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**Dividuality, Masculine Respectability and  
Reputation: Exploring the link between men's  
uptake of HIV treatment and their masculinity  
in rural eastern Uganda**

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**Godfrey Etyang Siu**

A Thesis submitted to the University of Glasgow in  
fulfilment of the requirement for the award of Degree  
of Doctor of Philosophy

**2013**

Medical Research Council, Social and Public Health  
Sciences Unit

## Abstract

This thesis discusses the link between men's HIV treatment seeking behaviour and their masculinity. It is based generally on ethnographic research conducted in Busia district, rural eastern Uganda, and specifically on 26 interviews conducted between 2009 and 2010 with different categories of men: treated for HIV, tested but dropped out of treatment, not tested but suspect HIV infection, and those with other health problems unrelated to HIV. The study explored how masculinity is constructed and discussed among the men from the Iteso ethnic group, how those notions of masculinity influence men's uptake of HIV treatment, and how HIV diagnosis and/or its treatment, in turn, affects men's perception of their masculinity. Thematic framework analysis identified recurrent themes and variations across the data.

The thesis argues that there are, essentially, two forms of masculinity in rural Uganda, one based on reputation, the other on respectability, and that these emerge in different contexts, and have different effects on men's behaviours regarding HIV testing and treatment. Respectable masculinities are endorsed largely by the wider society, while reputational masculinities are endorsed predominantly by the men themselves, although some ideals are shared by both. Theoretically, this categorisation is consistent with the distinction between the value systems of respectability and reputation as described by PJ Wilson (1969). Men's *dividuality* (Helle-Valle 2004), allowed them to, unproblematically, adopt the different and sometimes contradictory, forms of masculinity, in different social circumstances and phases of life.

Individual men can engage in a variety of HIV treatment seeking behaviours that typically correspond with different masculine ideologies and *dividualities*; some discouraging treatment seeking for HIV, others encouraging it. On the one hand, acknowledging illness is incompatible with men's notion of strength. Being diagnosed with HIV threatens respectability and ability to work and earn an income, hence treatment is delayed, while couple testing threatens men's freedom to engage in extramarital sex. On the other hand, HIV treatment may be undertaken and adhered to, in order to regain and maintain health, so as to fulfill family and societal expectations, notably that of provider and being a role model. Through the core themes of 'dented' and 'resuscitated' masculinities, this study suggests that HIV diagnosis negatively affected masculinity while treatment led to more positive ways to express masculinity.

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## Acknowledgements

I am so grateful to the people of Mam-Kiror for welcoming me to their village and families, and especially the family of Adam whom I lived with during the fieldwork. To the men I used to hang about with in different places, thank you for the drinks, and stories about the village. Special thanks go to all the study participants and most especially the 26 men that were interviewed.

I also thank all my contact persons from Busia district health office and from Busia Health Centre IV for helping during the process of negotiating access to the district and study village. Many thanks go to my research assistants Padde Rogers and Alice Papa for administering the questionnaires. Special thanks go to the three HIV counsellors at Busia HIV: Sylvester Wabwire, Okoyo Kamili and Margaret Misanya, for recruiting men to be interviewed. To Margaret, in particular, you will forever remain in my thoughts for your tireless commitment to ensure that my fieldwork was successful. Thank you also, Margaret, for the time we spent together, the stories we shared, including very intimate ones about your personal life, and for the gifts you gave me from your home: you ceased being a research assistant and became a sister to me.

I thank the MRC Social and Public Health Sciences Unit, Glasgow for hosting me and for the very stimulating and extremely supportive learning environment. I thank all the staff in this Unit, particularly the Administrative, Reception, Library and IT staff for their support. I am profoundly indebted to my fellow PhD students namely: Jane Hartley, Emily Smith, Catherine Stewart, Allison Teyan, Kalonde Kasengele, Caroline Sime, Sarah Gurney, Douglas Lonnie, Cathrine Nixon, Kathryn Skivington, Ellen Glasgow, Joanne Neary, Vittal Kittekkireddi, Gillian Ferguson, Nicola Boydell, Michael Green, Mathew Smith, Craig Donachie, Neil Bertrand, and Gregor Martin. Your presence, stories and support made me optimistic during the PhD studies. Your interest in my work resulted in stimulating discussions that provided great motivation and direction. Many of you read my draft chapters and provided very valuable comments and edits for which I will be forever grateful. In the MRC/UVRI Uganda Research Unit on AIDS, I would like to thank the social science team, especially, Martin Mbonye, for the valuable support and discussions of my work. I also thank all the administrative and IT staff of this unit for their support. Special thanks to the MRC/UVRI Uganda Research Unit on AIDS for funding the PhD study. In Makerere University I would like to thank the Office of VC for granting me study

leave. Special thanks go to all my colleagues from Child Health and Development Centre (CHDC). You have all been of valuable intellectual and practical support and encouraged me to be optimistic, both before and during the course of this PhD.

Special thanks to my supervisors Prof Janet Seeley and Prof Daniel Wight for the extremely valuable intellectual guidance, morale and financial support given to me throughout the course of PhD. Prof Janet Seeley, you inspired and gave me composure with your simple and assured approach to the PhD project. Prof Daniel Wight, you are simply meticulous and a delight to work with. I will forever be grateful for the intellectual guidance that both of you provided throughout the PhD time, and how you consistently challenged me into new ways of thinking about the thesis. I also thank Sarah Parry for editing the thesis, and Dr Hillary Thompson from MRC Social and Public Health Sciences Unit for kindly accepting to read the thesis before it was submitted.

Thanks to my family, including my father *Mzee* Simon Peter Etyang, mother Christine Akodoi Etyang, brothers, especially Peter and John, and all sisters for encouraging me. Thanks also to all my in-laws and their children who always encouraged and supported me and my family, materially and spiritually. Special thanks to my mother in-law Rev. Canon Lucy Langa for all the love and countless number of times you prayed for me.

I am deeply indebted to my dear wife Sarah Langa Siu, and my daughters Natasha, Nicole and Samara for their wonderful love and support, which made the PhD time worthwhile. Sarah, you led the prayers for my PhD scholarship and accompanied me the MRC in Entebbe to do the interview. Above all, you allowed me to go away from home for long periods to study. Natasha and Nicole, you often provided cheerful moments with your questions regarding my studies, such as why I just could not join you in your Day Care School instead of going to study in Glasgow. Sarah, our daughters and you were always patient with me, encouraged me throughout and accepted my not being social behaviour during the PhD study. Thank you also for always discussing and reading my work, Sarah. You always provided the motivation to finish!

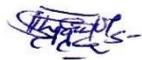
Finally, I thank the ALMIGHTY GOD, for, this is a wonderful testimony.

## Glossary of Ateso Words

<i>ere</i>		home, homestead, <i>colloq.</i> for man's reproductive organs
<i>ireria</i>		homes, homesteads
<i>ikalia</i>		families
<i>etogo (itogoi)</i>		house (houses)
<i>ejirani</i>	(Kiswahili)	neighbour
<i>lok'aduket</i>		neighbour
<i>epa'dukone</i>		neighbourhood/neighbourliness
<i>ikiliok</i>		men
<i>ekilokit</i>		a man
<i>aberu</i>		woman
<i>angor</i>		women
<i>esapat</i>		boy or male youth
<i>etelapt</i>		a boy
<i>isap</i>		boys
<i>itelapat</i>		male child
<i>ikoku</i>		a child
<i>apese</i>		girl
<i>apesur</i>		girls
<i>aturi</i>		age mate, generation
<i>amojong/emojong</i>		old woman/old man
<i>imojong</i>		old men
<i>ipolok</i>		elders (not necessarily age based)
<i>wazee</i>	(Kiswahili)	old people
<i>eboss</i>	(from English)	boss/employer/patron/big man
<i>idwe</i>		children
<i>eddya</i>		meat, fish, vegetables to be eaten with food
<i>ekitiibwa</i>	(from Luganda, kitiibwa)	respect, honour, glory
<i>ikamurak</i>		in-laws
<i>ibako</i>	(from Kiswahili/Luganda)	in-laws
<i>effesa</i>	(from Kiswahili)	gold

## Author's Declaration

I declare that, except where reference is made to the contribution of others, this PhD thesis is my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.



**Godfrey Etyang Siu**

*For my beloved wife, Sarah, and daughters Natasha, Nicole and Samara*

# Chapter 1 Introduction and background

## 1.1 Introduction

[...] also they [contractors] can fear to offer you work if they come to know that you are on drugs; they will ask themselves, ‘who are you to overwork that man in case he got any problem in your hands!’ [...] This means loss of earning; what will my children eat because they will still expect you to cater for the needs. For me when I stopped [taking] the medicine, I considered all these, because taking those drugs makes you dizzy and people will know (Alfred, age 38, stopped HIV treatment).

This excerpt is from Alfred, one of the 26 men interviewed during my 12 month fieldwork in Mam-Kiror village, Busia district, in eastern Uganda between August 2009 and August 2010. By the time of the research, Alfred had been on HIV treatment for about a year before dropping out. He had disclosed to his wife about his diagnosis and treatment but not to his fellow workers or the majority of his relatives. Throughout his interview, Alfred felt that his treatment had placed his work ethic and masculine reputation as a hard worker at stake, which threatened his ability to provide for his family, and so he decided to stop treatment for fear that he could not continue to conceal it. The focus of the thesis is on experiences and accounts like this from men who suspected HIV infection but had not tested, those who had tested for HIV but did not initiate treatment, and those who tested and initiated and maintained treatment.

## 1.2 Background and study questions

There is increasing interest in how gender, and masculinity in particular, influences differential access to HIV/AIDS treatment and care in resource limited settings (Hirsch 2007; Cornell, McIntyre et al. 2011). Although women in most parts of Sub-Saharan Africa (SSA), and Uganda in particular, remain significantly more infected with HIV than men (UNAIDS 2010), in recent years there has been growing evidence that, once infected, men are distinctively more disadvantaged in terms of access and use of HIV/AIDS treatment than women (Amuron, Coutinho et al. 2007; Muula, Ngulube et al. 2007; Braitstein, Boulle et al. 2008; Nattrass 2008; Birungi and Mills 2010; Ortego, Huedo-Medina et al. 2012). In Uganda there are fewer men on HIV treatment than women, they

tend to initiate HIV treatment later than women, are difficult to retain on treatment and have a higher mortality while on treatment compared to women (Mermin, Were et al. 2008; Amuron, Namara et al. 2009; Kigozi, Dobkin et al. 2009; Alibhai, Kipp et al. 2010; Kipp, Alibhai et al. 2010; Lubega, Nsabagasani et al. 2010; Mills, Bakanda et al. 2011; Nakigozi, Makumbi et al. 2011).

Men's under-utilisation of HIV/AIDS treatment in high prevalence settings is not only in stark contrast to the initial fears that men would disproportionately access ART compared to women (Pirkle, Nguyen et al. 2011), but it is also in contrast to their greater access to nearly all other services due to their more powerful position in society (Carael, Marais et al. 2009). Failure by men to access treatment at all, or early enough, means a significant care and economic burden to the health system and to their families, as well as increased chances of onward HIV transmission to their partners (Peacock, Redpath et al. 2008; Mills, Beyrer et al. 2012). The prevailing under-representation of men in the rollout of free HIV/AIDS treatment in resource limited settings, therefore, represents a critical policy concern, and highlights the urgent need to identify the factors that create disparities in access, in order to consider how they might be transformed to improve men's use of health services (Hirsch 2007).

Research on gender and masculinity in various settings has suggested that men tend to have multiple and sometimes conflicting ideas about what it means to be a man (Kimmel 2001; Barker and Ricardo 2005; Jewkes and Morrell 2010). From the perspective of seeking treatment for symptoms, the sociological and psychological literature generally holds that the health related activities and behaviour that men (and women) engage in are a means of constructing or demonstrating gender (Cameron and Bernardes 1998; Addis and Mahalik 2003; Courtenay 2003). It is commonly held that men and boys tend to experience great social pressure to endorse the stereotyped hyper-masculinity lifestyles and beliefs that males are strong, robust, tough, independent and self-reliant, brave and not caring for their bodies (Courtenay 2000; Seeley and Allison 2005; WHO 2007). Help seeking is seen to contradict these model gender virtues and norms (Cameron and Bernardes 1998; Courtenay 2003; Greig, Peacock et al. 2008; Bates, Hankivsky et al. 2009). However, other studies have shown that men are likely to take action on their health if they perceive that their symptoms are likely to interfere with their masculine social roles, such as their breadwinner role (Galdas, Cheater et al. 2005), or if they might hinder their sexual performance (O'Brien et al 2005).

Given the apparently contrasting evidence regarding the pattern of general treatment seeking behaviour among men, some scholars have argued for more detailed and context specific studies to categorise the varied perceptions and experiences of masculinity among men, and how it specifically impacts on their treatment seeking behaviour for specific illnesses (Courtenay 2003; Emslie and Hunt 2008). In other words, there is a need for a model that explains why men may seek help for some problems and not others or in certain contexts and not others for the same illness (Addis and Mahalik 2003; O'Brien, Hunt et al. 2005).

With regard to HIV/AIDS treatment in particular, most studies from Uganda and elsewhere in SSA, have only described the categorical gender differences in access to and uptake of treatment, without detailing how norms associated with masculinity may constrain or facilitate men's treatment seeking for the life-extending HIV medicines. There are, however, some important exceptions, from northern and southern Africa e.g., Bila and Egrot (2009), Mfecane (2010), Skovdal, Campbell et al. (2011) and Fitzgerald, Collumbien et al. (2010). These studies suggest that there is often a contradiction between men's understandings of masculinity and the bio-political representations of a good patient, undermining their use of HIV services. The majority of studies applying the concept of masculinity to understand the HIV/AIDS epidemic in SSA have concentrated largely on understanding men's sexuality and risk of infecting themselves and their partners, and on men's perceptions of life in the context of economic hardships exacerbated by the HIV/AIDS epidemic (Campbell 1997; Silberschmidt 2001; Brown, Sorrell et al. 2005; Tersbøl 2006; Walsh and Mitchell 2006; Bhana, Morrell et al. 2007; Simpson 2007; Campbell, Baty et al. 2008; Sanger 2008). Therefore, the experience of men who suspect or know they are infected with HIV, in particular the link between their accounts of masculinity and treatment seeking in the context of the increased opportunities for HIV/AIDS treatment, remains largely under-researched in SSA. This thesis seeks to contribute to the literature and discuss the multifaceted relationship between norms of masculinity and men's health seeking behaviour for HIV/AIDS in Mam-Kiror Village in Busia district, Eastern Uganda. Mam-Kiror is a pseudonym used to minimise inadvertently revealing participants' identities.

### **1.2.1 Study aim and research questions**

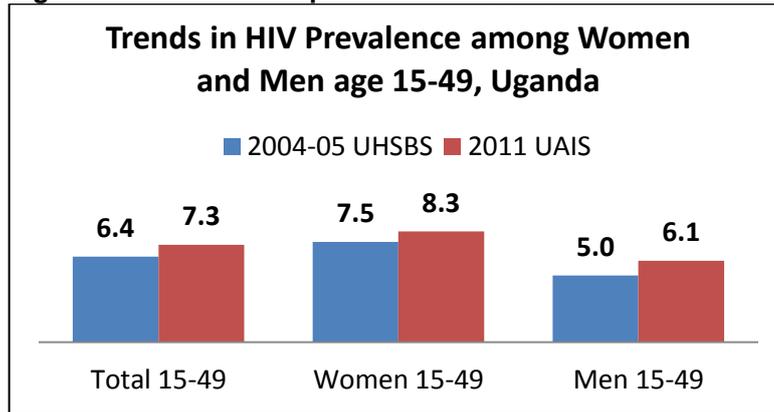
Using ethnographic approaches this study seeks explanations for the under-representation of men on HIV/AIDS treatment in Uganda. The aim is to examine how masculinity is constructed, maintained or undermined, and how ideas of masculinity influence access to, and utilisation of HIV/AIDS treatment. The study also explores how HIV/AIDS treatment, in turn, affects men's perception of their masculinity. There are three main questions that are addressed:

1. What is the cultural perception and construction of masculinity among the Iteso men of Busia district?
2. How do men's notions of masculinity influence their perception of, and response to, HIV/AIDS?
3. How does HIV/AIDS and/or treatment affect their masculine identities?

## **1.3 HIV/AIDS in Uganda**

### **1.3.1 Prevalence and distribution**

With between 1.2 and 2 million people living with HIV, and approximately 58% of them being women (Ministry of Health (MoH) [Uganda] 2007; WHO/UNAIDS/UNICEF 2007), the disease is clearly unequally distributed among the different sexes and remains an urgent public health problem in Uganda. During the 2005 Uganda national HIV sero-behavioural survey (UHSBS), the overall adult (15-49 years) prevalence of HIV in Uganda was reported to be 6.4 % (Ministry of Health [Uganda] and ORC Macro International 2006). The overall adult prevalence is now estimated to have risen to 7.3%, with women aged 15-49 having a higher HIV prevalence (8.3%) compared to men of the same age group (6.1%) (Ministry of Health (MoH) [Uganda] 2012) (see figure 1, below).

**Figure 1: Trends in HIV prevalence 2005-2011**

Source: Ministry of Health [MoH], 2012

Two main explanations may account for the gender variations in HIV prevalence. First, biologically, women are at least twice as vulnerable to infection as men, and second, women tend to experience greater economic disadvantage and poverty than men and have less ability to negotiate safer sex practices than men, which exposes them to higher risks of HIV infection (Türmen 2003; Uganda AIDS Commission 2007; RSPH 2012)i .

Further sex variations in HIV prevalence in Uganda can be observed when specific age groups are considered. In the age-group 15-24 years, HIV prevalence is higher among women compared to men (female: male ratio 3:2), while in the age-group 25-34 it is higher among men, with new male infections outnumbering those of females by 3:1 (Hladik, Musinguzi et al. 2007). The higher prevalence of HIV among women in the younger age group suggests that young women start sex earlier than men of the same age group, have sex with older men who are at a higher risk of being already infected, and become infected earlier in life than men (McGrath, Rwabukwali et al. 1993; Buvé, Bishikwabo-Nsarhaza et al. 2002).

Although young adults aged 15-24 remain substantially infected with HIV (4%), the epidemic has shifted to older, married or formerly married individuals. For example, HIV prevalence is highest among widowed women and men (32.4% and 31.4%, respectively) and lowest among women and men who have never been married (3.9% and 2.0%). In addition, HIV prevalence increases with age until it peaks at age 35-39 for women (12%) and at age 40-44 for men (11%) (Ministry of Health (MoH) [Uganda] 2012). In 2005 it was estimated that about 77% of all new adult HIV infections in males and 58% in women from 2001-2005 were among people aged 30 years and above (Uganda AIDS Commission 2007). While there remain much higher rates of HIV infection in pockets of the

traditionally “at risk populations,” including fishing communities, long distance truck drivers, sex workers, and mobile populations, data indicate a rising prevalence in groups previously thought to be at less risk, including those in marital unions, with existing data estimating that over 100,000 new HIV infections are occurring annually in married women and men (Ministry of Health [Uganda] and ORC Macro International 2006).

Current data further show that HIV prevalence in Uganda varies by region, from as low as 4.1% in Mid-eastern region, which includes Busia district, to 10.6% in Central Region. Women in urban areas have a higher HIV prevalence than those in rural areas (11% versus 8%), but there is no urban-rural difference in HIV infection among men (6.1%, each) (Ministry of Health (MoH) [Uganda] 2012). Whereas HIV prevalence is lower in rural areas, the majority of Ugandans live in rural areas, and therefore, comprise most of the people living with HIV/AIDS (Hladik, Musinguzi et al. 2007). There are now growing concerns about deterioration in some behavioural indicators, notably low condom use and an increase in multiple sexual partner, especially for men (Ministry of Health (MoH) [Uganda] 2012). Heterosexual transmission remains the major transmission route, contributing 76% of new HIV infections in Uganda while mother to child transmission contributes about 22% (Ministry of Health [Uganda] and ORC Macro International 2006).

### **1.3.2 Policy framework**

The provision of HIV/AIDS treatment constitutes one of the largest co-ordinated programmes of medical treatment ever delivered in sub-Saharan Africa. In Uganda provision of HIV/AIDS treatment now forms a key policy component of the national response to the epidemic. The antiretroviral therapy (ART) policy (Katabira, Kanya et al. 2009) emphasises the need to increase access to treatment through both public and private channels. Uganda, like many SSA countries, has improved its HIV/AIDS treatment programme within the framework of the WHO/UNAIDS ‘3 by 5’ initiative launched in 2003 to provide free antiretroviral treatment to three million people living with HIV/AIDS in resource poor countries by the end of 2005. Even though great progress in the supply of HIV/AIDS treatment has been made under these policy frameworks, access remains limited. For example, less than 50% of those in need of treatment were accessing it in Uganda by 2008 (WHO/UNAIDS 2008). The existing gender differences in access and use of HIV treatment are discussed in detail in Chapter 2.

### 1.3.3 Criteria for eligibility and access to treatment

The initiation of new patients on ART is dependent on the stage of their HIV infection/disease. The staging of HIV infection can either be defined clinically or on the basis of CD4 cell counts. In Uganda, to access free antiretroviral drugs (ARVs) through public health facilities, a number of criteria apply. The medical criterion for accessing ARVs is a CD4 cell count of 200/mm<sup>3</sup><sup>1</sup> or below, although there have been calls to revise it to allow more patients to join treatment earlier (Katabira, Kanya et al. 2009). In the absence of resources to afford CD4 tests and viral load counts, the WHO clinical staging, which recommends provision of ART to patients with HIV/AIDS clinical stage III or IV, is used. However, studies on the suitability of WHO clinical staging in Uganda have reported that relying on the clinical stages III and IV often delays patients' initiation on treatment, which risks patients' lives, as many patients with stages I and II tend to have CD4 below 200/mm<sup>3</sup> (Jaffar, Birungi et al. 2008). With or without ARVs, it is policy in Uganda, that all people who test HIV positive are put on daily Septrin (Cotrimoxazole) treatment, sometimes referred to as Pre-ART treatment, for prophylaxis, against common illnesses, such as diarrhoea, coughs and malaria (Mermin, Lule et al. 2004; Mermin, Lule et al. 2005).

In addition to the medical criteria, there are other patient specific economic and psychosocial factors, which may be used to assess a patient's readiness to use HIV treatment and their adherence. The application of these criteria is, however, more flexible than the medical ones, and appears to vary from programme to programme. These may include: interest and motivation in taking ART, presence of co-morbidities such as TB infection, having a treatment supporter, being resident within reasonable proximity of the providing institution, the potential benefits to dependants and the "first come, first served" principle (Katabira, Kanya et al. 2009; Sofaer, Kapiriri et al. 2009). Some treatment programmes in Uganda also tend to give lower priority to patients who have had prior treatment access (Colebunders, Kanya et al. 2005), meaning that patients who began buying medication before free treatment became available faced greater barriers in attempting to switch over to subsidized medication (Crane, Kawuma et al. 2006). Ideally,

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<sup>1</sup> CD4 lymphocyte cells (also called T-cells or T-helper cells) are the primary targets of HIV. The CD4 count and the CD4 percentage mark the degree of immunocompromise. The CD4 count is the number of CD4 cells per microliter (µL) of blood. It is used to stage the patient's disease, determine the risk of opportunistic illnesses, assess prognosis, and guide decisions about when to start antiretroviral therapy (ART) (Horizons/Population Council/International Centre for Reproductive Health, Ministry of Health Kenya: Adherence to ART in Adults. A guide for Trainers).

these criteria aim to increase the chances of access for those who most need HIV/AIDS treatment. However, it has been noted that targeting treatment based on some of these social characteristics may privilege some, such as mothers, to access treatment at the expense of others, and basing treatment on a “first come, first served” or on demand based allocation schemes, is likely to favour the more educated people with information (Bennett and Chanfreau 2005). Therefore, there remain many structural, cultural and individual barriers to equitable supply and increased uptake of HIV/AIDS treatment in Uganda.

### **1.3.4 Scaling-up access to treatment**

A free and uninterrupted supply of ARVs and septrin medication is essential for increasing and sustaining access to HIV/AIDS treatment. Prior to the introduction of free treatment of HIV/AIDS in Uganda in the early 2000s, individuals mainly accessed treatment through the UNAIDS HIV Drug Access Initiative (DAI) pilot programme developed in 1997 (Weidle, Malamba et al. 2002) on a fee for service arrangement. Due to widespread poverty, the majority of those who needed treatment could not afford it, while many of those who purchased drugs were unable to maintain a constant stock, leading to concerns about drug failure and high costs of second line regimens (Mugenyi 2008).

Issues of access to HIV/AIDS treatment in Uganda began to change around 2001 when generic medicines came onto the market (Whyte, Whyte et al. 2004; Mugenyi 2008), and more rapidly when an expansion plan to increase free access to ARV therapy was developed with support from WHO, under the National Strategic Framework for Expansion of HIV/AIDS Care in Uganda, from 2001-2006 (Amolo, Aceng et al. 2003). This was pursued through a phased approach and the scaling-up was expected to take place both in districts with no ARV therapy services and within districts already implementing ARV therapy, with the ultimate goal of ensuring that the services are expanded down to health centre IV level<sup>2</sup> and as well as community level (Amolo, Aceng et al. 2003).

Uganda’s early successful experience in providing ARV therapy attracted international support with big programmes such as Global Fund to Fight AIDS, Tuberculosis and

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<sup>2</sup> Uganda operates a decentralised health care system comprising: The District Hospital (although some recently created districts do not have it), HCIV at sub District or Constituency Level, HCIII at sub County and HCII at Parish level. There is no HCI but there are (supposed to be) Village Health Teams (VHTs) or medicine distributors, who operate at the village level and act as the first contact and referee for patients. Each of the four regions of the country has a regional referral hospital, and at the top of the healthcare chain, is the national referral hospital, located at Mulago in the capital Kampala.

Malaria, USA Presidential Emergency Plan for AIDS Relief (PEPFAR) and The World Bank Multi-Country HIV/AIDS Program for the Africa Region (MAP) and the Academic Alliance for AIDS Care, to provide funding for expanding delivery of free treatment (Amolo, Aceng et al. 2003). At the same time, civil society organisations and international programmes operating on a smaller scale such as The AIDS Support Organisation (TASO), AIDS Information Centre (AIC), Uganda Cares in Masaka, Médecins Sans Frontières (MSF) in Arua, Plan International, World Vision projects were offering free HIV/AIDS treatment and care to some patients (Whyte, Whyte et al. 2004).

These positive changes in the funding and management systems for ART delivery programmes have led to very encouraging trends in the increases in number of people accessing AIDS treatment every year. For example, by 2008, it was estimated that there were 153,718 active clients (of whom, 13,413 were children aged below 15 years and 140,305 adults) receiving ART in 336 facilities across the country, up from only 10,000 in 2003 (Namuwenge, Kirungi et al. 2008). This has brought HIV/AIDS treatment coverage to slightly less than 50% of those in need of it. By 2010, the estimated need for ART among both adults and children was 540,094 under the new eligibility criterion of DC4 350mm/3 but in the same year, only about 260,865 people accessed treatment. By 2011, access to ART had increased to 290,971 among both adults and children, bringing the total coverage of ART to 62% of all adults in need of it. Yet even if this rapid increase in provision of free HIV treatment in Uganda is very impressive, it masks gender differences and inequities in access to AIDS treatment, with men tending to use it less than women. The specific gender differences in access and the reasons for this will be discussed in detail in Chapter 2.

## **1.4 Thesis structure and delimitation**

This thesis is presented in 10 chapters. Chapter 2 reviews the literature on the relationship between masculine identity and men's treatment seeking for HIV/AIDS. It starts with a discussion of the key theoretical perspectives upon which the study is premised. It follows with a review of the literature on gender and health in general, and thereafter discusses the possible factors for men's poorer uptake of HIV testing and treatment in Uganda, where possible comparing it with other parts of SSA. The chapter then revisits the research questions in view of the literature and situates the key research issues within the broader theoretical discussions.

Chapter 3 deals with the study methodology. It discusses the theoretical underpinnings of the qualitative research and ethnographic methods employed, describes the study sample, and the fieldwork relations and ethics. It also outlines the data management and analysis procedures. A key feature of the chapter is its emphasis on the lessons learnt about the strengths and weakness of the research design and about my own subjectivity. This chapter also describes my approach to case studies and their value in the thesis.

Chapter 4 describes the basic elements of social life in the study setting. It provides details of the Iteso society and Mam-Kiror village in particular, and draws attention to issues salient to masculinity. Specifically, it focuses on family relations, relations between neighbours, economic structure and land ownership, leisure and the health system, setting the context in which men lived their lives, thereby aiding a better understanding of the rest of the thesis.

Chapter 5, 'Masculinity in Mam-Kiror Village,' addresses the central question: what are the social constructs of masculinity in the study setting? It explores how important attributes of masculinity are established, validated or undermined. Describing the existing dimensions of masculine identity helps in exploring how these ideals may influence men's views and experiences with HIV/AIDS and its treatment, in the later chapters.

Chapter 6 focuses on the significance placed upon work and money-making as measures of masculinity, and how these ideals impacted on men's experiences and perception of other dimensions of masculinity. The chapter tells us how subscribing to this masculine norm has both positive and negative consequences for men's health and prestige. A substantial part of the chapter describes men's most desired occupation – artisanal gold mining – at the time of the research and the masculine norms that were constructed around this occupation, which consequently affected HIV testing and treatment among some men.

Chapter 7 is about factors that influence men's uptake of HIV testing and initiation of treatment. Since most villagers in Mam-Kiror tended to only seek testing if they have already made the decision to seek treatment (should they be diagnosed HIV positive), men's uptake of testing and treatment are discussed together. This is done by examining the extent to which current norms and practices around HIV/AIDS testing are consistent

with the prevailing masculine norms and lifestyles, and how masculinity discouraged or encouraged initiation of treatment.

In Chapter 8, I consider men's treatment seeking behaviour after initiating treatment. The chapter explores factors that helped men to maintain treatment and those that led them to discontinue treatment, highlighting specific experiences and norms around masculinity that might be helpful in explaining men's treatment seeking.

Chapter 9 discusses how masculinity was affected by a positive HIV diagnosis and/or enrolling on treatment. The aim is to show how HIV/AIDS or its treatment helps or constrains men from developing new resources for expressing their masculinity.

Chapter 10 draws together the key findings and discusses them in relation to the existing literature. By framing the analysis around the theory of dividuality and the notions of respectability and reputation, the chapter discusses the ways in which different constructs of masculinity act as facilitators or barriers to undertaking HIV testing and treatment, and outlines the main thesis from this research.

In this thesis, I present empirical data (Chapters 4-9) separately from the literature and analytical framework. The empirical chapters privilege the participants' accounts - primarily men who were HIV positive or suspected that they might be - but they are complemented with data obtained from participant observation. Observation was conducted predominantly in eating places and bars, in the market area, and in respondents' homes and workplaces. It was primarily with men, and although beer drinking and mining groups were frequently observed I did not participate in them. Less data were collected from women, young people or children. Each of the empirical chapters is paired with a case story to provide an illuminating account of the social life and treatment trajectories of selected men, illustrating how different norms of masculinity shape men's decisions whether or not to seek HIV treatment.

# **Chapter 2: Theorising Masculinity and HIV treatment: Literature review and research issues**

## **2.1 Introduction**

A large body of research on men's treatment seeking depicts men as reluctant users of health services (e.g., Cameron and Bernardes 1998; Galdas, Cheater et al. 2005; Smith, Braunack-Mayer et al. 2006; Mahalik, Shaun et al. 2007). The under-representation of men in HIV/AIDS treatment in Uganda and some other SSA countries is a case in point. This chapter reviews the literature on gender and patterns of treatment seeking in general, and of HIV/AIDS in particular. It also specifically discusses the growing concerns about men's poorer access to and uptake of HIV/AIDS treatment, and the possible reasons for this.

It begins by discussing the concepts of gender and masculinity. This is followed with discussion of the concepts of respectability and reputation, and dividuality, which are the key theoretical perspectives used for interpreting the findings of this thesis. The chapter concludes with an attempt to situate the research questions stated in Chapter 1 within these theoretical discussions and summarise the key research issues to be explored within each question.

The literature reviewed was obtained predominantly by conducting searches of the Web of Science and Medline data bases. The main search terms, which were applied in various combinations, included: masculinity, femininity, gender, gender roles, sex roles, masculine roles, men and masculine identity, gender and health seeking, masculinity and health seeking, gender and HIV, men and HIV, gender and HIV treatment, masculinity and HIV treatment, and men and employment. Additional literature was obtained through Google scholar searches of the more sociological and anthropological literature. Where classical works, such as those relating to gender and masculinity theory, were required they were accessed from the Glasgow of University library through searches in the online catalogue. Special government of Uganda publications were accessed from the relevant departmental websites. A substantial proportion of the material used in this chapter focuses on Uganda and SSA but where relevant, material from other regions of the world is cited.

## 2.2 Gender and gender roles: nature or nurture?

The concepts 'gender' and 'masculinity' have considerable importance as analytical frameworks within HIV prevention, care and treatment in SSA where the impact of the epidemic has been severe and varied for both women and men. Despite the extensive literature on the subject of gender, its meaning remains contentious, and the concepts of gender and gender roles can be used in a variety of ways. Clarifying the meanings, differences and relationships between these concepts is essential for understanding and interpreting what it means to be a man or a woman in the context of high HIV prevalence and HIV/AIDS treatment.

Sociologists tend to distinguish 'gender' from 'sex' based on the idea that sex is a purely biological category, while gender is socially determined. While the existence of intersex and transgender people reveals that the biological category sex is more complex than the male-female binary as commonly understood, in most societies sex chromosomes, genitalia and the fixed anatomical organisation of a person, and their natural reproductive capacities, are universally used to express the differences between biological female and male persons (Anderson 1996). In contrast, gender denotes the social and psychological construction of characteristics, behaviour, expectations and roles considered appropriate for males or females (Hearn 2001). It is a mechanism by which notions of femininity and masculinity are constructed as normal and natural categories (Butler 2004). Gender is, however, not only a system of classification by which biological males and females are sorted and socialised into different sex roles; it also usually expresses the universal inequality between men and women, with men as a 'group' tending to enjoy more privileges than women as a 'group' (Kimmel 2000).

In most African societies, gender differences often translate into power inequalities and marked distinctions in roles and norms. Women are raised to be caregivers and nurturers of families, and submissive and dependent on men, while men are expected to be breadwinners for family and relatives, courageous risk takers, strong-willed, independent, and make decisions and provide leadership in the family (Gupta 2002; Barker and Ricardo 2005; Brown, Sorrell et al. 2005; Strebel, Crawford et al. 2006; Doyal, Anderson et al. 2009). Furthermore, in many African settings, including Uganda, it is generally accepted that men are naturally sexually adventurous, marriage makes a man complete, children belong to a man, sons (or sister's sons in matrilineal societies) provide continuity of the

man's lineage, and women do not inherit property (Goody 1969; McGrath, Rwabukwali et al. 1993).

In the social science literature, the debate about the differences between sex and gender, and how gender roles are acquired, is often set up as 'nature' versus 'nurture' or in the form of the more familiar categorisation of 'essentialism' versus 'social constructionism'. The fundamental question that these debates seek to answer is: to what extent should the differences between women and men be explained by biology (sex) or social factors (gender)? The nature hypothesis relies on biological differences to interpret and account for the differences in behaviour, roles, identities and positions of women and men in society. Because there are significant hormonal and anatomical differences between men and women, such as body size, which may affect their social experiences, the nature hypothesis accepts all differences between women and men in society as normal and inevitable (Kimmel 2000). In their own right, bodies/biology indeed matter in foregrounding differences in human experiences, and individual and group characteristics emerge from a complex interdependence between biological factors and social systems (Anderson 1996). Bodies, for example, give birth, age, and get sick, signifying the influence of both biological and social experiences and practices (Connell 2005). However, the nature perspective has been heavily criticised in the social sciences for being essentialist, deterministic or reductionist in explaining differences in sex roles, as it tends to simplify complex processes or events (Anderson 1996). It is argued, for example that, no single hormonal state can precisely predict all social behaviour (Connell 2011). The other limitation of the nature perspective is its failure to account for diversity among men and among women (Jewkes and Morrell 2010). As Anderson (1996) observes, while there may be general biological bases for human behaviour, nature alone cannot account for the complexities in patterns of human behaviour and roles.

In contrast, the nurture framework, which extends the views of the social constructionism paradigm, considers difference in roles between women and men, or more specifically, masculinity and femininity, as a product of how individuals are brought up or nurtured (Connell 2005; Jewkes and Morrell 2010). The main premise of the nurture school of thought is that rather than being natural or genetic, differences between women and men's behaviours are taught and learned through a process called socialisation, with the family, work place, and state institutions as main agents (Connell 2005). Commenting on the mechanism through which differential socialisation shapes gender differences, Kimmel (2000) states:

Men and women are different because we are taught to be different. From the moment of birth, males and females are treated differently. Gradually we acquire the traits, behaviour, and attitudes that our culture defines as “masculine or feminine”. We are not necessarily born different; we become different through the process of socialisation (Kimmel 2000, p.3)

Thus, contrary to the nature/essentialist viewpoint, this suggests that gender roles have a cultural basis, because if gender differences were determined by biological factors alone, there would not be a vast diversity of gender roles and relations both between societies/cultures and within societies (Anderson 1996). The strength of models that emphasise the cultural basis of gender roles is that they account for diversity and provide conceptual clarity about how gender inequalities may occur and the forms they may take (Jewkes and Morrell 2010).

Another fundamental issue in this debate is: to what extent do individuals have any agency in their acting out of gender roles? Many scholars agree that it would be wrong to interpret gender as a simple enactment of roles and difference as prescribed by society or institutions. It is argued that although gender roles are delineated by behavioural expectations and norms, once an individual knows those expectations and norms, he/she can adapt behaviours that project the gender he/she wishes to portray (Connell 2005). In other words, human beings are not passive creatures that internalise anything they encounter and reproduce it largely unconsciously; at least to some degree they select what they do. However, West and Zimmerman (1987) have used the phrase “doing gender” to assert that while people are not simply passive receivers of gender roles, they are strongly socially influenced. Thus, to them, gender is a routine, methodical, and recurring accomplishment for which men and women as members of a society are hostage to its production. This is because, if individuals fail to do gender appropriately, they are called to account for their character, motives and predisposition. Therefore, following West and Zimmerman, I argue that, although it is individuals who “do” gender, it is a situated doing, carried out in the virtual or real presence of others and institutions who are presumed to be oriented to its production (West and Zimmerman 1987).

Conceptualising gender as a social and cultural phenomenon reminds us that gender is a part of the social experience of both women and men, not just women, as the concept is sometimes taken to mean (Kent 1998; Connell 2011). This challenges scholars and practitioners in this field to pay attention to how men may be also affected by their gender.

In every society, gender intersects with other socio-economic categories such as age, social class, and education to create different sets of opportunities, concerns and consequences, including health, for men and women.

## 2.3 Masculinity: The multiplicity of masculinities

Masculinity is the social and cultural expression of what it means to a man (Kimmel 1987). However, because there is diversity in contexts and experiences upon which notions of masculinity are constructed, the meaning of masculinity may vary from society to society (Connell and Messerschmidt 2005). In most of the literature on gender, two main theories: the *gender role* theory and the *relational* theory have been widely employed to explain masculinity. It is commonly believed that masculinity cannot be understood apart from femininity, as it is usually through these binary gender categories that men and women, boys and girls primarily understand, explain and affirm their identities and roles (Segal 1993; Connell 2005).

From a gender-role perspective, once a sense of appropriate gender attributes and roles based on male or female biology have been acquired through socialisation, it presupposes the ability to distinguish oneself from the complementary but opposing identity and act in ways appropriate to one's sex (Brittan 1989). Masculine identity is conceived as the degree to which a person sees themselves as masculine given what it means to be a man in a particular society (Stets and Burke 2000). In most societies, characteristics and attributes commonly considered necessary for one to be masculine include, among others, being heterosexual, strong, independent, provider for one's family, and the decision maker in the family. It can be argued that when successfully enacted, these attributes and characteristics contribute to attainment of masculinity within two broad value systems; that is respectability and reputation (Wilson 1969). These value systems and their relevance in this thesis are elaborated in detail in a later section of this chapter. It is important to note that by considering feminine and masculine roles and attributes as complementary and reciprocally dependent on each other, the gender/sex-role theory assumes that the characteristics of each gender are valued by cultures/society (Demetriou 2001; Kimmel 2004). This would mean, for example, that women are esteemed for their submissiveness and men for aggressiveness. Therefore, while some gender roles and behaviour may overlap, men and women are expected to conform and subscribe to the culturally prescribed roles and identities, and act as masculine or feminine respectively. Those who

fail to fit, show limitations or resent these roles and norms as too restrictive, may be seen as deviant, and if they are men, they are designated unworthy, incomplete or inferior men (Connell 1993; Kimmel 2001); that is, 'less masculine'.

An important question in this discussion is: how do some characteristics become honoured and attached to men, and others subordinated and attached to women? In other words, why is masculinity usually presented as superior to femininity? The mechanism through which specific characteristics and attributes become honoured and attached to men, and others subordinated and attached to women is complex, but it may be understood by examining the process through which males exercise power in society. One of the most plausible explanations of how this might happen seems to be found in the work of feminist scholar Hester Eisenstein (1984). Drawing out the principles of patriarchy, she argues that because men tend to exercise cultural authority and hegemony, they are able to elevate maleness into a definition of normality, while according lower qualities to females. Usually, patriarchy privileges men by taking the male body as the 'standard' and fitting upon it a range of valued characteristics, and through comparison, viewing the female body as deficient, associated with weakness, with lack of control and with intuitive rather than reasoned action (Annandale and Clark 1996). This means that for women, their gender becomes a mark of inferiority while masculinity guarantees a dominant position to males. These assumptions of masculine superiority are lived out and reinforced within a social system where relations are hierarchically structured along gender lines giving men power that they unthinkingly take for granted (Segal 1993). Thus, even though men and women may have some universal characteristics, the attributes that are considered predominantly male are often portrayed as the standard framework and norms against which other attributes, especially the feminine ones, are evaluated (Anderson 1996).

Defining masculinity in terms of roles alone is often regarded as too simplistic and insufficient for explaining power and patterns of difference between women and men, and among men themselves. Gender relations and power differences do not only occur between men and women but also within these categories. In addition, conceptualising gender in this way, fails to account for individual behaviour differences in diverse situations, assumes passive learning of prescribed behaviour and underplays individual agency, and affirms male domination over women (Connell 1993; Connell 2005). The limitations of the gender role theory has led to a shift in the debate to focus more on variations between and within the different genders, resulting into the emergence of the concept of 'multiple

masculinities' and the relational theory of masculinity, which captures both the fact of contextual variability, complexity, multidimensionality of masculinity, and the power based or hierarchical nature of what it means to be a male person (Kimmel 1987; Connell 2005). The underlying assertion of the concept of multiple masculinities is that men are not a homogenous group; being male is not a fixed state of being, and that there is no single basic attribute of masculinity (Flood 2004). In Connell's words, "being male (or female) is a becoming; a condition actively under construction, [...] and the process and paths of becoming male are complex, and involve tensions and ambiguities" (Connell 2002, p.6). Therefore, there is a need to go beyond making assumptions about men in general, to explore men's multiple social and individual identities and differences.

Though most gender theorists now recognise that there are multiple masculinities, there is a widely held argument that these masculinities are often organised and patterned in some form of hierarchy of power relations. The chief architect of this idea is the Australian sociologist, RW Connell, who in 1988 introduced the concept of 'hegemonic masculinity' to analyse the configuration of gender relations and power among men, and distinguished it from other masculinities which Connell referred to as 'subordinate masculinities'. The theory of hegemonic masculinity proposes that in every society, there is usually a culturally dominant ideal of [hegemonic] masculinity against which all other masculinities are measured (Connell 2005). In this theory, the notion of hegemony articulates a process by which a social ascendancy is achieved through a synthesis of social, political and economic ideas and practices promoted by the leading group (Howson 2006). What hegemony does is to qualify, legitimise and naturalise the interests of the powerful while subordinating the claims of the other groups (Connell and Messerschmidt 2005). Hegemonic masculinity is therefore understood as both hegemony over women and hegemony over subordinate masculinities [other men], and is a reminder that certain masculinities are socially more central or more associated with authority and social power than others (Demetriou 2001).

Connell's concept of hegemonic masculinity has had considerable application in Africa, most especially in the areas of politics, nationalism, violence, and sexuality and HIV (see for example Ouzgane and Morrell 2005; Ratele 2008; Jewkes and Morrell 2010). Nevertheless, the theory of hegemonic masculinity has drawn a lot of academic debate, and in some cases, criticism by some scholars. For example, Noone and Stephens (2008) argued:

[.....] Because few men embody all the ideals of hegemonic masculinity and because the ideals are themselves unclear, the value of the concept for analysing masculinities is questionable. Besides, there is no single hegemonic masculinity, but rather a multiplicity of hegemonic sense-making or shared ‘intelligibilities’ that maintain male privilege (Noone and Stephens 2008).

The criticism of hegemonic masculinity forced Connell to rethink the concept and modify some of its original propositions, in particular reconsidering the one dimensional treatment of hierarchy (Connell and Messerschmidt 2005).

In summary, in the above discussion and the preceding one which introduced the subject of ‘gender’, I have demonstrated that the analysis of sex, gender, gender roles, and masculinity has been approached using different theoretical perspectives, and many concepts have emerged to represent various experiences. I have argued that sex is a natural category and gender results from nurture, and that, although gender and sex are linked, the concepts can be clearly distinguished. I have argued that the nurture and social constructionism theory offers a plausible perspective for understanding inequality and difference between men and women and among men as it provides diversity and explains change and inequalities in gender roles in society. I have also recognised individuals’ agency as they “do” gender, and, finally, shown that recent literature tends to analyse masculinities as multiple and relational.

### **2.3.1 Relevance of masculinity theory to this thesis**

It is evident that the social construction of gender or masculinity and femininity determines attitudes about what men and women are capable of, how they should behave, who will occupy positions of power, and affects almost all aspects of women’s and men’s lives, their needs, opportunities and access to resources (Kimmel 2004; Connell 2011). In the context of HIV in SSA, the accumulated research in the past three decades has concluded that understanding the meaning and experience of masculinity is central to understanding HIV risk among women and men, and developing appropriate preventive interventions for both genders (Greig, Kimmel et al. 2000; Hirsch 2007; Greig, Peacock et al. 2008).

Masculinity theories have developed three key arguments relevant to this study to explain men’s lives and treatment seeking for HIV/AIDS. First, masculinity is socially constructed rather than naturally or biologically determined. The important fact of men’s lives is not

that they are biologically males but that they become men, that is their sex may be male but their identity as men is developed through complex processes of interaction with culture, in which they learn the gender scripts appropriate to their culture and attempt to modify those scripts to make them more relevant to their life situations (Kimmel 2001). In studying masculinity among the Iteso of Busia district, this perspective accommodated the premise that in the era of high prevalence of HIV/AIDS and availability of HIV treatment, men, particularly those who are infected, might view themselves as men in ways that are fundamentally different from how they have done so previously.

Second, masculinities vary, that is the experience of masculinity is not uniform across or within cultural contexts. The central assertion here is that masculinity is dynamic, and enacted and sustained through and/or in different circumstances and as the society around a man changes through his lifetime. Hence it may vary according to the social groups of men that comprise a particular society. Therefore, we cannot speak of a unitary form of masculinity as if it were a single easily identifiable commodity; doing so risks suggesting that there is a single normative form, and making all the other masculinities problematic (Kimmel 2001). Hence, rather than speak of one 'masculinity', we should recognise the plurality or multiplicity of masculinities. In my study therefore, I was concerned about the possible coexistence of multiple masculinities in the same setting and the distinct ways in which men of Mam-Kiror tend to express their masculinity.

Third is the importance of adopting the life-course perspective to analysing men's lives and health. From this perspective the meaning of masculinity is not constant over the course of a man's life, but rather it will change as he grows and matures (Kimmel 2001). The central assertion is that as an individual moves through different life-stages, the issues that confront a man to prove himself and the structures through which this is done are fundamentally different and lead to different experiences of masculinity (Cameron and Bernardes 1998). In the context of this study, this perspective gave room for exploring the concepts of respectability and reputation (see 2.4 below) and allowed for an exploration and discussion of the ways in which new life experiences such as infection with HIV and the requirement to seek treatment transformed men's perception of their masculinity over time.

## 2.4 Masculine respectability and reputation

Although the sociological concepts of respectability and reputation have received little attention in the analysis of masculinity in SSA, there are several insightful examples of their application in research among Caribbean and the African American communities, which can be used to explain the experiences of being a man in Uganda in the context of HIV treatment. In this thesis, I draw from the notions of respectability and reputation as proposed by PJ Wilson in 1969. In a review of ethnographic studies of the social structure of Caribbean societies, Wilson (1969) suggested that there were two closely interconnected value systems –respectability and reputation – by which men related their position in society. The respectability-reputation model allowed him to explain the structure of social relations among men in the Caribbean societies by highlighting how men’s identities were produced, maintained, and challenged, how they govern the conduct of relations within the community, and the consequences of these value systems.

Wilson defined respectability as the degree of approximation of conformity to the standards and ideals of the whole legal society, and saw it as a value system governed by norms based largely on Eurocentric middle-class values. By ‘legal society’, Wilson implied the moral values of institutions such as the family and the church, in which one could participate in an official capacity. He asserted that respectability accrues from and/or is affirmed by proper attention to the requisites or values of marriage and providing for children, respectable levels of hard work and material possessions such as a home, economic independence and education, as well as the ideals of the church. Therefore, ‘respectability’ is concerned largely with morality and membership of the whole/external society, as well as a commitment to being a productive and active member of it.

By contrast, reputation is the honour or measure of a man’s worth that accrues to him as a result of his ‘masculine activities’. Reputation is oriented towards sexual matters and proficiency in all male activities and roles including sexual prowess, fathering many children, “gamesmanship” skills, including toughness and authority-defying behaviour, and being “smart”, as in skills for seducing women or outwitting others, and proficiency in undermining or circumventing the legal system (Wilson 1969). According to Wilson, reputation was shaped almost entirely by the perception of male peers; hence it is the image of one-self as a man which is confirmed by the opinion and reaction of others with whom one interacts. Wilson suggests that reputation reflects the congruence of the way a

man views himself and the way he is viewed by others (Wilson 1969 p.80). He noted that reputation relies upon the existence of peer groups of approximately equal life situations and life chances which provide the ingredients and platform of interaction.

Wilson observed that in Caribbean societies, men tend to participate most extensively in value systems based on reputation but with age and social maturity, measured by economic security and marriage, they move into a value system based upon respectability. This means that we may see men, particularly of a certain age group, as more centrally involved in reputational practices either as individuals or as collective actors. He also noted gender differences in the extent of participation in these ideals, associating women more with respectability and men with reputation. Wilson further argued that respectability attributes tend to contribute to the maintenance of social order and healthy family functioning, while reputational attributes potentially contribute to social disorder and unhealthy family functioning. Yet Wilson recognised the connection between the ideals of reputation and respectability, asserting that respectability can be contributed to by reputation, for example when a respectable occupation is carried out in style.

From Wilson's analysis above, there seems to be two ways in which 'reputation' and 'respectability' can be contrasted. One contrasts the unofficial, informal, anti-establishment or counter culture masculine values of 'reputation' with the formal, normative, establishment, and more gender neutral values of 'respectability.' A second contrast seems to be whether men's own self-identity always results in confirmation from those they interact with, and whether this is only possible within the reputation value system: 'reputation reflects the congruence of the way a man views himself and the way he is viewed by others'. This argument seems rather less plausible, since it is possible for there to be either congruence or contradiction in the way a man views himself and the way he is viewed by others, either within the value system of 'reputation' or 'respectability', as will be illustrated by the data from Mam-Kiror (see particularly Chapters 5 and 10).

In Wilson's argument, it is clear that the contrast between the valued attributes of respectability and reputation is maintained through economic capacity and social maturity. This means that respectability deals with elements of class, such as income, occupation and education as they relate to masculinity. Generally, it can also be conceived from Wilson's analysis that unlike reputation, respectability is concerned with elements or differences that

are products of the social structure rather than the presence or absence of individual attributes such as physical strength and other individual achievements.

Wilson's respectability/reputation theory has been used in a variety of social analyses by a number of scholars, mostly from the USA. Some have found it a powerful analytical paradigm and others contentious, while yet others have extended it. For example, interpreting the social life and challenges to transforming masculine risk taking among urban low income African Americans, Aronson, Whitehead et al. (2003) drew on the concepts of respectability and reputation as suggested by Wilson. They argued that the observed pattern of concurrent multiple sexual partnerships among their male participants could be attributed to reputational masculinity, and argued for programmes that addressed respectability attributes such as responsible fatherhood and economic provider roles. Tony Whitehead and colleagues in their work both in Jamaica and the USA (see Whitehead, Peterson et al. 1994; Whitehead 1997) not only agreed with Wilson about the constructs that were central for establishing respectability and reputation, but also extended the respectability/reputation notion by introducing the "Big Man/Little Man" and the "Strong Man/Weak Man" dichotomies, to describe the additional signs of the respectability-reputation value system used routinely by men to label fellow men. Little Men were men of lower economic status, but who were significantly concerned about becoming "Big Men". While financial capacity enabled Big Men easy access to respectability or being labelled "Big Men", the Little Men were left to pursue masculine strength through reputational attributes (Whitehead, Peterson et al. 1994). However, to date, Wilson's notions of respectability and reputation have not been specifically applied to analyse masculinity in SSA.

In my view, Wilson's designation of respectability attributes as 'western' and reputational attributes as 'indigenous' and largely destructive leads to the production/reproduction of a moralistic and stigmatising binary which links respectability predominantly with white hegemony while viewing reputation as an African ideal. There is evidence that values based on respectability and the "Big Man Status" were the basis of masculinity and respect in pre-colonial African societies (Morrell 1998; Barker and Ricardo 2005). Moreover, one might also observe that similar distinctions in value systems can be made *within* western societies, between conventional values of respectable, hard working men and anti-establishment/counter-culture values of marginalised working class men (Connell 1991; Wight 1993).

In spite of these limitations, Wilson's respectability-reputation model provides a relevant framework for interpreting men's HIV treatment seeking decisions, experiences and fears as related to their concerns about the need to preserve their reputation and earn respect in their families and society. When I return to this debate in Chapter 10, I will discuss the diverse and remarkable ways in which HIV infection and/or treatment threatened, altered or restored the resources and attributes necessary for achieving the normative masculine characteristics, resulting either in resuscitated or dented masculinity within the value systems of respectability and reputation.

## 2.5 [Contextualised] Dividuality and masculinity

Helle-Valle (2004) in his discussion of the construction of different sexual identities in Botswana provided theoretical insights drawn from the dividuality thesis. I draw on his work to facilitate a comprehensive understanding of the construction of multiple masculine identities to simultaneously conform to the values of respectability and reputation in Mam-Kiror society. Helle-Valle's concept of 'contextualised dividuality' is adapted from Marilyn Strathern's 1988 formulation of the dividuality theory, which asserted that far from being regarded as unique, indivisible entities (individuals), Melanesian persons conceived themselves to be as 'divisible' as they were 'indivisible' (Strathern 1988). According to the dividuality thesis, personal relations operate in a number of modes, but could predominantly be seen as *relations which separate*. The persons which exist within these conditions are not best described as individuals, but dividuals: they are separable into particular parts, relations, flows or elements. They are made up of a totality of multiple relationships, and so who they are, what they do is generated by their transactions with each other and with the material world (Fowler 2001).

In a persuasive analysis of the construction of multiple sexual identities in Africa with particular reference to Botswana, Helle-Valle (2004) emphasised the significance of contextualising personal [sexual] identity construction and the importance of dividual gender identity. The key theoretical principle he advanced was that contrary to the idea of *individuality* or *indivisibility*, which assumes that a person is un-divided and thinks and acts according to an essentially given identity, every subject is in very basic ways a different person (dividual) depending on the context and social relations they are part of (Helle-Valle 2004). Helle-Valle argued that the dividual concept of a person perceives him/her to comprise a complex of separable but essentially inter-dependent and interrelated

dimensions of social life. That is, every person belongs to multiple social contexts, in and out of which they move routinely. He argued that being dividual means acknowledging and relating the various communicative contexts in appropriate ways, and it involves an attempt to properly balance dividuality with being individual – confining one’s personality to their appropriate contexts.

Using this perspective, Helle-Valle was able to account for the co-existence of contradictory, and sometimes overlapping, sexual practices involving widespread extramarital sexual relationships, alongside sex in marital relationships and some people’s ability to participate in both. He argued that although these sexual relationships belonged to different social contexts, each of them was culturally recognised and had its rules and functions. For example, while sex in marital relationships was primarily (but not only) for procreation, extramarital sex was for pleasure and was characterised by discretion. Hence what could be considered meaningful sexual identity differed by social context. Helle-Valle argued that people involved in these relationships will, however, often experience ambivalence due to their sense of responsibility to handle various interests in ways that are culturally acceptable.

Recently, in an influential article, De Visser, Smith et al. (2009) developed the concept of ‘trading masculine capital’ to analyse whether men can use competence in key health-related masculine domain to compensate for other non-masculine behaviour. They suggested that displays of competence in hegemonically masculine fields provides some form of masculine ‘capital’, ‘credit’ or insurance which can be accrued and if necessary, traded to allow or compensate for non-masculine behaviour in other domains. A key feature of trading masculine attributes is that men compensate for lack of one masculine attribute by highlighting another masculine attribute in *the same* social context. This is crucial for realisation of positive health behaviour since given the possibility to trade masculinities; it may be possible, for example, for some men to accommodate non-masculine behaviours within an overall masculine identity in order to counter potential threats to their health. This assumption reflects some elements of dividuality as discussed by Helle-Valle. However, Helle-Valle’s use of the concept dividuality also differs from trading masculinity capital in that the main tenet of ‘dividuality’ is that people present themselves differently in *different* social contexts, and that a man’s or his main referent group’s perception of his masculinity changes gradually as the life cycle of a man changes. This is different than saying that a man’s sense of, and display of masculinity may be varied within the same context.

Drawing from these insights, in Chapter 10 I will discuss the significance of understanding diversity and contextualised dividuality in the construction of masculine identities and HIV related health behaviour amongst the men of Mam-Kiror, and try to account for the ability of men to enact different, and contradictory, forms of masculinity in different circumstances.

## **2.6 Gender and Health: An overview of difference**

The relationship between gender and health has been documented extensively in recent years. Although there is a particular European and American focus in the literature, generally, health surveys and epidemiological studies suggest that in almost all societies the patterns of seeking treatment for illness, as well as patterns of mortality and morbidity tend to differ for men and women (Hibbard and Pope 1983; van Wijk, van Vliet et al. 1996). Gender influences health status and health seeking behaviour in various ways. Whereas sex (biological factor) plays a bigger role in aetiology, onset and progression of disease, gender (social factor) influences exposure to risk and preventive behaviour, recognition of symptoms and severity of illness, how action is taken (help seeking behaviour), access to health services, and ability to adhere to prescribed treatment (Nathanson 1977; Cleary, Mechanic et al. 1982; Verbrugge 1985; Verbrugge 1989; Radley 1994). This chapter cannot review each of these influences but highlights the aspects central to my study.

### **2.6.1 Gender differences in life expectancy, mortality and morbidity**

Existing research on gender, health and illness is diverse and multiple methods and definitions have been applied to measure illness and health outcomes. Generally, research in both high and low income countries suggests that women as a group tend to have a longer life expectancy than men in the same socioeconomic circumstances as themselves, but in adulthood women suffer more illnesses and morbidity than men and are not necessarily healthier in their lifetime (Nathanson 1977; Hibbard and Pope 1983; Annandale and Hunt 1990; van Wijk and Kolk 1997; France 1998). However the extent of the gender gap in mortality and morbidity varies widely regionally, cross-culturally and historically, suggesting that social and contextual factors affect the health outcomes in many complex ways. For example, in most resource limited settings, the dangers of child

birth, a greater likelihood of reproductive health problems and poorer access to health services mean that women experience very high maternal mortality and morbidity (Vlassoff 1994; France 1998). In 2005 alone, for instance, there were about 530,000 maternal deaths world over and nearly half of these (270,000) occurred in SSA, with fourteen countries from this region having a maternal mortality of about 900 per 100,000 live births (Shah and Say 2007). In Uganda, the 2006 national demographic health survey recorded about 435 maternal deaths per 100,000 live births (Uganda Bureau of Statistics (UBOS) and ORC Macro International 2007).

In contrast, studies that have documented male health disadvantage have noted that not only do men have a shorter life span than women, but even in childhood, male children also tend to be more vulnerable to infant mortality than their female counterparts (France 1998). In Uganda, male adult mortality has been consistently higher than that of women for some years. For instance in the 2006 Uganda national demographic health survey, (and this was also true in the 2001 survey), the overall male mortality (9.3 deaths per 1,000 population) slightly higher than females' (8.2 deaths per 1,000 population) (Uganda Bureau of Statistics (UBOS) and ORC Macro International 2007). In terms of age-specific mortality rates, this survey showed that for age groups 15-24, female mortality slightly exceeded male mortality but the rates were nearly the same for women and men at ages 25-34, and above 35, male mortality exceeds female mortality by wider margins (Uganda Bureau of Statistics (UBOS) and ORC Macro International 2007).

The differences in health outcomes between men and women have, over the years, been of great interest to researchers, who have offered various possible explanations. The most consistent observation has been that although biological factors may determine sex differences in health outcomes, social factors are widely accountable for a significant part of these differences (Annandale and Hunt 2000). Many studies have argued that the gender difference may be associated with the differential risks acquired as a result of social roles, life styles and health behaviours that men and women engage in (Verbrugge 1985; Annandale and Hunt 1990). It is, for example, often observed that, because of gender division of labour, men tend to have a higher exposure to occupational risks and as a result experience higher morbidity and deaths from occupational hazards than women (Verbrugge 1989; Cameron and Bernardes 1998; France 1998). Furthermore, it has been noted that subscription to male gender ideologies such as those that cast men as courageous and adventurous encourages men to engage in risky practices, habits and behaviour such as

violence, smoking, over drinking and multiple sexual relationships, which endanger their health (Radley 1994; Courtenay and Keeling 2000; Greig, Kimmel et al. 2000).

Other studies suggest that the differences between men's and women's morbidity and mortality should be seen in terms of patterns of psychological factors, symptom reporting and health seeking. Such studies argue that women tend to more readily define bodily changes as illness symptoms and are more likely to report illness and consult more because, socially, the sick role makes it more acceptable for women to report illness (Annandale and Hunt 1990). These issues are the focus of the following section.

## **2.6.2 Gender differences in patterns of health seeking**

A large body of literature on gender and health care utilisation from diverse geographical and cultural contexts generally holds that there are gender differences in the way illness symptoms are perceived, evaluated and acted upon (Hibbard and Pope 1986). Most studies conducted in both Western and non-Western contexts have reported greater recognition and reporting of symptoms and health seeking amongst women than men for diverse health problems (e.g., Cameron and Bernardes 1998; Kroenke and Spitzer 1998; Courtenay and Keeling 2000; Yount, Agree et al. 2004). It is widely asserted that, compared to men, women tend to be more vigilant to notice symptoms, more likely to readily admit symptoms as a marker of illness or more likely to actively respond to them (Hibbard and Pope 1983; van Wijk and Kolk 1997; van Wijk and Kolk 1997; Fernandez, Schiaffino et al. 1999). For instance in Uganda, two recent research articles that compared beliefs about health and illness among men and women with diabetes mellitus, and their treatment seeking behaviour found some gender differences. Whereas women were more concerned about well-being, support in daily life and household activities, men tended to focus on the impact of their illness on sexual function and lifestyle. Men also reported fewer problems associated with the disease, while women reported more chronic pain in joints and were more concerned about follow-up treatment (Hjelm and Nambozi 2008; Hjelm and Atwine 2011). The gender variations in recognition of symptoms and in patterns of health care use are broadly attributed to the social and psychological constructions of masculinity and femininity (Addis and Mahalik 2003).

