STIs and TB
PITC:	Provider-initiated testing and counselling
PLWHAV:	People living with HIV/AIDS
SA:	South Africa
STDs:	Sexually transmitted diseases
STIs:	Sexually transmitted infections
UNAIDS:	The United Nations Programme on HIV/AIDS
VCT:	Voluntary counselling and testing
VMMC:	Voluntary medical male circumcision
WHO:	World Health Organization



CHAPTER 1: INTRODUCTION

This chapter introduces the topic- Avoiding truth in a time of knowledge: male youth refusing to test for HIV. The chapter presents statistics indicating the refusal to test by young males and proceeds to outline the refusal to test within the availability of HIV management and treatment services. The chapter also presents the importance of HIV Counselling and Testing (HCT) as an HIV preventative strategy which young males deliberately choose to ignore. The chapter concludes by outlining the overall structure of the report.

1.1 Introduction

In 2016, I was part of a field team tasked by the National Department of Health (NDOH) to investigate the barriers to the uptake of Voluntary Medical Male Circumcision (VMMC) in Kwazulu Natal (KZN). The objective of the fieldwork was to come up with recommendations to scale-up VMMC as an HIV preventative measure at a national level. One outstanding barrier to the uptake of VMMC especially among young males was the pre-HIV test requirement prior to conducting the procedure. Most young males wanted to circumcise, but they did not want to know their HIV status. Hence they did not participate in the circumcision programme. I was therefore interested in understanding why these males avoided knowledge about their HIV status while accepting medical knowledge about HIV and circumcision. As John F Kennedy once said “there are risks and costs to a programme of action. But they are far less than the long-range risks and costs of comfortable inaction” (John F Kennedy 1917-1963 in Callan and Thomas, 2009:126). Due to logistical constraints, the study was conducted in Naledi, a township located in Soweto instead of KZN. A detailed profile of and the justification for choosing Naledi as the research site is provided in the methodology section.

Statistics also confirm that there is low HCT uptake within South Africa’s (SA) male youth. The HIV epidemic in SA is defined by the United Nations Programme on HIV/AIDS (UNAIDS) as a hyper-endemic epidemic due to the country having above 15% of the population aged 15-49 living with HIV. The 2011 SA Census illustrated that about 10% of the South African population are adolescents aged 15-19 years old (Otwombe et al, 2015). According to MacPhail, Pettifor, Moyo & Rees (2009),



HIV/AIDS is a major public health concern among the South African youth. The 2012 national survey illustrated that HIV prevalence among youth aged 15-24 years, was 10.2%; 15.5% among young females and 4.8% among young males. The previous national health surveys show an increase in HIV testing within both gender youths over the years. However, it is important to note that the male uptake of HIV/AIDS Counselling and Testing (HCT) is increasing at a very low rate with a recorded 0.6% increase in 2012 (Shisana et.al, 2014) . Given the above statistics and my impressions in the male circumcision, it is important to continue to study male's unwillingness to test for HIV.

This study investigates why male youth still avoid HIV testing when the disease can be managed, whileone's HIV status remains confidential. The literature (Meiberg et al, 2008; Rohleder et.al, 2009 & Mambanga et.al, 2016) reveal that if people know their HIV/AIDS status, they are in a better position to manage their health as well as curb the spread of the HIV virus. HCT services thus facilitate the process for acquiring knowledge of male youth's HIV statuses. The HCT services are available and free to all citizens including young males who tend not to utilise them. HCT services include the provider-initiated testing and counselling (PICT) which conducts routine HIV testing and counselling on clients who attend health facilities regardless of their presenting illness, and the Voluntary Counselling and Testing (VCT) which is a client-initiated approach to counselling and testing for HIV. Thus, medical knowledge and social support for HIV have increased yet HIV testing rates remain low.

The refusal to test for HIV by young males is an important matter that needs to be examined considering that HCT is considered to be a key strategy through which the spread of HIV infection can be significantly reduced. Peltzer & Matseke (2013), note that HCT services in SA have become increasingly available and accessible in recent years with more than 4500 public health facilities providing the HCT services. HCT serves various purposes for controlling the HIV/AIDS epidemic (Nel, Yi, Sandfort, & Rich, 2013). The data drawn from HCT can enable public health officials to develop a statistical baseline of the rates of HIV infection incidence and prevalence for targeted populations. Moreover, continuous HIV surveillance is important for establishing national HIV/AIDS policy and related strategies (Nel et al, 2013).



Young males disadvantage themselves by refusing to test. This is because HCT from a healthcare perspective serves as an entry point for essential intervention opportunities with regard to early diagnosis and prevention, support and medical care services (Mambanga et.al, 2016). At an individual level, HCT may encourage people to practice HIV preventive behaviours (Nel et al, 2013). The practice of HIV preventive behaviours is likely to occur when other personal, structural and social factors fostering behaviour change are in place. It is also likely to happen when decision making around sexual risk reduction strategies are made possible on the basis of knowledge of one's HIV/AIDS status and knowledge of the HIV status of one's sex partner(s) (Nel et al, 2013). Thus, young males' refusal to test for HIV puts them in a vulnerable position with reference to HIV infection. The deliberate ignorance of HIV testing by the young males thus becomes an important matter that needs to be investigated.

This research report is organized in the following order: Chapter 2 provides a review of literature that focuses on writings by different authors who focus on HIV testing and prevention among men. It also presents deliberate ignorance as a conceptual framework guiding this study. Chapter 3 discusses the sampling method employed (purposive sampling). It also outlines the qualitative interview methods utilised by the study In addition, the chapter presents the methods used to analyse the data (thematic analysis). Chapter 4 presents the findings of the study. Chapter 5 discusses the findings to demonstrate the argument and establishes the link between testing avoidance and deliberate ignorance. Chapter 6, concludes the report and provides recommendations.

This chapter has introduced the topic - Avoiding truth in a time of knowledge: male youth refusing to test for HIV. The chapter has presented statistics indicating the refusal to test by young males and proceeded to outline their refusal to test within the availability of HIV management and treatment services. The chapter has also outlined the importance of HCT as an HIV preventative strategy which young males deliberately choose to ignore. In addition, the chapter has outlined the overall structure of the report. The next chapter reviews literature on factors that account for avoidance to test for HIV.



CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter critically discusses literature on factors that account for avoidance to test for HIV. It begins by outlining and assessing socio-structural factors responsible for HIV test avoidance since the 1990's. The chapter outlines and assesses gender norms, stigma, fear of the unknown and lack of trust in the health systems as the main socio-structural factors prohibiting HCT uptake. The chapter continues by discussing global interventions that have been put in place to address the outlined socio-structural factors. In addition, the chapter attempts a critical discussion of the interventions' limitations, leading to the identification of the gap in the literature. The chapter then concludes by suggesting how 'deliberate ignorance' theory clarifies the socio-structural explanations of HCT avoidance thereby framing the discussion of this study's findings. The study did not cover other socio-structural factors such as the low-perceived risk of infection. Therefore, the four structural barriers covered by the study, starting with gender norms are presented below.

2.2. Socio-structural barriers

2.2.1. Gender norms

Traditional gender roles decrease the likelihood for men to seek health services including HTC services. Men may believe that seeking health services is a sign of weakness and vulnerability (Peacock et.al, 2008; Leclerc-Madlala et al, 2009; Jewkes et al, 2009; Smith 2013; MenEngage Africa Network, 2013; and Mkhwanazi, 2014). Doyal (2016) further argues that women as compared to men have to seek antenatal care services which provide a favourable setting for women to test. These gender norms are justified in terms of traditional masculinity. Orr et.al (2017) argues that traditional masculinity influences health-seeking behaviour. Men believe that clinics are women's places and HIV is a women's disease. Orr et.al (2017) support Doyal's arguments by outlining that males are self-conscious and not at ease with visiting health facilities because usually young males cannot be found there for any other reasons besides HIV. Moreover, young males believe that once seen at health facilities, people will assume that they could be HIV infected (Orr et.al, 2017).

Therefore, men who visit health facilities are perceived to be weak. As a result they avoid visiting these facilities and also avoid HIV testing.

Men perceive illness as a sign of weakness. Therefore, they tend to avoid HCT and medical treatment until when they are severely ill (Shisana, 2005; Shisana et al, 2012; Orr et.al 2017). Masculine health-seeking behaviour increases AIDS-related mortality and exacerbates the negative attitudes towards condoms (MenEngage Africa Network 2013). These traditional conceptions of manhood are thus detrimental to young males. This is because the fear of being ill, being bedridden, dependent on others for help, and ultimately dying of AIDS threatens the traditional conception of what it means to be a male person, especially when one is still young between the age of 18 and 35 years old.

Masculinity is important for addressing young male's interactions with HIV testing. However, the issue of sexuality inclusion is also important. This is because there exist a group belonging to the Lesbian, Gay, Transgender, and Bisexual (LGTB) group within the young males' population. Therefore, it is important to represent the gay, transgender and bisexual male understandings and experiences of HIV because they are still males despite their sexuality. With reference to men who have sex with men (MSM), Lane et al (2011) found that there are gay men who also engage in sexual activity with women in order to hide their identities and behaviours. This is thus problematic because these men are difficult to target in terms of same-sex precise HIV prevention messaging tailored for MSM. As a result, most of these men miss important HIV prevention messages, and this absence of information increases the long-term risk of HIV infection among themselves together with their male and female partners (Sandfort et al, 2008 & Lane et al., 2011).

MSM may pose as straight in order to blend into the environments they find themselves in and may avoid seeking HIV testing because of the masculine pride attached to the behaviour. Sexual orientation is thus important in studying HIV/AIDS testing, transmission and contraction among varied populations. However, this study focuses on male youth's reluctance to test for HIV/AIDS regardless of their sexual orientation. According to Peacock et.al (2008); Mambanga et al (2016) and MenEngage Africa Network (2013), South African males are less likely to pursue HIV

testing and as a result, they are less likely to know their HIV status. The next section discusses how stigma inhibits the uptake of HIV testing.

2.2.2. Stigma

HIV/AIDS stigma is capable of reducing the will of people to test for HIV and their willingness to seek HIV treatment and prevention (Parker and Aggleton, 2003; Deacon et al, 2005; and Obermeyer and Osborn, 2007). This has been noted in the following countries: SA, Tanzania, Ghana, Indonesia, Botswana, Uganda, Ethiopia, Thailand, India, and Zimbabwe (Obermeyer and Osborn, 2007). HIV/AIDS stigma is defined by Deacon et.al (2005) as a long-lasting attribute of an individual who is HIV infected, which is undesirably valued by the society and it, therefore, disadvantages people living with HIV/AIDS (PLWHAV). Young et.al (2010), argue that stigma plays a significant role in people's decisions, behaviours and outcomes.

The fear of stigma is a dominant deterrent factor of HCT uptake in Sub-Saharan Africa (SSA) (Musheke et al, 2013). This is because, HIV transmission is predominantly heterosexual across SSA (Schoepf, 1995; & MacPhail et al, 2009). Therefore, being seen at a testing station is synonymous with sexual promiscuity and leads to assumptions of an HIV-positive status (Gilbert et al, 2010; Musheke et al, 2013 Scambler, 2009; & Young, et al, 2010). Subsequently, the fear of social exclusion also leads to HIV test avoidance across SSA. Musheke et al (2013), note that people fear losing sexual partners, social support and anticipate the possibilities of violence and abandonment, all of which inhibit the uptake of HIV testing.

Stigma is an element that goes hand in hand with discrimination and both these factors are sufficient to discourage male youth from testing. Across SA just like in other parts of the world, HIV/AIDS is widely viewed as an outcome of sexual excess and low moral character. Therefore, the people affected by the virus are inclined to hide their infections because when they reveal their status, they are subjected to victimization and discrimination (Rankin et al, 2005). According to Johnston (2001), the victimization and discrimination take place everywhere starting from the victim's homes, to the communities they live in, and even at their workplaces. The victimization and discrimination of HIV infected people, therefore, perpetuates a strong culture of silence as these people may fear rejection and isolation from their

close relatives and the communities they live in (Johnston, 2001). In Nigeria, stigma and discrimination have been found to be the most reported factors constituting a serious obstruction for VCT uptake and HIV prevention (Odimegwu et al, 2013). Yahaya et al (2010) found stigma, discrimination, poverty and ignorance as the main reasons for the low uptake of VCT in Kwara State of Nigeria.

The victimization and discrimination of HIV infected people thus instil the fear of testing in young males. This is pointed out by Lee and Kotler (2011) & Asaolu, et al (2016), who maintain that the youth are more afraid to test for HIV because of the stigma associated with it. They argue that the youth were adamant that if they tested positive for HIV, it would mean rejection, and loss of loved ones. Moreover, based on the findings by Lee and Kotler, the youth outlined that even taking the HIV test was stigmatised because when seen taking the test, people would have a negative attitude towards them (Lee & Kotler, 2011). Therefore, the arguments by Lee and Kotler support the argument by Goffman (1963) who argues that stigmatisation is a result of the information carried by human beings on a day-to-day basis about the victims of stigma. Therefore, the youth may feel inclined to avoid anything that links them to HCT services because they would not want people to assume they have HIV/AIDS and be stigmatised.

The refusal to test due to stigma thus point out that the knowledge other people possess about oneself is vital. It is so crucial that one may take life threatening decisions such as not testing for HIV because people will see them at the testing station. Atell (2013) outlines how important the knowledge held by the community about oneself is. According to Attell (2013), individuals tend to have varying identities in attempts to avoid stigma. These varied identities are adaptable and flexible depending on the social context one finds themselves in. According to Goffman (1963), these identities can be acknowledged as personal and social identities. Personal identities hold the true value to oneself whereas the social identity refers to the portrayed personality in situations where social information requires to be controlled (Goffman 1963). Stigma as a testing deterrent brings bout the feeling of fear among young males which is also a factor that deters them from testing. Therefore, the next section discusses how the fear of the unknown prohibits young male's uptake of HCT.

