

# **Masculinity and Men's health seeking behaviours amongst Black/African men: The case of Durban, KwaZulu-Natal, South Africa.**

By

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# COLLEGE OF HUMANITIES

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## ABSTRACT

Several researchers have looked at factors that influence men's health seeking behaviours and the influence of masculinity to get an understanding of men's underutilisation of health care services. However, not much focus has been placed on South African men and health seeking. This paper looks at factors responsible for shaping men's health seeking behaviours as well as their reasons for underutilisation of health services. The factors which determine health seeking behaviours amongst men can be influenced by physical accessibility, level of education, employment status, income level, cultural beliefs as well as political. It is imperative to note that the utilisation of both public and private health care is determined by socio-demographic factors, levels of education, religion, cultural beliefs and practices as well as society. Peers also play a fundamental role in the decision to seek health care.

The study of men's health seeking behaviours is imperative as it provides the opportunity to get an understanding of men's health and how masculinity facilitates underutilisation of health care services and its impact on men's general health and well-being. This study presents a case of male health seeking behaviour in W Section Umlazi Township conducted in the informal settlements. The study demonstrates vital health related behaviours shaped by the dominant masculine identities that are socially constructed and support men to engage in heavy drinking, drug use and engaging in unprotected sexual activities with multiple concurrent partners which affect men's health. It indicates that how men view manhood in relation to the masculine dominant discourse has an implication on health care and facilitates delayed health seeking or, even worse, not seeking health care until very late stages of illness. It is also imperative to note that there are other preferred health seeking alternatives such as the use of traditional medicine and cultural rituals as well as religious activities which are practiced in many communities.

The case study highlights factors such as the lack of both education and men's awareness of their own health, thus facilitating their underutilization of health care facilities and services. There is a need to focus on introducing new methods of improving men's health as well as strengthening educational campaigns which emphasize men's health and the illnesses which predominantly affect males.

There is a demand for policy advocacy focusing on men's health and the improvement thereof. Policy makers have the responsibility of formulating strategies to make health care facilities user friendly for both genders in order for men to feel comfortable to utilise facilities which were previously viewed as the domain of females. There needs to be a greater understanding of men's behaviour in order to change attitudes and improve men's health seeking practices.

## ACKNOWLEDGEMENTS

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## ACRONYMS AND ABBREVIATIONS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ARV</b>	Antiretroviral
<b>BoD</b>	Burden of Disease
<b>DOH</b>	Department of Health
<b>HIV</b>	Human Immunodeficiency Virus
<b>STATS SA</b>	Statistics South Africa
<b>STI</b>	Sexually Transmitted Infections
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organization
<b>CDC</b>	Centres for Disease Control and Prevention
<b>DHS</b>	Demographic and Health Survey
<b>VCT</b>	Voluntary Counselling and Testing
<b>DOH</b>	Department of Health

## DEFINITION OF ZULU AND SLANG TERMS

Amajita	Guys
Bhajiwe	Swollen testicles
Izintwala	Lice infestation
Iqhoks	Township slang for HIV/AIDS
Piece job:	Seasonal employment
Sangoma	Herbalist
Sugar Daddy provider	Old men who date young females and are their financial
Straight	Main girl friend
Skoon	Unprotected sex
Old lady	Mother

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## CHAPTER ONE

### Introduction

This research study looks at men's health seeking behaviours in relation to the dominant masculine discourse. The study seeks to identify factors which hinder men's utilization of both private and public health care facilities. It looks at underlying economic, cultural, political and socio-demographic factors which facilitate underutilisation of health care facilities as well as how masculinity manifests itself in health seeking.

#### 1.1 Background and problem statement

Health is a fundamental part of an individual's wellbeing, yet it remains sensitive, particularly when it concerns males and the notion of masculinity. In order to study health and health seeking in relation to masculinity, it is imperative to understand the definitions of health, health seeking as well as masculinity. Health is "determined not only by contact with the microbes and toxins which directly cause illness or by organ system failure, but also by other biological and social factors" (Social Determinants of Health, Chapter 2: 7). Similarly, the World Health Organisation (WHO) defines health as "the state of complete physical, mental and social well-being and not merely the absence of disease" (WHO, 1974:100). Both agencies define health in a holistic view which draws not only on biological factors, but the social determinants thereof as well.

Health seeking behaviour is defined as "the sequence of remedial actions that individuals undertake to rectify perceived ill health"(Rahman et al, 2001:32). Rahman et al, 2001 define health-seeking behaviour as "initiated with symptom definition, whereupon a strategy for treatment action is devised" (Rahman et al, 2001:32). The authors indicate that symptom identification does not result in immediate health seeking. They state that treatment choice involves multi factors related to "the type of illness, the severity of the illness, pre-existing beliefs about the cause of illness, the range and accessibility of therapeutic options available, and their perceived efficacy"(Rahman et al, 2001:32). According toMcKinlay,2005"men are not socialised into the health culture from an early age, and hence are less likely to develop

the confidence to seek preventative health care”(McKinlay,2005:26). Socio-economic, political and cultural factors are also accompanied by gender dynamics/ gender socialisation in the decision to seek health care.

Hegemonic masculinity (HM) “was understood as the pattern of practice (i.e., things done, not just a set of role expectations or an identity) that allowed men’s dominance over women to continue” (Connell & Messerschmidt, 2005:832). This masculinity shapes their character in society and is a factor in their health seeking behaviours. Courtney (1998) argues that certain behaviours associated with hegemonic masculinity have been associated with increased health risk behaviours.

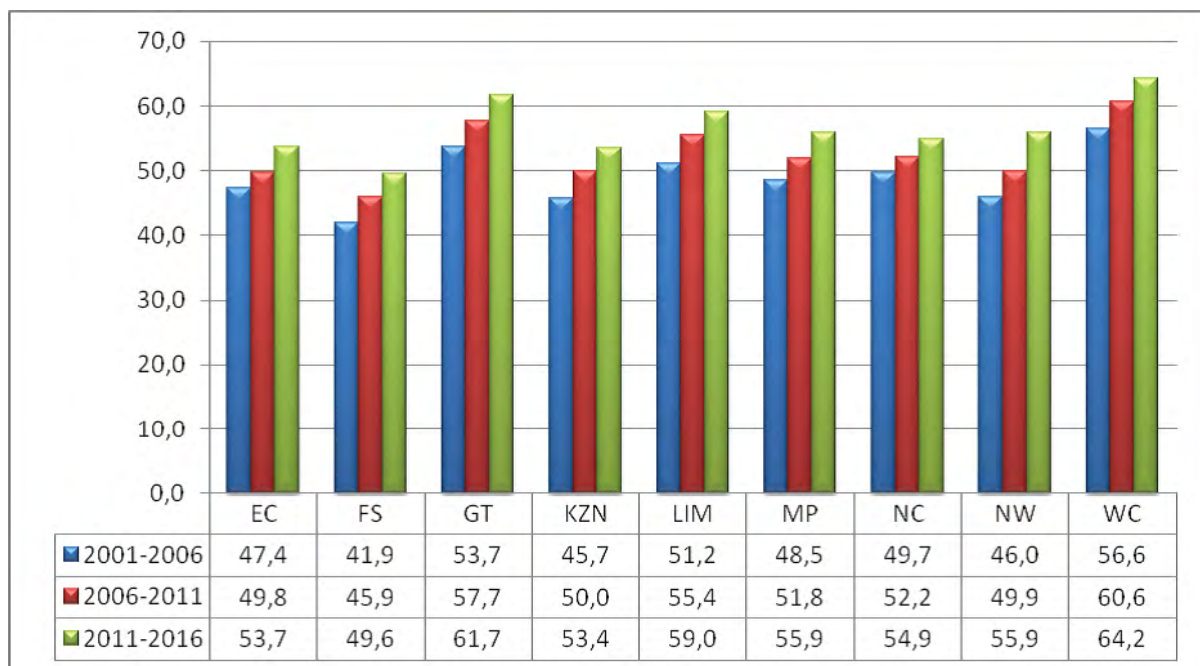
This paper examines a comparatively new reason for men’s lack of seeking health care services. This reason is based largely on the notion of masculinity as a possible barrier to health seeking by men. An investigation on masculinity and its impact on health seeking are of paramount importance both in theory and practice. Such an investigation will yield an understanding of why men are less likely to utilise public and private health care and will aid in the process of policy advocacy and designing interventions aimed at reducing men’s risky behaviours as well as improving health seeking amongst men.

The following section provides an overview of men’s attitudes towards health seeking and is an illustration of the global trends. It looks at the notions of manhood and how it impacts on men’s health. Gender comparisons reveal that “men are also more likely than women to suffer severe chronic conditions and fatal diseases” (Courtenay, 1998: np). Health studies conducted in the United States of America (USA) highlight that men are more susceptible to heart diseases, cancer, severe chronic illness and fatal illnesses which contribute to men’s decreased years of life (Kalben, 2002).

Most research conducted in the developing and developed countries indicates that there are gender inconsistencies in seeking health care as well as the general view and understanding of health and illness (Michael and Hearn, 2005). According to the literature by Mokdad et al, there is an estimate of about 50% of morbidity and mortality which is due to changeable health behaviours. These modifiable behaviours are accountable for the leading fatal illnesses amongst men such as heart disease and cancer (Mokdad et al, 2004). Research illustrates that worldwide, men have a lower life expectancy than their female counterparts (Courtenay,

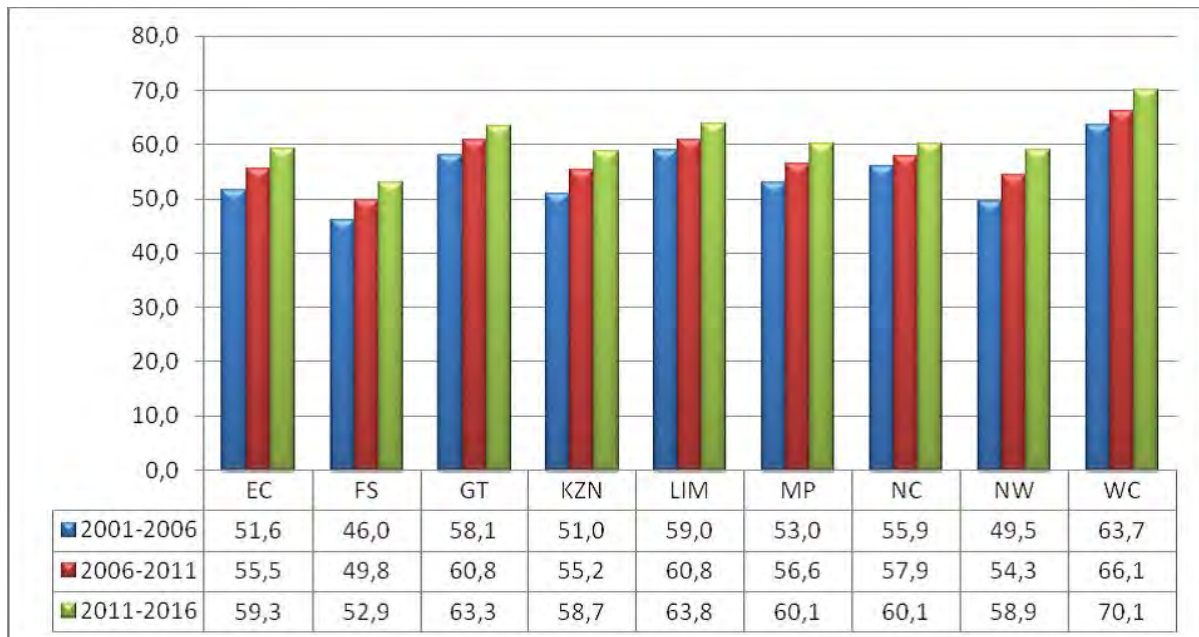
2003). In the United States, men die younger than females in the same age cohort and studies have shown that African American men die nearly 7 years younger than females in the same age cohort (Kalben 2002). Similarly, according to Statistic's South Africa (2006) not neglecting the impact of HIV/AIDS in South Africa), South African women in 2004 had a life expectancy 50.7 while South African men 45.1.

**Figure 1.1: Provincial average life expectancy at birth, 2001–2006, 2006–2011 and 2011–2016 (males).**



Source: Statistics South Africa Mid-year population estimates, 2013.

**Figure 1.2: Provincial average life expectancy at birth, 2001–2006, 2006–2011 and 2011–2016 (females).**



Source: Statistics South Africa Mid-year population estimates, 2013.