On the one hand, women's apparent eagerness to report symptoms and seek care is often attributed to social norms acquired through socialisation, that supposedly permit women to pay more attention to symptoms and define problems in medical terms, appear less stoic in

comparison to men, as well as to the gender roles that make it relatively convenient for women to seek services compared to men (Nathanson 1977; Cleary, Mechanic et al. 1982; Hibbard and Pope 1983). It is argued that women's greater responsibility for family health may increase the salience to them of health matters and influence their perception of symptom and response to illness (Scambler 1997; Courtenay and Keeling 2000; Yount, Agree et al. 2004). It is also suggested that due to the gender division of roles, women have more time and greater flexibility in scheduling medical appointments, and suffer less costs associated with medical care use than do men, who frequently lose time from paid work if they are to seek medical attention (Cleary, Mechanic et al. 1982). However, a few studies argue that women with a large number of obligations, especially those with young children to look after, are less likely to adopt a sick role compared to men due to the disruption that this would cause to the family (Radley 1994). Psychologically, although the literature is Eurocentric, it has been established that women tend to feel less social stigma associated with treatment seeking due to socialisation, and this may explain their greater use of health services (Emslie, Ridge et al. 2007).

On the other hand, the dominant masculine norms and values that dictate that men should adhere to characteristics such as superiority, independence, self-reliance, stoicism and suppression of emotion, may act as a barrier for men to appropriately access and use health services, as help-seeking is seen to contradict these values (Cameron and Bernardes 1998; Courtenay 2000; Courtenay and Keeling 2000; Addis and Mahalik 2003; Greig 2007). For instance, in a systematic review of sociocultural and clinical literature about the barriers to help-seeking in Western Europe, with particular reference to depression, Moller-Leimkuhler (2001) found that consultation rates and help-seeking patterns in men were consistently lower than in women. She concluded that low treatment rates for men could not be explained by better health, but by a discrepancy between perception of need and treatment seeking behaviour, arguing that the social norms of traditional masculinity make treatment seeking more difficult for men because of the inhibition against emotional expression. Therefore, this suggests that men are influenced more by social and cultural stereotypes to ignore symptoms and delay help-seeking than women.

However, the thesis of greater female than male use of health care for all kinds of common illnesses and in all circumstances has been challenged. Sometimes, the methodology and definition of measures used by these studies has been questioned (e.g., Macintyre, Ford et al. 1999; Hunt, Adamson et al. 2011). Increasingly, evidence from different geographical regions suggests that when age, social class, other social factors and illness type and

severity are carefully considered, the picture is more complex (Hunt, Adamson et al. 2011). Specifically, some studies have showed that for some illness conditions, women consult less, and that for other illnesses, there are either no gender differences in reporting of symptoms or that men tend to overrate their morbidity (Verbrugge 1989; Macintyre 1993; Macintyre, Hunt et al. 1996; Wyke, Hunt et al. 1998; Macintyre, Ford et al. 1999; Annandale and Hunt 2000; Hunt, Adamson et al. 2011). Moreover, another group of scholars have suggested that, in fact, there are more similarities than differences in men's and women's health seeking behaviour (Emslie, Ridge et al. 2007; Galdas, Johnson et al. 2010). This argument seems plausible as results from meta-analyses of psychological differences between men and women have proposed a gender similarities hypothesis, which, in stark contrast to the differences model, holds that men and women, and boys and girls, are vastly alike on most, but not all psychological variables (Hyde 2005). A study by Macintyre, Ford et al. (1999) on "whether women in Scotland, UK, over report morbidity" compared men's and women's responses to a standard question on long standing illnesses and found no conclusive evidence to support the hypothesis of female excess reporting of symptoms. These authors found that contrary to the widely held assumption that women would report higher rates of morbidity and readily report mental health problems, there was no significant gender difference in the initial reporting of symptoms; women were not more likely to report trivial conditions while men appeared slightly more likely to report a higher proportion of illness conditions.

These conclusions are supported by findings from other settings and historical periods. Verbrugge (1985) in a study of gender and health in the USA reported that although for minor symptoms men tend to delay help seeking, generally health care visits tended to be similar for both men and women for symptoms deemed to be severe. In another study that explored 'empirical explanations of sex differences in health and mortality' in the USA, Verbrugge (1989) reported that when risks and morbidity levels are controlled for, for both genders, women's excesses for therapeutic care for a range of illnesses diminished considerably; in fact, reversing to reveal excesses in male medical care use. She concluded that women's supposedly poorer health profile and excess medical care use largely stemmed from their roles and stress –an acquired risk – rather than from their attitudes.

In Uganda, published studies on gender patterns of health seeking for common illnesses are very limited but one quantitative study of the determinants of treatment seeking behaviour based on data from the 1999 national household survey involving 10, 696 participants (Lawson 2004) provides some insights on seeking help. This study reported that

approximately 70% of all people who had a recent illness sought health care for their symptoms but found no gender differences in rates of seeking treatment, 68.7% males versus 68.6% women. However, when income and education were considered, gender differences were observed with women's treatment seeking disproportionately greater as their incomes increased, while the positive impact of education was also particularly high for women's health seeking and for their children (Lawson 2004). Additionally, this study reported that women's treatment seeking increased at the peak of child bearing as well as in the age range when HIV incidence was highest (25-40) while men's treatment seeking tended to increase in middle and old age.

Although much of the research that has investigated the gender pattern of health seeking behavior has focused on explaining variations between the male and female genders, in recent years there has been an increase in studies concentrating on intra-gender analyses. In particular, there has been significant interest to explore variations in masculinities and how these affect help seeking amongst men. Two broad assertions have been made regarding this existing pattern. First, some men may feel free to embrace new ways of articulating their masculinity which brings health benefits, while others feel pressured to stick to attitudes, behaviour and practices of masculinity that may be harmful to their health (O'Brien, Hunt et al. 2005). Second, men may sometimes seek help for the same problem under some conditions and not others (Addis and Mahalik 2003). In particular, conditions that seriously threaten the resources used by men to express their masculinity may prompt them to seek help (O'Brien, Hart et al. 2007).

Overall, a number of accounts suggest that treatment seeking for particular illnesses may be undertaken by men as a means to (re)construct masculinity (Courtenay 2000; Robertson and Williams 2007). Research in Australia conducted among men with prostate cancer indicated that participants reformulated many ideals of hegemonic masculinity in response to functional body changes, and norms of hegemonic masculinity strongly influenced participants' philosophical resolve to 'fight' prostate cancer (Oliffe 2006). A number of studies also suggest that men tend to draw on sexuality and their family provider role as important aspects of identity to legitimate help-seeking. In a study of men's experiences of consultation in relation to their constructions of masculinity in Scotland, O'Brien, Hunt et al. (2005) found that men were more likely to take action on their health if they perceived that their symptoms were likely to interfere with their social roles such as the bread winner role or other valued masculinities such as if they might hinder their sexual performance. Similar impressions can be derived from the findings of a number of studies in SSA in

which men's health seeking for infertility and sexual health diseases is consistently reported to be higher (Dyer, Abrahams et al. 2004), better (Voeten, O'Hara et al. 2004), or similar to women's (Moreira, Brock et al. 2005).

In summary, the literature generally holds that societal definitions of roles and status for men and women are important in decisions to seek help for illness. While the desire to live up to masculine ideals and avoid being seen to be unmanly greatly undermines men's health seeking behaviour, there are circumstances and illnesses for which men may defy the social constructs that cast men as stoic and less concerned about health, to seek help for problems that threaten certain important aspects of their masculine identity.

## **2.7 Men's HIV testing and treatment seeking in Uganda and sub-Saharan Africa**

### **2.7.1 HIV Testing**

To access and/or accept treatment and care, people must test or be willing to know their HIV status diagnosis. In the last two decades, HIV counselling and testing (HCT) in Uganda has been provided through both public and private channels, and currently, every district in the country has HCT facilities, although location of the service varies between districts, and there is an urban bias. Many innovative approaches have been devised and promoted to increase uptake of HIV testing by different groups. These include individual and routine voluntary counselling and testing (VCT), couple testing, testing as a family, especially for those where a member is receiving HIV treatment, and home-based and community outreach testing. Others are testing for prevention of mother to child transmission of HIV (PMTCT), and provider initiated testing and counselling (PITC), in which a health provider, as part of standard medical practice, recommends testing to any patient attending other medical services with an 'opt out' option (Ministry of Health [Uganda] 2006; Ministry of Health [Uganda] 2003).

#### **2.7.1.1 Evidence for greater testing amongst women than men**

Despite the increased channels for accessing testing and counselling, HIV testing remains very low in most SSA countries, including Uganda (Glick 2005). By 2007 only about one

in every ten people were reported ever tested in this region (WHO/UNAIDS/UNICEF 2007), although there were wide variations between countries. In Uganda, only about 15% of the population of around 30 million were aware of their HIV sero-status by 2005 (Ministry of Health [Uganda] and ORC Macro International 2006).

There are gender differences in testing in Uganda, with women tending to test more than men. For example, during the 2004-05 Uganda national sero-behaviour survey involving 8,830 men and 10,826 women, aged 15-49, 11% of the men and 13% of the women who took part in the survey accepted to be tested for HIV (Ministry of Health [Uganda] and ORC Macro International 2006). The same survey reported that, overall, 15% of all women in Uganda and 12% of all men aged 15-49 have ever been tested for HIV. This not only indicated that the vast majority of Ugandans have never been tested for HIV, and therefore may not know their status, but it also highlighted the gender gap in testing. These national data contrast with some earlier small scale studies in Uganda, such as that of Nyblade, Menken et al. (2001), which reported that women were significantly less likely to receive voluntary counselling and testing (VCT) compared to men. They also differ from the observations that were made in a study that also offered counselling and testing in Rakai district, one of the first badly affected areas in Uganda, whereby in a sample of 10,618, with roughly equal men and women, no differences were found between females and males in accepting to receive the results of their HIV test (Matovu, Gray et al. 2005).

However, the gender variation in national testing rates in Uganda are consistent with trends observed in other east African countries, such as Kenya and Tanzania, where women have also been shown to be more likely to test than men (Msuya, Mbizvo et al. 2008; Njeru, Blystad et al. 2011). The gender gap in testing is also evident in a number of Southern African countries (e.g., Mwakiza, Nyirenda et al. 2009; Peltzer, Matseke et al. 2009; Mitchell, Cockcroft et al. 2010), as well as in West Africa (e.g, Obermeyer, Sankara et al. 2009), with males less likely to test compared to females.

### **2.7.1.2 Possible explanations for men's lower rates of testing than women**

A substantial body of research from SSA has identified a range of barriers to HIV testing, although often, without a gender dimension. The barriers commonly identified include lack of confidentiality of the test, stigmatizing beliefs and fear of discrimination in case of a

positive test, transport difficulties and low perceived risk of HIV infection (Hutchinson and Mahlalela 2006; Weiser, Heisler et al. 2006; Matovu and Makumbi 2007; Hult, Maurer et al. 2009; Mugisha, van Rensburg et al. 2010; Ostermann, Reddy et al. 2011). There are, however, some exceptions to these, notably, for example, Obermeyer and Osborn (2007); Bila and Egrot (2009) and Mwakiza, Nyirenda et al. (2009) who performed a gender analysis of differences in testing, and Bwambale et al. (2008) and Gage & Ali, (2005) who specifically focused on men's testing in Uganda. These studies suggest the following gender related explanations for men's lower rates of testing compared to women.

#### 2.7.1.2.1 Low perceived risk of HIV infection

Most studies have consistently reported that people are more likely to get tested if they have risky sexual behaviour (Peltzer, Matseke et al. 2009; Ostermann, Reddy et al. 2011), although there are a few exceptions that have found no association between risky sexual behaviour and uptake of HIV testing (e.g., Mitchell, Cockcroft et al. 2010). While it is often assumed that men tend to have more and riskier sexual relationships compared to women, a recent systematic review of the utilisation of counselling and testing in high prevalence settings has reported that generally men tend to underestimate their risk of HIV infection compared to women (Obermeyer and Osborn 2007). In Uganda, when men test due to the perceived risky sexual behaviour, the testers are most likely to be those with a history of paying for sex than other categories of men (Gage and Ali 2005). This negative attitude towards testing among men, despite being more likely to have risky sexual relations could be attributed to the traditional masculine ideal which endorses a sense of invulnerability among men.

#### 2.7.1.2.2 Fear of an HIV positive test and worries about disclosure

The other possible reason why men's testing is low is the fear of a positive test and stigmatising attitude and blame for bringing HIV into the family (Obermeyer, Sankara et al. 2009). During the Uganda HIV sero-behaviour survey 2006, not wanting to know the test result was a common reason cited by the participants for their unwillingness to test, with men significantly more likely than women to cite this reason (Ministry of Health [Uganda] and ORC Macro International 2006). This fear is confirmed by a study by Bwambale, Ssali et al. (2008) on 'voluntary counselling and testing among men in rural western Uganda' which found that men were extremely worried about being stigmatised and expressed concerns about confidentiality of their results. In that study, men who had

no intention of disclosing their HIV status if they were positive were more reluctant to test than those who expressed willingness to disclose. It is known that communication with sexual partners is strongly associated with HIV testing. In Uganda, men who have discussed HIV prevention with their spouse are more likely to have been tested for HIV and more willing to be tested if previously untested (Gage and Ali 2005). Bwambale, Ssali et al.'s study reported that men in western Uganda specifically expressed fear that their partners may deny them sexual rights in case they tested HIV positive (Bwambale, Ssali et al. 2008), although elsewhere, other studies have reported that fears of stigma and abandonment following a positive test result tend to be quite manifest among women (Obermeyer, Sankara et al. 2009). While the evidence from these studies conflicts and does not necessarily suggest that men worried more than women, it highlights the need to pay attention to how the fear of the test may deter men from using the service.

#### 2.7.1.2.3 Higher prevalence of testing programmes targeting women than men

The higher prevalence of female testing than for men in recent national surveys in many countries of SSA is evidence that a scale-up of women's testing programmes has taken place, reducing access barriers for them (Mwakiza, Nyirenda et al. 2009; Mitchell, Cockcroft et al. 2010). Given that these programmes have generally not done much to accommodate men's testing needs, the testing rates among men remain relatively lower (Peacock, Stemple et al. 2009).

## **2.7.2 Men and access to HIV treatment in Uganda and sub-Saharan Africa: The fears and the paradox**

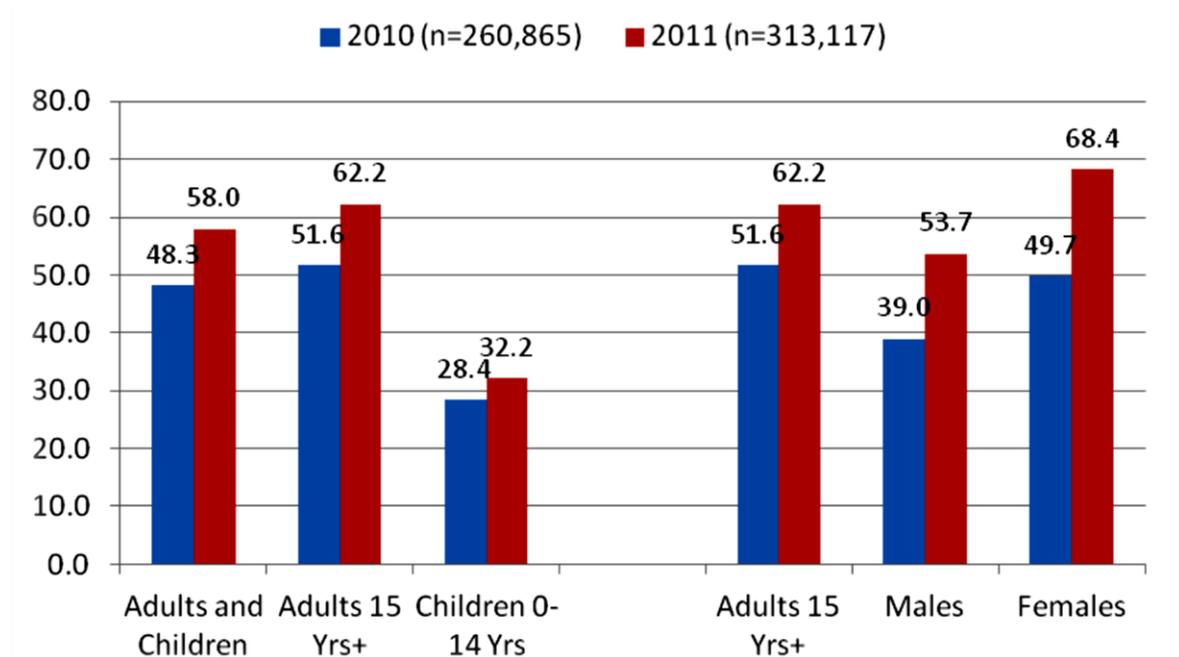
When HIV/AIDS treatment first became available to low income countries, there were policy concerns that it would be accessed primarily by men (WHO and UNAIDS 2004; WHO/UNAIDSa 2004; Silvester, Raven et al. 2005; Carael, Marais et al. 2009), since they tend to have greater control of economic resources and more confidence to make use of development services. This was a legitimate concern, and was confirmed by early evidence from the first fee-for-service antiretroviral programmes in Africa, such as those in Zambia and Uganda, where the majority of the patients were men (UNAIDS/UNFPA/UNIFEM 2004). In Africa, the argument for women's greater inclusion on treatment was framed around the 'woman vulnerability hypothesis' that recognises that gender inequity both in the domestic and societal spheres is a major structural driver of HIV risk, as well as

causing greater negative impacts of AIDS among women than men in SSA (Greig, Peacock et al. 2008; Jewkes and Morrell 2010).

Recently, however, an extensive body of research on gender and access to HIV/AIDS treatment in many SSA countries (e.g., Muula, Ngulube et al. 2007; Nattrass 2008), and Uganda in particular (e.g., Amuron, Coutinho et al. 2007; Braitstein, Boulle et al. 2008; Birungi and Mills 2010; Lubega, Nsabagasani et al. 2010; Nakigozi, Makumbi et al. 2011), has produced evidence of a consistently lower and delayed recruitment and retention of men in treatment programmes compared to women, as well as poorer health outcomes and higher mortality among men while on treatment compared to women (Braitstein, Brinkhof et al. 2006; Mermin, Were et al. 2008; Kipp, Alibhai et al. 2010).

In Uganda by 2010, the estimated need for ART among both adults and children was 540,094, based on the new eligibility criterion of DC4 350, but in the same year, only about 260,865 people accessed treatment. However, by 2011, access had increased to 290,971, bringing the total coverage of ART to 62% of all adults in need of it. Although there has been an increase in numbers on ART for both sexes over the years, men (53.7% of those in need) tend to use it less than women (68.4%), as seen in the figure below.

**Figure 2: Eligible adults and children receiving ART**



Source: Uganda AIDS Commission 2012

The trend towards gender discrepancy in HIV/AIDS treatment uptake in Uganda has also been reported by some grass root agencies that serve Busia district, where this research was conducted. For example the 2005 Annual Report for TASO Uganda, an agency which has eleven centres across the country, and is one of the leading providers of treatment in Busia and Tororo districts, noted that a year after introducing its ART programme, men constituted a small fraction of users of both antiretroviral drugs and Septrin drugs. It was reported that of the total enrolment of 5,788 patients at the time, there were 4,286 females and 1,502 males receiving antiretroviral drugs (TASO 2006), a ratio of three women to one man. A similar trend was observed in the enrolment for Septrin medicines, with only 13,202 males receiving Septrin out of a total of 48,034 clients receiving it in the eleven TASO Centres across the country.

Although a higher proportion of women than men are infected with HIV in resource limited settings, and women still face significant challenges in accessing HIV treatment men are also severely affected by the HIV epidemic, but in different ways from women. For men, once infected, they tend to be significantly more disadvantaged in terms of access to the life-extending treatment. In contrast to earlier fears that men might dominate treatment, their current lower access to it might better be referred to as “the male ART access paradox”. It prompts the question: why is it that despite their supposedly more powerful position than women, greater access to resources and information, men are accessing and using HIV treatment less than expected?

### **2.7.2.1 Possible reasons for men’s lower enrolment on HIV/AIDS treatment**

There is considerable knowledge about the barriers to take-up of, and adherence to HIV treatment in the general population in SSA (e.g., Dahab, Hamilton et al. 2006; Assefa, Damme et al. 2010; Fox, Mazimba et al. 2010; Dahab, Kielmann et al. 2011), and in Uganda in particular (e.g., Byakika-Tusiime, Oyugi et al. 2005; Crane, Kawuma et al. 2006; Wanyama, Castelnuovo et al. 2007; Jaffar, Munderi et al. 2008; Namuwenge, Kirungi et al. 2008; Ware, Idoko et al. 2009; Weiser, Tuller et al. 2010). In a recent systematic review of nineteen studies on ‘barriers to access to ART in developing countries’ that included Uganda, Posse, Meheus et al. (2008) grouped the barriers into health system-level and population-level barriers. They found that the most frequently reported barriers at the population-level were lack of information about ART, perceived high costs for ART and stigma, while long distance from home to the health facility, lack of co-ordination across services and limited involvement of the community in treatment

programme planning processes were most frequently cited at the health system-level. Although these barriers are infrequently disaggregated by gender, it is apparent that men and women face different sets of challenges and barriers in their efforts to access HIV treatment, resulting in wide gender discrepancies in pattern of access to treatment. It is also important to recognise the link between lower rates of testing and lower use of treatment. Getting tested is a pre-requisite for treatment, so all the barriers to men's testing are also barriers to treatment. The following factors may most probably explain such differences.

#### 2.7.2.1 Differences in rates of infection

In order to interpret the gender discrepancy in enrolment on treatment, it is vital to acknowledge the role of gender differences in HIV prevalence. As already described, more women in Uganda (8.3%) are infected with HIV compared to men (6.3%). With more women than men infected with HIV in Uganda, as in many other SSA countries, in absolute terms, a higher number of women than men would be expected to be on treatment, were there to be equity in the delivery of this service. However, in many SSA settings the rate of women's access exceeds the number of females in need of treatment, so their dominance in treatment programmes cannot be explained solely by the higher HIV prevalence among females compared to males (Muula, Ngulube et al. 2007).

#### 2.7.2.2 Differences in entry points to testing and treatment

Men's lower enrolment and women's better representation on treatment might reflect the fact that men and women have different entry points for testing and treatment (WHO/UNAIDS 2006), with men tending to have fewer targeted programmes than women (Peacock, Stemple et al. 2009). Due to high levels of advocacy for women's right to health, there has been an expansion of women's HIV and reproductive health programmes across SSA (Mills, Beyrer et al. 2012). This has given women a greater connection to special programmes through which they may access more information about the availability of testing and ART, for example programmes offering prevention of mother to child transmission of HIV services (PMTCT), but which generally do little to address men's needs (Tersbøl 2006; Peacock, Redpath et al. 2008; Peacock, Stemple et al. 2009).

The other dimension of this problem is that men tend to perceive sexual and reproductive health clinics as female spaces, hindering their HIV testing and treatment seeking efforts.

In a study by Larsson, Thorson et al. (2010) on why men do not test with their partners in antenatal care in eastern Uganda, and another in Zimbabwe by Skovdal, Campbell et al. (2011) on masculinity and men's access to HIV services, men described the clinics as female spaces, because they were dominated by women and children, discouraging them from accessing HIV related services. Similarly, among Africans living in the UK and other western European countries men were found to be less visible in clinics due to the belief that HIV services were primarily focused on women and children (Prost 2006). Research has also shown that in many SSA settings, reproductive health clinics in general tend to be less friendly to males in the sense that there are often more female providers holding positions as nurses and counsellors, whom men find it embarrassing to engage with (Toure 1996). Therefore, women's child bearing roles, and the tendency of HIV-related health promotion to take place in female-dominated contexts and exclude men, mean that women are likely to be more familiar with, and prepared for HIV treatment than men. This might leave men to seek treatment through mechanisms outside the public services, such as through pharmacies (Collumbien and Hawkes 2000).

#### 2.7.2.3 Differences in perceptions of care roles and responsibilities

The gender differences in enrolment on HIV/AIDS treatment might also be due to the differences in family care roles and responsibilities between women and men, with women's responsibilities for dependents likely to give them greater motivation to maintain their health. In a study by Bila and Egrot (2009) that explored gender asymmetry in HIV services in Burkina Faso, women described feeling obliged to be in good health so as to be able to care for their children as the main reason for their greater presence in HIV care facilities. Access to HIV care and medicine was seen by women in that study as necessary to cope with vital domestic and economic activities that support children's wellbeing and education. Research further reports that because women often have a major responsibility for children's care and for the care of adults in hospitals during illness, they tend to have more access to the health care system where HIV testing and treatment is likely to be recommended and offered to them (Muula, Ngulube et al. 2007; Le Cœur, Collins et al. 2009). In contrast, men tend to view hospital appointments and the long hours spent waiting to see a physician as compromising their ability to work and fulfil their head of house and provider duties, discouraging them from seeking HIV treatment (Remien, Chowdhury et al. 2009; Skovdal, Campbell et al. 2011).

#### 2.7.2.4 Reluctance to acknowledge that they are HIV positive

Men's under use of HIV treatment could also be due to their tendency to be more reluctant to publicly acknowledge that they are HIV positive. Compared to women, men tend to feel especially stigmatised because they are to blame for HIV infection (Prost 2006; Bwambale, Ssali et al. 2008). Furthermore, men often find the procedures involved in obtaining HIV treatment, such as queuing alongside women and following instructions, undermining their status and sense of control (Skovdal, Campbell et al. 2011). Conventional gender norms and notions of masculinity prevalent in many parts of SSA equate being manly with being strong and independent, and portray discussing health problems and seeking help as a weakness (Braitstein, Boulle et al. 2008; Natrass 2008). Participants in a study on 'gender asymmetry in HIV care in Burkina Faso' explained that unlike men who prioritise their masculine dignity and fail to seek help in care programmes, for women, the issue of shame, particularly in connection with accepting material assistance from outside the family, does not arise or appears to be secondary compared to the issue of economic and social survival for her and her children (Bila and Egrot 2009). This may explain why men refrain from expressing their emotional and practical needs for HIV services, and if they did, would rather conceal their access of HIV treatment.

## 2.8 Key research issues explored in this thesis

My theoretical stance to studying masculinity and treatment seeking for HIV combines the three concepts of 'dividuality', 'masculinity' and 'respectability/reputation' discussed above. Given the limited research that analyses the role of masculinity in influencing HIV treatment in SSA and Uganda in particular, this thesis explores several key issues in the context of the main research questions, outlined in Chapter 1, as follows.

*Research question 1:* What is the cultural perception and construction of masculinity among the Iteso men of Busia district? Under this, I explore the prevailing masculinities among the Iteso and how they are constructed and experienced. I pay attention to how men of different age groups and social circumstances present themselves and are perceived by others. The study also examines what the significant and predominant life experiences of the men infected with HIV were, particularly in relation to fatherhood, 'husband hood', family responsibility, widowhood, as they relate to how these men understood the meaning of masculinity.

*Research question 2:* How do men's notions of masculinity influence their perception of, and response to HIV/AIDS? This involves exploring men's decisions regarding whether or not to seek testing and treatment. What value do men attach to AIDS treatment? In particular it involved assessing men's understanding of the kind of treatment acceptable for their symptoms and the circumstances that prompted treatment seeking. The study attempts to understand how men drew on aspects of masculinity to interpret and decide whether or not they need to seek/accept treatment for HIV.

*Research question 3:* How do HIV/AIDS diagnosis and treatment affect masculinity? This seeks data on what it means to be HIV positive as a man, what it means for an HIV positive man to be on life-long treatment, and exploring whether HIV/AIDS treatment helped men to develop new resources for expressing their masculine identity, or did it reinforce notions of masculinity among the Iteso based on the prevailing social norms and stereotypes? How did they cope with and adjust to the disruption of their everyday and normal routines and other important sources of identity for a proper man, such as work, marriage, family responsibility, leisure activities?

To answer these questions, a qualitative research approach was adopted to deepen understanding of the social contexts which shape men's decision about health seeking for HIV. The application of this method is discussed in Chapter 3.

## **Chapter 3: Methodology**

### **3.1 Introduction**

This study is premised on the theory that there are multiple meanings and experiences of masculinity. A qualitative approach seemed particularly relevant to this philosophical position, since it privileges the exploration of multiple subjectivities. This chapter discusses the choice of the qualitative approach and methods that I applied during the fieldwork, the study sample and the application of ethics during the study. It also describes my pathway to Mam-Kiror village, in particular the process of negotiating access, and the nature of the social relations that evolved and became valuable aspects of fieldwork. The last parts of the chapter discuss the data management and analysis.

### **3.2 The qualitative methodology: Theoretical underpinnings and justification**

Qualitative research is an approach that usually emphasises detailed description of findings in words rather than quantification in the collection and analysis of data (Bryman 2004). It refers to ‘a family’ of research approaches namely phenomenology, ethnography and ethnomethodology which share the overarching goal to gain a deeper understanding and to explain the meaning people attach to their social experiences (Silverman 2006). For some scholars, qualitative research is everything that is not quantitative and as such, they tend to see it as an alternative to the positivist epistemology whose core assumption is that there exists quantifiable and measurable reality (Sarantakos 1998). However, there is a growing and well-founded line of argument that the distinction and tension created between the qualitative and quantitative approaches is sometimes over stretched and there is a need to recognise the value of each and their potential to support each other. Some scholars thus acknowledge that a mix of methods may at times be necessary in order to maximise the advantages of each (Bryman 2004).

The choice of a particular research approach is often informed by a theoretical perspective or paradigm that reflects the researcher’s philosophy or belief about the nature or essence of the social world (ontology) and about the nature of knowledge and how it is to be attained and described (epistemology) (Sarantakos 1998). Often seen as a direct contrast to

the positivist view that assumes an external reality created by nature, which can be counted, interpretivism involves the belief that reality is in people's minds, is internally experienced and is socially constructed through interaction and through people assigning subjective meaning to those experiences (Ritchie and Lewis 2003). The core assertion of the interpretive paradigm is that knowledge should be regarded as a social construct built up from the perceptions and experiences of people as social actors, rather than be seen as a fixed and objective entity separate from the actors.

In this context, the interpretive paradigm, which tends to employ the qualitative methodology, can be regarded as constructionist. Constructionism not only views knowledge as an outcome of interactions between individuals but also holds that social phenomena and meanings are multiple (Cresswell 2009) and are continually being accomplished or revised by social actors (Bryman 2004). The objective of an interpretive approach to research is to allow researchers to "describe the lived experiences of the individuals from their own viewpoints and to understand how people interpret their experiences" (Kolof, Dan et al. 2008, p.80). This most often involves a naturalistic and inductive style of research in order to arrive at theoretical insights and explanations grounded in the data which have been inductively derived rather than imposed as a result of prior assumptions about what the data and related theory might look like (Denzin and Lincoln 1994; Kolof, Dan et al. 2008). My goal to explore the relationship between masculinity and HIV testing and treatment using the qualitative approach is therefore positioned within the interpretive paradigm because it allowed in-depth exploration and greater flexibility in application of the research questions to particular experiences, which allowed for themes to emerge from the data rather than be pre-determined.

My approach was characterised by features common to other qualitative studies. These included: viewing social life in terms of process rather than in static terms, acknowledging that there are multiple perspectives, studying in-depth a small number of respondents, applying open ended interview methods that produced descriptive accounts and presenting information gathered in rich detail (Ritchie and Lewis 2003), which privileged the emic perspective, that is the participant's framing of meaning and experiences (Silverman 2006). A particular strength of the qualitative interviewing was my flexibility in tailoring the interview questions to the biography and experience of masculinity of a particular participant, rather than follow standard question format that might have been of little relevance to other respondents (Bryman 2004). The limitation most often levelled at

qualitative research is that it is unrepresentative. However, this criticism reflects a positivistic prejudiced assessment of the nature of qualitative research (Sarantakos 1998). Many qualitative researchers argue that qualitative research should be judged on the depth of its descriptions of the data and the flexibility with which the researcher demonstrates awareness of the influence of their own values and position during the entire study.

### **3.3 Pathways to Mam-Kiror village**

#### **3.3.1 Choice of the District and village of study**

Busia District was chosen for this research for four reasons. First, it is one of the districts with the highest HIV prevalence rates in Uganda. Second, as an Iteso, I wanted an Ateso speaking community, since local language and cultural competence are extremely valuable during data collection, especially in ethnographic studies (Sarantakos 1998). Third, I was aware through my previous research experience in the district that little ethnography had been conducted among the Southern Iteso living in Busia district, particularly that of masculine identity and care seeking. Fourth, because of previous research engagements in Busia district<sup>3</sup>, I was familiar with the area and had professional contacts within the health department, which were valuable during the process of negotiating access to the District.

The selection of Mam-Kiror as the study village was negotiated with the district health officials based on the following considerations. A fairly homogeneous rural settlement would make it easier to study particular cultural aspects about how masculinity may affect men's uptake of HIV/AIDS treatment rather than a heterogeneous, cosmopolitan urban area. Anecdotal data from the district also indicated that Mam-Kiror parish is one of the parishes with the highest HIV prevalence in Busia district. A preliminary visit to Mam-Kiror village, which aimed to further my knowledge of the area and negotiate access with local leaders, provided a good early impression of the potentially rich scope for exploring men's lives in this area. The key occupation of the men in the area at the time of research was artisanal gold mining. The number of health risks associated with this occupation, alongside the economic opportunities, cash payments and trading opportunities, not only worried the district health authorities involved in HIV prevention and care, but also seemed

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<sup>3</sup> During my research career of 5 years prior to starting the PhD, I had been involved in a number of health system research studies in Busia and Tororo Districts under the TORCH Project, which was collaboration between Makerere University Child Health and Development Centre and University of Copenhagen Denmark. In one of those studies I collaborated the Busia District Health Officer as a Co-PI

relevant to the study objective to understand men's way of life and perceptions of masculinity, risk and treatment seeking for HIV/AIDS. So, Mam-Kiror provided many features to help observe and explore the male way of life as it relates to their ideas of masculinity and health.

### **3.3.2 Negotiating access to the village**

The process of gaining access to the district and the village began in early 2009, which was the planning stage of the PhD study. To begin with, I made early informal phone contacts with some district officials, which was made easier by my prior professional relations with some officers in the health department. Between July and September 2009, I made two preliminary visits to the district and one to the study village, and held briefing meetings with the relevant officers and gatekeepers. The last of the three visits involved exploring options for accommodation and presenting to the district administration and security office the study clearance documents from both the President's Office and the Uganda National Council for Science and Technology; the national research regulating body.

On the basis of the documents secured, the district administrative office granted permission for the study to begin and provided reference letters to be delivered to the sub-country administration for endorsement and to the village leadership for information purposes. Although the process of gaining access was lengthy and at times undermined my eagerness to immerse myself in the village, it was essential to follow these steps and not to bypass any authority. This was particularly important in Mam-Kiror village because it had had numerous negative experiences and relationships with outsiders and government officials arising from struggles to control mining land. I learnt that negotiating access is not always linear, as one may, in fact, obtain tentative agreement from the lower officers before the top leaders. Ultimately however, the lower hierarchy will always expect a formal clearance from the authorities above them, which must be produced to enhance the concerned parties. Also, the early discussions with administrative and technical officers at different levels can provide ethnographic data towards understanding the social dynamics of the study area.

One of my main concerns was to explain to the whole village the purpose of my research, and that I had the support of the village political leadership. To do so, my planned strategy

was to hold a village meeting in the early days of my arrival in the village. However, fearing to raise expectation among residents for their needs to be met, in the manner development workers often did, the village chairman advised that a meeting for the entire village was not appropriate. Instead, on a number of occasions he led me from home to home introducing me to the residents. This process was quite useful but slow, and given that the village chairman had others duties to attend to, it was impossible to reach every household. Other strategies such as visiting men in their work place in the company of the village chairperson or other opinion leaders and friends, and the opportunity I was given to introduce myself during the Catholic Youth Conference in February, were equally very helpful in making people understand my presence in the community. Due to the highly gendered nature of the social interaction in Mam-Kiror, it was initially less easy to enter the domestic sphere and to some extent market stalls where women spent much of their time. This situation improved gradually as more people got to know me better and the purpose of my work, which I believe partly may have made men became less suspicious of me talking to women in the village.

### **3.4 Data collection: Three parts of the study**

This study was designed to have three closely inter linked parts. Part one involved a general ethnography of the study area predominantly relying on participant observation; the second part involved a household survey and the third was the focused ethnography involving in-depth interviews. A distinctive feature of ethnographic research is that it involves the researcher participating directly for an extended period of time in the research settings, if not also in activities, observing and talking with people in naturally occurring contexts to capture their social meanings (Silverman 2006). The participant observation method is well-established in medical sociology and anthropology, and is a particularly useful tool for those studying people's experience of suffering from chronic diseases (Vanderford, Jenks et al. 1997; Thorne and Paterson 2000).

#### **3.4.1 General ethnography**

The application of the ethnographic methods involved living in Mam-Kiror village for twelve months and interacting with local people, including the eventual interviewees (the 26 men), listening to and sharing their day-to-day stories and conversations, with a particular interest in understanding the social relations of being masculine in this setting.

Ethnographic research, which relies heavily on participant observation, spending an extended period of time in the field, and informal interviewing, can provide more valid data than structured interviews, group discussions or questionnaire surveys. The key difference is that a researcher is not creating an artificial research environment but is observing interactions that would probably be happening anyway. This means that data are less subject to social desirability biases, plus if the interviewees know that the researcher has already familiarised himself/herself with 'real' village life their own accounts are likely to be more valid (Goodson and Vassar 2011).

The first few months of fieldwork in Mam-Kiror involved engagement with the locals through conversations and incidental observations to establish relations and gain acceptance, as well as collecting vital information about the village relating to the local economy and different social groups of men. As the study progressed, I focused more on the daily life concerns and worries of men, including livelihood and social activities, their relationships with spouses, relatives and neighbours, and participation in village events. When appropriate, efforts were made to direct conversations to research issues, in particular about men's lives and health. Sometimes particular men were talked to alone but often conversations with them included others, such as family members, neighbours, peers or colleagues. To diversify and increase accuracy of accounts, I engaged with participants in multiple sites and contexts. Interactions with men took place in homes, work places, bars/restaurants, along the roadsides, social gatherings, or as we walked. Field notes were usually written up at the end of each day.

Through participant observation I was alerted particularly to the significance of money, work, family and the importance of norms of respectability and reputation for maintaining masculinity and men's social status; issues that are integral to the later analysis in this thesis. In addition, interactions with different men helped to conceal the focus on men with HIV, thereby protecting their identity. Perhaps the most important strength of using participant observation was that, as I share the same ethnic and linguistic background with the people from Mam-Kiror village, and so could be described as an 'insider' (discussed in more detail in 3.5.2), it offered an opportunity for me to deepen my understanding of issues that might have been familiar, and those that were not spoken about regularly, but were potent in people's social relations, for example, the dynamics in domestic relations in families where the man was infected with HIV. Yet doing participant observation in a familiar society can be problematic since it requires an effort to question what you have

learned to take for granted (Howarth 2002). Gomm (2004, p.221) highlights the potential challenge as follows:

...the last thing a naturalistic observer should want to do is to become a fully experienced member of the group who are being studied, because fully experienced members are the kinds of people who take for granted the things which researchers regard as puzzling.

In many ways, Gomm draws attention to the dilemmas that I experienced with regard to how to present myself and my ability to explore the familiar as though strange during the fieldwork, and these are discussed in detail under the Ethics section later in this Chapter. However, it has to be said that when conducting participant observation, I continually reflected on my assumptions and values and close affinity with the research context and how these might influence the data I collected. Furthermore, my two PhD supervisors, both from Britain, regularly questioned my assumptions and experiences, thereby facilitating a reflective perspective.

### **3.4.2 Household survey**

Beginning with a quantitative study can be a helpful approach to establish a sample of respondents and the broad contours of the field from which qualitative approaches can then be applied to look in-depth at key issues (Silverman 2006). Using semi-structured questionnaires (Sarantakos 1998), a household survey was undertaken three months into the fieldwork, primarily to help understand the setting better and connect with families, since as already discussed, the planned village meeting from which I was to be introduced to the community did not take place. This survey helped offset doubts that people had about the “true” reason for my presence in the village since despite my claim to be doing research for the past three months they had not seen me carry out questionnaire interviews, which they considered was the genuine form of research. It was also expected that the survey would help provide some insights on the gender patterns of treatment seeking for common illnesses, and help access and select a suitable sample of men who identify themselves as having HIV or its symptoms, for inclusion in the qualitative interviews.

Although the intention was to interview two adults (at least a male and a female) from each of the 153 households in the village, bringing the expected sample to 306 adults, a total of

only 195 adults (109 male, 89 females), was realised from 102 household visits, as some people were not found at home or at their work place during the survey visits or declined to take part “due to busy schedule.”

Two research assistants; a 28 year old male with a social science degree and some basic research experience, and a female nurse in her 40’s, experienced in interview research, helped conduct some of the survey interviews. Both were Iteso by ethnicity and spoke the local languages fluently. They received a one day orientation about the research project and participated in a one day pre-testing exercise and revision of the questionnaires.

Due to time constraints and because a large volume of data was realised from participant observation and in-depth interviews, a decision was made, in consultation with my supervisors, not to analyse the survey data for the purpose of the thesis. These data are being written-up to examine possible gender differences in treatment seeking for common illnesses.

### **3.4.3 Qualitative interviews and sampling**

#### **3.4.3.1 Sample size**

An important question in research design is always how many respondents are necessary for a study. In qualitative research there seems to be no definite formula and standard sample size. Although some researchers would claim that one might have to include as many participants as they can get depending on time and money available, that is a less plausible argument because that would mean an ambiguous sample size. There is a general agreement, however, that qualitative studies rely on small numbers of participants in order to generate detailed and multiple perspectives on a topic with a specific, homogeneous group of people (Bryman 2004), or that in the case of grounded theory researchers, they should sample until when any additional respondents stop to yield new insights (Baker and Edwards 2012). Generally, this would mean a small manageable sample of about 20-30 respondents, as very few would be problematic since variations are likely to be due to individual variation. Of course, if the aim was to collect data from different categories of people (e.g. women and men, young and old, different ethnicities, etc.), then that can lead to much larger samples with, for example, up to about 10 of each category.

Following these principles, I had planned to recruit a sample of about 28 men from four different sub-categories with respect to HIV infection and treatment, with roughly an equal proportion (7) from each of the sub-categories. In practice, however, I managed to realise a sample of 26 men from the sub-categories as follows:

- a) Nine men currently on HIV treatment (ART and/or Septrin [Cotrimoxazole]).
- b) Eight men who had tested HIV positive and would have benefited from treatment, but for some reason had not sought treatment or had initiated HIV treatment but dropped out.
- c) Six men who had not been diagnosed but for some reason suspected they might have HIV, for example those men whose partners were on AIDS treatment or had died of suspected/confirmed AIDS, or those who had been ill with symptoms they associated with HIV.
- d) Three men with other chronic health problems unrelated to HIV.

The main reason for including different categories of men in this part of the study was to enable comparison of those who successfully initiated and adhered to treatment and those that did not, so as to identify and describe the different social cultural and contextual factors that might influence men's ART treatment seeking. This would, for example, help offer explanations for what made men who decided to test and initiate treatment different from those who did not test.

Regarding the inclusion of undiagnosed men who suspected HIV infection, this study recognises that people who suspect HIV infection are not necessarily infected, not least as there is a tendency for people in some parts of SSA, including Uganda, to overestimate their likelihood of infection (Anglewicz and Kohler 2009; Seeley, Mbonye et al. 2011). HIV infection cannot accurately be diagnosed by symptoms alone. Even if they were infected, they may not be medically eligible for ART based on current criteria which rely on CD4 counts. A reliable HIV test and CD4 tests to establish medical eligibility for ART is often the standard method. However, the fact that many people in Mam-Kiror, male and female, young people and adults, believed that the majority of them, especially men, were infected with HIV is important for a study whose focus is on health seeking. It offers a wider scope for assessing people's decisions and perceptions regarding seeking a test and/or medical treatment for HIV. Men with other conditions unrelated to HIV were included primarily to protect the identity of men with HIV as the principal participants and

to provide some comparative data. As I did not disclose the identity of HIV positive men in the village, the inclusion of the three with other conditions in the study was unlikely to bring undue suspicion about their HIV status.

Additionally, it had been planned that if men can consent and arrange it, interviews or conversations would be held with their spouses, other family member or close friends, to generate supplementary information focusing the men's social situation and experiences with illness. Although many consented, only 11 men made arrangements for these conversations to take place, with others either failing or reluctant to inform the concerned people about it, despite several promises to do so, or feeling uncomfortable for such meetings, especially with family, to take place without them being present at the home. Thus, only a total of 6 wives and 5 friends of the 11 men who consented took part in the conversations.

### **3.4.3.2 How the men were recruited and challenges faced in recruitment**

The in-depth interviewees were selected through two sampling methods. The majority of the interviewees who were receiving treatment were accessed with the help of Busia Health Centre IV, a public treatment facility, which also helped to contact some men who had dropped out of treatment or who had been tested but had not sought HIV treatment. A total of twelve participants were accessed through the health facility. They were initially briefed about the study by their counsellors and when they indicated that they had voluntarily agreed to learn more about the study, they were asked either to contact or be contacted by the researcher (with the option of their counsellor being present) for a brief meeting at a place of their choice.

While recruitment through counsellors/health facility guaranteed inclusion of men whose HIV status was known, there could have been selection biases from these gate keepers. Judging from some of their conversations with me, the health workers wanted me to only talk to the patients they felt would not be problematic with respect to being open or demanding for material support, which was not within my ability to provide, or wanted me to talk mostly to the men who were not adherent since they were the "problem cases". A further limitation of using the health facility for accessing participants was that due to two refusals and inadequate contact details for other potential participants, it yielded only two

men out of the expected seven who had not sought or had dropped out of treatment. This necessitated a change in the sampling strategy to the snowball method.

The snowball process was facilitated by two of the participants receiving HIV treatment who knew others within the village who had either dropped out of treatment or who suspected that they were infected with HIV but had not tested. The main feature and strength of the snowball approach is that the sampling emerges through a process of reference where a participant refers the researcher to another potential participant (Denscombe 2010). Given the sensitivity of the topic and hidden nature of the sample, particularly of men who had not tested but suspected HIV infection, the snowball approach was valuable because the first introduction from referring participants enhanced my credibility and acceptance before potential participants. Emphasis was initially placed on recruiting participants from Mam-Kiror village, and then moving outwards, but keeping as close as possible to Mam-Kiror village in order to maximise overlap with the ethnographic base. Selecting a few participants from beyond Mam-Kiror village also helped anonymise the primary focus of the study on HIV positive men in this village.

Overall, five men who were contacted, (one dropped out of treatment, another tested but reportedly refused go for medical treatment, and the others not known to have tested but suspected infection) refused to take part, with two of them frankly telling the contact person “to leave them alone”. Although a few potential participants hesitated and/or refused to take part in the interviews, this challenge had been anticipated during the planning of the study. Even among those men who accepted to participate, some appeared less open to discuss their story with me until they got to know me better. To increase the trust of the potential participant, I often explained to them, without naming individuals, that many other men of similar characteristics were being interviewed.

### **3.4.3.3 The In-depth Interviews**

A central concern in this thesis is why some men seek HIV treatment and others discontinue it or do not initiate treatment at all, despite testing or suspecting that they are infected with HIV. But the “why” questions cannot often be asked or answered directly with simple answers, and may involve a variety of circumstantial and contextual factors and create links between apparently unrelated matters (Hakim 1987). To address this challenge and obtain the most detailed possible responses, I adopted in-depth interviewing

as the main technique for collecting data from the men suspecting or living with HIV. The interviews were based on a flexible topic guide, and for thirteen men who consented and were accessible, data collection was extended into repeat interviews or follow up focused conversations at later dates. The repeat conversation technique enabled exploration of how individual men's perspectives changed in response to some experience or event in their life during the time of the study (Hakim 1987).

The in-depth interviews with men elicited biographical information about the participant, their life history, families, responsibilities, economy and work, marriage, social responsibilities, health and sexuality. These have provided useful frameworks for understanding their treatment experience as it relates to their status as men. During the fieldwork some men became more motivated to interact with me. Many became more enlightened about the research topic and about their own health, with those who had not tested telling me how they urgently needed to obtain a test, and those who had stopped their treatment telling me about their plans to resume treatment. The research process therefore unintentionally acted as an intervention in its own right. Overall, the combination of in-depth interviewing and participant observation through an extended stay in the field and talking to men themselves and the local people in general about different aspects of masculinity and treatment seeking, allowed triangulation so that information could be corroborated, thus getting a better sense of how valid the responses were.

The interviewees' ages ranged between 27 and 51 years (median age was 39 years), and all except three had children of their own (see table 1, below).

**Table 1: Respondents Characteristics**

	Age	Education	Wife(s)	Children	Septin Only	Septin & ARVs	Other interviewed
<b>Men receiving HIV treatment</b>							
Abraham	50	P.6	2	16		Yes	Wife
Sylver	50	P.3	2	12		Yes	
Mike	31	P.2	1	1		Yes	Brother
Isaac	37	P.2	1	1		Yes	Wife
Salim	45	P.2	Widowed	None		Yes	Brother
Jeremiah	40	P.4	Separated	4		Yes	Wife
Noah	50	P.3	2	8		Yes	Brother
Leo	27	S.2	1	2	Yes		
Ben	36	P.6	1	2+3 Step		Yes	Wife
<b>Men who dropped treatment or did not seek it despite testing</b>							
Isaiah	49	P.4	1	11		Yes	Friend
Frank	45	P.3	Separated	None	Did not seek treatment		
Alfred	38	S.6	1	9		Yes	
Juma	51	P.2	1	12	Yes		Wife
Moses	46	P.4	1	8		Yes	Wife
Job	45	P.2	Separated	2	Yes		
Emma	42	P.5	Separated	4		Yes	
Jose	30	P.6	1	2		Yes	
<b>Men who suspect HIV infection but had not tested</b>					<b>Why suspected infection</b>		
Geoff	28	S.2	2	2	1 wife on ARVs		
Solomon	42	P.4	1	9	Cough/TB		Friend
JB	37	P.4	1	8	Illness, rival partner dead		
Paul	28	P.6	1	3	Illness, rival partner dead, many partners		
Sata	36	P.2	1	6	Illness, many partners		
Tony	39	P.2	1	4	Illness, many partners		
<b>Men with other chronic illnesses</b>					<b>Type of illness</b>		
Adam	43	P.6	1	6	Hypertension/CVD		
Elly	28	P.6	2	3	Syphilis/Gonorrhoea		
Charlie	35	P.4	Unmarried	None	Chronic back pain		

Key: P= Primary, S= Secondary

## **3.5 Ethics, my identity, social relations and dilemmas**

This study was reviewed and approved by the Science and Ethics committees of the Uganda Virus Research Institute and the University of Glasgow, Faculty of Social Science, and was cleared by the Uganda National Council for Science and Technology. Informed consent was obtained from all interviewees. Interviewees voluntarily consented to take part or withdraw from the study, and either signed in or provided a thumb print on the consent form. Pseudonyms are used for both the study village and participants to enhance confidentiality and anonymity. Despite observing these standard procedures, there were many important issues and dilemmas that characterised the social relationships I built with the people of Mam-Kiror village during the twelve months fieldwork which I will explore in detail below.

### **3.5.1 Initial anxiety and suspicions about the research project**

My early experiences in Mam-Kiror village were characterised by the residents' anxiety and uncertainties about the "real" aim of my presence, although I had explained that I was conducting research on men's experiences of illness and health seeking. Likewise I was anxious about how the field relations would evolve and their impact on the research. Initial feedback from those who had become closer to me in the early months, revealed that in spite of my efforts to introduce the goal of my stay in Mam-Kiror to whoever cared to listen, some people remained suspicious, assuming that I had an undeclared motive for being in the village and was probably spying. Two main factors appeared to reinforce these fears. First, past relationships between the Mam-Kiror community and some government officials/visitors (see Chapter 4 for details) was hostile due to wrangles relating to control over some of the mineral rich village land. In the past government officers, particularly those working with the geological and security departments, conducted land and mineral surveys with the view to reserve mineral land, much to the resistance of the residents. I entered Mam-Kiror at a time when there was a deep-seated mistrust of officials and any activities involving visiting households and questioning people, more so men and their activities.

Coupled with the understanding that the success of the research depended primarily on my personal decisions and efforts, the above misgivings and anxieties made my fieldwork

endeavours unpredictable at the time. On a number of occasions I was not sure what to do and if I was taking the right path. Discussions with academic colleagues and reading literature on fieldwork practices did little to settle the anxiety since I heard the common message from all that “each PhD research endeavour differs from another.” Encouraging discussions and positive comments on my written field reports by my supervisors provided the much needed confidence and the motivation to carry on.

Second, as a social scientist, my main research methods (participant observation and casual conversations) were unfamiliar to the people of Mam-Kiror. While I claimed to be doing research, my extended stay and informal conversations were different from the rapid questionnaire surveys that people were familiar with. A number of residents therefore concluded that I must have ulterior motives for being in Mam-Kiror. Furthermore, my lifestyle prompted suspicion. Some residents, who discussed their impression with me, argued that if indeed I was a researcher, then my approach was at odds with the usual practices of other visitors and researchers who had been to the area. Typically, “they are usually proud, selective with regard to the food they ate and in their interactions with local people,” (Male, aged 40). In addition, they said that genuine researchers often resided in big hotels in the town and only commuted to the field and accomplished their work in a few days.

The contrast between ‘other researchers’ and my approach was highlighted during the fieldwork when a research team of three from the Uganda National Bureau of Statistics came to Mam-Kiror, used questionnaires and interviewed their sample in two days. Weeks into my fieldwork even those who had believed that I was doing a study on health issues were still waiting for me to ‘start’ the study. “So when are you starting [to interview with a questionnaire]?” asked one of my male friends (aged 30). Moreover, the level of humility I had demonstrated by aspiring to live an ordinary life with the local people - mixing with, greeting, “even hand shaking them and eating local food”, as some observed - appeared to raise some questions about my claim to be from a premier academic institution like Makerere University. It was therefore rather ironic that an (ethnographic) approach to research which involves much greater commitment to learning about people’s lives by spending more time with them led to more suspicion, and that trying to minimise status differences between the researched and researcher may sometimes cause problems to the researcher who is expected to conform to her/his high status identity.

Part of my responsibility was the obligation to protect my interviewees' identities both within the village and while discussing my research with other interested parties such as my professional colleagues, family, or friends within the village. Maintaining this was complicated and sometimes required tactfulness and vagueness about the true identity of my respondents, which I found to be an ethical dilemma and against the local norms pertaining to conversations with friends/relatives. This was because, while these interested parties wished to know the details, I could only reveal so much about some participants, since I had promised to observe confidentiality about my participants.

As the study progressed and many more people got to know me better, their impression began to change, with many referring to me as "our man" or "our very own". In particular, when we conducted the house-hold survey we not only confirmed that we were genuine researchers who interviewed people, but it also connected me to many households and opened avenues for follow up visits and discussions, thereby facilitating further qualitative research.

### **3.5.2 My identity: 'Insider'/'outsider' binary**

The researcher's identity, his/her values, and the field relationships between him/her and the researched, are often discussed by anthropologists in terms of insider/outsider status. This distinction is critical in ethnographic studies because the researcher's position as an insider or outsider not only shapes her/his acceptability with those s/he is studying, but also affects what the researcher notices and constructs as knowledge. At the most basic level, to be an insider or outsider is about the extent to which a researcher is accepted as part of the natural social system, and specifically relates to how the social distance between the researcher and researched influences whether the researcher is seen or sees her/himself as an obvious intruder or native. The issues of language, ethnicity, gender, cultural competence, and social status are central to these roles (Warren and Tracy 2010).

My fieldwork experience in Mam-Kiror suggests that it may be misleading to present the position of a researcher as insider – outsider binary. Rather, it shows that regardless of the level of the researcher's preparedness with regard to the above social characteristics, being an insider or outsider is relative, the social distance never fully disappears, and in practice, a researcher is both; I simultaneously felt and/or was regarded by the people of Mam-Kiror as part of and apart from them (Sultana 2007). I also realised that both roles are necessary

to fulfil the goals of anthropologists to “make the strange familiar” (as an insider), and “to analyse the familiar as if it is strange” (as an outsider). As Hammersley (1989) argues: “There must always remain some part held back; some social and intellectual distance. For it is in the space created by this distance that the analytic work of the ethnographer gets done. Without that distance, without such analytic space, the ethnography can be little more than the autobiographical account of a personal conversion” (Hammersley 1989:90).

As I left Kampala city on the morning of 2<sup>nd</sup> October 2009 for Mam-Kiror to start fieldwork proper, I felt I was going home. This was because of several factors. First, I originate from Tororo district, which is only about 20kms away from Mam-Kiror, and is the parent district to Busia district. Second, I share the same ethnic background and speak the same language with the natives of Mam-Kiror. Third, although I had lived in Kampala for about half of my life, I was quite familiar with rural life, having been born and raised up in Tororo, a rural area with socio-economic characteristics that are, broadly speaking, quite similar to Mam-Kiror’s. In addition, as I have strong family ties, with my parents and most relatives, still living in Tororo, I frequently go home – to the village – and interact with the rural folk. This kind of background made going to Mam-Kiror appear a familiar experience to me, and became a valuable aspect of my identity, engagement with people and above all, how I posed certain questions and collected data while in Mam-Kiror.

Because Busia was originally part of Tororo, and many people from this place still receive some social services, such as health from Tororo, many of them identified positively with Tororo, and therefore, often placed me in context. Some few people knew my village of origin, while some others visited my home, and/or got to know my wife and other relatives who visited me while I was doing fieldwork in Mam-Kiror, making us feel rather more connected. Quite frequently, I was introduced by the leaders and by my friends to others in the village as: “This is our very own man.” This was to emphasise that I am an Itesot like the majority of them and also to refer to the fact that I was resident in Mam-Kiror village and could no longer fit the designation of “our visitor” as newcomers are commonly addressed.

My own masculinity, public and domestic, also became an important part of my day-to-day interactions with people as my interlocutors or I often used it as a point of reference. Being married and with children, and being employed were all facts that were referred to regularly during our conversations. “As a married man you know these things” or “It is not

easy being a man...you know this,” are the ways my friends sometimes talked to me when making a specific point or when expressing empathy during times when I had to rush to attend to an issue in my immediate or extended family. Many thus viewed some of my experiences as somewhat similar to their own. My engagement with men in Mam-Kiror prompted me to reflect on my own masculinity, in particular with regard to family relationships and roles, and work and aspirations, and also helped me to pose particular questions about their masculinity. There is no doubt that these commonalities and relationships helped me to build a productive and successful research relationship with the people of Mam-Kiror. My ability to blend with local people, my ability to converse in local dialect, and to understand and put local stories into context, to ride my bicycle around the village, and to visit and share meals with people, made me appear close and more accepted. One of the most memorable remarks I heard in relation to my effort to live like an ordinary person in the village was: “Godfrey is like a nursery school teacher who is not selective; he receives and talks to anybody, including some men who are ‘mental.’”

Many people in Mam-Kiror believed that my presence in their village positively impacted on their lives. A number often remarked that they had learnt a lot from talking to me and from my behaviour. In addition, occasionally, I gave financial support to some individuals (see section 3.5.3), while the family I lived with earned relatively handsomely from the rent I paid them. For many others, I gave them time and we discussed and reflected upon different aspects of life in Kampala city where I live, in the UK where I went to study, or other countries I had been to. We discussed schooling and people consulted me on issues related to University education. All these were seen as the value and usefulness of my presence in Mam-Kiror. This is what Warren and Tracy (2010) refer to as “researcher bargain”; the act of researcher being a useful one in the field.

However, it is important to note that, while similar historical and political processes might locate a researcher to his/her research participants, the “native” can be the “other” through a class privilege (Sultana 2007). Thus, my relatively better economic status, and my educational privilege, meant that to most people in Mam-Kiror, I looked, and possibly throughout the fieldwork, remained sophisticated: an outsider. In particular, being based in Kampala city, the dream destination for many, especially the younger people in Mam-Kiror, set me apart from them, as did my material possessions, especially the car that I drove there occasionally. My education also set me apart. Although many people did not seem to understand the academic level of my study as there is no equivalent Ateso word

for PhD study, they understood that I was pursuing further education but this is a level achieved by very few in Mam-Kiror. While my identity as a student seemed to disappear as the study progressed I remained open about this fact, and some people at times used it to distinguish me from others. Some people could have seen my student identity, especially those who may have hoped to access financial gains, as a less important social position and therefore saw no motivation to associate with me, meaning that I could have missed some important information from them. My student status may also have been the explanation for my experience of what Sultana (2007) has described as reverse power relations during fieldwork, especially among some district authorities and health staff, in their failure to honour appointments and the sometimes patronizing attitude. However, some people in Mam-Kiror referred to me as *mwalimu* ('teacher' in the Kiswahili language) because they understood that I work with Makerere University and despite being clear about my status as a student, some people, particularly the interviewees, still considered me a health worker/advisor.

The fact that while in Mam-Kiror I lived in the trading centre (commonly referred to as town), with one of the wealthiest and locally influential families, combined with their interests in business and community affairs, was also important in shaping people's perception of me during fieldwork. While planning for the study, this was exactly the type of family and place of residence I had hoped to avoid for the fear that it would isolate me from the majority of the village residents. My hope was to find a typical village household, with a man, spouse (s) and children to live with, in order not only to enhance my acceptance and recognition as one of the village residents but also to learn more about family relations and the everyday life of a typical village man. Finding accommodation in a traditional household, however, proved harder than I anticipated. Most families did not have an extra house/room or found it difficult to rearrange their living arrangements for such a purpose, especially since renting out houses/rooms by traditional households was not a familiar practice. The best and most realistic option was to rent a room in a local guest house owned by Adam, one of the successful businessmen in the area. Adam, who eventually became one of the key interviewees in the study, lived there too with his wife and two workers, but was occasionally joined by his four children, who lived with his brothers or were in boarding schools, and two of his married male siblings, who came to help.

My relationship with this family significantly improved when Adam accepted my suggestion to contribute to the expenses and share meals with his family. While this connected me more to Adam's family and friends, there were times when I felt living with this family had created a social distance that alienated me from some who wished to talk to me freely. In other cases, I felt tense and unsure how to react in situations when members of this family were involved in a conflict with other village residents (see Chapter 6: 6.5.2).

Perhaps the most difficult and overwhelming experience of the fieldwork, and which cast my insider/outsider status in sharper focus, was the very act of interacting with the men living with HIV themselves. These participants initially received me as a visitor but subsequently as a friend, a counsellor, an advisor, and eventually they referred to me often as a "brother". In telling their stories, the men revealed their struggles and hopes in their efforts to cope with their health condition and responsibilities. Sometimes HIV was at the background but most times, it was a central feature of our conversations. I became a confidant to many who revealed the most intimate stories that are reported in the findings chapters of the thesis, hearing in particular many distressing stories of how HIV and poverty had ruined previously hopeful lives and futures. In Uganda where poverty is widespread, people spoke a lot about material needs and requested financial help or for me to help them find a job in Kampala or a school for their child. While I offered financial help to the most desperate cases whenever possible, in most cases I was helpless and frustrated. Even when I sympathised with their experience of living with HIV, I was acutely aware that I do not truly know how it feels and what it means to live with HIV – that feeling is only understood by those individuals experiencing the problem.

Although the positive perception of me described above was crucial for the fieldwork and my motivation to carry on through the one year, there were instances when I did not feel I was truly part of the local setting and was ready to embrace every aspect of the local life. For example, occasionally I got bored of life in Mam-Kiror village or felt a sense of failure to fit into certain patterns of social behaviour, such as drinking alcohol and seducing women. My Christian values sometimes overshadowed my pledge to neutrality with regard to certain behaviours, leading me to negatively comment on the dangers of behaviours such as drinking alcohol and promiscuity. This further increased my awareness of the difference between some local residents and me.

Therefore, it can be argued that regardless of the level of preparedness and perception that one is a native, the fieldwork relationships will inevitably cast the researcher as both an insider and an outsider. The experience tends to be characterised both by ambivalences, discomfort, tensions and instabilities, and truly rewarding relationships of acceptance and friendships.