2.2.3. Fear of consequences of knowledge

There is a belief that what one does not know cannot hurt. For many people the pursuit of knowledge can yield discomforting information which may hurt the pursuer. The findings of a study conducted by Lee and Kotler (2011) found that youth had different reasons that discouraged them from accessing HIV testing services. The reasons suggested included: the fear of death, fear of finding out one is HIV infected, fear of rejection and fearing the unknown (Lee & Kotler, 2011). According to Obermeyer and Osborn (2007), people avoid testing for HIV because it is a life threatening disease. However, the fear is also about the social consequences that comes with the disease, which can include discrimination and violence, and the possibility of loss of employment (Obermeyer and Osborn, 2007).

The motive to test by an individual is influenced by their perceived ability to manage the disease. Therefore, most people in SSA still associate a positive HIV diagnosis with death and mental distress (Wallace, 2011; & Museke et al, 2013). These associations are still prevalent even with the availability of life-prolonging treatment, information and support services. As a result of lack of proper knowledge, individuals choose to deliberately avoid testing and put themselves and others at risk of HIV infection and transmission (Wallace, 2011).

The fear of a positive result is a recurrent theme in the literature (see Chariyalertsak et al., 2006; Rohleder et.al, 2009; Lee and Kotler 2011; Wallace, 2011; and Musheke et al, 2013). This fear is rooted in anxiety and the avoidance to face potential vulnerability. This is likely to happen especially if the person is still young. According to Wallace (2011) the fear of a positive diagnosis is framed in the context of recognition of an individual's mortality and the anticipated negative social responses to their HIV diagnosis. To add, it is also framed in the context of an individual's apprehension about the possible lifestyle changes required. In addition, concerns about access to medical care and treatment also come into play.

Tolou-Shams et al (2007) outlines three studies which highlight how the fear of a positive result deter MSM form testing. First, an in-depth exploratory study in Scotland examined the complexity of the decision-making process relating to HIV testing. The study incorporated both psychological and social factors and found that the uncertainty about the perceived ability to cope with a positive result, leading to

fear, was a significant barrier to HIV testing (Tolou-Shams et al, 2007). Second, an internet-based survey among at-risk Dutch MSM found that the fear of a positive result, and the anticipated unfavourable consequences to their lives and future was the most important barrier to testing for HIV. Third, fear and not wanting to know or not feeling ready to handle a positive result were dominant reasons for not testing in a cross-sectional survey among MSM in an STI clinic in Amsterdam (Tolou-Shams et al, 2007).

Some of the youth in Lee and Kotler's (2011) study preferred not to know than to know their HIV status. This, according to the youth, was because they alleged that it was easier to mention that they did not know their HIV status, rather than having to declare that they know their HIV status (Lee & Kotler, 2011). Fear of the unknown appeared as a recurrent theme in a study conducted by Orr et. al (2017) where it was found that males were more comfortable with not knowing their HIV status and waiting until they were seriously ill before seeking medical attention. This according to the male sample of the study was better than dying from the stress of knowing that one is HIV infected (Orr et.al, 2017).

This section clearly articulates that people may be aware of HIV and testing facilities, but choose to avoid testing due to the perceived risks, behaviours and fear of a positive result. The next section explores the lack of trust in health systems. It critically discusses the impact of health systems on HCT uptake.

2.2.4. Lack of trust in the health system

The uptake of HIV testing is influenced by people's trust in the health care system and providers. According to Musheke et al (2013), the lack of trust manifest itself in lack of confidence in individual health care workers and health institutions. Health facilities are the first line of defence in the fight against HIV/AIDS. This is because they have the tools and expertise to diagnose and treat HIV. However, SA citizens seem to possess little or no trust in these facilities. According to Rohleder et.al (2009), the lack of trust in the health-care system limits the uptake of HIV testing in South Africa. This is coupled with the perceived lack of confidentiality of counselling and testing services, and the fear of discrimination and poor treatment by health workers (Rohleder, et al., 2009). Moreover, people fear that the health workers may

disclose their HIV test results to other people if they test positive. In addition, some individuals may be afraid to disclose their HIV statuses to their partners if they are HIV infected. This, therefore, result in people choosing not to test for HIV.

Across SSA, individual perceptions of and experiences with health care facilities undermine the uptake of HCT services (Musheke et al, 2013). The perceived lack of confidentiality by health staff, and the lack of confidence in their competence discourages people from testing. Furthermore, the poor attitude of health staff also discourages people from testing. The distrust of HIV testing technologies in Uganda and Zambia and the perceived unreliability of test results in Uganda and Malawi discourages has been found to discourage people from testing (Musheke et al, 2013).

The service treatment provided by health facilities is important in securing visits by new and regular patients. Therefore, poor treatment not only deters regular patients, but also scares off potential new patients from coming to the health facilities. The service treatment is thus vital for encouraging or discouraging young males to visit health facilities for HIV testing. Nel et al (2013) argue that gender expression is closely linked with the unequal of treatment in South Africa's health facilities including the treatment of MSM. They draw on the findings of their study as well as various other studies to support their argument. The findings thereof, highlight that gender non-conforming MSM (those who act, dress and speak femininely) experienced more harassment in health facilities as compared to the gender conforming MSM.

Gender inequality and scrutiny is a challenge in public health facilities and it deters most of the young MSM from testing. The gender-conforming MSM could easily be considered as heterosexual males because the disguise of same-sex orientation through masculinity would possibly protect them from homophobic experiences. However, the disguise of same-sex orientation through masculinity could also deter them from seeking appropriate sexual health information (Nel et al, 2013). Orr et. al (2017) summarises some of the negative experiences of young males at public health facilities to include: Being judged by health personnel, being shouted at, and the violation of confidentiality by the health personnel. As a result of these mentioned

experiences, young males resort to avoiding testing for HIV or seeking the services in alien communities where they are not known (Orr et al, 2017).

The lack of trust in health systems also seems to be a challenge for the HCT uptake. This is problematic because health facilities are the most crucial point of entry for curbing the spread of HIV through diagnosis and treatment. The next section discusses the global interventions to address the low HCT uptake.

2.3. Global interventions to address low HCT uptake

Based on the above review of gender norms, stigma, fear of the unknown and lack of trust in the health systems as the socio-structural factors prohibiting HCT uptake, it is evident that low HCT uptake is a global challenge. Therefore, various countries have responded to the challenge in different ways. Some of the interventions adopted are presented in this section starting with interventions to address gender norms.

Gender norms

Castle et al., (2013) note that the feminization of health care services in Côte d'Ivoire was one of the main barriers to male participation in VCT. They argue that health care services tend to focus on maternal and child health services which include antenatal and immunization care. These services are viewed largely by both males and females as female domains (Castle et al, 2013). In 2006, the US CDC revised the recommendations for HIV testing for adults, adolescents and pregnant women in health care settings (Blonde, 2010). It proposed that HIV should be part of the routine clinical care, while reserving patient's rights to decline the systematic HIV test offer (Sumartojo, 2000; Blonde 2010; and Tolou-Shams et al. 2007). WHO suggested the establishment of youth-friendly health services (YFHS) as a good strategy to addressing the low uptake of health services including HIV testing (Vermeer et al, 2009).

The YFHS were thus established in Africa and the US. The elements of the YFHS included, integrating HIV testing into routine reproductive health and other health services, and training health staff on relevant skills for providing services to youth. Moreover, YFHS also had the elements of eliminating the requirements for parental consent for youth's HIV testing and using peer counsellors (Sebudde & Nangendo, 2009; Vermeer, Bos, Mbwambo, Kaaya, & Schaalma, 2009). In Thailand the NGO

Program for Appropriate Technology in Health (PATH) made use of youth-friendly chat room approach named 'the love clinic' to promote HCT and other reproductive health care services by partnering with selected clinics in Bangkok (Sirinirund et al., 2012).

The establishment of YFHS is more likely to encourage male youth to utilise health services and in so doing, it will increase their chances of testing for HIV. In addition to this, the establishment of YFHS, attempts to address the notion of health facilities being considered to be female dominated spaces as YFHS are focused on providing health services to youth in general. YFHS also attempt to tackle the issue of masculinity as the services are generalised to all youth irrespective of gender or sexuality. Considering that the world is evolving and so are the people, YFHS are more likely to appeal to the male youth as there are diseases that may compel them to visit health facilities such as STIs which would then facilitate the PITC process once at the health facility. As mentioned earlier, the YFHS are relevant in the modern era considering that sexuality is no longer culturally constructed and the constitution allows people to live true to their sexual identities.

The South African government decriminalized homosexuality in 1994 and this has led to the inclusion of MSM in the 2007-2011 NSP for HIV and STIs (Lane et al, 2011). In addition, the government provides social assistance in the form of monetary grants to HIV-infected people with a CD4 count of ≤ 200 (Leclerc-Madlala, 2006). The grant is provided on the condition that the HIV/AIDS infected recipient is not eligible to work and earn a living.

Stigma

Since stigma is important in the HIV/AIDS field because it shapes how people interact with the disease and each other, interventions are being implemented to address it. Gilbert et al. (2012) note that public health policy is one of the main drivers for the initiatives to address stigma through strategies such as public disclosure. Additional strategies to address stigma attempt to increase empathy and to reduce fear (Ashworth et al, 1994). This is achieved through the provision of correct HIV information. Also the development of psychological skills presumed to be important for the effective management of the emotional responses anticipated from different population groups affected by HIV/AIDS has been emphasised (Ashworth et

al., 1994; Hue & Kauffman, 1998; Mwambu, 1998; and Soskolne et al., 1993). Obermeyer (2009), notes that peer supporters are effective in addressing HIV/AIDS stigma and fear. Recruiting community members as peer supporters to provide psychological support has the potential to lower levels of social isolation and stigma experienced by PLWA (Obermeyer, 2009).

Fear of the unknown

Various interventions have been set in place to address the fear people possess about HIV. These various interventions have aimed to increase awareness, dismiss misconceptions and reduce negative attitudes about PLWA at a national level, community level and among HIV high-risk populations (Obermeyer, 2009). These strategies include mobilizing community leaders and empowering PLWA to lead advocacy activities, mass media campaigns and participatory education (Obermeyer, 2009).

The Nigerian government has implemented public health education campaigns as a strategy to educate people about HIV/AIDS. Pettifor et al (2013) suggest that media campaigns and community mobilization are suitable for changing youth's social norms. They maintain that mass messages can be effective in reinforcing HIV prevention and care messaging. The messages can also play a significant role in normalising HIV testing and uptake of new preventions technologies (Pettifor et al, 2013). The USA government established behavioural interventions such as HIV/AIDS education, counselling and testing, small group counselling and skills development and peer educators at the community level as measures to eliminate the fear of utilising HCT services (Sumartojo, 2010). According to Brown et al (2003), counselling is effective for teaching coping skills and resolving issues among family and community members. Counselling is likely to reduce anxiety and distress. Furthermore, counselling can reduce the negative consequences of disclosure and improve attitudes towards PLWA (Brown et al. 2003). Heijnders and van der Meij (2006) maintain that peer support groups are effective in boosting the self-esteem, coping skills and social integration of PLWA.



Lack of trust in the health systems

Sumartojo (2010) notes that biomedical and behavioural research in the USA has attempted to address the HIV epidemic. This has been done through the provision of HIV/AIDS treatment. In 1986, 25 Oregon counties in the USA provided anonymous HCT. Clients had the liberty to choose confidentiality or anonymity during their pre-test counselling. This initiative resulted in three times the amount of clients coming to test within three months of initiation. 49% of this population were MSM who reported that they would not have tested if their identities were guaranteed to be confidential and anonymous (Sumartojo, 2000). Anonymous clinics providing HCT services have also been established in Thailand's public hospitals since 1991 (Chariyalertsak et al., 2006). The anonymous and confidential testing methods were effectively implemented at a global scale and they provided positive results. These methods can also be attempted locally through randomised controlled trials. Though the methods seem to be promising, they have not been implemented in SA to scale up HCT.

To increase HCT uptake locally, the South African government scaled up HCT sites that offer PITC to more than 4500 public health facilities including non-medical sites and mobile services (Rohleder et al, 2009). Furthermore, the South African government further launched the national HCT campaign in 2010 which aimed at testing 15 million South Africans by June 2011. Currently, the South African government has launched the test and treat programme which allows all HIV infected individuals to start treatment as soon as they get diagnosed with the virus (Mambanga et al, 2016). The next section discussed the limitations of the above outlined interventions.

2.4. Limitations of Socio-structural interventions

Having outlined some of the interventions in place to address the low HCT uptake, it would be expected that HIV prevalence is reducing. However, the prevalence keeps on increasing among SA's youth with a recorded 10.2% of which 15.5% was among young females and 4.8% among young males in 2012 (Shisana et al, 2014). The constant increase in HIV prevalence thus indicates that there are limitations in the socio-structural factors and their interventions. Sumartojo (2000) maintains that



structural interventions are difficult to evaluate because they do not conform to conventional experimental designs. The effects of structural interventions are also difficult to measure. Therefore, it is difficult to investigate the cause of a behaviour fully and come up with an intervention that is likely to address the cause. Some of the structural factors are given more weight while others are undermined. Sumartojo (2000) found that, in Nigeria, faith-based organisations were an unexplored and underutilised structural factor for HIV/AIDS prevention, care and treatment. This was despite the expressed readiness displayed by some church leaders to be trained to become peer educators and reach out to their congregations (Sumartojo, 2000). The difficulty in assessing the impact of structural factors on people's behaviour is one of the limitations. Therefore, the limitations are presented with reference to the socio-structural factors in the discussion below.

Stigma

Stigma has been rightfully documented in the literature as responsible for being a deterrent of testing (Obermeyer, 2009 and Heijnders and van der Meij, 2006). However, few studies provide quantifiable methods of the effect of stigma on HIV testing. This is partly because of the dominance of psychological models in HIV behavioural research, which result in a multitude of cognitive measures of stigma rather than measures of actual stigmatising behaviours and their consequences (Heijnders and van der Meij, 2006). Therefore, the tendency of not providing quantifiable methods of the effect of stigma on HIV testing becomes reinforced by the ease with which information on beliefs can be collected in surveys, thus, setting aside the difficulty of observing behaviours or analysing the broader social factors that influence stigma (Obermeyer, 2009 and Heijnders and van der Meij, 2006).