Drawing from figure 1.1 and figure 1.2 above it is evident that South African males have a lower life expectancy compared to women. According to statistics South Africa Mid-year population estimates, in 2013, life expectancy at birth is estimated to be 57.7 years for males and 61.4 years for females. Male life expectancy continues to lag behind their female counterparts. It is also projected that in 2016 females will have 70.1 years of life while males stagger behind at 64.2 years of life (Stats S.A:2013). Courtenay (1998) argues that there is no biological explanation for women living longer than men and indicates that in the 1920's women and men had equal longevity. Courtenay further asserts that men are far more likely than women to engage in behaviour which places them at risk for endangering their health (Courtenay, 1998; 2000; 2003). He theorises that the low life expectancy amongst men is mainly caused by behavioural differences between men and women. He justifies his theorisation by suggesting that men “participate in risky sports, take risky employment, choose risky modes of travel, smoke more, drink more, and take drugs more when compared to women” (Courtenay, 1998; 2000; 2003). Men are more likely to be in possession of a weapon, and are likely to become involved in a fight (Courtenay, 1998) which results in their decreased years of life.

Recently, research on gender dynamics and health in relation to masculinity has described cultural norms about masculinity which affects men's health seeking behaviours. Gender research seeks to explore the relationship between men's health seeking behaviours and their interpretation of illness and how these factors facilitate underutilisation of health care. In addition to men being less likely to use preventative measures, Mahalik et al (2007) noted that men die from diseases that are curable if there is early detection of symptoms and health seeking. Courtenay, (2003) study illustrates that men are unlikely to seek help until very late stages of illness, even though they have a lower life expectancy and higher death rates. It is noted that even when primary health care is geographically, financially and culturally accessible to communities and provides more personalized care to the poor, utilisation amongst men is still relatively low in some countries (Doherty and Govender, 2004). Literature on men's health by Myburgh 2011 indicates that "men visit public health care facilities much less frequently than women" (Myburgh 2011: np). Masculinity and its impact on men's health seeking research has discovered various practices that men engage in and are renowned detrimental to their health (Courtenay, 2003). Courtenay argues that these detrimental practices are amenable to change as they are socially constructed (Courtenay, 2003).

Across the developed world men's health is renowned as poor according to a wide range of health measures. Literature indicates that the dominant masculine discourse that is adhered to by males may indeed have a negative effect on men's health (Courtenay, 2005) as it shapes how man view and understand health, their health behaviours and ultimately health seeking behaviours (Courtenay, 2005). The study of men's health seeking behaviour is imperative to understand and work towards improving men's health as well as reducing their health disparities, which has been the motive for this study.

South Africa is not unique to the global trend of men's underutilisation of health care services. In a study conducted in South Africa, Letsela and Ratele (2009), showed that the majority of men interviewed (63%) reported to never go for health care check-ups; while 37% indicated that they do. A total of 76% of those who do not go for health check-ups reported that they eventually do access health services when they are feeling severely ill, while 24% never go at all (Letsela and Raletle,2009). As a result, men's health has received

attention from different scholars with the aim of understanding men's health behaviours and their underutilisation of health care services in both the developing and developed world. Furthermore, it is argued that men are more likely compared to women to engage in behaviours that are detrimental to their health such smoking, high alcohol intake, unhealthy diet, lack of exercise, and adherence to safety practices such as the use of seat belts (Courtenay, 2003).

The country is faced with “a burden of disease from HIV, AIDS and TB; high maternal and child mortality; non-communicable diseases as well as violence and injuries” (NSDA, 2010-2014:4). South African is said to “account for 17%, which is estimated to be about 5.5 million people of the global burden of HIV infections” (The Lancet, 2009 cited in NSDA, 2010-2014:4). The South African 2011 national statistics on the nation's HIV prevalence confirm that approximately 5.38 million of people in South Africa are HIV positive (Stats SA, 2011). HIV prevalence in young women is much higher than in young men, especially in the 20–24 year age group (HRSC, 2008: 63). In 2008, HIV prevalence was more than four times higher in women aged 20–24 years (21.1% HIV prevalence) compared with men of the same age (5.1% HIV prevalence) (HRSC, 2008: 63). Even though statistics show that there are more HIV infected women than men, women are more likely to seek health care. Women are also more likely to utilise voluntary counselling and testing services (VCTs) and are in highly active antiretroviral treatment (HAART) programmes (Myburgh: 2011). This increases their survival opportunities compared to males. Where does this leave men as they are less likely to seek health care? Men's low use of HIV services in South Africa is a major concern.

The following section looks at the challenges in health care delivery in the South African context and the implications it has on men's health seeking behaviours.

## **1.2 Health Care delivery in South Africa**

South Africa enjoys health care as a human right for all, regardless of one's economic status. The South African government strives to promote equity in health by ensuring equitable access to basic quality health care for all South African citizens as well as legal long-term

residents (National Department of Health, 2007). According to the National Department of Health, 2007 annually, the South African government utilizes “ 8% or more of the gross national product (GNP) on the national health system, which includes both the public and private health sectors, 60% of this is spent in the private sector, which provides care to only 20% of the population the majority of the population (80%) relies on the public health system for health care which receives 40% of the expenditure on health” (National Department of Health, 2007:np).

The South African health care system is faced with many challenges which include inequitable health care, characterised by poor infrastructure, understaffed health facilities, low budgets and shortage of medicines amongst others (Ataguba et al : 2011). In an attempt to address the challenges faced by the public health care system and to improve the condition thereof, the State proposed a National Health Insurance. The National Health Insurance (NHI) “ is a “financing system which will ensure that all South African citizens are provided with vital healthcare, regardless of their employment status and ability to pay directly to the NHI” (National Department of Health , 2007:np).

Even though the South African Department of Health is faced with numerous health delivery challenges, efforts have been made to ensure the provision of health care facilities throughout the country. The DoH has ensured that health facilities are affordable and geographically accessible to the poor. This provision of health care services has not changed the health seeking patterns of men, as they are still reported as having a low uptake of health care services in South Africa in spite of the efforts which have been made. The following section looks at why the study focused particularly on men and their health seeking behaviours.

### **1.3 Why the study focuses on men’s health seeking behaviours**

It is evident from literature Craig et al, 2008 that “males continue to lag behind women in life expectancy and in health care utilization (Craig et al, 2008:474). As indicated earlier, in South Africa, life expectancy at birth for 2013 is estimated at 57.7 years for males and 61.4 years for females (Stats S.A:2013). To get an understanding on the life expectancy gap and men’s perception of health, it is crucial to understand how the socially constructed masculine



traits interact with masculinity and its impact on health seeking. Understanding gender socialisation is important in order to provide effective health care which men will utilise.

Craig et al, 2008 highlights that “in the 1920s, men were dying one year before women, by 2005; the life expectancy gender gap had grown to 5.2 years” (Craig et al, 2008:474). It is evident that men’s life expectancy has always been lower than that of women, but the gap is increasing. According to the Centres for Disease Control and Prevention (CDC) cited in Graig et al, 2008 , men are at “greater risk of death in every age group compared with women, with 1.6 times more mortality for all causes, 1.8 times for heart diseases, 1.4 times for cancers, and 2.4 times for accidents” (Craig et al, 2008:474). It is stated that “women’s utilisation of doctors annually for preventative services is 100% higher than that of males, even after controlling for age and pregnancy-related visits” (Craig et al, 2008:474). Statistics indicate that “33% do not pay regular visits to physicians, and almost a quarter of all men have not seen a physician in the past year” (Craig et al, 2008:474). This is also evident in South Africa, where African men have a lower life expectancy than White, Indian and Coloured men (Stats S.A:2013). This indicates that there is a need to focus on men’s health and more especially on Black males as they have a lower life expectancy.

#### **1.4 Policy Environment on Men’s Health seeking behaviours**

South Africa has made attempts towards improving the country's health care system with the aim of improving the general health status of all South Africans. Recently, the focus has been on the improvement of men’s health care which involves working in conjunction with men on a health policy which ensures gender equity in South Africa. This initiative was established by the National Department of Health in 2002 and developed Gender Guidelines which focused particularly on men’s health and acknowledged “the rights, responsibilities and needs of men in health policy” (Sonke Gender Justice, 2008).

The National Consultative Meeting on policy approaches was held on 17-18 September 2007 at the Birchwood Centre, Gauteng, with the primary objective of working with men to improve their health and achieve greater gender equality. The input from this meeting was incorporated into a report on policy approaches to working with men on sexual and reproductive health as well as rights and gender equality. The report concluded that the development of health policy engaging with men should be an “urgent priority” (Sonke Gender Justice, 2008). Some efforts have also been made in the NGO sector with the aim of

improving men's health. The Engender Non-profit Organisation in their project titled "Men as Partners" holds workshops with men to "confront harmful stereotypes of what it means to be a man and its implication on health" the organization also assists in "enhancing health care facilities and capacity building to provide men with quality care by training health care professionals to offer male-friendly services" (Engender, 2013: np).

Whilst more attempts have been made to improve health policies that focus on the overall health of the country, women's health has received more attention especially with regards to sexual and reproductive health in South Africa compared to the health of boys and men. Not much effort has been placed on the health care of men.

### **1.5 Significance of the study**

The study aims to generate an understanding of how Black or African men, specifically in the South African context of cultural diversity, high unemployment rates, and high levels of inequality, understand their masculine identity and how this impacts health seeking. As indicated earlier in this paper, the life expectancy in South Africa for White, Asian, and Coloured males is significantly higher than Black men as they have a life expectancy of 52 years of age which is the lowest this is attributed to the fact that men engage in behaviours which places them at risk for endangering their health. Therefore, there is great need to focus on African men's health.

This study was conducted in W Section uMlazi Durban, KwaZulu Natal, with the aim of describing and understanding men's health seeking behaviours. The site for the research was primarily selected because of the population characteristics such as migrants from rural areas as well as people from townships. It is characterised by both employed and unemployed men, which makes it possible to uncover health seeking amongst men of different socio-economic statuses and backgrounds. This study was carried out among Black men to capture their understanding and interpretation of health seeking in relation to masculinity, as well as how their employment status and level of education shapes their health seeking behaviour. Black men were chosen primarily because worldwide, they have a lower life expectancy at birth and this is also the case in South Africa, where Black men die younger compared to all other race groups (Stats S.A, 2006) which has been the rationale for this study.

## **1.6 Objectives of the Study**

This study seeks to shed light on men's health seeking behaviours and how masculinity facilitates under usage of health services in W Section uMlazi Durban, KwaZulu Natal, South Africa. The main objective of this study is to investigate the rationale behind men's underutilisation of health services and how masculinity facilitates underutilisation of health services. The sub-objectives are as follows:

- To explore how gender norms and masculinity relates to health seeking behaviours amongst men.
- To investigate the factors which hinder men's access to health services and health promoting behaviours.
- To assess men's awareness of their own health and their view illness and the causes thereof.
- To investigate the role and relationship of the service provider towards men's health seeking behaviours.

### **Key research questions:**

- How do participants define manhood?
- How do participants define health?
- How does the definition of manhood affect participant's decision to access health services?
- How do men view illness and the causes of illness?
- What are men's attitudes towards health promotion?
- What are men's attitudes towards health seeking?
- How would participants describe their relationship with health care providers?
- What are the participant's barriers to health seeking and how can they be eradicated?

- Do men have any suggestions on how men's access to health care services could be improved?
- What is the role of the service provider/s towards men's health seeking behaviours?