### **3.5.3 Friendship and reciprocity**

A central feature of the field relations and friendships that developed with various people was the tendency to be hospitable and reciprocate offers. My research project had a humble small budget to compensate the interviewees for their time and/or transport expenses. So I had planned to observe very stringent measures with regard to financial rewards to the people in Mam-Kiror. However, I was struck by the level of hospitality and concern to entertain me that I received from participants and more generally from other people who got to know me in the village, making me to become more flexible in my financial decisions.

To reciprocate the drinks and bites that these friends offered regularly at the trading centre and hospitality offered in some homes by women, I usually offered back something, beyond what the research budget had catered for. However, being familiar with the Ugandan culture, and specifically the Iteso norms, it was important to observe the appropriate level and forms of reciprocity, and be open about it, especially when dealing with women, in order to avoid being misunderstood for seeking sexual favours or being labelled as “misleading” or seducing someone’s wife or daughter. While a drink or a meal in the trading centre would be appropriate for a man, material items such as sugar and/or bread taken home were more appropriate for a woman, since it was not common practice for women to eat and drink in restaurants/bars.

Although it was costly and difficult to justify these expenditures in terms of the research or personal budget, I did not consider reciprocating my participants’ time and hospitality to be exploitative. In fact, it fitted well into the way of life in this area and served to connect me further to my friends and the families I was visiting. During my stay in the village I was often referred to as “son”, “brother” or “friend”, by various people. In Ateso language, these terms not only refer to the biological relationship but also often suggest the sociality and expectation, or the acknowledgement, of the other people’s usefulness. Thus, I would

not have been a good son, brother or friend if I was not turning up with a gift such as sugar or a bar of soap once in a while. Sometimes the nature of reciprocity expected was not financial but rather the requirement to demonstrate the spirit of mutual assistance, solidarity and acting in a socially acceptable manner towards someone who considers you to be his/her friend. For, example, even when I would set aside a specific moment to do strictly PhD work and promised to abide by it, such as typing the notes, I found it hard to turn down an invitation to take a village stroll in the evening or an invitation to a funeral of a friend's relative. This flexibility may have enhanced my acceptability in the village.

However, there were times and instances when I could not reciprocate or act as some people expected, which may have left them frustrated. The most common instance of this was with regard to purchasing beers for people, which I never did whenever requested because of my Christian values against beer drinking.

## **3.6 Data recording and analysis**

### **3.6.1 Thematic framework analysis and Nvivo aided coding**

The process of recording, analysing the data and writing up the thesis was guided by the principles of framework analysis. Sometimes referred to as the thematic framework method, the framework approach is a matrix based analytic method, which facilitates rigorous, transparent data management and analysis, such that all the stages involved in the analytical hierarchy can be systematically conducted (Ritchie & Lewis 2003). The framework method is used to organise data according to key themes, concepts and emergent categories and relies on a five step process of analysis, involving familiarization with data, identifying themes, indexing (or coding), charting and interpretation (Srivastava and Thomson 2009). While these steps appear linear, clear cut and quite restrictive, they were not applied strictly in that order to my data, since in reality analysis was an iterative process which involved forward and back steps, and greater flexibility in the analysis. In some cases the steps overlapped and intersected with each other, while indexing or coding was achieved through the use of NVivo 8 Software. The specific procedures followed during the entire analysis are described in detail below.

### 3.6.1.1 Familiarisation with data: Audio transcription and writing up field notes.

With the exception of three interviews that were not audio recorded due to technical hitches with the recording equipment, recordings of twenty three interviews in Ateso, were obtained. Follow-up visits were not audio recorded but detailed notes from the conversations with those men were taken. In addition, there were a further five audio recordings of interviews with wives of some of the interviewed men. The interviews lasted between 50 and 90 minutes. These interviews were then translated and transcribed; half by an experienced translator and the others by me. Though it was challenging for me to transcribe the many and long audio's, the key advantages were that I had the opportunity to listen repeatedly to the interview, becoming familiar with what the participant said allowing me to start thinking about codes for later analysis. Typed transcripts made it possible to import the data into NVivo for systematic coding.

I also personally typed detailed notes for 76 of the total 109 observations on my laptop computer, and obtained secretarial support in the nearby Busia town for the others that had been hand written but which I could not type due to instances of electricity blackouts or failure to keep up with multiple tasks during the fieldwork. As with the transcripts, the process of typing field notes involved paying attention to potentially interesting topics for creating themes. Hence both the process of interview transcription and typing of detailed field notes were a crucial part of the preliminary stage of analysis in determining codes.

### 3.6.1.2 Preliminary analysis to determine the codes and coding schedule

The next step was to understand the material and to develop a list of thematic areas/categories for constructing a coding schedule. As recommended by Ritchie and Lewis (2003), it was not necessary to include all the data from interviewees or field notes into the familiarisation process to build the preliminary conceptual framework for developing the coding schedule. Following a discussion with my supervisors and a careful assessment of the data, I made a decision to purposefully select ten data sets among the field notes and 26 interviews and reviewed them to help with creation of the coding schedule.

Overall, the research objectives guided the decision on which data to include in constructing the coding schedule, but special attention was also paid to ensure that data sets selected were balanced to cover the different dimensions of men's life. Following a discussion with my supervisors, six major themes were developed each with a range of relevant sub-themes. The major themes were: families and relatives, being manly, masculine work ethic and economics, general health seeking, social relations of HIV testing and men and HIV treatment. Themes that were explicit from the fieldnotes and participants' accounts were prioritized for coding over those that I had a priori, but further analytic reading of transcripts and field notes yielded other unexpected sub-categories, including "*akitopol ere*" (family's economic progress) as a more central masculine role than providing for daily food for family, "pattern of compulsory consumption expenditure as a masculine ideal", "importance of pressure from colleagues in testing", "the significance of occupational identity in understanding HIV treatment seeking behaviour" and "the use of ability to work hard again as a measure of the efficacy of HIV treatment".

### 3.6.1.3 NVivo assisted coding and management of data

NVivo 8 Software was used to manage, code, and retrieve data. As highlighted in the literature on qualitative research, coding is about identifying all segments of data that relate to the particular themes listed in the coding schedule (Ritchie & Lewis, 2003). Coding can be viewed as a way to indicate that a concept or theme has been identified from the data and that for that particular theme the evidence is found in a certain section of a given transcript.

All the data from the twenty-six interviewees were coded systematically while due to its large volume, a decision was made to fully code about 70% of the field notes, using the following criteria: all field notes from the uninterrupted conversations/people's interactions with the least intrusion by the researcher at the time of collection, were prioritised for coding fully since they represented the most natural data compared to where my presence might have changed the interactions occurring. Other field notes were roughly grouped into the relevant topics they logically belonged to. Six topical areas were identified namely: gender, economy, money, marriage, family and health. The remaining 30% of the field notes consisted of general issues, such as reflective notes on my experiences and

relationships with people in the village, which though useful, were less crucial to building evidence on notions of masculinity and treatment seeking for HIV/AIDS.

In NVivo, a case may be a person or an institution, and NVivo can help to gather together, into one document, all content/data from different sources that belong to that particular case. Each case was one of the original twenty-six interviewed men. Of these, eleven had data ranging from the in-depth interview and follow up conversations, to interviews with their partners and friends, with some of these cases comprising up to nine different sources/data pieces. Once all case material was brought together, systematic coding was then undertaken. This involved reading through the relevant section of a transcript or transcripts within NVivo project and pooling together the relevant segments into a node, which is the NVivo equivalent of a theme. The themes or nodes were structured under a higher order/broader topics and subtopics on the basis of their links and relationships with each other, eliminating the need for an independent indexing system. In some cases, there were more complex relationships, in which data coded in a given sub-theme was further coded into either a new theme or another theme within the same major theme. Altogether, there were 36 sub-codes.

NVivo assisted coding had one major advantage: it facilitated quick exploration of the data whether as original transcripts or in coded form. In general, the coding undertaken helped in the process of reducing the large amounts of data generated during fieldwork, into meaningful and manageable amounts, and the process of coding, and the codes themselves, helped in the development of impressions of relevant findings and their explanations.

### 3.6.1.4 Moving forward after NVivo: charting, summarising and writing up

The importance of the analytical process lies not with how we use the codings and concepts, and certainly not in whether we use computer software or manual ways of manipulating the data...the important work of analysis lies in establishing and thinking about linkages in the data...and in identification of relevant concepts (Coffey and Atkinson 1996 p.27).

This excerpt highlights the need to recognise the limits of NVivo coding and urges the analyst to move their analysis beyond it to a stage where complex patterns and meanings

can be attributed to those codes. Once the range of NVivo coded themes were judged to have covered the range of data comprehensively, matrices were used to chart and display them and concisely summarise the data. Following Ritchie & Lewis (2003), each of the main themes was charted/displayed in its own matrix created using Microsoft word. A matrix was made up of a thematic issue or node that had been created and coded in NVivo, and its column titles were the sub-themes under that main theme while the row labels were the individual participants and/or field notes. A total of six matrices/charts were designed and into which the retrieved NVivo codes or their meanings would then be summarised

The main strength of charting was that it helped in condensing data, identifying recurrent themes and similarities, and identifying unique cases. Most importantly it aided the building of arguments and checking emerging hypotheses against relevant data, for instance, in seeking explanations why for some men testing and treatment threatened their masculinity and, for others, it restored their masculinity, or how and why economic circumstances and work were linked to ART use. These procedures made the process of data analysis rigorous enough to make valid conclusions.

### **3.6.2 Case studies**

To help represent the complex processes and context of treatment seeking for HIV, seven case studies from the men interviewed have been selected to provide in-depth accounts of their experiences, and specific events and processes (Denscombe 2010). This facilitated the development of further insights on relationships, which may not have been possible by merely reporting from the NVivo coded interviews. The case studies, provided at the beginning of each chapter, were carefully selected to represent both typical and extreme cases. I provide details of each case and highlight features and issues that are relevant for further discussion and comparison with other participants and with other charted data.

## **3.7 Strengths and Limitations of the data and research approach**

While this research has both a theoretical and practical value, as will be shown in the findings chapters and the conclusion, there were some limitations in the design, fieldwork and analysis that need to be highlighted. Key among them was my role as a researcher/data collector. While I endeavoured to deconstruct my personal values during the fieldwork

process, it was difficult to shake off all values in all instances of interaction with the participants. For instance, whenever men discussed drinking of beers, I often discouraged heavy drinking due to my Christian beliefs against beer drinking, and also because of the awareness of the medical and psychosocial problems associated it. Hence some of my personal values may have biased how I perceived alternative world views. Thus, a different set of themes may have been discovered or emphasised by a different researcher.

There may also have been some problems with the validity of the data collected. First, it may pertain to the interviewees' self-presentation. I largely relied on self-reported data, although I had a lot of participant observation data too, to triangulate it with. Generally, it is possible that some men may have not felt free to discuss certain issues, especially of a very intimate nature, and therefore may have portrayed themselves differently, as a way to construct an image they perceived would be socially desirable. My line of interview and interaction with men could have also created an improved sense of the importance of health, and may have been responsible for the resolutions that some men made to undertake testing during the interviews/interactions. Furthermore, limited data were collected from boys and women, yet more awareness of their perspectives, especially of all the wives/sexual partners of the men interviewed might have led to a fuller understanding of the range of men's experiences and perceptions regarding HIV treatment.

Another issue relates to the problem of generalizability. I have previously alluded to this limitation and suggested that the small number of participants in this qualitative research means that the findings cannot be regarded as widely applicable across contexts. I recognise that given the highly contextualised interpretation and explanation of the findings, they are not representative and may be of limited use in other contexts. In particular, the characteristics of these men's employment (artisan gold mining), especially the hard manual work and organisation into teams, and the importance of these in the construction of masculinity and men's self-identity, is atypical to most other parts of Uganda. However, as will be discussed in Chapter 10, a number of other key components of masculinity seen in Mam-Kiror are fairly common across Uganda. Furthermore, in Uganda, it is hardly possible to speak of completely unique settings anymore with regard to knowledge of HIV and availability of public HIV testing services, as knowledge of HIV is very high and nearly all settings are reasonably serviced with testing facilities. Additionally, while this ethnographic study does not generate answers that can be applied universally in Uganda or SSA, I believe that it raises important questions that might be asked in many settings in Uganda and beyond.

## **Chapter 4: Welcome to Mam-Kiror Village**

### **4.1 Introduction**

“Welcome to Mam-Kiror,” the village Chairman started, after carefully listening to me introduce myself and my research to him on my first day in the village. The phrase “welcome to Mam-Kiror” was also often used by other people who were meeting me for the first time; sometimes sarcastically expressing what was believed to be unique yet negative elements of Mam-Kiror life. It was my extended stay in Mam-Kiror and interaction with various members of the village that helped me learn much more about it.

This chapter highlights important elements of Mam-Kiror life where the residents’ perspectives are contrasted with the official government data relating to the village. It begins by illustrating the key demographic features and brief history of the village. It then focuses on specific aspects of Mam-Kiror village life including families, relations between neighbours, economic structure and land ownership, education, leisure, and the health system. Although gender is a fundamental factor in how life was lived and talked about in the village, this chapter does not aim to present a detailed gendered perspective of important elements of life; this is the focus of Chapter 5. Although the characteristics of the village and people described here are generalised, it should be noted that some people’s circumstances changed during the research period; in particular, some moved from one social sub-group to another, changed occupations, moved residence, changed marital status, wealth status or religious denomination.

### **4.2 The place and people**

#### **4.2.1 Location**

Measuring approximately one and a half square kilometres in size, Mam-Kiror is one of the five villages that make up Mam-Kiror parish in Busitema sub-County, Busia District. The village is located about 4.5 km from Busia Border Town. Busia district is approximately 196km from Kampala, the capital city of Uganda, and was until about 14





off from the trading centre to the south east, linking the village to another sub-County (see figure 4). The iron roofed privately owned commercial premises and few market stalls that were concentrated around the intersection, formed the trading centre of Mam-Kiror village, which is sometimes referred to as “the town” by the residents. These buildings, many of which were built only in the past few years, were evidence of recent economic progress. This was a source of pride and has brought higher status for the owners. In the western part of the village, just next to the trading centre, there sat a private gold mining company covering approximately one third of the village land. With a high concrete block wall which stretched about 400 metres along the trading centre, this mining company was effectively sealed off from the preying eyes of members of the public who were completing business transactions. Beyond the trading centre, the majority of the homesteads comprised huts, with no electricity supply, just like much of the trading centre. The village was littered with huge mounds of soil and deep and large pits, some covered in bush, others exposed, all being evidence of the predominant and favoured money making activity among men in the village: artisanal (small-scale) gold mining.

#### **4.2.2 Population of Mam-Kiror village**

In 2009 Mam-Kiror village had an estimated population of 748 people in 153 households, with 49 of the households located in its trading centre (Uganda Bureau of Statistics 2009<sup>5</sup>). Though it had a resident population of only 215 people, the number in the trading centre at any single moment could be estimated to be more than double this, especially during late evenings and parts of the night. These would be people from both within the village and its neighbours, who were attracted by the different commercial and social opportunities offered by the trading centre. The nature of the population of Mam-Kiror should be understood from the broader state of the population in the entire district. According to the 2002 national population census, Busia District had 47,886 households and a total population of 225,008, 52% of them females, and 83% living in the rural areas and largely dependent on subsistence farming (Uganda Bureau of Statistics 2002). In 2002 the district had a predominantly young population with 57% aged below 18 years. The fertility rate was about 7.4%, higher than the national average of 6.7%, and the annual population growth rate was 2.7%. The population density was about 325 persons per square kilometre.

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<sup>5</sup> This source is used because the national population census does not collect village level data.

Busia district is said to have two main ethnic groups, Samia and Bagwe, but has many others: a substantial population of the Iteso people live in the North East of the District, as well as other migrant groups, who reside mostly in the urban areas. Busia is a one county district, with 10 sub-Counties, including one urban town council, 58 parishes and 543 villages.

### 4.2.3 History of the Iteso of Mam-Kiror village

Unlike the rest of Mam-Kiror village which was predominantly Iteso by ethnicity, the population living at Mam-Kiror's trading centre was ethnically mixed, with the Samia people being the second most numerous after the Iteso people. The Iteso people are believed to be the second largest ethnic group in Uganda. Ateso language was the most widely spoken in the village but Lusamia and Luganda were often the languages spoken between people of different ethnic groups, reflecting the overall influence of these two groups in the multi-ethnic Busia District. The Iteso people also spoke Kiswahili, and though to not common and not always fluent, some spoke English. The Ateso language spoken in Mam-Kiror is characterised by a significant amount of loan words from other languages, and similar to the Iteso of Serere (Vincent 1971), the Iteso of Mam-Kiror were often comfortable shifting from one language to another.

There was no specific literature about the Iteso of Mam-Kiror or even of Busia Uganda. Therefore the history of the Iteso of Mam Kiror comes from the oral accounts of the historical events in the village given by elders and leaders whom I talked to, and from the framework of the accounts that were described in earlier ethnographic studies of their Kenyan counterparts, or from Tororo, the district this group formerly belonged to. Together with those of Busia Kenya, and those of neighbouring Tororo District, the Iteso of Busia Uganda are referred to as the southern Iteso<sup>6</sup>. Often described as Nilo-Hamites, the Iteso are said to have originated<sup>7</sup> from Ethiopia (Lawrance 1957). The southern Iteso, are a relatively small ethnic group and live in a predominantly Bantu-Speaking area of

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<sup>6</sup> They are separated from their northern Iteso counterparts occupying the former Teso District of Uganda by the Bagishu and Bagwere people.

<sup>7</sup> During their migration southwards through Karamoja, some Iteso settled in Teso District, while a smaller group moved farther southwards and settled around Tororo and western Kenya. Some historical accounts suggest that during their migration, the group that could not move any further due to their old age – that is, the tired old men who failed to move (*aikar imojong*) – remained in Karamoja and became the Karamojong (Webster et al. 1973).

Kenya and Uganda. Even though the Iteso are said to be sedentary agriculturalists (Karp, 1978), quite dissimilar to pastoral groups such as the Karamojong with whom they are thought to have a common origin, it is recorded that they too were pastoralists in the past. However following external influences from the Bantu people, and the popularisation of cash crops by colonialists in the early 20<sup>th</sup> century, the Iteso became increasingly involved in crop cultivation (Lawrance 1957; Jones 2009). Generally the Iteso are an upwardly mobile group of people (Karp 1978) and so they are dispersed in many other non Ateso speaking districts, including cities like Kampala and Nairobi.

The Iteso people often identified themselves to me on the basis of their ethnicity, but within Mam-Kiror village there appeared to be evidence of considerable social influences upon them by the neighbouring Samia and Dho'Padhola people, as well as their Kenyan neighbours, most notably through intermarriages and dialect. The inhabitants of Mam-Kiror also made distinctions amongst themselves based on whether they were original natives or immigrants into the village. Unlike the first or second generation immigrants, many of those who identified themselves as 'natives' spoke with a sense of nostalgia about how they or their ancestors had been part of the history of the village, and also how their ancestors owned the land upon which the trading centre now stood or how they had helped establish the trading centre. Given this sense of nostalgia among those considered themselves natives of Mam-Kiror, relationships between them and non-natives were complex and sometimes tense. For example, while many immigrants had become integrated into the village, for those who were not of Iteso origin, their ethnicity or clan tended to remain as the framework of their wider identity and reference. In Mam-Kiror, the entry of a new member into the village, especially a man, was often seen in terms of the potential negative social influences of his presence in the village; his capacity to disorganise social life, and increase the competition for the limited opportunities, particularly mining related or access to sexual partners, were a source of concern for men. This greatly influenced the extent of to which non-natives were incorporated into the social structure of the village. To some extent, this was the impression people held of me as well when I began fieldwork in Mam-Kiror, as discussed in Chapter 3. A similar response has been previously noted among other clusters of the Iteso people. Joan Vincent (1971) in her ethnography of the 'African Elite' in Gondo, Serere, found that in the polyethnic Gondo community, the dominant Iteso, relegated the minority ethnic groups or outsiders into a position of marginality, and perceived them as exploiters who furthered their own operations and interests. In Mam-Kiror, newcomers who lived in rented houses in the

trading centre were even less integrated, and were viewed as temporary workers who were there for only a short stay. Ethnicity appeared to be important for political interaction and ascendance to the top village leadership than it was for other relationships between the Iteso and other members of the village. Political ascendance was much more difficult for a non-native, especially to be people's representative as a councillor at the sub-County.

However, although in some cases newcomers tended to receive harsher scrutiny than others in the event of salient issues such as offences committed or notable achievements the day-to-day relations among people in general did not appear to be influenced much by ethnic status. As Mam-Kiror was increasingly becoming open to the outside world, due to its commercial potential, different people in the village acknowledged that other forms of identity, such as artisan miners versus non-miners, or peasant farmers versus teachers, were more important than ethnicity. Generally, as found elsewhere in Teso (Vincent 1971) relations among the Iteso of Mam-Kiror and others of different cultural backgrounds in the village appeared to be largely based on recognition of the inter-dependences based on common business and economic interests, transactions, and good neighbourliness. In 2009, just before my fieldwork commenced, Mam-Kiror trading centre had been parcelled out of the rest of the main Mam-Kiror village and gazetted by the District to become a separate village. However, by the time I completed the 12 months field work in August 2010, the trading centre had still not been officially commissioned as a separate village, and so it was still under the same leadership as Mam-Kiror village. No one appeared to know when it would become operational.

#### **4.2.4 General overview of the institutional landscape in Mam-Kiror**

Mam-Kiror village was filled by a broad spectrum of formal and informal social and political institutions and groups that different people identified with, whose presence not only perpetuated social distinctions but also created competing and conflicting interests. They operated at different levels and influenced each other and members of the society in multiple ways. Writing about the institutional landscape and change among the Iteso of Kumi, Jones (2009) suggests that social institutions reproduce themselves by borrowing from each other and from their own past, but he also argued that the extent of institutional change should be seen as a reflection of the capacity of individuals or groups of individuals to argue for certain outcomes. In Mam-Kiror village the most important institutions were

ranked by the residents both in terms of their effectiveness and their own participation in them.

At the district, sub-County and village levels, the polity or government was represented by a hierarchy of political actors and administrators. These included the centrally appointed district administrators who provided technical guidance in service delivery and performed the role of planning programmes, and supervising and disciplining other staff, and the District Local Government comprising a 5-tier (LCI-LCV) system. The Local Council V (LCV) is a body of elected members headed by a chairperson, who represent the interest of the local constituents in a legislative Chamber. The Local Council III (LCIII) Committee is another body of elected political members based at the sub-County, and the technical wing of the sub-County was under the sub-County Chief. The village was managed by the Local Council 1 (LCI) committee. This is an elected nine-member committee, comprising of at least one woman, which administered the village on behalf of government, and is the lowest leadership structure in the Ugandan 5 tier system (LCI-V) of decentralisation. In 1971, Vincent Joan, enumerated a relatively similar institutional hierarchy in Gondo society, suggesting that despite changes in terms used to describe specific the positions, these institutions had remained relatively stable in form and roles, confirming Ben Jones' (2009) argument that structures tend to be relatively resilient and practices persist over time. Theoretically, these structures directed all the government's programmes aimed at transforming the district. In Joan Vincent's (1971) argument, these structures form the main arena in which forces of the central government penetrated the social fabric, and perhaps encountered resistance from the local leadership.

The LCI committee is expected to that ensure there is law and order, judge village and family disputes, and link the village to the higher level councils and to development programmes. However, in practice, many of the members of LCI committee were relatively inactive. The day-to-day running of village affairs and decision-making tended to be concentrated in the hands of the three top members of the executive, namely the Chairman, the Defence Secretary and the General Secretary. They were the focal point for any mobilisation needed and they were the gate keepers and contact persons in the village. They also provided conflict resolution and controlled the use of the village stamp, the official seal used to certify documents, as well as any fees that accrued. Overall, there was a positive perception of the role of the LCI council, although sometimes they were accused of bias and favouring the rich members of the village. However, there were often mixed

perceptions of the effectiveness of the higher structures, including the police and development workers. They were perceived to be inefficient and very slow in delivering public services, if any, in the village, such as security, water, and health care.

Besides the village council, there was another centre of power and influence within the village: a group of self-made men who were economically well-off and prominent, or the 'Big Men', as they were commonly referred to in the village. Joan Vincent (1971) in her ethnographic study of the Gondo community in Serere in Northern Teso, used the concept 'Big Men' to describe a group of self-made and influential men; the elite. They did not rise to the top through the established political and administrative echelons but their rise in prestige hierarchy was a result of their entrepreneurial skills in making use of all resources and facilities at their disposal, in much the same way as the elders of Oledai village in Kumi, described by Jones (2009). Those men were active, had a strong political voice, were popular, and were often the focal point of their group sociability and had powers of patronage over others in the village. According to Vincent, the basic determinants of the elite rank were sex and social maturity: no woman, no young or single person could acquire the elite position. In addition, polygyny and ability to sponsor others and offer plenty of beer parties achieved one a big man status and prestige. This description of the 'Big Men' in Gondo to a large extent fitted what I observed about how some men attained the 'Big Man' status and their influence in Mam-Kiror village, although there were some Gondo qualities that were of limited importance in Mam-Kiror. For example, while wealth, patronage, and having an active political voice were important, polygyny had lost its importance for achieving the Big Man status in Mam-Kiror. Polygyny was a contested marital union and many forces, including economic hardships and the church teaching undermined the construction of a popular identity through multiple marriages. However, in Mam-Kiror, similar to the Gondo, involvement in religious activities and proficiency in day-to-day activities, though important for achieving an admired identity, they did not contribute to the 'Big Man' status since they often did not convert into political capital. Big Men were prominent power brokers, village patrons, economic entrepreneurs and the local economy was firmly in their hands, as they controlled trade and market systems by buying local agricultural products and the gold mined by the local artisans, and gave small loans to various people. Given their central role as gatekeepers, progressive business men, power and 'any deal brokers', these local entrepreneurs were at the higher end of the village hierarchy, and were often close associates with members of the LCI committee. Being associates or peers of the village political leaders, they also often performed the role of

their informal advisors, often making it difficult to separate the roles of these Big Men from those of the LCI leaders. This sometimes led to some people failing to acknowledge the authority and decisions of the LCI council, claiming they had been influenced by others.

Religious institutions and religion was an important feature of Mam-Kiror's social landscape. The Iteso people are self-confessed nominal Christians of one denomination or another (Karp 1978). Although I did not carry out a census, informal observations of people's church attendance and talking to people in the village suggested that the majority of the residents in Mam-Kiror were Catholics. Within Mam-Kiror village there was one Catholic Church, one Anglican Church and three Pentecostal Churches. There was also a mosque located within the trading centre, which had been constructed a year before I started fieldwork but the Muslims were the minority in the area. Karp (1978) suggests that Islam did not spread rapidly in Teso due to the Iteso's lack of contact with traders from the Coast. However, during the fieldwork, conversion to Islam was the new trend in Mam-Kiror, especially among fairly economically successful men and their families. While religiosity is a personal experience, people of Mam-Kiror often discussed the social aspects of religion, such as its role in bringing social cohesion and shaping social behaviour, and they used it to understand complicated circumstances such as suffering of the community and individuals. People in Mam-Kiror acknowledged that evolving religious identities make possible new ways of behaving. In the context of this research, these ideas are helpful in understanding the ways in which masculinity is shaped but also gets shaped by religion. For example, in the case of Islam in Mam-Kiror, because most who converted to Islam were relatively economically powerful and socially influential, Islam was appealing and symbolised modernity. Its believers also saw themselves as standing for higher social morals; in particular they spoke about their fidelity in marriage. There was also some understanding among this group that being Muslim, in particular being circumcised, which was not a cultural practice among the Iteso, was associated with a lesser risk of HIV infection. Many Muslim men had heard that Muslims had a lower prevalence of HIV compared to other groups (based on the national HIV survey 2004/05), and that the government was recommending circumcision for all men as a way to reduce HIV infection.

The Pentecostals or Born Again Christians ('Savedees'), or *Balokole* as they are locally referred to, attracted a fairly large number of followers and represented a modern Christian faith, which emphasised the strength of a person's relationship with God compared to the

traditional Catholic and Anglican mission churches. The central tenet in Pentecostal theology is ‘becoming saved’ by accepting Jesus Christ as one’s personal saviour, and rejecting all sin, including smoking, alcohol consumption, sexual immorality and others. However, Pentecostals were held with mixed regard, with the male youth and middle-aged men especially highly critical of the reputation of some Born Again Christians, including their leaders. A common assertion was that many of those who converted to Pentecostalism had a previous record of scandals or were simply searching for easier ways to enrich themselves through the free collections and gifts. In general, religious beliefs, and particularly going to religious services, appeared peripheral to some people in the village and integral to others. While the Muslim men went to the mosque more frequently than their wives, Christian women and children tended to dominate church compared to the men. For the children, this may have been due to their fathers demanding that they go to church, as I sometimes observed in some homes.

There were other informal village, clan or peer group level institutions in Mam-Kiror, which defined the dominant organisational principles in Mam-Kiror. There were two dominant clans in Mam-Kiror. Clans were usually concerned with land ownership and perpetration of clan values and the morality of sharing and helping clan’s men in times of need (see 4.3.1. and 4.3.2 for relations and obligations between kin). Labour groups also existed among the cultivators but more so among the artisanal gold miners. While farming labour groups were often made up of neighbours, who were usually women, who come together seasonally to work on each other’s field, mining groups were often male peers from different parts of the village or its neighbourhood, who joined labour to mine together and share the proceeds equally on the understanding that each made equal labour contribution. Furthermore, mining groups also had organised burial societies among themselves, usually contributing to burial costs if they lost a colleagues or if a colleague lost a relative. Within the village, there were also various forms of credit and savings groups formed by different people. Compared to the Savings and Credit Co-operative Savings (SACCOS) groups which were structured with proper regulations and leadership structure, and was mixed in terms of membership, the two *abukonokin* (rotating fund) groups usually comprised women, were more informal, flexible and tended to raise smaller amounts of money. However, both groups shared some common problems: it was common for some of their members to fail to honour their obligation to contribute or to return the loans they had been advanced, and also some members lacked confidence, trust and respect of the institutional structure.

The gold mining company found in the village was a big private investment whose presence was, however, viewed largely as a threat to people's livelihood rather than enhancing their welfare. The mining company is a subsidiary of a bigger one registered in Ontario, Canada, and also in South Africa, and holds a lease to mine gold in the Busitema area. Talking to the residents, especially men, quickly gave the impression that this institution was imposed on the people. The poor relationship between it and the people was a product of the local artisan miner's efforts to undermine the company's control over the mineral rich land it had rented from government. This relationship is described in detail in Chapter 6.

There were few NGOs involved in delivery of social services in Mam-Kiror at the time of the study. The AIDS Support Organisation (TASO) and World Vision Uganda were the only two prominent ones that the people could name at the time. TASO had offices in Tororo, about 24kms away, not in Busia, but it was present in the village through its medical service outreach to Busia District, normally stationed in the town, from where Mam-Kiror residents would access them. TASO supported some of its clients in the village with income generation projects.

While these institutions provided a system of organising social life, by defining acceptable and appropriate roles, norms, regulations by which people interpreted their positions and social relations, their structure and functions at the time of the research primarily reflected a landscape of change and tension in how they influence individuals and each other. Although these village level institutions were central in organising social life, they were frequently undermined by some people, who sometimes failed to acknowledge the legitimacy of their structures and leaders.

## **4.3 Family structure, relations and obligations**

### **4.3.1 Structure and relations in families**

The Uganda national population census 2002 (Uganda Bureau of Statistics, 2002) recorded the average size of family or *ere*<sup>8</sup> in Mam-Kiror parish to be 4.7 people. This was slightly

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<sup>8</sup> The word *ere* can refer either the family or compounds/homesteads. In another context, it might be used to refer to a man's sexual organs, for the very fact that it is what enables him to get a family.

less than the 4.9 Busia district average but equal to the national average. The national census did not capture village level data, but from my observations, an average *ere* in Mam-Kiror village appeared to have around six people, and the village seemed to be more densely settled compared to its neighbours. Families were quite similar in their structure, often with extended family members living together and a high prevalence of polygamy. A few *ireria* (homesteads) in Mam-Kiror village had an iron roofed house, indicating the owners' higher economic status, but most *ireria* consisted of round huts made of mud/wattle walls and thatched with grass. As it is the responsibility of the men to construct *itogoi* (houses), all men, including teenage boys, regardless of marital status, are expected to construct their own *etogo* or *itogoi*. Those without an *etogo* or who have not constructed an *etogo* for their dependents are often mocked as having failed to demonstrate manliness.

Marriage was considered the foundation for establishing a family. The significance of marriage for masculinity is discussed in detail in Chapter 5. Although I did not survey the distribution of different kinds of marriages, many of the people I got to know were married customarily through payment of bridewealth, or were co-habiting. Church weddings were rare and far more costly; throughout the one year I lived in the village, there was only one. Civil marriage was unheard of, and it is unlikely that an average man or woman in Mam-Kiror village knew what it entailed. There were different patterns of payment of bridewealth and values attached to it. Marrying the first wife may involve some degree of family involvement, particularly the groom's father negotiating bridewealth with the bride's parents, and contributing it, but bridewealth for any subsequent wife is often raised by the groom himself, sometimes with the help of the bride herself, after she has started to live with him. The "well-to-do men" paid more bridewealth, brought many other additional gifts, and often helped their in-laws to prepare an elaborate marriage ceremony. But poorer men may offer nothing for marriage, and often their marriage would be resented by the woman's parents, which undermined their status and significantly threatened the sense of masculinity gained through marriage. Due to the limited availability of cows, the traditional gifts paid as bride-price, and generalised poverty, men talked about marrying "free wives" these days, and this particularly applied to second wives for whom, often, very little bridewealth was paid. However, these second wives were not less socially valued in society, although they were vulnerable to being undermined by first wives.

Inheritance of widows existed, but many people said it had largely changed in form. I was told that due to fear of HIV and other burdens associated with an extra family, there was an

implicit understanding that brothers of dead men are only installed as ceremonial caretakers who represented or supported the widow and her children when important decisions had to be made, rather than as husbands culturally sanctioned to have sexual/reproductive rights over the widow. Many people believed that the widow herself, if still sexually active, was expected to retain the right to decide who to have sexual relations with. As such, it was reported that quite often, especially for widows suspected to be infected with HIV, men from the neighbourhood or who were not aware of their status, were the most likely to develop sexual relations with them. However, men who inherited their sisters-in-law appeared to have significant interest in the property and resources of their departed brothers, with the general cultural consensus being that it was in the best interest of the orphans and the wider family for a surviving brother to inherit his brother's property because widows purportedly tend to focus on only their children and family of origin.

### **4.3.2 Obligations within families and among kin**

The Iteso are a patrilineal and patrilocal group of people. However, both the blood relatives and the affines were extremely important in people's lives. People not only talked about relations with cousins, uncles and grandparents from their father's side but also emphasised the role of relatives from the mother's side in their lives. In principle, being part of, and identifying with, clan relatives was considered obligatory because in the words of most people, "they are the ones who will bury you." Because of this, solidarity with clansmen was portrayed as imperative. Yet there was frequent conflict between families and kinsmen, especially with regard to control of land and joint business decisions. Some family members even formed alliances against one another. In contrast to the husband's side of the family, men appeared to enjoy more respect and harmony with the in-laws. This might be because there was little to compete for between them and/or because they usually lived apart from each other, meaning conflict between them was minimal. However, there was often a discrepancy between the degree to which a wife expected her husband to help his in-laws and the extent to which the husband's own people expected him to help them. Predictably, wives expected more from their husbands and yet his side of the family kin often resented this inclination, particularly if they believed that they were getting less assistance from their son.

In discussing kinship obligations to help and to meet responsibilities, two categories – “good relative” and “bad relative” – often emerged from various people, and were used to portray the extent to which kin fulfilled their moral expectations to fellow kinsmen. People kept track of their relatives, whether close or distant (both by descent and by locality), and remembered them as good or bad relatives depending on how much those relatives “ate with them” or helped, especially in times of illness or lack of school fees. Within immediate families, siblings and parents tended to favour those relatives who earned and regularly gave them money, and referred to them as good brother/sister or good child. Similarly, the extended relatives described kin who helped them regularly as good and those who did not as bad, although in comparison to the immediate family members, the distant kin were less rigid in applying this classification. The distant relatives reported that, generally, they learnt to set lower expectations for help from their kin, and in extreme cases, extended relatives were often portrayed as less keen to assist but instead as always begrudging or aspiring to sabotage others’ progress. Therefore, family units in this village did not have fixed interpersonal relations. Instead, relations within families were vulnerable to being severed and repaired from time to time, and the values and the extent to which people were committed to wider kinship and non-kin ties varied from family to family.

### **4.3 Social status divisions between families**

In Mam-Kiror village, like in most parts of rural Uganda, the most important indicators of wealth/income include amount of land, type of roof and ownership of a commercial building or some form of business. Having educated children/siblings working in the town was also seen to signify wealth, especially, if they regularly helped. Despite having structural similarities, families in Mam-Kiror varied in terms of social status within the village and in terms of their histories/legacies. This in turn influenced the relationships between families and their access to different opportunities. Regardless of whether they belonged to the same clan, there were frequent inter-family grievances over disparities in material wealth. Although often expressed in subtle ways in order to avoid direct confrontations with others, pre-existing status differences among families in Mam-Kiror village sometimes manifested in quarrels, witchcraft and enmity, as found among other groups Iteso in Katakwi (de Berry 2004). Quarrels, especially between men, were often characterised by references to the existing material inequality between them, but also other perceived deficiencies in their masculinity, with the tendency for the wealthier one’s to use

their privileged status to undermine and insult the poorer ones. However, in a manner similar to the Iteso of Katakwi (de Berry 2004), the people of Mam-Kiror tended to manage and control the tensions between families by avoiding their enemies. This was, nevertheless harder for the families that lived in the trading centre compared to those in other parts of the village, since their homes were often located very close to each other.

In the village there were families and/or clans with a legacy or history that they sought either to preserve or to forget. The histories were seen in terms of factors like generational wealth, family and homestead size, moral reputations, history of educating children or external connections such as dealings with government programmes, or involvement with religious institutions. The relatively affluent and/or prestigious families/individuals were admired but they were also the subject of close attention and gossip. Any developments in such families received wide publicity and analysis in the village. For example, it could be a daughter becoming pregnant outside of marriage, their son's excessive alcohol consumption, running down the assets of the family, acquiring new assets and in some cases, it may be an affliction like HIV in the family. If the experiences were negative, wealthier families/members were gossiped about and stigmatised widely for "engaging in shaming/less befitting stuff" compared to when these happened to poorer families. Occupying a higher status thus appeared more constraining for the members of those families, and there was some "exceptionalism" about them in terms of acceptable conduct in comparison to people from poorer families whose deviant conduct was easily explained away as "expected" or "understandable", or in other cases would simply go unnoticed.

Within the village, some rich men were considered to be dishonourable because they sometimes exploited poorer families/individuals, for example, by lending money at high interest rates or by grabbing their land or cheaply buying land from them when they were in desperate need for money, for instance in the event of sickness or bereavement. Yet, such men were also admired for their economic position, especially by the younger men, who usually got employment from their patron and for whom controlling and spending money constituted a significant source of masculine power and identity, as will be discussed in Chapter 5.

#### **4.4 Relations between neighbours**

Neighbourhood (*epa' dukone*) and neighbours (*luk' aduket* or *ijiranin*) were an integral part of inter-family relations where status and virtue were significant for both men and women.

Although neighbouring homesteads were often of one's kin, there were many families, especially in the trading centre, whose neighbours were not relatives. These neighbours shared many social norms and role modelled each other both directly and indirectly. Members of the neighbourhood interacted regularly and frequently reciprocated different kinds of assistance and advice, and borrowed from each other things like hand hoes, bicycles, food, and money.

Unlike men who were more outgoing and mobile within the village and had many friends throughout the village and beyond, women's friendships and interactions tended to be confined to the immediate neighbourhood, and revolved around concerns about their roles as mothers/wives and issues of home making, including farming activities. Women's concept of neighbourly relations and friendship was oriented to domestic work, particularly doing tasks together (e.g., getting wood, water, doing washing), lending resources for domestic work, helping in activities. They were also oriented towards caring and entertaining others in the domestic arena, while men's relations with neighbours, especially with fellow men, were predominantly work or leisure focused.

The pattern and extent to which neighbours shared was largely dependent on their economic status, with neighbours of relatively similar economic status tending to enjoy better and amicable relations than if their economic statuses varied greatly. Feeling economically superior or impoverished compared to one's neighbours, often encouraged rivalry, jealousy, oppression or exploitation, which sometimes severed relations between neighbours. Although neighbourhood relations were valued, there were neighbours who were regularly in dispute. Often disagreements between male neighbours were centred around wrangles over land or boundaries, or on straying livestock that destroyed crops, or accusations of witchcraft and rivalry over women. In contrast, disputes between female neighbours often centred around gossip, jealousy, and breach of trust, or on fights between their respective children, and also on witchcraft, though to a limited extent compared to men.

## **4.5 Gender relations**

### **4.5.1 Relations between men and women**

Divisions on the basis of gender into *ikiliok* (men) and *angor or aberu* (women) were strongly emphasised. All *Ikiliok* and all *aberu* were believed to share particular abilities

and characteristics which were thought to be of biological origin. It is on the basis of these assumed abilities and characteristics that relationships and patterns of appropriate identities and behaviour were practised. As a patriarchal society, men were heads of households with authority over women and other members of the family. How masculinity was expressed, reinforced or lost, in the hierarchy of gender relations both in society and family are discussed in detail in Chapter 5. HIV infection and/or its treatment had significant impacts on the power relations between men and women. This will be discussed in Chapter 9.

#### **4.5.2 Relations between men: the significance of *aturin* (generations)**

The Iteso word *aturi* (pl. *aturin*) stands for a group based on relative age. This classification is vague, however, since the age span of the kinds of groups covered by the word *aturi* could be as little as one year or as much as fifty years (Karp 1978). But as Karp makes it clear, although this word can be used in a number of related senses, there is a common element of meaning in all contexts in which it is used. The most inclusive use of the word *aturi* is one which translates to ‘generation’. Karp suggests that during the pre-colonial period, there existed only two *aturin* in the generation sense of the word: *aturi nak’itelepai* (generation of boys) and *aturi na’kimojong* (generation of elders). While the former referred to the active men of society and were people who fought in wars, went on raids, farmed, herded cattle and had children, the latter group remained at home and, led prayers and participated primarily in the public rituals. However, another use of the word *aturi* is a group of men who were born about the same time, and so when an Itesot describes their own *aturi*, in the sense of a group of coevals born around the same time, it is always with great a deal of nostalgia: often, they imply the common experiences, contests or most frequently the friendship that developed from childhood and that they try to maintain (Karp 1978).

In Mam-Kiror there were several recognisable *aturin* in which males were grouped and upon which their status and position was evaluated, but there was no or only mild reference, if any, to the existence of corresponding *aturin* among women, indicating the inappropriateness of this form of categorisation among women. Earlier ethnographies among the Iteso, have argued that word *aturi* never applied to women, most probably because of the lack of status ascribed to women in the leadership hierarchy (Karp 1978). Thus, while relations based on *aturin* were valued by both men and women in Mam-Kiror

village, they were more strongly observed among men than among women in their day-to-day relations. These *aturin* corresponded with typical developmental stages and included: *ikoku nitelepat* (baby boy), *aturi na'kidwe* (child), *isap luk'katumunak* (adolescent/teenage boys [13-19 years]), *isapa/itelepai or aturi na'kisap* (male youth [15-24 years]), *ikiliok* (men, husbands) and *imojong/mzee* (old men) or *luk'apolok* (big people, both in terms of age and social status). There was overlap, however, between *aturi na'kisap* and *isap luk'atumunak*.

In general, *aturin* represented a hierarchical order, defining seniority and power, and were more important in social occasions, such as funerals or clan meetings, but it also influenced how day-to-day relations were to be organised. It was customary for the older *aturin* to make the decisions and the younger *aturin* to implement them. There were certain preconceptions of the behaviour expected of people of different *aturin*, but the younger *aturin* were expected to always show respect to the older ones. In reality there were great variations in the quality of relationships between the different male *aturin*. For example, the relationships between *aturi nak'isap* (adolescent boys/male youth) on the one hand and *ikiliok* (husbands, men) on the other, could be characterised as often that of resentment and competition, while that between *luk'apolok* (older men) and *aturi na'kisap* (male youth) was seen as relations of superior versus inferior social status. On the other hand, the relationship between *ikiliok* (husbands, men) and *imojong* (old men) was seen as that of friendship and equality, while the relations between *luk'apolok/ikiliok* and *aturi na'kidwe* was that of supervisor versus supervised.

As such, there was always a conscious awareness of the importance of doing something that resonated with one's *aturi*. 'Mature men', for example, were not expected to behave like *itelepai* (boys/youth), particularly with regard to sexual behaviour. The older *aturin* tended to dominate the younger *aturin*, although the younger energetic *aturin* often sought to challenge this social order. Yet there were some men and boys who did not behave as defined by their *aturin*, earning respect or disgrace depending on the achievement, failure or behaviour in question. For instance, some young men had many accomplishments through which they not only gained influence but which put them socially above some of their older counter-parts. This included earning a regular income, or demonstrating a distinguished work ethic. On the other hand, there were older men whose behaviour disgraced not only themselves but also members of their own *aturi*, such as having sexual relations with young girls.

## 4.6 Economic structure of Mam-Kiror Village

### 4.6.1 General economic structure and livelihoods

There were no large economic establishments in Mam-Kiror village apart from the gold mining company that operated in a rather closed<sup>9</sup> manner to the public. However, with several small shops, roadside stalls and small eateries, four drug shops/clinics and one lodging place, and a relatively regular access to cash among people due to gold mining, Mam-Kiror had the potential to develop into a dynamic place in terms of trade and entertainment related services. Many residents told me that just under a decade ago both the village and the trading centre were remote and less attractive places but were “now developed.” They measured the development of their area by referring predominantly to the private commercial establishments in the trading centre such as buildings, shops, and modern bars that were selling bottled beers and soft drinks. In addition, the existence of modern entertainment and games like pool, video halls and digital TV giving access to viewing events in the external world, especially English football games, had made Mam-Kiror more attractive than other neighbouring villages.

During the time I lived in the village, there was only one old public minibus that plied the Busia-Tororo route via Mam-Kiror village, either once a day or every two days. This meant that people of Mam-Kiror lacked cheap and reliable means of transport. One man in the village had a private car and another two had commercial trucks but many people, especially men, owned bicycles and there was an increasing number of people who owned motorcycles, which alongside bicycles, served as the main form of taxi.

The occupations in the village were quite diverse and included petty trading, selling agricultural labour, subsistence agriculture and artisanal gold mining (discussed in detail in Chapter 6). While the average per capita income in Busia district, according to official

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<sup>9</sup> This Mining Company is a multi-national firm. It was licensed by Government around 1994 and given lease hold for some of the village land. Because of the sensitivity of collecting information relating to its operations, I was unable to establish how many people it employed. However, the residents told me that the company employed mainly foreigners, especially from Kenya and almost no local people. The relationship between the Mining Company and the local people is often hostile due to conflicts over control of mining land. For example to ensure that locals stopped illegal artisan mining on its land and other disputed mine sites, the Company has hired private armed guards who often clash with defiant residents (see also *The New Vision*, Tuesday, 21 December 2010).

statistics, was generally low at US\$ 154, and over 60% (172, 059 people in 28, 677 households) in the district were living in absolute poverty (Busia District Community Based Services Department and Busia District Planning Unit 2007), the majority of the people of Mam-Kiror believed that their village was better off economically compared to most others. They attributed this to the relatively regular incomes that accrued from artisanal gold mining and trade, and believed that this was attracting more people to their village. In spite of these relatively promising circumstances, the economic status of Mam-Kiror ought to be understood from the wider context of national statistics that record that eastern Uganda is one of the more impoverished regions of the country. In fact, there were many poor families or individuals who persistently lacked basic necessities in Mam-Kiror. Although people worried considerably about how to save and improve their economic status, the most pressing everyday economic concerns in the village were about “survival”. Both men and women were thus confronted by the necessity of labouring hard on a daily basis for their livelihoods. Money problems and poverty remained the most generalised everyday concerns throughout my fieldwork, to the extent that these phrases had become a common part of everyday speech and dialogue and even greeting. Income inequality and exploitation also appeared to be emerging features of Mam-Kiror village, with the labourers usually underpaid.

#### **4.6.2 Agriculture**

Even though the official district data categorises the people of Mam-Kiror Parish as predominantly subsistence farmers like other rural dwellers of Busia district (Busia District Planning Unit 2006), the people of Mam-Kiror, in particular the men, did not consider themselves to be heavily reliant on agriculture for their livelihoods and economic progress, unlike women, who depended on farming activities. For the majority of men, artisanal mining was the most important source of income. Nonetheless, many households carried out cultivation and reared some livestock for both cash and subsistence. Although the pre-colonial Iteso agriculture was based on cultivation of eleusin (millet), which was eaten mixed with cassava and large portions of this crop go into making *ajon* beer (a beer brewed locally from millet, sorghum, or cassava), which graced almost all social occasions (Karp 1978), in Mam-Kiror, maize and sweet potatoes had replaced millet and cassava as the main staple foods grown by households. This is because besides being less labour intensive, they had a higher demand and commercial value when sold in the nearby Busia town and across the border in Kenya. Other crops commonly grown in the area, largely for

subsistence and by mostly women and children, included ground nuts and beans. Goats were the most commonly kept domestic animals while very few families, with children mostly responsible, reared cattle because grazing land was limited and cattle disease have been rampant in the whole of eastern Uganda. In many parts of Iteso, much of the labour input into farming used to be communal, done through the institution of neighbourhood beer party (Karp 1978). While this practice still persists in parts of Northern Teso (Jones, 2009), in contemporary Mam-Kiror, communal digging of fields in exchange for beer was not common. When neighbours teamed-up to cultivate on each other's field, it was usually done on a rotational basis, and although one might provide food and drinks, it would be done to show courteousness rather than to fulfil an obligation. In Mam-Kiror, households with side businesses were considered to have higher economic status because of the greater economic security provided; hence many aspired to establish a business (see Chapter 5 for detailed discussion of the importance of business to masculinity).

### **4.6.3 Land ownership and control**

As elsewhere in Uganda, land ownership and inheritance was of significant importance in Mam-Kiror village, particularly for men. Men were defined or defined themselves in terms of how much land they possessed. Some had purchased private land but most owned customarily inherited land on which they established homesteads. With the exception of the land that the government had leased to the private mining company, all village land was held under the customary system, mostly under families. It was not surveyed and had no certificates of titles. This land was measured in the form of acres, but amounts varied greatly between individual families, with some having up to 10 acres, and others having very small pieces or no land at all. In the trading centre, dictated by the emerging need for commercial premises, land was being parcelled and sold in small plots or strips of about 50ft x100 ft, just enough to accommodate a sizeable commercial building. There was an increased desire especially among men to buy such land for investment.

However, among the village residents there was a lack of clarity about the government's position on land with mineral resources, land on which a large number of families were residing, and had been for generations. The uncertainty and anxiety over land ownership was heightened by the fact that the private mining company claimed lease ownership of about 150 acres within the village, and had barred some of the families from utilising the land, even though such families had lived on it for generations. The mining company

maintained that according to its agreement with government, it was mandated to offer compensation to such families to vacate the land. The impact of this on families was diverse. Some resented any offers to leave the land while others had yielded and sold their land to the company or other individuals, often times at 'giveaway' prices (Womakuyu 2010).

Passing on land to a son and inheriting land from a father was widely perceived as a vital social obligation of the parties involved. It was expected that all sons inherit an equal amount of land. Although it was understood that the father could choose not to give out his land or selectively allocate it to the sons, such a move often led to wrangles with the disgruntled sons. Sons whose parents had some land, therefore, anticipated being given a portion. Many referred to it as "my share", making it appear to be a father's obligation and a son's right rather than a privilege, a situation which often led to disputes between fathers and sons or siblings if they felt their right to their "deserved" share of land was being infringed. Even fairly well-off sons still expected to get their share of land from their father and rejecting land bequeathed by a father, unless there was a convincing explanation, raised many questions about the son's commitment to being part of the family. However, because land was increasingly getting smaller with each subsequent division, very few fathers were able to pass on any reasonable size of land to their sons. This was of concern to many fathers as land was seen as the most sustainable gift to sons. Compared to land, the transfer of other assets, especially bridewealth to sons, however, involved more choices. The degree of selectivity here seemed to depend on the closeness between a father and his children or between siblings. For example, Anthony, the oldest and married son in their home complained of his father giving preferential treatment to his younger brother when sharing cows that were received from the marriage of their sister. He argued that although he has already paid some bridewealth for his wife through his own effort, he deserved at least one of the three cows that came from his sister's marriage.

Once land has been passed on to a son, decisions on how to use it were largely left to the individual man. However, decisions to sell such land were ideally controlled by the wider family. The understanding in many families was that ancestral land should not be sold, particularly to people outside the family. Nevertheless, it was not uncommon for men to sell their ancestral land, sometimes leading to family tensions. In one of the homes, I witnessed a stormy discussion by members of an extended family when a grandson demanded, on behalf of his chronically ill father, for his deceased grandfathers' (paternal

grandfather) land to be shared amongst his father and uncles so that he can sell some of his fathers' share to support his education. During the discussion, the ill man whose right to sell was being discussed, was rarely consulted and in the end, the decision went against him and his son. This not only suggests that rights to sell inherited land are sometimes conditional but also showed that certain circumstances like long term illness can sometimes render men peripheral and less significant in matters pertaining to control of family land. Most times even a decision to sell privately purchased land is contested by a man's relatives, because to them land is a valuable asset that every man should have. In general, the more cohesive and united the extended family was, the more restrictive they tended to be regarding the members' right to sell any of their land.

Renting land for cultivation and/or artisanal mining was a popular practice in the village. Being the dominant decision makers on how their land was used, men rarely consulted other members of their families when they sought to rent out their land, especially if it was for mining purposes. Although women tended to have a greater say on renting out the cultivable land compared to the land for mining in which men often had greater interest, men tended to keep most of the rent, even if he is renting land that his wife would otherwise use for cultivating crops and from which she could potentially gain some income. Nevertheless, it was generally expected that men would be reasonable enough not to let out all their land despite having rights over land letting. Those men who rented out a large proportion of their land and left the family with little for cultivation would be criticised by the extended family or neighbours, and accused of acting selfishly rather than in the family's interest. The reason was that this was thought to make the family vulnerable to food shortage. The richer men in the village owned more land and although they sometimes offered it to be cultivated by poorer households free of charge, it was often in return for a share of the harvest rather than cash. Such men and their families were renowned as patrons in the village. However it created and sustained a social distinction of inequality in which the relatively poor people were being exploited, yet disguised as patronage. Failure to give a share of the harvest to the landlord would automatically lead to being stripped of the right to use the land.

However, while inherited land was vital, and failure to by the father to fairly share it among son's bred family conflicts, the onus to expand one's wealth, often measured in terms of land, and sustain a family lay on the individual man. Every man was therefore expected to buy more land to augment what he received from the father. This experience

has also been noted among the neighbouring Gisu men. In societies such as this, dependence on inheritance perpetuates land and status inequalities because there was no mechanism for redistribution of rights to the poorer members of the community or to compensate for the landless (Heald 1988).

## 4.7 Education

Universal free primary education (UPE) accessed through a school located in the village or from the neighbouring villages was the most significant and positive way in which government's role and presence was talked about in Mam-Kiror village. UPE, started by Government in 1997, was highly valued and many parents endeavoured to enrol their children into primary education. By 2008, there were about 1,560 pupils enrolled in Mam-Kiror Primary School, with 710 being males. There was one private secondary school in Mam-Kiror with a total enrolment of 700, 450 of them being males. Yet the school dropout rate was high and was a serious concern of the village as children, especially boys, often dropped out to engage in artisanal gold mining (Egessa 2009). Although the literacy rate in Busia District was 63% (45.1% female, 73.3% male) (Busia District Community Based Services Department and Busia District Planning Unit 2007), many people in Mam-Kiror village did not progress beyond primary school. I was struck by the number of people who told me that they had dropped out at primary level due to lack of money, in spite of the fact that some went to school during the era of free primary education, and that they themselves were often earning money, which if saved, might have enabled continuation of schooling. The problematic classes seemed to be between primary four and seven for both boys and girls. Many said that early money making opportunities through involvement in gold mining activities led many boys to lose interest in schooling and to drop out, while girls dropped out mostly because of early marriage or to go and work as domestic servants in the towns.

Historical factors also appeared to explain the pattern of school completion. My count of the seven most educated children in the village (either recently completed or currently pursuing a university degree/diploma), revealed that five were from families where some other member (whether nuclear or immediate extended) had earlier attained fairly good education and/or worked and lived in towns. This suggests that the value of education is passed down through the generations, with people with a history of family achievement in this area likely to impress upon their children to complete school. This is illustrated by

Gilbert, (age 25), who came from a “well-to-do” extended family of educated people, with three of them holding university degrees and another cousin finalising his studies. In 2009, Gilbert was in his second year in one of the Universities in Kampala but decided to take a self-initiated break from his course to concentrate on gold mining and making money from the richly productive mine site that had been discovered on his uncle’s land. His uncle who was sponsoring his fees was angered and was looking to force him back to study. As I discussed his studies with him, Gilbert said, “As you see me here, I will one day go back to finish my course. I do not want to be the only one to break the family history. In our home people have degrees, so I have to study [chuckles].”

Teachers constituted the largest number of professionals and wage earning people in the village. In total, there were about 28 teachers working in both the primary and secondary school, and five of them lived in Mam-Kiror. Their services in school were valued. In society, they were generally considered to know more than other people by virtue of their training and influence. It was therefore common to find that teachers were often consulted for advice, provided career guidance or were often asked to assist in drafting letters and agreements by various people in the village. However, teachers’ low incomes and the reprehensible behaviour of some, such as drunkenness, greatly undermined the status accorded to teachers, since they were not expected to have such vices.

## **4.8 Leisure, lifestyle, social events and religion**

The people of Mam-Kiror experienced and explained their lifestyles in terms of the economic factors and general progress of the village. Only a few explained their lifestyles in terms of their health condition or other factors. Social life in the village varied greatly. While some people lived subdued lifestyles because of insufficient money or religious values, others, in particular the men who earned income, had a vibrant social life and lifestyle that did not reflect living in a poor village. This category of people often talked about and anticipated *akinyam ejaret* (eating/enjoying life).

Modern lifestyles were considered prestigious, although the older men still relied on the more traditional forms of status, such as owning a building or land. Many people, particularly the male youth, wore the latest fashion clothes and shoes, sung the latest songs coming from the city, and possessed cell phones. A considerable number of men, mostly in their thirties and below, talked about their regular dancing and drinking sprees in Busia

town centre whenever they earned substantial amounts of money through gold mining. During these excursions they would outspend the town folks and monopolise the company of the women. Some said that men from Mam-Kiror village were renowned and reputed in many circles in the town as big spenders. Alongside heavy drinking by groups that regularly earned from gold sales, was a widespread practice of seeking women for sex. This theme is discussed in detail in Chapter 5, but it is also a form of leisure and a component of perceptions about social status and masculinity. The village chairman revealed:

It [lifestyle here] is about enjoying life and wanting to prove who can bring more women and who has capacity to win women. These days it is about being able to bring and have sex with women from outside Mam-Kiror, those exotic women of high standard. Men go all the way to Busia, Malaba, Mbale town and Kampala city to sleep with women. In fact they do not only sleep with them but also bring them along to be seen with. When one man brings a woman from some place, another man plans the same, works so hard, gets his money and also brings one from another place (Chairman, December 29<sup>th</sup>, 2009).

During my stay in the village, a businessman constructed a dancing hall at the trading centre and equipped it with the biggest music system ever used in the village. This caused a lot of excitement, especially among men, and effectively contributed to a more vibrant social life in the form of dance, drink and sex-oriented entertainment in the village. Entry fee to the dance was about US\$ 0.5 and, often, the patrons were the young unmarried men. Although some older men often hung around the dancing hall and targeted the women for company, in general, older and married men rarely joined the dance. There was a perception by many, including those men themselves that it was indecent and inappropriate for them to dance with the younger folk in a local club. Doing so would mean showing a bad example to the young ones, some of whom were relatives. Another reason was that as there would most likely be relatives in the dancehall, information about the married men's conduct during the night would be relayed back to their wives and other relatives, which would undermine their reputation. It was due to these fears that some men often preferred to go to dance and spend leisure time in Busia town or in other towns where they would be free to enjoy themselves without being watched by people who knew them.

In contrast to the men, women's attendance in these discos was generally harshly judged. It was not condoned and was restricted by their families, and those who attended were seen

as lacking morals. On the other hand, female companions were required during the dances and so girls/women from the town and other villages were invited and sometimes facilitated with transport to attend. From what I was told, many of the girls who came either worked as bar waitresses or sex workers in the town. Though infrequent, there were physical fights among male cliques during the dances. This was usually attributed to drunkenness and rivalry over girls, but in most cases, these fights were an opportunity to settle previous grudges and to assert supremacy over others.

A new culture of lodging in the trading centre had been introduced when a five room guest house was constructed in 2008 by one of the local businessmen. Although it accommodated the occasional visitors to the village, most of its customers were the local men, who often used it for a few hours having sex with partners other than their wives. While this was a familiar kind of behaviour to those who are exposed to urban life, the practice of renting a room to have sex with unofficial partners was new, strange, and unacceptable to many in this rural area. In particular, elders and women questioned the necessity of such a service in their area, arguing that it facilitated people to commit infidelity. However, none of the people who held this view succeeded in getting this lodge closed as the owner was a powerful patron in the village and friends with the local leadership.

The economic potential and social life of Mam-Kiror village had also been noticed by the other providers of leisure services from outside of the village. Beer and soft drink promoters, mobile phone providers, and music artists scheduled to be performing in Busia town, regularly went to promote their services in Mam-Kiror village. Religious institutions were no exception in noticing the potential of Mam-Kiror, with Christian films sometimes being shown by the local pastors in the trading centre. However these events were irregular compared to entertainment related activities. Government services such as outreach HIV testing were provided once during the period of my stay in the village. Health officials feared an increase in HIV infection in the area due to the commercialisation of the village and the possibility of interaction with some of the HIV high risk populations in border towns.

The *ajon* beer drinking groups were an especially distinct category in Mam-Kiror village. They were mostly older and poorer men who were often unable to afford the expensive factory manufactured beers, for which for example just one bottle (500ml) would cost

more than the total amount one needed for a day's *ajon* drink. *Ajon* is typically drunk by sharing. A pot is filled with the drink and surrounded by people who then use tubes to suck and drinking can go on for hours. There were four *ajon* bars within the trading centre with regular patrons, although non-regulars are also welcome. Men were the predominant drinkers in these bars because it was not within the social norms for women to drink daily, especially in bars. I was told by many members of different groups that a common tacit goal for drinking together was to provide a forum for them to foster a spirit of togetherness and sharing of ideas. Two of the groups also had another goal: to contribute a small fee of 500 Ugandan shillings (US\$ 0.25) on a weekly basis to buy a bull to be shared among members at Christmas. Buying plenty of meat for Christmas is one of the most important obligations for men, yet it requires a lump sum which most men would not have. So by saving a small fee throughout the year, they are assured of several kilos of meat for Christmas, enabling them to fulfil this obligation as household heads.

Funerals were perhaps the most significant social event which brought together nearly the entire village to express solidarity with the bereaved. Funerals for adults typically involve three days of mourning before burial takes place. Attendance on the burial day is more significant, and for adults of both sexes, being seen at the funeral on the burial day is good for one's name and respectability as described, elsewhere by Jones (2007). There was a village condolence book through which financial contributions were raised to help the bereaved families. The normal contribution was 1,000 shillings (US\$0.5) but contributing was not mandatory. The condolence book was the initiative of the artisanal miners, who frequently lost colleagues or relatives due to mine accidents, and was most widely used if the dead person was a miner.

With the exception of funerals, there were limited rituals or meetings in the village that regularly brought together or integrated the whole village. The closest to this, which was low key and usually drew largely the young, was the local primary school's annual preparation for the District sports competitions.