Parkera and Aggleton (2003) note that most of the interventions to address stigma are somewhat problematic in a sense that they aim to increase tolerance of HIV/AIDS infected people within the society instead of addressing the actual diseases. Heijnders and van der Meij (2006) point out that most of the interventions take a biomedical and a general approach.

Therefore, as the HIV/AIDS stigma intervention policy drafters attempt to empower people through tolerance enforcing strategies, they take a top-down approach in which interventions are not compatible with the beneficiaries (Rhodes, Holland and

Hartnoll, 1991). The stigma is then elevated since interventions to address it are not people centred. In addition to stigma, the role of health facilities in the fight against HIV/AIDS is important. However, this sector is also faced with limitations which are noted below.

Fear of the unknown

Rohleder et al (2009), argue that HCT has become progressively accessible in South Africa during the recent years. However, the uptake of HTC remains low despite it proving to be an effective preventative method and a point of entry into HIV support, care, and treatment services. Rohleder et.al (2009) equate the low uptake of HIV testing in South Africa to the absence or weak social norms responsible for promoting the knowledge of one's HIV status. They argue that, the beliefs of the negative consequences associated with knowing one's HIV status undermine the norms that support the knowledge of one's status. These norms are further undermined by the notion that one cannot do anything if they are infected (Rohleder, et al., 2009). Rohleder's argument is however challenged by various authors see (Parkera and Aggleton, 2003; Leclerc-Madlala, 2006; and Nattrass, 2005) who note how the HIV/AIDS grant makes HIV/AIDS stigma normal and bearable to PLWA.

Nattrass (2005) points out that once the person receiving the AIDS social grant is healthy again due to ART, the grant is, therefore, withdrawn. This is a major problem with the HIV/AIDS grant policy as various scholars and medical practitioners pointed out that it leaves HIV-infected people with a choice between being sick while retaining the grant, or being healthy and losing the grant (Leclerc-Madlala, 2006). Such a choice in the contemporary SA where most people's socio-economic conditions are poor, is a recipe for disaster. The disaster is noted by Leclerc-Madlala (2006) who maintains that for many poor and unemployed South Africans and citizens of San Francisco, HIV/AIDS government benefits have become a bargaining chip necessary to stand in as household income.

Such grants have now turned to become a means of survival in poverty stricken areas to an extent that some of the people actually want to get infected with HIV in order to have access to them. Some of the HIV infected people go to an extent of bribing medical practitioners in order to be granted the AIDS-disability certificate to start accessing the grants (Leclerc-Madlala, 2006). Of importance and relevance to

this report is how the grant has made people to be totally ignorant of HIV/AIDS stigma, how it has made people not to be afraid of HIV/AIDS and risk their health for monetary benefits. Poverty thus shows how the discussed socio-structural factors attributing to testing avoidance can be disregarded. It shows that people are willing to test if there is some benefit beyond knowing their status and treating or maintaining it.

Lack of trust in the health systems

Public health systems in most developing countries seem to be experiencing similar challenges with regard of rolling out public health services to citizens. The major setback is finance which determines and shapes how the public health sector functions. Poor management, inefficient resource allocation and utilization, poor leadership, and political instability presents a challenge for the health care system (Monjok et al, 2010). In relation to health systems, Hardon et al. (2007) writes on the lack of staff, poor quality counselling, and work-overload as the challenges to HCT uptake and ART adherence. Therefore, the lack of staff, poor quality counselling, and work-overload as challenges faced by health facilities are most likely to discourage young males from testing for HIV.

In terms of work-overload, Hardon et al. (2007), write about Uganda and Tanzania where HCT and ART were scaled up without increasing the health staff to deal with the increasing demand of the services. This resulted in the health staff being overworked and thus struggling to cope with the large number of patients present at clinics daily (Hardon et al., 2007; Obermeyer, 2009: and Eaton & Kalichman, 2013). Monjok et al (2010) also note that majority of the health care systems in SSA are weak as a result of human resource shortages. This human resource shortages are thus caused by migration of health workers to developed nations in search of better working conditions, increased wages, incentives for further training, and better economic achievement (Monjok et al, 2010).

Weak health systems with stretched resources result in health care providers having insufficient training, time or space to provide effective and efficient quality HIV counselling and testing (Coovadia, 2000; and Eaton & Kalichman, 2013). Good counselling is essential for HCT and ART adherence because it ensures that the patients are well informed about the testing procedures and medication processes.



Hardon et al (2007) point out that counselling in the public health facilities of Uganda was done by nurses who did not receive adequate training as a result of the public health facilities not being able to afford good quality training courses for counsellors.

Due to being under-staffed, public health facilities get overcrowded and as a result, patients spend most of their time waiting on queues. The long waiting time is also noted by Hardon et al. (2007), who maintain that it is a challenge to testing and treatment. They note that in Tanzania, one could expect to spend at least 6 hours at the clinic (Hardon et al., 2007). To add on, the excessive amount of time required to wait for ART at clinics is sometimes not ideal for individuals that are employed as they are placed at risk of choosing to either lose employment or to endure deteriorating health. Thus Coovadia (2000) notes that even when health facilities have the policy of routinely recommending HIV testing and counselling, providers may not consistently follow the policy due to the weak health systems.

Based on the above discussion, it is evident that there are limitations to the socio-structural factors' interventions to address the low HCT uptake. The next section illustrate how these limitations present a gap in the literature. It further illustrate how deliberate ignorance can clarify the socio-structural factors and thus contribute to the existing body of literature.

2.5. Literature gap

The above section discussed socio-structural limitations in order to illustrate that there is a missing link between the interventions to address the avoidance of HCT and the intended beneficiaries. This is evident in the continuous increase in HIV prevalence among the youth as reported annually. The missing link between HCT interventions and beneficiaries is well outlined by Sumartojo (2000). According to Sumartojo (2000), socio-structural factors are focused on changing individual behaviour and thinking. They attempt to change individual's knowledge and motivations without addressing the root causes that stimulates the HIV risk behaviour. This is problematic because behaviour is in most cases a result of a persons' conscious decision. There is a problem with HIV/AIDS public education campaigns. These campaigns are useful in creating HIV/AIDS knowledge but studies have shown that they are less likely to convince people to use the knowledge for



better behaviour (Sumartojo, 2000; Chariyalertsak et al., 2006; and Pettifor et al, 2013). Sumartojo's (2000) findings in Nigeria are a good example as she found that even though the public health education campaigns did create knowledge about HIV/AIDS, they have not been successful in convincing the public of the other routes of contracting HIV (Sumartojo, 2000). The socio-structural limitations thus illustrate that the interventions take a general approach to addressing HCT avoidance and in doing so, they isolate the target market which the interventions are aimed at. The isolation results in governments wasting money on unused interventions which have to constantly be revised.

Researchers are overwhelmed by the lack of methodologies relevant for studying the relationship between health contexts and health outcomes (Sumartojo, 2000). The lack of new and rigorous research methods thus makes it difficult for researchers to scientifically defend the effectiveness of structural approaches to health research. This may further explain the persistence of testing avoidance given that a lot has been studied about the socio-structural factors, and interventions have been put in place to address them. Therefore, this study investigates how deliberate ignorance clarifies the socio-structural factors that explain avoidance of HCT. By so doing, new understandings to testing avoidance are uncovered and this adds to the existing body of literature on the topic.

2.6. Conceptual framework 'deliberate ignorance'

The objective of this report is to investigate the reasons behind young males' refusal to test for HIV/AIDS in the context of the availability of HIV/AIDS information, treatment and support services. Therefore, the relationship between truth, belief and evidence as a process of knowledge construction is an important factor to consider and investigate. The researcher attempts to frame the report within the concept of 'deliberate ignorance' as an emotion regulation and regret-avoidance mechanism'. This concept is therefore drawn from the broad theory of ignorance (agnoiology) by James Frederick Ferrier.

Deliberate ignorance is a behaviour seeking to avert the attainment of existing but possibly unwanted information (Hertwig and Engel, 2016). It is an individual or collective conscious decision not to seek or use information as opposed to the

inability to access it (Gigerenzer, 1015 & Hertwig and Engel, 2016). Individuals may opt to evade possible frightening health information if it threatens their cherished beliefs, and if they anticipate mental distress, fear, and cognitive dissonance (Hertwig and Engel, 2016). This study seeks to unpack the reasons for seeking to avert the attainment of knowledge of HIV status by young males. Golman, Hagmann, & Loewenstein (2016) express the view that, once individuals recognise the significance of information in its own right, it follows that they may choose to allocate attention to it in ways that respond to possible motivations. In this regard, people are likely to pay attention to information that may tend to be positive while remaining inattentive to unfavourable information (Golman et al, 2016).

Deliberate ignorance implies disappointment aversion. At times, recurring disappointment aversion in dynamic situations, leads to information avoidance until all the uncertainty can be resolved (Andries and Haddad 2014; Artstein-Avidan and Dillenberger 2015; and Dillenberger, 2010). This is confirmed by Golman et al (2016) who argue that people are less likely to avoid seeking information provided that they attain direct and immediate utility benefits from doing so. Golamn et al (2016) proceed to provide an example of people at risk of disease such as genetic disorders. They point out that, these people may be able to lead happy lives until disease symptoms start to emerge or test results coerce them to come to terms with the reality of their situations (Golamn et al, 2016). Useful information is naturally avoided provided that people have to make important decisions with that particular information (Kőszegi, 2006). Disappointment aversion takes place if the balance of evidence is just above the threshold required for a positive judgement. If the availability of additional information is likely to reaffirm one's negative belief, and if additional information is less likely to produce a positive outcome (Kőszegi 2006).

Deliberate ignorance can foster the ability for individuals to enjoy future events through the preservation of affirmative emotions of surprise and uncertainty concerning fundamental personal events (Shani et al, 2012 and Gigerenzer, 2017). Melnyk et al (2012) posit that people can deliberately ignore taking decisions that are most likely to result in the most regret. As an example, people can deliberately choose to ignore health information outcomes such as HIV testing provided that they cannot control the occurrence of such events coupled with their consequences (Melnyk et al, 2012).



The disadvantage of deliberate ignorance is that once an individual makes a wrong decision that is irreversible, they are inclined to avoid seeking information that may suggest that the decision was wrong (Melnyk et al, 2012; Shani et al, 2012; & Hertwig and Engel, 2016). According to Golman et al (2016), deliberate ignorance deprives individuals of potentially important involvement in decision making. A person who does not test for a treatable disease, for example, may not obtain treatment for their condition and might further transmit the disease to others (Golman et al, 2016). These consequences are most common in HIV/AIDS, where drug treatment that prolongs life and reduces the chances of HIV transmission is available (Golman et al, 2016).

The failure to seek health information is therefore likely to result in the spread of disease. Brashers, Goldsmith and Hsieh (2002) identify the spread of disease as one of the disadvantages of deliberate ignorance. They argue that the failure to test for contagious diseases such as HIV/AIDS can lead to their spread. Caplin and Eliaz (2003) note that the fear of testing by an individual imposes a negative externality on others. The individual may fail to take necessary precautions to prevent spreading the disease to others leading to a reduction in societal welfare (Caplin and Eliaz 2003).

Golman et al (2016) proceed to outline that deliberate ignorance deprives individuals of potentially important feedback they could use to improve their behaviour. They provide an example of school teachers who choose not to pursue their teaching rates. These teachers deprive themselves of information useful to improve their teaching because of the inability to tolerate criticism (Golman et al, 2016). In relation to this study, deliberate ignorance may deprive male youth of knowing their HIV status be it positive or negative and as a result male youth will have no motive to improve on their behaviour.

The concept of deliberate ignorance is taken from Ferrier's broader theory of ignorance. Ferrier develops his philosophy in the form of a negative reaction to the philosophy of common sense established by his predecessors who include Sir William Hamilton. His philosophy is clearly presented in his major work 'the Institutes of Metaphysic' published first in 1854. This work sets out Ferrier's fully developed philosophy and sets out his new Scottish Philosophy. According to Keefe (2007),

Ferrier uses the deductive method in attempt to derive the necessary truths of reason which he put in his words as the "enlightened principles of common sense". The Institutes of Metaphysic is divided into three main sections namely, the epistemology, followed by agnoiology (theory of ignorance) and this is lastly followed by ontology.

Agnoiology asks the question 'what is ignorance?' (Thomson, 1964). It is of interest for this report and as such I focus specifically on this section of Ferrier's Institutes of Metaphysic. Keefe (2007) continues to maintain that Ferrier's aim with the Institutes of Metaphysic was to remedy the inattention of man's ordinary thinking. For Ferrier, one such 'inattention of man's ordinary thinking' is the differentiation between the noumenal ("In the philosophy of Kant, an object as it is in itself independent of the mind, as opposed to a phenomenon" (The free dictionary, n.d)) and the phenomenal world. Keefe (2007) notes that Ferrier in his theory of ignorance attempts to clarify the laws of cognition and illustrate that things-in-themselves are both unknowable and inconceivable. By doing this, he develops an idealist account of cognition which differentiates his philosophy from not only Reid but also from Kant and his own friend and mentor Sir William Hamilton (Keefe, 2007). In relating Ferrier's Agnoiology to this report, the researcher attempts to probe the laws of cognition within the young male population in relation to HIV testing. The researcher wants to investigate if young males have the ability to choose not to know their HIV status deliberately and if this choice is likely to defy the standard norms of common sense. This is because common sense would deduce that since HIV/AIDS information, treatment and support services are available and accessible, they should be interested in knowing their HIV statuses

Following the trail of common sense, one should really ask how common is common sense? Graham (2015) notes that Ferrier defines ignorance as "an intellectual defect, imperfection, privation, or shortcoming". In this regard, ignorance refers not only to the absence of knowledge but to the lack of knowledge, a shortage of something which an intelligent being can possess. He differentiates ignorance to nescience which is not knowing the unknowable. In this regard, he maintains that ignorance indicates an imperfection whereas nescience is a sign of the perfection of reason. By outlining this difference Ferrier illustrates that human ignorance is an element that can be clarified and understood systematically. With reference to this

report, the researcher attempts to understand if young males' ignorance with regard to HCT is due to a lack or shortage of information. This follows the evidence of a slow increase rate in HCT services uptake presented by the NHS of SA.