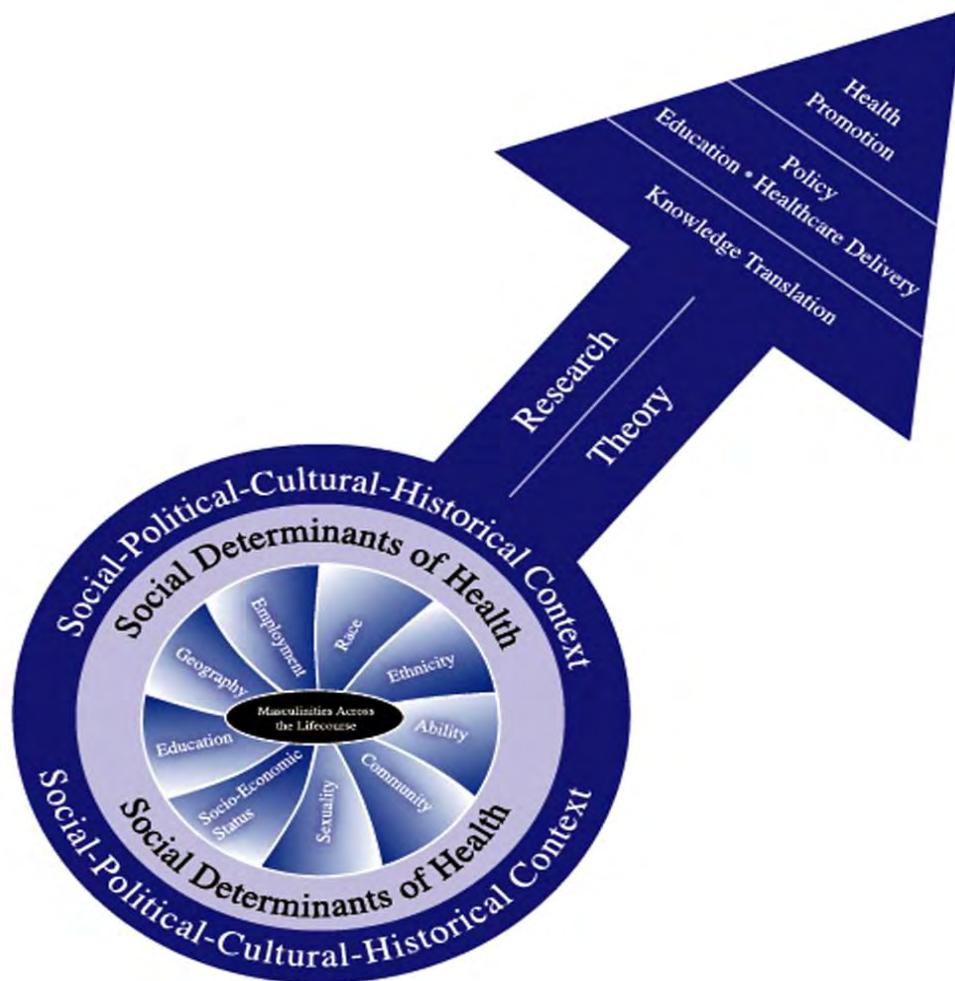
## **1.7 Theoretical Framework:**

This study looks at the health seeking behaviours of men through the lens of health, illness, men and masculinity framework which is about masculinity and socio-demographic factors which affect health seeking and health related behaviours among men of different age groups (Evens et al 2011). The framework aims to link masculinity and demographic factors to men's health seeking and health related behaviours. Evens et al (2011) states that, "masculinities interact with other social determinants of health creating health disparities" (Evens et al 2011:7).

The framework outlines the interconnectedness of men's health and masculinity and gives an understanding of the various reasons that can be attributed to men's health seeking behaviours. It outlines possible barriers such as socio-economic status, ethnicity, sexuality, ability, geography, community, education and employment which may result in the underutilisation of health services throughout the life course of males in relation to masculinity. This framework also incorporates attitudes, norms and also socio-demographic factors which may hinder accessing health care amongst individuals (Evens et al.2011). The theory highlights unexplored health disparities among men which are associated with age, employment, education, socio-economic status, ethnicity and sexuality. This study utilises this framework as it illustrates possible reasons for the underutilisation of health care services and the individual's level of need or driving force to access health. The model enables the researcher to add to the body of knowledge on factors that impact on men's health seeking behaviours. This framework is relevant for this study as it looks at the health of men taking masculine identity into account. It takes into consideration how health across the life span may be influenced by this identity and its impact on accessing health care.

Framework was devised in a developed country setting so revisions may be necessary to accommodate the specific context under study – i.e. townships in South Africa, predominantly Zulu in culture.

**Figure.1.3 The HIMM (Health, Illness, Men and Masculinities) Framework for understanding men and their health.**



Source: *jmh* vol. 8, No. 1, pp. 12, March 2011

## **1.8 Organization of the study dissertation**

This dissertation consists of another four chapters:

Chapter two presents the literature reviewed on men's understanding and interpretation of health care and health seeking. It looks at how men view health and captures men's awareness of their health and how they view illness and the causes of illness. The chapter further inspects the relationship between men's experiences in accessing health services and their health seeking behaviours. It also includes gender norms, masculinity and other possible factors which hinder men's access to health services and health promoting behaviors.

Chapter three presents the research methodology used in this study and looks at the study sample, the sample selection process and the collection and how the data will be analysed.

Chapter four presents the findings of the in-depth interviews.

Chapter five presents the discussions of the findings of the study, the recommendations and final conclusion.

## **CHAPTER 2 LITERATURE REVIEW**

### **Introduction**

The chapter reviews literature on men's health and their health seeking behaviors in relation to masculinity. It discusses factors which hinder men's utilisation of health care facilities, their reasons for delayed health seeking, their definition of manhood, how they view illness and whether these definitions facilitate underutilisation of health care services. The model figure 2.1 below will be used as a guide to the literature review. The figure 2.1 highlights some of the factors that facilitate underutilization of health care services by males. The factors that affect health seeking can be categorised as follows: socio-economic factors, ethnicity/ cultural beliefs, sexuality, ability/access, geography, community, social construct of gender, education and employment as highlighted in the theoretical base of the study.

**Figure 2.1: Literature review guide**





## **2.1 Public health care as a gendered space and the notion of Masculinity.**

Studies by Hausmann-Muela, Ribera and Nyamongo (2003) revealed that men and women's public health care utilisation trends differ significantly in both the developed and the developing world. It is indicated that "Gender and health are related through multiple pathways. Gender roles and norms and the gender based division of labour interact with education, employment status, income, culture, household position, age, and physical and social environments" (Social Determinants of Health, Chapter 2: 20). It is evident that women utilise health care facilities more than their male counterparts. Myburgh (2011) argues that the availability of reproductive healthcare services in public health care centres could account for the disproportionate use of health care services by males compared to their female counterparts and also indicates that health care facilities are viewed as favouring females, hence makes health care facilities a gendered place. The author further states that females visit health care facilities for childcare purposes, family planning (contraceptive use), during pregnancy amongst others, thus perpetuating the notion of the clinic being viewed as a gendered space, as more services are for the uptake of females.

In addition, a report by the Sonke Gender Justice Project (2008) cited in Myburgh, 2011: np indicates that "in the context of the often overburdened and under-resourced public health clinics in South Africa, neither men nor women view the clinic as a "friendly" space/ environment, but that both groups view the clinic largely as female domain" (Sonke Gender Justice Project, 2008: np).

Similarly, Myburgh, 2011, argues that "because clinics are dominated by women, they have potentially become a hostile environment for men, women "dominate" clinics, because they are often the majority of staff in the clinic holding positions as nurses or counsellors"(Myburgh, 2011:np). The writer highlights that not only do women dominate health care as users of the health care centres but as well as working professionals in the clinics. She further touches on the disclosure and openness aspect, indicating that men are obliged to disclose personal information to female workers during consultation who requires openness and honesty, which could pose a potential challenge to the dominant masculine identity.

In a study conducted in South Africa among native Xhosa-speaking inhabitants, the findings of the study indicated that it is “not seen as culturally appropriate for men to talk to women about certain problems such as sexual or genital problems”,(Myburgh,2011:np). In the clinical setting, such discussions are unavoidable, especially in the case where one is suffering from a sexually transmitted illness. When men seek health care, they are obliged to discuss culturally forbidden matters with females, which could be a major contributing factor to men’s underutilisation of health care. Myburgh, 2011, further argues that men’s use of public health care could be viewed as a sign of acknowledging weakness associated with femininity, which strongly conflicts the masculine identity(Myburgh, 2011:np).

The commonly adhered masculinity norms are implicated in men’s hesitancy to utilise healthcare services. Courtenay (2003) argues that across cultures there is evidence that masculinity is perceived as providing a sense of immunity. Men are socialised to be self-reliant, not to openly display their emotions, and not to seek assistance in times of need (Courtenay, 2003). The differences between males and female utilisation of healthcare services have been largely attributed to male socialisation and their socially constructed masculine identities. The definition of what a man is, as defined by society, largely shapes men’s masculine identities and lifestyles. Society’s definition of manhood ultimately defines men’s understanding and interpretation of their own health and thus their utilisation of health care services.

These socializations have largely shaped the way in which males perceive their roles in society, their lifestyle choices and ultimately shape their beliefs, attitudes and their health seeking behaviors.

## **2.2 Definition of manhood and the concept of masculinity**

According to Sonke Gender Justice, 2008,“men are not a homogenous group, nor is “masculinity” a monolithic concept, and this is reflected by men’s diverse experiences of health” (Sonke Gender Justice, 2008:3). Connell and Messerschmidt (2005) assert that masculinity is not a stable, biologically based phenomenon, but rather intricately tied to the concept of gender, including power relationships and dynamics. The writers further argue that masculinity consists of multiple hierarchies of socially-constructed discourses or narratives of masculine identity (Connell and Messerschmidt, 2005).

Sociologists argued that there are explicit behaviours related with traditional forms of masculinity which are more likely to be detrimental to men’s health (Tudiver’and Talbot: 1999). (Connell, 1987, 1995), states that the dominant masculine discourse which is characterised by being strong and not showing weakness, risk taking, playing the provider role amongst others may affect how men view health seeking.

Similarly, Courtenay (2000) argue that the social construct of what men should be and how men define manhood has a negative impact on their health and health behaviours. Figure 2.1 below demonstrates some of the social constructions of what girls/women and boys/men should be.

**Table 2.1 Conceptions of Masculinity and Femininity**

<b>Girls</b>	<b>Boys</b>
Femininity	Masculinity
Good	Dangerous & disrespectful
Helpful	Lazy
Weak	Strong, problem solvers & Sporty
Domestic	Smart
Passive	Active
Cosmetic	Natural
Mother	Worker
Dependent	Independent
Intelligent	Intellectually inferior
Quiet	Outspoken
Mature	Independent; Free
Materialistic want nice things)	Controlling

Source: Burke, Stets and Pirog-Good 1988; Spence 1985

Courtenay (2003) argues that the socialisation of men as being independent, unsentimental, strong, problem solvers, who are not vulnerable, and deny pain has an impact on how men view help seeking and accessing health services. Courtenay (2003) further illustrates that ideas of masculinity limit men’s knowledge and awareness of health since health is associated with femininity. Men have limited knowledge and awareness of health which results in delayed health seeking and leads to detrimental circumstances. He draws the

conclusion that denial of pain by men leads to denial of symptoms, symptoms that are medically curable with early seeking of health care. He asserts that denial of symptom results to preventable deaths (Courtenay, 2003).

Men's own perception of always being in control of situations delays health seeking as they often wait to see if the illness will be healed automatically or get out of "control" (Vittie and Willock, 2006). Such behaviours amongst men are said to be highly influenced by cultural stereotypes to ignore identified symptoms, health screening and use of preventive health care. The factors mentioned above result in men underutilising health services or seeking early intervention.

A study by Annette, et al (2009) on gender differences in health and health care utilisation in various ethnic groups in the Netherlands illustrates that men had a common belief or understanding, that in order to seek health care, symptoms must have been present for a period of time. This demonstrates delayed health seeking until late stages of disease, when the illness becomes severe. The researchers highlight that research participants had ideologies which guided them in terms of health seeking and in which most of them were highly influenced by masculinity. 'Macho does not show weakness' which the researchers referred to as a commonly used term amongst the participants. Men view themselves as problem solvers who cannot show weakness and can solve their own health related problems. From this study, it is evident that men associate illness with loss of independence and invasion of privacy which challenges masculine discourses. Success was associated with lack of illness and being able to take charge /authority and take chances (Annette, et al, 2009).

Brown, Sorrell, and Raffaelli (2005) argue that "there is no plurality of masculinity and that it is shaped by a variety of characteristics such as race, class, age, religious background and geographic location"(Brown, Sorrell, and Raffaelli, 2005:586). The authors argue that the "masculinities which arise and take on particular nuances because of these characteristics, are not all equal, instead, cultural groups construct ideal notions of masculinity" (Brown, Sorrell, and Raffaelli, 2005:586). Brown, Sorrell, and Raffaelli further state that these ideal notions of masculinity bring into existence the hegemonic masculinity, the masculinity which men use to measure themselves against, and are measured against by others" (Brown, Sorrell, and Raffaelli, 2005:586). They further state that these hegemonic masculinities have the power to

dictate how men define and understand health as well as prescribe certain values, beliefs and behaviours which define manhood.

Similarly, Courtenay (2003) identifies some hegemonic masculinity ideals and how they affect men's health and their health seeking behaviours, which he states are almost universal. An example of this is the case of men's health seeking behaviours in New Zealand and the United States of America, which have been confirmed as more similar to the behaviour of men in some parts of Africa. Masculine identities have been defined as "the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, and the display of aggressive behaviour and physical dominance" (Courtenay, 2003:104). These masculine identities shape how males interpret health care utilisation and the notion of weakness which they associated with health seeking and self-help as a solution rather than seeking help.