## **4.9 Health system in Mam-Kiror**

Busia district has very poor health facilities and indicators. HIV prevalence is estimated at 10%, above the national rate of 7.3%. TB is a major problem, sanitation is poor, and contraceptive use is low at 7.6% (Busia District Planning Unit 2006) compared to the

national rate of 24% (Uganda Bureau of Statistics and Macro International Inc, 2007). Only 37% of the population in the district are within 2km of a government health facility, and the decentralised<sup>10</sup> health system, like in most parts of the country, continues to suffer shortages of staff and medical supplies and under-budgeting. In spite of these constraints, the District prioritised the delivery of various health services including HIV counselling, testing and treatment through seven HC III health centres found at every sub-County level, through its only health centre IV found at the town centre, and through the newly designated District Hospital at Masafu.

There was no public health facility in Mam-Kiror village or parish apart from the four small private drug shops that functioned as clinics, and some general merchandise shops that also regularly stocked some antibiotics and antimalarials,. The nearest medical health services were found in Busia town, about 4.5km away, where there was the Busia Health Centre IV and numerous private clinics. Busitema Health Centre III, the public health facility meant to serve Busitema sub-County as a whole including Mam-Kiror village, was about 5.5 km away, while the district referral hospital located at Masafu sub-County was nearly 12 km from Mam-Kiror via Busia town. During the field work the structure meant to accommodate the government health centre II was nearly complete, this being the lowest level of health care delivery in the Ugandan health system. However, no one in the village, including the leadership, seemed to know when this health centre was likely to be completed. TASO was the only health service based NGO with a relatively active presence in Mam-Kiror village; doing so through its livelihood support projects to some of its patients, and through provision of HIV counselling, testing and treatment both at its fixed service point in Tororo and outreach point in Busia Health Centre IV. World Vision, another NGO with a health component, was relatively unknown in the village save for an HIV education sign post with its logo erected in the trading centre.

Traditional and religious healing were also important elements of health care in the village and its neighbourhood. Although there was only one renowned traditional practitioner who reportedly offered treatment with herbal medicine and through divination, many people believed that residents regularly and secretly consulted traditional healers and witch doctors outside the village for a range of medical and social problems. It was believed that there were problems that could be dealt with efficiently by the formal medical services,

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<sup>10</sup> Decentralising the health care system to the districts was premised on the assumption that when lower level health care delivery structures are given more power, responsibility and participation, they would prioritise health care financing and efficiency in delivery.

such as malaria, and there were those that were appropriately dealt with by the traditional healers or required indigenous solutions such as being possessed by ancestral spirits. Traditional healing was reportedly commonly sought for diagnostic purposes, curing illness, averting misfortune or potential calamity, especially in case of threats from adversaries, and dealing with marital problems. Herbalists, mostly from Kenya, frequently hawked different kinds of herbs in the village targeting a range of illnesses including cardiovascular diseases and diabetes. Faith healing locally referred to as, “praying for and anointing” also existed, especially among Pentecostals and Catholics.

## **4.10 Conclusion**

This chapter has outlined the main features of social life in Mam-Kiror. It has described the patrilineal kinships system and networks of mutual obligations between kin and neighbours, and identified the main status distinctions within the village. The profound gender divisions in society were outlined as well as the main features of the economy, based on artisanal gold-mining. Both these topics will be returned to in more detail in Chapters 5 and 6.

## Chapter 5: Masculinity in Mam-Kiror

### 5.0 Introduction

The significance of masculinity in the uptake of treatment of HIV is the central focus of the thesis. This chapter describes the social constructs of masculinity in Mam-Kiror village, in particular how they are established, validated or undermined. By describing the dimensions of masculine identity in Mam-Kiror, the context is set for discussing how masculinity may influence men's engagement with HIV/AIDS services. It begins with the story of Paul, focusing on major events in his life, and his perceptions, definitions and experiences of manliness, and follows on with an overview of how the different genders conceive and discuss what it means to be manly. There is then a discussion of the most common types of masculinities and attributes that demonstrate that one was sufficiently masculine in Mam-Kiror Village. The masculine identities established by men suspecting HIV infection or who were receiving HIV treatment will be discussed in detail in Chapter 9.

### 5.1 Paul's story: Multiple masculine identities

Paul was 28 years old, and from a family of seven children (five girls and two boys). He was married to one wife and had two children. Paul stopped school in primary six when he was 18 years old and attributed it to various factors. "I was a real grown up man with beards and looked older than other pupils, and we were a bit rebellious... Also because I would go to school with a lot of money earned from gold mining and the teachers did not like it, so they harassed me." Paul added, "We became men in primary school. I got to know many things; money and even women long time ago."

I interviewed Paul as a participant in the category of men suspecting HIV infection, but also, on various occasions, held informal conversations with him and his friends. During the fieldwork, Paul's work changed from a butcher in Busia town to artisanal gold miner which he referred to as "my old-time and indispensable occupation." When Paul earned money from his work, he ensured that he supported his wife by buying her *eddy* (meat, fish, and other sauce which is bought) but he also always made sure he "enjoyed" some of it himself. Paul had a reputation as a party-goer who enjoyed a night out. His nickname 'Saddam', named after former Iraqi president Saddam Hussein, reflected his strong-willed

attitude and personality, which both endeared him to others and undermined his image, depending on the audience. During the fieldwork Paul twice had a physical fight with other men over money issues. In one of these fights, which attracted a lot of cheering from the crowds in the trading centre, Paul was beaten by his physically stronger employer, who was also his cousin, for misusing the capital for the butchery business on gambling activities. Many comments from the crowd suggested that Paul deserved his humiliation “for being an irresponsible spender of money which did not belong to him”, while his aggressor was praised for his physical strength and demonstrating the qualities of a “big man” who did not tolerate indiscipline. In the other fight, Paul was resisting repaying a debt and this resulted in his arrest by the police. He was only released after his mother intervened by selling her goats to fund his repayments.

Throughout the time I interacted or observed him, Paul presented a very mixed impression of his perception of his masculinity. Sometimes he was markedly animated and self-elevated about his status as a man, sometimes worried about his health, life, and family, and at other times he expressed feelings of a man who no longer cared about any threats and risks to his life. In a conversation involving two of his closest friends, Paul admitted practising risky sexual behaviour, revealing that he had had unprotected sex with many women both within and outside the village, some of whom were already infected with HIV. Paul narrated thus: “sometimes I only learn later that the woman is in TASO [HIV positive] or that she was also relating with other men who were infected with *slim* [HIV]. But in other instances, I was aware of their HIV status but drunkenness is to blame, it is always the cause!” Sounding worried at times, Paul added: “For example, I recently succeeded a man who died of *slim* disease [AIDS] by loving his girlfriend. I knew about it [their relationship] but I was drunk and the woman was too attractive.”

Paul and friends also attributed their risky sexual behaviour to money. “You cannot sleep hungry when you have money, can you?” asked Paul. He said that for him and his friends, spending money on other sexual partners was no problem as long as his housewife’s needs, especially *eddy*, were taken care of. Both Paul and his two friends pitied men who were committed to sexual fidelity with only their wives, describing them as “men [living] in women’s bottles or handbags,” implying that they were dominated by their wives. In spite of this, Paul did not believe in marrying multiple wives saying, “[monogamy] yes, that one, I will agree; two women are difficult, you will be adding problems at home, for

example the burden of taking care of the children will be big.” Overall, Paul’s everyday life and interaction with his close peers appeared to involve an emphasis on the masculine norm of working hard and making money, or solving conflicts or obtaining money through physical means or deceit, and bragging about sexual conquests.

Paul’s story raises several important issues regarding the social and individual expectations about manliness, and will be used, along with others, throughout this chapter to provide evidence of how masculinity was constructed in Mam-Kiror.

## **5.2 Overview of discourses about manliness in Mam-Kiror**

The most frequent question I posed to various people was: “What does it mean to be sufficiently manly in this area?” In response, people often set their explanations to the local context of Mam-Kiror by repeatedly stating that “you know, here in Mam-Kiror ...” or “for us men of Mam-Kiror...” or “as an Iteso man...” However, there was also a tendency by some people to refer to the wider social contexts beyond Mam-Kiror or to simply leave their comments unspecific to any one social group of men. In this way, participants specifically attributed and linked patterns of some phenomena about masculinity to Mam-Kiror or Iteso society, while at the same time considering other patterns and aspects of prevailing male behaviour to be general phenomena. Often Mam-Kiror was presented as distinct from other social contexts because of both the opportunities and risks to men’s lives and their families that come with the mining culture and activities, which was their favoured occupation.

The views between women and men varied about what it means to be sufficiently manly, although there was some shared general understanding of masculinity. Women tended to have a more assured or fixed view of a singular version of masculinity. “Men of Mam-Kiror are like that”, was the women’s most common way of responding to my questions regarding what it means to be a man in Mam-Kiror. In contrast, men often set out their definitions of masculinity by first distinguishing it from femininity, often beginning with the phrase: “Being a man is not being like a woman”. In describing the difference between men and women, men particularly referred to the underlying anatomical and physical

differences between males and females, and also portrayed men as generally intellectual superior to women. The gender differences, and in particular, men's perceived superiority and dominance over women, were frequently justified by biblical, Koranic and other stories as the will of God. As naturally and intellectually superior beings, men were presented as people who are physically strong, courageous, fearless, and protectors of women and children. The degree of one's success in these roles defined one's masculinity.

However, both men and women critically evaluated the concept of masculinity and used the distinction between *ekilokit cut* (real man) and *ikilokit* (little man) to assess men. It was argued that being anatomically male, did not automatically translate or qualify one to have a desirable image of masculinity. The various discussions held during the fieldwork conveyed people's belief that masculine status can be gained or lost during the life course, and that becoming a real man was not a straight forward process. Men often stated "it is not easy becoming a man" or "being a man is not a joke," to describe the personal challenges that characterised their lives as they grew through the life stages from being born a male person, to being a child, to being a young male person, to a mature adult male and then the last stage of old age. So becoming a proper man was ultimately measured by how competently one negotiated through the challenges and achieved an admirable identity in society. Participants acknowledged that given that different men had different life chances and experiences there were various ways of being manly, and that these were not fixed. Overall, however, the people of Mam-Kiror associated masculinity with a range of biological and physical characteristics as well as social roles and psychological features, such as one's personality and self-conduct in the different social institutions such as family, society, and work places.

## **5.3 Prevailing Masculinities in Mam-Kiror**

### **5.3.1 Marriage and fatherhood**

Marriage between man and woman occupied a central position in the social lives of the people of Mam-Kiror and provided the main context in which men established and maintained masculine status and power. A man is not considered a complete adult unless he gets married and raises a family. Early marriage is tolerated and even encouraged for both males and females, especially if they are no longer attending school. Paul is an

example of a man who came under pressure to endorse and fulfil this core normative expectation, getting married soon after dropping out of school in primary six. Responding to the question regarding what made men in his area sufficiently masculine, Paul simply stated: “Marriage and children; for a ‘mature’ man, it is these.” A man who did not marry early enough, such as Charlie who was not yet married at 35 years, or one who lost his only wife and never replaced her was belittled, especially by peers. These men were referred by the English word “bachelor” to emphasise their inferior status compared to those who were married and who were said to be “decorated with ranks”, depending on the number of wives. Unmarried men were perceived by the different social groups as less serious about life and irresponsible. In general, men without wives were given a marginal status both in their families and in society. Their leadership potential was doubted and undermined since, as one married middle aged man put it: “they did not even know how to establish and coordinate the affairs of the smallest [family] unit.”

Power in decision-making, handling of conflict within the family, and the social value of a woman being dependent on the man were believed to be key issues at stake when a man marries. As such, a marriage should be patrilocal, involving a woman moving to man’s house and not the other way round, in which case the man would feel constrained to assert his power as husband and man in the home, since the home is not his. Although a number of men and women spoke of monogamy as the ideal form of marriage, men’s potential for polygamy was anticipated, and if it occurred, it was explained as “just part of what it means to be a man.” Polygamy was believed to be an inevitable masculine ideal for various reasons. Both men and women considered it to be the more practical and suitable form of marriage since, as it was commonly stated, “Men have an insatiable sexual desire, which is impossible for one woman to fulfil, especially during pregnancy when sex should be minimised to prevent harming the unborn baby.” In addition, most men stated that wives were often troublesome and so marrying an additional wife was a strategy commonly used to “trim the wings” and discipline such women, since they will realise that the man has other options for sex, companionship and to get children.

Socially, polygynists tended to command some attention and admiration, being most esteemed in all-male sub-cultures and social gatherings. The tendency for men to use polygamy to validate social status and conform to others’ standards of manliness is highlighted in Paul’s account as well as in other interviews and field notes. One

polygynous man explained that the desire to disprove other men's assumptions about them and gain esteem may lead some men into multiple marriages.

When you are with your friends very many things happen that can force you to find another woman. Those with more than one wife laugh at others, saying that you have been bewitched and are under the wife's control and cannot marry another woman. All the demeaning jokes are thrown at you and they challenge you to prove yourself. They mock you to the extent that some of them stake to sponsor your next marriage expenses if they ever learnt that you have managed to find a new wife. In the end, you also want to prove your capability and so you end up bringing another woman (Middle aged man, January 2010).

However, poorer men were more likely to be stigmatised for polygamy; they were considered to be unrealistic and taking on additional provider responsibilities which were beyond them, as the following excerpt from a conversation highlights:

[...] yes, marriage and wives yes [are central], but even if you have wives and yet without a source of earning, there is no significance. You will still be 'nobody' in the eyes of other men and in fact you will even be worse off. They will say even you; you have also brought another woman! (Middle aged man, January 2010).

Paul's account provides further evidence to suggest that the masculine ideal of having several wives is closely linked to the ideal of being wealthy, since to have wives, and even more so sexual partners, requires money. Paul maintained that men like him, with limited incomes, deserved to marry only one wife:

Paul: Life of today needs one wife....life is bad.

Godfrey: How?

Paul: No work these days, work is less.

Godfrey: Does it mean you marry because you have work?

Paul: Yes, you marry when you have work because there will be money and they [women] don't refuse. Men marry to make a name and show that he has money.

Polygyny was resented by some people because it undermined the stability of marriage. Both monogamous and polygynous men themselves thought that polygamy often leads to less happiness for a man than monogamy. This is reportedly so because polygamists often have to deal with persistent conflicts with wives, between wives or between children of different wives. “You become an LCI chairman, always resolving conflicts but they do not end,” stated Adam, a wealthy former polygamist. Max, another middle aged man, relatively successful gold buyer and polygamist with four wives, was perhaps the most explicit about how polygamy may sometimes undermine a man’s status and enjoyment of life, and bring him humiliation:

They [wives] will toss you; you come to her home and she will tell you go back to your [other] home; the home of your loved wife. Then you ask yourself: who is the man of this home, is there another man in this home these days or what? Sometimes you even don’t get meals, or you have to eat from the Centre [restaurant] here because each of them will tell you that she did not know you would come to her house. In the end, you just remain ashamed (Field notes, March 5th 2010).

The practice of polygamy in Mam-Kiror was not homogenous, however, either in its arrangement or function. While some men kept all their wives in the same household, the most common arrangement was to establish separate homesteads for the different wives within the village. It was particularly admired if one was able to establish another home in the trading centre, usually referred to as ‘the town home’, where the man would either live with one of his wives or alone and then have the opportunity to have sex with other partners. There were men who did not marry second wives but kept partners whom they called their “women,” which could be understood as concubines. There were stable polygamists who had lived with their wives for a long time, and were respected for succeeding in this in spite of the challenges involved. There were also serial polygamists who earned a positive reputation with men but not with women, for their ability to easily replace wives that left them with others. However, there were also periods when some polygamists had no wives, often because they had separated from them. In times like these, such men appeared to worry more about lack of domestic help than about other roles the wives fulfilled, such as providing sex or companionship, as Job’s story illustrates:

Job, aged 45 years, lived with his second wife when I first visited him for an interview in May 2010. She cooked and did all the housework, according to Job. Her caring role even became more significant when Job fell ill. But when I visited Job a month later, his wife had separated from him, making life hard for him. “Things were a little better when she was around last month. At least she would cook and help me but now I can even sleep without water in the house. The other day I finished three days without water in the house until I called the neighbour's child to fetch some for me.”

Clearly, Job greatly missed the caring roles of his wife but he did not express the same sense of distress about being lonely and lacking a companion.

Married men worried about their in-laws' (*ikamurak/bako*) perception of their masculinity. As being a respectable in-law was a highly cherished value, most men were anxious about how their behaviour might affect their self-image and respect from the in-laws. Responsible and restrained sexual behaviour and being able to provide financial assistance to the in-laws were two core expectations, and failure to fulfil these, significantly threatened men's respectability and esteem.

### **5.3.1.1 Men's 'rule'**

Men are the commanders of their homes; commanders [men] are the ones who decide and advise [...] (Frank, age 45, March 2010).

Frank was born into a large extended family of twenty children from four mothers. He grew up seeing his father wield a lot of power over his wives and children. “Our father was tough, our mothers were terrified of him and we the children had to obey all orders.” All the four wives Frank married over the years had separated from him because, as he put it, “I could not tolerate women who do not listen to me.”

As this account suggests, men's rule and power over women in their families was a prominent feature of masculinity in homes in Mam-Kiror. It did not matter whether a man was rich or poor; as long as he had a home of his own he was usually the most powerful in it, enjoying unrivalled authority. The exceptional situation in which a man's authority in the family appeared to be significantly undermined was during periods of severe chronic

illness, such as when ill with AIDS-related illness, as will be discussed in detail in Chapter 9. However, normatively and typically, a real man demonstrated sufficient authority as head of household. By emphasising that “Commanders are the ones who decide and advise....,” Frank asserted men’s dominance and power to direct and control their wives, while Frank’s intolerance of “women who do not listen” suggests that men considered it normative for women to be subordinate to men.

Although a woman’s status and influence in the family and society rose with seniority in age and status of her children, in general, the position of the husband remained relatively supreme. Becoming wealthier not only earned men more respect, but in many cases also made them feared figures, both in their homes and neighbourhood. With money, men became even more powerful, and unchallengeable even if in the wrong. A number of wives revealed their fears to offend their rich husbands, and were often urged by others not to confront or undermine their husbands, even on intimate matters such as promiscuity. They described how their husbands often disregard their advice and listened only to their peers or relatives.

Nevertheless, men recognised women’s roles as wives, mothers, sisters and daughters. “Without a woman, you have got no home,” was a common way of acknowledging the important role of wives in making and maintaining the home. Due to this, *ekilokit cut* (real man) was expected to provide the necessary support for the woman to effectively perform his roles in the family. For example, when Frank was asked to elaborate further what distinguished one as a real man, he said: “[...] also men should work with women, helping them for example giving a wife some business because she can help the family.” As we saw from Paul’s story, he too believed that it was good practice for the man to do all it takes to support the woman materially. However, there was a tendency by both males and females in the village to view the roles performed by women in the home as a natural obligation. This meant that most women neither got, nor expected, much credit when they did these roles perfectly but were heavily criticised by males as well as fellow women, and in some cases abused, if they did not fulfil these family care chores. Violence against women, daughters as well as against sisters by their brothers was generally condoned and considered legitimate by both men and women if they proved inefficient in their core social roles such as cooking for the man and family.

### 5.3.1.2 Dependence on women

Although masculinity is extremely important in men's lives, nevertheless it does not prevent them from acknowledging the important role of women. The predominant view among men, which most women agreed with, was that men gained a high social status through their dependence on sisters, mothers and daughters in two ways.

First, in polygynous families a common approach to dividing land between sons was by first apportioning it to the different mothers from whom their sons would then get "their share". Some young men looked forward to the time when their father would divide the land, allocating some to their mother so that they could get their share, and recognised it as a helpful way to minimise grudges during the process of distribution.

Second, a number of men described how they became men only after the sisters got married and the family received bridewealth and other material support, which the brothers used to attain an education, marry or to buy land. While they did not imply that the bridewealth belonged to their sisters rather than fathers, many men highly valued such life changing opportunities and attributed them to their sisters. Some men frequently told of how they were brought up and "made men" by their elder married sisters, while others revealed that they presently occupied land bought for them by their sisters or mothers. Paul was a proud owner of land which his mother had bought for him, and Adam (age 43), talked with nostalgia about his late sister who intervened and bought them (four male siblings and mother) land after years of conflict with their extended family. In other families, sisters and/or daughters who were financially well-off extended support to close relatives including brothers even after the brothers became adults. Mothers also talked about tolerating bad marriages, characterised with extreme poverty, neglect or violence from husbands or co-wives, only because they did not want to abandon their young sons before they were raised to "become men." This is reflected in the account of Mama Josephine, a mother of two boys and two girls, whose husband had abandoned her in the village home while he lived in the city with another woman for many years and rarely sent support: "I could have left this home, but when I look at these boys, I say no, let me tolerate and raise them up until they also become men," she narrated (Mama Josephine, July 2010). Gody, one of her sons admitted, in a separate conversation, that it was their mother who had stood by them and made them men.

### 5.3.1.3 Family provisioning role

As Paul's story shows, to be considered sufficiently masculine, one must have a wife as well as children. Paul, as well as other participants, repeatedly discussed the significance of having children, of their sex, and the ideal number of children. Fathering children is a confirmation of sexual activity, another dimension of masculinity. All accounts from both men and women emphasised that fathering a number of children, and fulfilling the role of a father as provider and protector of those children, was a strong manifestation of masculinity. A number of men described marrying an additional wife to get children and/or divorcing other wives if they did not reproduce. It was striking, however, that the majority of men I spoke to appeared to desire a limited number of children, arguing that a large number did not necessarily make one more masculine than other men. Paul, for example, argued that although children confirmed masculinity, their number had to be limited because bringing them up was challenging, saying: "These days life is hard, so four [children], is okay." Like Paul, many men worried that they would fail to give children a decent upbringing devoid of deficiencies, which would undermine their esteem as men. A small number of children, they believed, enhanced the prospects of leading a relatively better economic life and being respected as an outstanding family.

When discussing sex preferences most men initially claimed that the sex of one's children did not affect how one's status as a man was judged. Leo (age 27 years), one of the interviewees receiving HIV treatment, stated: "All children are children". Paul too, expressed similar views saying "[...] as long as there are children in the home, people will still say 'that is Mr X's child.'" However, further questioning of some men revealed that, although daughters were valued because they tended to offer more financial help to their parents than did sons, men preferred sons because they ensured continuity of the man's lineage, as revealed in the dialogue with Paul, a father of only boys:

Godfrey: Okay, but how do you feel having only boys?

Paul: I am still young; you never know what the future has for me. You never know, I may produce a girl...laughter. You know girls are also good, they help you their parents so much unlike boys who mind

about their own families when they get their wives. But boys, for them, they just keep the family name, which is very important.

This is precisely how Emma (42), another interviewee, described why he preferred to have children of both sexes. Emma had four children, three boys and a girl aged between 6 and 12 years, and although he believed that having only same sex children did not make one less manly, he argued that having mixed sexes was vital as boys ensured continuity of the man's lineage and identity and daughters assured a secure future for their parents:

Emma: A boy is the heir when you die. He is the one who expands the family.

Godfrey: What about girls?

Emma: Those ones go for marriage and the home remains alone...  
[Laughter]...but even those ones build [their father's home] because they help parents a lot materially, more than boys.

Men repeatedly emphasised family provisioning as a core responsibility of men and failure to fulfil this role fundamentally undermined their social value as heads of households and their masculinity. However, in discussing how this role was fulfilled, participants used three local emic concepts with varied implications. It was stressed that providing for family extends beyond putting food on the table and includes *akidar ere* (taking care of the family), *akitopol ere* (the family's economic advancement) and *aki'ngarakit aberu* (helping the woman). The breadwinner role was, however, usually described by both men and women as "*aki'ngarakit aberu*" hence less mandatory. With women playing the crucial roles of producing, processing and preparing staple food on a day-to-day basis, men's main role in feeding the family was providing the *eddy*, which if they persistently failed to do they would be blamed by their family. A man, for example, is rarely blamed for lack of flour required for making *atap* (cassava/millet/maize meal) in the home, but a responsible man should endeavour to regularly provide *eddy* for the family to diversify their diet. However, unlike women's food provisioning role which was less dependent on cash, the *eddy* provided by the men often required money, and hence fulfilment of this masculine role was tied to the man's financial status. While keeping livestock and fowl, and providing *eddy* from them would safeguard a man's masculinity, this was less regular because poverty made it difficult to accumulate these items.

Aware that *eddy* was highly appreciated by wives, some men provided it to portray that they were good and caring husbands, while disguising other private expenditures that might be resented by wives, such as on drinking or extramarital partners. Paul, who admitted to frequently buying sex from non-marital partners in the nearby town, revealed: “For me, spending money with my women [extra-marital partners] is not a problem as long as the housewife is taken care of by buying her *eddy* and other nice things.” Like Paul, many men in the village said that regularly “helping the wife,” particularly by buying *eddy*, not only averted potential complaints of neglect by wives but also lessened their own sense of guilt in the likely event that they spent large proportions of income on leisure activities.

The concepts of *akidar ere* and *akitopol ere*, however, articulate a wider dimension of men’s provider role. They may incorporate the breadwinner role as it is conventionally understood but, more importantly, refer to men’s fundamental roles of providing the strategic developmental needs of the family. These typically included children’s education, health care, provision of resources such as land and bridewealth to sons, and ensuring the family’s prosperity. These roles were not presented as helping the wife but as things the man ought to do for his children. Men would be judged more harshly by both society and family for failing to fulfil these roles. For example, wives would often authoritatively say, “he [the man] has not paid the children’s fees” and not “he has not helped me pay the children’s fees.” Men were expected to provide money for treatment when their children were sick, and women, including those separated from their husbands, often had more confidence and backing from other people to assertively ask their husbands for money for children’s medical care than for anything else. Men themselves presented the *akidar ere/akitopol ere* roles as their most vital roles; a man will not, for example, offer money for buying *eddy* or other things if he is trying to save for children’s school fees/scholastic materials. Men were also greatly concerned about acquiring land and accumulating other assets for the children’s future use, and did not particularly see these as women’s roles.

Men portrayed themselves as struggling predominantly for the welfare of others under their care, rather than for their individual benefits, even though they often spent significantly on their leisure. Fulfilling family responsibilities towards dependents was an important measure of success as a man. Yet, the majority of men acknowledged failing to perform the *akidar ere/akitopol ere*, with most citing poverty. Most women, however, did not agree

entirely with this explanation and instead believed that men wasted money in non-developmental ventures or on selfish consumption, such as on alcohol. In some cases, illness was cited as the cause of men's failure to fulfil this masculine obligation, as discussed in Chapters 7, 8 and 9.

#### **5.3.1.4 Protecting children and family's respectability**

Part of the obligation to *akidar ere* for men, was the responsibility to protect the family and bring up “*idwe luk'iponesio; lu' eyon'ganara, ko josi ke'kitiibwa* (morally upright; respectful children). Men aspired to ensure that their children were seen as properly raised and were respectful. It was therefore common for men to rebuke and express their frustration with children who did not listen to them, as one man did to his 17 year old son in my presence:

This boy of mine does not listen to me. ‘How do you bring [marry] a woman when you have nothing and yet you continue being lazy? If you don't listen to me, then you should leave my compound. If you think you are now a grown up.... I don't want you to embarrass my family, and make people think I failed to teach you [basic ethics]’ (Oyaka, June 10<sup>th</sup> 2010).

By rebuking his son in this way, Oyaka was keen to ensure that his son worked harder and earned money to be able to look after his new bride. Yet Oyaka's comment “...I don't want you to embarrass my family,” also hints at how the father's esteem and family's respectability was associated with his children's behaviour and work ethic. Like Oyaka, many men repeatedly worried that “ultimately, as heads of households, they were blamed for the children's moral failure,” and that this is often associated with feelings of shame to the man and loss of family respect. Given these concerns, the relations between fathers and their growing sons as well as daughters, varied from family to family but typically, these relations were characterised by sons' fear of their fathers and fathers' reminders and assertions of their masculine authority as heads of households, who desire to protect the family's respectability. The case of Abraham, one of the interviewees, illustrated men's concern to maintain their authority, clearly as he introduced his sons to me. Referring to his 18 year old and second born son, who had recently dropped out of school, Abraham commented:

[...] this one thinks he has become a man. He decided to bring a girl [marry] but I have told him that even with a wife, he still has to go back to school next term. This is my home, so he must accept what I am saying. He has to give me my *ekitiibwa* (my deserved respect).

This excerpt, like the preceding one about Oyaka's son, highlights that boys experienced contradictions in the gender roles they were expected to perform. For young men, even before they assumed adulthood, they were expected to marry and be less dependent on their families and fathers. They were expected to take responsibility for themselves and others, and take hard decisions and at times risks, as part of preparing to be a proper man. They were also expected to learn to work, and particularly to make money and spend responsibly. However, they were not expected to be wholly independent, especially if they were still living in their fathers' home. To many young men of Mam-Kiror who had opportunities to access money and felt a sense of 'maturity', this was a paradox that left them in uncertain positions and dilemmas about their construction of masculinity.

Generally, teenage boys appeared to enjoy a better relationship with mothers than fathers. They feared their fathers and older male siblings, believing that they prevented them from enjoying their youth. They also rejected the common view among adults that their involvement in gold mining and money-making at an early age led to antisocial behaviour. Typically, men did not associate the role of a father with being affectionate and gentle to their growing children, especially the male youths, but rather to guarding against problematic behaviour among them; a role that required the father to be a strict disciplinarian. This often involved threatening and/or beating the rebellious sons to ensure they conformed and were respectful of authority. However, boys believed they had enough tricks to outmanoeuvre their strict fathers/guardians. To them, being deceitful was part of what it means to be "smart" and intelligent as a boy. Boys also believed that their fathers or other adults were being unnecessarily tough and misguided in their perception of young people's behaviour, in particular with regard to associating access to money with antisocial behaviour. "I am either already spoilt or not before [getting money] and money cannot be blamed", remarked one youth, aged approximately 15 years.

Besides the obligation to provide physical protection to their daughters, like they did to their wives, fathers controlled the behaviours of their daughters in almost in the same way

that they did their wives. Daughters were encouraged to serve and respect male siblings. Like the male siblings, girls' relationships with their fathers were characterised by anxiety, with girls fearing to wrong their fathers. Fathers' (and mothers') main concern for their daughters was the latter's vulnerability to sexual exploitation by men and boys. Although fathers did not tolerate sexual advances from men to their daughters, regardless of their age, girls in the village frequently faced sexual pressures from men and boys, and some girls that I got to know had premarital pregnancies. These sexual and marriage pressures on girls, however, appeared to ease up as a girl got older and advanced with her schooling. Often older and more educated girls were seen by potential suitors within the village as unapproachable since their high education meant a higher social class for them, setting them apart from most men in the area. In instances where fathers learnt of a relationship in which their daughters/sisters were involved, they often directly confronted not only the girl, but also the men in question, and sometimes serious disputes developed. However, wealthier men who had relationships with young women generally tended to appear 'untouchable' and were either feared and/or tolerated, or easily compromised the girls' family with money.

It was not just the fathers who were accredited with the responsibility of protecting daughters. In particular, brothers often executed this responsibility keenly with regard to the sexual behaviour of their sisters as illustrated in the case of Steve, a man I had got to know well:

Steve, a 30 year old man, and his two male friends were called upon by his 'mother' (wife of his father's brother) to help discipline his cousin, Nyaburu, after she was suspected of being involved in a premarital sexual relationship. When Nyaburu reported a pregnancy a few weeks later, Steve and other cousins were again involved in discussing 'the way forward' with the accused man. Steve proudly told me that following the 'pressure' and threats he and his friends put on Nyaburu and the accused man, the man admitted responsibility and accepted to take Nyaburu as his [5<sup>th</sup>] wife.

This excerpt illustrates how boys were encouraged to actively monitor and sanction their sisters' behaviour, especially regarding their sexuality and decisions to get married and/or have children before marriage. In doing this, brothers learnt to play the role of protecting the honour of the family as performed by their fathers, and ultimately they took over these

roles as their fathers grew older. Due to this, young women without brothers, or only younger brothers were thought to be vulnerable to going astray due to insufficient men in the family to “watch over them”, even when there was a father. Any supposed misbehaviour from such girls, particularly relating to premarital sex or pregnancy, was often linked to lack of brothers who should have prevented them.

### **5.3.2 Material ownership and entrepreneurship**

Material ownership was a central symbol of status differences and an expression of masculinity in Mam-Kiror, and appeared to override other status symbols such as education and seniority in age. My attention was drawn to the significance of material assets by a bitter verbal exchange which I overheard one morning in May 2010 between two men at Mam-Kiror trading centre:

Man A: “What have you got with which you are better than me? You are proud for nothing. You are just wearing sandals and you claim to be better than me? You are nothing, we are all men.”

Man B: “And you, what have you got, have you got anything? You are even still living on your father’s land and you are also claiming that you are a man?”

As illustrated above, in Mam-Kiror village ownership of material goods was one criterion for being considered sufficiently manly and commanding respect. Men who did not own anything “worth talking about”, as put by one man, were often ridiculed and judged as failures. Typical possessions that enhanced masculinity included domestic fowl, other livestock, land, especially that was bought with personal savings, a bicycle, and for some, a motorcycle for taxi business or other small business enterprise. A small number of men owned a piece of land or a building for commerce in the trading centre or by the roadside. These were often described as “having money” and were by far the most respected.

Owning a business enterprise, however small the capital investment, significantly distinguished one as a serious and independent man, and indicated capacity to meet various obligations, which more often than not required cash. Men with any kind of business were admired and respected by others; they were renowned in the village for providing a useful service and for patronage, especially through extension of credit to fellow villagers.

Wealthier men with businesses were often more confident and loudest while making use of

public spaces like bars, and asserted their public masculinity with relative ease and affirmation from others. The range of small businesses operated included groceries, clothes shops, hair salons, and produce marketing or operating a bar. Although a few men operated evening market stalls dealing in fresh and dried foods, or managed restaurants, these businesses were thought to be less suitable for men because they related closely to women's roles in the home. Of the eighteen men living with HIV who were interviewed, only one had a business at the time of the study. Six had previously operated some businesses whose collapse they all attributed mostly to the disruptions caused by the onset of their illness. However, most of them reported an increased desire to start a new business or resurrect an old one, both as a source of regular income to keep an adequate diet recommended for people living with HIV and to be able to contribute to family needs.

Raising capital to start a business was generally a challenge to men in Mam-Kiror and the sources were limited: savings from one's labour, sale of assets like land, and short term loans from local savings groups or from fellow men. Selling land to raise business capital was, however, generally seen as acting in an unmanly manner, and was often resisted by family or other kin because land was an important asset to be passed on to children. Working hard and saving or borrowing was perhaps the most important means of getting resources to start a business. The significance of the work ethic in contributing towards masculine identity is the subject of the next chapter. However, suffice to mention that some men living with HIV felt they could not work as hard as they had before becoming infected, undermining their ability to save. Others believed that their frequent illness and being known to be on HIV treatment meant that lenders, especially private lenders, were often reluctant to provide them loans, as described by Isaiah, aged 49:

Of course they [lenders] may not tell you directly that it because of sickness but you will just know from how the person talks to you. They can dodge you, promise you and dodge you and ask you questions about repayment. The next time you will hear from other people that that man does not lend his money to a sick man who will not have a way to pay back and can even die before paying back. But if those who are not sick go they are given.

A high status was also acquired from having one's wife doing some business. Starting-up a business for a wife was, therefore, often described as an important aspect of being a good husband, and greatly improved one's masculine credentials both in the family and in the

public domain. For this reason many men aspired to find their wives some small scale trading in the trading centre, such as running a kiosk or a market stall. Yet, their limited capital meant that the majority of men were unable to achieve this, causing anxiety and low self-esteem.

### **5.3.3 Sexual achievement**

Sexual functioning was a key attribute of what it meant to be sufficiently manly in Mam-Kiror. Participants did not discuss homosexuality but there were a few men who had heard about the on-going debates about this subject in the city, and were highly critical of the practice. Given the sensitivity of the subject of homosexuality in Uganda, and my personal reservations, I did not attempt to steer the discussions towards that topic. There was often tension, however, between women and men, in their perception of how masculinity was established or confirmed through heterosexuality. While wives discussed mostly the procreative role of sex, for the majority of men, sex with many partners was not only for fathering children but also for the man's pleasure. Sexual prowess and ability to seduce women successfully was a means to affirming masculinity before peers and partners. Men without wives or sexual partners were often negatively labelled, particularly by peers, and teased and pressured to prove that they were not impotent. Hence a substantial number of accounts from men with multiple sexual partners revealed that sex with many partners was often sought to conform to peers' notions of appropriate sexual lifestyle and virility. For example, Paul's account of his sexual lifestyle reveals a close similarity with that of his close peers.

It appeared that getting married did not significantly reduce men's involvement in multiple sexual relations but only affected the way it was pursued. Married men conducted their extramarital relationships largely in a clandestine manner, but if for some reason it got exposed, it was justified as a legitimate way of searching for another wife. As such, men may be criticised for extramarital relations, but only cautiously, since the women they are dating could eventually become wives. Because of this, wives usually felt powerless or less motivated to confront their husband's for infidelity, with some resorting to encouraging their husbands to bring their new partner to become wives. They believed that this would lessen the husbands' expenditure of family resources on maintaining a concubine, and also that it would minimise the risks of HIV because the other woman would be faithful to their husband, compared with if she continued to live in her own house, where she might easily

be approached by another man. Many men acknowledged that their secret sexual relationships increased risk of HIV infection, since the secrecy denied them the opportunity to learn more about the sexual histories of their potential partners from informed sources. As we saw from Paul's story, he sometimes engaged in sexual relations with women only to learn later that those women were infected with HIV.

Subscribing to the masculinity of sexual achievement meant that men competed intensely for, and often shared sexual partners, some of whom were women married to other men, despite often emphasising that wives are not shared. A number of men disclosed that they had frequently had sex with a woman whom someone else within the village was also in a relationship with at the same time. There was a great sense of pride to have been the first in the village to "taste" or "sample" [have sex with] a particular woman, especially a newcomer. Many men could name members of their past and present sexual network within the village but said they would not give-up those relationships since this would be perceived as demonstrating masculine weakness. On a number of occasions, for example, I witnessed Paul and others like him who were reputed for their virility proudly announce to rival suitors that they had already "passed through" [had sex with] the girl that those rivals boasted about as lovers. The importance of being the first man to 'taste' a newcomer to the village related to the reputation attained from others, since this often implied superior seduction skills and/or use of money. Condom use with these extramarital or new partners was limited, with the majority of the men stating that using condoms was not a practice they were accustomed to, and besides, condoms were difficult to find within the village. Men rarely linked their reasons for not using condoms to other factors, such as their religious faith, but frequently talked about need for sexual enjoyment or the desire to get children. However many did recognise the risks associated with carelessness. Some men with HIV linked their infection to their own risky sexual behaviour, while others sometimes told their rival partners that "If am dead (infected with HIV) they you are also in the list of those who are infected."

There was a close association between access to money and sexual achievement. Both men and women in the village claimed that it was impossible for a man to have money and fail to attract many sexual partners. Since women would be accessed through money offers, it was believed that the number of one's sexual partners confirmed one's wealth and spending power. In a conversation, one young adult man expressed the risk and dilemma of having regular access to money from gold sales as follows: "When you have money you

can get any woman you wish, [...] but it can also make you get even the [high risk] women you could not have got.” According to Paul, men from Mam-Kiror village were renowned in the nearby Busia town as big spenders, “to the extent that we often dominate the company of sex-workers and have sex with several of them at same time.”

However, extra-marital sex was not the practice of all men, especially men recognised as more religious, often Born Again Men but also some Muslims, who talked about the importance of sexual fidelity in the era of widespread HIV. Men who were not promiscuous were highly admired by many people of both sexes, and often referred to as exemplary men. Their position against infidelity was respected, especially by women. Furthermore, the majority of men talked about the importance of sexual abstinence when ill with suspected STIs (although HIV was not mentioned) in order to protect their wives from infection. For example, Elly (28) who had suffered from syphilis, said he concealed the infection and tactfully avoided having sex with his wife until he was fully cured, to protect his wife’s health and feelings in case she asked about the source of infection. Similarly, when Paul realised he had acquired an STI, he did not reveal it to his wife but avoided having sex with her until he completed his treatment. When probed why he did not disclose to his wife, Paul replied: “Because I fear she may ask me where I got it from...and the stay gets disorganised [family conflicts arise].” These examples indicate that under certain circumstances, men can avoid risky sexual activity with their wives in order to demonstrate their love and devotion to them, thereby presenting an identity of a good husband. The expression of fear of wives is also interesting in that it is in stark contrast to the impression that men are always superior and dominant over wives, as implied for example by men declaring themselves “commanders of the home.”

Men’s extramarital sexual relations also appeared to be influenced by the age of their children, with men who had older children reporting the need to be cautious in extramarital dealings in the interest of their children. In Mam-Kiror, whenever adults talked about “being old” their children, rather than their personal age, was often used as a reference. In this community, people with grown up children were expected to behave decently and respectably by demonstrating sexual morality. In particular, men with children thought to have reached the sexually active age were expected to quit the (sexual) stage to show respect and avoid the potential risk of becoming a rival sexual partner to one’s own children. In a conversation on this subject, a father of eight in his 50’s said: “We have now to stop these things [sexual infidelity], children are already grown up; you might meet your son where he had also gone to graze [for sexual adventures].”

It is important to note that casual sex or extramarital relationships were not seen as the privilege of only men. As I observed and was frequently told, a new culture and pattern of relationships between women, especially bar maids and local men, was emerging.

Although they were often subjected to widespread gossip and direct insults, it appeared that the unmarried women especially were becoming increasingly assertive about their sexuality, and sought casual sexual relationships with confidence. Men who frequently interacted with this group of women, reported that such women engaged in sex when and as they wished, with any man of their choice, and left these relationships without any feeling of shame when they realised that the men were beginning to make extra demands such as controlling them or demanding marriage. For example, in a conversation with me and his friends, Paul told us of how dismayed he had been when he found the girl he had been with only the previous night becoming cosy with another man in a bar and she acted as if she had never known him. Paul's friends lightly blamed the girl but advised him to "come-to-reality", for he was dealing with women of "today". I interpreted their comments to mean an admission that men acknowledged that sexual freedom was no longer men's privilege. During the fieldwork, I got to know of several newly arrived women in the village who did not delay starting to have sexual relationships with different men or even getting involved in a short term marriage.

To summarise the expression of masculinity through sexual achievement, men in Mam-Kiror drew on conflicting notions of sexuality to construct manliness. On the one hand, sexual promiscuity demonstrated one kind of masculinity which was affirmed mostly among peers. On the other hand, fidelity, caring for one's wife and abstaining from promiscuity in the 'interest' of grown up children and respectability demonstrated another kind of masculinity, which appeared to resonate with the expectations of the wider public about proper male sexual behaviour in the modern era.

### **5.3.4 Wisdom and respectability**

Wisdom and respectability (*ekitiibwa*) or *etwan lo'eyongite*, (a man who is respected) were other examples of what was considered a central feature of being sufficiently masculine in Mam-Kiror. *Ekitiibwa* (respectability) was especially repeatedly discussed and presented as an important attribute by which men should be evaluated. Respect accrued from successful enactment of other masculinities, most importantly marriage and raising a stable

economically successful family. Not only were men expected to earn respect through their positive deeds in the society, they were also expected to show respect to others, especially to the elders, in order to be regarded as respectable. In pursuit of respect, men tended to assert themselves as leaders, teachers and advisors in families and society. A man was highly regarded if he demonstrated intellectual prowess and ability to think independently and maturely. Educational attainment, especially higher education, was identified as an important ideal, although only a few people were highly educated in this village. In Mam-Kiror where gold mining has drawn most men out of school, achieving higher education was considered a measure of self-control, and confidence in one's intellectual abilities. For some men, the additional prize of completing higher education was ascendance to political and social offices such as village councils and clan structures, as these qualities demonstrated ability to head and lead others.

Although old age was highly regarded as an indicator of wisdom, economic success enhanced the degree of respect accorded to men. Poor men gained less respect than the rich men who were honoured with the titles such as *Lok'apolon* (The Big Man) or *Mzee* (although *mzee* is a respectful way of addressing an old man in Kiswahili), regardless of their age. Often richer men were referred to as "Boss", "Mzee" or "Daddy", reflecting how respectable they were before others. The source of one's wealth did not seem to matter much with regard to the degree of respectability one was accorded, although men who accumulated wealth rapidly were considered to be very "smart" and intelligent, and were often consulted for advice and help. Sexual behaviour was also an important element of respectability.

### **5.3.5 Physical prowess and competitiveness**

Demonstration of physical prowess helped to distinguish "real men" from the rest. The highly physical demands of the predominant occupations of gold mining and bicycle taxi riding meant that a substantial number of men in Mam-Kiror were physically strong, and some were as well built as professional body builders. Muscles and strength were treasured and needed to be demonstrated, tested and proved regularly, especially by doing heavy work, and by competence during fights.

However, although physical build was admired, there was a general belief that what really mattered in order to prove one's masculinity through strength was one's courage and

resilience when faced with daunting prospects, tasks or risks. Hence one might be less physically endowed but respected for one's bravery and determination to challenge the hurdles of everyday life, while others were well-known for aggressiveness and fearlessness, and being fast to express anger. Men like Paul, who found themselves failing to match their opponents either physically or by demonstrating masculine courage when confronted, experienced embarrassment, undermining their sense of masculinity. Showing fearlessness and assertiveness regardless of one's size gave a sense of self-dependence. Aggressiveness and bravery were often celebrated and cowardice was vilified with jokes and insults. The gold miners, nonetheless, tended to regard themselves as tougher than other men, both physically and psychologically, because they did the toughest and riskiest work.

The masculinity of physicality and courage was also often discussed in relation to competitiveness and economic success. Men frequently talked about aspiring to "become somebody" or how "some man in the village has also now become somebody" – by which they meant achieving a high status – through ambition, hard work and being effective or "sharp" when an opportunity presented. It was believed that, in contemporary Mam-Kiror, for a man to become "somebody", two conditions were necessary: First, the determination to work hard. Second and most important, it required "being sharp". I captured three main metaphors that were used to describe different categories of men, which portrayed the desirability of shrewdness for one to be considered more manly than others. These were *ebang* (stupid man), *ekar akwap* (failed man), and *ekwana/echo/erai sharpu* (sharp man). The last two concepts were used to refer to the ability of some men to manipulate situations or other people and to cleverly take advantage of the social and economic opportunities that presented themselves. *Echo* referred to both business acumen and abilities to take advantage of other opportunities within the village, although *ekwana* and *sharpu* were also used in reference to unrivalled abilities to win sexual partners. The other two concepts (*ebang* and *ekar akwap*) were usually applied in reference to men who failed to make use of their opportunities and/or wealth in ways that benefited their families, or those whose behaviour and life style led them into some catastrophic consequences. Failure, for example, in business and reversing back to economic insecurity was attributed to foolishness, and it greatly undermined a formerly successful man's self-image and masculinity. This feeling is particularly strong if the loss of wealth was attributed to reckless behaviour associated with promiscuity, infidelity and alcoholism. Many people I

spoke to, especially women believed that most men were wasteful in their expenditure, and were therefore fit to be described as *ebang* (the stupid).

In relation to success, competitiveness was strongly endorsed in Mam-Kiror as a useful attribute for men. The two most important aspects of men's lives where competitiveness was justified, and considered a measure of masculinity were competition for resources, especially land and other income generating opportunities, and competing for women. As I observed and was often told, some artisanal miners found themselves involved in (violent) resistance to what they perceived as exploitation, either by unscrupulous fellow miners or institutions (such as tax bodies and the mining company). The spirit of competitiveness and use of force, in some instances, and their link with the masculinity of ownership meant that some men acquired more private land and other resources than others, while the prestige of not giving a sexual partner to a rival partner was often celebrated before peers, as will be discussed later.

In the various accounts, a discourse of "justified violence" emerged, by which it was believed that violence was appropriate in certain circumstances, but not in other circumstances. Men argued that there were circumstances when physical aggression was a justifiable way to act as a man, for example, when attempting to protect personal or shared resources like land, or in defending one's family from external aggression. Violence was viewed as an inevitable way to express the masculine duty of protecting family and society. On the other hand it was acknowledged that violence could, under different circumstances, not contribute to masculine esteem. For example, aggression towards vulnerable persons such as children or innocent people was not endorsed as a way to show manliness. Women were also occasionally mentioned among those not to be threatened; there were beliefs that men had a right to 'punish' their wives but should do so 'lightly' to prevent harm.

The men who rejected violence as a mode of demonstrating masculinity argued that the world [of Mam-Kiror] had become modernised and that there were many better alternative ways of showing true manliness without being aggressive. It was believed that demonstrating intelligence, understanding and other mental competences was a more reasonable and productive way of being a proper male person. It was given argued the stringent application of the laws "these days" violence was unproductive since one risked being jailed. Though there were exceptions, it was the richer men that tended to hold this

view. This group had many alternative ways to derive their masculine power. In addition, because they were so influential in different aspects of village life, including village management, the richer men easily justified any of their acts of violence against other people as acts they undertook to enforce discipline in the society. Moreover, due to their riches and patronage, few people dared to challenge them for fear of losing favours, unlike the poorer men who were more provoked into violence. With apparently limited alternatives to assert their manliness, poorer men found it difficult to assert themselves except through aggressiveness, anger and threats to others.

### **5.3.6 'Compulsory' consumerism**

Confidence in social situations and sharing with other people was generally portrayed as part of what it means to be a "properly groomed person", but this attribute was emphasised more for the males. "Being with others", "seeking out friends" "being outgoing" were common phrases, often used to imply that a man or boy ought to allocate time to interact with others on a regular basis. Living in isolation opened one's moral conduct to questioning. This was unlike women and girls whose interaction with other people was generally expected to be minimal, specific to a purpose and restricted more to their homes than to public areas. Often, men's interactions took place at the trading centre, in bars and other leisure places such as roadsides, or at places of work, particularly at the gold mines, where men spent much of their time together.

The commitment to be social and outgoing came with the obligation to *akimor* (eating/sharing with others) and a culture of 'compulsory' spending. Men emphasised that unlike in the past when 'eating with others' was about hospitality provided at home and was less commodified and less masculine, the norm of eating with others had become more commodified and at the same time more masculine, for two main reasons. First, because it required money and consumption of purchased goods especially outside the home, and second, because eating with others did not involve women cooking, or woman's space. In contrast, women's concept of hospitality remained oriented to their homes and eating of food prepared by them. For example, sometimes, when I visited families, I witnessed a conflict of opinions in the way males and females expressed their concerns about how to entertain me, with men tending to complain about lack of money to buy or take me out for a drink while women would be concerned about making me a meal.

While the ability to make much money was a proof of the masculine attribute of hard-work and/or “smartness”, spending money without demonstrating a concern to economise earned one a reputation and high status, and set one apart from others. The predominant attitude among men, especially the middle aged and young men, was that economising and being stingy was an admission that one lacked financial security or skills to make more money, which undermined one’s reputation and masculinity. Overspending was therefore the norm regardless of one’s income level. Village parties and local night dances in the trading centre, in particular, were occasions to display money, status and demonstrate that one was less concerned about economising. Nicknames and titles were important ways of describing the various reputations acquired with regard to how one spent one’s money. Two examples can be contrasted here. Mr Kula-Pessa (Mr Eat Money) was a man reputed for extravagance, while Mr Mukono Gamu, (Mr. Gum in the Hand) was a fairly wealthy but stingy and economical man. Although Mr Mukono Gamu commanded a high status socially, he was less popular among peers and those who were oriented to spending as a means to establish a reputation. In contrast, throughout the fieldwork, Mr Kula-Pessa lived up to his reputation, and usually ensured that whenever he earned money from gold mining, he temporarily suspended working, as he had enough money to spend lavishly. To “save face” as many often stated, men therefore found themselves forced into a compulsory expenditure pattern and culture. It was common to find men and boys reciprocate rounds of beers, sodas, bites or taking turns to pay for others’ meals in restaurants. Consistent failure to reciprocate often earned one a derogatory nickname. As will be shown in the next chapter, men who worked in the mines tended to feel more obliged to spend on their colleagues compared to other men. Because they usually worked in groups, contributed labour and shared the proceeds equally, colleagues not only knew what others earned, but often also felt that what their colleagues earned was directly attributable to their efforts as well, and therefore, often made demands for their colleagues to spend some of it on them.

A spending pattern oriented more to friends than to family contradicted men’s roles as providers of material needs and other resources for their families, as discussed earlier. Many men admitted to this paradox, and acknowledged the detrimental effect of the quest to maintain a reputation through spending but indicated that they did not know how to resolve it, as “being and eating with others was part of being a good man”. Yet women strongly criticised this spending and interaction pattern among the men, with many believing that their husbands were being misled by friends and peers. Thus men faced the

dilemma to balance their peers' expectations and their wives' desires for them to be the caring husband who did not "waste" money.

Among the young and, to a lesser extent, middle aged men, masculine reputation was also established by demonstrating superior understanding of dress fashion and purchasing modern accessories such as bangles, baggie jeans and heavy shoes, sun glasses and fashionable hairstyles, as well as familiarity with the latest songs and dance styles. Owning the latest mobile phone or clothes elevated one's status, even though these items were often already very common in the cities. Men and boys often talked about their regular dancing and drinking sprees in the nearby Busia town centre or in Mbale, the second largest city in Uganda, where they outspent the urban folk. Well-travelled men who knew Kampala or Nairobi or Mombasa in Kenya, were held in high esteem because they were not only considered to be carefree spenders but also were seen as more exposed to cosmopolitan influences, with many interesting stories and a different outlook to life.

## **5.4 Conclusion**

This chapter has highlighted that there are multiple ways of acting and being masculine in Mam-Kiror village. The actual value attached to each of the different dimensions of masculinity varies by circumstance and by audience. For example, while multiple sexual partners were valued by peers, men presented themselves to wives as faithful and loving husbands. The religious institutions, the family and older people in the community, were the other key audiences that encouraged the expression of masculinity through having children within the context of marriage, proper family care, valued respectability and discouraged extramarital affairs. In contrast, the young adult males and peers tend to aspire for masculinities expressed in terms of sexual achievement, competitiveness and physical strength, and value reputations acquired through having and spending money. The dimensions of manliness were largely conceptualised and set out in relation to men's expected social roles in existing social institutions and structures like family, clan and relationships at work. The discourses acknowledged that one's masculinity is not inherent from one's physical/biological nature as a male being and that becoming a real man was not a straight forward linear process that necessarily corresponded with biological maturity as an adult male.

There is the belief that masculine status can be gained/achieved and sustained through certain norms and lost through others. But how do men in Mam-Kiror establish their masculinity through certain attributes and not through others? The findings suggest that certain ways of being manly seem to be losing social appeal and are becoming unpopular, while others are rising in popularity. To be seen as truly masculine among peers, expenditure, multiple marriages and sexual achievement were crucial resources, yet, from the point of view of the public, sexual fidelity and not extramarital sexual exploits earned more masculine points for the men. Masculine status awarded by the public seemed to be considered more important than the masculinities constructed in private spheres and men felt constrained to conform. The masculine ideals of ownership and economic success cut across other cherished means of expressing and asserting masculinity in Mam-Kiror such as masculinity of marriage and sexual achievement, expenditure and family provisioning. These issues will be returned to in the subsequent chapters, starting with the next chapter which specifically looks at how masculinity was linked to economic circumstances and a work ethic.

## **Chapter 6: Income, Employment and Masculinity in Mam-Kiror**

### **6.1 Introduction**

As discussed in the previous chapter, a work ethic and money-making were repeatedly emphasised as important sources of masculinity. Having work and money enhanced other masculine attributes, for example for one to have more wives or sexual partners, one needed to have money. In this chapter, I explore in detail the masculine norms, practices and concerns associated with work and income in Mam-Kiror, and in doing so provide the background to understand how a masculine work ethic and economic circumstances might influence men's HIV testing and treatment seeking behaviour.

This chapter begins with Juma's story, illustrating the context and circumstances of work as it relates to different aspects of men's lives, including health. It describes his life history and provides an overview of the value attached to having work. Thereafter, the chapter describes the prevailing categories of work in Mam-Kiror, and gives details of the structure and organisation of artisanal gold mining, the main source of cash income in this village, with the aim of highlighting the masculine norms and discourses resulting from men's inclination to work hard and make-money.

### **6.2 Juma's story: money and teamwork**

At 51, Juma was the oldest man interviewed during the fieldwork. He had only one wife; although in the past he had had more, as he described: "I had women, some have divorced, and some have died; and now I am left with one wife." Juma had ten children, eight of them born to his current wife. All these children, except one married daughter, were still dependent on him.

In spite of having had only two years of schooling, Juma had had opportunities for formal employment with different companies in the past. In one he was a cargo lorry conductor, and then he worked in a bread factory and later in a mining company as a manual labourer. Juma's latest attempt at formal employment was during my fieldwork when he got a job with a mineral exploration company that took him to the western part of the country. This

was, however, short lived as he returned to the village after only two months because the company declined to offer him a longer contract. Juma had previously tried on several occasions doing private business too. At one time he was a fishmonger and on different occasions he traded in cattle, saying “you know as a family man, conditions [obligations] force you to try this and that; for the children.” However, the job that Juma had worked in consistently over many years was artisanal gold mining in the village. This was Juma’s main job during my fieldwork. He described it as his historical job: “I started digging gold many years ago. I dug it for almost twenty years and left but now again I am back to it.”

Juma’s job as an artisanal gold miner was quite challenging and risky. He described the challenges as follows: “I am in the trenches [digging gold] there trying to earn a little for my family, but most of the trenches are now very deep and have got water, making mining difficult.” The major risk of this occupation is accidents when the mine collapses burying miners underground. Juma has witnessed a number of his colleagues and village mates get buried. “Sometimes we dig out dead bodies and so many people have run away from this job.” But he recalls that in the days prior to falling ill as a result of HIV, he was a very well built man who not only worked hard, but was also very courageous and had no fear of any mine site.

However, ever since his diagnosis with HIV in 2008, Juma’s ability to work has been significantly affected. Although the illness disrupted working prior to testing, Juma argued that the septrin drugs that he took for HIV treatment for three months had far more negative impacts on his work ability as he constantly suffered from their side-effects. Since the mining tasks are carried out largely with other men in groups, and output is shared on the assumption of equal labour contribution, Juma worried that frequent absences due to drug side-effects or disclosing his illness to colleagues, would disadvantage him. “Our work is difficult, when you leave only your friends, you do not get anything. This is the nature of our job, you have to be there and we are used to it. It is the only job we know.” This is the main reason Juma chose to drop his treatment. Juma indicated that he wished to stop mining work given his health condition, but poverty and the pressing family obligations dictated he continued working. Besides, this was the only reliable job Juma knew and it was “our job, the job of men here.” “Sometimes I don’t have energy to do it but I say, ‘no, let me go out and work for the sake of my family even if I am sick.’ ” The truth of this assertion became apparent to me when I witnessed how Juma laboured hard to raise money for the treatment of his 12 year old son who fell ill for about three months

during my fieldwork. Besides his earnings, Juma borrowed significant sums of money from the village savings groups to support his son's treatment. He told me that lenders had trusted him because they knew his reputation as a hard worker. In spite of being treated in various hospitals including the national referral hospital, Juma's son died. Days after the burial of his son, Juma lamented to me: "I wasted a lot of money and time yet the child has still died. Now I am already worried about how to pay back the huge debts. But I have got to work hard and repay the money; there is no excuse. So, nowadays I work twice as much as any of the members working in the mine site."

Juma's story, like those of many other men interviewed and/or observed during fieldwork, reveals how work and personal success, especially in the mines, was important in conforming to an ideal image of masculinity in Mam-Kiror. Why this is the case will be considered below, starting with a description of the structure of employment and the dominant categories of work in this village.

### **6.3 Employment opportunities and livelihoods**

Having work to do and making money was an important theme of everyday discourse in Mam-Kiror village. Morin (2004) has stated that while there is always a tendency to think of work as a job that provides for basic subsistence needs, that is not its only function. Work is, above all, an activity through which an individual fits into the world, creates new relations, uses his/her talents, and learns, grows and develops his/her identity and a sense of belonging. Although the participants in this study predominantly discussed paid work/employment, they often also emphasised the social value of work, either explicitly or implicitly. Their understanding of work, therefore, encompassed productive activities for economic benefits as well as the symbolic and social processes through which ethos and identity were maintained (Cohen 1979).

Juma's recurrent concern, for example, was that without a proper job, he would not be able to earn adequate money and provide for his children, undermining his role as a provider and status as a self-sufficient man. Throughout my fieldwork this was a familiar way in which men discussed work. For example, Elly's (age 28) account highlighted how a typical man perceived the centrality of work for masculinity:

Godfrey: What makes a man sufficiently manly?

Elly: When you have work.

Godfrey: Which type of work?

Elly: That which brings you money; then you are a man.

However, other values of work were articulated in many narratives during the study. These related to both the meaning attached to the very fact of having work and to the category of work itself. As Juma's story suggests, working helped him feel connected to a wider network of fellow men and maintaining a sense of self-worth and identity before other members of society. Similarly, when probed further during the interview about the values attached to different kinds of work, Elly spoke as follows:

Godfrey: So, which work is highly regarded as work for men and why?

Elly: Like having a grocery shop and *effesa* (gold mining) before you can consider engaging in other kinds of work. It is these activities that you can tell others as you leave your home that you are going for work. Like this work of ours of mining gold, when you join other men and work with them, then you are able to show that you can also work hard like others.

Although Elly's narrative still positioned money making as a central goal of work, when he talks about "being with other men and showing that one is also able to work hard," he introduces a social value of physically-demanding work, particularly regarding self-worth, to his conceptualisation of work. Like Juma and many other men interviewed and/or observed, Elly's account underscores the significance of ability to work hard physically as a means to maintaining connections with other men and affirming one's reputation as a hard worker.

Being a rural area, Mam-Kiror village had a limited range of types of work. Subsistence cultivation was dominated by women, while the majority of men were involved in artisanal gold mining. Other people earned their livelihoods through small-scale trading or through operating bicycle or motorcycle taxis popularly known as *boda bodas*. Formal employment that earned people a regular salary was not common in Mam-Kiror village. Generally, there were few paid casual work opportunities in the village and they had to be competed for, therefore one's reputation of hard work and strength counted a lot. It is important to note however that within the village, some men's sources of livelihood were multiple and

varied considerably: today, one might be a porter in a construction site, tomorrow a labourer crushing gold ore and the next day a produce dealer. This meant that people's economic situation varied from one day to the next, and was also dependent on their ability to work hard and spend frugally.

As a result of hard work and frugality some men had accumulated material possessions, typically domestic fowl and other animals, bicycles, a piece of land or even a small business enterprise. Men who did not own anything “worth talking about” were often ridiculed, especially by fellow men, and judged as lacking vision, as failures, and their self-worth and masculinity publicly challenged. The quest for material ownership compelled men to work hard, sometimes in risky ventures in complete disregard for their own welfare and health. Thus, while work was seen by men as creating both social and economic benefits, many acknowledged that work circumstances also came with some undesirable consequences to their masculinity. Men living with HIV were particularly emphatic about the centrality of money and working relationships in their lives and in supporting ART. This is discussed in detail in Chapters 7 and 8.

## **6.4 The dominance of artisanal gold mining and the designation of cultivation as plan ‘B’**

“For us here, cultivation is plan ‘B’; men only do it when gold mining has failed”, (Joel, informal conversation, November 2009).

This brief statement captures the status that artisanal gold mining occupied in the economic and social lives of men in Mam-Kiror village and its neighbours. While some men, such as Elly described other income generating work, such as having a grocery shop as being as valuable for one's masculinity as gold mining, for the majority gold mining played the most central role in their livelihood and identity construction. Juma's story illustrates that although he had attempted to work in other sectors and sometimes wished for a better paying and more satisfying job, Juma had always returned to engage in artisanal mining and spoke about the mining occupation with a sense of nostalgia, describing it as “an indispensable historical occupation”. Nearly every person that I talked to in the study village, whether or not I specifically steered the conversation to it, told some story about gold mining. Men in particular repeatedly described the positive as well as negative ways in which gold mining had shaped their social and economic lives and identities, as well as

how the village was being transformed by the gold resource. In fact, most people in Mam-Kiror village preferred to describe their village as “a gold mining village” rather than subsistence cultivation dependent. Generally, artisanal mining was acknowledged to be a unique occupation and the miners viewed themselves a distinct group with a unique work ethic, identity, risks and prospects.