The slow increase in HIV testing rates within SA's young male population triggers the thought that the perhaps the process of HIV knowledge construction is somehow flawed at certain points. Ferrier maintains that an imperfection or shortcoming depicts a level of shortfall in something that is consistent with a human being's nature to possess knowledge (Keefe, 2007). Therefore the possession of knowledge is thus consistent with a human's nature. According to Tuana (2004), Ferrier was of the view that ignorance signified the want of knowledge and therefore, the possession of ignorance in an intelligent human was an imperfection. Looking at HIV testing, the researcher is interested in proving or disproving the notion that young males' possess the imperfection of ignorance as outlined by Ferrier. The researcher is also interested in bringing to the surface, the reasons behind the possession or dispossession of this imperfection.

In light of ignorance, Keefe (2007) points out that intelligence fails to know something which could be known by other intelligence. This is explained by Ferrier (1856) who notes that there is a possibility of other intelligent beings with a higher or lesser level of ignorance than human beings. Thus, there may be some things of which human beings are and will always be ignorant of. However Ferrier (1856) maintains that the criteria for anything to be deemed an object of ignorance is that it must be consistent with the laws of knowledge and it must be known to some intelligence (Ferrier in Keefe, 2007). The HIV status is in this regard consistent with the laws of knowledge. It is voluntary in that it requires individuals to seek it in order to know it. It is in this regard that the theory of ignorance comes into good play when youth males chose to ignore the knowledge of their HIV status. This report attempts to depict the ignorance practiced by young males in relation to the uptake of HCT services and provide possible remedies to it.

Just like any other theory, concept or framework, Ferrier's theory of ignorance must also consist of some limitations. He describes the limits to his agnoiology by stating "It only proves that what man or any other intelligence may happen to be ignorant of, need not, of necessity, be unknown to all other intelligences (supposing that other

intelligences exist)" (Ferrier in Keefe, 2007). The words of Ferrier are explained by Keefe (2007) who notes that they merely prove that whatever knowledge the intelligence is ignorant of, may nevertheless be known actually if an intelligence exists competent to know it. To add on, the knowledge may possibly not be known even if such intelligence should exist (Keefe, 2007). Thus, ignorance is a defect, it is a failure to know what can be unknown. Keefe (2007) argues that the theory of ignorance is closely similar to epistemology. This is because as Ferrier argues, a person may only be ignorant of knowledge that may possibly be known by some intelligence. In the words of Keefe, "a person cannot be ignorant of either the subject in itself or the object in itself. The ego and matter per se are the unknowable which means they are contradictory and as such cannot be the objects of knowledge or ignorance" (Keffe, 2007: 39).

Deliberate ignorance remains a suitable concept for this study, having outlined the advantages and disadvantages of deliberate ignorance, and the broad theory of ignorance. Deliberate ignorance will help the researcher to delve into the behaviour of male youth pertaining to HIV knowledge and reasons that make them to shy away from obtaining such knowledge. Deliberate ignorance will continue to help the researcher to investigate whether male youth chose to ignore testing for HIV and the reasons behind their choice. In addition, deliberate ignorance will help the researcher to draw a link between knowledge constructions by male youth in relation to HIV testing. This will be achieved through using deliberate ignorance as a tool to determine whether or not male youth deliberately chose to ignore testing, if they postpone testing, or if they want to test and there are obstacles preventing them from testing. Deliberate ignorance will be used as a tool in a sense that it will be used to highlight the gaps between HCT socio-structural interventions and the young males. It will be used to reflect the understandings of HCT by young males and how they interact with HCT interventions.

2.7. Conclusion

This review explored gender norms, stigma, fear of the unknown and lack of trust in the health systems as the socio-structural factors prohibiting HCT uptake. It acknowledged these existing socio-structural factors as not only discouraging young males, but all males and to a certain extent females, from testing. The current study



intends to not dismiss, belittle, or duplicate the above-outlined factors. It rather attempts to establish a new lens through which the underlying factors to the ones acknowledged can be discovered and thus understood. The establishment of deliberate ignorance as a conceptual framework to investigating HCT is a contribution this study makes to the existing body of literature. The use of deliberate ignorance deepens the understanding of testing avoidance by young males. In addition, deliberate ignorance outlines the gaps within HCT socio-structural interventions and young males as the intended beneficiaries.

The chapter reviewed literature based on the topic; avoiding truth in a time of knowledge: male youth refusing to test for HIV. It also outlined deliberate ignorance as the conceptual framework guiding the study. The next chapter will discuss the methods used to investigate male youth's avoidance to test for HIV.



CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter critically discusses the methods used to investigate male youth's avoidance to test for HIV. It begins by presenting the research question, sub-questions and objective. This is subsequently followed by the research approach which informs the sampling and recruitment techniques. The chapter continues by providing a discussion of the methods used to collect data and the process of data analysis. The chapter then concludes by discussing ethical protocols observed in carrying out the investigation of male youth's avoidance to test for HIV.

3.2. Research question, sub-questions and objective

Main research question

Why do young males refuse to test for HIV given the availability of HIV/AIDS information, treatment and support services?

Research sub-questions

- Why are young males comfortable to live with ignorance of knowing their HIV status?

- What are the possible consequences associated with knowing one's HIV status?

- What are the knowledges and perceptions male youth possess about HIV testing?

Objective

- To use deliberate ignorance as an alternative conceptual approach to study the avoidance of HIV Counselling and Testing (HCT) uptake by male youth.

3.3. Research approach

This study adopted a qualitative research approach in an attempt to gain an in-depth understanding of why male youth avoid testing for HIV. A qualitative research approach seeks to find thorough and deeper understanding of the characteristics included in a study (Macnee and McCabe, 2008:122; & Cant et.al, 2009:163). Ritchie and Lewis (2003) define qualitative research as a positioned activity that puts the

researcher in the world. It is made up of a set of interpretive material practices that makes the world to be visible. These practices depict the world in a series of representations including interviews, field notes, conversations and recordings (Ritchie and Lewis, 2003). A qualitative approach was relevant for this study because it placed the researcher in the world of the participants and allowed him to harness their interpretations of HIV testing.

Qualitative research uses an interpretive and a naturalistic approach that tries to understand occurrences in a context-specific setting such as the real world (Golafshani, 2003; & Ritchie and Lewis, 2003). Phenomena are studied in their natural environment with the aim of trying to interpret and make sense of occurrences based on the meanings attached to them by the people (Golafshani, 2003; & Ritchie and Lewis, 2003). According to Golafshani (2003), qualitative research produces findings that are arrived at through using real-world settings where the occurrences being studied unfold naturally. The researcher conducted this study in a natural setting to the participants and used vernacular language (Tswana, Sotho and Sepedi) to better enable engagement with the participants. Naledi, the research site, is a Sotho dominated Township, therefore almost all the participants spoke Sotho.

Qualitative research has some strengths and weaknesses. These are presented in relation to the current study starting with the strengths. Qualitative research allows for an investigation of sensitive matters, it requires minimal human resources and it can be applied in multiple fields of investigation (Boxill, Chambers, & Wint, 1997). In relation to this study, the researcher used a qualitative research approach to engage male youth about their avoidance to test for HIV. The researcher also probed participants about their sexual conduct. Participants were able to disclose their HIV diagnosis to the researcher because of the qualitative approach and setting of the interviews. The researcher was the sole conductor of this study, and this enabled him to better understand the data gathered and the accounts given by participants based on their different experiences. The same study approach can be applied in different settings to inquire HIV testing avoidance.

Qualitative research makes use of smaller samples from which it is hard to generalise. Qualitative research is costly to conduct, and relies on the subjective

assessments made in the data collection phase (Boxill et al 1997). This study had 15 male youth participants who are not sufficient to be representive of the male youth population of Naledi. The researcher also used taxis to travel to and from Naledi for four days to conduct the interviews which was a costly process. On the first day of interviews, the researcher arrived late due to transport delays and found that the participants had left the research point (friend's house). He had to revisit their homes to look for them and ask them to come for the interviews.

3.4. Sampling and recruitment

Sampling technique

Participants for this research were purposively selected. Macnee et.al (2008:122) points out that purposive sampling includes participants who share a specific type of experience. Individuals who illustrate possession of similar characteristics and individuals who possess the same understanding on a particular subject. The criteria of participant selection for this study was that one had to be male, 18 years old or above, and a resident of Naledi. Purposive sampling is suitable for small sample studies (Macnee et.al, 2008). It is effective for harnessing primary data from a limited number of participants. Purposive sampling is cost and time effective and requires minimal resources which makes it suitable for this study because the sample is small and the researcher is the sole conductor.

Participants

The study sample was 15 males between the ages 18 to 35 years who live in Soweto, Naledi section. According to Statistics South Africa (2011), the name Soweto derives from the first two letters of each word in the phrase South-Western-Townships. Soweto is home to the largest urban black community in South Africa (Wall and Staff 2009). It has a total population of 1,271,628 (Statistics South Africa, 2011). It is located 20 kilometres Southwest of Johannesburg and it is made up of numerous segments (including Naledi) that cover up to 62 square miles (Staff, 2009). According to Statistics South Africa (2011), of the total 1,271,628 population, 49,6% are males, 50.4% are females.

The National Commission Act of 1996 defines youth as all people who fall between the age categories of 14 and 35 (Holm 2017). Males between 14 and 17 were



excluded in this study because they are legally considered young to self-consent to participation. On the other hand, males 18 and above are assumed to be sexually active and are therefore, presumed to be at high risk of contracting HIV. Mathew proved this assumption wrong as he is 19 and not sexually active at the time of interviews.

3.5. Methods of data collection

Data collection procedure

Interviews were used to acquire data from participants. According to Das (146:2009), an interview is a conversation that takes place between two people (namely the interviewer and the interviewee) with the sole purpose of collecting information from the interviewee. Interviews provide the researcher with the ability to observe social cues and use them to enrich the information provided by the interviewees (Opdenakker, 2006). The social cues include voice intonation and body language displayed by the interviewees. They provide extra information to be added to the verbal answers provided during the interviews (Opdenakker, 2006). Face to face interviews eliminate the possibility of time delays between question and answer. They allow both the interviewer and interviewee to directly react to what the other says or does (Opdenakker, 2006). This makes the interviewee's responses more spontaneous, without an extended reflection.

Research instruments

Semi-structured interviews were used to enable the researcher to probe the replies provided by respondents further. Das (146:2009) posits that semi-structured interviews promote a degree of flexibility as the interviews take a conversational approach. Ritchie et al (2005) note that semi-structured interviews have a flexible agenda in the form of pre-determined themes to focus on during interviews even though the discussion may differ between interviews with different participants. In this research, the researcher adopted the conversational approach to the interviews. The approach worked because participants were at ease during the interviews. They were open and talked freely about their experiences with HCT.

The strengths of semi-structured interviews include their suitability to harness the real views and beliefs held by participants. According to Walsh and Wigens (2003),



semi-structured interviews limit pre-judgment through allowing for minimal pre-determined questions. This view is supported by Cramb (2001) who notes that semi-structured interviews can be matched to individuals and their circumstances. They allow for new questions to emerge during interviews and this expands the amount of knowledge acquired by the researcher. They also allow for the researcher to explore what participants really mean or really believe as they engage in the interview (Walsh and Wigens, 2003). This was evident in this research as the researcher used the first batch of interviews to inform and improve the questionnaire for the following batch of interviews. In addition to this Gratton and Jones (2004) note that semi-structured interviews allow for the development of significant themes that may not arise from structured interviews.

This development enables participants to reveal insight into their attitudes and behaviour which may not readily be apparent (Gratton and Jones, 2004). Saks and Allsop (2012) further note that semi-structured interviews are useful for exploring complex research fields. They address the 'how' and 'why' questions from the perception of personal experience and they allow for the adjustability of interviews depending on the personalities of participants. This study addressed the question, why do young males still refuse to test for HIV given that HIV/AIDS information, treatment and support services are available? Semi-structured interviews were thus considered to be ideal for harnessing participant's views. Williq (2013) further notes that data collected through semi-structured interviews is compatible to various methods of analysis such as interpretive phenomenology, grounded theory and discourse analysis.

Walsh and Wigens (2003) warn that with semi-structured interviews, the physical presence of the researcher in data-gathering poses both an advantage as well as a disadvantage. With reference to the advantage, they point out that participants may respond to questions fully in the presence of the researcher. Moreover, the researcher may provide necessary clarifications with reference to research questions and also harness deeper explanations from the answers given by participants (Walsh and Wigens, 2003). The presence of the researcher during the interviews put participants at ease because both parties were males talking about HIV testing and relationships. Some of these topics were most common among males, therefore gender made the interviews easy in this regard. In considering the disadvantage,

Walsh and Wigens (2003), argue that the presence of researchers may impose a bias effect on the responses provided by participants during interviews.

Looking into the disadvantages of semi-structured interviews, Kajornboon (2005) warns that inexperienced semi-structured interviewers may not probe the responses by participants. This may result in important information not being acquired for the study. The researcher tried to probe the responses by participants as efficiently and effectively as possible to avoid having data that could not be thematically analysed. Walsh and Wigens (2003), note that participants commonly provide too much information during semi-structured interviews and most of the information is frequently not usable because it goes into too much depth in the subject at hand. Samson provided too much information during his interview following his experience as an HIV peer educator. Most of Samson's information was not linked to the purpose of the study as he tried by all means to show the good side of HIV testing while the researcher was interested in the bad side and why young males avoid testing. Walsh and Wigens (2003) also maintain that semi-structured interviews take too much time to complete and even longer to transcribe into written records of what the participants shared. This challenge was experienced in this research. Some of the participants such as Samson and Peter took too long answering the questions. They would explain their answers and end up deviating from the initial question. Therefore, the researcher had to practice patience and lead them back to the questions as politely as possible.

The interviews took around 30 to 45 minutes to complete and transcribing each interview took a minimum of 2 hours and 30 minutes. Walsh and Wigens (2003) warn that the reliability of data produced by semi-structured interviews is low because participants are less likely to be asked exactly the same questions. This means that data is difficult to compare as it is likely to differ based on the difference in questions posed (Walsh and Wigens, 2003). For this research, the data was somewhat similar in a sense that it could be thematically analysed. However, the questioning differed (guided by the main questionnaire) based on each participant.