The notion of self-help is based on the belief that individuals can help themselves to overcome health related problems, but this results in a delay in seeking medical attention. Health seeking is associated with femininity and viewed as the acceptance of 'defeat', admitting illness or weakness and conflicts with the core values of masculinity as opposed to self-help which is viewed as masculine. Health seeking is understood as diminishing male dominance/power which results in a state of powerlessness.

The Actuarial Society of South Africa's 2003 survey highlights the notion of self-help preventing men from accessing health care. The survey found that 43% of HAART patients were male, but only about 36 percent of the patients accessed HAART treatment.

These findings suggest that masculinity affects men's health seeking behaviours. The result of Nattrass's 2004 survey of 566 Khayelitsha residents showed that two-thirds of participants agreed or strongly agreed with the statement that, "men think of ill-health as a sign of weakness", which explained why they sought medical attention less often than women. Similarly, the Demographic and Health Survey (DHS) indicates that men, across all racial groups, utilise primary health care services less.

The following section looks at how men view health and causes of illness. Their view on health and causes of illness ultimately determines health seeking as well as health seeking paths.

### **2.3 View of health, illness and the causes of illness.**

It is crucial to get an understanding of how men view health and illness in order to fully understand their health seeking behaviours in relation to masculinity. How men define and understand health informs how, when and where they seek health care. This section explores how men view health and the different health seeking routes they make use of subsequent to identifying symptoms of disease. It also looks at how men view illness and what informs men's decisions to seek health care and their preferred service providers.

Albrecht (2006) argues that "Health is a metaphor for well-being; to be healthy means to be of sound mind and body, to be integrated; to be whole" (Albrecht; 2006:267). Gilman (1995) cited in Albrecht, 2006 states that one understands that the interpretation of health is largely shaped by cultural values which informs health seeking behaviours. Similarly, Turner, 2000 cited in (Albrecht, 2006: 268) indicates that "understanding of health in the medical literature stems from the views of ill health on discussions around pathology. He asserts that in the social sciences, illness is culturally constructed and is associated with the dominant social, political and moral order".

Illness is viewed differently by different population groups, with some associating ill-health with natural or supernatural agents. This further determines different treatment choices (McVittie & Willock 2006). Similarly, Albrecht (2006) highlights how different societies view health differently, supporting the views of McVittie & Willock (2006). He indicates that Western medicine's evaluation and indication of a healthy body is done through a series of technological laboratory tests to determine individual health, while other societies adopt a more traditional stance. He makes an illustration that in some society's social structure, health is expressed through dreams and hallucinations about spirits and ancestors (Albrecht, 2006). These understandings and interpretations of health determine health seeking as well as health seeking methods.

In support of McVittie & Willock (2006)2006, several authors have also pointed out that an illness does not have one analogous or standard view (Janzen 1978, Greenwood 1992, Hausmann-Muela et al.1998). They theorise that difference society's view illness differently,

which therefore informs their health seeking behaviours and treatment choices. Janzen (1978) cited in Hausmann-Muela et al.,(2003) study titled ‘The Quest for Therapy in Lower Zaire’ showed how people associate illness with witchcraft. Jazen’s study observed that viruses and bacteria were perceived as strongly linked with witchcraft, one of the respondents in the study explained how “a healthy body would let pass contaminated food without provoking negative effects, whereas in a bewitched body, the ill-causing agents of the same food would be retained and eventually penetrate into the blood” (Hausmann-Muela et al., 2003: 7).

Similarly, Hausmann-Muela et al. (1998) study in Tanzania uncovered that malaria and witchcraft were perceived as interrelated in that particular society. Participants in this study believed “that witchcraft can impede biomedical treatment from working or malaria parasites from being detected in the blood” (Hausmann-Muela et al., 2003:7). This then determines health seeking and the type of help an individual is most likely to utilise. The common view or common behaviour is that people with malaria must seek treatment from a traditional healer who can remove the witchcraft prior to attending the hospital for malaria treatment. Hausmann-Muela et al. (1998) discovered that there are treatment sequences which determine the use of traditional and biomedical resources which follow logic of interpreting and re-interpreting illness.

A study conducted by Greenwood in Morocco (1992) highlighted illness classification, showing that illness was classified as prophetic and health seeking was through humoral medicine. Greenwood described how illnesses can be categorised by different societies. This supports the argument that illness is unique to different population groups and does not have a standard universal view. These writers confirm how concepts from different knowledge sources integrate and give unique interpretations of health and health seeking behaviours. The interaction of concepts of natural or super natural determines the treatment-seeking route.

The following section looks at the health seeking process and what influences decision to seek health care from different health service providers.

## **2.4 Health seeking process**

According to Smith et al, (2006) health seeking is “considered to be the recognition of a health concern together with the range of actions that result, one of which is health service utilization” (Smith et al,2006:np). Health seeking behaviour and illness in literature is

understood as a complex interaction of different knowledge sources which shapes the illness understanding of locals and their health seeking behaviours (Uzma et al, 1999). Health seeking behaviour is viewed in a holistic approach as being part of a person's family or a community's identity and is influenced by social, personal and cultural experiences. Similarly Shaik (2006) states that, "health seeking behaviour is not merely dependent on individual's choice or circumstances, but depends largely on the dynamics of communities which have influence over the wellbeing of the inhabitants"(Shaik, 2006: np). Uzma et al (1999), argues that the process of health seeking encompasses various steps and suggests that health seeking should not be viewed as merely seeking help, but as a process.

Rahman (2000) asserts that health seeking is not a simple individual choice or act which can be explained by a single model of health seeking behaviour as there are different social factors that should be taken into consideration before accessing health care. (Tipping and Segall, 1995 cited in MacKian, 2003) In his study he demonstrates that "the decision to attend a particular health care facility is the combined result of personal need, social forces, actions of health care providers, the location of services and the unofficial practices of doctors"(MacKian, 2003:4). It has been noted that in some cases not accessing health care has very little to do with physical facilities at a particular service point but rather men not opting to use health services. Pearson and Makadzange (2008) support the view that health seeking should not be viewed solely as an individual choice to seek help but rather as a complex intersection of different social and cultural norms that are commonly practised amongst societies.

Pearson and Makadzange (2008) study demonstrates that there is a path to seeking health in the context of developing countries which determines whether the illness is viewed as a natural or super natural illness. They state that there is an initial stage, which is the identification of symptoms and condition. The secondary stage is the seeking of information and advice (information and advice was preferably obtained from local elders as they are viewed as having information, experience and are more approachable). The final stage is the seeking and accessing of treatment.



The most common way of addressing illness within that particular community was:

(1) **Self remedy:** Finding your own cure for the illness after consulting with elders in the community which in this case were elderly men;

(2) **Traditional and spiritual health care:** Commonly used when the illnesses is associated with supernatural forces (witchcraft) which are perceived to be incurable by the biomedical approach. Spiritual health care is used when the illness is associated with committing a sin and is as a result of punishment from God or dissatisfied ancestors;

(3) **Formal health care:** The last option in curing illness is the use of western medicine which is used if the illness is incurable by self-remedy or the tradition and spiritual health care.

People make health seeking decisions which are highly influenced by religion, culture and spirituality which plays a huge role in how societies define illness and the approach they take in addressing illness. (Tan, Cheah, & Teo, 2005; Yamasaki-Nakagawa et al., 2001; Yanagisawa, Mey, & Wakai, 2004 cited in Shaikh, 2008) state that “cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in mostly rural communities” (Shaikh, 2008:752). Advice of the elder women is an very influential the decision making process of health seeking. With regards to the decision to seek health care, factors such as pre-consultation with traditional healers and elders in the community who recommend alternative medicine, is usually associated with delayed health seeking. This is due to the fact that individuals spend time exploring alternative traditional medicines. If these medicines prove not to be of assistance, then the clinics are used at later stages, resulting in delayed health care.

In a research study conducted by Pearson and Makadzange (2008) in Zimbabwe, they highlighted two different approaches used in seeking health care, namely the traditional ethno medical and biomedical approach. They indicated that illness is categorised as resulting from natural and supernatural forces which then determine health seeking. If the cause is natural, the disease is attributed to a pathogen which enters the man's body, over which the victim has no control and this is referred to as sexual dysfunction or stress which diminishes a man's libido or psychological illness. Alternatively if the cause of illness is thought to be supernatural, it may be the result of displeased ancestors (invisible forces) or religious spirits, then the illness is attributed to immoral social and sexual behaviour and the afflicted person is

perceived as requiring divination to enable the healing process. Witchcraft is associated with a jealous person who is able to enforce magical powers on the individual resulting in illness.

When examining the context of developed countries, there are religious factors which determine health seeking. This further illustrates that there are numerous factors which affect the individual's (men) decision to seek healthcare. A study conducted by Cessaly and Cheatham (2007), in North Carolina also supports the idea that in developed countries, there may be spiritual factors which affect health seeking. The study illustrates that religion plays a huge role in seeking health care. Findings of this study reveal that people believe the body is God's temple and that health care is sought because the temple should be kept clean and healthy. On the other hand, illness was also viewed as punishment from God for all sins. Spirituality plays a major role in seeking health care as it can facilitate or hinder access to health services.

While studies mentioned in this section demonstrate how disease can be attributed to natural and supernatural forces, which ultimately informs health seeking patterns and behaviours, it is important to note that there are socio-demographic factors which influence health seeking which will be elaborated in the following sub-section.

## **2.5 Socio-demographic factors influencing health seeking**

Numerous factors have been highlighted as possible barriers of health, these include economic status as well as socio-demographic status of individuals (Shaikh and Hatcher, 2008). These factors include geographical location, socio-economic status, employment status, educational level and lifestyle. Age, gender, culture practices, beliefs as well as marital status also play a fundamental role in health seeking behaviours. Shaikh and Hatcher (2008) argue that "cultural practices and beliefs have been prevalent regardless of age, socio-economic status of the family and level of education" (Shaikh and Hatcher, 2008:50). They also affect awareness and recognition of severity of illness as well as acceptability of service (Shaikh and Hatcher, 2008).

### **2.5.1 Geography and socio-economic status**

Accessing health services is influenced by an individual's socio-economic status as well as place of residence. Health indicators highlight that there noticeable health inequalities that are determined by income level as well as residence (WHO, 2006). Socio-economic factors

determine people's livelihoods and these include the type of dwelling and communities which people reside in, as well as the type of public services they receive and their affordability. WHO (2006) asserts that socio-economic factors determine whether people live in unhealthy environments which are crowded and in poor quality housing characterised by malnutrition, congenital problems, poverty and lack of education. These factors contribute strongly to one's health and the issue of affordability and accessibility. Poverty stricken communities have or are said to have lifestyle-related diseases, which are usually caused by stress and results in smoking and substance abuse, lack of exercise and the consumption of junk food amongst other unhealthy behaviours (WHO,2006). Low income communities suffer from illnesses which are caused by their environment and social backgrounds.

The cost of medical care has been noted as a barrier to seeking medical care globally. The poor who are vulnerable are largely affected by these health inequalities which affect health both at the individual and community. Poverty is a major contributor to ill health due to living conditions and dietary plans for low income families. The World Health Organisation (2006) indicates that the "poor who are sick face a high financial burden and use less and lower-cost care" (Social Determinants of Health, Chapter 2: 8).

According to the World Health Organisation (2006), a study in Vietnam showed that "poor, ethnic minorities and people in remote areas are the most vulnerable populations there evidence of pollution and poor enforcement of occupational health and safety, and traffic safety standards which posed a threat to the people's health"(Social Determinants of Health, Chapter 2: 8). The study highlights the high use of tobacco, alcohol and food consumption in the poverty stricken population (WHO, 2006). It is noted that there is a strong relationship between one's lifestyle and their socio-economic status, which ultimately determines their health outcomes. Comparatively, Sheikh (2006) asserts that "members of poor households in rural areas are most likely to be undernourished, use unsafe water sources and be exposed to indoor smoke from solid fuels" (Sheikh,2006:np). This further perpetuates ill-health due to their living conditions.

When looking at physical accessibility, people living in remote areas have less access to health care facilities compared to those in the townships and suburbs. Similarly, research done by Pearson and Makadzange (2008) in Zimbabwe shows that availability and accessibility to health care services is also a barrier in seeking health care.