Gold was discovered in the area by the colonialists in the 1930s but following the initial withdrawal of the exploration companies after only a decade of mining, due to concerns about the grade and volume of gold, artisanal mining commenced in the area and continued to the present day (Mbonimpa, Barifaijo et al. 2007). However, according to the village residents, important changes regarding the extent and freedom of the local people to mine in the area have occurred in the last couple of decades. I was told that the renewed interest by a private mining company to carry out mining in the area, and its subsequent licencing by the Government in the 1990's, led to a corresponding heightening of local people's interest to increase their control over the land so as to maintain their private mining. With the mining company claiming *bona fide* ownership rights over a sizeable portion of the village land through government leasing and the residents claiming customary ownership of the same land, the result has been frequent conflict and clashes. Nevertheless, throughout the fieldwork period, the local people continued to carry out artisanal mining freely in parts of the village where they believe they have land rights. Although it was a relatively small scale and informal industry, it was the desired work of an average man in this village, with some men repeatedly stating that gold mining is the only occupation they have ever had or could ever do. Among the twenty six men interviewed during the fieldwork, only one man was formally employed and earned a regular salary, another was a builder, and two reported being exclusively involved in cultivation. Although only ten of these men reported being involved in artisanal gold mining at the time of the study, all of them had been at some stage in their life. There was a tendency among men to drift in and out of gold mining work from time to time.

Gold mining was popular for its quick money-generating potential. To the majority of the men in this village the availability of gold represented multiple prospects and raised aspirations. There were several examples of men that had succeeded economically through gold mining while many more looked forward and were hopeful of *aki'fualu* (break through), as they commonly put it. The concept *aki'fualu* is drawn from the Swahili word *fualu*, meaning success, but was frequently used by people of Mam-Kiror village to denote

a 'stroke of luck' in relation to gold mining. Most men involved in the mining argued that from their experience, acquiring wealth from their work was far more dependent on luck than on hard work. They said only a few of their counterparts had been lucky to earn big gold money which they mostly invested in buying motorcycles or establishing shops, in the process significantly transforming their individual statuses and family wealth. Despite the belief that the breakthrough needed great fortune, men still believed that one needed to work consistently to enhance one's chances of striking the fortune. Men were thus hopeful, anxious and sometimes frustrated with their work.

In reality, the earnings varied depending on the amount and richness of the ore mined. While some people had earned large incomes from it, the incomes were generally small, of which a sizeable proportion was taken by the costs incurred. However, these earnings were higher and more regular than those from cultivation. As a result, for many of the men in this area, farm work was not considered a better alternative; it was done more as a matter of tradition and routine rather than as a principal occupation and means of daily survival. Hence it was plan B as described by Joel.

## **6.4 Organization of gold mining work**

### **6.4.1 Structure of gold mining groups**

Mining work typically involved men working in groups ranging between five and twenty members; often these were relatives, or close friends. There were very few criteria one had to fulfil to join a mining group. However there was an emphasis on physical strength. The groups usually lasted for only the period of a particular mining term, which varied a lot depending on output realised, although it would sometimes last for up to a few months. After a group has been disbanded, members were free to join other groups. All sites were located on land owned by individual men's/families but would be accessed by paying rent or with permission from the land owner to mine free of charge. Further details of these criteria will be provided later. In a single site measuring approximately 50m<sup>2</sup> there would be several groups working in it, and there were often more than one operational site at any one time. Typically, mining would be carried out for a few weeks until the point when the members felt they had obtained a substantial amount of ore, which was then shared among members or if they felt that the ore was exhausted. To ensure fairness, every member was entitled to an equal amount of ore measured in tins or bags, on the premise that everyone worked equally.

Teaming up was important for two reasons: First, to enable men to pool the initial fees usually required to rent land from the land owners, which would otherwise be too expensive for one or a few individuals, and second, to supply the joint labour required for the highly laborious activities during the mining process. Even in situations when some wealthier men rented portions of mining land as individuals, they often hired groups of men to work for them. By virtue of this arrangement, it meant that men depended a lot on each other in their work. It also meant that men spent much of their time together, mostly in the mine sites or in the trading centre relaxing together after work.

Women were rarely involved in any gold mining activities, largely because the work was considered too physically demanding for them. When I asked why women were not involved in contributing labour in the mines, yet they carried out most of the cultivation which was equally exhausting and laborious, both men and women argued that cultivation was incomparable to digging gold, which was not only strenuous but also dangerous and required the courage or heart of man. However, for the very few women who occasionally got involved in mining in some way, they were often involved either as a dormant member who only contributed membership fees and received a lesser share of the ore due to their lack of labour contribution, or they paid membership fees and hired some men to contribute labour on their behalf. Some women with grown up sons but who were not fully independent sometimes designated those sons to work on their behalf. Such women were often widowed/single mothers, and it is highly likely that if they had husbands, their husbands would be the ones involved in these mining activities on behalf of the family. On a few occasions, I saw a few women, mostly older ones, and very young girls, scavenging on the debris after men had collected the more precious ore. During very busy and productive mining periods, some women supplied food and drinks to the miners on site. However, as the trading centre was within the vicinity of most sites, the established eating houses were in easy reach.

#### **6.4.2 Mining techniques and circumstances**

Not all land in the village had gold, so miners often have to identify a piece with deposits. This involves guess work and scavenging on different plots of land within the village. The procedure of accessing such land will be described in the next section. When an area with prospective gold has been found, members of mining teams may carry out a trial production to ascertain the quality of the gold before the interested groups divide the area

into portions to start mining. They then embark on mining work; involving mostly open cast mining although tunnelling was also done to a smaller extent. Rudimentary tools including hand hoes, chisels, and spades were used.

Productivity in each of the two key phases of the mining process – extraction of ore and processing – depended on physical effort, mainly due to the fact that the activities were carried out using basic tools. Usually the extracted ore is heaped or placed inside bags and kept at the site before being shared. This meant it had to be guarded both day and night. The men designated to guard, on a rotational basis, usually slept outside as night raids and robberies had been reported, sometimes armed.

A specific site was mined until it was felt that the gold ore was exhausted. This is done by either visual inspection of the ore or by extracting a sample for testing. Sometimes mining a specific site was abandoned if men felt the pit had become too deep, making it too difficult to get the ore and soil out, or if there was a risk of a serious accident. In other cases, the pit filled up with water forcing the closure of the site as it was too uneconomical to drain it either manually or by use of a water pump. There was no well-defined mining “season” as there was almost always some mining activity taking place in the village but there was a strong belief by the miners that gold was a seasonal commodity. There were dry spells when the gold was ‘lost’ and the boom periods when mining sites were a ‘beehive’ of activity. However, my observations revealed that the reported seasonality of gold should in fact be seen as the time when prospective miners took the time to explore new sites and to start the extraction process, rather than actual natural seasons of availability/unavailability of gold. The most active mining ‘season’ tended to be the dry season or when there was less rain.

There were other activities associated with the mining process. These included manually crushing/pounding the ore into powder, washing it in the streams and using mercury to recover the gold. These activities were often performed by young men or boys for a small fee. Although it was physically exhausting, it brought instant payment upon completion of the job. The final stage was to sell the gold to the local buyer.

### **6.4.3 Mining and land ownership**

Not everyone involved in mining gold did so on their own land, so some form of arrangement with land owners to secure mining rights was necessary. Various

arrangements were possible. Usually, permission to mining groups was based on payment to the land owner of a certain percentage of the gold extracted, or a down payment of a certain fee. On some occasions, although this was said to have been mostly in the past, permission to mine was granted for free based on friendships and the land owners or their children would be part of the mining groups. Sometimes, some miners bullied the weaker landowners into allowing mining of their land, drawing on a discourse of common ownership of natural resources, which had some legitimacy given that land was still held under the traditional form of ownership.

In general, the arrangements between miners and the land owners, and even between miners themselves, were largely informal. Miners were vulnerable to exploitation from the landowners but land owners themselves were sometimes cheated. This could lead to resentment and tension. Ironically, despite being resented at times, a land owner that could successfully manipulate the different groups of miners to his advantage and accumulated large amounts of money through these unfair ways, later becoming economically powerful, came to be admired and considered “smart”.

#### **6.4.4 Mining and capital**

Most money lenders in the village were also gold buyers. Those who depended on them most were poorer men seeking short term loans/capital to invest in mining activities, such as membership fees, hiring of tools or paying for meals while at work. Sometimes men also borrowed to meet domestic expenses or in case of an emergency. The loans were usually repaid in the equivalent amount of gold, or could be repaid in cash after the gold had been sold. While this arrangement facilitated the mining process it created dependence on money lenders/gold buyers and resulted in accepting appalling terms and conditions. Some men would be in perpetual debt and therefore forced to spend long hours, including nights, working hard in the mines. Juma, for example, had borrowed widely when he had problems and was compelled to work “twice as hard” as everybody else in order to raise money.

In months when gold output was low, demand for labour and wages would fall. Sometimes there were disputes with employers over unpaid wages or with work colleagues over missing ore. These cases were rarely settled at the level of village leadership (LCs or opinion leaders). The first option, especially for the younger men, seemed to be fights as a

mechanism to resolve their differences. The fact that men tended to choose this path of conflict resolution as a first option was indicative of the virtue accorded to aggressiveness and physical strength as a marker of masculinity among men in Mam-Kiror. Quite often during such clashes spectators tended to gather, cheering and making comments such as “*weka yeye chini*”, meaning ‘put him down’, inciting the parties involved.

## **6.5 Notions of masculinity constructed through work and mining**

Interactions with the community in general and the miners themselves revealed that there are characteristics, norms, attitudes and practices that are thought to be peculiar to those participating in mining, suggesting a distinct subculture and performance of masculinity in ways that were significantly different from other men in the village.

### **6.5.1 Work ethic and families**

Men, particularly regular miners, repeatedly presented the notion of a work ethic, suffering and risk of harm or death, as part of what it means to be a responsible man with family obligations. Their narratives of why they toiled so hard in the extremely laborious gold mining activities projected their family support roles as the primary reason that motivated them into those strenuous activities. As we saw from Juma, his account consistently engendered a perceived relationship between his ability, as household head, to work and the family’s wellbeing and progress. Often the majority of men in Mam-Kiror presented their explanation as *akijar nakere* (family survival) or *akitopol ere* (family economic progress), thereby positioning themselves as providers for their families as well as persons with responsibility for the family’s progress. In conforming to such a work ethic, some men developed an increasingly fatalistic attitude which considered their health as the necessary sacrifice for their dependents’ livelihood. Juma, for example, speaks of having previously dug out dead bodies of his colleagues who perished as a result of mine accidents and yet he was not deterred from mining because he wanted a living for his children.

In general to show that they were serious about money making, men were expected to go the “extra mile” to earn money required for various purposes, and often the main

justification for going the extra mile was their family. From observations and interviews I learnt that when men negotiated for work or money they often hoped to use their family to secure goodwill. Practices such as cheating others, quarrelling over money issues, or reluctance to pay taxes, were often justified in relation to family pressures which alleviated any guilt. At the other extreme was a person like Solomon, married with nine children, who after developing symptoms of tuberculosis (TB) was forced by poor health to stop work. Although he found it hard to accept it initially, he eventually “stopped worrying too much”, arguing that “I had after all worked hard enough in the past and my reputation as a hard worker was well known.” In addition, he had acquired a piece of land from his work and therefore felt less pressure or shame not to be working as hard anymore.

### **6.5.2 Collaboration and competition in the mines**

Mining sites were arenas for collaboration, teamwork and competitiveness. Pooling of labour meant that men depended a lot on each other for their work, developed a collective work ethic and a strong sense of shared responsibility towards each other. This culture of working together resulted in the development of strong group values of solidarity, loyalty, friendship and sharing. The collegial spirit and emotional bonds established through working relations led men to develop a strong sense of “brotherhood”, as they often referred to each other, regardless of whether they were related.

The miners’ strong feeling of a sense of brotherhood and connection to co-workers appeared to significantly influence their motivation to remain in the occupation and commitment to working every day. The feeling of collective identity and attachment to the mining occupation partly fostered a culture that was associated with willingness to ignore exhaustion and risk and encouraged the assertion of masculine courage during work as a measure of one’s worth and ability before other men. Moreover, as the success of the group depended on the presence of all or most of the members, absenteeism was discouraged, with the main consequence being loss of earnings. For example, when Juma’s son was ill, he missed a few days of work, which made him extremely anxious because his earnings and safety of his gold ore depended on his daily presence at the mine with co-workers. In Mam-Kiror, it was common for men to discuss upcoming work plans and other potential opportunities while socializing, especially late in the evenings. So, people who often worked together tended to socialise together. Keeping company with other men was a strategy to keep connected in case of any work opportunities

However, relationships with colleagues and work related contacts were not always cordial. There were frequent disagreements arising from competition for the rights to mine, sharing tools such as water pumps or simply over status. Often situations like these degenerated into physical confrontation, in which men attempted to demonstrate supremacy in fighting skills. For example, one day in March 2010, a quarrel started between two young men in a night club owned by one of the local gold dealers and turned into a fight between rival camps of supporters/suppliers of another gold dealer and those of the club owner. One of the boys involved was a worker at the night club and the other was known to be working with a group that mined gold at the site owned by the other gold dealer. Although the disagreement was triggered by the refusal by the other boy to pay the entry fee into the club, his reaction to being denied entry was in reference to gold rivalry. This led the supporters of the club owner to conclude that he could have been sent by rivals to incite them. When the confrontation resumed the following morning as the matter was being resolved before a group of elders, the rival gold dealers themselves were involved with each trying to dispute the other's influence and status in the village.

### **6.5.3 Reputation and hard work**

Prolific miners often enjoyed some sort of celebrity status by many in the village, including children and women. Such men who had distinguished themselves as hard workers were often lauded in specific ways that endorsed their abilities. Often you would hear remarks such as “*amongo ngini nges I wesat, n`ges ilanyit kane keere*” meaning, “that ‘bull’ is the one who knows best how to mine, better than anyone else”. Because of being viewed this way, some men were not only highly sought after to join teams but also had specific tasks reserved for them that distinguished them as specialists and fearless.

There were many examples of this, but Musa (age 25) was one of the most prominent. During a stroll around the mines with two friends one morning in April 2010, we found Musa working hard to try and crack open a hard rock. He was being assisted by another man who helped hold down the chisel as he hammered it with a mallet that appeared to weigh several kilograms. I was told that he had volunteered to do this part of the job himself as he often does. I was further told that in the whole group of about nine, he was the one who could manage that kind of work. Yet Musa was not the giant in his group. Although he had been on it for a few hours with little success, Musa did not give up.

Apparently, Musa, like a number of other men, was reputed for taking on the toughest tasks of breaking the hard rocks, tasks which others feared could cause them chest problems. Musa's case is interesting because while he might have often volunteered to take on hard tasks, his motivation might have been to defend his well-established reputation as a hard worker. Like Musa, most miners, including Juma, carried the impression that others evaluated them on the basis of their previous work ethic, which they must reproduce in order to affirm or maintain their masculine reputation.

There were many accounts that illustrated how personal success and experience in mining were significant for constructing masculine identity. For example, in Juma's story, besides the cash that accrued from mining, he proudly recounted his experience and skills in mining which put him level with or above other miners. Longevity in the industry was also a source of pride and status; it demonstrated enduring physical strength and gave a strong sense of occupational identity as a miner, as Juma portrayed in recounting over 20 years' experience in the mining industry and previous reputation as a strong man.

#### **6.5.4 Opportunities for mentorship and discussion of men's issues**

Work environments, in particular the mining sites, provided the opportunity for men to mentor others into particular sub-cultures and masculine constructs. It was at work and during interaction with work colleagues that men evaluated others' strengths and hard work, mentored and pressurised them to be manly, and sanctioned, rejected or validated others' attributes of being sufficiently manly. The mines were isolated 'male only territories', where men seemed to find it easier to engage in talk about their manliness, sexuality and health that would otherwise be embarrassing if spoken in the presence of other groups, especially women and children. Men, particularly if they belonged to the same group of peers, often joked and teased each other regarding their sexualities. For example, during an observation of a group of 9 men (aged approx. 20-40) returning from a mine in the afternoon of 10 April 2010, I witnessed when these men collectively mocked and challenged a friend of theirs to pursue his separated wife and bring her back. This reaction was prompted when another man passed by who was reported to be planning to marry the same woman. In urging their friend to go after his wife before she was snatched, one man said "I will not accept being party to this, to be a friend to a weakling." Another man asked "...how do you feel seeing your rival suitor pass by? You must be made of a

different material, because had it been me, I would not allow that to happen!” In response, the concerned man admitted that he was trying to get his wife back, and that is the reason he was working hard to get money.

It is also at work that men freely recounted and compared their sexual adventures and achievements and evaluated the risk of catching STIs, including HIV. It was also during this time that men closely observed others’ health and noted symptoms that may require treatment or being ignored. A number of interviewed men, including Solomon, Job and Tony, revealed that it was work colleagues who recommended health seeking after growing concerned about their illnesses, yet others found it very threatening for their work and masculinity to disclose HIV diagnosis and/or treatment to colleagues, as will be discussed in Chapter 8.

## **6.6 “Gold money is good but it is killing us”: money in Mam-Kiror.**

While households in this rural but economically developing community did not entirely rely on money for their subsistence, concerns about money dominated their day-to-day lives, particularly for men. All people I interacted with in Mam-Kiror village, whether or not known to be HIV positive, young or adult, female or male, poor or wealthier, were incredibly concerned about money. Unsurprisingly men considered money an essential necessity in their day to day lives, be it for putting *eddy* (sauce like meat or fish for the family’s consumption) on the table, paying school fees, paying a debt or to comfortably belong to and fit into other men’s company. Since the village, particularly the trading centre, was in the process of modernising with new developments such as modern bars, a night club, and video halls with international TV, there were new lifestyles that tempted most people and necessitated cash.

### **6.6.1 Money and social status**

Ability to make money was widely associated with masculinity in Mam-Kiror. Men who did not earn regularly often felt emasculated in the face of their own families as well as before other men. Through mining activities and other businesses, some individuals had bought assets, constructed houses and led lifestyles different from others. The various male social groups, such as beer drinking groups, were based on many factors, but the most

crucial was money. There was an awareness of differences between those who primarily mined and those who did other activities; with the miners known to have more money. Often professionals such as teachers were respected for their historical role in society but were also seen as some of the most needy who regularly borrowed from gold miners or business people.

In interviews, observations and conversations with different people, it was widely acknowledged that money was used to adequately perform the majority of roles that demonstrated masculinity, ranging from family provisioning to engaging in sexual infidelity to excess alcohol consumption and to climbing the social ladder. Money was also used to subordinate and marginalise other men and women, as was discussed in Chapter 5.

### **6.6.2 Sharing money with friends: Dilemmas and tension with family**

A central aspect of men's work relationships in Mam-Kiror was the tendency to spend leisure time with co-workers and other peers after work, during which they often shared drinks and food and enjoyed other forms of entertainment. Generosity after pay day, particularly from selling gold, was a generally expected norm. Co-workers often reminded others not to be stingy or sometimes openly demanded a drink or a meal or something else from peers known to have earned from the sale of gold. As a result, men tended to be under pressure to spend significant portions of their money on drinking and eating with friends. The following extract from my field notes written in December 2009, illustrates how men commonly behaved when with colleagues.

It was about 11.20 am. I was just hanging about in front of Mister's shop as I often did. Three men had taken seats under the tree that we usually sit on. I was close enough to hear their conversation and follow how they interacted. They were work colleagues discussing *effesa* (gold) but this was not what captured my attention most; what did was the way they willingly bought drinks for each other. First, one of them told his friends he was going to pick himself a drink. But he did not get a drink for only himself but bought for the rest as well. When another joined them, I also did. No sooner had I sat, than the newly arrived man also went to the shop and bought himself a soda as well as me. I had observed this a few times before and wanted to understand the value

attached to this practice. When another two men joined us, they requested for soda too; asking: “Who is in charge [of buying]?” The man who had bought for me arose and did what had been asked. It is at this point that another man remarked: “Brother, when something [money] is there we shall share. That is what makes us men, because today it is me and tomorrow it is you [who has it]” (Field notes, December 2009)

However, this custom to spend on friends conflicted not only with personal or society’s expectations for them to be frugal and save, but also with wives’ desires and expectations for their husbands to spend more on the family. In a conversation with me, one woman expressed her resentment and frustration with men’s pattern of consumption as follows:

Men are pretending to be working hard for the family and children but are spending nearly all their money in bars, restaurants and lodges. ‘The worst time for women in Mam-Kiror is actually when the men earn money from their gold. The men divert to eat every meal including breakfast, lunch and dinner from the hotels. A man returns home only at night (Wife of polygynous gold digger and buyer, July 2010).

In general, although the relatively regular income from gold was widely seen as an essential part of life, there was a shared concern in the community that many men tended to engage in irrelevant and risky expenditure patterns, and hence gold money was dangerous money to men’s lives and their families. A key concern was the perception that gold money exposed men to the risk of HIV. Money was seen as problematic because it afforded men access to risky sexual relationships both within the village and in the nearby border town, and excessive alcohol consumption. For example, in a conversation with Mama J and her nephew Gilbert, they argued that in their view, “everybody in Mam-Kiror is dead [HIV infected]”, associating it with the frequent access to money by especially the miners. While concluding his argument, Gilbert remarked that: “gold money is good but it is also killing us” (Casual conversation, Mama J and Gilbert, August 2010). Confirming the anxiety around regular access to money, Juma, while discussing with me why he had decided to disclose his HIV infection to his two elder children, said: “I wanted them to know and they learn that I got it when I had money,” (May 2010). However, consistent with some of my own observations, the older men argued that the younger miners were more susceptible to wasting their money through excessive drinking and pursuing sexual

partners compared to older men. In a conversation in March 2010, one older miner aged about 50 argued: “It is mostly these younger men who are driven by *eraa* (lifestyle desire) and whenever they earn money from the sale of gold, they first abandon working and resort to spending on alcohol and women until the money is finished.” Comparing gold money and money from other sources such as trading, cultivation or sale of poultry, Esau, a butcher in the village, repeatedly argued that people who earned money from other sources were more careful in their spending because they were aware of how irregular their sources were or because, in the case of businessmen like him, capital was needed for business continuity.

### **6.6.3 Credit and money-lenders**

As previously stated, there was widespread short term borrowing of money, particularly by men involved in gold mining. Credit was often needed for re-investment into the mining activities. For example, Juma always borrowed when he needed to hire extra labour to mine for him. Many men also approached me to lend them money to support their activities. However, perpetual borrowing often resulted in loan defaults, especially if the yield from the mining was poor. As a result, men often lost bicycles, household items and sometimes land to the lenders. Yet, not only these items were lost; sometimes due to debts, men ended up being incarcerated in police cells. Paul was one of the many victims of failure to repay debts, whose experience I witnessed during the fieldwork, as highlighted in the previous chapter. Such experiences undermined men’s sense of masculinity since they were often belittled by others.

## **6.7 Conclusion**

This chapter has explored the importance of work in men’s masculine identity, providing insights into how work circumstances and experiences may negatively or positively affect men’s construction and perception of their masculinity. The predominant occupation and source of cash for men in Mam-Kiror village is artisanal gold mining. This chapter shows that what were seen as the characteristics of masculinity were shaped largely by mining. Mining fostered attitudes and habits such as competitiveness, a work ethic to earn and provide for one’s family, as well as through maintaining masculine reputation as a hardworking man. The mining sites were largely male only environments, and so offered the spaces for men to approve and reject other men’s attributes of masculinity. Miners

portrayed themselves as a distinct category of men who had embraced the challenges and risks of the mining occupation and were under pressure to conform to the characteristics for which miners were reputed. Sometimes this enhanced their self-worth and masculinity but sometimes it undermined their reputation. The central role of masculinity assessed in terms of work ethic and money making in men's uptake of HIV treatment will be considered in the following chapters.

## Chapter 7: Masculinity, HIV testing and Treatment Initiation

### 7.1 Introduction

This chapter explores the factors that influence men's uptake of HIV testing and treatment initiation from the perspective of the prevailing masculine identities discussed in Chapter 5. It begins with Solomon's story which highlights his experiences and concerns surrounding his decision about whether to undertake an HIV test and/or initiate treatment, and the way specific aspects of his masculinity influenced testing and initiation. This is followed by a discussion of how and with whom men talked about HIV testing, with the aim to contextualise the decisions behind taking an HIV test. The chapter then discusses the barriers and facilitators of testing and treatment initiation, exploring in particular how those factors related to ideals about masculinity.

### 7.2 Solomon's story: Confronting the 'mountain'<sup>11</sup>

Solomon was 42 years old, talkative and interesting to chat with. He looked ill and coughed quite a lot each time I met him. He had one wife, nine children and five grandchildren. He had dropped out of school in primary four due to lack of fees. Solomon described himself as "doing nothing" since 2007 when he significantly reduced his strenuous mining work, which had been his main source of income.

Solomon attributed his illness, especially the chest pain, to his hazardous work but since this was his main source of income he could not easily stop it. However, as the illness persisted, his work colleagues grew concerned and advised him to stop doing the more strenuous activities. Solomon did not feel offended by this attention from his friends, believing that they wanted to save his life. However, his limited contribution to the collaborative mining work meant that when the ore was being shared amongst the group

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<sup>11</sup> While the term 'mountain' was used by Solomon to denote how daunting the mission of testing was, Tororo town, where TASO, the largest and most well-known HIV testing and support centre is located, is famous for its cone shaped and sizeable rock. In the Ateso language, which is not as precise as English, a rock is referred to as a mountain. It is therefore common for people to say they are going to the mountain when they mean they are going to Tororo.

members, he received less. This often angered him and meant that he was unable to fulfil his role of providing for the family.

Although he appeared to live in denial that the chronic cough was linked to HIV, Solomon admitted to risky sexual behaviour in the past which might have exposed him to HIV.

“Now if you are a man, do you sleep with only your wife? Don’t you have some outside there; can’t you get another girl friend outside there? I had two; one became like my wife, for the second one, I was just doing it secretly until I gave up later.” However, Solomon’s friend Ben (an interviewee living with HIV) believes that Solomon knows that he is already infected with HIV because his wife was rumoured to have had a sexual relationship with Moses (age 46), another study participant who was living with HIV and died during the course of study. “I often find Solomon taking alcohol and appearing so drunk and whenever I asked [why he is behaving so], he says ‘my friend Ben, thoughts! They are too many.’ So, he seems to be worried by the death of Moses,” Ben narrated.

Solomon has had difficulty deciding whether to take an HIV test despite advice from various people. “My wife told me to go to hospital (for an HIV test), but I asked her, ‘who told you that my sickness is AIDS? My sickness is the chest pain’ [...] and she just kept quiet.’ Another time she said that we go and test but I told her ‘you go by yourself, for me also I will go.’” Solomon’s mother also suggested that he sought medical treatment: “[...] my mother also, she says I have lost most of my children and you also want to die! Go to hospital but I said no, not yet.” However, Solomon’s peers and work colleagues made the greater efforts to ensure that he went to hospital, frequently providing medical advice and sometimes offering to transport or accompany him to hospital. “You know here, everybody will tell you to go to the mountain [TASO] when you are like this. The boys (friends) keep telling me, but I refused, up to now, I have not stepped into the hospital for that [HIV] test. “You know at the time I was still strong, the body was still fighting the thing [illness] on its own [naturally].”But now, where it has reached, I think I need to go for an AIDS test. I am ready to climb the mountain [chuckles]. I am ready to go where anybody takes me, I will go.”

Solomon had been reluctant to go to hospital because he was still studying his symptoms to see if they were connected to HIV as some people were suggesting, and also because he could not go to the hospital without ‘enough’ money of his own, saying: “I told him [friend], you want me to go to hospital even without a shilling in the pocket! I might need

to have a snack and you will buy that too when you have already offered transport and fuel, as if I am a child? He stated further: “So, it is the financial status of a man, you can go there and they surprise you with an admission. Like a few days ago my daughter had a swollen neck, I gave 15,000 shillings for her to go to hospital and reaching there, admission straight away, and I had to run around to find more money. Now what will you do, who will look for money if you the man has, instead, been admitted?”

Another reason for Solomon’s delayed decision to go for a test was, “also what my mother will think [if I am found to be HIV positive]? You know she is worried.” Also, Solomon did not feel comfortable going to one of the hospitals recommended by his friends for fear that his anonymity will be breached, saying: “Some [friends] had suggested taking me to Alupe hospital just across in Kenya but I fear such nearby places because people will just meet with you there. I do not want to go where you also find other people [who know you] and they start saying, ‘you are also here, oh my colleague, this and that.’”

Although he had hesitated to seek an HIV test, Solomon recognised that without one, he could not confirm his illness, saying: “It is the machine; the computer that determines.” It was also during this meeting that Solomon revealed that he had been diagnosed with TB before, but he rejected the kind of treatment prescribed for him: “You know I was tested at Majengo Clinic in Busia town for TB sometime back before you came here. They told me that the treatment would be 60 injections but I refused that treatment. I just didn’t like it; I can’t manage all those injections. I refused the moment they told me about it. I even left their papers (medical forms) with them. I cannot be going back for that treatment.” Solomon said he would probably have accepted tablets instead.” “Sixty injections are too many and considering that one gets only 1 injection per day, it means going to the clinic for 60 days. I cannot manage such a life,” he said with smile.

While Solomon acknowledges the possibility of discrimination and stigma if he tested positive, he spoke rather proudly about his ability to cope. “For those who think so [that I am infected], I am also not with them, I go with those who are pro-me, those who do this [demonstrates with his hands the signs of avoidance and makes another with lips indicating how people negatively portray others], I am not scared.” “I had most things on this earth whether it is money I have also tried to see [possess], whether land, I have also got, even there is some money I have saved in the form of a plot (of land) which I had bought for children. So I can decide to sell part of it, if things are bad.”

As Solomon's story hints, men's HIV testing and treatment seeking decisions were made in a context that was strongly influenced by both the individual and societal expectations of what it means to be sufficiently manly. In particular, it sheds light on the discourses about HIV testing and role of others, the significance of symptoms, the influence of economic circumstances, the role of a man, and the fear of an HIV positive test. These influences are discussed below.

### **7.3 Perceptions and discourses about HIV testing**

Whether or not to undertake an HIV test or delay it is a process that begins with an attempt to make sense of the symptoms and to evaluating one's risk. Often the evaluation of risk, symptoms and the need to test, involved discussion with others.

As Solomon's story suggests, men evaluated their risk of infection and talked about HIV testing with various categories of people, including mothers, spouses and friends. However, from many accounts there was overwhelming evidence that, for these men, the discussion about HIV risk predominantly takes place outside the domestic sphere. It was with friends/peers that men reviewed their sexual histories and jointly discussed their risk of HIV infection. In contrast, discussing such issues with a spouse or other family members, as we saw in Solomon's story, was believed to be inappropriate and threatening, as it would involve talking about sexual fidelity, which many men admitted breaching. Even though a minority of the participants acknowledged that their wives were also inclined to extramarital relationships, it was generally believed that men were more promiscuous, and therefore they tended to avoid discussing their sexuality with their wives, for fear of blame for bringing sickness. For example, Emma described why, before he sought a test, he first chose to talk about HIV risk with a friend:

[...] because he used to go there [for HIV treatment] and I said maybe I have the same problem like him. Also when you have a problem like this one, you tell a fellow man first because you know he can understand how it came about. You can talk about it with a friend and also talk about your movements [sexual contacts].

It was not only during the interviews that men's tendency to analyse information about their sexual contacts and risk with fellow men was expressed; these views were also evident from the many informal conversations conducted during the course of the study. For instance in a conversation between two young men discussing whether or not to undertake a test during an HIV testing outreach event that was being conducted in their village, one of them said to his friend: "Man, I really urge you, do not miss this chance as you know where [sexual contacts] we have passed."

Compared to wives and other family members, friends frankly assessed and discussed each other's risk of being infected, since they were often privy to information about each other's sexual relations. Sata (age 36, not tested but suspects HIV infection) revealed that he sometimes shared his concerns about his health with friends, but those friends often frankly pointed to his past risky sexual contacts:

Whenever I tell a friend that I am feeling pain all over the body, that friend just responds by saying, 'why don't you go for an HIV test?' They can say 'you have had many women, and now you are pretending that you don't know what is paining you!' So it might be true [that I am infected] because when I look back, and yet friends are also saying that you used to bring women, and you never know you could get any disease!

In the majority of the narratives, there was strong evidence that men tended to resent and silence their wives if they tried to discuss, or believed that their husbands might be at risk, of HIV. This underscored the unequal power relations between partners as Solomon's story shows. When his wife suggested that he should go for an HIV test following the persistent cough, Solomon's response to her was: "who told you that my sickness is AIDS? My sickness is the chest pain [...] and she just kept quiet". In contrast men's reactions to their friends' assessment of their HIV risk were generally positive, with minimal resentment. The following remark by JB (age 37, not tested, suspects infection) summarises why men tolerated their friends' evaluation of their risk but resented their wives'.

When it comes to those things (sexual affairs and risk), friends cannot be said to be accusing; they see everything but for a wife, she just guesses, so you can deny and ask her 'have you seen me [with another woman]?'

Women's accounts also confirmed that there were far less discussions about HIV risk and testing between their husbands and themselves, only increasing if there were obvious symptoms or events which pointed to the possibility that both/one of them may be infected with HIV. The wife of Abraham responded as follows when I asked whether anybody in the family had talked to her husband about HIV testing before he undertook it: "Nobody, I think he himself; it must be from talking with his friends." Abraham's (age 50, receiving treatment) wife admitted that she did not suggest that her husband goes for HIV testing because it was not their norm to discuss HIV as a couple. Similarly, 50 year old Noah's two wives both said that discussions about testing between couples were limited, and Noah had never discussed the possibility of HIV infection in the family, even when he fell ill which he did frequently. It was only after he had secretly tested and started treatment that he was prepared to talk about it.

Whether they had tested or not, the men generally recognised the value of HIV testing, but tended to link it with initiation of treatment rather than as a means to primary prevention. As Solomon's example illustrates, even when he had hesitated for a long time to undertake an HIV test, he acknowledged that ultimately testing would be necessary for him not only to confirm illness but also to access treatment. This was the experience of many who had tested.

Noah told of how he eventually decided to get tested in order to benefit from treatment after suffering frequent illnesses: "I said what I want is to know whether I have the disease such that I begin taking the medicine and my lifespan increases." Participants understood that treatment extends life, enabling them to fulfil important roles as a father, as seen from Tony's (39 years, not tested) account below:

I have to get prepared to start (HIV treatment) such that may be it can allow you (to live for) even 2 years just, such that it finds children when they have also at least grown up a bit. [...] so that if it finds clever [grown up] children, they can say 'papa died and so we should ensure we work harder.' You can also be able to show your children the boundaries of their land.

It was not only men who had tested or suspected HIV infection who appreciated the significance of early testing. Participant observation showed that there was a general awareness of the importance of testing; and that it was a necessary entry point into treatment and care. For example, while speaking about his friends' advice, Tony remarked:

“Oh, when people learnt about this [his illness] they came in large numbers, especially the friends you have been working with, they give you advice to go and test and start taking the drugs [ARVS] immediately.”

## **7.4 Barriers to HIV testing and treatment initiation**

### **7.4.1 The ambiguity of HIV symptoms and absence of a debilitating condition**

For most men, the uncertainty about the symptoms of HIV considerably delayed testing and/or initiation of treatment. As Solomon’s story suggests, despite acknowledging that their sexual behaviour could have exposed them to the risk of HIV, most men considered testing if certain signs presented and if no obvious symptoms showed at all they would see no immediate need for an HIV test or treatment. For example, despite suffering chronic cough, and being advised by friends to seek an HIV test, Solomon explained his delay to test as follows: “I am still studying it; whether it is really chest pain and cough or this AIDS that people are talking of.”

With the exception of three men who were selected for reasons other than HIV infection/suspicion, all the other twenty-three men interviewed reported having suffered a variety of illness symptoms. The most common were body pain/chest aches, fevers and prolonged coughs, or more specifically TB. Because many of these symptoms were recurrent, and were frequently suffered by more than one man, particularly those involved in artisanal gold mining, their ill health was often attributed to causes other than HIV. As Solomon described:

It [chest and cough] just started to pain [...] I think it may be the heavy work which I did while still physically strong. [...] you could go to dig deep underground to mine gold, and then also the smoke from the kerosene candles used inside there [tunnels], I think it is what brought this pain in the chest.

The men did not only associate their symptoms with their hazardous work, but also easily explained them away, especially the persistent coughs, as “everybody’s illness”, since it was rampant among miners. Mike (age 31 and currently receiving HIV treatment) was an interesting example, and described his experience with symptoms as follows:

I didn't know which type of disease I was suffering from! For me I thought maybe it's because of the heavy work I was doing, of crushing stones [gold ore] or that it is the dust which has affected me, so I did not do much because I was seeing it as a common problem here.

The failure by most of the men to link their symptoms to HIV infection meant that the first treatment options sought by the majority of them were often unrelated to HIV/AIDS disease, and were predominantly antibiotics and herbal medicines. A substantial number of men also reported that they had done “nothing” to try to confirm the type of illness or to alleviate the symptoms. This was particularly so if there were no visible symptoms or if they were perceived to be less serious than those expected of the HIV/AIDS disease. Men, who believed that they still looked physically strong and had not been incapacitated, saw no need for immediate treatment. This perception is well illustrated in Solomon's evaluation of his health and decision not to seek help: “[...] also the energy is there except the pains I am experiencing; but [for] AIDS, I hear it completely weakens one. This suggests that it is difficult to get people who are apparently healthy to start taking HIV treatment.

## **7.4.2 Male independence**

The social and individual construction of male independence affected men's HIV testing and/treatment initiation in a number of contradictory ways.

### **7.4.2.1 Men's wish to be independent and resilient and unwillingness to admit to problems**

Men were reluctant to acknowledge symptoms of HIV and define them as serious enough to warrant seeking prompt care. This attitude was attributed to the social construction of men as independent and resilient. Most narratives from both the general public and the men interviewed suggested that men generally take longer than women to admit failure to resolve a problem, even when it is obviously overwhelming them, because socially it is important for a man to be independent minded and be in control of situations. Being dismissive about the need for urgent help was an important way to assert their difference from women, and from other weaker men. In a conversation in June 2010 in which Twaha (a friend of mine in the village, age 30) was describing his cousin's delay to seek treatment

for suspected HIV, he contrasted men's general treatment seeking behaviour from women's as follows:

Men are stubborn; they say, 'I will first wait and see'! So, *Ikiliok edakanaro adekis kikarak konye'cut* (men are usually just carried to hospital when they have been overwhelmed by illness) unlike the women who often go by themselves when still fairly strong. Men wait until they are too sick to know anything; maybe this is because of shame but it is just how men are; you have to show that you are still strong.

Therefore, it was widely asserted that not testing was an intrinsic expression of masculine courage and self-control amidst crisis. Due to this attitude, some men appeared to consider their delay to start HIV treatment as an achievement that attested to their enduring physical strength and courage despite the symptoms. Solomon was a good example of this: When justifying why he had hesitated to get tested in spite of the recurrent symptoms suggestive of HIV, he expressed a sense of emotional strength and the feeling that he was still in control of his health, saying: "I was still strong, the body was still fighting the thing [illness] on its own." In contrast, when his body became progressively weaker, Solomon began to acknowledge failure to maintain his independence and was ready to test and assume the sick role identity, stating that: "[...] where it has reached, I think I need to go for an AIDS test."

Also, men's desire to demonstrate a sense of self-sufficiency, especially financially, and avoid embarrassment, explains their reluctance to discuss their health problems with other people. Although they seemed to be quite willing to discuss health issues with other men, as illustrated in Chapter 6, there was a belief that complaining frequently to other people, especially to non-family members about their problems, may be mistaken as an admission of failure to manage personal affairs and begging for financial assistance, which would undermine one's image. Thus, the failure by some men to share their problems may have prevented them from accessing the information and support necessary to access HIV testing and/or treatment health.

The accounts suggest that men's sense of achievement and esteem resulting from delaying to test or to start treatment, as it demonstrated their resilience, differed by occupation and by age. The stories of Juma, Isaiah and Solomon suggest that men whose current

employment was gold mining were more anxious about the low esteem resulting from failure to demonstrate resilience and the courage of a man against testing and admitting being ill, than men from other local occupations. For, instance, both Solomon and Juma, delayed to test because they still had strength and both also repeatedly discussed how they were renowned to be very strong men at work. Overall, however, the younger men were more anxious about failure to demonstrate independence through strength than the older men. Older men tended to have a more flexible and resigned attitude towards strength/resilience as a means to express themselves, and most felt more assured about coping with HIV diagnosis because of the resources they had. Solomon's story highlighted this picture clearly, when he attempts to disassociate himself from dependence on resilience of a man to delay testing by arguing that in the event that he tested and people attempted to discriminate against him, he would not be bothered by it because:

I had most things on this earth whether it is money I have also tried to see [possess], whether land, I have also got, even there is some money I have saved in form of a plot (of land) which I had bought for children. So I can decide to sell part of it, if things are bad.

#### **7.4.2.2 Reliance on wives for their health care/decisions on health**

In contrast to the view that emphasised male independence, a number of men as well as women claimed that the inability by men to initiate testing and/or HIV/AIDS treatment early enough and on their own could, in fact, be attributed to the fact that generally, men were actually dependent on others, especially women, for care and nurture. It was argued that men tend to develop an unconscious instinct of dependency which is deployed in many different aspects of their lives, including times of illness, which consequently impacts on decisions and timing of their treatment seeking. In a conversation in December 2009, one man (age 30) narrated that:

You know the problem with men is that they take long to decide on illness because they are too used to being looked after. Everything is done for them by women, and so if a woman is not vigilant to arrange for him to get treatment or to call upon relatives, the man can die in the house.

The significance of the phrase "...men are usually just carried to hospital..." as commonly used was not used to describe the process of getting the sick man to a health facility, but

indicated the source and timing of the decision to seek care, confirming that men seem to find it difficult to make a decision on their own to seek help when in need.

Related to the above problem was men's reported inability to easily seek care from their parents/mothers. Comparing themselves to women (sisters) who frequently found it easy to return to their home for care, getting married and setting up an independent home from their parents, was in some ways a disadvantage to them because it constrained their ability to access the reliable help from one's family in case the wife failed to fulfil her care obligations towards him or if she was separated from him. Elaborating this view, Salim, who took a long time to get tested for HIV, for various reasons including lack of family support as he often had poor relations with relatives, narrated: "Unlike women, a man cannot say 'I've gone back to our home for care'. He must endure it because there is nowhere to return to. You can't go back to your fathers' compound like you are a child." This, according to most men, implied a health care disadvantage to men in terms of the timeliness and quality of the care they got during illness. Many women, especially those from the economically better families, admitted that, irrespective of the kind of illness, they could easily return to their parents' or brothers' homes if conditions became intolerable in their marital homes. My observation and visits to some families also confirmed that there were a number of women with HIV who had been "brought back" by their relatives to be cared for.

#### **7.4.2.3 Men's responsibility to look after their families**

Some accounts have suggested that the imperative to care for wives and children led men into neglecting their own health. The narratives indicated that due to the social construction of men as providers for others, men tend to view their own health needs as peripheral to that of their dependents, which they often prioritised and supported at their own expense, in order to demonstrate that they were responsible men. In several conversations, men argued that if at a given point in time both the man and wife were ill and resources and time to obtain care were limited, as is often the case, "the man would automatically prioritise the health of his wife." In the narratives, it was evident that the social value of women's roles, such as child care, domestic chores and being a wife, favoured prioritisation of women's health, since, as one man put it during a conversation: "men gained more masculine pride through having a functional family than through being healthy and having no family".

Many men argued that it was during sickness of family members that the public watched with keen interest how men approached the situation and would blame the man severely for being negligent and irresponsible if they did nothing for the sick in their family, as the following extract from a conversation with two men in December 2009 shows:

[...] people in the community or in your family will say ‘you have neglected your wife and children,’ but no one will complain that you have not performed your responsibilities to yourself. [...] the problem is that as they are growing up, boys are taught to be oriented towards looking after others. So you can say that men are indirectly encouraged to forget about themselves.

### **7.4.3 The fear of a positive HIV test result**

Although it was rarely expressed explicitly, the fear of a positive result was an important barrier to early testing, and treatment initiation. Men repeatedly described that it was difficult to bear the bad news of a positive HIV diagnosis and many would, if possible, wish to avoid or postpone knowing it as much as possible. Solomon described how when his friend’s mother as well as his own advised him to seek an HIV test, his instinctive reaction was: “No, not yet”. To Solomon, he was simply not ready to receive the potentially bad news, more so since he was not sure how his mother would react to it. In many similar narratives, deciding to undertake an HIV test was daunting and threatening. As JB put it, “It is difficult. It is like deciding to climb the Tororo rock, and so, you have to be prepared.” Similarly, even though Solomon confessed to me that he had always found it difficult to go for an HIV test in the past but he was now ready to get tested, his use of the phrase ‘I am now ready to climb the mountain’ to describe his desire to go to Tororo for an HIV test, reinforced the view that going for a test remained an enormous task.

Another reason why men feared a positive test was that it devastated lives and the ‘certainty’ of death, despite HIV treatment, reportedly caused frustration and led some men into wasteful expenditure of their resources, undermining their masculine esteem gained from ownership. With the exception of three men (Abraham, Noah and Salim) who were receiving treatment and claimed to have adjusted well to the reality of living with HIV, all men believed that regardless of the psychosocial support and treatment received, people with HIV had shorter a lifespan compared to those without it. A number of men cited examples of other men they had known in the village or elsewhere whom they said

squandered their assets following HIV diagnosis, and therefore argued that it was better to delay getting tested, only doing so when the signs of HIV have become obvious.

Men's anxiety about having an HIV test and disclosing it was also tied to their sexual relationships, with some, especially the younger men, fearing they may be rejected by their extramarital partners and/or blamed by their wives for bringing the disease if they tested positive first. In a conversation in February 2010, one man described how he believed the anxiety about one's risky sexual history discouraged many men from testing since: 'To go to a doctor to say you have slim or syphilis is to report that you have had an affair with some woman; that you have had sex and you got infected.' Similar views were expressed by interviewees. For example, Paul who had experienced symptoms but had feared to test attributed it to not wanting to "disorganise my wife in case the news were bad". While this may demonstrate Paul's high regard for family stability, it contradicted the imperative to care for others.

#### **7.4.4 Fear of loss of masculine respectability**

Men reported that a positive HIV diagnosis undermines a man's dignity, especially before in-laws and the relatives who would know and negatively evaluate their sexual behaviour and sense of judgement. Although the impact of suspicion of HIV on the basis of obvious symptoms was also acknowledged, testing and admitting HIV seropositivity was seen as a serious let-down of family and dependents, and others who looked to them as role models. For example, while describing the possible negative assessment of his sense of judgement if he tested HIV positive, JB (age 37) narrated:

Testing would not be bad but as per now, my father left me with many children, and then my own family, so these are the fears I have, at least if my sister had completed her teaching course and started working, it would be fine. The thing is people thought that you were wise.

Developing the theme of respectability more explicitly, Geoff (age 28) who had not tested but whose wife was confirmed to be HIV positive worried that if he was to be diagnosed with HIV not only will it be a let-down of the high hopes relatives have in him, but it would also profoundly damage his moral identity among those who regarded him as a man of upright morals and therefore least expected him to have HIV:

[...] then last year she [wife] went to Red Cross [health centre] and when she returned she told me that she is positive. Eh! I wondered. “Are you really talking the truth or...? Then she said ‘yes.’” I wondered how [HIV could have come]. So they told me also to go to Red Cross [for a test]. But for me when I was at school I was a blood donor. That thing made my life not to be okay [disturbed him]. I am wondering, and to date I have never gone for HIV testing. I am just wondering, now what will my brothers say? They are the ones who paid my school fees and they know that I am okay morally; that I do not have manners like that [which put me at risk of HIV].

Sylver (age 50 years), and clan leader, also attributed his hesitation to seek a test, not until he was extremely ill, to fear to lose social honour associated with his position as a clan leader and family head. Although many people later welcomed his decision to seek treatment, he had worried that being diagnosed with HIV gave a bad example to others:

There was a lot of fear and I took many years to accept, not until things became so bad and then I went and received counselling and testing. You know I thought about my family; all these people looking unto me, and then also being the leader of our clan. What example was I giving people, they don't expect this. So I first kept thinking, because *etemarete itunga ayi* [what opinion will people make of it?

Isaiah (age 49), who believed that many knew about his infection with HIV on the basis of the obvious symptoms he had suffered, discussed the fears of testing HIV positive specifically with regard to a man's age and status, and relationships with in-laws. He emphasised that older men, like him, were judged more harshly and lost respect because society expects them to be sexually conservative.

You see, in this place of ours, everybody will be saying ‘now look, the man you thought was good, sickness has already affected.’ So they will say that even old men do not respect themselves!’ It is bad, especially for us with big children. And then the issue of in-laws...I was terrified *emame bobo ayongit ijo* [no more respect for you]. So you fear to test.

### 7.4.5 Transport and economic related constraints

Many men who had not sought an HIV test repeatedly identified transport costs as an obstacle to getting tested. This was in spite of the fact that HIV testing facilities were generally near, on average a round trip costing less than US\$2. TASO, the facility that was most known for specialising in HIV testing and support services was however a little farther away in another district, and would cost about US\$4 for a round trip. Ideally, these amounts should not represent a substantial expenditure for a one-off service such as an HIV test for the men of Mam-Kiror village, but still the transport barrier was mentioned frequently.

However, when probed, the majority of the men provided a broader definition of ‘transport’ to mean all finances required during a hospital visit including the fare, and more crucially, the additional pocket money required for any contingencies during the visit. Drawing from previous experiences, men reasoned that a hospital visit/outpatient care was a very unpredictable experience, as one could not anticipate the decision/recommendation of the health worker after the diagnosis with regard to further tests, treatments or hospital admission. These possibilities required being ‘prepared’ with extra money over and above the transport fare as Solomon emphasised. Thus, the need to have enough money to cater for “transport plus other incidentals”, as JB, Tony, and Solomon repeatedly stated, led men to defer seeking testing as long as they believed they did not have sufficient money to feel comfortable at the clinic. Moreover many other men repeatedly stated that since their incomes were unpredictable, it was usually tricky for them to fix and fulfil appointments for testing or treatment.

Men’s most common concern about money was that they might be seriously embarrassed and their sense of esteem undermined if during their visit to the facility for a test, they failed to meet costs on other little incidentals. Solomon, for example, articulated this concern by saying: “As a man you cannot go to the hospital with only transport fare, as there may be other eventualities; those small things, and it would be embarrassing for a man to fail to meet them.” Furthermore, some men doubted that HIV testing in government facilities was totally free of charge. Tony, who had expressed a desire to test, expressed his anxiety as follows: “The money is what I do not have; I may reach there in Tororo [hospital] and money is asked and also the transport.” Some men observed that unlike women who would find it easy to explain to the health workers their lack of money by

saying their husbands did not give enough, men would not be able to deflect their inability to pay for services to anyone else, leading to shame.

There was a tension between men's desire to finance their transportation to obtain an HIV test from selling a family asset and the expectation that a man should preserve assets for the future use of their children and family. For example, JB wanted to sell either his goat or bicycle to raise sufficient transport to a facility to be tested, but his friend Ben (age 36, receiving treatment) advised him against it as those items were valuable family assets which a man should not "misuse" or which may be more valuable in case he was diagnosed and starts treatment. In a conversation focusing on JB, Ben (who was receiving treatment) narrated: "I told him that as a man he (JB) needs the goat for the family and the bicycle will be useful during treatment, so he should not misuse them."

Some men who had suspected HIV infection had also deferred testing due to work related concerns. Men expressed fear that being known to be sick and/or receiving treatment would discourage employer/colleagues from working with a sick person, undermining earning and ability to support family. This factor also explains why some men who initiated treatment eventually dropped it, as will be discussed in the next chapter.

## **7.4.6 Health service factors**

A wide range of limitations to testing and treatment initiation associated with the health services were discussed by the study participants, many of which I confirmed during participant observations, including unrealistic testing schedules and time restrictions, fear of health worker initiated testing as well as the problem that some men termed 'inhospitable' hospital environments.

### **7.4.6.1 Scheduling of testing services**

The organisation and scheduling of testing services in the health centres was by far the most frequently mentioned barrier to testing. In the majority of public testing facilities, in an attempt to streamline service delivery, HIV testing has been designated and fixed to specific days of the week and times of the day. This means that to access them at the right time, intending users must be aware of these days and times, which, however, was not the case for many village residents. Details about these services were not usually advertised at the community level. Most men considered this a major hindrance to testing as they would

be turned away if they went on the wrong day/time. Some men reported being told, “Sorry you are late, come back tomorrow,” or “we do not test people on this day, come back another day,” when they visited facilities to get tested. This was exactly what I witnessed in a public facility when two men (approximately in their 20’s) who arrived late for testing were turned away by a counsellor who explained that the lab and counselling services were already closed. She advised them to come back early the same day of the next week. Whether they returned is unknown as there is no means of tracking them. But due to all the other demands on people’s time and money, it can be difficult for many men to return to seek testing.

Waiting times were also a hindrance and had an impact on work. They were often too long and required a lot of patience, yet as men repeatedly stated, “men naturally lacked the patience and discipline required especially in public health facilities.” Some said that men are generally trained/expected to be swift and less of time-wasters, while others cited work concerns as the reason men lacked patience when they visited health facilities. Elly (age 28), one of the men who had contemplated testing, put this simply: “Also work, I don’t have time; I have to look for what to feed the family with.” Similarly, in a separate conversation with three men over the same subject, one man observed:

When you go to the hospital, you must be prepared to spend a long time there, sometimes the entire day if you are not careful, which is a problem because you might be missing your work. This is bad for us here because when you work (mine gold) in a group your friends will note each time you are away and give you less ore.

Although fewer participants specifically commented on provider initiated testing, mainly because they were not directly asked this question, those who talked about it were concerned that the fear of being asked to test for HIV when they are “not yet ready” may discourage some men from visiting health facilities. As we can see from Solomon, part of the reason he had not established consistent contact with a particular health facility to treat his chronic cough/TB was because of fear of being subjected to an HIV test. He said:

I hear in any hospital, a test has to be done especially for this disease [HIV] even if you have chest pains etc. [...] you might think that it is chest pain yet it is something else; that is what the boys [friends] are telling me.

A recurrent obstacle to testing cited by a number of men in the village was that they did “not know where to test from.” In theory it is possible to map out the locations of both public and private providers of HIV testing services for the people of Mam-Kiror village as most were close by. For example, two public facilities – Busitema Health Centre III and Busia Health Centre IV – located only a few kilometres from Mam-Kiror should, ideally, have been known by the majority of the residents. A host of private providers of testing services also operated in Busia town, while other public facilities could be found in the neighbouring sub-Counties and districts, notably the renowned TASO, in Tororo district. Thus, the claim by some men that they did not know where to go was rather surprising. When probed to confirm this, several men revealed that although they knew the physical locations of these facilities, the main problem, particularly with the most reputed facility (TASO), was that they themselves had never been there before and so were not familiar with it. Many therefore felt incompetent to manoeuvre through the different procedures and departments if they went on their own. Many felt it would be awkward and shameful for a man, who is expected to be knowledgeable and confident in public settings, not to know where to go and what to do while in the facility. As a result some preferred to wait and be accompanied by other men who were familiar with the service and procedure.

During a number of conversations, many men also decried the absence of safe parking lots for their bicycles or motorcycles in many of the health facilities; describing these facilities as “inhospitable” or “unwelcoming”, and citing it as a hindrance to making facility visits. Many said that they were expected to park their bicycles under an unguarded tree within or outside the facility, risking them being stolen. This was exactly the unfortunate experience of David (not interviewed), one of the men receiving HIV treatment, who during my fieldwork borrowed a bicycle to pick up his medicines but the bicycle got stolen at the facility. Despite his explanations and pleas for forgiveness, he was made to pay the owner for the bicycle.

#### **7.4.6.2 Negative perceptions of different testing options**

There was strong criticism of two main testing options: couple testing and community based outreach. Couple testing was seen as an unrealistic strategy that did not consider the common pattern of marriage relationships and sexual lifestyles in the village, and therefore it was perceived as threatening to male authority and relations with their wives in two main ways. First couple testing requires that both man and woman go together to a health provider for counselling and testing so that they know their HIV status together. However,

many men argued that with a tendency for men to pursue clandestine extramarital relationships, the requirement that testing is done as a couple would potentially lead to disclosure of those extramarital affairs. This risked severing relations with their partners or wives. For example, in an interview with Elly, who had contracted an STI from an extramarital relationship and treated it without informing either of his two wives, he expressed the following concern:

If you get such a disease or any other and go for treatment, the health workers tell you to bring even your wife or girlfriend to get the same treatment. But you know that is also a difficult thing, to bring a woman who is not yours to test for HIV with you at the same time? Then everybody will just know that you have been cheating.

The anxiety about the potentially disempowering element of couple testing was also strongly expressed during participant observation as the following excerpts from two separate conversations in February and June 2010 illustrate:

For some men, they might have cheated with a married woman and they cannot take along with them somebody else's wife for testing. So when you say testing with your friend [sexual partner], it is a very difficult thing. It is like the doctor saying list for me the women you have cheated with and bring them here (Man, age 30).

That [couple testing] is the most difficult thing. I keep hearing it over the radio that people to test with your friends [partners] but this is not easy. Many men are just cheating with other people's wives so where will they test from. They do not want to be seen together, only meet at night (Man, age 20).

Men were also bothered about the practicalities and necessity of couple testing in steady marriages. Solomon blatantly refused his wife's suggestion that they go to test as a couple. Couple testing in polygynous marriages was particularly believed to be unfeasible and needlessly demanding to the man, as one participant argued:

If you cannot test alone, can you now carry your wife to go and test? How many times will I go for testing if one has two or three women and then also others who are not his? Don't you see that it will be difficult?

The second opposition to couple testing equated it to a man appearing in courts of law with his wife to answer questions before a doctor as the 'judge'. Several men, both during the interviews and conversations, argued that a man would find it difficult, embarrassing and disempowering to talk, especially in case of a positive diagnosis, with a medical person in the presence of his wife. Other men argued that there was a tendency for some wives, who felt protected by the health worker during the testing process, to over assert their powers over their husbands, questioning their misdeeds and blaming them for risking their lives with HIV. In a conversation in January 2010 which explored the views of four men on this topic, all men expressed strong reservations about couple testing, labelling it disempowering. One of them remarked:

As you talk to the health worker, there are some questions that you have to answer but you cannot do it before your wife. That is why we do not want to go for testing with our wives. It is as if you are before a court, and as you know women can get authority over the man when other people are there; she knows you cannot prevent her from talking. So your wife may ask you how the disease came about. So you have to reveal the extra affairs that you have got because the doctor asks you about your partners, telling you to come with them all for testing [Man, age 40).

Men's views about the challenges of couple testing did not appear to differ by age. For example, in a separate conversation with two younger men (one of them married), views similar to the above were expressed, emphasising the possibility of a man being humiliated during couple testing or if accompanied by another family member:

How then do you explain when the doctor asks how you might have got the infection when your wife is there? For other sicknesses like malaria it is easy to say you did not sleep under a mosquito net or there are many mosquitoes, but what about this disease? It is shameful for you as a man even in the eyes of your family. In fact I think you can lose all your power as you try to explain before the doctor and your wife what happened. That is the reason some men

test alone and keep quiet for some time as they think of how to tell their wives (Man, age 25, December 2009).

Similar to couple testing, men were very anxious about Home-Based and Community Centre Outreach testing. Although it was recognised to eliminate the barrier of distance and the problem of lack of knowledge of where to find testing services, men emphasised that home-based or Community Centre Outreach testing was potentially problematic to the men's social relations, hence making men reluctant to test. This is because these approaches introduced a distinctively undesirable obstacle, the public monitoring of testers and non-testers in the village. It was stated that whenever there was a home-based or community testing event in the village, some villagers had developed a tendency to monitor who tested and who did not, and why. Both deciding to get tested and declining to get tested prompted speculation among fellow villagers. This involved evaluating those individuals' sexual contacts and making damaging allegations about them. In many ways this informal monitoring of testers and non-testers was stigmatising and men were often the prime targets of this scrutiny because, generally, they were more likely to have had extramarital relationships and were therefore believed to need testing, as illustrated by the following extract from a conversation with a man (age 50) in March 2010:

There are some people in the village whom I know are sick but have never tested, so the other time when testing service was brought to the Centre, I went there to see if they would come for testing but I did not see them, many of them fear and these are mostly men, they fear a lot because they know their behaviour.

During the fieldwork, my observation of a community HIV testing outreach event in the village confirmed the existence of lay monitoring of HIV testers in the village and how it discouraged testing especially among men. The event, organised by district health workers, was conducted in the shade of a tree located in the trading centre on December 9th, 2009. Despite modest formal mobilisation, word spread through the village, and because men tended to hang around the trading centre a lot, many must have heard. Although many people (mostly men) converged around the testing area as the testing and counselling activities progressed, only 136 people, 67 of them men, were tested. When I asked some of the men around the testing area why they had come, they told me that "we have come to see what is going on." Another man said that he would not test under such an arrangement because there were far too many people watching:

There will be many who want to ask you later how the result was. It is like when children get school holiday and each has their report card with them, there are those who want to discuss other's report.

Although a minority of men argued that they would not mind the public learning that they undertook testing during the community testing event, most assessed their own risk of infection as low. For example, in a conversation with two young men in December 2009 about the merits of testing during the community outreaches, one of them (age 25) said:

Now what will I fear? I cannot fear anything [regarding HIV testing in public]. Those who fear know that their movement is bad. You see there are some men whom you can just know that they have a problem.

This narrative suggests that people may have confidence to test publicly to prove their sero-negativity but might want to avoid testing in the presence of others if they expect a positive HIV test result.

## **7.5 Factors that might prompt testing and treatment initiation**

While many factors delayed or prevented men from testing all together and/or initiating treatment, there were other factors and circumstances that created an urgent need for men to test and/or join into HIV treatment. It is important to note that these factors do not act in isolation and therefore no single factor explains why men saw the need to test urgently.

### **7.5.1 Interference with ability to work**

Illnesses that considerably threatened their masculine roles, particularly the ability to work or to socialise with others in the public arenas, created an urgent need to test. For example, during their respective interviews Mike (age 31) and Juma (age 51) described their experiences as follows:

The way I was feeling! Besides pain all over the body, I was coughing and sometimes blood. When I saw that I was not able to work, I said no, this thing

is bad, I am going to check. Before that, I was working a lot, then the pain begun and kept on increasing and also the cough and headache was too much, nonstop, I could not work and could not be with others; just home all the time. When I went to test, I realized that I had this disease.” (Mike, May 2010).

[...] the back pain, sometimes the chest, sometimes cough was too much, for a long time, and when I saw that I could no longer do work, especially heavy work, I could feel tired all the time and weak to go out for work, then I said let me test myself and from the test it was positive (Juma, May 2010).

In Solomon’s story, we saw that he was not ready to test because he still had energy, in spite of the cough persisting. However, in a subsequent conversation his narrative appeared to confirm the role of a debilitating illness in influencing his desire to test saying, “the illness has kept me coiled-up in bed and at home for weeks; I cannot work and [cannot] even go out to the centre to be with others. So I think where it has reached, I need to check.” Similarly, Emma (age 42, dropped treatment) narrated how minor symptoms had delayed his seeking treatment but eventually when he experienced more severe symptoms, which affected work, he decided to go and test in order to enrol for treatment:

It first started weakening my body, then headache started, and then coughs, all the while I was still saying ‘let me wait’. By the time I realised, the body was in a bad shape and then I decided to go for testing to start taking the drugs.

With the exception of one, all those who initiated treatment immediately after being diagnosed with HIV, did so because they had experienced untold suffering due to illnesses. Isaiah (age 49) described the dramatic experience of how a severe illness attack compelled him to seek treatment in TASO, arriving there when he was desperately in need of treatment:

Let me say my body had changed so much that even up to now my tongue has failed to become okay. My tongue darkened, the body too was very dark and I was feeling a lot of pain that I never expected to heal. [...] and when we reached [TASO] I was taken for testing, [...] and told that you are sick. After that I was given medicine to start swallowing.... I was disappointed that I wasn’t admitted and yet my condition necessitated admission. Let me say I was just waiting for them to say anything [regarding treatment] and I would accept;

... even breathing was difficult and I was just lying on the floor. I was very weak to say or do anything myself.