In addition to the semi-structured interviews, several instruments were used to collect data from participants. The instruments included a field diary to take notes

during field work, a voice recorder (phone) to record the interviews and observations made by the researcher.

Field notes are essential for supplementing the use of a voice recorder in qualitative research. They can help the researcher to formulate new questions during the interview, particularly, where it might be necessary to probe something that was said earlier on in the interview (Patton, 2014). King and Horrocks (2010), note that this allows for the researcher not to interrupt the mind flow of participants and at the same time, not to miss important information. Patton (2014) proceeds to note that, looking over field notes before transcribing the interview recordings helps in ensuring that the inquiry is unfolding in the direction hoped for. It can stimulate early insights that might be significant to pursue in subsequent interviews while still in the field (Patton, 2014). Moreover, field notes are relevant for facilitating later analysis and locating important quotations from the recordings and they also serve as backup in unfortunate events that the recordings malfunction or get erased (Patton, 2014).

Filed notes are good on the researchers' side because of the above mentioned reasons. However, they are not so good for the participants. Given (2008) maintains that taking notes in qualitative research is likely to reduce eye contact between the researcher and the respondents. She proceeds to note that note taking may also lead to respondents being sensitive to when the researcher takes or does not take notes. This may apply to situations where, long potions of respondent's responses may not generate any notes (Given, 2008). Holloway and Galvin (2016), add to this by noting that note-taking is more likely to disturb participants during interviews and it also makes it difficult for the researcher to listen to the participants attentively. They advise that contextual notes should be made prior the interviews and others immediately after the interviews when thoughts are still clear in the minds of researchers (Holloway and Galvin (2016). The researcher in this study made notes immediately after each interview to avoid interrupting the flow of interviews, losing important information and relying solely on the voice recordings.

With reference to voice recorders. Rubin and Babbie (2016) note that voice recorders are essential in qualitative research because they enable researcher to pay full attention to the respondents. Likewise, they enable researchers to capture and narrate the words communicated by respondents. They also enable the

researches to fully engage the respondents and probe the responses further (Rubin and Babbie, 2016). Ritchie and Lewis (2003) further maintain that voice recorders provide an accurate verbatim record of interviews. They capture the language used by participants including their hesitations and tone in far more detail than would ever be possible in note-taking (Ritchie and Lewis, 2003).

Even though voice recorders are good for research, like any other instrument, they also have downfalls. Rubin and Babbie (2016) advise that in interviews, voice recorders cannot capture all the relevant aspects of the social procedures. DePoy and Gitlin (2013) support the advice by Rubin and Babbie (2016), by noting that voice recorders cannot capture the reactions by respondents such as excitement, frowning smiling etc. They further point out that voice recordings are time consuming to transcribe, taking an average of six to ten hours to transcribe an hour's recording (DePoy and Gitlin, 2013). A phone voice recorder was used for this research and it provided recordings that supplemented the notes taken during the interviews. The researcher took a long time to transcribe all 15 interviews.

Application of research instruments

The researcher drafted a set of predetermined questions and allowed room for new questions to emerge during the face-to-face interview sessions with the study participants. The interviews took place in a secure and private room with only the researcher and one participant present per interview. The researcher proceeded by recording the face-to-face interviews with study participants using a cell-phone voice recorder. This was done only when the participants consented to being recorded. Lastly the researcher observed how the study participants conducted themselves during the interviews and soon after every interview the researcher wrote down notes of observations which enhanced the data collected.

Measures to ensure rigour

The utilisation of different data collection instruments and theories account as triangulation which was a method of ensuring rigour in this study. According to Taylor, Kermode, & Roberts (2006:235) triangulation is the application of various methods to the study of a single phenomenon, in order to guarantee the validity of that particular phenomenon. Chilisa and Preece (2005) state that triangulation is

based on the assumption that the application of various data methods, data sources or investigators can eliminate biases in the study. They note that triangulation takes various forms which include, methodological triangulation, investigator triangulation, theoretical triangulation, and the triangulation of data sources (Chilisa and Preece, 2005).

3.6. Data analysis

Data generated by this study was analysed using the thematic content analysis method. Thematic analysis is defined by Buchman (2015:403) as a qualitative research method that utilises labelling and iterative restructuring of data sections to identify themes. Burnard et al (2008) further point out that thematic content analysis as a research analysing method, arose from the grounded theory research approach. Burnard et al (2008) note that thematic content analysis can be applied in multiple types of qualitative work including, phenomenology and ethnography.

The procedure of data analysis involved five phases. During phase one, the written and recorded responses from participants were collected and transcribed. In phase two the researcher repeatedly read through the transcripts in order to familiarise himself with the content and therefore outline emergent themes. During phase three, similar responses were grouped and placed under the themes formulated. The researcher further analysed the grouped responses under each theme in phase four. This enabled the researcher to refine themes and move some of the responses to relevant themes. In the last phase, each theme was interpreted in relation to how deliberate ignorance can complement the socio-structural factors that explain avoidance of HCT. The formulated themes and findings are presented in the findings chapter of this study. The findings are therefore discussed in the discussion chapter.

3.7. Ethical considerations

Ethics are essential in ensuring the safety of both the researcher and the participants in research. They serve as guidelines for conduct to all parties involved in research. It is therefore important that research adheres to ethical protocols in place. This research attempted to do so. According to Forrester (2010) ethics are concerned with the morality of human conduct in relation to social research. Ethics, therefore, refer to the moral deliberation, choice and accountability on the part of the



researcher throughout the entire research process (Forrester 2010). The standard ethical protocols observed in this study are presented below.

Informed consent (available as appendice A)

Participants were required to provide participation consent prior study participation. According to Forrester (2010), participants should take part in the study willingly and they should be well informed about the study prior to providing participation consent. Judas was fine in participating only on condition that the researcher was not going to test him for HIV. The researcher was not there to test people and assured Judas that that was not the case. He then willingly participated in the study. Participant's information remained confidential in this study. Peter was greatly concerned with confidentiality as he disclosed his positive HIV status to the researcher and sought assurance that the information would not be shared in an identifiable manner. The researcher assured Peter of this. Forrester (2010) argues that care should be taken with personally identifying information of participants, so as to meet anonymity requirements. Participants were allowed to withdraw their participation at any given time and they were also allowed to withdraw their information at will. Participants were also provided with a contact details sheet for future correspondence. Some of the participants such as Isaac and Petrous did not want to share their contact details.

Participation risks

It is expected that participation in research must have some associated risks be it direct or indirect risks. Seidman (2006) note that there are two types of risks in qualitative research and they are, risks during the interviews and risks after the interviews are complete. Participants in this study were informed about the risks involved with their participation prior to them participating.

With reference to participation risks during the interview process, Seidman (2006), points out that the process of in-depth interviewing may unveil areas that cause emotional discomfort for the participants. This is dependent on the potential sensitivity of the area of study. This study explored a sensitive topic, hence it was likely for participants to fall victim to emotional discomfort. This is because they were reflecting on their sexual conduct and possibilities of being infected or not being infected with HIV. Therefore, participants in this research were informed prior to the



start of the interviews that the interviewing process would at times cause discomfort as some of the questions were too personal. The participants were therefore, referred to their local clinics for counselling in the event of a possible emotional discomfort.

Writing about participant risk after the interview, Dickson-Swift et al (2008) maintain that the breach of confidentiality is a serious problem and poses a great risk to research participants. They argue that this is because the breach may lead to the participant being embarrassed within their social and economic spaces (Dickson-Swift et al, 2008). To control the breach of confidentiality, participant quotes were translated into English. Pseudo names were also used for anonymity purposes.

3.8. Conclusion

The current chapter critically discussed the methods used in the study to investigate why male youth avoid to test for HIV. It also discussed the research approach, the methodology and ethical considerations. The next chapter presents findings of the study and illustrates how deliberate ignorance complements the avoidance of HIV testing.



Chapter 4: RESEARCH FINDINGS

This chapter presents the findings of the study. As mentioned in the previous chapter, data was collected from fifteen (15) participants using purposeful sampling. The aim of the study was to use the concept of deliberate ignorance to discuss the avoidance to test for HIV. The chapter presents the analyses of findings in terms of the following broad themes; HIV awareness, HIV risk behaviour, interaction with health facilities, and HIV testing.

4.1 HIV awareness

Participants understand HIV to be a virus that has killed a lot of people. Most of the participants expressed some level of distress upon hearing the word HIV. Joshua's exasperation illustrates this point as follows:

> "*HIV is another word which when comes you just see that problems are coming and you see that if it infect you it will be something very wrong. You start thinking about how you will live once you have HIV, what will it change for you, and that even when you will have sex, will you be able to have children that don't have HIV. Yes things like that. Maybe also if you have cracks and you kiss a person who also has something, then it gets transmitted*" (Joshua (not real name)).

Some of the participants have been exposed to HIV-infected family members, close friends, girlfriends and neighbours. Peter admitted to being one of the people living with HIV and even stated that he was on ART treatment. This admission happened in the course of the interview with some information already covered. Peter's precise confession was as follows:

> "*Truly speaking I am one of them who has a pandemic. I am using ARVs as we speak. You have to go through some classes before ARVs. I don't know how come I be so open to you, I don't know. The way you ask me the questions makes me to be open and free and talk to you and give you the right information that you need*" (Peter (not real name)).

The confession by Peter made it clear that he was not intending on disclosing his HIV status, however, he felt comfortable to share it as the interview progressed.



Participants exposed to PLWA fear the disease based on seeing its effects on the PLWA they have been exposed to. This point is illustrated by Isaac who said:

> "*Yes I saw a couple of HIV infected people. I might say even at my yard maybe I saw 2 to 3 of HIV infected people. When I saw them I became scared. I did not feel well when I saw that when this thing [HIV] has infected you it leaves you in a very bad condition. Especially if you are not taking treatment*" (Isaac (not real name)).

The general understanding of and exposure to PLWA illustrated the possession of HIV medical knowledge by the participants. The participants had knowledge on how the disease can be transmitted and acquired. Most participants understand that the common ways of contracting and transmitting HIV include, unprotected sex, blood transfusion and by exposure to wounds. John shared his perspective based on both his general and prison experiences and stated that:

> "*If let's say I have a cut and someone with a cut touches me on the cut while I'm bleeding and sick and my blood mixes with theirs, obviously they will get infected with the HIV. The other thing we did as prisoners, is that you can sleep with another HIV infected prisoner and not get infected with HIV that same time when you got to check at the hospital. When you get there [hospital] they will tell you that you are alright but you have to return after three months to check again. It's like they don't know at that moment*" (John (not real name)).

Other methods mentioned as ways of acquiring and transmitting the virus included accidents and the sharing of needles. With possession of such information, one would expect that the participants are willing to protect themselves from HIV infection at all times. In protecting themselves, the participants can visit health facilities to test for the disease and treating it in the event of a positive diagnosis.

With reference to HIV treatment, the participants had limited knowledge about ART. The participants confused ART with a 'currently unavailable' cure for the disease. One such participant was Joshua who said:



"*I am not sure, but maybe if you treat it right like if you eat healthy food, taking pills on time and going for treatment ya*" when asked if there is a cure available for HIV.

The limited knowledge of ART is further evident in the observations made by the researcher. Some participants did not have in-depth knowledge on the importance and impact of the ARV treatment on PLWHAV. John shared his views on the ART and the views are somewhat sceptical of public treatment. He stated:

"*Yes, they [PLWHAV] are given treatment at the hospitals. I cannot say the treatment is wrong or right because now there are surgeries available. So some of these places such as Bhara for example, do you think at Bhara they can give you treatment that arrived today? But then the surgeries are able to give you because you go with money to them and they also are running a business*".

Having covered general and medical HIV knowledge including treatment, participant were asked about HIV prevention. Participants mentioned the use of condoms and wearing protective rubber gloves as effective ways of preventing HIV infection. Daniel added that it is important to know the status of one's partner in addition to the use of condoms as an effective way to prevent HIV transmission and contraction. In addition, the participants mentioned not sharing needles when injecting drugs, abstaining from sex and acquiring as much knowledge about HIV as possible as additional preventative measures. Mathew had this to say when asked about HIV prevention:

"*there are preventative measures that the DOH uses to stop the virus from being distributed to everyone*" (Mathew (not real name)).

With the evident knowledge about HIV transmission, contraction and prevention, some participants maintain a belief in folk and lay theories about the disease.

Scientifically there is no cure for HIV yet. However, my interaction with participants revealed that most were not sure about the availability or unavailability of a cure. Most of the participants were unsure of the availability of a cure. However, John firmly believes that a cure exists. He was of the view that a higher power (God) has the ability to cure the virus. John's precise words about the cure for were:



"*You know what I can tell you is that for now there is no cure but there is only one person who can create the cure and that person is God. He [God] can send you or someone else just like leaders that are ruling up and down, so with the cure for HIV he is the only one that knows of it and can send you or me by giving us wisdom of the cure. I have to acknowledge that the wisdom is therefore not mine but God's and he is the one that helped me come up with the cure*".

Such views are important to inform the personal conduct of young males in relation to HIV testing. The next section dwells on the risk interaction of young males and HIV.

4.2. HIV risk behavior

Early sex debut

Majority of the participants started to engage in sex at an early age. This was due to a series of varied but common reasons stated by the participants. These reasons included peer pressure, wanting to prove manhood to oneself, the desire to be cool, curiosity, the stage of adolescence and naughtiness. The participants started engaging in sexual activities between the ages 12 and 20. Petrous (not real name) shared the age of his first sex debut as follows:

"*you see that one I don't want to tell you lies. I don't know when I started because we were naughty as kids you know. Maybe 17-18 somewhere there* [estimation]".

Almost all the participants who made an early debut to sexual activity did not use condoms. This is also because of varied reasons which include: the lack of knowledge about condoms, the dangers of unprotected sex, HIV/AIDS, not knowing where to get condoms and lack of access to condoms. The impact of early sex debut and the non-use of condoms is depicted very well in the words of Judas (not real name) who stated:

"*nah it was something out of mind at that time and you know things were happening at a fast pace at that time considering that we were teenagers. We were not thinking about things such as AIDS*".