They also highlight that in some cases, even “when health services are available, the costs of seeking them are often more than poor patients and households can afford, thus causing the poor to delay health seeking or disrupt treatment, and often forcing them deeper into poverty” (Social Determinants of Health, Chapter 2: 10). In addition, travel costs associated with seeking health have also been identified as potential barriers for the poor and unemployed.

### **2.5.2 Employment status**

Unemployment amongst men and their participation in minimum paying jobs is indicated as a barrier to health care service utilisation. Courtenay et al (2000) study in the USA also supports the fact that economic disparity hinders health care utilisation. In his study he discovered that people without medical insurance coverage were less likely to use health services. Similarly, recently employed men were also highly unlikely to use health services because of the fear of being viewed as weak, sickly and incompetent workers.

Men’s working conditions expose them to greater chances of work injuries or injuries caused by accidents surrounding their work place. When compared to women, “men are more likely than women to work in and around motor vehicles and outside near roads, and are therefore more subject to injury and death from vehicle accidents”(Social Determinants of Health, Chapter 2: 21). Therefore, “worldwide, men are over-represented in nearly all forms of injury” (Sonke Gender Justice, 2007:11), which is related to their socio-economic status and as a result of gendering of occupations, “such that masculinity becomes equated with the willingness to do the dangerous jobs that ‘lesser’ men would be afraid of doing” (Sonke Gender Justice, 2007:11). According to The Lancet (2001), due to unemployment, “many men fail to get routine check-ups, preventive care or health counselling and often ignore symptoms or delay seeking medical attention when sick or in pain” (The Lancet 2001:1813).

### **2.6 Education and Lifestyle**

Education and lifestyle play an important role in health care, “education is a key determinant of health at both individual and community levels” (Social Determinants of Health, Chapter 2:13),it reduces poverty through increased employment opportunities, and is also capable of providing skills for attaining better health, increased knowledge about preventative measures as well as assisting in the decisions to seek proper health care.

Low levels of education are perceived as a prohibiting factor in the utilisation of health care services. A study conducted in USA by Ferrante et al, (2011) amongst highly educated men illustrates that educated, employed and married men were more likely to seek health care, while married men with lower education levels were unlikely to seek health care and even with visible symptoms of illness, health seeking was not an option until very late stages of illness.

Education is also a determinant of lifestyle choices and health outcomes. Statistics indicate that heavy alcohol consumption is reported highly among individuals with lower education attainment. In China, 26.3% of men and 1.3% of women with less than 6 years of school are reported drinking more than once a day, compared with only 7.4% of men and 0.2% of women with more than 13 years in school” (Social Determinants of Health, Chapter 2:17) High alcohol uptake levels and other drug use is viewed as a coping mechanism for the poor and is use as a strategy to cope with stress of not being able to gain employment. Such behaviours are implicated in the negative impact of the general health of societies as well as health seeking behaviours.

Uneducated men with a lower socio-economic status are more likely to indulge excessively in alcohol use and suffer from hypertension as well as a range of physical and psycho-social pathologies as well as injuries (WHO:2006). According to the World Health Organisation (2006), illness due to tobacco use currently results in nearly 5 million deaths annually worldwide, more than those due to AIDS, drugs, homicides and accidents combined. It is estimated that tobacco products kill more than 2 million people a year, accounting for 12.8% of all male and 2.7% of all female deaths(Social Determinants of Health, Chapter 2:18). The following section looks at other possible barriers that hinder men’s health seeking.

## **2.7 Other barriers**

Among other identified barriers to seeking primary health care are age and peer pressure, which insinuates that health seeking is a threat to manhood eg. Coronary screening (Cessaly and Cheatham 2007). The lack of knowledge about illness and screening also leads to men not accessing health services (Gerrtsen and Deville 2009). The stigma attached to seeking help associated with Sexually Transmitted Diseases (STDs) also facilitates non usage of health services because of embarrassment and shyness of infected persons (Pearson and Makadzange 2008). A study conducted in the USA by Cessaly and Cheatham (2007) shows

that the history of the legacy of discrimination plays a huge role in Black American men not seeking help because of the mistrust of white health professionals.

A study conducted by Letsela and Ratele (2009) on South African men and their health seeking behaviors' uncovered that the lack of medical aid, distrust of public services, the view that visiting health services is a waste of their time, the fear of finding out that one is unwell and the idea that health check-ups are for others who are weaker affected health seeking amongst the research participants. This study validates other findings which indicate that men see visiting health services as a feminine activity (Letsela and Ratele 2009).

Socio-demographic factors such as employment status, education attainment, lifestyle, access to services and place of residence, amongst others, also play a major role in informing the decision to utilise health care. The following sub-section looks at health promotion and how it can play an pivotal role in facilitating health seeking.

## **2.8 Health promotion**

Williamson (2000) cited inMcKinlay (2005)indicates that “while health promotion places emphasis on individual behaviour, the view of health behaviour should be broadened to other determinants of health, including policy directives to enhance population health as well as the reduction of inequality and improvement of social justice”(McKinlay,2005:24). The writer places emphasis on the need to view health behaviours holistically rather than attributing it to attitudes and norms. Lee and Owen (2002) argue that behaviour and attitudes are explained not by gender, but by the behaviour and attitudes associated with particular careers and lifestyle choices which determine health promotion.

Narcissism also affects men's decisions to access health care services as they view health seeking as associated with a certain class, leading to the ostracising men who seek help. Buckley and Tuama (2010) indicate that for men who engage in health promotion such as the utilisation of sunscreen for protection from skin cancer, screening tests, cutting down on smoking and drinking and promoting positive health behaviours are viewed as a feminine and do not maintain a “macho” identity. Behaviours such as excessive smoking, competitive drinking, unhealthy diet and opting to engage in hard labour are viewed as being manly (Buckley and Tuama, 2010).

## **2.9 Role of the service provider towards men's health seeking behaviours and Relationship between health providers and male patients.**

Buckley and Tuama (2010) highlighted that there is a need for understanding of men's health needs in order to address male health seeking behaviour and men's health in general. The authors assert that the understanding of the provider of men's health and the dimensions involved in seeking health care will encourage men to go for routine checks. The writers highlight the importance of targeting disadvantaged groups and that health policies should be formulated in such a way that they encourage men to seek help. There is a need for a change of attitude from service providers and how they handle male patients with the assumption that this would yield positive health seeking behaviours amongst males.

In addition, Gerrtsen and Deville (2009) highlight the issue of distrust of health workers which facilitated underutilisation of public health services. They assert that nurses can play an imperative role in health services by ensuring more responsive and effective interventions as well as attitudes towards health seeking. It is noted that nurses can play an important role in ensuring health seeking if their day-to-day clinical practice is knowledgeable of men's beliefs, values, and their understanding of health seeking.

Gerrtsen and Deville (2009) in their study also point out that men felt that the health workers were providing insufficient information about their health. A radical change in clinical practice imperative, the clinical setting should be more gender sensitive and should be able to cater for male patients. Health providers must improve men's accessibility to health services and promote men's health seeking, taking into account the role played by societal inequalities in further exacerbating some men's lack of access (Buckley and Tuama, 2010).

However, current studies are unable to provide sufficient data to enable clinical and policy change when addressing issues of masculinity and health seeking behaviours.

## **2.10 Concluding remarks**

Literature indicates that there is a significant difference in male and female health seeking patterns. Males visit health care facilities relatively less than females and have a lower life expectancy compared to their female counterparts. The chapter has highlighted some of the dominant masculine discourses which have been said to hinder males from seeking health care. This chapter has discussed factors which hinder men's access to health care services,

including men's view of illness and the causes of illness, cultural and socio-demographic factors, economic and physical accessibility, education level, lifestyle and the role of service providers amongst others.



## **CHAPTER THREE RESEARCH DESIGN AND METHODOLOGY**

### **Introduction**

This chapter outlines the data collection methods which were used in the research and also illustrates and explains the methodological approach. The study was conducted amongst African males ranging from the ages (18-65) in W Section uMlazi township, Durban South Africa. The study was designed to examine health seeking behaviors amongst African males and how dominant masculine discourse facilitates underutilisation of health care services.

The layout of this chapter is as follows: firstly the chapter will give a description of the study units and W Section uMlazi area, where the research took place. Secondly, it will show how the researcher gained entry to the research site and the selection criteria of the research participants. Thirdly, the chapter will present the structure of the research participants. Finally, the chapter will demonstrate the methods used as well as justification of those methods.

There is a need to explore if being a man influences healthy lifestyle choices, health seeking and how it is influenced by of the concept of masculinity. This can be understood by using data collecting methods which enable men to share their understanding of health care and health seeking as well as their relationship with the health system.

The study made use of qualitative methods to assist in answering the following sub questions:

- What are the possible barriers which result in men's under usage of health services?
- Is masculinity associated with under usage of health care services?

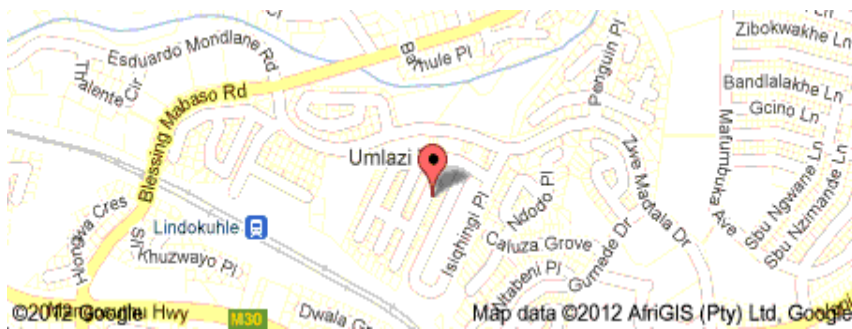
This study aims to capture the reasons behind men's underutilisation of health care, as well as uncover whether their experiences in seeking health care facilitates their health seeking behaviours.

### **3.1 Research context: Durban uMlazi W Section (Kwazulu-Natal)**

The study was conducted in KwaZulu-Natal, South Africa, a province located in the southeast part of the country and the second most populous. KwaZulu Natal is characterised by four population groups: 68% African, 20% Indian, 9% White, and 3% Coloured. The research was undertaken in uMlazi W Section which is the second largest township in South

Africa, and is characterised by both formal and informal settlements. uMlazi is a township on the east coast of KwaZulu-Natal, South Africa and is located south-west of Durban. This research was conducted in W Section in uMlazi's informal settlements.

**Figure: 3.1 Research Area**



Source: Google maps, 2012

**Figure: 3.2 Research site**



Source: sdinet, 2013

Umlazi Township reflects a typical South African township setting. According to Thomson et al, (2001) “poor housing is both an indicator of poverty and as well as a target for interventions to improve public health and reduce inequalities in health” (Thomson et al, 2001:187). Informal housing is characterised by usage of fossil fuels for domestic purposes

such as cooking, lighting and heating, accompanied by a lack of piped water. In some cases the government has been able to place tap systems where residents are able to access water, but there is still a challenge in access to water for poor South Africans. According to Statistics South Africa (2000), there are approximately “5 million households in South Africa currently using fossil fuels for domestic purposes, seven out of ten households in low-income metropolitan areas rely on kerosene for domestic purposes, 21% of households using kerosene for cooking, 14% for heating and 13% for lighting” (Muller et al, 2003:2015), leading to widespread problems of poor indoor air quality with enormous health implications. This is said to have multiple health implications at household level.

South Africa is faced with a high burden of disease (BoD) which is characterised not only by communicable diseases such as HIV/AIDS and TB, but also non-communicable diseases; violence and injuries (Mayosi et al, 2006:1). South African townships are largely affected by these challenges. In addition, South Africa has witnessed an increase in the unemployment rate from 25.5% in 2000 and 31.2% in March of 2003, with the lowest record witnessed in December 2008 of 21.9% (Stats S.A, 2008). It is reported that the unemployment rate increased to an estimated 25.5% in the third quarter of 2012 (Stats S.A, 2012). According to the Quartley Labour Force Survey: Quarter 1 (January to March), 2013 the number of unemployed reached 4.6 million in the first quarter of 2013 (Stats S.A, 2013). KwaZulu-Natal, as a province, is not exempt from these numerous socio-economic challenges which include high levels of poverty, unemployment as well as the burden of disease. The following sub-section looks at the data collection methods which were used in the study as well as the justification of these methods.

### **3.2 Methods of data collection**

This section looks at the methods which were used to collect the data in the field. The study took a qualitative approach to get a detailed understanding of men’s health and their perceptions of health and health seeking, offering a wide range of epistemological points of view, research strategies, and specific techniques for understanding people in their natural context (Mathews 1987 cited in Denzin and Lincoln, 2000). It describes it from the point of view of the people who participated in this case study i.e. the male participants in the study. “Qualitative research is concerned with the opinions, experiences and feelings of individuals, producing subjective data and social phenomena as they occur naturally” (Hancock, 2002; 2).