Isaiah's experience was a familiar one across the majority of men living with HIV who variously described having had no option but to seek treatment as they could "no longer tolerate the suffering."

### **7.5.2 Family responsibilities**

The understanding that HIV/AIDS treatment extends life, enabling a man to continue fulfilling roles of a father and husband, was an incentive to initiate treatment. Although some did not refer explicitly to fatherhood obligations as the motivating factor, there was evidence that many who were on treatment or desired to join it valued the positive benefits to their families arising from their improved lives after accessing treatment.

Responsibilities and obligations for children were the main reasons for wanting to live a few more years. For example, when Tony (age 39, not tested but suspects HIV infection) described that he has to get organised and start treatment such that it can allow him some additional years to raise his children, he was in fact specifically acknowledging that treatment extends life, allowing one to continue performing his roles as a father.

In contrast, Job (age 45) who had no children and who had separated from his wife during my fieldwork, did not initiate ART despite having tested HIV positive over a year prior to the commencement of my fieldwork. When asked about his reluctance to seek treatment, he linked it to his family circumstances, in particular discussing the lack of children and wife, and suggesting that he had nothing to 'live for':

At least if you have children, you can say let me also try to keep these children but now where can you get the energy [incentive]. You are not worried about anything; just saying 'even if I go since life is hard'.

Furthermore, feeling a strong sense of obligation to other kin or people who had helped in the course of the illness provided the motivation to initiate HIV treatment. A number of men discussed how they decided to enrol for HIV/AIDS treatment because they felt it was the right thing to do given the care and love the relatives had demonstrated during the time they had been ill from suspected HIV. Jeremiah's (age 40, receiving treatment) experience was a striking example. When seriously ill prior to testing, his brothers offered different

kinds of material and medical help: purchasing medicines for treatment of symptoms, a trip to the city for better care at a brother's home, another brother accompanying him to hospital to test/initiate HIV treatment, and another readily availing his motorcycle for the transportation during and after initiation of treatment. Jeremiah said that the encouragement, support and care prior to testing, "made me feel loved and wanted by my people, and so agreeing to seek HIV treatment was the right thing to do." Mike was another good example, emphasising that he had felt it within himself that he needed to show a sense of responsibility for his own health given how much support his brother and mother had shown him. Yet still, for many of the men who received support/encouragement to seek treatment from their brothers (or other relatives), it often came much later after realising that the symptoms/illnesses had reached a life threatening stage. The support received did not, however, reflect the socio-economic status of the relatives, but reflected more the quality of the social relationships amongst siblings, with families in more harmonious relationships tending to offer more encouragement and support.

### **7.5.2 Death of spouse or rival sexual partner**

The death of spouse or of a rival sexual partner increased the likelihood that a man might have contracted HIV and therefore needed to check. For example, for Ben, his symptoms did not prompt testing but the death of his wife was the decisive factor for him to test:

It was in 2008 when I lost her. She was very sick, only for one month and unfortunately passed away. After burying her, I got concerned about my health because before that I was not feeling well. I was feeling a lot of unexplainable pain all over the body even before she died and so I decided to go for testing.

For men like Tony and JB (both contemplating testing), Mike (on ARVs), and a few others in the village, the death from AIDS or serious sickness of men who had had a sexual relationship with the same woman as them was the ultimate reason for their determination to get tested immediately. JB explained:

Although I have been feeling sickly and a bit concerned that I might have a problem, the death of Mr Micah last week due to this disease [AIDS] has made me more worried because some time back, he also used to go to the same woman I used to go to. So, I also now want to go and check this body.

Generally, however, as discussed previously, most men who assumed they were already infected saw no immediate need for an HIV test, not until the obvious symptoms were present and the illness was serious. So, most men perceived the main purpose of testing as a way to access treatment. There was also a tendency amongst villagers towards an exaggerated perception of HIV prevalence in Mam-Kiror, particularly for men. Men often told me: “We are all sick here; you think people here are healthy! There are just few people who are okay.” In part this belief that many of them are infected contributed to a reluctance to test, with some men saying: “If the thing (HIV) is there (in the body) it will just come out by itself.” Like Solomon, several interviewees, as well as several men from the general population, said they would consider testing only if they have come to the final conclusion that they had HIV and had reached the stage of needing treatment, as expressed during a conversation, in December 2009, between men in the village: “For me I think I can only test after I have fallen sick a number of times and I know that I am now infected with slim, so that I can start taking the medicine.”

#### **7.5.4 Pressure from friends and colleagues**

Many of the stories I heard about men’s experiences of, or intentions about, HIV testing underlined the role of friends/workmates, although there were some counter-examples such as Abraham (age 50) who got tested through personal determination rather than involvement of other parties. Like Solomon, described above, most participants described how friends/peers with whom they worked or interacted recognised symptoms and recommended testing and/or sometimes offered to ‘escort’ them to test. Mike, Noah, Isaiah, Isaac, Sylver, Jeremiah, Jose and Emma, all sought a test following recommendation and/or being accompanied by friends. Also Tony, Solomon, JB and Sata, who had not yet tested but suspected infection, described coming under pressure or receiving advice from work friends. Tony said: “[...] they [friends] are always telling me to first test, because they see that I have no energy, I no longer go to dig with them as a group etc, etc.” Paul (age 28 years), another man who had not yet tested, also provided an insightful comment that distinctively illustrates the strong beliefs and respect some men have of their peers, saying: “I would have gone if a friend took me.”

From the conversations with different men in the village, there were men who believed that knowing friends/colleagues who had tested or wished to test would motivate them to get

tested too. They argued that it is less stigmatising to test together, especially if you are good friends, with a similar sexual history, although they were concerned about disclosure. For example, during a conversation between three men who were discussing the impact of knowing that a friend had tested, one of them said: “You know for us men, you first want to hear that your friend also went [for HIV testing] or has started (taking AIDS) medicine then you can say, aaah, let me also go.” Another man added: “It is a good idea to plan to go with a friend to test. You get the courage also because you know that may be you have had similar [sexual] adventures.”

Men who were known to be receiving treatment were particularly instrumental in encouraging friends to get tested and also start taking treatment. Noah, Abraham and Isaac, for example, revealed that they not only had encouraged others to test but frequently received requests from friends for advice. Isaac (age 37) narrated:

There are men who come to me asking me ‘man, which hospital did you go to?’ For example someone may be having boils etc, they fear to discuss with their wives, so they come to a friend like me. So I can maybe tell them that today is not a day for testing but you get ready I will take you there.

Nonetheless, in all these discourses about the role of friends, trust was important. The participants who had great trust in their colleagues, and were not worried about being discriminated against by them, were less reluctant to test and disclose. These were often the older men such as Noah, age 50 years, Sylver, age 50 years, and Salim, age 45 years. In contrast, those who had faced discrimination, and/or had been previously cheated by work colleagues, such as Solomon, were reluctant to follow their advice to get tested.

## **7.6 Conclusion**

This chapter has described the complex factors that both negatively and positively influenced testing and treatment initiation. These factors, whether classified as social/economic, individual or health system factors, were intertwined with themes of masculinity. The chapter shows that the current norms, practices and context of HIV testing, particularly of couple testing, were inconsistent with a number of masculine values and norms prevailing in the study setting, discouraging men from testing. The ambiguity of HIV symptoms and the absence of debilitating conditions, the social construction of males

as independent minded, the fear of a positive result and death, and the loss of masculine respectability were important barriers to testing and treatment initiation. Inflexible HIV testing schedules in most public facilities were also a major hindrance, particularly because they impacted on work. The decisions to seek a test and/or treatment were often prompted by the death of a spouse or rival sexual partner, by symptoms that interfered with work, by desire to extend life and fulfil family responsibilities or by the pressure from peers. Nonetheless, testing and treatment initiation was often a last resort, with most of the men being “carried to the hospital” when illness had overwhelmed them.

## **Chapter 8: Masculinity, HIV treatment maintenance, Adherence and Discontinuation**

### **8.1 Introduction**

In Chapter 7, we saw the factors that encouraged or discouraged men from testing and/or initiating HIV treatment. In this chapter I will consider men's treatment seeking behaviour after initiating treatment. The chapter explores the factors that helped men to maintain treatment and those that led to discontinuation of treatment, in particular, assessing how norms and constructs of masculinity might help to explain why men may maintain or drop out of HIV treatment. Understanding how notions of masculinity affect men's use of HIV/AIDS treatment is important because it can help to highlight opportunities and challenges of rolling out treatment to men. The key question addressed in this chapter is: why did some men adhere to/maintain the use of ART, while others dropped it after initiating it?

The chapter begins with the stories of two men: Noah, who by the time of field work had maintained his treatment for eight years, and Isaiah who initiated treatment but dropped out after only eleven months. It follows with a discussion of the factors that help to maintain treatment and then discusses the factors that lead to discontinuation of treatment.

### **8.2 Noah and Isaiah**

#### **8.2.1 Noah's story: Treatment maintenance**

Noah was 50 years old, married to two wives and had six children; two of them born after starting ART. He had four years schooling and by the time he tested in 2003, his main livelihood source was subsistence cultivation, although he had previously engaged in a variety of activities including artisanal gold mining and petty trading. By the time he decided to test for HIV, the illness had left his health devastated, as well as his social life and economic status. "I was physically weak, no longer able to support my family and depended on my wives to produce food and manage the family's subsistence." As Noah was unable to personally take the lead role in cultivation as he had before testing, his family constantly lacked food and his reputation as a hardworking and independent man

was destroyed. “People, particularly fellow men, from the neighbourhood, would come to my home only to sympathise with me for the terrible illness and circumstances in my home.” This made Noah question his masculine worth and identity. “The home was collapsing; it was as if there was no man in the home,” Noah recalled.

When he decided to test for HIV he did so without informing his wives because he feared their reaction. He later took them too for testing, one tested positive and started receiving treatment alongside him. Noah had been encouraged to test by his friend/neighbour (Juma), who later, after some years also tested positive. Following his initiation on ART, a lot changed for Noah. He regained his health, and with time became physically strong, able to do hard work and increase his contribution to supporting the family. During the fieldwork, I learnt that Noah was one of the most renowned and hardworking subsistence farmers in the village. Noah was also one of the few men living with HIV in the village who had received, from TASO, his treatment provider, some support for a livelihood in the form of goats and a set of four oxen, for ploughing, which he co-owned with two other men, and sometimes hired out to plough other people’s land, which was an additional livelihood to subsistence. Although rearing the animals was a hectic activity, it was not as laborious as the gold mining, which was the main alternative work for men in his village. Noah was happy that unlike gold mining, which often demanded joint labour contribution and working in groups with other men, the livelihood projects he was engaged in were private and one worked with a great deal of flexibility. Unfortunately due to rampant cattle disease, two of the oxen died during the fieldwork, forcing Noah and his colleagues to suspend the use of oxen to plough. By the time I concluded fieldwork they had not yet determined the future of this livelihood source but were planning a meeting with the livestock extension officer who works with their treatment provider.

Noah did not envisage a life without ART: “It is because of those drugs that I have strength and energy, so I cannot think of stopping or question why I am taking. [...] without them I would not be alive. I would be useless.”

### **8.2.2 Isaiah’s story: Treatment discontinuation**

At the time of fieldwork, Isaiah was 49 years old. Following his second wife’s separation from him many years back, Isaiah decided not to seek another wife and remained with only one wife to raise their eleven children. He had six years of schooling. Prior to HIV

diagnosis he owned a small shop and had a side income of gold mining. Isaiah's illness started in early 2008 and greatly disorganised his otherwise stable life and family, as he narrates: "I fell very sick and got many challenges; wasting a lot of money and selling my properties without improvement. You sell a goat or something else and they (clinics) could eat your money; all my capital went for treatment."

Isaiah recalls that due to the fear of being diagnosed HIV positive, he hesitated to test for HIV despite experiencing repeated symptoms, which were being treated using both bio-medical and herbal treatment. However, it was not until he saw that he could not bear the sickness anymore that Isaiah requested a village mate who had been going to TASO to take him there too. "So I asked my relatives to carry me to the trading centre to meet that man. I cried out to the man, 'I am finished, first take me to TASO (Tororo), maybe it is from there that I can get to know what exactly I am suffering from.' " At the time, Isaiah did not have any money for transport but his cousin was sympathetic and lent them both the fare. Isaiah recalls that his condition was so bad that his only wish as he waited for the tests was to be told to start taking medicine. So when the test confirmed that he was HIV positive, and he was given ART drugs, he readily started taking them. But after nearly a year of monthly visits to the clinic, Isaiah stopped, saying: "I got defeated by the high transport costs. I sold everything at home and finished them. ...even sold the bicycle and even the small work [business] I was doing died...and yet that is where I would put salt and *eddy* into the house."

However, there were other challenges that Isaiah faced which contributed to his non-compliance to treatment. For a few months, he took his medicine silently without disclosing to his wife. But when she learnt that they were AIDS drugs, she blamed him for bringing the infection saying, 'you have killed me...I used to warn you about your women...' Her resentment increased when she too later tested HIV positive, although it later reduced following repeated counselling from the clinic. His in-laws and children got to know the reason for their quarrel, leaving Isaiah feeling disgraced. So taking the ART drugs always reminded him of how upset his wife was. "I first wanted to disassociate myself from those drugs for a while because I could feel bad...whenever you pick the medicine, you remember her, she cries because of you." Also, taking those medicines daily made Isaiah realise that, "*kumbe* [that in fact] I am still this sick."

## 8.3 Factors that help maintain treatment

To explore the factors that may help men to stay on HIV treatment once initiated, I draw from the eight other men who were receiving treatment at the time of fieldwork. Of these nine interviewees, one was receiving septrin drugs only while the rest were receiving both septrin and antiretroviral drugs. These men had been on treatment for various lengths of time, ranging from just under a year to eight years, without interruption. Once these men had initiated treatment, a number of factors provided the incentive to stay on it.

### 8.3.1 Raising a family and reclaiming social worth

As with treatment initiation, many men who had successfully maintained their treatment repeatedly drew on the social constructs of male caring and provider roles. The importance of staying on HIV treatment was thus discussed in terms of the necessity for the man to stay alive and be healthy to perform his family role. While reflecting on their “near death” experiences before the ART, many men, including Noah, described themselves as having been “resurrected” (*akikwarun*) due to treatment, in the process enabling them to regain their family roles. Isaac equated being on ART to being on a life-support system, saying: “These medicines are the ones giving me life-support; it is like being on ‘life’ ....the way they put someone on life [support system if organs are failing] in hospital, so that I can at least do something for the family.”

Emphasising the centrality of treatment in rebuilding their social lives and ability to perform their roles as a father and head of the family, most men argued that before the treatment, they were worthless since the illness had made them dysfunctional. As we saw Noah simply stated that [without the ART] he “would be useless”. The reference to uselessness suggests that the men, who had witnessed positive changes in their health, especially valued the benefits that accrued to their families as a result of them regaining productivity, and attributed it to the life-saving treatment they were on. In particular men on treatment frequently discussed how as heads of families it was vital for them to be alive and help their children cope with the social conditions they faced, typically by supporting their education and health, providing land, and by being the father-figure. While married men rarely explicitly discussed their continued uptake of HIV treatment in terms of the need to stay alive and look after their wife, those who were not living with a wife had a prominent concern that separated wives should return or they should find a woman to

marry following improved health. For example, Salim (age 45) had neither children nor a wife but he revealed his desire to marry because he wanted children, and had grown confident about his ability to support a wife since his health as well as involvement in economically productive activities had substantially improved following ART.

A number of participants also discussed the significance of ARVs in rebuilding their public self-worth after illness relating to HIV. Prior to treatment their health was devastated and deprived them of a respectable social status. For example, Salim and Abraham both described how ARVs had enabled them to regain not only their physical health but also social value and recognition before their relatives, who had “written them off” as worthless. Salim described how his brothers, who had rejected him following the illness and loss of income prior to ART, once again associated with him. He attributed this to the fact that he had not only recovered physically but was becoming well established, independent and able to offer assistance to many of them. Discussing their public image, some men on treatment, such as Abraham, believed that being adherent to treatment provided a model example to others and was consistent with the obligation to give a good example, as an older man in the community. Others stated that as their health improved members of their social network had started to evaluate them more positively than before treatment, and considered them to be significant and valuable company, as described by Noah:

I have improved health wise; back then I was so sick but now I am fair and because of this, people now do not even pay attention to me. That time [when I was bed ridden] everybody, especially fellow men, were visiting me to sympathise and say sorry for the sickness but now they visit me to talk me, to share ideas, to plan or to get something from another man, just like I can go to another man’s home for extra help that I may need.

These resurrection stories and narratives about self-worth, therefore, represented the ray of hope that ART was to many aspects of men’s family and social lives. They show how ART turned the most desperate and hopeless situation into being optimistic about regaining their position in the social order and performing their social roles as men. That many of the men linked the positive contributions they were making in their families to their treatment, and stressed their resolve not to abandon it, was good testimony of the benefits of ART to their masculinity. ART had restored what AIDS had removed from them – health and a

respectable social status – and by extension all the advantages that came with the good health.

However, the majority of the positive accounts about the importance of adhering to treatment in order to support their family and to attain social worth were mostly expressed by men who had been on ART more than one year, compared to those who had been on it for a shorter time. The former appeared more comfortable with their identity as HIV patients compared to the new entrants into the treatment programme, and portrayed themselves as less concerned about the stigma of being HIV positive but concerned about the more adverse impacts of the disease and lack of treatment on their expression of masculinity. This suggests that successfully adjusting psychologically to the reality of being an ART patient, which likely happens with time, was important in giving men the opportunity to think about the positive benefits of HIV treatment for their expression of masculinity, rather than being preoccupied with the fear of stigmatisation as well as having to deal with side-effects of drugs, which tend to be common in the first year of treatment initiation.

### **8.3.2 Livelihood support from treatment providers**

Receiving livelihood support from the treatment providers was a vital incentive for men to continue HIV treatment. This was because, first, it helped address a major concern about ability to provide for their families which had been affected by HIV illness. Second, it provided alternative solitary employment that allowed flexible working and little worry about disclosure to colleagues, in contrast to work with other men. Those who had received livelihood support appeared to feel a greater sense of commitment to their treatment. For example, compared to others, men like Noah, Salim, and Abraham who often expressed their commitment to their treatment, were recipients of goats, oxen and/or children's school fees, from the economic and livelihood support programme run by their treatment provider. Some men described adherence as a legitimate moral obligation for them since they were fortunate beneficiaries. Some were aware that HIV treatment was very expensive and that the government was spending huge sums of money on them, and so, as Abraham stated: "The most sensible thing to do was to show co-operation through adhering to treatment."

By the time of the fieldwork, TASO, an NGO, was the only treatment provider in the area still supporting some of its clients with livelihood projects, although to a lower extent than it had done in the past. The US government funded Centres for Disease Control and Prevention (CDC) ten year research project in Tororo district, which was offering food/nutritional support, clean water and home visits to its ART patients, was also winding up its operations. The Ministry of Health – providing HIV treatment through Busia Health Centre IV and Masafu Hospital – did not provide any of these kinds of support, and none of the men interviewed discussed accessing any direct economic support through the mainstream government agencies.

### **8.3.3 HIV Treatment of a spouse**

Receiving medicine alongside one's partner was one of the factors that encouraged some men to maintain their own HIV treatment. Although the fear of wives' reaction to a positive diagnosis discouraged some men from testing and initiating treatment, as discussed in Chapter 7, once tested and initiated on treatment, adherence became easier for the man if his wife (or wives) was herself receiving treatment. These men argued that adherence would have been compromised by the fear and uncertainty of their wives' perception of them since wives would think that they had brought the disease and would not be understanding or supportive.

Noah, for example, stated that he was "less anxious now than before" because he was not the only one in his family taking the ART medicine. Though regretful that one of his two wives eventually tested positive as well, he believed that her being on treatment too made her more tolerant and supportive, and less resentful to him, compared to the discordant one who sometimes irritated. This gave him a peaceful mind to focus on treatment. Noah's experience is also echoed in Ben's, who talked about the way the unfortunate positive diagnosis of his wife had ironically helped to lessen his anxiety and discomfort with his treatment in the presence of his wife. He said, "...it is bad that she now has it [HIV] too. I was worried...but she has said nothing about it, and now it is easier for me, when I will be talking about my medicine, she understands." Isaac's anxiety about taking his medicine was lessened because his wife was already taking it. Since her experience was the same as his, they frequently openly discussed their treatment and easily understood each other's feelings and experiences. This appeared to be separately confirmed by Isaac's wife, who when discussing with me about their experience of living with HIV in the family, said "...I

was confused about the source of the problem [infection] but we said ‘since we are now both getting treatment, that is the important thing’. We need these drugs to be alive.’

In contrast, a number of men, including Isaiah and Jose (age 30), experienced great anxiety about disclosing to their wives, who had not tested, and partially attributed their failure to adhere to treatment, or decision to stop treatment completely, to the fear that their wives might find out.

All the men whose wives were on HIV treatment reported the direct and practical involvement of wives in their treatment efforts. Often their wives encouraged them to continue treatment and for a few, their wives occasionally picked up medicines for them. Leo’s (age 27 years) example was illustrative. Not only did he test after his wife, and got an invitation to enrol for treatment through the antenatal care programme attended by his wife, but he also acknowledged the help of his wife in regularly picking-up his pills for him, without which his continued access to treatment would have been in doubt. He stated:

I collect the drugs myself, but sometimes I send her when I am busy. You know I go early in the morning to do my work and often I take long to come back. We can delay waiting for maize [to be supplied] so the wife brings for me my drugs. [...] the problem that I find when collecting the drugs is if you are told to come to the clinic when everybody is supposed to come, you line for long hours [before you can be served].

However, spouse’s picking up drugs for one another was not the official or standard practice. In all treatment programmes, patients need to be seen individually and regularly by clinicians to monitor their health. Thus, some men were not as fortunate as Leo, as their providers would not allow partners, or any other person, to collect medicines for them, even if they were both receiving treatment from the same facility. Most men receiving treatment understood this policy and indeed emphasised that they would not allow this restriction to distract their commitment to treatment, yet they were critical of it, arguing that treatment seeking would be easier, less stressful and cost less, if spouses were allowed to pick up drugs for each other. Noah discussed the burden of having to make two different trips of about thirty kilometres each to the same HIV clinic in the same week; one for his own appointment and another when he transported his wife on a bicycle for her appointment:

[...] like last week when I went twice; on my appointment and hers, since then I am still feeling a lot of back pain because of riding the bicycle, and has even slowed my work of digging. They [health workers] do not allow one person to collect the medicine for two. You know for you to talk to them, your file must be there if not you don't talk to them....you don't enter inside [the clinic]; you sit outside like a visitor. They say also have your day of appointment.

The men who had dropped treatment but expressed desire to return for treatment in future also linked their hopes to their wives' possible future treatment. This was in spite of some of the wives being confirmed to be HIV negative. For example, although his wife was discordant by HIV status, Juma (51), in response to the question about his future treatment plans, said: "We shall go back together [for treatment] with my wife." This was precisely the opinion held by Jose (age 30 years), who had never disclosed to his wife any of his HIV information, when asked a similar question: "I will start again when she [wife] also starts." From these experiences, we see that both HIV status and treatment discordance may in some ways be problematic to men's treatment efforts as many of them worried about being blamed and resented for bringing the virus, while their wife's treatment was an incentive for men to maintain their own treatment. It is important to note that in all accounts, there were no reports, either from men or women, of any couples sharing their ART drugs with each other.

### **8.3.4 Care and support from families**

Although men generally believe that compared to women, men tend to receive less support from their families when ill, as discussed in Chapter 7, some men living with HIV recounted stories of how the care they had received from other relatives had positively impacted on their uptake of treatment. Those men emphasised that they often felt that it was a moral obligation to reciprocate to those who had shown them love, by them taking their treatment. The support received was either in material form such as food and money, or being taken to hospital. While various relatives, including brothers, mothers, and sisters, provided valuable care, mothers were perhaps the most assured source of support, care and encouragement to maintain treatment. Jeremiah, whose first wife had left him just before his illness symptoms struck, and the other two soon after the HIV symptoms showed, relied heavily on his ageing mother to prepare meals and occasionally wash him. Mike, age 31, also on treatment, kept his medicine in his mother's house situated in a separate

compound (or sometimes his brother's house), and relied on her not to disclose his treatment to his wife. This might have threatened his treatment as her disapproval would be a bitter reminder of his "worthlessness." Even Moses, who had taken ART drugs for nearly 8 years before stopping, reported that of all his care givers, his wife and children inclusive, it was only his mother who had consistently been compassionate, never insulted him because of his status, and often encouraged him to remain on treatment.

Compared to brothers, sisters were perceived to be generally more understanding and less arrogant when they helped. Men such as Ben (on ART) reported receiving regular assistance from sisters, particularly in the form of food supplies, saying, "You know, I don't have enough food these days but my sister brings cassava for flour. Otherwise I don't know what would happen; where I would put this woman and the children...and also this medicine needs eating [sufficient food]." The most frequently discussed contribution of male siblings was in assisting to take them to hospital to initiate treatment and/or assisting with transportation to the clinic when needed. However, brothers were sometimes criticised for being inconsistent in their support.

While many of the men who received consistent support were motivated to adhere to their treatment, it was surprising that for some of those who had no support, rather than hinder them, the lack of support from relatives encouraged them. They argued that they wanted to be on treatment to prove their relatives wrong and demonstrate that they can regain health without them; that is to demonstrate their independence. Salim, Ben, and Sylvester were the best examples of this; with each of them narrating similar accounts of how their rejection by their siblings, especially brothers, due to their persistent need for support or their own failure to support those relatives, encouraged them to embrace treatment and ensure they were healthy and self-sufficient again.

## **8.4 Factors that may lead to treatment discontinuation or threaten adherence**

From a biomedical point of view, HIV treatment is essential to save and prolong life. Therefore it would seem to be unthinkable to initiate treatment but fail to adhere to it or drop out of it altogether. In this section I discuss how this related to notions of masculinity.

## **8.4.1 Meaning and perception of HIV/AIDS medicines**

Participants' accounts repeatedly showed that the perceptions men held about HIV/AIDS treatments in general, and specifically the experiences and identities created by receiving and taking ARVs or septrin drugs, negatively impacted on their adherence to treatment in varied ways. In particular, drug side-effects, drug toxicity/power, and the stigma of ART will be discussed below.

### **8.4.1.1 Medicine side-effects**

Side-effects of taking the drugs and their unpredictability were a serious setback to patients' treatment efforts. Although most men said they had been warned by health workers or by fellow patients about particular side-effects, many reported that their adherence was threatened or actually interrupted because of devastating side-effects. Swollen feet, feeling persistently nauseated, a hot, itchy or a darkened body and malaise were common. Most participants said that the multitude of side-effects made normal life with ART very complicated and unpredictable. So, coming to terms with the impact of medication, especially in the early months, was a major challenge for the majority of the men. There were many exceptions of men who had successfully adopted ART and accepted or learned to live with its limitations, including side-effects, saying perseverance was key, but for others, side-effects were a source of constant frustration, leading them to question their long term commitment to taking the drugs. For Alfred (dropped treatment) described how, body itching may reduce with time only to give way to new side-effects such as becoming too hot or one's body and nails darkening, while others like Juma (dropped septrin), who emphasised that side-effects were his main reason for dropping treatment, cited persistent nausea as the major problem.

Generally, participants who had dropped their treatment reported their irritation and frustration upon realising that the treatment which they had expected to redeem them from poor health and suffering instead exacerbated their worries through its multiple side-effects, distressing them. But for the majority of the men, worries about side-effects were discussed more in relation to their impact on work, as will be discussed later in this chapter. For men who were concerned about socialising with others, which was a common masculine norm, drug side-effects compromised their ability to keep their diagnosis and treatment secret. This theme was developed most explicitly in the case of Juma who dropped septrin. He narrated:

[...] a multitude of problems like headache and feeling too hot and wanting to throw up for several hours whenever I swallowed the drugs and they could not go away. [...] and you know when with colleagues, I saw that people who are inquisitive will know.”

There are a number of similar accounts in this study. This indicates that even though men may be aware of the need to take their medication, the unpleasant experiences with the drugs prevented them from realising the full benefits of being on treatment, forcing them to reconsider its uptake. To these participants, the very act of undertaking treatment to get health relief generated more uncertainty about one's health. Moreover, for some men, like Alfred, the feeling that health workers had not offered sufficient explanations or solutions to their troubles with side-effects was more frustrating. He said, ‘...they said there was nothing else they could do because they were the drugs they had....and because I did not want to bother them anymore, I decided that I will not take their ARVs.’”

Nonetheless, several accounts did show that although such men dropped their treatment due to side-effects, they remained extremely concerned about the fragile state of their health and a number of them reported recurrences of illness after stopping HIV treatment. But as a strategy to manage their illnesses in the absence of prescribed HIV treatment, most, including Isaiah, Jose and Alfred, resorted to the practice of using other common antibiotics and antimalarial drugs whenever they felt unwell. They reasoned that after all, they had seen some of those very antibiotics being prescribed for HIV patients. Although none of the participants reported using non-biomedical treatments such as herbs, one participant informed me that his cousin, who declined to take part in the study, had on various occasions rejected the opportunity to enrol for ART in preference for herbal medicines. It could be argued that some participants, who had dropped out of ART, were reluctant to discuss their own use of herbal medicine. But given the long period of in-depth interaction with these participants, it is unlikely that I missed such information.

It was not only the direct effect of the side-effects on the physical body that appeared to discourage some men from ART. For others, it was the emotional toll of being on HIV treatment that sooner or later began to express itself, leading them to question whether they should carry on with ART. A number of stories showed that the experience of living on ART was not only extremely frustrating but was also very emotionally isolating because

daily medication was a stark daily reminder of one's 'differentness' and separated them from others who were not like them. Taking ARVs on a daily basis was a reminder, as Alfred (dropped ART) said: "It makes you realise that mmm, so I am worse off than other men!" While the compassion received due to illness also made men feel different, they felt more frustrated that the drugs also caused more challenges. This feeling caused Alfred to question his self-identity. In particular, the thought of having many people, including children, showing compassion to him due to his treatment, was a hindrance rather than an incentive for Alfred's uptake of treatment. Moses had similar reasons to abandon treatment. Besides the drug fatigue, taking ARVs for over eight years had turned into a haunting experience, always reminding him of the reality of the afflictions he has lived through over the years. Asked why the reality of experiencing AIDS did not encourage him to continue treatment in order to avoid it, Alfred did not give a definite answer. He appeared to admit that taking medicine is the right thing to do; saying, "Yes, that is true...but added that, "you know it is hard, taking those medicines also!" This suggests that a combination of factors were at play, including pill fatigue and the possibility of a fatalistic attitude.

#### **8.4.1.2 Drug 'power' and perceived toxicity or failure**

While all men knew that HIV treatment was supposed to be life long, and many knew that non adherence was dangerous, some men believed that taking ART medicines for too long was equally unsafe in the long run, or that drugs were sometimes too "powerful" for their bodies to tolerate. Drawing mainly from the examples of other AIDS patients they knew in their neighbourhoods, men who were uncertain of the safety of HIV medicines described incidences of "sudden death" arising from what they believed was the result of drug toxicity or failure of long term ART treatment. This concern was most prominently expressed by Isaiah and Juma (age 51) when explaining their decisions to discontinue their treatment. When asked if he did not think that dropping out of treatment would turn out to be more dangerous compared to the side-effects he had experienced, Juma agreed but argued that the ART drugs might be potentially harmful as well when taken over a long time:

What you are saying is true, even me I am sometimes worried, saying that maybe I am messing [by not taking medicine], but then you also see...you know there are some people who have taken them for a long time and then die quickly within days, when the medicine refuses to work. You just hear that so

and so has died; only two days of sickness! That is what these drugs can do, when you have taken them for long, it reaches a time... and you die abruptly.

The perception that ART drugs would eventually fail to work, or that they became toxic to the body with disastrous consequences when taken over a long time, was common in the community. This concern was frequently expressed during conversations, with a number of people saying that they were often surprised by the way some people who were on ART and looked very healthy died suddenly. It was speculated that the ART drugs may have become toxic or too powerful for the body, causing such deaths. However, others believed that regardless of treatment adherence, the HIV virus tended to become more ruthless with time, and that when it eventually “comes back,” it was more lethal and overpowered all the drugs.

Both the men who had maintained treatment and those who had ceased collecting their medicines emphasised that unlike other common drugs such as antimalarials, the HIV/AIDS drugs were very powerful, with an exceptional capacity to weaken the body, and that they were particularly problematic if taken on an empty stomach or when one’s health had deteriorated. The belief that ART drugs were too powerful for some patients’ bodies led some men or their carers to devise the strategy of temporarily discontinuing or under dosing as ways to adapt drug use to suit their body’s strength. The ability of one’s body to cope with the power of drugs was assessed in terms of the physical state of the body and perceived severity of their illness, with those considered to be too ill assumed to be incapable of tolerating full treatment, as illustrated in the case of Moses. During the fieldwork, Moses stopped taking his medicines for a period of three months but when his condition worsened, and he became weaker, both he and his wife grew extremely worried about this trend. With encouragement from his wife, Moses resumed taking the drugs that had been kept. However, his wife decided that as he was very weak, he would not take the full dose as recommended, and so instead of the prescribed two ARV pills and a septrin tablet per day, she would give him one ARV pill and one septrin tablet. When I asked her why she decided so, she reasoned that Moses was far too weak to take a full dose of the strong ARVs:

I have been giving him medicine for a long time now and I know how much his body can manage. These days he is too weak, so I give him just enough; not too much. Also I fear if he dies because of too much medicine, I may be blamed by his people.

This fear about overloading a weak body with the strong medicines and attributing poor health to the effect of drugs, rather than to failure to adhere to the drugs, was rather odd given that many men had in the first place started taking those drugs when they were too ill and therefore had weak bodies, and also given that health would worsen without ART. This may suggest a disjuncture between lay and biomedical concepts of health and illness. Nonetheless, there was evidence that men who had dropped treatment (as well as those still receiving it), roughly understood the relationship between the drugs they were taking and the state of their illness, often described as the level of *isirikali* (body soldiers or CD4 counts). Many knew that medicines were changed – often to stronger ones – if the *isirikali* became weaker or fewer. It also has to be noted that with the small numbers of men on various types of medicine, it is difficult to comment sufficiently on what impact the type of drug being used – septrin only or ARVs plus Septrin – had on treatment discontinuation.

#### **8.4.1.3 Concealing HIV status**

The labelling of persons receiving ART as ‘clients’ by their providers was found to be unpopular among some men, because this word was well known to the public as designating HIV positive people, and therefore would inadvertently lead to disclosure. This resulted in some men wanting to disassociate themselves from HIV treatment. Although only a minority of the interviewed men explicitly discussed this issue, their expression of distress was profound. Participants who had not publicly disclosed did not wish to be publicly associated with their treatment provider, but worried that the label of client created that identity. Participants reported that it was common practice for some counsellors coming from the neighbourhood to refer to them as ‘our clients’, when discussing with other people, which distressed them. This concern was expressed by Juma, Jose, as well as Ben, who although still receiving his treatment, was most concerned about confidentiality of his treatment information.

Similar to the concerns raised above about the label ‘client’, the label ‘OB’ [Old Boy] used in the way that old school mates refer to each other, was sometimes used by men on treatment to refer to others known to be like them in the village. This may have been a way to forge an identity with others of their kind. Abraham and Noah, two of the men on treatment who had publicly disclosed, were implicated for often using this concept, without knowing that others were uncomfortable with it. Ben (age 36 years) who was receiving treatment with Abraham in the same place, described how “...Abraham...ahhhh! he will

find you [with other men] and say, ‘OB, you are here’, or ‘...we of TASO...,’ ” without minding whether other people are there....It is Abraham spoiling for us treatment and discouraging others.” Isaiah (dropped treatment from the same clinic as Abraham) also complained of Abraham’s tendency to publicly talk about their HIV treatment. He said, “when he [Abraham] meets you, even if in the presence of other men here in the centre, he will say for example, ‘we the sick’....who are on drugs....are not supposed to drink etc etc.’ ” For Isaiah, and others like him who were not publicly disclosed, the OB label led to involuntary disclosure. Isaiah told me that part of the reason he requested transfer to another provider, and eventually dropped treatment altogether when his request was declined, was because he wanted to avoid meeting Abraham in the clinic as he often embarrassed him by trying to publicise their HIV positive identity.

Interestingly, Abraham himself perceived his actions differently. He considered it well-intentioned and believed there was need for HIV patients to have solidarity and assert themselves in their society. He also believed that as he had lived with the virus for a long time and had adapted to treatment successfully, he had a moral obligation to assist other men too. What we see from all these narratives and experiences is that the ART drugs themselves were extensively stigmatised, especially in view of the perceived role in increasing the risk of HIV by lessening the visibility of HIV illness.

#### **8.4.1.4 Stigmatisation of AIDS drugs**

The different accounts from both conversations and interviews have revealed that the stigma attached to ART drugs, threatened adherence and in some cases resulted in men discontinuing treatment for fear of being associated with ART. The stigma ascribed to being a recipient of ART drugs arose in many complex ways. First, while the villagers generally tended to sympathise with those persons who had been devastated by AIDS disease and recommended treatment for them, the healing bodies and weight gain of many of those who had adopted treatment were widely viewed as a threat to the sexual wellbeing of others in the village. Within the village, it was well known that improved health due to ART meant that HIV/AIDS was no longer easily visible among the infected and, therefore, fears of onward transmission from these men were heightened. Irrespective of actual sexual behaviour adopted by the men in question, they were generally viewed with suspicion and their sexual behaviour negatively perceived and monitored. However, most strikingly, ART was directly blamed for causing this behaviour, as the following extract from Isaiah’s story illustrates:

Oh many people in the area look at you badly, as an enemy. Take for example, if I came to this home [his friends' home where the interview was conducted] without any clear statement, it will be a sad story regardless of the time and reason for coming. You [HIV positive] are not only feared but also suspected seriously and all your movements are watched. Even when you marry your own woman, people still see it as a big mistake; a kind of sin. You will hear people saying, this one is just continuing to kill us. A person will not hesitate to point fingers at you and saying, 'those of you on drugs are doing this and that.' That is why it is not good if people know that you are on treatment, you are suspected all the time.

This extract clearly shows that ART treatment was central to men living with HIV being perceived as potentially dangerous. These medicines were blamed for aiding men to pursue risky sexual behaviour without being recognised through visible bodily signs as was the case before treatment. One of the most common comments that I overheard from men who believed they were at risk due to other's use of ART and was critical of them was: "These drugs are finishing us."

The stigmatisation of ART drugs was particularly embedded in the language and politics of everyday interpersonal relations and disputes amongst men in the village. As discussed by the majority of the men who had dropped their treatment (as well as some still on treatment), and as I overheard during fieldwork, remarks with a critical tone such as, "...that man's drugs have made him fat, or dark, or have caused his feet to swell..." Or "...the drugs are deceiving/influencing him to doing this and that....," were commonly used to discuss and sometimes to insult men known to be on HIV treatment. Men living with HIV particularly reported that it was common for other people to undermine those with HIV and distinguish themselves by insinuating that the HIV and/or treatment was causing them to behave the way they did. The following extract from Ben illustrates the way ART drugs were often used by fellow men as a tool for stigmatising those receiving it and emphasizing difference:

When people are aware [of your treatment], they use it against you whenever there is anything [grudge] between you. Someone [an adversary] will tell you, 'I

know your slim (HIV/AIDS) is disturbing you...I know, it is nothing but your drugs that are disturbing you.'

#### **8.4.1.5 Improved health**

For some men, improved health following treatment resulted in intermittent taking of ARVs, taking them only when the illness struck hardest and discontinuing it thereafter when they felt better. Although just a few interviewees explicitly admitted to this practice, we can see from Moses' story above, as well as in the case of Alfred, Juma, and Isaiah, that some men sought treatment to relieve them of the most serious symptoms of HIV and once they felt better, they saw no need to continue with treatment. As Isaiah's story showed, he sought treatment when very ill and described his need for ARVs then as: "[...] I was just waiting for them [the health workers] to say anything [to start him on treatment] and I would accept... I was so sick, just lying on the floor." However, in spite of knowing that it is supposed to be life-long, Isaiah stopped taking his drugs less than twelve months after starting. Even though he was no longer collecting his medicines by the time of fieldwork, Isaiah, like a number of other men who had stopped going for treatment, still considered himself to be a member of the TASO treatment programme. He often identified himself as, "We the members of TASO..." and expressed hope to return for treatment in the future. The trend to seek treatment only when feeling ill was also expressed clearly in Alfred's comment that, "at the time I stopped taking medicine I could do a marathon," as well as in Juma's account, in which he remarked:

By the time I stopped [taking the Septrin drugs], I had somehow improved but the medicine was affecting my body a lot [causing nausea]... I looked at where things were going, I was not so sick, I said no, my body is still strong.

In summary, this section has outlined the main ways in which the perceptions of HIV medicines and positive HIV status affected adherence or staying on treatment. It has described the role of side-effects, drug power/toxicity, the perception that health has improved, and the stigma of using HIV treatment. In the next section, I will consider economic and work related factors and how they threatened adherence and/or led men to drop their treatment.

## **8.4.2 Masculine work ethic and economic concerns**

In Chapter 6 I discussed the significance of employment and income for masculinity. The masculine norms, relationships, practices and concerns associated with employment and money making and spending were discussed. In this section I will now consider the ways in which those norms and values discouraged men's treatment seeking for HIV/AIDS.

### **8.4.2.1 Depletion of family resources through treatment of HIV symptoms and/or maintaining ART**

Participants reported spending large proportions of income alleviating symptoms prior to confirming their HIV infection. This undermined the sense of masculinity men gained from material ownership and family provisioning, and undermined the value of work. Isaiah told how he sold off family property and incurred high expenses on treating his illness before it was confirmed that he had HIV. Elaborating how this affected his performance as a provider, Isaiah stated:

I was running my small shop from where I could put salt and sugar in the house. All the capital went into my treatment before I realised it was HIV. We wasted money trying different treatments here and there.

Although enrolling on free ART reduced expenses on medicines, other costs of maintaining oneself on HIV treatment, especially transport remained significant given men's limited incomes and assets. As they continued to draw from the limited resource base to support their ART, some men realised that they would be left with nothing to pass on to the children, especially in the event of death. Although a man is not necessarily judged more harshly for failing to bequeath anything to children than for being infected with HIV and failing to treat it, irrespective of HIV, it was socially important for a man's self-esteem to provide resources for children as Juma described:

I was feeling a bit of a sense of irresponsibility as a man just because everything was going, and I said what if I die, what will I leave the children with, what will people say? That that man squandered everything and left children with nothing!

As the extract suggests, those expenditures contradicted and undermined men's ability to fulfil their core masculine role of being a provider, especially of the productive resources which would ensure the family's prosperity. In part, due to this consideration men such as Isaiah and Juma stopped collecting their medicines; with Isaiah simply saying that: "I got defeated by the high transport costs."

#### **8.4.2.2 Occupational identity and fear of exclusion from work**

Many men expressed fears that disclosing their HIV diagnosis and treatment to employers and work colleagues could reduce job offers and/or collaborative work as their peers feared to work with persons known to be ill. To prevent losing job offers, collaborations and money-making opportunities, some men who failed to disguise their treatment chose to abandon it, especially if their health had improved. Men who often worked with others in groups felt more threatened by their HIV diagnosis and/or treatment compared to men who worked individually or privately. This is because in contract or collaborative work, such as artisanal gold mining or construction, showing weakness is detrimental to the group and is disapproved of, hence being known to be HIV positive or receiving treatment made one vulnerable to being side-lined due to the belief that the sickness would be disruptive to the team's ability to work normally. An example of this was Alfred (age 38 years), a builder who regularly worked with others and expressed anxiety about possible negative reaction of both his contractors and his work colleagues if they realized that he was on ART. He believed that his colleagues and employers would feel uncomfortable working with a known sick person for fear of blame in case his illness worsened due to exhausting work, while job competitors may use information about his health against him, saying:

[...] also they [contractors] can fear to offer you work if they come know that you are on drugs; they will ask themselves, 'who are you to overwork that man in case he got any problem in your hands!' [...] This means loss of earning; what will my children eat because they will still expect you to cater for the needs.

While Alfred's fears suggested anticipated stigma, others, such as Solom (age 42) and Job (age 45), were actually marginalised by their co-workers for being known to be in poor health. Solomon was side-lined by his fellow miners who had themselves recommended that he takes on lighter tasks following his infection with chronic cough, which many suspected to be symptoms of TB/HIV. He said:

They told me to do the lighter work but started giving me less share of the ore; say for example out of [an expected] five tins of ore, they gave me two or one, and this could bring quarrels because I was not happy.

Some men who were declined loans for business or other purposes also attributed it to lenders not trusting them because they were living with HIV/AIDS. In the extract below, for example, Isaiah described what he believed was a common ordeal for men known to be on HIV/AIDS drugs:

Isaiah: What this sickness has affected in my life is, you know, like us, the sick, you cannot freely co-operate with others who are not sick. You can go to some and in someone's mind he knows that that one is on drugs so even if you try to say, for example, ask for a loan someone will say 'No, this one will die without paying me,' hence someone will refuse.

Godfrey: Someone refuses to lend you money! Do they tell you why?

Isaiah: Of course they may not tell you directly that it is because of sickness but you will just know from how the person talks to you. They can dodge you, promise you and dodge you and ask you questions about repayment. The next time you will hear from other people that so and so does not lend his money to a sick man who will not have a way to pay back and can even die before paying back. But if those not sick go they are given. You know all of us try to get assistance from others but I have seen that a man who is sick suffers a lot; they don't give you and when you leave he back bites you, saying that one is on drugs.

Participants also discussed the impact of drug side-effects on employment and masculinity. The majority of the accounts showed that side-effects destabilised physical work, affecting the sense of masculinity gained from being able to work hard and consequently leading some men to discontinue treatment. Many indicated that they were less able to disguise their HIV infection and carry on with work when on treatment because of side-effects, which made them feel worse while at work. For those who had not disclosed their status or treatment, this risked exposing their illness. Juma, who started taking septrin and later dropped it, provided a revealing account of how disruptive side-effects could be to men's

work. Juma was diagnosed with HIV following repeated bouts of illness, one of which necessitated hospital admission in early 2008. Being married, with nine children and the main provider in the home through his gold mining work, Juma was relieved to start HIV treatment with septrin prophylaxis. In his words, “I was happy that the (septrin) treatment was going to help so that I can continue my work (as an artisanal gold miner) with my colleagues.” Juma also believed that the treatment was timely as it would prevent obvious symptoms and thus help disguise the illness further from colleagues. However, soon after he started taking the daily septrin prophylaxis, a multitude of drug side-effects set in, including frequent headaches, body pain, feeling too hot, sweaty and nauseated for several hours whenever he swallowed the drugs. Sometimes these problems were more severe than some of the symptoms he had experienced prior to testing, greatly affecting his involvement in the mining activities. Juma said he tolerated these side-effects for three months but when he made the decision to discontinue taking these medicines for a few weeks, the side-effects disappeared. His wife who had witnessed his awful experience with the drugs supported his decision to drop them, but on condition that he agreed to buy and take other medicines in case his overall health deteriorated later.

Men who identified themselves as primarily involved in mining, as opposed to other occupations, appeared to be extremely sensitive to the negative impact of HIV and/or treatment on their work and construction of masculinity. Longevity and personal success in this industry brought pride and many described mining work as historically men’s work. Quitting mining was therefore difficult and a man could lose the hard won image of a hard worker. Among the many examples, Juma’s was most revealing: “It [mining] is the work that we men of this place know. For example, I started digging gold many years ago. I dug it for almost 20 years and left but now again I am back to it.” Although Juma recognised that the changes in his health due to HIV/treatment were incompatible with the mining job, he felt pressured to maintain this occupation in order to protect his identity, saying:

The energy was there for a long time but not these days. But for them [colleagues], they still think like that because my record of digging gold was good, I was a very strong man. So, even if you are weak, you just keep on as they know I am not a lazy man.

### **8.4.2.3 Failure to take time off work for clinic appointments**

Some participants reported that they had dropped out of treatment after failing to find time to leave work periodically to go for treatment. Taking time off when doing collaborative work was particularly problematic in two ways. First, one had to offer an explanation to colleagues for one's absence. Without an appropriate explanation or in the event of non-disclosure, colleagues would then speculate the reason for these frequent absences and visits to town. Second, being away from work sites on some days left one susceptible to being side-lined by colleagues in the event of some vital work deals or opportunities.

Emma, who worked as a member of a gold mining group, reported that sometimes clinic appointments fell on days when they, as a group, were meant to undertake the most vital activity in the mining process such as exploring/establishing a new site, apportioning responsibilities or sharing the gold ore realised from days/weeks of mining. Everybody's presence is vital during such activities to avoid missing out on money. Emma admitted that these activities did not always coincide with clinic appointments and sometimes argued that they were not the sole reason for his dropping out. But he also revealed that once clinic appointments had been missed a few times due to work or other commitments, the fear of being reprimanded for missing them compounded the reluctance to go for ART, even when work should not have been a considerable barrier. He explained:

You know, sometimes you see that work has tied you. You know with this work of ours (gold mining), people can cheat you when sharing the ore, so you have to be there on that day [of sharing], and so you miss to go there [for medicine]. But when you want to next time, you start to fear what they will say. Those people are tough.”

Taking time off work appeared to be an on-going challenge for most men, including those still receiving their treatment as was illustrated in the case of Leo (on Septrin), a produce dealer who expressed great concerns about time constraints. However, Leo was lucky that his provider allowed his wife to sometimes pick up his drugs for him when she picked up her own as described earlier.

### **8.4.2.4 Fear of exhausting the gains from ART treatment**

The majority of the participants on treatment believed that despite being on medication, their health remained fragile. Many thus remained anxious and fearful that engaging in

strenuous work would undo the health benefits of ART. This led some of them to opt out of hard work, which in turn damaged their reputation as hard working men. Others, particularly those who were taking ARV drugs, also saw ART as unsatisfactory, reporting that even though their health had improved due to the HIV treatment, their physical strength and productivity had declined compared with other men and to their former selves, yet many of their productive activities required these characteristics. Hence ART did not seem to profoundly restore their work-related masculine pride as they would have wished. Ben (36 years on ART), explained that ever since he started treatment just over a year ago his involvement in heavy work had reduced significantly because he had “no energy” to work hard like other men and he deeply regretted it because it affected his earning capacity.

I have to be careful not to harm myself further. So whenever I go to where people are mining from, I don't get involved, I just observe, and chat with them. [...] I feel shamed especially because at the end of the day, the courageous men are the ones with money and you will be admiring them but what can I do, I have to choose either to die now or try to push a bit.

For men who had not disclosed their treatment to colleagues and other relatives, yet had reduced their workload, not working normally was questionable and heightened speculation about possible reasons why they did not work as hard anymore. They often had to deal with questions and pressures from others and many described losing their reputation as hard workers as they sought to avoid strenuous work to prevent further damage to their health which had improved due to treatment. Since the health workers had advised that they should not over exert themselves, men on treatment were in a dilemma whether or not to return to work and how much work to do.

Overall, in spite of ART, men living with HIV or those suspecting HIV infection believed that they did not compare favourably with other men around them in terms of the ability to accumulate resources from their work, which greatly affected their self-identity. They said that for them, even when they attempted to work hard, much of their earnings which would normally be re-invested in work or in other ventures was spent managing their precarious health. Isaiah's comment below captures well how this perceived difference was discussed:

What makes their life [the lives of other men] better is that whatever they do they do it better without disturbance, it's not disorganised like yours because

with yours if you tend to work very hard, it's that very thing you do in the name of trying to earn something also that will actually increase the sickness in your body. Therefore whatever you get again goes (is spent on the illness) but for the other one his remain intact and progresses, but for us all plans are spoiled.

When duration on treatment was considered, the threat to their health and men's working relations appeared to vary. Men who had been on treatment for longer tended to report more positive experiences about the impact of their status or treatment efforts on their work ethic and relationship with other workers. On the other hand, intense anxiety was evident among men who had been on drugs for a shorter time, with the majority of those who had ceased taking ARVs or septrin citing work-related concerns also falling into this group.

### **8.4.3 Transport and other financial challenges**

Just as men discussed transport as a barrier to testing (Chapter 7), a number of them also cited transport difficulties as a major threat that could lead to discontinuation of treatment. Although the transport fares were generally small, many men argued that they were poor and could not easily afford regular transportation to collect their medicine. Others reported that because they had no steady income, it was often difficult to plan for transport to fulfil the clinic appointments, which were not flexible. Coupled with fear of sanctions if they previously missed appointments, transport uncertainties led some to cease going for treatment altogether. Furthermore, like men who had deferred testing because they felt they may not afford other incidentals during the trip to the health facility, men who abandoned HIV treatment described how in practice one needed more than just transport fares when going for medical appointments.

Generally, men were concerned about the daily challenge of living in a context of widespread poverty and lack of material goods to lead a decent life, and sometimes claimed that this made life with ART meaningless. Many expressed a concern that the persistent worries about their economic circumstances and other problems might prove more destructive to their health than the HIV disease itself. For example, during the later months of the field work, I saw Ben grow particularly distressed and frustrated due to a combination of events that all required significant amounts of money. A fire razed his main

living hut, leaving him needing to construct and refurnish another one. In addition to this tragic incident, his wife's delivery date was due yet he had no money. When he asked his only teenage daughter to vacate for him the only remaining hut and move to sleep in the house of other relatives, she responded by disappearing from home for weeks, leaving Ben cursing his troubles. During this time, Ben did not only miss one of his clinic appointments, undermining adherence, but he also expressed some suicidal thoughts, saying: "Godfrey, one day, you might just come to learn that your friend Ben is no more. I am tired of problems." With his consent, I linked Ben to a counsellor to discuss his challenges.

#### **8.4.4 Wives' and in-laws' negative reactions**

As well as affecting decisions to test, negative reactions to their diagnosis and its treatment by their wives was in part responsible for the decision to drop ART among some men. Three of the eight men who had dropped or failed to initiate treatment discussed this issue, although others also admitted that the criticism from their wives sometimes hurt them. For example, both Isaiah and Emma reported that their wives resented the bad news and felt betrayed. The turbulent relationship that followed, especially during the early months of treatment disclosure, made these men feel distressed and guilty, in turn affecting their continuation with treatment. In particular, Emma reported that with encouragement from her relatives, his wife left him on learning that the medicines he was taking were for HIV/AIDS. By her own choice, she left their four children whose daily food needs he could not manage alone if he did not force himself back to hard work. This also meant that he found it increasingly difficult to spare any money and time to go to the hospital. Moreover, as his wife had returned to her parents' home, Emma was worried that she had could have told all the in-laws, and expressed the view that he was "not worthy" meeting his in-laws again.

Isaiah's experience reveals a slightly different perspective to Emma's, and shows how vulnerable men are to failing to adhere to medicine if the feeling of guilt for bringing HIV persisted. After testing and starting treatment, he did not tell his wife of the diagnosis and although she suspected based on his symptoms, she did not ask and he continued to take his drugs well. But when his wife eventually confirmed the diagnosis through Isaiah's friend who had helped take him to test, she was extremely bitter and regularly cried and blamed him for "killing her", even in front of the children. This experience was traumatic

and made Isaiah regretful, and so whenever he took his drugs, he was reminded about his wife's reaction. In spite of having been told by health workers that adherence to treatment reduced the likelihood of transmission to one's spouse, which should have slightly reduced Isaiah's guilt, he believed that his wife was also already infected, since she had been having unprotected sexual intercourse with him prior to HIV diagnosis. Hence, Isaiah's decision to discontinue his treatment was partly a way to reduce the tension and guilt on his part; "I just wanted to disassociate myself from it for a while." When his wife eventually tested positive months later and started taking ARVs herself, the tension between them reduced, and she started to encourage him to take his medicine again.

#### **8.4.5 Fear of the repercussions of defaulting prevented men from returning for treatment**

All the men who had dropped out of treatment expressed the hope that they would at an appropriate time resume taking treatment. Many of them expressed the desire to resume treatment during the field work, which may have been prompted by discussions during the course of the interviews. However, all of them were afraid that the health workers would rebuke them or even deny them treatment having been warned against absconding. Many of them worried that they would not have adequate explanations for having absconded and described the process of re-establishing contact with the provider as likely to be tense, as health workers would blame them. This could undermine their respectable social status and sense of masculinity. When Isaiah, for example, narrated his reservations about trying to resume receiving ART, he expressed profound fear of loss of respect and being shamed by health workers, which was contrary to his expectations of how an adult man like him deserves to be handled:

[...] and you know even now, in case I got the opportunity to go back [for treatment], I am sure it will be a serious case, it will involve *ewosan lo'epol noi* (very serious interrogation). In fact, I think they will send me away because it is a big case: 'where have you been' is what they will ask. The other people [providers] are too tough. They will reject any reason and you remain ashamed. It involves being shouted upon like a child, don't you see, no respect at all! I have seen it from some others who have taken time and then gone back. Let me say the other people are no nonsense people, they will send you away and shame you, and so that is my worry.

Similar to Isaiah, Juma, Jose, and Alfred were extremely doubtful of their chances of being readmitted for treatment in case they returned. Juma said: “I do not know what to do [whether to go back to the same clinic], but I see that there is no way; I think those people will refuse me.” As discussed earlier, aware of the possibility of being blamed or rejected for absconding, some men continued to collect their medicine and receive counselling without letting the providers know that they had stopped taking their drugs. For instance, Alfred had been doing this for five months at the time of his interview explaining that, in the event that he suddenly fell very ill, he would still be considered a member of that clinic.

The health workers involved in the delivery of ART in one of the clinics refuted the claim that providers would reject any patient who returns after absconding, saying that at the worst, such patients are put on a waiting list if there is no more capacity for new patients. However, they admitted that it was common practice when being counselled for some ART patients to be warned and threatened with rejection in cases they absconded and later returned with more serious illness. Justifying the use of such a threat, one health worker said: “This is done as a strategy to ensure strict adherence, especially among men because they are usually not serious with treatment.”

## **8.5 Conclusion**

This chapter has described the factors that may encourage men to maintain HIV treatment and those that may threaten adherence and/or lead them to discontinue treatment. Although participants did not always describe it using the notion of masculinity as a prism, the chapter has discussed various circumstances, notions and behaviours associated with masculinity that may be at stake as men considered maintaining or dropping HIV treatment. On the one hand, the concern to extend life and raise a family, a spouse’s own treatment and support, support from other family members, as well as the livelihood and other economic support from treatment providers, provided an incentive for men to maintain treatment. On the other hand, the stigma attributed to using ART, drug side-effects, the fear of losing job offers if known to be sick or on ART, and having a strong sense of occupational identity, which made changing occupation and adjusting work schedules difficult, threatened adherence and/or staying on treatment since the demands of ART contradicted these norms and undermined men’s ideal masculinity. The conflicting

factors encouraging or discouraging treatment adherence can be explained in terms of different concepts of masculinity. This distinction will be considered in Chapter 10, and the key question that I will try to address is whether those who remain on treatment aspire to/adhere to a different concept of masculinity from those who abandon treatment.

## **Chapter 9: How HIV diagnosis and/or treatment affected masculine identity: ‘Dented and Resuscitated Masculinities.’**

### **9.1 Introduction**

In Chapter 5, I introduced the different attributes and norms that men of Mam-Kiror village were expected to demonstrate and conform to, in order to be considered sufficiently masculine. I presented a discussion of employment and money, examining the specific ways in which men’s work was structured and organised, and the benefits that were accrued in Chapter 6. In Chapter 7 I explored how masculine identities influenced testing and treatment initiation, and in Chapter 8 I considered why men stayed on, or dropped out of treatment. The present chapter examines the relationship between masculinity and ART the other way around: how was masculinity affected by a positive HIV diagnosis and treatment. The fundamental questions that the chapter attempts to address are: how does the concept of masculinity change with the availability of ART treatment? Does HIV/AIDS treatment help men develop new contexts and ideals for expressing their masculinity or does it reinforce pre-existing cultural notions of masculinity among men receiving it?

The chapter begins with two case stories, presenting contrasting experiences of ‘dented’ and ‘resuscitated’ masculinities. It then discusses the changes to men’s ideologies of masculinity following HIV/ART. The data used here are predominantly from the interviews with the main sample of twenty three men who either suspected infection or were already diagnosed with HIV, but are supplemented with material from discussions with spouses and friends. Additional insights come from my observations and conversations with various people in the village during the fieldwork.

### **9.2 Jeremiah and Isaac**

#### **9.2.1 Jeremiah’s story: Dented Masculinities**

Forty year old Jeremiah was receiving HIV treatment at the time of fieldwork. He was a father of four children, aged between 2 and 14 years, born to two of his three wives. By the

time fieldwork commenced in late 2009, all of Jeremiah's three wives had separated from him. Two of them had left him within "a few months" following the onset of his repeated ill-health, while the first wife had separated about a year earlier resenting his decision to marry other women, although she had tolerated them for some time. On the insistence of Jeremiah, his first wife left behind her two sons and took along with her the daughter, who was older than the boys. These children were initially taken care of by their step-mothers but when they too left, Jeremiah's old mother frequently helped, especially with cooking. At other times the children looked after themselves and their father. Jeremiah's first wife, however, had been monitoring the developments in her home, including her husband's eventual separation from the other wives. She returned in February 2010 when Jeremiah was very ill and told me that she had returned because she sympathised with her husband's condition and wanted to take care of him as well as her children. However, during the remaining six months of my fieldwork, this woman did not consistently stay at home with her husband and children; frequently going away for several weeks, at times without her husband's consent. Each time she went to live in a small border town where she had been working in a bar.

Like most men in his village, Jeremiah had minimal schooling; he studied up to primary four, but had been one of the relatively successful artisan gold miners prior to his illness. Jeremiah was diagnosed with HIV following serious and prolonged illnesses that often required hospitalisation. The illness, which his wives suspected could have been HIV, greatly undermined his relationship with them, leading to their eventual departure. Jeremiah recalled that unlike his first wife, the other two married him due to his earning ability and when this fell following illness, they became disrespectful, and in time left him. They each carried away with them most of the household items, such as couches and utensils. Jeremiah described his experience with one of his wives: "...and worst of all, when I told her to bring the child back to me, she sent three people to tell me that the child was not mine." Jeremiah's mother-in-law openly showed disrespect to him too, and repeatedly disputed that he was the true father of her daughter's child. Jeremiah attributed all this to his diminished ability to provide for them, and although very perturbed that his status as father to the child was being doubted, Jeremiah told me that at the time, he was very weak physically and hence incapable of challenging what his wife had revealed. "I was confused, I wondered how [come the child is not mine], but because I was already becoming weak, I had nothing to do. I did not have the strength and time to start engaging her or pursuing her to tell me what happened," Jeremiah said.

It was not only the disputed paternity and inability to provide for his wives which had severely tested Jeremiah's status as a family head. During my fieldwork, I came to realise that his relationship with the first wife who had returned was fragile and challenged his position as husband and head of the family. Although this woman's return had relieved his 12 and 10 year old sons and his aging mother of some household chores, Jeremiah was unhappy that she did not respect him and was "misbehaving" [suspected infidelity] with other men. She often went out to drink with other people in the nearby trading centre and returned home late in the night in complete disregard of how her husband felt. Jeremiah said he had no strength to enforce her to respect him or prevent her from going out, and besides, he also did not want to antagonise her lest she left again. During the different visits I made to their home and held conversations with both of them, I often witnessed the wife appearing to overrule Jeremiah on various issues.

Jeremiah also deeply regretted that by being bed-ridden for a long period [almost two years], the sickness had isolated him from the rest of the men in the village. He felt that by not being in regular contact with fellow men, many opportunities, including those to make money, had bypassed him as he had not got to know or involved in what other men were doing.

Nevertheless, Jeremiah was very positive about the impact of treatment and, towards the end of my fieldwork, presented his masculinity as somewhat restored. He strongly believed in the wonderful effect of his ARVs in improving his health and regaining his self-worth. In one of our meetings he remarked: "[...] you wait when the body improves; you will soon see me at the trading centre with other men." This is exactly what I saw in the last month of the fieldwork, during which Jeremiah started to make public appearances, much to the disbelief of many who had known about the severity of his illness.