The participants proceeded to highlight the fact that sex is a taboo topic for kids and as a result, they would not talk about it in the presence of elders. This also impacted negatively on the practice of safe sex because free condoms are available at health facilities but not easily accessible to young males. This is because young males are considered too young to be engaging in sexual activities. From this, it follows that young males are left with no option but to engage in unprotected sexual intercourse because apart from the free government condoms, they were very less likely to afford buying condoms at shops and pharmacies. Even for those that resorted to using condoms in their early sex debut, the classification of sex as a taboo impacted negatively on the consistent use of condoms by these young males. The none-use and inconsistent condom use became a habit which the young males grew with and still uphold even at an older age.

Negative feelings about condom use

When speaking about feelings concerning condoms, the participants clearly outlined that they possess the knowledge on benefits of using condoms. However, most of the participants were not happy with the use of condoms because they associated condoms with reduced sexual pleasure. With reference to condom feelings Joshua stated:

> "*they do protect but sometimes you feel like they don't take you where you want to go. You don't feel right. I just use it for my protection even though sometimes I feel like I can just take it out but then you'll never know you see? That's the problem.*"

Joshua's account depicts that condoms are used not by will but rather because they offer protection against HIV, STIs and unplanned or unwanted pregnancies.

The participants were clearly not happy with using condoms for sexual activity. This claim is clearly outlined in the words of John who stated:

> "*I can say condoms are safe, again I can say they are not safe because they are not the same they come in kinds and kinds. As an example matekwane [cannabis], there is cannabis that grows naturally from the soil and then there is one that is grown in plastics called swazi, skunk etc. So you see that thing is different?"* (John).



Such views about condoms fuel unsafe sexual practices among young males and their partners.

Majority of the participants articulated inconsistent condom use during sex with their partners. This is despite possession of the knowledge of the danger they put themselves in when they do not consistently use condoms. Majority of the participants mentioned that the female partners they engaged in sexual activity with did not really mind whether or not if a condom was used. Petrous is one of the participants who expressed an opinion supporting male domination with regard to negotiating the terms of sex more especially with side girlfriends. He stated:

> "*With side girlfriends I was using it. But honestly speaking there are some ladies I did not use it with maybe one or two because I didn't have it and we were not by my house. Most girls don't question the issue of using a condom during sex and they don't fight you if you don't use it"* (Petrous).

The most common place for participants to meet their side girlfriends is taverns and parties. The participants are therefore more likely to be intoxicated when they meet their side girlfriends and engage in unsafe sexual activity. Petrous who is currently single confirmed this behaviour when he stated:

> "*currently no [not in a relationship]. I previously had a girlfriend and she was alone. But to tell you the honest truth before God, you know what. She was alone but if I got a chance like maybe we are partying somewhere and it's nice, I get maybe another person and she likes me, I will take that person and sleep with them for that day*" (Petrous).

Isaac differentiates between two different types of ladies based on his own experiences and states that

> "*Even you know that girls are not the same. There is that one girl that maybe when you are holding each other and get in the sexual mood. When the time for sex comes she then agrees to not using protection and you [guy] also go in raw. Then there is another girl who will stop you and say 'brother I do not do that [unprotected sex] myself'. My current main girlfriend does not take any chances. She's that person who does not want to go to clinics for preventing*

and she is also not ready to have a child. So this makes her strict on the use of protection" (Isaac).

Trust that is not evidence-based

All the participants who claimed that they knew their partner/s HIV status were all basing their claims on hearsay. None of them went for couples testing or saw the actual test results of their partners. Abraham is one of the participants who clarified that deliberate ignorance is indeed an element at play when it comes to HIV infection and relationships. When asked about the knowledge of his partner(s) HIV status he had this to say:

> "*I know the status of only one. The one I have been with for a long time. She once told me that she tested last of last year. It came as a conversation between me and her for her to tell me*" (Abraham (not real name)).

Abraham's view leads one to think that HIV is a disease that is meant for a particular group of people. Similarly, this view also leads one into thinking that some people are not meant to have HIV. Such people are the main girlfriends to most males and this finding is presented next.

Following up on the lack of evidence for the sexual partner's HIV status, majority of the participants in relationships believed that their main partners were not HIV infected. This thus facilitates the inconsistent or the none-use of condoms with these partners. This behaviour depicts deliberate ignorance on both sides of both the male and female partners because there is a form of trust which is established on frivolous grounds that are likely to be deadly for one partner if the other is HIV infected. This frivolous trust is captured well in the words of Job (not real name) who maintained:

> *"I use condoms on the one night stands and other girls that I find but on my main girlfriend I don't use it. The reason I use condoms on one night stands is because I don't trust them. I don't know where they come from, who they have been with, I just get them there and we have sex. With my main girlfriend I don't use it because even if I am not fully sure about her, I do spend a lot of time with her."*



The issue of trust between the participants and their main partners was also a major factor deterring participants' knowledge of each other's HIV status. This was because asking about it implied doubt about the health of the other partner and this would impact negatively on the relationship. This is clearly articulated by Mathew who stated:

> "*No. I never even asked because it is a topic which people are sensitive around, so if you ask her about her status she will feel offended and want to know why you want to know about her status or maybe you heard something somewhere about her*" (Mathew).

The participants know about HIV and they still engage in risky behaviour. Therefore, the next section discussed the participants' interaction with health facilities.

4.3. Interaction with health facilities

Almost all of the participants had visited a health facility either shortly before the time of the interview or a long time ago. The common reason for visiting the health facilities was the issue of influenza. Other reasons included TB, HIV treatment, tonsils, pain and munesium. During their visits, the service experiences were described by participants as being both good and bad. The difference in experiences is a result of encountering different health staff and visiting different health facilities. On the positive side of the visits, the participants mentioned receiving treatment for their varied illnesses and being treated by a friendly and professional health staff. Daniel is one of the participants who was happy with the health facility services as he stated:

> "*the service is good, even the nurses are humble when you are also humble. They become happy when they see that you want to live*" (Daniel (not real name))

On the bad side, some of the participants mentioned that health staff only dealt with what issues they as patients mentioned to them. To add on, the health facilities were described as places of long queues which made the services to be slow. Furthermore, the system of reporting to casualty, nurse then doctor was described as a time wasting and unnecessary procedure by the participants. Peter is one of the participants who shared his bad experiences with health facilities as he stated:



"*The people at our clinics don't care. Truly speaking, they don't care, they only do what brings you to the clinic. For example if you are experiencing pencil they will say those who are here for pencil one side, those for papers one side and give them their prescriptions and medications. Sometimes they don't even check you, you can say that you have flu and they give you flu medication without checking you*" (Peter).

The bad service by health facilities is therefore likely to be a challenge to HCT uptake. This is because patients need to be offered an HIV test when they visit the health facilities for any illness. A minority of the participants agreed that they had been offered an HIV test by the health staff besides the reason for their visit. This in light of the literature which states that PITC is part of HCT and should be offered to all people visiting health facilities regardless of their pressing illness (Rohleder et.al, 2009). Job is one of the participants who was offered an HIV test during his visit to a health facility. When asked about the HIV test offer he said:

"*Yes they did, they offered tests for high blood, sugar diabetes and even HIV. The tests are not compulsory, they offer you and if you don't want to take them you can focus on the pressing illness that brought you to the clinic and leave*" (Job).

The account by Job indicates that health staff are aware that they should offer patients HIV tests during their visits to health facilities and they do so. However, it is only a minority of the health staff that practice the PITC principle.

A majority of the participants mentioned not being offered an HIV test during their visit to the health facilities. These participants maintained that the health staff only paid attention to the pressing reason that brought them to the health facilities. Therefore, HIV testing is considered to be a voluntary aspect (VCT) by most health practitioners. HIV is a topic that is sometimes never spoken of by health practitioners during the patients' visits to health facilities. Peter is one of the participants who has never received an HIV test offer at the health facilities. He had this to say about the matter:

"*Unless you as an individual you tell yourself that I am going to test today, it is very rare to find any nurse or doctor that can refer you to testing when you get*

to the clinic. The last time I was at hospital I saw the people who erect tents [mobile testing stations]. Those are the people who are able to call you and offer you an HIV test" (Peter).

MMC was one service that got most young males to test for HIV. The circumcised participants were asked if they were tested prior to their procedure and all the traditionally circumcised participants stated that they had not been tested prior to the ritual. Some of the medically circumcised participants agreed that they had been tested for HIV prior to the procedure. Others stated that they were too young to remember the details of their circumcision procedures. Of interest was Joshua's account about the matter. Joshua had this to say:

"*That's the problem, they didn't test me. At that time, it was already late you see, and we were the last group before they would knock off. I was already in the process of being tested and was told just to pass and go to get circumcised*" (Joshua).

Having MMC as one of the health services that encouraged young males to test. The next section presents the participants' views on HIV testing.

4.4. HIV testing

Generally, all the participants strongly agreed that testing for HIV is important. According to the participants, a person should test for HIV so that one knows where he/she stands in life (health wise). This will help the person to take corrective actions towards safeguarding their lives and the lives of others through taking treatment, using protection for sexual activity and not spreading the disease further. The participants maintained that testing for HIV clears one's conscience because they get to know their status.

Talking about the disadvantages of HIV testing, Samson (not real name) maintained that there are absolutely no disadvantages. He expressed his view as follows on the matter:

"*There are no disadvantages for testing, because you need honesty. We focus too much on the disadvantages and that's what kills us because we don't look at ourselves as individuals in terms of how to progress with life and*



by doing that, we are holding ourselves back. That is why in most cases we tell people who are about to start medication [ART] to be in school where they educate them" (Simon (not real name)).

However, such a view was not only held by Samson, but other participants as well. A variety of explanations were stated by the participants. These explanations include fear of a positive diagnosis, the impact of living life knowing that one is HIV infected, depression and the possibility of committing suicide. Adding to this list of explanations was Paul who mentioned that the testing facilities were actually the spaces whereby people got infected with HIV. He stated:

"*Yes there are disadvantages because as people we don't believe in one thing, some people will tell you that they don't want to test because the people who test us are the once who infect us with AIDS through the syringes*" (Paul (not real name)).

In addition, the participants mentioned that when a person is living with HIV and is not aware of his or her status, he/she can expose oneself to opportunistic diseases and even AIDS. Such people further risk death by not knowing and taking treatment. They risk spreading the virus to other people unknowingly. According to the participants, the major disadvantage of HIV testing was having to live with the disease at a young age. This was an opinion expressed by Isaac who stated:

"*it is fear. According to me, the thing that scares me is that I do not want to see myself living on pills. I want to live like this knowing that even when I go out partying, I do not have to stress about coming back to take the pills. And if I skip the pills then I start getting sick*" (Isaac).

Isaac's view suggests that the young males consider themselves as being too young to commit to lifelong treatment. Therefore, the participants resort to avoiding HIV testing.

Majority of the participants did not know their status. Some were unsure about it and others knew theirs. Those that did not know mentioned never taking an HIV test as a reason for not knowing. Petrous was one of these participants and he expressed the following view about the matter:



> "*I have never tested in my life. Maybe I tested when I went to do circumcision and was too young. But even now, I have never went to the clinic to test, even when the mobile testing people call me by the streets, I just pass them*" (Petrous).

The unsure participants ascribed their not knowing their status to proxy testing and self-diagnosis. Mathew demonstrate this point by maintaining:

> "*I was never involved in sexual activities, so I was never sexually active with anyone whereby I can say I need to go and test. I was never sick to an extent that it became force for me to go and test and see what's happening with me*"

when speaking about HIV testing. Those that admitted to knowing their statuses mentioned that they had once tested for the disease.

The participants who had tested before were asked about the date of their last test and the responses ranged from when they had their circumcision done to the last six months. Majority of these participants had last tested a long time back. John is a good example as he mentioned to have last tested in 2004. However, some of the participants like Samson stated that they test regularly. Samson expressed the view that he goes for couples testing with his partner which pushes him to test regularly. His exact words were:

> "*I have my partner and we don't exceed four months having not gone to the testing station*" (Samson).

All the participants who had never tested believe they were not HIV-infected. Majority of the participants believed that there are chances of them getting infected in future. One of these participants was Joshua who said:

> "*I say maybe it might infect me because you can never know what might happen. There are a lot of ways through which it enters the body right*" (Joshua).

To support their claim, the participants mentioned inconsistent condom use as a protective measure. Abraham mentioned practicing the self-diagnosis process as a method of knowing he is not HIV-infected even though he was not completely sure. He stated:



> "*the belief that I do not have it [HIV] is there. There are no signs of any symptoms you see? Physically I am healthy so even though I am not 100% sure that I am fine, I believe that I am fine*" (Abraham).

Peter on the other hand admitted to already living with the disease and had this to say:

> "*I already have it. I think I got it through a car accident because I was once involved in a car accident where a lot people including myself got hurt and our got blood mixed*" (Peter).

Petrous suspects that he might have the disease despite having never tested. This feeling according to him is because he had unprotected sex with a couple of ladies whom he assumed were sick.

Converse to the rest of the participants, Cain (not real name) and John firmly believe and maintain that they would never get infected with HIV. Cain gave no account to his belief but John mentioned God's protection as his shield. His precise words were as follows:

> "*based on my belief and not somebody else's belief, I will not get it [HIV]. That is my belief. I am doing nothing to prevent HIV infection aside from just believing that God will protect me against it*"

The participants were asked the reasons they did not test and discouragement was one factor that seemed to dominate the reasons why they were unwilling to seek HCT services. The participants fear testing because they are scared of being told they are infected. Some like Abraham have lived in fear and even learned to normalise the fear so that it does not bother them any longer. He had this to say about not testing:

> "*at first it was the issue of being scared to go test. But now, I am used to it [fear]. As I am condomising, sometimes I do not use it you see? Therefore, the chances are there that I am positive*" (Abraham).