This method enabled me, as a researcher, to ascertain insightful information and a deeper understanding of males and their health seeking behaviors.

According to Flick (2004, 18), qualitative research describes life's world 'from the inside out'.

Qualitative research is grounded on "the premise that knowledge about humans is not possible without describing human experience as it is lived and defined by the people themselves" (Polit and Hungler, 1994:401). As highlighted by Polit and Hungler, it is crucial that the people describe their own experiences, which leads to the study's utilization of qualitative methods. In this research, the participants were able to share their health seeking behaviors and the reasons behind non utilisation of health services. Flick (2004) asserts that "qualitative research has a strong orientation to everyday events on everyday knowledge of those under investigation"(Flick, 2004:31). This method allows for the participants to be able to speak out about their experiences and is not based on pre-determined answers. "It gives voice to those whose views are rarely heard", in this case, male participants and their health seeking behaviors (Sofaer, 1999, 253).

According to Ulin et al (2002), the purpose of "qualitative research is to generate knowledge of social events by understanding what they mean to people, investigating and documenting how people interact with each other and how they interpret and interact with the world around them". Blanche, Kelly and Durrheim (1999) indicate that qualitative methods aim to generate knowledge about people in their natural setting and seek to understand feelings, experiences, social situations that affect them. Within qualitative methods, in-depth interviews were used as a tool to collect data and are elaborated below.

The following sub-section looks at the recruitment of research participants.

### **3.3 Recruitment of candidates and selection of participants**

Recruitment of participants to be interviewed was done via a friend who introduced me to the ward counselor through whom I gained authorisation to conduct the interviews, followed by an introduction to potential participants with whom I built trust and a good rapport, as I was introduced to them by one of their own. There was a sense of familiarity as I had frequented the neighbourhood, interacted with various people as well as visited their local areas of interest. As the friend was female and was not one of the research participants there was minimal bias as she was only involved in the identification of potential research participants

and as a researcher I choose participants with similar socio-economic characteristic who are part of the same social group.

### 3.3.1 Sample selection

The study employed non-probability sampling, which indicates that chance of selecting a particular individual to participate in the study is done purposefully and is not determined by the statistical principle of randomness (De Vos 1998). Given (2008) argues that purposive sampling is virtually synonymous with qualitative research and that selecting this type of sampling allows the researcher a series of strategic choices about with whom, where and how their research is conducted. Participants for this study were selected on the basis that they are most likely to give responses which will fulfill the purpose and objective of the study, which is to explore men’s understanding and interpretation of health as well as health seeking behaviours in relation to masculinity. This was done by purposefully selecting males above the age of 18 years, which meant that the participants could make their own informed decisions regarding health seeking and did not require parents’ consent . This enabled me to fulfill my study objective.

### 3.3.2 Data collection methods

A total of 18 interviews were conducted in Umlazi. The participants of my research were from various age groups these included African males ranging from the ages (18-65).

**Table 3.1 sample characteristics of the research participants.**

o	Respondent Gender	Age	Employment	Marital Status	Level of Education
1	RM1	19	Unemployed	Single	Grade 12
2	RM2	27	Technical assistance Mechanics company	Single living with mother of 2 children	Grade 11
3	RM3	21	Umlazi Baker	Single	Grade 12
4	RM4	20	Unemployed	Single	University student
5	RM5	18	Taxi conductor	Single	Grade 9

6	RM6	20	Unemployed	Single	University student
7	RM7	27	Part-time employment (time of interview unemployed)	Single living with partner	Grade 10
8	RM8	28	Part time employed (time of interview unemployed)	Married	Grade 7
9	RM9	20	Unemployed	Single	Grade 8
10	RM10	25	Unemployed	Single	University student
11	RM11	29	Construction worker (contract)	Single living with partner	Grade 11
12	RM12	26	Part-time employment (time of interview unemployed)	Single	FET graduate
13	RM13	18	Unemployed	Single	Grade 12 student
14	RM14	21	Welder	Single	Grade 11
15	RM15	29	Toyota, shift attendant	Married	Grade 11
16	RM16	24	Security	Single	Grade 12
17	RM17	29	Construction worker (contract)	Married	No schooling
18	RM18	18	Unemployed	Single	Grade 12 student

### 3.3.3 In-depth Interviews

Data used for this study was collected through qualitative in-depth interviews in order to gain a deeper perspective of men's understanding and interpretation of health and the impact of masculinity on their health seeking behaviour. Boyce and Neal (2006; 3) argue that in-depth interviews are a useful tool to attaining in exploring issues in depth. This also afforded research participants the opportunity to talk broadly about their health seeking experiences and allowed to obtain detailed answers to questions posed in the study. The participants were able to share their experiences and the strategies they employ when in need of health care, preferred health seeking methods as well as the health seeking processes they had undergone.

A semi-structured Interview guide was designed and covered seven sections to capture men's health seeking behaviours. These are: socio-economic and demographic factors affecting health seeking, participant's views of health seeking and masculinity, reasons for seeking health care, the health seeking process, religion and traditional methods of health, attitude towards health seeking, knowledge and awareness of their own health, experiences during health seeking and suggestions on how men's access to health care can be improved. The interview guide served to probe, obtain information and pose open-ended questions to allow for deeper explanations and understanding of men's health related topics.

The interviews took place at an informal home which I had requested to use for the duration of the research to ensure privacy and confidentiality of the participants as health is a sensitive subject. All interviews were conducted in Zulu and translated to English, open-ended and ranged between forty five minutes to sixty minutes. With prior consent from participants, interviews were digitally recorded and field notes were taken during the interview. I acknowledge the challenges of using in-depth interviews as they are time consuming. Fundamentally, to obtain in-depth information may result in participants being annoyed due to interview length. Transcribing interviews and analyzing the results is also a lengthy process. The interview guide used is provided in the appendices and indicates the topics covered in the interviews.

### **3.3.4 Observation**

During the course of the research I was also able to observe the neighborhood setting and also interacted with people. I mingled with mostly the young men who had just finished school as well as those who were seeking employment. I was also able to observe the social and economic setting in uMlazi, most of my respondent's homes were half empty and looked as if people were on the move. Their bedrooms were full of suitcases and boxes where they stored their clothing, and their paraffin stoves and candles were neatly packed and covered with plastic. Their shacks had huge nail holes on the aluminum roofs and in the walls, big enough to see passersby on the street. Living conditions in the squatter camps are overcrowded and one shack housed more than five family members. These informal settlements are characterised by poverty, high unemployment and hunger.

### 3.4 Analysis

The interpretive analysis and thematic analysis were used to analyse the data gathered during the interviews and allowed me to narrate this using a variety of different inductive and interactive techniques. The study made use of the thematic analysis of both inductive and deductive analysis. The thematic phases used to analyzing data are as follows:

- (1) Transcribing data, transcribing of interviews which involved reading and re-reading interviews to generate codes.
- (2) Generating codes, coding data systematically.
- (3) Generating themes, codes used to generate themes as well as gathering data to.
- (4) Reviewing themes and ensuring that codes are in the relevant themes and forming a thematic map for analysis.
- (5) Defining and naming themes, which involved the defining and naming of themes and how the data will be analyzed.
- (6) Producing the report, this involves going back to the research questions and the literature review to form an academic report that is guided by a theoretical position.

In the inductive analysis the data was coded into themes that were driven by the data collected in the field.

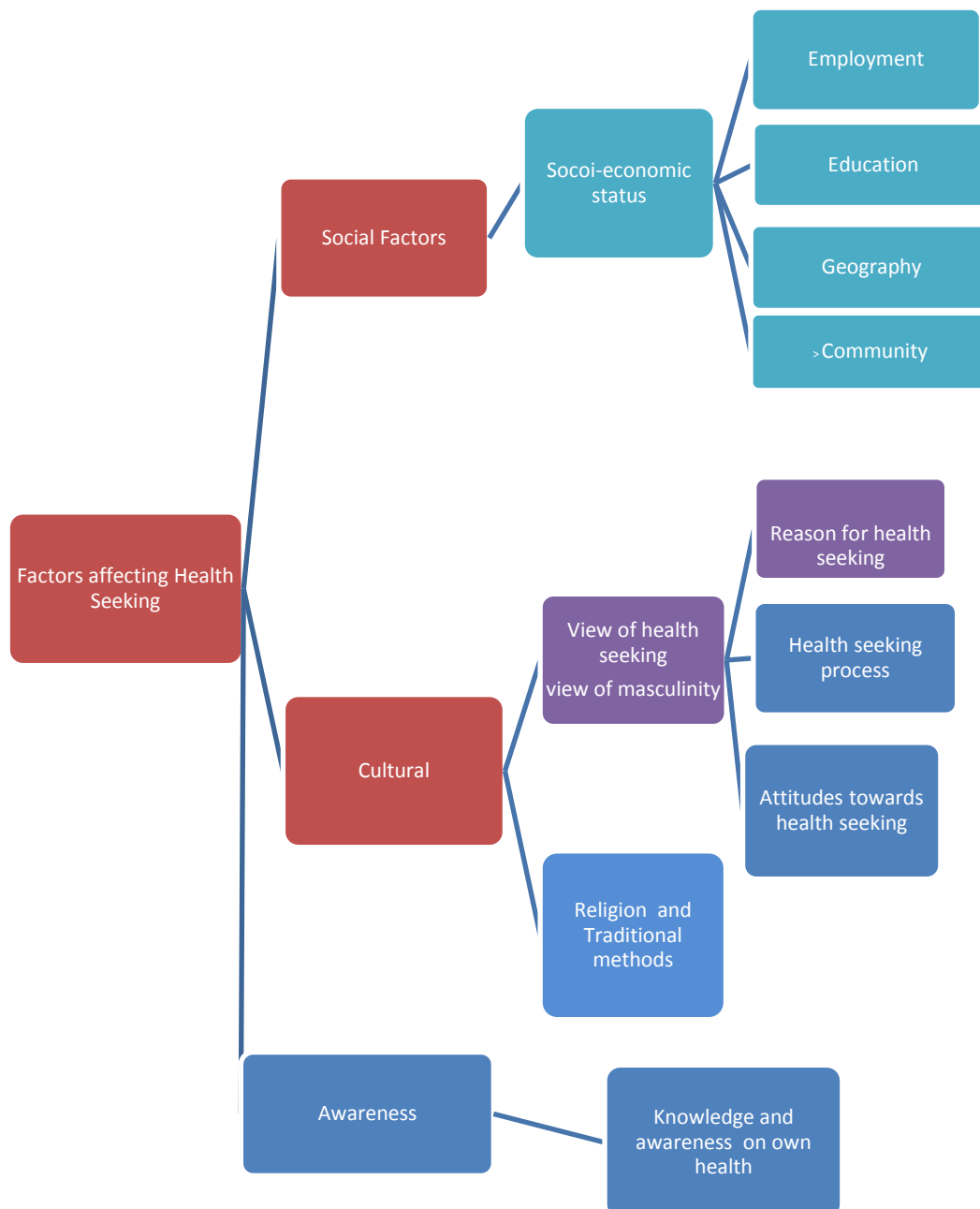
Interpretive analysis enables the researcher to “piece together people's words, observations, and documents into a coherent picture expressed through the voices of the participants” (Jessup and Trauth 2000, 12). As a result, I was able to “piece together people's words, my observations, and to document these into a coherent picture expressed through the voices of the participants”. The narrative data was broken down and rearranged to produce a comprehensive analysis of men’s perceptions of health and health seeking. The interpretive research method assumes that people’s subjective experiences are real, that we can understand others experiences by interacting with them and qualitative methods are most appropriate for this goal (Terreblanche and Durrheim, 1999:134) (Jessup and Trauth 2000:12). This was employed to ensure that combined information gathered from interviews and observations during interviews could be interpreted. The use of an interpretive analysis also allowed me as a researcher to be able to write about men and their health seeking behaviors and whether they are influenced by masculinity.

The theory used in the study also aided the way in which I organised and interpreted my data which I had collected, to form a coherent story. The figure 3.2 below indicates how men’s



health seeking behaviours were analysed, the analytical framework which has been designed to analyse this study and looks at factors affecting men's health seeking behaviors.