A more explicit story of resuscitation due to ART is illustrated by Isaac as below.

### **9.2.2 Isaac's story: Resuscitated masculinities**

Isaac, aged 37 years, and schooled up to primary four, was an energetic looking man and well built, which provided evidence of his involvement in the hugely laborious artisanal gold mining work. He had been on ART since 2004 when he tested positive following recurrent Kaposi sarcoma and other generalised illnesses. This was also the time when his

third and only surviving wife had been diagnosed with HIV through antenatal care, following three miscarriages.

Isaac narrated that at the time of their diagnosis, he was very confused as to which of them had brought the HIV infection. Although he was at times inclined to assume that it was his wife, as she had come from another marriage where the husband was reportedly ill, Isaac was aware that his own sexual history was risky and that rumours had once circulated that some previous partner of his was infected with HIV. “I had thought of sending her [wife] away but I said, ‘let me wait, I think I have been having this *kisipi* [Kaposi sarcoma], so it might be me who brought it through my own ways.’” As well as the counselling they received, Isaac said the fact that both of them were on treatment calmed them further since they had a similar challenge. Isaac also praised the “reasonable” reaction of his wife after she tested positive first, which made him believe that she was a loyal wife determined to face whatever adversities together with him. He recalled her saying, ““I would have wished to be okay [HIV negative]. If I was a bad woman, I would have fled from there [after receiving the results] but because I love you, I decided to come back.””

Prior to testing positive for HIV, Isaac’s major concern was that at his age, he still had no children. His first two wives had not borne him any children and he had hoped that his current wife would. However, as he put it, “little did I know that this disease [HIV disease] was the one killing the children my wife had conceived!” Following confirmation of his HIV seropositivity, and two more miscarriages, public and family commentary about him began to grow for him to “stop wasting time trying to have children.” It was thought that people with HIV stood no chance of having healthy children. Isaac interpreted this as an additional insult to his masculinity and social status, further raising his personal determination to have a child of his own.

So, when he realised that it was possible to have a child after ART, Isaac opted to try again, this time after discussing his desires with his counsellor. “As a man, I was distressed by the possibility of leaving the world without a child; I knew there was something lacking in my life because nothing would show that I was also a man in our family. So, I told the counsellor that I was perturbed, and then the counsellor said, okay it [permission] is granted.” With ART and having followed the counsellor’s advice to take his wife to the hospital for delivery, Isaac’s dream of having a child of his own, free from HIV, was realised. The birth of his daughter considerably reversed his family’s and the public’s

perception of him, his wife, and the treatment they were receiving. Isaac narrated in detail how ART transformed his identity as a man and a father:

I was happy to have gone [for ART]. Had I not gone, many things would have bypassed me; even getting a child, in fact this one would not be alive, I would not be a man with a full family. That time before I got a child, people, including my brothers would talk ill of me saying; ‘this one also with slim [HIV] is also trying to produce children! Will they really become proper children?’ But when they saw that we eventually got a child and it was walking, they could not believe! ...they just appreciated and told me that ‘we have now believed that these medicines can work; that it is real.’ ...My married sisters also came from far places to see our child and they went back to their places knowing that the child is okay. I did not mind the sex of the child, because this is a real blessing. But there were still some people in the village who disputed that the child was born without HIV, saying that ‘it is just a made up story’ ...but I tell them “the child is okay; it has no *slim* [HIV].”

Following his success with ART, Isaac resolved to adhere to the recommendations of the counsellors, including the expectation that one does not have extramarital sexual relationships. Isaac said that on hindsight, he believed extramarital sex is not the right way to live as a man as “... it is dangerous to health ...so I am different now.” He summed up the overall impact of ART on his life as “...although there are days that are different and you feel ‘downhearted’, I think it is better to just stay alive, try working and look after your family...so overall, I’ve experienced more positive impacts, especially in terms of my future plans.”

### **9.3 Masculinity after HIV diagnosis and/or ART treatment**

While discussing their experience of living with HIV, men commented on what had happened to their lives and masculinity following HIV and/or ART, and compared it with their practices and perceptions of masculinity as they were growing up and as young adults. In general, men’s identities as HIV/ART patients were constructed around understandings of their current and potential social roles and positions in their society, rather than reducing their circumstances to a medical problem. The men repeatedly

discussed their health condition from the perspective of husbands, fathers, brothers, sons in-law, friends or as co-workers. Additionally, they often discussed their condition in view of their future aspirations, offering valuable insights into their understandings of their masculinity in the context of HIV/ART. The narratives revealed quite diverse experiences of masculinity but, predictably, all interviews portrayed HIV diagnosis, and/or treatment initiation or rejection, as the greatest turning point in their view of the world, sense of self-worth and identity as men. For the purpose of this thesis, the impacts on men's masculinity following a positive diagnosis and/or undertaking HIV treatment can be divided into two groups: negative impacts that suggested that masculinities were dented and positive ones that showed that in some ways, masculinities were resuscitated or “resurrected”, as some men put it.

### **9.3.1 Dented masculinities**

Participants' accounts revealed that both HIV illness and ART negatively impacted on masculinity in multiple ways. While some participants clearly distinguished the challenges of HIV diagnosis on their masculinity from those resulting from ART, in other cases, this distinction was not obvious in the narratives. HIV/ART were discussed as one condition, without necessarily making a distinction between HIV diagnosis and going on to ART. This may be because for some, ART was initiated immediately following their diagnosis with HIV. These issues are discussed below.

#### **9.3.1.1 HIV and Wives: powerlessness, authority and control**

Men were very anxious about the way their diagnosis and/or treatment had affected their expression of masculinity in their homes, especially before their wives. As we saw in Jeremiah's account, he lost authority over his wives because he was physically weak and had failed to provide for them. Like Jeremiah, many participants reported a degree of powerlessness and loss of control over their families following their positive HIV diagnosis, although the majority reported still enjoying the privilege of being household heads. For most men, the loss of physical strength, a resource they often relied on for ‘enforcing’ orders and punishing disobedient family members, was the main way in which masculine authority was lost in the home. This concern was mostly expressed by men who had been very ill prior to ART, such as Jeremiah, or those who, over time, grew weaker due to illness despite ART, such as Moses. These men, and others like them, reported increased defiance of their orders and the undermining of their authority by their wives

who now had no fear of being assaulted or censured. In the extreme cases, some men now feared physical violence from their wives, while many reported having repeatedly experienced verbal abuse. For example, Jeremiah, who despite initiating ART was still relatively ill for the most part of my fieldwork, expressed frustration that his wife no longer listened to him but he had “no way of prevailing over her” since he was physically weaker than her:

You see I cannot say much about her. She does so many things which I am not happy with, for example she can go to drink with other people and return late at night...she even comes for discos and returns in the morning. In my condition [illness/weak body] I am not able to stop her. I could not tell her...I do not know what is in her mind, so I feared.

As we saw in the case of Jeremiah his sense of authority as head of family was further significantly challenged when his wife disputed that he was her child’s father. Having children was a highly valued indicator of masculinity, and to have one’s paternity disputed by one’s own wife was one of the most humiliating ways to challenge a man’s masculinity. Yet, due to illness, Jeremiah was unable to immediately pursue and question his wife over such an important issue in his life. The lack of physical strength to ensure that their wishes were achieved was, therefore, a great concern to men. Some wives of men that were sicker or weaker confirmed this changing gender power dynamic, with a number of them maintaining that they had ceased to see their husbands as threatening. Moses’ wife for instance admitted experiencing a shift in power balance and authority between her and her husband due to his advancing illness, with her progressively becoming the more dominant person in the family. On a number of occasions, she told me “...I am now stronger than him physically, so he cannot beat [or harass] me...” While she desired that her husband improved, Moses’ wife expressed a sense of relief that her husband’s aggressiveness towards her and the children had considerably reduced, compared to his former self. Thus, the various narratives have revealed that the disease associated with HIV had not only resulted in considerably diminished strength but also, for many men, the loss of use of violence.

Men living with AIDS also experienced a loss of control and authority as they had to rely so much on wives and children for care, particularly feeding and washing them, and to earn money for family expenditure as well as ensuring family progress. For many, irrespective of ART, their ability to provide for the family’s needs including school fees, medical and

wealth to be inherited had reduced substantially due to the illness (see Chapter 7 and 8). This meant that wives, as well as children, had to increase their participation in meeting these obligations, especially in times when their husband/father was bed-ridden, which for most, was frequent and often prolonged. With far more limited contributions to the domestic needs, and yet reliant on what others could provide, some men talked about “losing a voice in the home,” greatly undermining their self-confidence as a family head. As Jeremiah repeatedly complained, he hated begging from others for basic material as well as school needs to support his children, but saw no choice. This lack of material independence due to the impact of HIV resulted in Jeremiah feeling that he was less manly:

[...] I could take care of my children and I never begged from people but now I have to keep begging. [I beg] things like soap, sugar or school requirements and it often requires me to do so myself; to go and beg which is difficult, it is as if I am not a man. ... like now, exam fees, I am just trying somebody...I feel very bad.

A number of men regretted the loss of the family provider role, which they, as heads of families, usually used as a mechanism for controlling/disciplining their dependents either by availing it or by withdrawing it. Instead, many of the men had to ‘trade’ their traditional masculine privilege and the power they should have exercised in the family, for care and support from wives and children leading to a complete reversal of roles and influence. Moses, for example, said that his children and wife often disregarded him and, in one of our conversations, used the phrase “pleading” with them to do what he wished but none listened to him. Some fathers had to comply with the terms set by their children who earned an income, some of whom were as young as ten years, because of what these children could provide for their care. However, the degree of powerlessness felt due to their inability to provide for your family varied with their health.

Irrespective of treatment, the men reported that their HIV status had left them extremely vulnerable to being criticised by their wives at the slightest provocation. Many men felt that their women tended to express their power through victimising and blaming them, leading them to feel guilty and disgraced. For example, in the event of disagreements, some wives tended to remind them of their role in bringing the infection and at times told them to seek care/support from those women from whom they got infected, or even threatened to leave, although very few actually divorced. Like Jeremiah, whose wife was

evidently dominant over him, Job (not tested but he suspected infection) also decried his growing powerlessness before his wife who was “often up” against him; verbally abusing him for his inability to provide, yet in the past she used to respect him. He said: “...eh eh, she no longer considers me important. You cannot say a word...and yet when I was okay... she married me because of the money I was making...oh, I was also a real man.”

From the many accounts given by interviewees, there is a great sense of guilt associated with being seen as having infected one’s wife with HIV or as putting her at the risk of HIV infection. It was apparent from the way men such as Juma, Abraham and Noah (all in discordant relationships) and Ben and Isaiah (whose wives were negative but later became infected), expressed their concerns that it was emotionally challenging for those men to hear their wives’ worries or grieving about being put at risk and yet they felt “unable to do anything to stop it”. This included maintaining consistent use of condoms, which many said were unavailable or simply “strange to them, after years of unprotected sex.” On their part, despite fears that their husbands would infect them with HIV, some women reported being sympathetic to the guilt that their men carried for being the ones who brought the virus. Abraham’s wife, for instance, said she had accepted and understood her husband’s circumstances and had assured him that these things [infection] could happen to everyone. Noah’s two wives described their reaction as “just kept quiet about it and accepted [the risk]”, and so did Juma’s wife, although she attributed her supportive reaction to the fact that she was a Born Again Christian. Ben’s wife drew on the social construction of womanhood and motherhood, saying that she could not leave her marriage because, “when you come to a marriage, you come with determination to stay no matter the adversities.”

Overall, men living with HIV and/or ART underwent varied but generally challenging experiences with regard to their expression of authority and power within the domestic sphere. The care they received and the relationships with their households were complex and largely disempowering. A number of men endured levels of mistreatment and oppression in ways that substantially contradicted their expectation to enjoy the traditional masculine privilege of respect. However, it appeared that the degree of powerlessness felt by the men following HIV or ART was related to the extent to which the men had experienced loss of family resources, due to illness prior to testing or during treatment. The sense of inability to meet family needs did not appear to differ by age. Both younger and older men expressed similar concerns. Only one man (Leo, receiving septrin) argued that his ability to provide was never significantly altered by HIV as he was already “struggling”

with life before the infection. To him, his life as a man had continued with the usual challenges and worries regarding his livelihood.

### 9.3.1.2 Loss of self-confidence about sexual ability

Irrespective of treatment, the majority of the participants revealed having experienced physical, emotional as well as social censure with regard to affirming their sexuality following HIV diagnosis. Their illness prior to testing had resulted in physical dysfunction that made issues of sex rather meaningless. So when ART improved their health, a number of men reported regaining the ability to engage in sex. However, in spite of the ART the majority of them described facing enormous psychological and physical difficulties and expressed a strong sense of low self-confidence in their abilities to make successful sexual advances. This was due to two main factors. First, for some, due to slow recovery despite ART, as in the case of Jeremiah, Moses and Isaiah, they were unable to consider any form of sex so long as they were still weak. Second, nearly all of the men revealed that although they had improved physically, adjusting to a normal sexual life was a significant challenge and described sex with ART as “different” or “needed time” to be re-established,” or that “sex drive had reduced”, while others stated that, even in marriage, “sex had to be minimised.”

The main reason for reportedly reduced sexual intercourse with their wives despite ART was the feeling that they were less physically attractive and desirable to their wives. This concern was articulated by Jeremiah: “Now we do not [have sex]. What can I say to her! I just look at myself and I know I am not able, even she can say, ‘and you are sick.’”. Other men frankly stated that being on ART made sex less emotionally appealing because swallowing ART drugs on a daily basis had a psychological effect of making them feel too ill, or their wives thought they were. Isaiah (who eventually dropped ART) described his experience as follows:

With regard to those issues [sex], there was nothing much to talk about because you have to go slow. You see when I became sick, I was so sick that I was thought to be dying anytime, so now, when I look at myself I cannot even bother with that [sex]. Let me say that even with the drugs, I could not see my wife accepting me because she had already started to refuse. So in this condition, when you are not well like this, you do not even have *agongong*

[morale/drive], *emame etau* [there is no interest]. But before we got this problem, everything was okay and there were no quarrels over that.

Similarly, although Alfred (dropped ART) stated that he was still capable of having sexual intercourse even at the time he was taking the medicines, he appeared to contradict himself by admitting that ART had a substantial negative impact on his perception of his sexuality. He said:

I am still strong... but when you are taking those drugs, you have this thing in your mind that you are sick and your wife also thinks that you are sick, so when you go to those things [sex], you cannot do anything...because you take them [drugs] at night and they make you weak [impotent] and your wife can think you are sick.

However, the narratives of men like Alfred also seem to mirror what they had been told by their counsellors: to abstain from sex and conserve energy. As Ben described, “they say that when you are in this situation, one round [of sex] is like running ten kilometres; it takes a lot of energy, and also we have to be careful not to catch another dangerous virus.”

Some wives of the interviewed men also confirmed that ART treatment appeared to have affected their husbands’ sexual abilities. The wives of Abraham as well as Noah, for example, acknowledged that their husbands had become relatively impotent following ART, but were quick to add that they were understanding and ready to adjust to their husband’s capabilities. For instance, Abraham’s wife described her husband’s decreasing sexual abilities and how she had accepted to live with it as follows:

[His sexual performance] has reduced...sometimes he apologises. But I also know that when you are on these drugs, they make you drowsy, so there is no need for me to be demanding.... So, on that one, whatever he can manage is what I will accommodate.

Overall, these accounts about wives finding them less desirable for sex and the reported reduction of sexual activity due to the need to conserve energy and avoid re-infection, showed that for some men, HIV treatment did not substantially lead to the restoration of normal sexual activity. Some men remained uncertain about when to resume and lacked

confidence. This was not always the case, however, and some men, such as Noah and Isaac, have had children after ART.

However, it was rather striking that half of the eight men with sero-discordant wives did not talk about the fear of passing on HIV to them as the primary reason for their reduced interest in sex. Four men – Abraham, Juma, Noah and Mike – expressed anxiety about the risk of infecting their discordant wives, and Ben and Isaiah whose wives eventually tested HIV positive expressed guilt. But like all other interviewees, these participants, with the exception of Abraham who reported regularly using condoms, either said that their wives had not supported regular condom use or, as we have already seen, that there was nothing to do since condoms were not easily available to them. The view that “there was nothing to do” to prevent wives from getting infected, was shared by the women themselves. For example Juma’s wife used the same phrase as the men, saying: “there was nothing to do,” as they always had no condoms and also did not see the need for them. There was a strong feeling among different couples that discordant partners were, in fact, already infected but the test machine had not yet picked up the infection. For some of these couples, therefore, unprotected sex continued, with them resorting to periodic testing of the wife as a way to monitor whether she had contracted HIV. As expected, the risk was real; three women reported that they had eventually tested HIV positive after their husbands. The emphasis by both men and women about “having nothing to do” with regard to change of sexual practices, in spite of knowing about condoms, was evidence of a belief by these discordant couples that there were limited alternative ways to enjoy intimacy even with HIV/ART.

### **9.3.1.3 Stigmatised sexual advances**

In their narratives, many participants also highlighted the stigmatisation of sexual activity by people known to be living with HIV. Men reported that irrespective of treatment, there were widespread negative perceptions of their sexuality, relationships and reproductive behaviour. This stigma, usually expressed in the form of gossip and sometimes direct taunting of the victim, was extreme if the man was believed to be in a relationship with a non-marital partner, and more so, one who was assumed not to be infected. As a result, many men living with HIV reported that they had opted to stay away from non-marital sexual relations or if they got involved, they pursued those relationships with utmost secrecy. Participants revealed that unlike men with unknown HIV status who might discuss their relationships with their peers, men with HIV could not discuss it even with peers for

fear of being criticised, undermining their expression of masculinity through sexuality and reproduction. This is what Isaiah (dropped ART), during one conversation with me, described as “being driven underground and hiding all the time from people as if you are not a man.” This meant that even ART did not significantly help men to recapture the confidence to try and restore their masculinity through sexual activity.

With such experiences, it was therefore less surprising that with the exception of two men (Ben and Mike, both on ART and who remarried to replace wives) all other interviewees reported neither initiating new sexual relationships nor having attempted to re-establish old relationships outside marriage ever since their HIV diagnosis. However, there may have been underreporting of their sexual relationships since, during the time of fieldwork, I became aware of at least three non-interviewees in the village known to be on HIV treatment who were reputed to be involved in non-marital sexual relationships. Two of these men had been separated from their wives. During the fieldwork, one of them was assaulted by rival youths over a bar maid, describing him as a killer for knowingly spreading HIV. However, these three men were relatively younger compared to the majority of the interviewees who emphasised their lack of interest in extramarital sex, suggesting that age may have an important influence in the pattern of sexual activity following HIV diagnosis/ART

Overall, men’s narratives about their sexual lives with HIV/ART were largely characterised with tales of regret about their past sexual behaviour and also doubt and a sense of guilt about present sexual behaviour. Although one man – Mike – the only man who believed he got HIV from his “cheating” wife, presented his HIV diagnosis as that of undeserved misfortune, many of the other seventeen men living with HIV who were interviewed, as well as the six who suspected HIV infection, portrayed their fate as that of self-acquired misfortune. These men believed they contracted HIV from their own extramarital relationships or from their second wives. Hence in discussing the risk of HIV in their family, almost all the men linked their infection to their previous pursuit of extramarital sexual partners, and rarely referred to the sexual behaviour of their own wives. This suggests that they were aware of the negative consequences of subscribing to a form of masculinity that involved sexual achievement.

### 9.3.1.2 Loneliness and isolation from male dominated social spaces

Participants repeatedly stated that living with HIV, and for some, its treatment, had resulted in a loss of a social life as the requirement for successful treatment forced them to regulate or give up completely a range of leisure activities and interacting with others. In the public sphere, the most important social aspect of masculinity that the majority of men lost due to HIV was the freedom to enjoy the conventional male oriented pattern of interaction and use of social spaces, as is neatly illustrated by Jeremiah's story. He explained rather enviously that:

[Before I fell ill] I used to be with other men; doing work together, moving from place to place and especially in the evening hanging out. But now [due to illness] I have to accept to be like the child who remains to keep the home.

Clearly, Jeremiah felt distressed and at a loss because he no longer enjoyed the free, unencumbered lifestyle of other men in the village. He told me that this was the part of his experience with the illness which he had come to hate most. In particular, participants discussed how their illnesses before ART had disorganised and disadvantaged their social life by "grounding them" to the domestic sphere or by "isolating" or "restricting" them to their sick beds for long periods. Although ART was expected to resolve this problem by healing their bodies, freeing them to enter the social arena again, for some men this transformation was not instant. For instance, Jeremiah found the effects of ART slow: "...but you have to accept it because I cannot change this condition now, it has to be slowly." Some unlucky men reported that despite ART, they sometimes suffered prolonged illness episodes which continued to intermittently disrupt their relationships in their social network and the opportunities that these presented. For most participants, this involuntary isolation from colleagues and friends was a strange lifestyle which was both difficult and frustrating to learn and accept.

Furthermore, most of those on treatment referred to the "rules" of ART, such as the requirement for reduced smoking or alcohol consumption, for which most men in the village were known, and adherence to strict and fixed time schedules for swallowing the drugs, which had caused additional and fundamental lifestyle changes. Drinking alcohol had been a source of pleasure, a means to overcome worries, or a social activity during which one met and interacted with others. But proper adherence to HIV treatment imposed restrictions on alcohol use and discouraged smoking, despite these being considered

important activities that usually brought men together. In addition, disclosing one's status/treatment to others exposed one to forms of positive discrimination from colleagues who often advised against alcohol consumption, which further resulted not only in a sense of isolation but also in reduced opportunity to express their identities.

A few men (Salim, Noah and Abraham) downplayed the importance of adhering to the common norm of male oriented interaction and going out to socialise, saying that the time they spent at home was beneficial to the family. However the majority were frustrated by engaging in family roles such as child care. For example, Ben, who had not disclosed his infection/treatment to most of his friends, said that he occasionally felt pressured to join them for a drink in case they question his lifestyle change. Sometimes he joined other men simply because he could not tolerate the boredom and "loneliness", in spite of having a wife and children. This may suggest that irrespective of the implications for ART, men may sometimes relapse into the conventional lifestyles as a way to match the lifestyles of their male friends, in the process avoiding the feeling of deviance from normative masculine behaviour.

However, the extent to which men felt their masculinity undermined by social exclusion varied according to their level of disclosure of their HIV status to peers and the public. Men who had disclosed or who believed that the majority of their friends were aware of their infection/treatment, notably Noah and Abraham, found it easier to reject peer or personal pressure to execute normative masculinity behaviour as a proof of being sufficiently manly. For example, Noah often told me that he had nothing to disguise when he was with friends, and in case he came under pressure to do something that he felt was not right for his health, he often excused himself by referring to his health/medication condition. In contrast, as we saw from Ben who had not disclosed, he often had to associate with friends and occasionally joined them in drinking alcohol, despite being fearful that alcohol may affect his medication. Age was another factor that shaped men's sense of self-worth. The older men (40+) were more self-assured and felt they had nothing much to lose in terms of social lifestyles. Many of them said they had already "seen it all after all", as Solomon put it, while others argued that their seniority in age ensured that they enjoyed some respect from the village and, therefore, saw no reason to execute other behaviour to express manliness.

Overall, the belief that they did not fit into the truly masculine demeanour of other men in

the village was recognisable in the majority of the stories. In spite of ART, nearly all the men felt that the recovery of their masculinity through ART was temporary and subject to dramatic changes, since HIV was irreversible and ultimately fatal. For these men, upon confirming their HIV diagnosis, they began to question themselves; asking what they could do from here and what their place in the world really was, and these questions seemed to persist in spite of ART. For example, Isaac described his reaction to the positive test and the ART treatment which started immediately in the following way: "... I felt a burden in my heart. I asked myself, 'now what has happened to my life?'" However, there were many individual variations with regard to how specific masculinities had been impacted, resulting in some men presenting their masculinities as primarily dented in contrast to other men's masculinities being primarily resuscitated, while others presented their masculine identities as partly dented and partly resuscitated.

### **9.3.2 Resuscitated masculinities**

From some of the stories, it was evident that men whose lives and sense of masculinity had been greatly devastated or seriously threatened by HIV wanted to turn around and take control of many aspects of their lives, and they found ART to be the appropriate resource for this process to occur. It will be demonstrated that ART presented opportunities for men to regain the performance of some normative ideals of masculinity, but it also allowed them to re-examine common norms and develop a different sense/attributes of masculinity which they thought were consistent with and safe for their life with HIV.

#### **9.3.2.1 Fatherhood: enhanced prospects and hopes to have children**

Without exception, the value of children was underlined as a man's most important legacy; an avenue through which they will be most remembered as men who once existed in their clans. For a number of men like Isaac, HIV infection had paralysed or frustrated their attempts to have children but ART re-energised their expectations and efforts. By making it possible to have HIV free children (through reduced viral load and PMTCT), HIV treatment gave hope for and/or enabled some men to have offspring or add children, thus fulfilling social and individual expectations. In particular, men such as Noah, who said he "had not yet had enough children", or those who had none at the time they tested positive, such as Isaac, spoke very positively about the role of ART in enabling them to have the

children they desired. This success with regard to fatherhood confirmed their masculinity as 'complete' men.

As we saw in Isaac's story, when his wife lost each of their four unborn babies due to suspected HIV-related causes, his relatives and friends mockingly told him to stop wasting time and admit he would not have any children. But with ART, Isaac's dream for fatherhood was salvaged when his wife gave birth to an HIV negative baby, in the process transforming his image and endearing him to his family once again. Salim, who had no children of his own by the time of the field work, was optimistic that with improved health following ART, he would marry and have children "...so that when I die, people would know I am not gone for nothing, my lineage would remain in the clan." Noah, who had only two children at the time he tested positive, went ahead to add four more saying, "I saw that the children were not enough...and also, I had been told that with this medicine, you can get children even if you are in a state like ours." Similarly, Ben who had no son of his own at the time he tested positive said he had been told by counsellors to take his drugs well enough to enhance his chances of having HIV free children if he wanted more. Ben got a son during my fieldwork, and eagerly awaited the scheduled medical tests to determine the child's HIV status.

Although some men knew that a child being born without HIV was mostly dependent on whether the mother was infected, not the father, and whether she received the nevirapine drug during child birth, most believed and told of how their own medication contributed significantly to the reduction in risk of fathering an HIV positive child. However, most men on ART portrayed their decisions to have children as being under the regulation and control of the health workers, rather than being dependent on their own free will as adults. Men like Isaac who narrated that they had had their children "after receiving permission from health workers" felt more confident when justifying to the public and to me their decisions to have children despite HIV. But those who did not get permission or had never discussed their plans with counsellors, such as Leo, expressed a sense of guilt and uncertainty as to whether they were doing the right thing.

In spite of the belief that with ART they could now have HIV free children, the majority of the men said they were cautious not to have a large number of children, whom they cannot bring up. These men argued that they were poor, and had a shorter lifespan compared to

other men, within which to bring up children. Men who had had the number of children they felt was adequate (the range was 6-11) did not discuss the role of ART in terms of opportunities to father more children but in terms of being able to stay alive to care for them. As discussed in Chapter 8, for this category of men, many of whose social roles as fathers had been disrupted by HIV illness, treatment became a central means to try and restore the ideal of being a responsible father and family man.

### **9.3.2.2 Positive attitudes towards gender equality**

Participants' accounts suggested that many men, in response to changes in their health and/or the demands of ART treatment, reviewed their previous high risk ways and adopted a more reflexive and flexible approach to demonstrating their masculinity. This included increased tolerance to gender equality at home and rejection of extramarital relationships, saying that their new lifestyles were in fact the "appropriate" ways to live as men.

The majority of the participants believed and regretted that their infection was a result of their own risky sexual behaviour, rather than that of their wives, and spoke about the need for responsible sexual behaviour. In this regard, most of them talked of no longer being tempted by infidelity. As shown earlier in this chapter, for some men, like Jeremiah, they were still physically weak and so issues of sex had little meaning to them, while others like Isaiah had little self-confidence that new partners would accept them, given their appearance or renowned 'bad' sexual past. But most men simply argued that they had come to realise it was not good practice to have sexual partners outside marriage. In particular, most men receiving treatment questioned and dismissed the value of engagement in multiple sexual relationships, a position that was partly attributed to the counselling they had received. Men such as Noah, Abraham, Mike and Isaac (all on treatment) repeatedly challenged the notion of infidelity as a marker of masculinity and none of them talked about the prospects of finding new partners, either soon or later. These participants reported that they could no longer afford to express their masculinity through multiple sexual relations because it would expose themselves to the risk of more drug resistant HIV virus strains, which would undermine the gains of ART, indicating that they were not responsible enough for their health. Thus, for the majority of men on ART, extramarital affairs were now being seen as unhealthy to their bodies and to their partners, which contrasted with their view point prior to diagnosis and treatment initiation when they were

sexually adventurous. Nevertheless, it is worth recalling that many of these men were also aware of the public's judgemental views about the sexual activity of those known to be living with HIV and on ART, and so this may have further compelled them to be less inclined to extramarital affairs. Furthermore, some may have underreported involvement in extramarital relationships.

There was strong evidence suggesting that the HIV illness, and/or its treatment had, in varied ways, positively impacted on men's perception of their wives as well as attitudes towards gender equality within their homes. Although some men had experienced a masculine crisis when they lost their dominance in the home due to illness and overreliance on other family members, there were many men living with HIV who were found to have developed attitudes that were relatively tolerant towards equality with their wives. From both the interviews and the informal observations of domestic relations that I conducted during the repeated visits to some of the homes, the majority of men with HIV appeared to accept equality and were less inclined to use domestic violence than in the past as a way to assert their manliness. In many ways this arose from their realisation that, in fact, their wives and children played crucial support roles in their care and therefore a confrontational life at home would be of no benefit to their treatment efforts.

Some men acknowledged gender equality by referring to the notion that "we are all human", as frequently stated by Noah, Juma and Abraham. But this tendency towards egalitarian domestic relations might also be explained by the sense of guilt that weighed upon most men, as being the ones that brought HIV infection home. Given this belief, men did not wish to frequently antagonise their wives whom they felt had tolerated them despite their "weaknesses". Many categorically answered 'no' to my question whether they found their new lifestyles and forms of masculinity to be detrimental, constraining and less manly. This blatant denial was frequent among men whose accounts revealed evidence of disruption of their masculine identity.

### **9.3.2.3 Healthier bodies: ART and increased attentiveness to health and body**

Throughout the study period, it was clear that notions of independence, ability to look after one's family, work and to live a decent family life, were attributes of masculinity that were

of significant concern for men living with HIV. As recounted by many of the men, without ART, HIV/AIDS illness rendered them significantly “weak and useless”. This reference to uselessness was an admission that many aspects of their social and physical identity as men were significantly threatened and challenged. But for the majority of those who initiated ART treatment, with the exception of instances of side-effects, the physical recovery was rapid, consequently enabling them to engage in the performance of social practices and roles that affirmed their identities as men. For example, when Jeremiah looked forward to “...soon being seen with other men following improved body/health,” he was not only referring to the importance of body strength but was also articulating the notion of restoration of the social body. In this case, the physical body, which was recovering due to ART, was valued as an essential element for enjoying male social company.

Participants also indicated that HIV infection, in particular its treatment, had led them to become more attentive to their health in ways that they had never been before. In particular men on treatment admitted that they always paid close attention to the body changes they experienced, especially regarding weight loss and gain or loss of strength, and were very sensitive to how their lifestyles might impact on their ART treatment and health. A number of participants argued that although norms and practices such as alcohol consumption and smoking were common among men in the village, they were not the only things men could do to express masculinity. A number of men admitted that their increased attentiveness to health was an exceptional health practice/experience, similar to women, but argued that it was vital for men too to care about their health. Many of them contended that in view of the unique and lifelong medication they were receiving, it was most appropriate to be mindful and caring for one’s health if they were to gain the most from their treatment. Abraham, Noah and Salim (all on ART), for example, spoke very confidently about their ability to challenge anybody who asked them about their changed lifestyles and potential stigmatisation from other men, since ART were more crucial than anything else for prolonging their lives. Some participants, such as Isaac, Jeremiah and Salim, argued that norms such as smoking and drinking were less important to their social identities, maintaining that, instead, what mattered first and foremost was *akijar* (life) and *angaleu* (health), followed by the opportunity afforded by ART for one to perform essential manly roles in their families. In a way, this was a rejection of the stereotype that might construct men as often uncaring about their health.

However, some variations were observable with regard to the extent to which men felt comfortable adopting the less conventional lifestyles relating to their health and bodies when age was considered. Older men (aged 40+) appeared less worried about adopting the less conventional masculine lifestyles and were more concerned about looking after their health well compared to younger men on treatment. Nevertheless, generally, men receiving ART appeared far less anxious about the prospects of embracing less conventional practices compared to the men who had dropped/failed to initiate treatment, who remained much more worried about failure to fulfil normative behaviour such as drinking and smoking. For example although both Ben (on ART) and Alfred (dropped ART) stated that they drank alcohol, Ben stated that on various occasions the risk of drinking for his fairly successful treatment sometimes led him to resist the temptation to drink a lot while Alfred said he found it difficult to do without drinking. Ben also felt privileged and believed that because of ART, he knew more about how to care for himself than did other men. While comparing himself to one man who had dropped ART and drunk ‘normally’, Ben stated: “You see when you are sick and on treatment, they tell you not to do those things in excess. Like for me, I drink, but only the local millet brew, not *waragi* [crude local gin], and not too much.” Hence, we can see that men on ART drew on their medication regime to rationalise their rejection of some of the predominant but potentially dangerous masculine practices. In this process they offset the dilemmas and pressures requiring them to always measure up to the standard masculine norms.

## 9.4 Conclusion

This chapter has examined the constructions of masculinity following HIV diagnosis and/or after initiation of treatment. Although some men’s masculinities were primarily dented in contrast to other men’s masculinities being primarily resuscitated, most presented their masculine identities as partly dented and resuscitated. Prior to illness and diagnosis of HIV infection, men endorsed the conventional perceptions of what it means to be a man, especially engagement in multiple sexual relationships, authority and control over family, providing for family, and confidence in the use of social and public spaces. However, following HIV illness men’s ability to fulfil most of their obligations, and express their masculinity through some of the ideals that they had previously internalised, was significantly threatened. Irrespective of treatment, men reported a loss of authority over wives and children either because they were physically weaker or because they had failed to provide for them. Illness significantly threatened the enactment of masculinity through

fathering children, although this opportunity might be restored with HIV treatment. Despite treatment, remaining as heavily reliant on wives and children for care and support meant that men felt vulnerable and were easily criticised. The rules of ART such as reduced sex and the social sanctioning of sexual activity by infected people also meant that men were less confident about their sexual abilities. Irrespective of HIV treatment, most men failed to enjoy conventional male oriented lifestyles.

Although, the crisis created by HIV diagnosis also offered contexts for re-examining some ideals of what it means to be a man, the resuscitation of masculinity was largely the result of HIV treatment improving health. In particular, as a response to changes in their health and the demands of treatment, men reviewed their previous high risk ways of being manly and adopted more reflexive types of masculinity, including greater tolerance to equality with wives, rejection of multiple sexual relationships, and increased attention to their health, arguing that these were the “proper” ways to live as a man. Positive perceptions of masculinity were particularly common among the men who were receiving HIV treatment, especially because successful treatment and care, demanded responsible living and relations with carers.

## **Chapter 10: Discussion and Conclusion**

### **10.1 Introduction**

As the question of gender equality in access to HIV treatment in high prevalence settings attracts more interest, the role of masculinity in influencing its access and uptake, in particular will grow in importance. This is because recent evidence suggests that men tend to under-utilise treatment compared to women in most parts of SSA. Until now, no study in Uganda had specifically explored how masculinity influences treatment seeking for HIV among men. This thesis specifically explores the cultural construction of masculinity among men from the Iteso ethnic group, how their notions of masculinity influence men's perception of, and response to, HIV/AIDS, and how living with HIV/AIDS and/or its treatment, in turn, affects men's perception of their masculinity.

In this chapter, I review my findings and interpret them from the perspective of existing literature and theoretical perspectives. In particular, I use Helle-Valle's (2004) theory of contextualised dividuality, and PJ Wilson's (1969) concepts of respectability and reputation, to examine the construction of masculinity and the dynamics of men's treatment seeking practices in Mam-Kiror. The goal is to discuss how masculinity shapes men's uptake of ART by exploring why and when men may or may not seek HIV treatment.

### **10.2 Constructs of masculinity: distinguishing two forms of masculinities in Mam-Kiror**

Chapter 5 described the prevailing constructs of masculinity and showed that men in Mam-Kiror drew from a range of norms and attributes to fulfil the social and individual expectations of being sufficiently masculine. Although the people of Mam-Kiror appeared to share the same general understandings of masculinity, there was variability both within and between individual men. Broadly, the findings suggest that there are essentially two overlapping forms of masculinity in Mam-Kiror, one based on 'reputation' and the other on 'respectability' (Wilson 1969), each consisting of various masculine ideals. However, these two overlap, in that there are 'ideals' of masculinity that are endorsed both 'amongst men themselves' and 'by the wider society'. Whereas by 'wider society' I mean the

distinction between those concerned primarily with male respectability, who are primarily women, in-laws, religious ministers, but also include other men, etc., and those concerned with reputation, who are entirely men, the distinction was at times more complex, as it was sometimes between those with whom one wants to establish one's respectability, whether men or women, such as one's affines, and those with whom one wants to establish one's reputation, such as one's work mates, or rival sexual partners.

The masculine ideals predominantly endorsed by the men amongst themselves included predatory sexual achievement and fathering many children, physical strength, a strong work ethic, financial independence and material ownership, male friendships, socialising, and spending time on leisure activities. Those endorsed by the wider society included marriage and family establishment, fathering children and providing for them, strong work ethic, sexual fidelity, demonstration of wisdom and respect of others. While previous research in both Uganda and other SSA settings has also identified many of these constructs of masculinity (see Barker and Ricardo 2005; Brown, Sorrell et al. 2005; Nyanzi 2006; Nyanzi, Nassimbwa et al. 2008; Nyanzi, Nyanzi-Wakholi et al. 2008; Mfecane 2011), much of it has not specifically discussed them in terms of the distinction between values predominantly endorsed by men amongst themselves and those endorsed by the wider society.

In his analysis of the dominant social structure of Caribbean societies, Wilson (1969) argued that respectability and reputation were two contrasting but important value systems by which people are evaluated. Respectability accrues from conformity with formal, normative, establishment values, especially marriage and providing for one's family, while reputation accrues predominantly from unofficial, informal, anti-establishment masculine values, such as multiple sexual relations and fathering many children. Among the Iteso of Kumi district, eastern Uganda, propriety or notions of proper behaviour have been identified as important attributes of social relations among the people, and were demonstrated through public displays in formal institutions such as the church, (village) court or during burial ceremonies (Jones 2009). The findings from Mam Kiror confirm this, and further suggest that compared to older men, the younger men were freer to practice norms of both respectability and reputation, although they tended to be oriented more to the expression of masculinity through reputational attributes. As one got older, the scope to express hegemonic masculinity reduced significantly while allowing the practice of non-hegemonic masculinity, as these men were expected to draw conservatively from

respectable attributes. It should be noted, however, that although younger men are likely to express or endorse values of reputational masculinity in the social context of interaction with peers, workmates, rival sexual partners and extra-marital partners, it is not always quite as simple as exclusively male company versus mixed company. For instance, if a man is in the company of his wife's brother or father, he is likely to present himself as a respectable man, even though this contradicts the masculine values he largely stands for when with other males.

De Visser, Smith et al. (2009) have described men's capacity to display different masculine behaviour in different social domain as 'trading masculine capital'. These authors argue that displays of competence in hegemonically masculine fields can provide masculine capital which can be accrued, and if necessary traded, to allow or compensate for non-hegemonic masculine behaviour in other domains. However, given that within different social fields different values are attributed to different masculine and non-masculine values, the ability to trade masculinities may be limited. This may explain why some men in Mam-Kiror, particularly the younger men, may have found it more constraining to practice non-reputational masculinity, since peers, their core reference group, evaluated them mostly in terms of reputation.

As seen in Chapter 5, marrying and having children helps men establish their masculinity because having a wife accorded a man a respectable status in society, and fathering children was a proof of sexual functioning and fertility, a highly valued attribute of manhood. This masculine ideal is shared by everyone in Mam-Kiror, and is consistent with Wilson's suggestion that respectability is derived from conforming to the ideals of the total society, and is affirmed most of all through marriage and having children (Wilson 1969). Providing for the family was also an important index of conformity to the value system of respectability in Mam-Kiror. In much of the literature, the concept of "bread winner" is frequently used to represent men's principal role in families (Moser 1993; Morrell and Richter 2004; Barker and Ricardo 2005; Tietcheu 2006). Men are traditionally expected or imagined to be the main providers for the day-to-day food for the family. However, locally in Mam-Kiror, it is women that performed a more central role than men in food provision primarily because they did most of the cultivation of food and gathering of vegetables, as has been observed in recent years in many parts of SSA (Silberschmidt 2001; Bantebya-Kyomuhendo and McIntosh 2004; Cornwall 2005).

While fathers may not have accessed food for their families as their primary obligation, and were rarely blamed for lack of it, they were expected by the family and society to fulfil the core masculine role of *akitopol ere* (ensuring family's economic progress). *Akitopol ere* was a central concept among the people of Mam-Kiror used to articulate a much wider dimension of men's provider role. Though it may have incorporated the bread winner role as is conventionally understood, often, and more crucially, it referred to the fundamental role of fulfilling the strategic developmental needs of the family, including children's education, medical needs, providing land and ensuring the family's future prosperity. Thus, unlike the breadwinner role which was often described as "helping the woman", and hence less mandatory, family economic progress was regarded as what the man ought to do for his family, and men would be judged more harshly for failing in this role. In general, a man's social recognition and sense of masculinity was enhanced significantly if he worked hard and provided resources that would ultimately transform the children's future. Yet, due to widespread poverty, "wasteful" expenditure and the impact of HIV, most men reported failing to *akitopol ere*, which greatly undermined their masculinity.

There were contrasting views of how sexual achievement was evaluated as a measure of masculinity. For the majority of men, especially the younger ones, sexuality was an arena by which virility, as well as power and superiority, was expressed before both women and fellow men. However there were counter-arguments from the wider society, including wives and relatives, that respect was lost, especially for older men, by failing to exercise self-control and minimise the number of sexual partners, and by spending family resources on them. In Mam-Kiror, the younger men and their peers and rival sexual partners were especially conscious about the need to display a convincing reputation with regard to sexual achievement, and they valued multiple sexual relationships, as has been found in many other SSA settings (Barker and Ricardo 2005; Brown, Sorrell et al. 2005; Nyanzi, Nyanzi-Wakholi et al. 2008; Jewkes and Morrell 2010; Ragnarsson, Townsend et al. 2010; Plummer and Wight 2011; Jonason and Fisher 2008). In particular, in Mam-Kiror sexual achievement was often constructed by men as a competition and sexuality was viewed as a performance in which seduction skills and money were demonstrated and reputation achieved. This led to widespread implicit or explicit contests for sexual partners, most especially to be the first man in the village to have a sexual relationship with a new woman coming into the village. In this way, sexual conquest reinforced sexual conquest. Since there was a common understanding among especially fellow men and sexual partners that, often, men accessed multiple sexual partners primarily by offering them money, the

number of sexual partners that a man had attested to his wealth and ability to spend (Helle-Valle 2004; Steinberg 2009; Plummer and Wight 2011). From this, it can be seen that the reputation of sexual achievement was constructed particularly with reference to what other men, especially peers and rival sexual partners, thought. Such reputational values, especially the demonstration of sexual virility, Wilson argues, often reflects a congruence of the way a man views himself and the way he is viewed by others who affirm them, particularly male peers of approximately similar life situations and chances (Wilson 1969).

Yet Wilson's contention above only partially reflects the experience of men in Mam-Kiror, since the practice of sexuality as masculinity was sometimes much more complex. For example, to be a great womaniser, who spent a lot of money on sexual partners, was ridiculed and despised by the wider society and also by some other men who were more concerned with respectability than reputation, who emphasised self-control and upright morals with regard to sexuality. Similarly, sexually promiscuous men themselves did not have a singular thought on fidelity (Helle-Valle 2004); one man was capable of presenting himself as a loving and caring husband to his wife, while in the context of interaction with peers and rival partners, present himself as a strong and powerful rival sexual partner. This suggests that theoretically it is possible for there to be both congruence and contradiction in the way a man views himself and the way he is viewed by others within the value system of reputation or respectability.

The findings that material possessions, having money, and achieving financial independence were important for achieving a desirable masculine image in Mam-Kiror is consistent with previous studies from many other SSA settings (Barker and Ricardo 2005; Brown, Sorrell et al. 2005). Marrying and establishing a successful family was particularly linked with income and being financially stable, while the reputation and ideal of having many wives, and more so new sexual partners, required money. The significance of business enterprise for esteem was also widely discussed by the people of Mam-Kiror. Owning a business gave an opportunity for men to gain admiration and popularity within the community, especially through offering credit and patronage. Businessmen and self-employed men also enjoyed greater flexibility and autonomy than those without any form of business in spending and investment decision-making, which was consistent with the romanticized ideal of power and masculine independence among the men in this area.

Employment was a central theme in men's discussion of their masculinity in Mam-Kiror, as found in other settings of SSA (Barker and Ricardo 2005; Mfecane 2010; Mfecane

2011). In Mam-Kiror artisanal gold mining was the predominant source of cash for men. Compared to other local occupations, the mining occupation was associated with particular attitudes towards work, reputation and sub-cultures that helped shape men's notions of masculinity in many distinct and complex ways. It was often at work that men mentored, evaluated, validated or rejected others' attributes of being sufficiently manly. The mining work environment offered the male-only space in which men would discuss freely their sexual adventures and evaluate the risks of catching STIs including HIV, and identify symptoms that required treatment or could be ignored (Siu, Wight et al. 2012).

While the gold miners were not a homogenous group, they particularly tended to portray themselves as a distinct category of like-minded men who had embraced the challenges and risks of the mining occupation. Also they were under pressure to conform to characteristics that miners were reputed for, such as undertaking physically strenuous work, demonstrations of physical strength, team work ethic, and overspending on leisure activities, which enhanced their self-identity. This attitude appeared to compel men into working hard, sometimes in risky ventures with disregard for their own welfare and health. Many personal accounts also illustrated how personal success, experience and in particular longevity in the mining industry were significant for constructing men's masculinity. Many miners proudly recounted their experience and skills in mining which put them above non-miners and also above other miners. This confirms Wilson's observation that a reputation may be achieved through proficiency in male activities, including demonstration of physical strength (Wilson 1969).

Through working and earning an income, some men gained the confidence to fulfil the individual and social expectations that they provide for their families and work towards their family's economic advancement. The result was that some men accumulated material possessions and were accorded a high status, and those who did not own anything were often ridiculed and their self-worth and masculinity were challenged.

Whereas the ability to make money proved the valued masculine attribute of hard work and/or shrewdness, overspending was a predominant attitude and norm among men, especially the miners. This was because economising showed one's sense of financial insecurity and undermined a man's esteem before others. Men would be granted nicknames that corresponded with the reputation they had earned regarding how they handled and spent their money. Generally, glorifying nicknames often pressured men to live up to their hard-working reputation, especially those reputed to be free spenders. In

contrast, men were extremely sensitive about derogatory nicknames, and often responded through violence to reclaim “the respect of their name.”

The study found that when men were earning an income, many appeared to be trapped in a form of “compulsory” expenditure, primarily on leisure, which contradicted their attempts to ensure their family’s economic progress. While they also sometimes spent on items that enhanced their status in the family, much of the day-to-day expenditure and consumption, especially by the younger men, was oriented towards a lifestyle that boosted their reputation before their peers and sexual partners. For example, besides the need to support the extramarital partners, men often reciprocated drinks and meals in restaurants and bars with friends. This pattern of expenditure could possibly be understood from the principles of “social exchange and consumption” as applied in sociological analyses. Ekeh (1974) refers to the obligation to give, to receive, and to repay as “the triple obligation of exchange,” and argues that every social exchange transaction creates interpersonal social bonds that not only tie one person to another but one segment of society to another. He argued that the morality of this exchange comes to be recognised in its own right and individuals behave in conformity to it. In a discussion of “the economics of reputation” among the Caribbean societies, Wilson noted that a concern to achieve a reputation often led low status men to spend disproportionately on luxuries and relatively expensive commodities (Wilson 1969). However, the men of Mam-Kiror confirmed that, as the gifts to others do not usually benefit the advancement of their family, the norm to spend more on friends and sexual partners than on their family was often frustrating and left men seriously torn between two contradicting masculine ideals, as has been reported in Botswana (Helle-Valle 2004).

In summary, I have shown that there are two main overlapping forms of masculinity that the men of Mam-Kiror subscribed to: reputation and respectability, each of them consisting of various masculine ideals. This not only confirms the proposition that masculinity is plural and that there is no single male gender identity (Kimmel 2001) but it also opens up a discussion on these two very important notions not customarily addressed in debates on the construction of masculinity in SSA. The different masculine identities displayed by the men of Mam-Kiror were shaped by a complex interaction of cultural, economic, moral, age and health related factors (Connell 2005). The notions “doing gender” (West and Zimmerman 1987) and “performing masculinity” (Morrell and Ouzgane 2007) convey the idea of men’s agency and capture the reflective and diverse ways in which men of Mam-Kiror acted and reconciled conflicting masculine identities. The data overwhelmingly

suggest that masculinity was not purely instinctive or natural, but nor was it entirely determined by social norms and only acted out according to prescribed gender roles. The accounts suggest that men could reject or modify their subscription to some norms of masculinity and confirm that masculine practices/behaviour are learned and can be unlearned (Donaldson 1993; Jewkes and Morrell 2010).

Rather than support the popular theory espoused by R. W. Connell and others that in every society although there is more than one masculinity, there is usually a single culturally dominant/hegemonic model of masculinity against which all other (subordinate) masculinities are evaluated (Connell 1993; Connell 2005), the discourses from Mam-Kiror did not indicate hierarchies of masculinity. Instead, men predominantly assessed themselves and were assessed by others in terms of the extent to which they fulfilled either the respectability or reputational attributes of masculinity, and would, therefore, be described as either sufficiently masculine (*ekilokit cut*) or less masculine (*ikilokit*). In other instances, depending on the behaviour/qualities displayed, a man was simply described as having demonstrated appropriate or inappropriate behaviour, and would be judged positively or negatively, suggesting not all aspects that contribute to men's social standing are inevitably about masculinity. Therefore, rather than suggest that the attributes displayed by men in Mam-Kiror are all components of a single masculinity and that some are socially more important than others, I argue that it is more useful to consider their varying importance in different circumstances as demonstrating different kinds of masculinity co-existing in Mam-Kiror.

The concept of contextualised dividuality, as developed by Helle-Valle, offers useful insights to help to understand the enactment of different and sometimes contradictory masculinities in Mam-Kiror. In interpreting the expression of multiple sexual identities in Botswana, Helle-Valle emphasised the significance of social contexts, and argued that social norms required people to present themselves and act as appropriate to the immediate social context, even if this contradicted how they presented themselves in a different context. While some cultures attach importance to *individuality*, Helle-Valle made sense of multiple expressions of sexual identity by arguing that in Botswana (and this is also true in Tanzania, see Plummer and Wight (2011) people's self-identity recognises their 'dividuality'. Helle-Valle used this perspective to illustrate what can be considered meaningful sexual practice in a particular context and that people will often experience ambivalence due to their sense of responsibility to handle various interests in ways that are

culturally acceptable. This, according to Helle-Valle, involves acknowledging and relating the various communicative contexts in adequate ways, and implies an attempt at proper balancing between dividuality – confining one’s personality to its appropriate contexts – and being *individuals*. For example, as it was found in Mam-Kiror, the sexually promiscuous men themselves did not have a singular thought on fidelity (Helle-Valle 2004); one man was capable of presenting himself as a loving and caring husband to his wife, while in the context of interaction with peers and rival partners, he could present himself as a strong and powerful rival sexual partner. Since specific situations meant that men displayed various relevant attributes of masculinity, it was not unusual for a given masculine attribute to come to the fore and be highly valued and admired in one context, but in another context, be in the background and in some instances, even stigmatised.

The idea that ‘doing/performing’ gender is a situated performance, as discussed by West and Zimmerman (1987), is illustrated neatly by the findings from Mam-Kiror, as well as in Helle-Valle’s dividuality concept. Given that a particular masculine attribute considered valuable in one situation, may, in another context of interaction or phase of life, be conveniently substituted by an alternative, the performance of masculinity is inevitably context dependent. Generally, men’s self-presentations, within their communities as well as within the interviews, demonstrated tensions, dilemmas and ambiguities in how different circumstances, contexts and social situations or groupings, demand modifications to gender presentations. But I argue that men’s dividuality allowed them to adopt different and contradictory forms of masculinity in different circumstances, and to simultaneously conform to values of reputation and respectability as we have seen throughout this section.

### **10.3 How masculinity affects HIV treatment seeking**

Chapters 7 and 8 described the way men’s access to and use of HIV testing and treatment were influenced by norms and practices associated with masculinity. Participants recounted both positive and negative ways in which HIV testing and treatment seeking was intertwined with norms of masculinity; some discouraged men from seeking treatment, while others encouraged them to do so. These findings confirm a substantial amount of literature on barriers to, and facilitators of, patient retention on ART but they also challenge some of the previous research findings and add some specific insights regarding men’s experiences. While participants sometimes did not discuss treatment seeking for HIV from the perspective of masculinity, the majority provided a variety of circumstantial

information and real life examples of the complex processes through which norms and practices associated with masculinity negatively or positively affected access to HIV treatment.

### **10.3.1 How masculinity may undermine HIV testing and treatment seeking**

The study shows that the decision not to undertake an HIV test, or start treatment, did not only involve personal evaluation of one's risks of being infected, and state of physical health, but it also involved assessing the potential influence that testing HIV positive would have on other peoples' perception of one's masculinity.

Despite acknowledging that their sexual behaviour had put them at risk of HIV infection, most men relied on the presence of HIV symptoms to know when to get tested and subsequently initiate treatment. However, severe HIV symptoms usually appear after the recommended stage to start treatment are often ambiguous and some, such as prolonged cough and body aches, could be attributed to other conditions. Men particularly linked their severe chest pains and prolonged coughs to the hazards of gold mining and explained them as everybody's illness, since these were extremely common, thereby delaying HIV testing and treatment seeking. Previous studies have also noted a strong link between symptom misinterpretation and delay to seek treatment for HIV (Siegel, Levine et al. 1989; Siegel, Schrimshaw et al. 1999). It was striking that even when symptoms could be associated with HIV, some men delayed to seek testing or treatment because they were still physically strong. Whereas the Uganda national ART guidelines recommend Septrin prophylaxis for all people diagnosed with HIV regardless of HIV disease stage, and ARV drugs for all those in AIDS clinical stage III or with a CD4 count of 200/mm<sup>3</sup> or below, studies have consistently found that as long as people of both sexes, with HIV are asymptomatic, they are likely to perceive themselves as healthy and see no need for immediate medical treatment (Fagan, Beer et al. 2011; Jenness, Myers et al. 2012), although this tends to be common among men (Nyanzi-Wakholi, Lara et al. 2009). This is especially so since the notion of an asymptomatic illness or seeking care for an illness which is not presenting severe symptoms contradicts lay or common sense perceptions of what being sick means (Siegel, Levine et al. 1989; Siegel, Schrimshaw et al. 1999).

The findings further showed that when they eventually sought treatment for HIV, some men did it to alleviate the acute illness and dropped it when they appeared to regain better health. This supports recent findings in Central Uganda in which ‘normalisation’ of health following treatment was found to be a major risk factor for dropping out, as people strive to return to the regular routines of everyday life, work, relationships and leisure (Alamo, Colebunders et al. 2012). It has been shown that ART patients often base their subjective experiences and perceptions of improved health on psychological and physiological wellbeing, rather than biomedical measures denoted by CD4 cell counts and viral load alone (Wong and Ussher 2008; Musheke, Bond et al. 2012). In the present study, the men who had been on treatment for a shorter time (one year or less) tended to describe many negative sentiments about treatment and problems of adjustment to life with ART compared to those who had been on it longer, who argued that with persistence they had become used to the routine of taking the medicines. Previous studies in Uganda have produced inconsistent results about the impact that the duration on treatment had on treatment discontinuation, with some suggesting that a shorter duration on treatment was a risk factor for treatment discontinuation (Kiguba, Byakika-Tusiime et al. 2007; Larson, Brennan et al. 2010), and others suggesting that a longer time (over 1 year) is a risk factor. In one of the studies reporting a negative influence of a shorter duration on treatment, it was interpreted that individuals who had just started ART had not yet adjusted well enough to treatment and, therefore, were likely to experience interruptions attributable to early drug toxicities (Kiguba, Byakika-Tusiime et al. 2007). In contrast, studies reporting that a longer duration on treatment had a negative impact on treatment continuation suggested that the result could have been due to stabilisation of patient’s health, which encouraged patients attrition (Fox and Rosen 2010; Alamo, Colebunders et al. 2012). This makes a proper evaluation of the impact of this factor difficult.

However, the data from my study appear to support the interpretation offered by Kiguba and colleagues. In addition, I found a difference in personal goals of men who had been on treatment for a shorter time, who tended to discuss predominantly the immediate restoration of their physical health, and those who had been on treatment longer, who largely discussed their social worth and benefits that accrued to their families and society, which were vital for their public masculine identity. This suggests that it may be useful for providers to pay attention to the early months of treatment where the risk of dropping ART is higher and promote ART for its longer term social benefits.

Studies employing a gender perspective in their analyses of uptake of HIV treatment have found that concerns about physical health tend to have a stronger positive association with enrolment in HIV care for men than for women (Durantini and Albarracin 2012). In the present study, a desire to present an image of physical and emotional strength was an important barrier to HIV testing and treatment. For some men, not starting or delaying to start ART was an achievement and an important part of their identity which attested to their physical and emotional strength. This suggests a negative influence of the social construction of men as robust, stoic and independent minded, as other studies in SSA have found (Nattrass 2008; Mfecane 2011). Generally, men of Mam-Kiror endorsed being resilient and dismissive of problems as minor, and so they were reluctant to acknowledge the seriousness of the HIV symptoms and assume an identity of a sick person until the symptoms were acute and life threatening. This confirms other studies that have suggested that men tend to respond to threats to health in less healthy ways than women, and tend to adopt strategies such as denial, distraction, and are usually less vigilant to acknowledge the need for help (Courtenay 2003). The data particularly suggest that younger men may have found it more difficult to admit to physical weakness and accept that they were ill, although there were also some older men (over 40) who discussed the importance of physical strength for their construction of an idealised identity. This is because perhaps at their age, the younger men were more oriented to expression of masculinity through physical strength which was more important to them than the components of respectable masculinity. It was evident that the younger men tended to be oriented towards treatment because it would give rapid improvement in health status, while the older men tended to focus more on its social benefits and implications for other people such as dependents, which are realised in the longer term through normalisation of life.

The phrase “men are carried to hospital” was frequently used to describe the pattern of treatment seeking decision-making in Mam-Kiror. This suggests that, first, men often seem to find it difficult on their own to determine when to seek treatment and second there exists a different kind of dependency whereby men tend to rely on others, especially wives, for their health care decisions. Although men believed that getting married made them more independent from parents, they admitted that they were not entirely independent since they often required the care of their female relations, alongside or in the absence of their wives. In the present study, the two men who did not enrol for treatment despite testing HIV positive, and another two who dropped out during the course of the study, were at the time separated from their wives. In West Africa, it has been found that women’s HIV care

giving role often extends to queuing for their husbands during medical consultation because men tend to feel greater shame (Bila and Egrot 2009), and that being unmarried is a risk factor for late initiation into HIV treatment (Pirkle, Nguyen et al. 2011). The male dependency on others for health care decisions suggests a high likelihood of delaying or failing to enrol for HIV treatment if they had no female family members on which to rely for help, and supports the assertion that generally men tend to consider responsibility for health to be women's business (Cameron and Bernardes 1998).

One of the most noticeable findings of this study was that the fear of losing masculine respectability if diagnosed with HIV undermined men's take-up of testing and treatment. The role of respectability as an obstacle to HIV treatment and care among men has not previously been described, as related discussions both in Uganda and other countries of SSA have often centred on the subject of stigma. Many studies suggest that men tend to experience greater stigma than women because, often, they are to blame for bringing the HIV infection (Obermeyer and Osborn 2007; Nyanzi-Wakholi, Lara et al. 2009; Wyrod 2011). Although stigma remains central to how men cope with HIV, their experiences of stigma are often tied to the sense of insecurity about identity as valuable and respectable men in the community (Wyrod 2011). Therefore, I argue that as an explanatory concept for men's reluctance to use HIV services, stigma appears to be insufficient to describe the specific concerns about masculinity as articulated by men in Mam-Kiror. These men specifically used the phrases: *emame bobo ayong'it ijo* (no more respect/dignity for you) and *etemarete itunga' ayi* (what opinion will people make of it) to describe how others might assess their masculinity should they be diagnosed with HIV. The main explanation for this was that since the wider society expected men to be wiser and exercise self-control in sexual decision-making, acquiring HIV was interpreted as a failure in the man's sense of judgement, which undermines the respect and approval accorded by others, particularly by the in-laws and the immediate relatives, who least expect such an outcome. Similar impressions have been expressed in a recent study of how masculinity acts as a barrier to men's use of HIV services in Zimbabwe, which found that while having multiple sexual partners is a valued sign of virility, it was important for one's masculinity to have healthy sexuality and so testing HIV positive was seen as a sign of weakness and failure, undermining disclosure and use of HIV services (Skovdal, Campbell et al. 2011).

The process of obtaining a test through couple testing and community outreach testing was found to be threatening to the man's authority and undermined masculinity, thereby

discouraging testing and treatment initiation. Although some studies have observed that couples tend to be reluctant to seek testing together for fear of blame and physical abuse (Allen, Karita et al. 2007), many others have argued that couple testing may simplify disclosure, particularly because the health worker assumes the responsibility to reveal the bad news (Matovu, Gray et al. 2005; Matovu and Makumbi 2007). However, men in my study maintained that in the context of widespread extramarital affairs by men, couple testing led to disclosure of those relationships, which would then severely affect their relationships with their wives and destabilise their families. This dilemma can be interpreted in terms of contextualised dividuality. Men can fairly unproblematically present themselves as faithful husbands (and endorsing respectable masculinity) in one context and as womanisers (and endorsing reputational masculinity) in other contexts, but to attend testing with their wives brings the two contradictory 'dividualities' together, as in the funeral Helle-Valle (2004, p.202-204) describes.

Men also complained that there was a tendency for some wives, who felt protected by the health worker during the testing, to blame men for bringing the infection, as has been found by another study from eastern Uganda (Larsson, Thorson et al. 2010), which undermined men's dominant position in a marital relationship. Men also found home based or community based testing to be a threat to confidentiality because community members tended to observe who did and did not test, with men often being the prime targets of gossip, since they were likely to have taken part in riskier sexual activity. Studies in SSA have shown that despite appearing to be widely acceptable in many settings, home-based testing and counselling interventions continue to be undermined by fears of negative consequences from knowing one's HIV status, including stigma, blame, physical abuse, or divorce (Njau, Watt et al. 2011).

This study confirms previous research on financial barriers to the retention of ART patients in resource constrained settings, which has found that in spite of receiving free treatment, transport and food expenses remain an important challenge (McGuire, Munyenembe et al. 2010; Miller, Ketlhapile et al. 2010; Alamo, Colebunders et al. 2012). However, the existing studies have paid little attention to the way such expenses threaten men's expression of masculinity. This study shows that seeking treatment for symptoms prior to testing and initiation of HIV treatment exhausted already limited resources, undermining the sense of masculinity gained through ownership and providing for the family. Despite receiving free HIV treatment, the costs of maintaining ART, including travel costs and

other incidentals during the monthly appointments, remained substantial given men's limited incomes. This forced them into selling valuable family assets, and those who worried that the family would be left with nothing as they continued spending a greater amount on treatment, stopped going regularly to collect their prescription. In a setting where masculinity was assessed in terms of the material assets saved for the family and the ability to ensure the family's economic progress, expenses incurred through treatment of symptoms prior to HIV diagnosis and then HIV treatment significantly worried men and threatened their treatment adherence (Siu, Wight et al. 2012). In spite of treatment, men living with HIV/AIDS believed that they were comparatively physically weaker than other men, and that they could not accumulate wealth since their productivity had declined or because much of their earnings would be spent on managing their fragile health.