Apart from fear, the participants associate HIV diagnosis with death. They believe that being told that one is HIV-infected means that they are dying. Promiscuous

behaviour was also mentioned as a reason for avoiding HIV testing and for Paul HIV was an issue that did not cross his mind. Paul mentioned that:

> "*testing is something that never crosses my mind. Even if I come across mobile testing stations, I don't have a chat with the testing people, I just pass them*"

Participants were asked if they would be interested in taking an HIV test if provided with the opportunity at the end of the interviews. Majority mentioned that following the interview, they saw the importance of testing. As a result, they would like to test. Some even went to an extent of stating that they would visit health facilities and get tested. John was one of the participants who said he would visit a clinic to test. He said:

> "*now since you ask if I might be interested in knowing my status, you are showing me manhood. This means even tomorrow I can volunteer myself, take a taxi and go to test*" (John).

However, the participants still raised concerns of fear as a barrier to them wanting to test. This is Joshua's view regarding the will to test:

> "*I do want to know but I am scared, that is why even when I see the tents, I ignore them. I don't see it as an important thing and it is not there in my mind. So that is why I don't go to test. Also living with pills is not a healthy thing. I am still young, I will still want to attend parties and will end up forgetting to take them because I shall have left them by the house you see? Now when I leave here I will test so that I can be sure of my status if I have time*" (Joshua).

A minority of the participants firmly denied that they are willing to test even after the interviews. This was based on their past promiscuous behaviour and the fear of being HIV-infected. Among these minority group was Judas who had this to say about the will to test:

> "*for now, man yoh for me to get tested? I get scared and I don't know what scares me. So the fear is natural so I don't know what scares me but I get very scared*" (Judas).



4.5. Conclusion

This chapter has presented the findings of the study, based on the following broad themes: HIV awareness, HIV risk behaviour, interaction with health facilities, and HIV testing. The next chapter discusses the findings in relation to the concept of deliberate ignorance. It illustrate how the concept of deliberate ignorance is relevant to the avoidance of HIV testing by young males.



Chapter 5: Discussion

The study sought to investigate how deliberate ignorance can complement the socio-structural factors that explain avoidance of HCT. Therefore, this chapter argues that although young males have biomedical knowledge of HIV, they do not use this knowledge and turn to deliberate ignorance to avoid taking responsibility of their lives by not testing. The discussion is broken down into three sections. The first section discusses possession of HIV knowledge and deliberate ignorance. The second section discusses the none-use of the possessed HIV knowledge and the last section discusses how the failure to use the possessed HIV knowledge results in responsibility shifting. Overall, the findings from this study suggest that the young males deliberately choose to ignore HIV testing even in the presence of information, treatment and support services.

5.1. Knowledge possession of HIV and its dangers

The young males possess relevant general knowledge about HIV/AIDS which they do not use to their advantage. They are knowledgeable about transmission, prevention and even the treatment of the virus. However, they choose not to know about their status. This finding is in line with the literature on socio-structural interventions to address the lack of HIV knowledge resulting in stigma and fear. The findings by Pettifor et al (2013) suggest that the implementation of public health education campaigns as a strategy to educate people about HIV/AIDS is one of the effective methods. The authors are of the view that media campaigns and community mobilization are suitable for changing youth's social norms. In addition, Pettifor et al (2013) maintain that mass messages can be effective in reinforcing HIV prevention and care. Media campaigns and community mobilization can also play a significant role in normalising HIV testing and uptake of new preventions technologies (Pettifor et al, 2013).

The possession of HIV knowledge by the young males is not used as most of them admitted to practicing unprotected sex. The practice of unprotected sex is discussed in detail in the next section. The none-use of HIV knowledge shows a limitation in the socio-structural interventions to address the knowledge gap. . This finding is also in line with the literature as Sumartojo (2000), argues that the socio-structural interventions are focused on changing individual behaviour and thinking. Socio-



structural interventions attempt to change individual's knowledge and motivations without addressing the root causes that stimulates the HIV risk behaviour. This is problematic because behaviour is in most cases a result of a persons' conscious decision. This seems to be a problem with HIV/AIDS public education campaigns. They are useful in creating HIV/AIDS knowledge but studies have shown that they are less likely to convince people to use the knowledge for better behaviour (Sumartojo, 2000; Chariyalertsak et al., 2006; and Pettifor et al, 2013). Sumartojo's findings in Nigeria are a good example as she found that even though public health education campaigns did create knowledge about HIV/AIDS, they have not been successful in convincing the public of the other routes of contracting HIV (Sumartojo, 2000).

In relation to deliberate ignorance, Shani et al (2012) and Gigerenzer (2017) maintain that deliberate ignorance can foster the ability for individuals to enjoy future events through the preservation of affirmative emotions of surprise and uncertainty concerning fundamental personal events. Melnyk et al (2012) outline that people can deliberately ignore taking decisions that are most likely to result in the most regret. As an example, people can deliberately choose to ignore risk health information outcomes provided that they cannot control the occurrence of such events coupled to their consequences (Melnyk et al, 2012). Therefore, the young males in this study deliberately ignore HIV testing despite having its biomedical knowledge. The young males choose to deliberately ignore testing despite knowing the importance and advantages of testing.

The knowledge possession is intertwined with misconceptions about the disease. Participants believed that God can cure HIV and testing personnel are responsible for infecting people with the disease. Such misconceptions are echoed by Dickinson (2014) who maintains that HIV is flooded with numerous myths which are important for understanding the refusal to seek HCT services. South African townships have been exposed to public health information since the 1980s (Dickinson, 2014), However, alternative explanations to those of medical science continue to circulate. Dickinson identifies three main HIV/AIDS folk myths namely: racial ideas and less political authority, traditional African beliefs, and religious beliefs (Dickinson, 2014). The outlined myths by Dickinson and findings of this study depict factors that trigger the will to ignore testing by young males. Young males weigh the advantages and

disadvantages of testing and make a decision based on the factors they presume carry more weight. In this regard, the young males use the possessed HIV knowledge to examine themselves in terms of their behaviour and their beliefs which are not good to avoid testing. The young males thus socially construct ignorance. According to Smithson (1985), ignorance is socially constructed and pervades social life in significant ways. People are socialised against holding other specific views the same way as they are socialised to accept and hold certain views of reality. Therefore, the outlined HIV myths and misconceptions socialise the young males to deliberately avoid testing and ignore the possessed HIV biomedical knowledge.

Based on the above argument, deliberate ignorance shows that the young males are aware of HIV and the interventions to address it. However, the interventions are detached from the young males in a sense that they only provide information on avoiding and treating HIV. The lack of cure for HIV/AIDS thus leads the young males to disregarding the provided HIV education. Therefore, it would help to consider tailoring HIV messages and education to the young males' personal level instead of at a general level. Deliberate ignorance also shows that the young males are manipulating the available HIV information to suit their desired beliefs and this is missed by education campaigns as they assume behaviour change on the part of education recipients. Therefore, it would be helpful if the implementation of education campaigns could have monitoring and evaluation phases in order to ensure that they do not only disseminate information but they follow up to ensure that the information is used effectively by the beneficiaries.

5.2. None-use of the HIV knowledge and risk exposure

Most of the participants do not engage in HIV preventative activities. Some of the participants seemed a bit reckless in their daily lives which institute ignorance. The young males thus possessed sufficient information to influence safe HIV behaviour which they chose to deliberately ignore and engage in HIV risky behaviour.

Reckless sexual behaviour was found to be the norm among the young males. First, the young males seemingly engaged in sex at an early age. Early sexual debut is probably problematic because the young males are likely to be ignorant on the use of condoms. This is supported by literature which reveals that early sex debut poses a serious threat to young males because they engage in unprotected sexual activity



(Shisana, 2005 and MenEngage Africa Network, 2013). As a result, they expose themselves and their partners to HIV and STD infections. The young males are ignorant of the consequences of unprotected at this stage. Therefore, by choosing to ignore risks of immediate pleasurable sexual activities, the young males allow themselves to over engage in further risky behaviour (Thunström et al, 2016).

Participants preferred unprotected sex as compared to protected sex. This applies to all age groups that engage in sex. None of the participants agreed to know the HIV status of their main partner based on doing a couples testing or seeing the partners' individual HIV test results. These sexual relations depict deliberate ignorance in a sense that the young males wilfully avoid the possessed HIV knowledge and behave selfishly (Mazar et al., 2008; Benabou and Tirole, 2011). Deliberate ignorance thus helps the young males to avoid conflict between selfish and pro-social motives and in so doing, they maintain a positive social image (Mazar et al., 2008).

Such sexual relations highlight a pattern of knowledge generation based on uncertified trust that is likely to be fatal to one of the partners if HIV is involved. This is explained by Ferrier (1856 in Keefe, 2007), who notes that there is a possibility of other intelligent beings with a higher or lesser level of ignorance than human beings. Thus, there may be some things of which human beings are and will always be ignorant of. The findings illustrate deliberate ignorance in a sense that the participants manipulate their beliefs by selecting the sources of information they consult while ignoring some sources altogether (Akerlof & Dickens, 1982). The issue of trust between the participants and their main partners was also a major factor deterring the knowledge of their HIV status (Melnyk et al's, 2012). This was because asking about it implied doubt about the health of the other partner and this would impact negatively on the relationship. Therefore, even the interaction with health facilities was not sufficient to encourage knowledge of the young males' statuses.

The literature (Sumartojo, 2000; Rohleder et.al, 2009; Nel et al, 2013; and Musheke et al, 2013), reveals that health facilities play a massive role with reference to HCT. The kind of services rendered at such facilities is likely to lure in or push away more people from coming into the facilities for HCT. The young males in this study were not hesitant to visit health facilities for treatable diseases such as flu. This finding contradicts the literature, see (Sumartojo, 2000; Rohleder et.al, 2009; Nel et al,



2013; and Musheke et al, 2013) which reveals that males are hesitant to visit health facilities because they presume them to be women's spaces. In addition, some of the participants were happy with the competency of the health staff which also contradicts the literature (see, Rohleder et al, 2009 and Musheke et al, 2013). However, majority of the participants expressed dissatisfaction with the competency of the staff and the overall services provided.

In relation to HCT, most of the participants were not offered an HIV test during their last visit at a health facility. This contradicts the PITC recommendation by the United Nations Programme on HIV/AIDS (UNAIDS) and WHO to conduct routine HIV testing and counselling on clients who attend health facilities regardless of their presenting illness (Sumartojo, 2000; Tolou-Shams et al. 2007; Deblonde et al 2010; and Leon et.al, 2010). The health staff have delegated the responsibility of HCT services to mobile testing stations which are vastly distributed within Naledi and even at some of the health facilities gates. Furthermore, the health staff wait on the patients to request the HIV test in addition to their pressing illness. This means that they are still implementing VCT which according to Leon et.al (2010), proved to be ineffective as an HIV prevention strategy because it is a client-initiated approach.

The health staff thus practice deliberate ignorance by not offering patients HIV tests during their visits to health facilities. The deliberate ignorance practiced by the health staff then discourages young males from testing because they are not offered the services unless they ask for them. Based on the socio-structural factors outlined in chapter 2 (fear, stigma, gender norms etc) the young males are less likely to request an HIV test voluntarily. Therefore, they are less likely to test hence the constant low uptake of HCT. The deliberate ignorance not to offer young males an HIV test is therefore detrimental to their uptake of testing and their overall health. This is because the young males miss the chances of early diagnosis and treatment if infected and chances of behaviour change if not infected. Deliberate ignorance allows for the health staff to choose ignorance of the negative impact their actions have on the young males. It allows the health staff to be more self-serving instead of people serving (Dana et al., 2007; Conrads and Irlenbusch, 2013; and Grossman, 2015).



It is evident from the above argument that deliberate ignorance sheds light on the risky behaviour the young males engage in wilfully. To add, deliberate ignorance also highlight the impact of intimate partners and health staff on the risky behaviour by the young males. The literature maintains that the uptake of HIV testing is influenced by people's trust in the health care system and providers. According to Musheke et al (2013), the lack of trust manifest itself in lack of confidence in individual health care workers and health institutions. Health facilities are the first line of defence in the fight against HIV/AIDS. This is because they have the tools and expertise to diagnose and treat HIV. Therefore, it is important for health facilities to implement strict recommendations of PITC to encourage young males to test (Rohleder, et al., 2009). This is because the young males have no problems with visiting health facilities for treatable diseases. In addition, the delegation of HCT to mobile service providers is problematic because the mobile service providers may be from a private space. This may result in difficulties in tracking the number of people that test and the number of those on treatment. Therefore, a working relationship needs to be forged between the public and private HCT service providers to ensure that young males test and get the relevant health services.

5.3. Attribute lack of responsibility to fear

The participants believed that it is important for one to test for HIV. They outlined the advantages and disadvantages of testing at a general level. Based on the expressed views, the main advantage of testing was knowing one's HIV status while the main disadvantage was having to live on lifelong medication. The disadvantage thus illustrate that testing implies that one is HIV-infected and this deters people from testing. The participants suggested that people weigh the advantages of testing against the disadvantages and thus choose not test. This is an act of deliberate ignorance because the people have a motive to avoid potentially bad news given that they have no means to prevent it (Gigerenzer, 2017).

The young males avoid testing in order to maintain the belief that they are not infected. They avoid testing in order to maintain the previous negative-test result of ten years ago. The lack of cure for HIV also comes to play as a deterrent factor for young males to test. This is because they consider themselves as being too young for committing to life-long HIV treatment. The young males still want to have fun and

enjoy life through partying and testing threatens these plans as it would mean constant times for medication consumption in the event of a positive diagnosis. With reference to deliberate ignorance, the young males avoid the responsibility of possibly being infected with HIV due to their previous promiscuous behaviour by avoiding testing (Thunström et al, 2014). The young males were also ignorant of how their avoidance of testing affect other people around them.

Most of the young males believed that there are chances of them getting infected with HIV in future based on their promiscuous behaviour. These findings suggest that the young males deliberately choose to remain ignorant to the possibility of being HIV-infected as a strategy to avoid responsibility in a personal and social sense (McGoey, 2012, and Gross & McGoey, 2015). Nyholt, Yu, & Visscher (2009) provide an example with James Watson's case. They maintain that Watson declined diagnostic information for his genetic susceptibility to late-onset Alzheimer's, a disease believed to have taken his grandmother's life. Watson's information decline was believed to be because of the thought that the benefits of knowing would be undone by the lack of medical treatment or cure (Nyholt, Yu, & Visscher, 2009).