**Figure 3.3 Analysis Model**



**Table 3.2 Components of pseudo names**

<b>Codes</b>	<b>Interpretation of code</b>
R	Respondent
M	Male
Number	Age of the respondent

### **3.5 Trustworthiness**

**This section details the strategies employed to ensure the credibility, transferability, dependability and confirmability of this study.**

a) **Credibility**

The research project used credible qualitative research sampling techniques in identifying study participants. Purposive sampling techniques were utilised. The purpose of the selection of the sample was more about credibility as opposed to representativeness. To ensure credibility as a researcher I ensured that I built rapport with the research participants to ensure that they felt comfortable sharing reliable information. I expressed the issue of confidentiality which made participants at ease and were reassured that the information they share with the researcher will not be shared with others but will be used only for research purposes and that their names will not be revealed.

In addition, questioning during data collection I asked the same question slightly differently to check the responses are the same. The thick description of the results is a credibility strategy.

#### b) Transferability

The provision of a detailed description of the study context allows the reader to determine what comparisons can be reasonably made with a different context

#### c) Dependability

Study materials, data, transcripts, notes, coded materials, interview notes and records are all available for record purposes. Research materials are kept and can be verified to attest that conclusions, findings, interpretations refer to what is supported by the data and that there is coherence between data and the findings (Barbie and Mouton, 2001). In-depth description of the methodology can be used to repeat the study

#### d) Confirmability of Results

As it would be the case above, all study materials will be made available for confirmability purposes. These include among others, raw data, processed data and analysis products, synthesis data reconstruction, also tools development information and also interview notes (Barbie and Mouton, 2001). All preliminary reports and though trail will be made available for confirmability purposes. The information on how the research told were developed is made available (Ibid.)

Each finding was also checked against literature and other findings elsewhere

### 3.6 Limitations of the study

In-depth interviews are time consuming and expensive to conduct. Self-reporting bias is also a major problem with in-depth interviews, particularly when dealing with topics of a sensitive nature such as health related behavior's, as they also touch on sexually transmitted illnesses. As health is a sensitive subject, participants may report, for example, that they use condoms when they actually don't, for fear of being labelled as negligent. Some participants may feel embarrassed when asked to reveal if they use protection during sex, and if they have to disclose having a sexually transmitted illness in the past. There may be a possibility of participants giving socially desirable responses. According to Catania et al. (1990:340),

gathering information on sexual and HIV/AIDS matters is subject to "measurement error" and "participation bias". To ensure accurate responses, questions were rephrased and asked in a manner which would yield more reliable results. For example, if a respondent indicates that he does in fact use condoms but he has had an STI previously, this enables the researcher to probe and to ask the respondent to justify their response.

As the study was only conducted in Umlazi, it is not a representation of South African men, but rather a small sample which refers to men's health seeking in the W-section community. Therefore, the findings of the study cannot be generalised to all males in KwaZulu Natal or South Africa, but provides a glimpse into health seeking amongst males.

The results are based on the interpretive method where the researcher pieces together information to make a coherent story. Thus, it is the researchers understanding of events which shape how the story is told.

### **3.7 Concluding remarks**

This chapter has illustrated how participants were selected for this study, their structure as well as the methods used to gather data from the field. Most importantly, it has indicated how the data will be coded and analysed as well as how validity and reliability was ensured. The following section proved results of the study based on theoretical grounds as well as data collected in the field.

## **CHAPTER FOUR FINDINGS**

### **Introduction**

This chapter outlines the results of the research based on the The HIMM (Health, Illness, Men and Masculinities) Framework to explore men's understanding and interpretation of health. It is structured as follows:

Firstly, it will look at how men define manhood and health as well as their general view on health. The chapter will also discuss men's awareness of their own health and how that shapes health seeking behaviours. It also touches on socio-demographic factors such as education attainment, socio-economic status, geographical location and how these factors affect health care utilisation by men. The chapter outlines the health seeking process which includes peer consultation, traditional healers and religious beliefs and how these factors impend on health seeking or facilitate delayed health seeking. Men's attitudes towards health promotion are also explored as well as the notion of fear versus the notion of masculinity. Lastly, the chapter looks at men's experience in health care centres and how it hinders their access to health care facilities.

### **4.1 Definition of manhood**

Manhood is associated with the ability of one to solve their own problems and being able to provide solutions for any challenges which one encounters, whether health related or in their social environment. The general view of all who participated in the study confirmed this, as all 18 men generally defined and understood manhood as one's ability to provide security for one's family, be it financial, social and physical security.

Similarly, Barker and Ricardo (2005) support the idea that playing the provider role for the family by being financially independent and employed are significant signs of masculinity. Manhood is understood as the ability to provide rather than being provided for. This raises the question of whether this generally perceived characteristic of being a provider can in fact affect health seeking or being provided care. The research participants indicated that they perceived being a man as having the responsibility to change their socio-economic conditions. The fact that manhood is only defined in terms of one's socio-economic responsibility could be attributed to the fact that the research was undertaken in the uMlazi

informal settlements, a poverty stricken neighbourhood which characterised by high unemployment. A man is therefore also viewed as a role model who should provide guidance to the youngsters in the community as well as play the role of a problem solver. When participants were asked how they defined manhood, one respondent indicated that being a man entails the financial responsibility of taking care of family as he states below:

Respondent [R17:37] states,

“Being a man means providing for my family, taking care of the old lady, like now I’m not working I have piece jobs so I make sure that the yard is clean and I help my mother with getting water from the tap”.

Correspondingly, the respondent quoted below places an emphasis on the male as a role model and the notion of responsibility.

“It starts at home. You need to be of assistance at home and be able to take care of the family. You need to know that from your salary you have money for yourself and the other portion goes home for food and other household needs. That’s why they take you to school so that you can be of assistance to them. If there is a leak at home it’s not my mother’s responsibility I should take care of that. The yard needs to be kept clean by a male. There are children growing up in the community you need to be a role model, because they look up to you as they grown up. I need to make sure that I am able to lead them in the right direction. If I see a child misbehaving, I should be able to call them to order. Here we live as a family though not blood relatives but we are family” [R3:22].

The respondent gives a definition of a “handy man” man as one who is able to solve all household problems. They define a man who is responsible, not only for financial support, but also what he perceives as male household chores. The following respondent enhances the dominant view that males have an inherent responsibility of being a provider, role model and a societal builder within the community.

[R15:29] states

“As a man, I have to provide for my mother and my sister, I need to make sure that we eat. Even here I don’t have to be acting inappropriately because there are young children here and I have to be their role model”.

The definition of a man by his moral sense and sense of responsibility was echoed by a younger man (only 20)

“A male is someone who can differentiate between good and bad. It’s someone who is responsible for the family and makes wise decisions” [R4:20]

This notion of man as a provider as opposed to receiver raises the question of whether these perceived provider characteristics of men applies to their health seeking. Males, as early as during their teen years, associate manhood with being responsible for others and the need to be a provider and therefore could suggest that providing health care for males may be a challenge as they are socially constructed to play the provider role. Smith, Braunack-Mayer and Gary Wittert (2006) suggest that the socially constructed ideologies of masculinity are indeed highly influential in the understanding and interpretation of health by men and could possibly facilitate or hinder health seeking.

How men view and define manhood shapes their interpretation on health as well as health care utilisation. The following sub-section gives us an understanding of men’s view of health and its implications on their health seeking behaviour.

#### **4.2 How men view health**

The notion of being a provider has an impact on how men view health and health seeking. It is evident from the study that there are similarities in how both young and adult males view health. Both view health as the absence of illness and symptoms of disease and perceive being healthy as being able to undertake their daily activities and associate it with physical wellbeing. Before further discussing the findings of men’s health view, it is important to highlight the general view of health. Several authors have pointed out that an illness does not have one analogous or standard view (Janzen, 1978). As indicated earlier in the study, illness is viewed differently by different population groups. Some associate health with natural or supernatural agents which further determines different treatment choices (McVittie & Willock 2006).

This study uncovered that illness is viewed as an event which weakens a man’s body as well as his being. As indicated by the respondent below

“When I’m feeling sick I’m not myself. I don’t feel good because I am sometimes not able to provide for my family, even if I had to protect my family I will not be able to because I’m weak you see I’m not a man” [R14:28].

The majority of participants referred to being ill as having a problem. Illness is viewed as affecting one's being and social status in the community and is viewed as degrading and, to a certain extent, makes men feel as if they lose respect in their communities when they are ill. An ill body is viewed as an “incomplete” body. Ill health is viewed as a negative event which takes place in a human body. When ill, one does not consider themselves as a complete being. The following respondent states the feeling of helplessness during time of illness:

“You know when you are sick you are helpless. You cannot take care of yourself and you need people to feed you. That is not good for a man. You need to be able to look after yourself” [RM2:27].

The notion of being taken care of is not ideal, but rather self-help and helping others is more acceptable. Similarly, Tudiver and Talbot (1999) argue that there are implications associated with different forms of masculinity, these forms of masculinity entail resistance, males displaying hegemonic masculinity identities such as not showing fear and weakness due to illness which, further threaten men's health. This means that men will not seek health care when ill as they are against the idea of being provided for. In addition Connell, 1987, 1995; Courtenay, 2000: 687 indicate that being masculine is to “embody physically and portray verbally competence in particular social domains, including sport and physical activity, alcohol and drug use, and sexual activity”. They argue that men who do not subscribe to the dominant discourse of masculinity therefore fail to meet behavioural standards and may succumb to labelling as wimps (Edley and Wetherell, 1997). From the responses given by participants, one can conclude that men feel they are being a burden to their families when sick, as the following respond indicates.

“When you are sick you need someone to take care of you right? I don't feel right if my aunt or my mother has to look after me. I'm a big man and I should be taking care of them. When I am feeling sick I don't feel right because I feel like I am unable to handle myself” [RM7:27].

The idea of being cared for is not desirable for most men. As he indicates, he is a “big man”, hence he needs not to be taken care of by the females in his life but rather he should be taking care and providing the necessary support they require.

In addition to men's view of manhood and understating of illness and the notion of self-help, visiting public health care was mainly associated with severity of illness. Participants referred to being taken to the clinic by a family member. They also indicated that there are financial implications for those who send them to health care facilities. Similarly, Hausmann-Muela, Ribera and Nyamongo (2003) study supports the fact that there are financial implications to



health seeking. As outlined in the theoretical framework, one socio-economic status does play a profound role in health care utilisation.

“If I need to go to the clinic, my mother will have to pay for a car to take me to Prince Mshiyeni hospital if the ambulance does not come. So now she will pay 150 rands for me” [RM12:25].

He highlights the financial burden to his mother of having to pay for his transportation cost to the hospital, further cementing the fact that men have to be critically ill to the point where they are unable to walk or use public transportation to access health care facilities for them to consider seeking health. Financial implications of seeking health care are thus a major factor in delayed health seeking, as many participants indicated that being sick becomes a financial burden for those who need to care for them during their time of illness.

The following sub-section looks at men’s lack of knowledge and awareness of their own health and how it further hinders health care utilisation. The section also highlights how one’s education attainment influences their health seeking behaviours.

### **4.3 Knowledge and Awareness**

It is critical to understand men’s knowledge and awareness of their own health as this determines their health seeking behaviour.

#### **4.3.1 Health screening**

The research was aimed to capture men’s view on health seeking and this was achieved by asking questions relating to health screening. When asked if they had visited health care facilities for health screening purposes, all participants indicated that they had never visited health care facilities solely for health screening. The participants were not aware that such services existed and that they could access them. Most indicated that visiting health care services was only for the sick. It was not possible to gather any information on health screening as the term “health screening” was foreign to the respondents. The option of visiting health screening when there was no sign of ill health was not viewed as necessary. Visiting the health care facility meant that one was severely ill.

One can argue that there is a lack of efforts to educate men on health and their susceptibility to certain illnesses which may affect them. Most respondents appeared to know very little about common illnesses and possible healthcare provisions and screening for such. When the

participants were asked on cancer screening, they indicated that they were only aware of lung cancer, so if they did not smoke they were not at risk of cancer. Health education remains a challenge, due to lack of resources to access vulnerable groups and as well as deconstructing social ideologies of masculinity hence the inability to address key issue on men's health. It was revealed during interviews that most men have not undergone any health screening apart from the common and in most cases compulsory/routine blood pressure examination that every patient undergoes when visiting a health facility. None of the males had undergone any important health screening and mostly had no knowledge of such services or procedure. Table 4.3 below indicates these important health screening procedures.