Masculinity assessed in terms of work ethic and money making can threaten HIV treatment among men. Consistent with other studies (Liu, Canada et al. 2011), this one identified the fear of discrimination and associated stigma as important barriers to employment among men living with HIV in Mam-Kiror. Disclosing HIV treatment to fellow workers or employers left them vulnerable to being judged as unable to carry out strenuous work or as incompetent, leading to a decline in job offers and collaborative work since others were reluctant to work with persons known to be sick and on medication. This greatly undermined their reputation as hard workers and ability to provide for families. It has been suggested that in response to the physical challenges of work, some people on HIV treatment tended to reduce their workload or hours or to quit employment altogether (Blalock, McDaniel et al. 2002). However, work is a crucial aspect in the process of redefining personhood following ART, especially amongst men who greatly rely on their strength for physical labour (Alcano 2009). In this study, the majority of the men involved in gold mining possessed a very strong sense of occupational identity, and being a gold miner had a higher status than other local occupations and was financially more attractive, making quitting it difficult, as also found in the Congo (Perks 2011). Furthermore, because men relied on collaborative work and work was organised on the premise that everyone worked at the same rate, adjusting the workload and schedule was problematic since it showed weakness, undermining the sense of masculinity gained through demonstration of physical strength and work ethic (Siu, Wight et al. 2012). Thus, some men living with HIV chose not to disclose to work colleagues, which affected their adherence, while those who feared they could not continue to conceal their treatment abandoned it, especially if their health had stabilised. For others, the fear of losing the gains made through HIV treatment

significantly threatened the enactment of masculinity through ability to work hard, leaving them disgruntled about their self-worth.

The side-effects of taking ART drugs were discussed by men as risk factors to dropping treatment. Other studies, both in and outside Uganda, show that side-effects are common and are not unique to men, with the most frequent side-effects for both sexes being fatigue, dizziness, nausea, joint pain and abdominal pain. (Kiguba, Byakika-Tusiime et al. 2007; Parkes-Ratanshi, Bufumbo et al. 2010; daCosta DiBonaventura, Gupta et al. 2012; Musheke, Bond et al. 2012). The multiplicity, unpredictability and recurrence of the side-effects, as well as the failure by health providers to offer alternative solutions or better explanations, was perhaps the greatest source of frustration for the men in the present study, leading them to question their long term prospects of taking ART drugs. There was a belief that drugs were powerful and if used over a long time, would become toxic to the body. Participants felt that the side-effects distressed life, and compromised their ability to conceal their treatment, leading to a reduced self-assessed quality of life, as discussed by daCosta DiBonaventura, Gupta et al. (2012). Although misconceptions about ART drugs are common in Uganda (Lubega, Nsabagasani et al. 2010), there are genuine risks of side-effects and morbidity, especially during the first six months of ART (Lawn, Harries et al. 2008). This means that some of the men's concerns about the treatment were justified.

The finding that poor health could be attributed to the effect of drugs rather than to failure to adhere was, however, peculiar in this study, given that most men had started ART when acutely ill, and that their health could deteriorate when treatment stopped. This perhaps reflects a shift in the perception of the underlying goal of treatment rather than a denial of the life-saving benefit of it. Taking the medication affected productivity by destabilising work, which affected their ability to meet their obligations. In a study from a South African village (Mfecane 2011), ART was found to be an impediment to men's independence and ability to freely interact with other men in the public sphere because the drug side-effects and the adjustments in lifestyle due to ART made HIV infection more visible.

In spite of the worries about the side-effects of ART, there were very limited reports of herbal medicine use or spiritual healing (only two participants reported to have ever "tried" these options) as alternative or concurrent therapies. Previous studies in Western, Central and East Central Uganda, as well as those from outside Uganda, have found a substantial usage of herbal medicine and spiritual healing among HIV patients, but have reported

conflicting results about their impact on adherence to ART (Kiguba, Byakika-Tusiime et al. 2007; Nattrass 2008; Lubega, Tumwesigye et al. 2011; Lubinga, Kintu et al. 2012). For example, Kiguba, Byakika-Tusiime et al., and Lubinga, Kintu's et al., and Nattrass (in South Africa) have all found that herbs and spiritual healing were used by patients as complementary rather than as alternative therapies to ART, but Lubega, Tumwesigye et al. have found that the use of herbal and spiritual healing significantly affected enrolment into pre-ART programmes. The gender dimension in the use of traditional African medicine in the context of HIV treatment has not been discussed in Uganda, but studies from Southern Africa have found that men tend to be more sceptical about western medicine and have a greater preference for traditional medicine compared to women (Campbell 1997; Nattrass 2008). There are three possible explanations for the variance amongst these findings and also between them and the findings from Mam-Kiror. First, my small sample size could have resulted in missing the men who used alternative therapies to ART. Second, it may be argued that some of my participants, especially those who dropped ART, were reluctant to discuss alternative treatments. In particular, given that I was associated with the Medical Research Council and Makerere University College of Health Sciences, some may have thought that I would be critical of non-bio-medical treatment, although it is unlikely that they could have hidden the information from me for the entire research period and during the repeated interactions. Third, it could be that there is a cultural difference in the perceptions of the role of herbal medicine in HIV treatment among different ethnic groups in Uganda, which future studies could pay attention to.

A positive linkage has been reported between ART and reduction of HIV stigma in many SSA settings. ART reduces stigma through weakening the link between AIDS and death and disfigurement, and through facilitating a return to productive activities. ART can also facilitate disclosure, and the establishment of space for support and realisation of a sense of comfort with HIV, which reduce stigma through normalisation of the disease (Roura, Wringe et al. 2009; Zuch and Lurie 2012). Although this positive linkage was also acknowledged by participants in the present study, many personal accounts revealed that the ART drugs had themselves acquired a stigmatised identity in Mam-Kiror, and this was described as a possible obstacle to men's adherence to HIV treatment. The connection between the stigma ascribed to ART and adherence was most explicitly discussed in relation to disclosure and men's sexual behaviour. The healed bodies of those on treatment meant that their HIV infection was no longer visible, and because some men were renowned for engaging in multiple sexual relations, ART was blamed and stigmatised as

responsible for the invisibility of HIV and consequently, the risk posed by such men to the sexual wellbeing of rival sexual partners in the village. Such a concern has been reported by research in Tanzania (Roura, Urassa et al. 2008), although without a gender dimension.

In examining how health service related factors affect access to testing and treatment, studies in Uganda have repeatedly identified waiting time in the clinics, workload and poor counselling skills of health workers as barriers to initiation of ART and treatment compliance (Lubega, Nsabagasani et al. 2010; Alamo, Colebunders et al. 2012). A study in Malawi has also found that compared to women, men are less likely to return to ART care once they have defaulted (Tweya, Gareta et al. 2010). My study participants confirmed most of these barriers and discussed the gender dimensions of these barriers, particularly how they threatened their masculinity. Waiting times were reported to be too long and often incompatible with men's work schedules, in particular by men who worked in occupations that relied on team work. For men who had not disclosed being on treatment it was even harder to leave work on a regular basis, without offering an appropriate explanation. An additional complicating factor was male socialisation. Participants argued that, generally, men were socialised to be impatient and to be less of time wasters, which directly conflicts with the discipline demanded in seeking HIV services from the usually congested and inflexible public health care system, as has been shown by a similar study in Zimbabwe (Skovdal, Campbell et al. 2011). Men also complained that their failure to fulfil a particular ART appointment, regardless of the reason, meant that they would be reprimanded by the health workers during the next visit. Those who had stopped their treatment but realised the need to return were especially overwhelmed by fear of being rebuked by health workers, often before other patients, having been warned against absconding. This was humiliating and insulting to their masculinity, particularly if reprimanded by female health workers. In South Africa, unsupportive reactions and breaching of trust by health workers has been found to be a risk factor for men stopping attending health services, since they tend to have high expectations for health workers to behave professionally (Fitzgerald, Collumbien et al. 2010).

### **10.3.2 How masculinity may encourage HIV testing and treatment seeking**

This study shows that not all masculine norms and practices always work to men's disadvantage with regard to uptake of HIV treatment: there are some that have positive influences on HIV testing and treatment seeking.

The majority of the men who initiated and complied with HIV treatment attributed their decision to the need to extend life, be able to work and provide for families, and to regain a social life, following disruption caused by HIV-related illness. This means that HIV testing and treatment may be sought and adhered to by men in order to improve their health and in the process regain their ability to enact their masculine reputation as hard workers and family providers. However, the desire to regain social worth through contributing positively to family and society following HIV-related illness and ART is not intrinsic to men. Studies from diverse settings which have investigated the social value of ART to people living with HIV have generally indicated that ART facilitates adjustment and transition to living with HIV as a chronic condition, allowing them to take control of their lives and focus on being productive persons, who are contributing positively to their families and society (McReynolds 2001; Timmons and Fesko 2004; Seeley and Russell 2010). Nonetheless, it may be argued that restoration of physical health and ability due to ART is particularly crucial to the men in Mam-Kiror since, being predominantly involved in highly laborious and collective work as gold miners, their identity and masculinity is assessed chiefly in terms of their work ethic and physical strength, as was found among male factory workers in Italy (Alcano 2009). It was an especially striking finding that some men used their ability to labour consistently as a measure of the impact of ART on their health, suggesting that they were likely to adhere to treatment as long as it translates into positive benefits at work.

This study found that wives who were themselves on treatment sometimes played a vital role in encouraging men to initiate and/or maintain ART. Men described them as more understanding and supportive to their own treatment efforts, since they shared similar experiences compared to those who were not on treatment. Other studies show that couples who have disclosed to each other and received counselling from the same health facility are likely to adhere better to HIV treatment (Kiguba, Byakika-Tusiime et al. 2007). Men who had dropped treatment and expressed desire to return in the future also linked their hopes to their wives' possible future treatment, saying they would resume it when their wives also start taking the drugs. The predominant argument was that in the case of sero and/or treatment discordance, treatment compliance is compromised by the wives' negative perception of them, since wives would think that they had brought the disease. A study on barriers and facilitators of use of HIV services in West Africa found that educated women tend to initiate HIV treatment earlier than non-educated women, and that often the

education of wives also tends to have a positive impact on HIV health service utilisation by men (Pirkle, Nguyen et al. 2011). The same study also found that unmarried men are likely to initiate treatment later than married counterparts. This appears consistent with the findings in the present study, in which the only two men who did not initiate treatment despite testing HIV positive, and the other two who dropped treatment during the course of the study, were, at the time, separated from their wives. In Zimbabwe, wives' persuasion of their husbands has been found to be an important factor in men's acceptance to use HIV services (Skovdal, Campbell et al. 2011).

This study has also found that pressure and advice from colleagues encouraged some men to get tested and initiate treatment. In particular, as men tended to spend a lot of time together working and socialising, colleagues could recognise symptoms and frankly discuss the risk of HIV infection with them, and recommend medical treatment. This confirms previous research among small scale enterprises in Kabale district, western Uganda, which found that co-workers tend to advise each other on HIV testing (Twinomugisha, Danie et al. 2011). In Mam-Kiror, since discussions of health matters within work teams is quite common, and seems a vital aspect of health seeking for sexual health problems, it may be useful for health promotion to encourage such opportunities among colleagues and members of their social networks (Siu, Wight et al. 2012), with the hope that these interactions may generate new understandings of masculinity that are more conducive to health management (Nattrass 2008). However, because of failure to disclose after testing for fear of work related discrimination, some men could not rely on their friends for support to stay on HIV treatment.

Income support projects of treatment providers were a vital incentive to initiate and continue treatment among men concerned to provide for their families. This is because the livelihood support ensured they continued to fulfil their role as providers and heads of family, in spite of the illness. Those projects also provided alternative private and flexible employment and one did not worry much about disclosure to colleagues, as would be the case with work that is jointly carried out (Siu, Wight et al. 2012).

This section and the previous one have illustrated that men's decisions about whether or not to seek treatment for HIV were unlikely to be shaped by a single masculine value but by a complex interaction of a variety of masculinities, *within* the value systems of respectability and reputation. This confirms the notion that individual men can engage in a

variety of health seeking behaviours that typically correspond to different ideologies (Addis and Mahalik 2003). The above discussions raise a fundamental question that needs to be answered in order to propose the main thesis of this research: why did some men fail to seek treatment at all, and others commenced but dropped it, despite knowing that treatment was lifesaving, while others started treatment and maintained it?

### **10.3.3 Why some men did not seek HIV treatment, dropped treatment once initiated, or initiated treatment and complied.**

From the findings of this research, there seems to be no single definitive answer to this question. However, the study suggests that men tend to attach specific meanings to health seeking for HIV depending on the social context, pressures and personal circumstances of their lives. Three main possible explanations for variance in the pattern of HIV treatment seeking among men can be suggested. First, possessing a strong sense of occupational identity and working group norms, and regarding physical strength as a core measure of masculinity, discouraged some men from seeking testing or maintaining treatment. If treatment was thought to have failed to restore strength to the previous level, or caused side-effects that were disruptive to work or that made it difficult to conceal the diagnosis, it was readily dropped, because treatment prevented the demonstration of one's previous work ethic and preservation of the collective work identity (Siu, Wight et al. 2012).

Second, in facilitating shifting from mining to alternative self-employed occupations, the income support provided to some men by treatment providers meant that treatment came to enhance rather than threaten their masculine work ethic, ability to provide for family and sense of self-worth. HIV status and treatment could be more readily concealed and, if disclosed, there was no danger of being marginalised by other workers. The economic support or livelihood projects from treatment providers or aid agencies were, thus, useful both in restoring masculinity and in motivating adherence to HIV treatment, since they not only allow men to fulfil their key roles as providers but also enabled those who worked in collaborative employment to shift into flexible self-employment, which could be undertaken without having to worry about disclosure of HIV treatment to colleagues.

Third, age and social maturity, measured by marriage and economic security (Wilson 1969), and having grown-up children and holding other social responsibilities, appear to be crucial factors in men's interpretation of the meaning and value of HIV treatment. Younger men may find it particularly difficult to adopt treatment compared to older men because

they conform more to the values of reputation masculinity such as hard work and peer groups influences than to those of the respectability. These include the need to maintain an appearance of independence, being physically strong and competitive which take greater precedence over other values. However, many of the behavioural adjustments and demands of ART, such as the requirement to admit weakness and accept the sick patient identity, reducing work rate, and reducing sexual partners and playing an active role in taking good care of one's health, were inconsistent with the above fundamentals of the reputational value system, and this undermined HIV treatment seeking and adherence. In contrast, older men found many of the norms based upon the reputational value system to be inaccessible and questioned whether these were realistic to them, since at their age their failures and accomplishments as men were evaluated less in terms of the attributes above, but more in terms of whether they raised a respectable family and the extent to which they conformed to other values of the wider society. Thus, although the older men worried about loss of respectability by testing HIV positive, once diagnosed, they tended to emphasise the importance of living longer on ART, so that it would allow them to stabilise families and fulfil other societal obligations, and they saw undertaking ART and protecting health as a step towards reclaiming social-worth and respectability. In South Africa, it has been observed that older men, established in their social roles, were more secure and better able to disclose and negotiate family support, which was vital for their use of HIV services, than the younger men who tended to express greater feelings of failure with regard to building and supporting families (Fitzgerald, Collumbien et al. 2010).

Therefore, it can be argued that the individual man's decision whether or not to seek treatment for HIV reflects his subjective perception of the social pressure and appraisal by his core reference groups (family/society or peers), either in favour or against his disclosure that he is HIV positive and/or is receiving treatment. Where respectability, measured by the extent of conformity to the values of the wider society such as fathering children and performing family responsibilities, is the standard norm at stake for the reference group, men are likely to seek treatment, in order to extend their performance of vital social roles and conform to the wider societal ideals of masculinity. However, when a man perceives that reputation masculinity is central to his position within his peer group and co-workers, he is less likely to have favourable attitudes towards admitting HIV infection and/or seeking treatment, since the demands of ART appear to conflict with the value systems, such as independence and strength, for which his masculinity is primarily evaluated.

## 10.4 How HIV/AIDS and its treatment affects masculinity

Given that men do not have a single belief about masculinity and their experiences of HIV/AIDS and/or treatment, their concerns with regard to how living with HIV and/or treatment affected their masculinity also varied. Broadly, the men described both negative impacts that suggested that existing masculine identities were dented and positive ones that showed that in some ways, masculinities were resuscitated. In addition, they also described how treatment *transformed* the construction of masculinity.

Prior to their diagnosis with HIV, men tended to endorse the standard norms of what it meant to be a man in Mam-Kiror, especially engagement in multiple sexual relationships, authority and control over family, providing for family, and confidence in the use of social and public spaces. However, following HIV/AIDS, and or treatment, men described experiencing a shift in roles and identities, some of which were described as positive and others as negative.

HIV diagnosis was traumatic and caused a lot of anxiety and uncertainty with regard to fulfilment of the different aspects of masculinity. In addition to the physical impact of illness, many participants described losing a social life, which was detrimental to their male gender identity. Irrespective of treatment, men reported a loss of authority over wives and children either because they were physically weaker or because they had failed to provide for them. Due to ill health and dependence on spouses for care, some men experienced role reversal in their household, with wives becoming more dominant in decision-making and sometimes “disrespectful”. Furthermore, in spite of ART, some men remained heavily reliant on wives and children for material support. This left such men vulnerable to blame and criticism by their wives and children, undermining their masculine authority as household heads. Illness also significantly threatened the enactment of masculinity through fathering children, although there was a feeling that this chance was restored with HIV treatment. Furthermore, the rules of ART, such as the requirement to reduce (risky) sexual activity, also meant that men were less confident about their sexual abilities. Overall most men reported failing to enjoy conventional male oriented lifestyles after initiating treatment. This is because, although they expressed the desire to return to normal life, they were aware that in spite of ART their infection was irreversible and that they could no longer express their masculinity through enactment of many of the ideals of both respectability and reputation masculinity. Therefore, as part of coping with HIV/ART,

some men believed that it was more realistic to accept the consequences of their infection and adopt identities that were meaningful to their treatment and own sense of self-worth. The older men, in particular, reviewed high-risk masculine behaviours and adopted more reflexive masculinities, specifically, most rejecting extramarital relationships. These older men argued that not fitting into conventional behaviour did not mean that their masculinity was negatively affected, suggesting that, to a large extent, HIV treatment created a framework for enacting more liberal attitudes towards most especially the normative ideals of reputational masculinity.

Studies that have focused on identity reconstruction following a chronic illness, such as cancer, coronary heart disease and depression, have consistently demonstrated that the diagnosis not only impacts on someone's state of health, but often it also directly intervenes in (re)shaping his or her subjectivity and identity (Livneh, Lott et al. 2004; Gregory 2005; Emslie, Ridge et al. 2006; Emslie, Ridge et al. 2007; Emslie and Hunt 2009). Diagnosis is usually intertwined with demands to adopt certain specified lifestyle behaviours to improve his/her condition while abandoning the harmful ones, and simultaneously impacting on their identity. As Gregory (2005) has put it, "there is often a tension between the notion of being able to lead a normal life and the requirement to follow medical advice, because being normal means not being ill."

Within the area of HIV, a number of studies, mostly from Southern Africa, have considered the way ART intersects with masculinity, and document men's attitudes towards coping and support, men's relationship with their families and peers, and their perceptions of their ability to fulfil the normative masculine standards (e.g., Fitzgerald, Collumbien et al. 2010; Mfecane 2010; Mfecane 2011). Collectively, these studies have shown that while improvements in health following treatment increased optimism about the future, this was often undermined by men's concerns about being unable to meet strongly gendered expectations in relation to family and work (Fitzgerald, Collumbien et al. 2010). In his research on men with HIV in a township in South Africa, Mfecane (2011) found that while most men experienced changes in lifestyles, they still attempted to prove their masculinity through the standard normative masculine ideals, such as fathering children, having employment and being providers for their families. However, among construction workers in Italy, ART has been described as extremely invasive: its powerful effect may extend life but it can also shatter the person's 'lifeworld' and force a redefinition of the self, of one's possibilities and priorities, thus greatly influencing ART uptake and adherence to treatment (Alcano 2009).

Sexual functioning was an important aspect of discussion regarding masculinity and HIV or its treatment, with many men reporting challenges, although a few reported a revival of their sexuality. Erectile dysfunction has been reported to be fairly common among men experiencing a range of chronic illnesses, especially hypertension and diabetes, and is associated with a poor quality of life as it affects emotional, social, sexual and recreational aspects of life (Idung, Abasiubong et al. 2012). Studies that have compared men infected with HIV and those without HIV, have reported a higher prevalence of erectile dysfunction in the former, arguing that this could be considered a peculiar clinical hallmark of HIV (Zona, Guaraldi et al. 2012). It has further been found that among HIV infected men with erectile dysfunction, the condition tends to be associated with increasing age, longer duration of HIV infection and longer duration of HIV usage (Crum-Cianflone, Bavaro et al. 2007).

The extent to which men in the present study felt at a loss with regard to (re)constructing normative masculine identities, especially in relation to independence and no longer being the dominant powerful male in the household, differed with the level of resource depletion following HIV, but not with age. Although all men portrayed some of their masculinities as partly dented and others as partly resuscitated, the men whose resources and income sources had been exhausted significantly by illness expressed greater feelings of loss and failure with regard to their abilities to express the traditional masculine identities, compared to others who appeared to be in a relatively better economic situation. This is consistent with the finding, among black men living with HIV in the UK, that a loss of earning power due to HIV fundamentally affected gender dynamics in households, with men being particularly deeply concerned about their loss of control and authority to have a final say in domestic decision-making (Doyal, Anderson et al. 2009). However, a study in South Africa suggests that age might also be an important factor with regard to feelings of loss, with the younger men tending to be more fragile in their belief about their abilities in building and supporting families, and constructing a sensible identity, compared to older men who are more assured and who may feel they would lose little by dispensing with certain normative behaviour (Fitzgerald, Collumbien et al. 2010).

This study was influenced by my identity and social position in many ways. In Chapter 3, I examined some of the ways this might have happened. Inevitably my identity and extended presence in the village and in the private lives of interviewees shaped the discourses and

practices of the participants, and what I observed and recorded. For example, in some instances being an insider, that is a married, Itesot man, who had lived in a rural setting for a substantial part of my life, made it difficult for me to recognise the boundaries of the field, since I shared many of the participants' own experiences or could visualise them in my own home or extended family. Also, some individuals tended to behave properly or indifferently in my presence. While I had great success in engaging and interacting with different categories of people and felt that I had endeared myself to many, this might have been a reflection of the norm to be courteous to a patron like me, rather than a true reflection of how people normally lived with others within their families and community. During the fieldwork, many people tried to develop me as a patron or helper. I was also often troubled by the plight of my participants, especially those living with HIV. My reactions to their stories of suffering varied; sometimes attempting to help, and this sometimes clouded my main project – to collect data.

In some instances, however, I was perceived as an outsider, and there were indicators that some informants were suspicious or doubtful, or might have been frustrated with my presence in the village, observing them impassively as they struggled to live like them. As I sometimes noted, rather than discuss with me as a researcher, some comments and responses made by participants both during interviews and observations, might have been reactions to my gender, educational and economic status, sexuality, or age and boyish appearance, which distinguished me from them. I sometimes overheard statements such as: “For, you, you are still young man...” or “For you who live in the city...” made about me. This can be interpreted as an acknowledgment by the participants that I did not share with them common experiences, and although I often approached such comments with care and openness, they may have affected some people's interest in my work. However, people's alteration of their behaviours in my presence and perception of my outsider status, should not necessarily be interpreted as a limitation: it simply portrayed how those individuals perceived themselves and wanted to be perceived, which offered important insights about their identity construction, and is consistent with the dividuality thesis. As Monahan and Fisher (2010) argue, rather than invalidate the data derived from stage managed performances, we should embrace such data not as a representation of singular truth necessarily, but as rich symbolic text that can lend themselves to multiple meanings and interpretations. Therefore, in spite of some limitations, this study generates some important insights study about constructions of masculinity and how they shape men's treatment seeking for HIV, which have important implications for public health.

## 10.5 Conclusion

To the best of my knowledge, this is the first study in Uganda to explore how masculinity affects men's uptake of HIV treatment by comparing men who are currently receiving treatment, those who have dropped it, those who refused to initiate it despite testing positive and those who have not tested but believe they are infected. However, this qualitative study is not representative of all men in Uganda. It was conducted among a small sample of rural men involved predominantly in artisanal gold mining, which as an occupation tends to shape perceptions of masculinity in some distinct ways.

This study shows that irrespective of HIV, men of Mam-Kiror drew from a range of ideals and attributes to fulfil the social and individual expectations of being sufficiently masculine. Those masculine ideals can be broadly categorised into two main forms of masculinity – respectable masculinity and reputational masculinity – each with various ideals. Respectable masculinities are endorsed largely by the wider society, while reputational masculinities are endorsed predominantly by the men themselves. However, these two overlap, in that there are 'ideals' of masculinity that are endorsed both 'amongst men themselves' and 'by the wider society'. Theoretically, this categorisation is consistent with the distinction between the value systems of respectability and reputation as described by PJ Wilson (1969), in which respectability accrued from performance and conformity with formal, normative, establishment values, especially marriage and providing for family, while reputation accrued predominantly from unofficial, informal, anti-establishment masculine values, such as multiple sexual relations and fathering many children.

While some of the masculinities enacted by men contradicted each other, others were complementary. By suggesting that people are capable of separating dimensions of their social life depending on context in order to present and sustain different identity positions, the concept of *dividuality* (Helle-Valle 2004) helps explain how men can adopt different, and contradictory, forms of masculinity in different circumstances, and therefore how some men could simultaneously conform to the values of both reputational masculinity and respectable masculinity.

This study shows that individual men can engage in a variety of treatment seeking behaviours that typically correspond with different ideologies and individualities; some discouraging treatment seeking for HIV, others encouraging it. On the one hand, HIV treatment may be undertaken and adhered to, in order to regain and maintain health, so as to fulfill family and societal roles, notably that of provider and being a role model. On the other hand, the expression of masculinity through hard physical work, income generation and sexual achievement may compromise men's uptake of HIV testing and treatment since the demands and limits of ART tend to conflict with these norms of masculinity. It can therefore be argued that the characteristics and values attributed to respectable masculinity appear to predominantly have a positive influence on men's uptake of HIV treatment, while those associated with the reputational masculinity predominantly undermine treatment seeking for HIV.

In spite of these influences of masculinity, it should be noted that masculinity is not the only factor that can influence men's uptake of HIV treatment in a setting such as Mam-Kiror. Factors as diverse as limited supply of ART, weak health care systems with inadequate skills capacity to deliver ART, and generalised poverty, limit the capacity of people to benefit from treatment (Loewenson and McCoy 2004; McCoy, Chopra et al. 2005; Crane, Kawuma et al. 2006). Future large scale studies may be needed to explore variations in men's responses to ART across different employment sectors, and also to compare how both women and men experience HIV treatment. Furthermore, future research could investigate how the influence of masculinity on testing and treatment changes as treatment becomes widely available and those living with HIV age (Siu, Wight et al. 2012).

This research has some implications for public health and ART programmes. Programmes that seek to encourage testing and treatment need to pay attention to what works for men, given all the cultural gender ideologies, material constraints and social pressure in getting them on treatment. What works should be harnessed, for example, men could be encouraged to go test with colleagues, and support for livelihoods can help men provide for their families and encourages them to stay on HIV treatment.

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# Appendices

## Appendix 1: Published research article from the data

Godfrey E Siu et al. *Journal of the International AIDS Society* 2012, 15(Suppl 1):17368  
<http://www.jiasociety.org/content/15/3/17368> | <http://dx.doi.org/10.7448/IAS.15.3.17368>



### Research article

## How a masculine work ethic and economic circumstances affect uptake of HIV treatment: experiences of men from an artisanal gold mining community in rural eastern Uganda

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### Abstract

**Background:** Current data from Uganda indicate that, compared to women, men are under-represented in HIV treatment, seek treatment later and have a higher mortality while on antiretroviral therapy (ART). By focusing on a masculine work ethic as one of the most predominant expressions of masculinity, this study explores why for some men HIV treatment enhances their masculinity while for others it undermines masculine work identity, leading them to discontinue the treatment.

**Methods:** Participant observation and 26 in-depth interviews with men were conducted in a gold mining village in Eastern Uganda between August 2009 and August 2010. Interviewees included men who were taking HIV treatment, who had discontinued treatment, who suspected HIV infection but had not sought testing, or who had other symptoms unrelated to HIV infection.

**Results:** Many participants reported spending large proportions of their income, alleviating symptoms prior to confirming their HIV infection. This seriously undermined their sense of masculinity gained from providing for their families. Disclosing HIV diagnosis and treatment to employers and work colleagues could reduce job offers and/or collaborative work, as colleagues feared working with “ill” people. Drug side-effects affected work, leading some men to discontinue the treatment. Despite being on ART, some men believed their health remained fragile, leading them to opt out of hard work, contradicting their reputation as hard workers. However, some men on treatment talked about “resurrecting” due to ART and linked their current abilities to work again to good adherence. For some men, it was work colleagues who suggested testing and treatment-seeking following symptoms.

**Conclusions:** The central role of a work ethic in expressing masculinity can both encourage and discourage men’s treatment-seeking for AIDS. HIV testing and treatment may be sought in order to improve health and get back to work, thereby in the process regaining one’s masculine reputation as a hard worker and provider for one’s family. However, disclosure can affect opportunities for work and drug side-effects disrupt one’s ability to labour, undermining the sense of masculinity gained from work. HIV support organizations need to recognize how economic and gender concerns impact on treatment decisions and help men deal with work-related fears.

**Keywords:** masculinity; work ethic; HIV treatment.

Received 9 January 2012; Revised 20 March 2012; Accepted 29 April 2012; Published 14 June 2012

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### Background

HIV prevalence remains highly gendered in sub-Saharan Africa (SSA), with women constituting approximately 60% of all people living with HIV-related disease [1]. Women’s greater vulnerability to HIV infection arises mostly from the gendered order of their societies. Economic disadvantage and poverty; cultural practices such as widow inheritance; sexual double standards that favour men’s sexual infidelity; and a power imbalance in decision-making processes in the domestic and societal spheres are major drivers of HIV risk among women in SSA [2,3]. In this context, there are legitimate policy concerns about the impacts of HIV-related disease on women. However, many recent studies in Uganda as well as other parts of SSA have consistently shown that although women remain more vulnerable to HIV

infection, once infected, men tend to be disadvantaged in terms of access to treatment and care [4–11].

In Uganda, men are not only under-represented in HIV treatment programmes but also often initiate treatment later, are easily lost to follow-up and have poorer health outcomes and higher mortality while on antiretroviral therapy (ART) than women [12–16]. Some studies suggest that the social values and roles associated with femininity often create favourable conditions for women to engage with HIV services, while the social behaviour, values and roles associated with masculinity tend to negatively affect men’s use of HIV services [17–19]. However, few studies go beyond descriptions of these differentials to provide detailed accounts of the particular processes through which dominant masculine roles may constrain or facilitate men’s access to

and use of HIV treatment [20]. This paper attempts to address this gap by focusing on how masculinity expressed in terms of work ethic influences men's response to the need to test and seek HIV treatment among the Iteso men of Mam-Kiror village, Busia District, Eastern Uganda. Mam-Kiror is a pseudonym used to minimize inadvertently disclosing the participants' identities. We adopt the participants' understanding and refer to both ART and Septrin drugs (cotrimoxazole) as HIV treatment.

### Gender roles and masculinity in sub-Saharan Africa

Gender denotes the social construction of characteristics, norms, roles and behaviour generally considered appropriate for males or females [21]. Gender is, however, not only a system of classification by which biological males and females are sorted and socialized into different sex roles. It also usually expresses the universal inequality between men and women, with men as a "group" tending to enjoy more privileges than women as a "group" [22]. Unequal power relations and cultural norms shape the social roles that men and women are expected to fulfil, what constitutes "men's work" and "women's work", the conditions in which they work and the value attributed to their work.

Despite the strong tradition, especially among feminist scholars, to challenge the assumption that gender division of roles and norms is natural, most literature tends to list conventional gender norms and roles that cut across cultural settings. In most cultures, women are socialized into feminine norms of subordination, passiveness, loyalty and silence, especially about their sexuality and rights, and perform reproductive roles, that is responsibility for child bearing and rearing and family nurturing, while income earning is considered their secondary role [23]. Men are generally depicted as physically strong, dominant over women, sexually active, independent, risk-takers and decision-makers, and are expected to engage primarily in productive work to financially provide for their wives and children, usually referred to as a "breadwinner role" [21,22,24].

However, in all societies, and in Africa in particular, the pattern of gender relations and roles in the family, the work place and society is changing rapidly. Contemporary gender roles in Africa are no longer clear or largely complementary as they were in the pre-colonial era [25–27]. By introducing wage labour and employment for men, the colonial powers significantly transformed men's gender role and identity from being primarily hunters and warriors, who defended families and depended on women for food, to reliance on wages to support their families [28–30]. Yet recently men have found it difficult to fulfil these gender roles, due to socio-economic changes, especially unemployment and the HIV/AIDS epidemic, which has disempowered them and led to loss of self-esteem [29–31].

### Living and working with HIV/AIDS

Current data on HIV prevalence in Uganda shows that it is concentrated in the 24 to 49 age group [32], a group which

performs critical economic and social roles for families, communities and the country.

Without treatment, people living with HIV experience multiple HIV-related illnesses, which hamper their ability to work. In addition, in Uganda as in many other settings in SSA [33], people living with HIV continue to experience various levels of stigma and discrimination at their place of work. However, with effective treatment the experience of people living with HIV shifts from a terminal illness to chronic manageable disease, permitting someone to remain in work or return to work [34,35]. Work is not only for economic benefit. McReynolds [36] explored the meaning of work to people living with HIV in the USA and reported that participants emphasized certain norms and values of working in spite of HIV-related illnesses; work, to her participants, served as a measure that all was not lost, that the person living with HIV was still contributing to collective life and was continuing to fight for survival. In exploring the meaning of work among our participants, we adopt a definition of work that encompasses productive activities for economic benefits as well as the symbolic and social processes through which ethos and identity are maintained [37].

## Methods

### Ethics statement

The paper is from a PhD study exploring masculine identities and treatment-seeking for AIDS in Eastern Uganda reviewed by the Science and Ethics committees of The Uganda Virus Research Institute and The University of Glasgow Faculty of Social Science, and cleared by the Uganda National Council for Science and Technology. Informed consent was obtained from all interviewees. Pseudonyms are used for both the study village and participants to enhance confidentiality.

### Study setting, sample and data collection

This paper draws on ethnographic data collected from an artisanal gold mining community between August 2009 and August 2010. Mam-Kiror village is located in Busia District, 196 km South East of Kampala, the capital city of Uganda. The village had a population of about 750 people, the majority of whom were the Iteso people. HIV prevalence in the district is estimated to be 10%, higher than the national prevalence of 6.5%. Most people in the village had less than 7 years of schooling, and due to a limited number of formal sectors in the area, education was not a primary means to accessing work.

GES, a male Iteso in his early 30s, conducted participant observation and complemented it with 26 in-depth interviews with men. Interviewees comprised nine men receiving free HIV treatment from a public facility, eight who had dropped out or had not initiated treatment despite testing, six who suspected HIV infection but had not sought testing and three men who had other health concerns unrelated to HIV infection, who were included primarily to mask the ethnographic focus on men with HIV by undertaking the study with a more diverse group of men. The interviewees were selected through purposeful and snowball sampling methods. The majority of the interviewees on treatment were accessed with the help of treatment providers who also

helped to contact some men who had dropped out of treatment or who had been tested but had not sought HIV treatment. The snowball process was facilitated by two of the participants receiving HIV treatment who knew others within the village who had either dropped out of treatment or who suspected that they were infected with HIV-related disease but had not tested. Interviews were loosely structured, based on a flexible topic guide, which included “what it means to be man”, “experiences with HIV/AIDS” and “how work and family’s economic situation have impacted on treatment efforts”. The interviews lasted between 50 and 90 minutes and were conducted in Ateso language. They were audio recorded and transcribed.

The interviewees were between 27 and 51 years old, and all except three had children of their own. Although only 10 men reported being actively involved in artisanal gold mining at the time of the interview, all of them had been at some stage in their life. Three men had recently closed their businesses due to illness or other challenges. However, it became apparent as fieldwork progressed that most of the men had multiple livelihood sources but generally earned small incomes.

Participant observation involved GES living in the study village for a year and interacting with local people, including the interviewees, listening to and sharing their day-to-day stories and conversations, as they related to social life, masculinity and health. Sometimes I talked to particular men individually but often conversations with them included others, such as family members, neighbours, peers or colleagues. Interactions took place in different contexts and sites within the village including homes, work places, bars, restaurants, social gatherings, or as we walked. Field notes were usually written out at the end of each day.

#### Data analysis

Thematic framework analysis [38] was performed and managed using NVivo 8. The process involved summarizing the data systematically in a matrix, comparing cases, and checking emerging hypotheses against all relevant data. The initial step involved transcription and translation of the interviews by an experienced translator, and importing data into NVivo 8 in preparation for coding. GES then read the 26 transcripts, and the 22 pieces of observation notes (approximately 35 hours of participant observation data) that focused on the subjects of work, economy and money, to identify preliminary thematic categories for creating a coding schedule. Themes that were explicit from the fieldnotes and participants’ accounts were prioritized for coding, but further analytic reading of transcripts and field notes yielded other unexpected categories, including “*akitopol ere* (family’s economic progress) as a more central masculine role”, “the significance of occupational identity” and “the use of ability to work hard again as a measure of the efficacy of HIV treatment”. All three authors then discussed the identified thematic areas and agreed on a final coding frame.

Systematic coding was then undertaken by GES and involved pooling together the relevant segments of data into a “node”, which is the NVivo equivalent of a theme. The themes or nodes were structured under higher-order

themes, with subthemes on the basis of their links and relationships with each other. A matrix table was subsequently used to chart the NVivo coded themes, displaying and generating concepts that precisely summarized what the codes and data were implying and to establish patterns, variations and recurrent themes across the codes. This process enabled us to check hypotheses against relevant data, for instance, in seeking explanations for how and why for some men economic circumstances and work threatened uptake of AIDS treatment.

## Results

### Masculinity in Mam-Kiror village

Men in Mam-Kiror village drew from a wide range of norms and practices to fulfil the social and individual expectations of being manly. They subscribed to various constructs of masculinity including those related to marriage and sexual achievement, respectability, being outgoing, male oriented friendships, work ethic and “sacrifice” for family, money-making and property ownership. Although not all men in the village displayed all of these attributes all of the time and in equal measure, these ideals more or less provided the framework within which men interpreted the meaning of undertaking HIV testing and/or treatment. In particular, having work to do and making money was an important theme of everyday discourse among men and was considered a pertinent signifier of being sufficiently masculine. Work and money enhanced other masculine credentials, for example, to have a wife, or wives/additional sexual partners, one needed to have money.

### Categories of work, men’s economic circumstances and constructions of masculinity

For the men of Mam-Kiror village, masculinity was measured predominantly in terms of one’s work, resources/money earned and the extent to which a man was able to support his family. Although the most pressing everyday economic concern in the village was about “survival”, people also worried about how to save and improve their economic status. However, Mam-Kiror village had a limited range of types of work. Men had to compete for the limited casual paid work, for which a reputation of hard work and strength helped. This meant that men’s economic situation varied over time; often proportionately to their ability to work hard and expenditure pattern. The majority of the population in the village, especially women, were subsistence farmers while the majority of men carried out small-scale artisanal gold miners to access cash. The mining method was open cast, and extraction and processing of the ore was rudimentary and labour intensive. This was characterized by men working in small and independent groups of 5 to 20 members in order to pool labour and financial resources to hire equipment and a portion of mining land. Sometimes, individual miners were hired to mine for a daily wage by wealthier men. The ore mined by group members is shared equally on the assumption that every member has made equal labour contribution. Although highly laborious and accident prone, gold mining was popular among men for its quick and more regular

money-generating potential compared to other non-mining occupations.

To the men, material assets – typically domestic fowl and animals, a bicycle or motorcycle, and for a few, a piece of land or a small business enterprise – were important sources of self-esteem and status. Men who did not own anything “worth talking about”, as many people often put it, were often ridiculed and judged as failures, especially by fellow men, and their self-worth and masculinity challenged. The quest for material ownership as a measure of masculinity compelled men to work hard, usually in risky ventures, with complete disregard for their own welfare and health. Men living with HIV or suspecting HIV infection were particularly emphatic about the centrality and urgency of money, work and working relationships in their lives and in their quest for HIV therapy.

In this area, working and work environments, in particular the mining sites, were important for constructing various dominant dimensions of masculinity. With mining activities structured and organized predominantly into groups of men who carried out the hugely laborious mining tasks, a distinct masculine work ethic and norms of hard work, demonstrations of physical strength, interdependence and teamwork were emphasized. It was at work that men evaluated, mentored, validated or rejected others’ attributes of being sufficiently manly. Mining sites were also arenas for competition, conflicts and sabotage, especially between different groups but sometimes also amongst group members. Furthermore, the mines were relatively isolated male-only territories, where men seemed to find it easier to engage in talk about their manliness, sexuality and health, which would otherwise be embarrassing if discussed in the presence of other groups such as women and children. Men’s narratives of why they toiled so hard projected the family as the primary motivation into the incredibly strenuous work of gold mining. Most men used the phrase “family’s survival”, thereby drawing on the dominant masculine discourse of men as providers for their families. For the men living with HIV, many of these norms and expectations and circumstances of work were perceived to be contradictory to the demands and experiences of living with HIV or its treatment, which required both living “normally” and continuing with one’s social roles, as well as being patients who cared for their health.

### How masculine work ideologies and economic concerns threaten men’s uptake of testing and treatment

#### Depletion of family resources while trying to treat symptoms of HIV-related disease or to support ART

Many participants reported spending large proportions of income, alleviating symptoms prior to confirming their HIV infection. This seriously undermined the sense of masculinity that men gained from material ownership and family provisioning, as illustrated in the account of Isaiah, a 49-year-old man who had stopped receiving ART:

Many times when you start falling sick, it is not only your health that deteriorates but everything of

yours. Everything that was running well under your control gets disorganized when this illness strikes, for example in my case, I was running my small shop from where I could put salt and sugar in the house but all the capital went into my treatment before I realized it was HIV. We wasted money trying different treatments here and there.

Enrolling on free HIV treatment drastically reduced the expenses on treatment of symptoms, but transport costs and other incidentals incurred during pill refill, and CD4 test appointments still constituted a significant expenditure to men’s small incomes and forced them into selling family assets such as land, goats or business stock. Most participants described these expenditures as having “left them with nothing”, and those who worried that they were bound to lose everything they owned, such as Isaiah, stopped going for treatment. Worries about the impact of their treatment on family’s resources were further heightened when men considered their obligations as fathers and providers of future productive resources for their children. Juma, a 51 year old, who had discontinued Septrin treatment narrated that the illnesses that preceded HIV diagnosis forced him to reduce work, yet as he continued to spend on treatment, he realized that he spared nothing for the children:

I was feeling a bit of a sense of irresponsibility as a man just because everything was going, and I said what if I die, what I will leave the children with, what will people say; that that man squandered everything and left children with nothing?

As Juma’s narrative suggests, irrespective of their treatment or HIV status, fathers were expected by society and their families to fulfil some core masculine roles. Fathers may not have accessed food for their families, but they were expected to perform the role of *akitopol ere* (ensuring family economic progress) as their core obligation. The concept of *akitopol ere* articulates a wider dimension of men’s provider role; it may incorporate breadwinning as is conventionally understood but, more importantly, refers to men’s other fundamental roles of providing the strategic developmental needs of the family, including children’s education, medical needs, providing land and ensuring the family’s future prosperity. Unlike breadwinning that was often described as “helping the woman”, and hence less mandatory, family economic progress was regarded as what the man ought to do for their family. Men would be judged more harshly for failing in this role. In general, a *proper* man was expected to work hard and provide resources that would ultimately transform the children’s future. While many men admitted to failing *akitopol ere*, citing poverty as the main reason for their failures, they acknowledged that one had to act in ways that showed they were not wasteful of the available resources that would be of great use to children. However, AIDS, and, for some, its treatment was seen to exacerbate the challenge of *akitopol ere*, hence undermining masculinity.

With the exception of one man, all those who had initiated and later discontinued their treatment, as well those who did not initiate it despite testing, were not receiving any support

in the form of livelihood projects from their treatment providers or government. Frank (45 years of age, who did not initiate treatment) for example, lamented the absence of special support for him to care for his children, while Isaiah who initiated treatment and later dropped out, described himself and others like him who were not receiving support as "... neglected by government yet it knows that the illness has greatly devastated our economic bases and strength to work". In other cases, withdrawal of support also undermined men's commitment to treatment as seen from Moses' example. Moses, who discontinued ART after 7 years, had received psychosocial care and material support, including food, clean water and transport for clinic appointments under the Home-Based AIDS Care Research Project by CDC-Uganda. However, when CDC ceased its operations and transitioned patients to another treatment programme where such benefits were not offered, Moses was deeply aggrieved by the loss of this support, and in part attributed his cessation of treatment to this, saying: "My people (treatment providers) have also neglected me. I even see no need for their drugs". In contrast, men like Noah, 50 years of age; Salim, 45 years of age, and Abraham, 50 years of age, who repeatedly emphasized their commitment to staying on treatment, were recipients of goats, oxen and/or support for children's education expenses, as part of livelihood and social support programme from their treatment provider, a different one from Moses'.

#### **Fear of exclusion from work and the desire to maintain occupational identity**

Men living with HIV and/or on treatment feared that disclosing their HIV diagnosis and treatment to employers and work colleagues could reduce job offers and/or collaborative work as colleagues feared working with "ill" persons, undermining both their reputation as capable workers and ability to provide for families. Men who often worked with others in groups in the mines or in construction sites felt more threatened by their treatment compared to men who worked individually/privately, and those who feared they could not continue to conceal their treatment chose to abandon it. Such men were, however, also the most likely to have improved substantially due to treatment and therefore found it easier to drop the treatment. These men reported that in contract or collaborative work, showing weakness is disapproved of and is detrimental to the group, hence being known to be HIV positive or receiving treatment made one vulnerable to being side-lined due to the belief that the sickness would be disruptive to the team's ability to work normally. For example, Alfred (38 years of age, discontinued ART), a builder who regularly worked with others, expressed anxiety about the possible negative reaction of both his contractors and his colleagues if they realized that he was taking ART. He believed that his colleagues or employers would feel uncomfortable working with a known sick person for fear of blame, in case his illness worsened due to work, while job competitors may use information about his health against him, which would affect his ability to provide for family:

The contractor can fear to offer you work if they come to know that you are on drugs; they will ask themselves, "who are you to overwork that man in case he got any problem in your hands!"

Unlike Alfred, whose fears reflected anticipated stigma, other men reported actual experiences of work-related marginalization by colleagues due to their HIV status. An example of this was Solomon (42 years of age, not tested but suspecting HIV infection), who reported being side-lined by his gold mining colleagues who had themselves recommended that he took on lighter tasks following his infection with chronic cough, which many suspected to be symptomatic of TB/HIV-related disease:

They told me to do the lighter work but later started giving me less share of the ore; say for example out of an expected five basins of ore, they gave me two or one, and this could bring quarrels because I was not happy.

However, disclosure of status to colleagues did not always lead to negative reactions; some men received sympathy and health advice from work colleagues. Yet, the sympathy from colleagues made some men feel different, leading them to question their self-identity. This is illustrated by Tony's (39 years of age, suspecting HIV-related disease but not tested) explanation below, which highlighted not only how his poor health affected his ability to work and the relations with work colleagues, but also how it impacted on perceptions of his manliness:

They (colleagues) said I should first go for testing to find out what I am suffering from /.../ and that they will not forget about me completely; they will pass by home and give me also something (assistance) in case they have got. /.../ I see them sympathizing with me for my condition, that because I was also a hardworking man before this sickness started. So, I see that I am now different from other men.

Drug "side-effects" destabilized employment/work, affecting the sense of masculinity gained from being able to work and consequently led some men to discontinue treatment. Such men suggested that they were less able to disguise their HIV infection and carry on with work when on treatment because of side-effects. The early months of treatment in particular made them feel "worse" while at work. For those who had not disclosed their status or treatment, this risked exposing their illness.

Men identifying themselves primarily as miners tended to demonstrate a greater sense of occupational identity compared to men involved in other non-mining occupations and appeared to be more concerned about the impact of HIV-related disease on their working relationships. They frequently described mining work as historically men's occupation and presented it as the means through which they established a desired identity and confirmed a work ethic before others. For example, Juma explained: "It [mining] is the work that we men of this place know. For example, I started digging gold many years ago. I dug it for almost 20

years and left but now again I am back to it." By referring to the gendered dimension of the mining occupation, Juma and others like him highlighted how adherence to this gender work norm made quitting the mining occupation difficult, despite the apparent incompatibility of this job with their current state of health:

The energy was there long time but not these days. But for them [colleagues], they still think like that because my record of digging gold was good, I was very strong man. So, even if you are weak, you just keep on as they know I am not a lazy man.

Some men, partly aided by the external livelihood support, had successfully switched to cultivation or other alternative private employment following HIV diagnosis. Although they made less reference to current occupational identity issues, they too often expressed a profound desire to engage in work that helped re-establish their roles as providers, such as cultivation for economic reasons. However, men who had been on treatment longer tended to report more positive experiences about the impact of their treatment efforts on their work ethic and relationship with other workers, and also appeared less vulnerable to treatment cessations.

#### **Fear of exhausting the gains from ART treatment**

The majority of the participants on treatment believed that despite being on medication, their health remained fragile. Many thus remained anxious and fearful that engaging in strenuous work would undo the health benefits of ART. This led some of them to opt out of hard work, which in turn contradicted their reputation as hardworking men. Others also reported that even though their health had improved due to the HIV treatment, their physical strength and productivity had declined compared with other men and to their old selves, yet many of their productive activities required these characteristics. Hence, for some, ART did not seem to profoundly restore their work-related masculine pride as they would have wished, and this might be a risk factor for discontinuation of ART. Ben, a 36 year old on ART, explained that ever since he started treatment just over a year ago his involvement in heavy work had been reduced significantly because he "has less energy" to work hard like other men and he deeply regretted it because it affected his earning:

I have to be careful not to harm myself further. So whenever I go to where people are mining from, I don't get involved, I just observe, and chat with them. /.../ I feel shamed especially because at the end of the day, the courageous men are the ones with money and you will be admiring them but what can I do, I have to choose either to die now or try to push a bit.

Overall, men living with HIV/ART or those suspecting HIV infection believed that they did not compare favourably with other men around them in terms of the ability to demonstrate the desired work ethic and/or accumulate resources from their work, which greatly affected their self-esteem. They said that for them, even when they attempt to work

hard, much of the money and other economic gains from their work, which would be re-invested in work or in other ventures, is spent managing their precarious health. Isaiah's comment below captures well how this perceived difference was discussed:

What makes their life [other men's] better is that whatever they do they do it better without disturbance, it's not disorganized like yours because with yours if you tend to work very hard, it's that very thing you do in the name of trying to earn something that will eventually increase the sickness in your body. Therefore whatever you get again goes on the illness, but for the other one his remain intact and progresses, but for us all plans are spoiled.

#### **How the masculine work ideology and norms positively influence men's uptake of HIV testing and treatment**

##### **Work colleagues monitor their health and suggest a test/treatment**

The majority of the participants narrated how, in various ways, their decision as to whether or not to seek an HIV test or treatment was influenced by colleagues with whom they often worked. As most men spent much of their time in the gold mines working with others, colleagues were able to notice changes in their health and suggested that they seek medical treatment. For example, Solomon who was contemplating testing explained how his friends grew concerned about his health:

Just like we are seated now and I am coughing can't someone suggest to take you to hospital? So my friends, I am with them all the time working, and they said, "You need to go for treatment. You might die when we are just seeing you here sick and yet we are friends".

Participants also revealed that illnesses that threatened their ability to work or to spend leisure time with other men indicated an urgent need to test for HIV-related disease and seek treatment. One example came from Mike (31 years of age, on ART):

The way I was feeling! Besides pain all over the body, I was coughing and sometimes blood. When I saw that I was not able to work, I said no, this thing is bad, I am going to check. Before that, I was working a lot, then the pain begun and kept on increasing and also the cough and headache was too much, non-stop, I could not work and could not be with others; just home all the time. When I went to test, I realized that I had this disease.

##### **"Resurrecting" due to ART and being able to walk and work again**

Men who had successfully initiated and sustained their ART treatment presented accounts that suggested that by restoring their physical health and strength, ART also rejuvenated their masculinities in various ways. Several men said they had "resurrected (*akikwarun*) after being

counted dead" and were now able to walk and work again. For example, Noah, 50 years old, a subsistence cultivator, who had been on ART for 8 years said: "I am just okay with my drugs, they are the ones that have made me able to work again, because without them, I cannot work." Thus, HIV testing and treatment may be undertaken by some men to regain health, self-worth, ability to work and provide material support for their families, consequently regaining their masculine worth.

Some men whose health had dramatically improved due to ART were reputed to be the hardest working in the village, prompting ambivalent comments such as, "why do the sick men tend to overwork themselves!" Noah and his cousin Salim were two renowned examples; both engaging in relatively successful subsistence cultivation. From talking with and observing the routine activities of Noah, Salim and Isaac, it emerged that being able to work was used by some men as a tool to measure the extent to which their health had improved due to ART. In particular, being able to work in physically demanding jobs like cultivation, "just like before HIV diagnosis", was used for interpreting the gains of ART, which encouraged them to adhere to treatment. For example, Noah said "I am able to work just normally, so I know my body is well and the drugs are working". While this finding appeared to be inconsistent with the views of other men such as Ben, who feared to undo the benefits of ART by overworking, overall, the stories of hard work and resurrection show the ray of hope that ART represented for many aspects of these men's social and economic lives. They illustrate how ART turned the most desperate and hopeless situation into optimism and a reconnection with their social world in which they again could play their social roles as men. To these men, ART had restored what AIDS had removed from them - strength and health - and by extension all the advantages that followed the good health.

## Discussion

This paper draws attention to the complex ways in which work-related values and norms may influence men's testing and use of HIV treatment in a rural setting. Although there was diversity in the participants' experiences, the dominant concerns repeatedly expressed in their accounts provide vital insights into how a masculine work ethic and economic circumstances affect HIV testing and treatment.

Our findings suggest that the expression of masculinity through hard work and money-making can both encourage and discourage men's HIV treatment-seeking. On the one hand, HIV testing and treatment may be sought and adhered to by men in order to improve their health and get back to work, and in the process regaining their masculine reputation and worth as hard workers and providers for their families. Several studies show that as people's health improves due to ART, it enables a return to "normal" life, rekindling various hopes and dreams, including performance of social roles and ability to work again [35,37,39]. We argue that this may be particularly crucial for our sample of men, as their masculinity is assessed predominantly in terms of their work ethic and reputation as hard workers. Some men receiving HIV treatment used their ability to labour as a measure of the

impact of ART on their health, with those who were again able to work consistently attributing this to their medicine.

For a number of participants, the decision to seek testing was influenced by their work colleagues who evaluated symptoms, frankly discussed risk of HIV infection with them and recommended medical treatment. This finding supports previous research among small-scale enterprises in Kabale district, Western Uganda, which found that co-workers tend to advise each other on HIV testing [40]. Although in our study disclosure after testing was portrayed as problematic, discussion of health matters within work teams was quite common and seems a vital aspect of health seeking for sexual health problems. It may therefore be useful for health promotion to encourage such opportunities among colleagues and members of their social networks.

On the other hand, a masculinity judged in terms of money-making, savings and hard work compromises men's uptake of HIV testing and treatment in various ways. Consistent with other studies [41], our findings show that drug side-effects, fear of discrimination and felt stigma are important barriers to employment among people living with HIV. Men who had discontinued ART expressed strong views that medical side-effects were disruptive to work, while many feared that disclosing HIV treatment to fellow workers or employers would leave them vulnerable to being judged as unable to work or as incompetent. Some studies have suggested that people on HIV treatment tend to respond to the challenges of work variously, with some quitting work altogether while others reduce their workload or hours of labour [42]. However for the majority of our participants, who relied on teamwork, adjusting both the workload and schedule were difficult, because work was organized on the premise that everyone worked at the same rate and showing weakness undermined one's sense of masculinity. Furthermore, quitting mining was difficult because it was financially more attractive and had higher status than other local occupations, as found in the Congo [43]. In a context where great emphasis is placed on material possessions as an expression of masculinity, men were compelled by individual and social pressure to work hard irrespective of their health, while others worried that spending saving on supporting ART left them with nothing, undermining the masculinity of ownership.

In view of the foregoing analysis, a fundamental question then is: why do some men find HIV treatment beneficial for their masculine work ethic and identity and others find that it undermines their masculine identity? Our findings do not offer a definite answer to this question but suggest two possible explanations. First, possessing a strong sense of occupational identity, sharing working group norms and regarding physical strength as a core measure of masculinity discouraged men from seeking testing or maintaining treatment. If treatment was thought to have failed to restore strength to the previous level, or caused side-effects that were disruptive to work, it was readily dropped because it prevented the demonstration of one's previous work ethic and preservation of the collective work identity.

Second, shifting from mining to alternative self-employed occupations meant that HIV treatment came to enhance rather than threaten their masculine work ethic. HIV status and treatment could be more readily concealed and, if disclosed, there was no danger of being marginalized by other workers. Economic support or livelihood projects from treatment providers or aid agencies were useful in restoring masculinity, since they allowed men to fulfil their key roles as providers. However, for many men their most vital value appeared to be that they enabled men to shift into non-mining work, which could be undertaken without having to worry about disclosure of HIV treatment to colleagues.

Nearly all the men interviewed in this study were involved in demanding manual labour of some kind, so we are unsure how male workers with less physically demanding work would respond to ART. Future large-scale research may be needed to explore the variations of men's response to ART across different employment sectors. Studies employing both quantitative and qualitative methods could address generalizability concerns, which was the main limitation with our sample. Furthermore, future research might investigate how the influence of masculinity on HIV testing and treatment changes as those living with HIV age and treatment is taken up more widely.

## Conclusions

Recently, there have been global calls to pay greater attention to those who risk exclusion from HIV/AIDS treatment, care and prevention because of their gender roles and behaviour. This paper argues that the expression of masculinity through a work ethic and money-making promotes both favourable and unfavourable behaviour for men's health seeking in relation to HIV/AIDS treatment. Although treatment improved most men's health and enabled them to work again, in the process regaining self-worth, drug side-effects and disclosing HIV diagnosis and treatment to employers and work colleagues resulted in many men fearing to be, or actually being, judged as unable to work and being marginalized from work. This significantly undermined their masculine reputation as hard workers, earners and providers for their families, leading many not to initiate HIV treatment or to drop out. HIV treatment providers and aid agencies need to focus on how masculine work ethic and economic circumstances undermine men's access to treatment and develop interventions to support them. Future studies need to explore the pattern of access to, and experiences of using, HIV treatment among men in different work structures and industries.

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### Competing interests

Authors have no competing interests to declare.

### Authors' contributions

GES took the lead role in conceptualizing and designing the study, collected data, carried out the analysis and drafted the manuscript. DW and JAS

participated in conceptualizing the study and advised GES during the analysis and drafting of the manuscript. All the authors read and approved the final manuscript.

### Acknowledgements

We would like to thank the interviewees and all the people of Mam-Kiror village for participating in the study. We also thank the health workers, especially the counsellors, who helped contact some interviewees. Our gratitude also goes to Kathryn Skivington, Ellen Glasgow, Vittal Katikireddi, Catherine Nixon and Gregor Martin from the MRC SPHSU, Glasgow, who commented on the earlier versions of the manuscript, and other colleagues whose interest in and discussion of our work helped generate useful insights. Finally, we thank the participants of "The Structural Drivers of HIV Conference" that was held in September 2011 in the University of East Anglia, UK, for their comments during the presentation of the results on which this paper is based. The funding for this research was provided by the Medical Research Council/Uganda Virus Research Institute, Research Unit on AIDS for a studentship on Masculinity and HIV treatment in Uganda.

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## Appendix 2: Interview Schedule

# **Men, health and illness: Masculine identity and treatment seeking for HIV in Busia, eastern Uganda**

### **Topic Guide for Interviews with men**

This open-ended interview will begin with a general question asking the participant to talk about their life situation/ social worlds and then, for men who have disclosed that they are living with HIV tries to narrow down this issue, exploring their experiences relating to treatment as the conversation/ study progresses. It is hoped that most of the issues sought in this study regarding treatment seeking and masculinity will come out naturally in a conversation about the participant's life but using this topic guide, the following issues followed with appropriate probes will be explored. Questions about what it means to be a man should be asked towards the end of the interview.

A sheet containing information about the study will be presented/ read to the participant and informed consent will be sought from each participant.

#### **Topic 1: About social and cultural worlds of the participant**

- Age/birth, education
- Marital status and history, children
- Residential history and mobility (migration in last few years)
- Basic genealogy, identifying key family background and relations
- Economy, work, income and livelihood history, etc.

#### **Topic 2: The story of participant's health/ illness (and experience with HIV/AIDS, ARV treatment (if appropriate for men who have disclosed))**

- Illness history (dates, places, events, experiences, difficulties associated with status as a man)
- Testing and counselling history (decisions, dates, places, events/ incidences, fears experiences, factors)
- Treatment seeking history (dates, options, places, factors, fears and stigma)
- Difficulties and problems in accessing different treatments

#### **Topic 3: Social issues and roles (in relation to HIV and treatment)**

- Disclosure issues (methods, who knows, who deserves to know, who should disclose, concerns, how new identity with AIDS influences how they relate with other people –
- Changes in life since your diagnosis (ways HIV has affected dreams of being a real/ proper man, whether sometimes feel that they are living as less than a man e.g. in terms of restrictions/limitations on reproduction, sexuality, patterns of consumption of certain things. Also having to learn a new but potentially emasculating discipline)

- Stigma related (how think others knowing they are on treatment or their HIV status affects them - care and support, love/ affection, feeling of exclusion and peer pressure, new relationships and sexuality. Where they feel most comfortable with regard to their treatment and status as HIV/AIDS patient)
- How HIV/AIDS treatment affects roles/what changes have occurred
  - at home e.g. as a husband, father, provider, marital status
  - community e.g. as leader, participation as active member, ability to pay different fees and meet different community obligations/ being or desire to be exempted, associating with other - what concerns/ fears)
  - children (how they motivate to keep healthy)
  - work (daily activities) – how HIV treatment affects work

#### Topic 4: Meaning of different treatments AIDS for men

- Perceptions of different AIDS treatment - ART, septrin, or traditional treatment (effectiveness, risks to health and reproduction, being on treatment when apparently not sick and perception of when appropriate to treat HIV, treating a chronic incurable disease/ duration, CD4 tests - including return appointments and what they meant about one's sickness, etc.)
- Other difficulties, values, rules, restrictions and expectations when on medicines – e.g. drinking, smoking, unprotected sex and partners
- Perceptions and experiences with reliance on health workers, including monitoring at clinic and/ or home for the entire life and effects on one's manliness (does the treatment process relegate one to a dependence that emasculates)

#### Topic 5: Lay conceptualizations and enactments of masculinity

- Socio-cultural constructions of masculinity (perceptions and definition of a man, paying attention to reference to biology and gender)
- Different categories of men in Mam-Kiror or among the Iteso people
- Circumstances under which men are encouraged to prove themselves, or forced to prove themselves, and when men feel inadequate or sufficiently masculine
- Changes in what it means to a man: Changes that have occurred in how men are perceived, what men are supposed to be. What changes have occurred in the era of HIV – pre-enlightenment of limited information and superstitions, era of awareness, era of VCT and pre ART, era of ART
- Perceptions of costs and advantages of masculinity (influence of his masculinity in terms of accessing and obtaining testing, counselling and treatment - why some men appear to have greater difficulties or less motivation to seek HIV testing and treatment, and why others seek testing and treatment).

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