The dominant HIV testing deterrent factor among the young males was fear. The young males feared a positive diagnosis. The young males have learnt to normalise the fear of testing so that it cannot bother them. Moreover, the findings indicate that the young males associate being HIV-infected with imminent death. This is despite the life prolonging ART available to all people. These findings are in line with Lee and Kotler (2011) who found that youth had varied expressions that kept them from accessing HIV testing services. These included the fear of death, fear of finding out one is HIV infected, fear of rejection and fearing the unknown (Lee & Kotler, 2011). Orr et.al (2017) further found that young males were more comfortable with not knowing their HIV status and waiting until they were seriously ill before seeking medical attention. This, according to the male sample of the study was better than dying from the stress of knowing that one is HIV infected (Orr et.al, 2017). Thus, Rohleder et.al (2009) equate the low uptake of HIV testing in South Africa to the absence or weak social norms responsible for promoting the knowledge of one's HIV status. Rohleder et.al (2009) argue that the beliefs of the negative consequences associated with knowing one's HIV status undermine the norms that support the

knowledge of one's status. These norms are further undermined by the notion that one cannot do anything if they are infected (Rohleder, et al., 2009).

The findings and literature illustrate that the young males use deliberate ignorance as a defence mechanism against potentially unpleasant information. Smithson (1985) and Smithson (2008) maintain that people can possess defensible justifications to remain ignorant about information that is directly relevant to them. This applies even when the information is readily available. He observes and makes an example about the low uptake of genetic marker tests by individuals with a hereditary risk of life threatening diseases such as colon cancer (Smithson 1985). In light of HIV testing the young males use the fear of a positive diagnosis and death as their justifications for avoiding to test. This is despite HCT services being easily and widely accessible to them.

5.4. Conclusion

Overall, the literature, findings and deliberate ignorance suggest that young males know the dangers of HIV. They also have knowledge about measures to protect themselves from infection, yet they still engage in risky behaviour hence exposing themselves to the diseases. The young males then resort to deliberately avoiding testing as a strategic plan to maintain a sense of not being infected. The young males thus continue to engage in risky behaviour and shift the responsibility of their actions to fear which they do not feel when risking their health. They further shift the responsibility to their female sexual partners who are at an inferior position in terms of negotiating terms for safe sex. The findings of this study further indicate that even though the socio-structural factors are sufficient to explain the avoidance to test, deliberate ignorance clarifies that the interventions to address the socio-structural factors are not compatible with the beneficiaries' beliefs. The interventions take a general approach ignoring that people are different and require different interventions to convince them to take up HCT.

This chapter argued that the young males have biomedical knowledge of HIV which they do not use and turn to deliberate ignorance for avoiding responsibility by not testing. The argument was broken down into three sections namely, knowledge possession of HIV knowledge, none-use of the possessed HIV knowledge and the failure to use the possessed HIV knowledge resulting in responsibility shifting. The



next chapter concludes the report and provides recommendations for future research, heath policy, and health facilities.



Chapter 6: Recommendations and conclusions

Deliberate ignorance clarifies the gaps between HCT socio-structural interventions and the intended beneficiaries. It deepens the understanding of an individual's perspective about the will to avoid testing. Based on the findings and discussions of this study, the following recommendations are considered to be suitable for future research and health policy. The current study dwelt on four socio-structural factors that were dominant in the reviewed literature which are gender norms, stigma, fear of the unknown and lack of trust in the health systems. However, the study did not cover other socio-structural factors such as the low-perceived risk of infection. Therefore it is recommended that future research dwells on the broader socio-structural factors resulting in HCT avoidance.

The study had a sample of 15 young males from a population of thousands in Naledi. This was due to financial and logistical constraints and it limits the study because the findings cannot be generalized to all the young males of Naledi. Therefore, the researcher recommends that further research must be conducted at a broader scale with the participation of more young males so that more information can be obtained and the possibility of generalizing can be enhanced. Further research must also be conducted in relation to the integration of HIV education between the home, school and health care facility environments. This is because environments play a significant role in the behaviour of young males. Therefore if the outlined three environments encourage young males to test for HIV and engage in protective behaviour, they are likely to succeed.

With regard to health policy, it is recommended that the NDOH should invest resources in home based testing services. This is because the participants in this study showed interest in testing in a comfortable space with a person from outside their township. Therefore, deploying outsider agents to do house to house testing in the location is likely to get more young males tested. This recommendation is in line with the literature. The health provider's background characteristics, attitudes, perseverance and their ability to gain client's trust and build good rapport, encourages patients to get tested (Obermeyer & Osborn,2007 and Obermeyer, 2009).



In addition to home-based testing services, the NDOH should look into context-specific interventions. This is because people are different. As an example Soweto is divided into different sections with different language speaking people located in them. Therefore, the difference in environmental settings brings about a difference in the lifestyles of the people. As a result, HCT interventions that are effective in Orlando West may not be as effective in Naledi. Thus the need for context-specific HCT interventions. To supplement the context-specific interventions, the NDOH should also look into individualising the interventions to address the low uptake of HCT. The NDOH should break away from quantifying people's beliefs and start measuring the actual behavioural causes of the beliefs and their consequences. Obermeyer & Osborn (2007) and Obermeyer (2009) note that when health providers personalize information about HIV risks and frame the messages in terms of personal gains, clients are more likely to decide to get tested.

The proper application of the above mentioned recommendations is more likely to result in attempting to overcome the avoidance to test by young males. Furthermore, the proper implementation of the recommendations is more likely to reduce the constantly increasing HIV prevalence.



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Appendice A: Participant information sheet and consent form

PROJECT: Avoiding Truth in a Time of Knowledge: Male Youth Refusing to Test for HIV

Information and consent form

Background:
HIV/AIDS is a major public health concern among the South African youth. The 2012 national survey illustrated that the HIV prevalence among youth aged 15-24 years, is 10.2%; 15.5% among young females and 4.8% among young males. Youth aged between 15-24 years accounts for roughly 50% of all new HIV infections (Asaolu, et al, 2016). The majority of the HIV-infected youth are less likely to know of their infections. This study seeks to investigate the reluctance to test for HIV/AIDS by male youth provided that HIV/AIDS information, treatment and support services are available.

No obligation participation:
Please also note that you are under no obligation to participate in this study. You may also change your mind about participating at any time in the study. You will not be penalized or disadvantaged in any way should you decide to discontinue your participation. However, I hope that through your participation I will be able to understand what male youth think about HIV testing.

Intellectual Property:
The intellectual property of the research findings and information, as well as the content of the final publications of the social research belongs to the University of the Witwatersrand. I acknowledge however your participation in this study and I will acknowledge your participation (to an extent that is appropriate) in the dissemination of findings and presentation of final findings should you wish so.

Commercialization:
The research reported on here is done for educational purposes, although I cannot exclude the possibility that this might have commercial applications. In the event of commercialisation an agreement will be concluded with you that will stipulate the terms and conditions of the negotiations between Wits and yourself.

Confidentiality:
You have the opportunity to request that no identifying information be made available by this project. I may record information that may identify you in written, oral and visual form. Should you request so, no identifying information will be made available through the communication and educational materials emanating from this study. Information that may identify you will be protected and saved on a password protected laptop and for back-up purposes it will also be saved on password-protected Dropbox. The data will only be accessed by the researcher and parties authorised by the researcher (supervisor & Wits University only for the purpose of the study).

General:
Should you want to be included in future communication emanating from this study, please do include your name and contact details on a separate piece of paper so I can record that. I do not foresee any risk or harm from participating in this study, however Wits will at all times be indemnified against any loss, injury or damage encountered due to the participation by yourself in this study. The risks associated with participating in this study are no greater than you would encounter daily in chatting to a friend or another person about health issues. You are advised to visit any local clinic for counselling should you feel overwhelmed by participating in this study

Communication:
Should you have any complaints about any ethical aspect of participating in this research, or if you feel that you have been harmed in any way by participating in this study please contact the School of Social Sciences. Prof Samuel Kariuki: Development Studies programme coordinator. Tel: 011 717 4435 or email:Samuel.Kariuki@Wits.ac.za

You may also call my supervisor Dr Raji if you have any concerns or questions about the research at: +27 11 717 4434 or email: Rajohane.Matshedisho@Wits.ac.za



CONSENT

I …….hereby agree to participate in social research of probing the explanations that attribute to male youth's reluctance to seek HIV testing. I understand that I am participating freely and that I am not being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term. By signing this consent, I acknowledge that I have read the information and consent form.

……..

Signature of participant **Date**:……..

I hereby request that my identity be kept confidential in the communications emanating from this project.

……..

Signature of participant **Date**:……..

CONSENT FOR VOICE AND VIDEO RECORDING

I hereby agree to the voice- and video-recording of my participation in the study.

……..

Signature of participant **Date**:……..

I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage.

……..

Signature of participant **Date**:……..

Recording of details for future communication

Names and contact details for future correspondence.

Please note that all reasonable efforts will be made to contact all participants individually if it is appropriate.

Name and Surname		**Telephone number**	**email address**
1			
2			
3			
4			
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Appendice B: Research questionnaire

Provided that HIV/AIDS information, treatment and support services are available, why do young males still refuse to test for HIV?

Introduction

Hi, my name is **Tshepo**, I am a student at the University of the Witwatersrand. I have asked to interview you to find out what youth males think of HIV testing. I am interested in learning the reasons behind the male youth's refusal to test for HIV.

This research requires your willingness to participate and to provide honest answers. The interview will take approximately **45** minutes. There will be no rewards offered for participation in this research, however, your responses will help me, Wits University and possibly other people to understand the reasons behind the refusal to test by male youth.

Your responses will be reported anonymously. This means that your name will not be written down with your answers anywhere in the research report. Please feel free to answer the questions to the best of your abilities and should you not understand any question, please do ask me to clarify or even rephrase the question.

Do you agree to partake in this interview? If yes, the researcher must provide the informed consent for signing.

Background information (to be completed by researcher)

1	Date of the interview	
2	Time of the interview	
3	Participant name and surname	
4	Participant contact details	



Questionnaire

1. Tell me about yourself (Demographics).

1.1. Where were you born?

1.2. Where did you grow up?

1.3. How old are you currently?

1.4. Which language do you speak most at home?

2. Let's talk a bit about HIV (general knowledge).

2.1. What comes to your mind when I say HIV/AIDS?

2.2. How can HIV/AIDS be transmitted from one person to the next?

2.3. Would you say HIV/AIDS can/cannot be cured? If yes, how?

2.4. Can HIV/AIDS be prevented? If yes, how?

- Is there treatment for HIV infected people? If yes, what do you think of the treatment?

2.5. Do you think it is important to test for HIV?

- What do you think are the benefits of testing for HIV/AIDS?

- What would you say are the disadvantages of testing for HIV?

- Where can one test for HIV in this area?

2.6. Have you ever been exposed to an HIV infected person in your life?

- If yes, can you share your experience of been exposed to that person/s?

- If no, what are your thoughts on people living with HIV/AIDS?

3. Now let us talk about relationships and sex (Sexual behaviour).

3.1. What are your thoughts on dating?

3.2. Are you currently in a relationship? If yes,

- How would you describe your relationship with your partner/s? (If in a relationship)



- Do you know the HIV/AIDS status of your partner/s?

3.4. Have you ever had sex with anyone? If yes,

- How old were you when you first had sex?

- When was the last time you had sex with someone?

3.7. How do you feel about condoms?

- Did/will you use a condom the first time you had sex with someone?

- Did you use a condom the last time you had sex with someone?

- How often do you use condoms?

4. Now let us have a conversation about health facilities (By health facilities I refer to clinics, hospitals, private medical facilities and where a person would get medical attention when not feeling well).

4.1. Do you make use of health facilities?

-What encouraged/discouraged you from utilising health facilities?

4.2. When was the last time you visited a health facility?

- How was your experience at the health facility during your last visit?

- What was the reason behind your visit at the health facility?

4.3. Where you offered an HIV/AIDS test by the health staff during your last visit?

5. I am now going to ask you a few questions about circumcision.

5.1. How do you feel about circumcision?

5.2. Is circumcision in any way linked to HIV/AIDS? If yes how?

5.3. Are you circumcised?

- If circumcised, where was the circumcision performed?

5.4. What encouraged you to/not to circumcise?

6. Let's evaluate your risk of contracting HIV (HIV risk perception).



6.1. What are the odds of you contracting or not contracting HIV/AIDS?

6.2. What are you currently doing to support your response to 5.1?

7. Now let us talk about HIV testing.

7.1. Do you know your HIV/AIDS status?

- If yes how do you know?

- When was the last time you tested for HIV/AIDS?

7.2. What encouraged/discouraged you to know your HIV/AIDS status?

7.3. Would you be interested in taking the HIV/AIDS test if given the chance? Elaborate

8. Is there anything that you think is important and was not covered in this interview?

Thank you for participating in this research, your time and information are deeply valued.

school of SOCIAL SCIENCES

SOSS Human Research Ethics Committee

Clearance Certificate

Protocol Number:	**DEV/18/03/01**
Project Title:	**'Avoiding truth in a time of knowledge: Male youth refusing to test for HIV'**
Investigator's Name:	**Mr Tshepo Evans Baloyi**
Department:	**Development Studies**
Date Reviewed:	**June 2017**
Decision of Committee:	**Approved / Unconditionally**
Expiry Date:	**June 2019**
Date:	**14 March 2018**

UNIVERSITY OF THE WITWATERSRAND
School of Social Sciences
2018 -03- 14
JOHANNESBURG

Head of School _____

Professor Mucha Musemwa

CC supervisor: **Dr Rajohane Matshedisho**

Declaration of Investigator

To be completed in duplicate and one copy to be returned to Ms. Sarah Mfupa in the School of Social Sciences, Room 152, 1st Floor, Robert Sobukwe Block.

I fully understand the conditions under which I am authorised to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. If any departure from the research procedure as approved, I undertake to resubmit the protocol to the committee.

_____ _____

Student Signature **Date**