**Table 4.3. Health Screening for Males**

<b>Physical Exam</b>	Reviews overall health status, perform a thorough physical exam.
<b>Blood Pressure</b>	High blood pressure (hypertension) has no symptoms, but can cause permanent damage to body organs.
<b>TB Skin Test</b>	Test used to determine if someone has developed an immune response to the bacterium that causes tuberculosis. Should be done on occasion of exposure or suggestive symptoms at direction of physician. Some occupations may require more frequent testing for public health indications.
<b>Blood Tests &amp; Urinalysis</b>	Screens for various illnesses and diseases (such as cholesterol, diabetes, kidney or thyroid dysfunction) before symptoms occur.
<b>EKG</b>	Electrocardiogram screens for heart abnormalities.

<b>Tetanus Booster</b>	Prevents lockjaw.
<b>Rectal Exam</b>	Screens for hemorrhoids, lower rectal problems, colon and prostate cancer.
<b>PSA Blood Test</b>	Prostate Specific Antigen (PSA) is produced by the prostate. Levels rise when there is an abnormality such as an infection, enlargement or cancer.
<b>Hemoccult</b>	Screens the stool for microscopic amounts of blood that can be the first indication of polyps or colon cancer.
<b>Colorectal Health</b>	A flexible scope examines the rectum, sigmoid and descending colon for cancer at its earliest and treatable stages. It also detects polyps, which are beginning growths that can progress to cancer if not found early.
<b>Chest X-Ray</b>	Should be considered in smokers over the age of 45. The usefulness of this test on a yearly basis is debatable due to poor cure rates of lung cancer.
<b>Bone Health</b>	Bone mineral density test.
<b>Testosterone Screening</b>	Low testosterone symptoms include low sex drive, erectile dysfunction, fatigue and depression. Initial screening for symptoms with a questionnaire followed by a simple blood test.

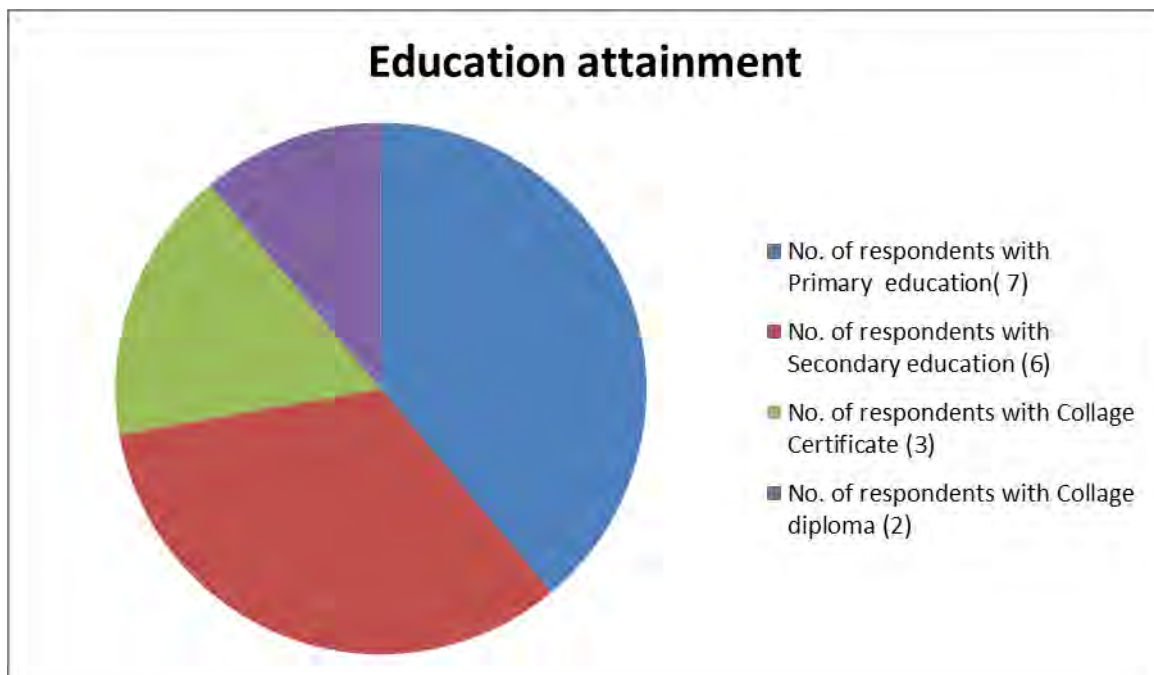
Source: [www.menshealthnetwork.org](http://www.menshealthnetwork.org)

As indicated in table 4.1, high blood pressure (hypertension) has no symptoms which suggest that patients should undergo regular screening to avoid health implications. Similarly blood pressure and Urinalysis screening is imperative and screens for various diseases such as (cholesterol, diabetes, kidney or thyroid dysfunction) which is detectable in the body before symptoms occur, but due to lack of knowledge, men cannot access these services. Men do not undergo Colorectal health screening, which is the screening of cancer at treatable stages. Colorectal screening is vital for men as it can prevent the growth cancer cell (polyps) with early diagnosis. Lack of knowledge plays a major role in men’s underutilisation of health care facilities as well as health screening. The following section looks at how one's education attainment facilitates or hinders seeking health care.

#### 4.4 Educational attainment and seeking health care

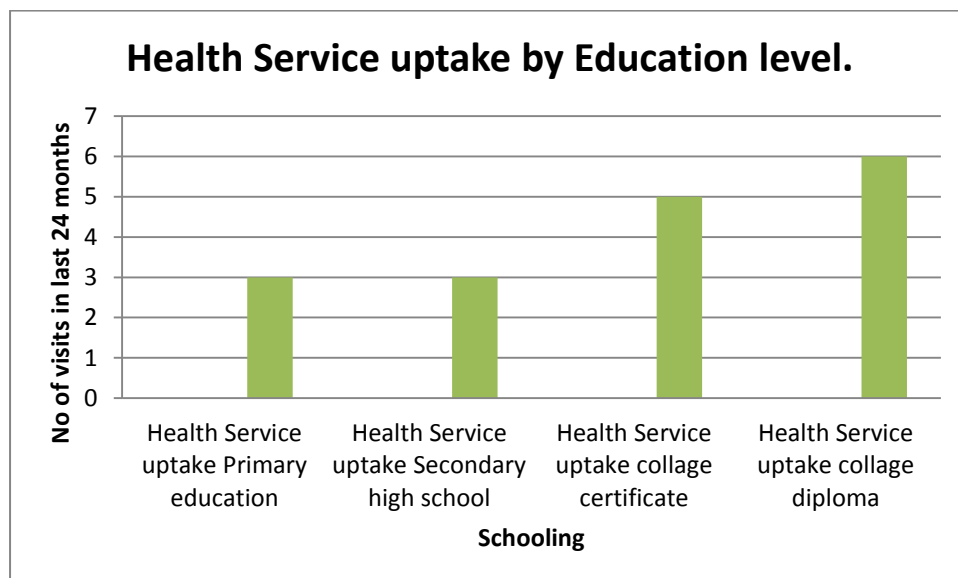
Reporting of health care utilisation amongst males differs with different education levels. Males with college education expressed that they had used health care services more often compared to those with primary and secondary education. The chart below gives an indication of the respondent’s education attainment.

**Table 4.4.1 Education attainment**



Source: Data 2013

**Table 4.3 Health Service uptake by Education level.**



Source: Data 2013

From the table 4.2 we determine that most participants had primary and secondary education. Very few participants had tertiary education. The table 4.3 above also indicates the notable relationship between education level and health seeking where in men with tertiary education and those who were currently enrolled in tertiary institutions reported to have visited health care facilities more often than males with a high school and primary school education. When asked when last they visited a health care facility, those with tertiary education and those currently enrolled in tertiary institutions indicated that they had last visited a health facility between six to nine months ago at the time of the interview. On the other hand, men with primary and high school education did not recall the last time they visited health care facilities and which, according to many, was possibly during childhood. Others however, reported it had been between a year and two for STI related illnesses or two to three years for circumcision. When participants were asked how long they took to visit health care facilities when they are feeling ill, males with tertiary education reported to seek health care earlier when they had symptoms of disease, even though they also indicated delaying seeking health care while they waited to see if they could be healed without medical attention. They

indicated a time period of three to seven days before seeking health care, while those with lower education levels reported fourteen to twenty one days before seeking health care. It is evident that both males with primary/secondary education and males with tertiary education delay health seeking, however it is the extent to which they delay seeking help which differs significantly. It is evident from the study that regardless of the education levels, there are similarities in how men view certain illness as not necessitating medical attention such as a flu and headache as these were not viewed as a sign of ill health, thus not necessitating assessment by medical professionals. It is important to note that both males with tertiary education as well as males with high school education were all unfamiliar with the practice of health screening. The commonly shared view was that people visit health care facilities only when ill.

It is interesting to note that in South Africa, the high prevalence of HIV shifted all State, NGO and donor efforts to only focusing on HIV/AIDS education campaigns. Not much attention has been placed on other life threatening illnesses which mostly affect males. When the participant was asked about colon and prostate cancer screening he indicated the following:

“We don’t know much about cancer, only people who smoke have cancer, I don’t smoke so I’m not in danger of getting cancer, I didn’t know about what you are asking me, I don’t know any other kind of cancer [RM4:20]”

It is interesting to note that when the above respondent is not familiar with the topic, he shifts to using ‘We’ and enables the researcher to get the idea that he is not the only person who does not have this particular information. One could question if this feeling of we all don’t know displays masculine traits.

The following respondent currently enrolled in a tertiary institution states the following when questioned on health screening particularly Colorectal Health and rectal exam:

“I will not lie to you, I did not know that there was such a cancer, I smoke and I know the risk of lung cancer, but I do not know any other type of cancer” [RM10:25].

From the responses gathered when participants were questioned about health screening, it is obvious that there is a greater need for male education to disseminate information on illness/diseases that affect males and to encourage health screening not only focusing solely on HIV. There needs to be policy advocacy focused on the improvement of men’s health as

well as improving men's health education to yield positive health outcomes. The following section looks at Geographical location from health facilities and how that can facilitate or hinder health seeking.

#### 4.5 Geography

The study uncovered that accessibility to public health facilities was not a challenge, as the nearest clinic was situated within a 5 kilometer radius from the participants' homes. The study uncovered that even though the clinic was geographically accessible, participants did not make use of the clinic regularly. This was mainly attributed to the fact that some men had temporary jobs and could not stay away from work unless severely ill, while others indicated that they did not feel the need to go to the clinic as they would be given 'Panado' (a brand of paracetamol). They also felt that clinic staff are unhelpful.

The only instance where geographical location played a role was when participants became severely ill and needed to be taken to the nearest hospital, Prince Mshiyeni, which is an estimated 20 kilometers from the participants' neighbourhood. The financial implications now come into play as participants have to be transported to hospital further away from their homes as the respondent below indicates.

“If I need to go to the hospital, my mother will have to pay for a car to take me to Emshiyeni hospital if the ambulance does not come. So now she will pay R150 for me” [RM12:25].

This suggests that males delay health seeking until a point where they become weak and are no able to access health care without help, therefore forcing their families to spend on transportation costs. This finding supports as well as contrasts the theoretical base of this study which asserts that geographical location has financial implications that impact on health seeking. In support of the framework, participants indicated that there were financial implications associated with health seeking. They indicated their family's financial commitment of sending them to hospital. The framework does not consider cases where the clinic is geographically accessible but individuals choose not to make use of the clinic.

In addition, men who choose not to seek health care for reasons such as nurse attitudes and those who do not have faith in the public health services are not accounted for in the theory. However, literature does support the notion of alternative health care utilisation such as traditional healers who will be explored later in the study. However, it is important to note that nurses can play a major role in ensuring and providing a male friendly service.

The following sub-section looks at how one's socio-economic status impacts on health seeking behaviors.

#### **4.5 Socio-Economic status**

The socio-economic factors take a rather unique explanation from the commonly known reasons for not accessing health care. Where people state that they are unable to afford public transport to the nearest clinic, as they are unemployed. The theoretic position of this study supports the fact that unemployment could be a potential barrier to seeking health care. In my study, as mentioned earlier, the nearest health facility is within walking distance from the research site, hence there is no need for transportation costs to access health care unless severely ill, but participants in the study still reported not visiting the nearest public health care facilities. The study uncovered that as males delayed seeking health care, they find themselves in a position where they have to spend on transportation cost as the nearest clinic does not cater for the critically ill or with severe illness and they need to be referred to the nearest hospital. It is evident that delayed health care has financial implications which could have been avoided if health seeking had not been delayed. As some of the participants had part time employment, they indicated that taking time off temporary employment was not ideal. With the unemployment rate in their community so high, participants would not risk being viewed as sickly and not being able to perform work duties.

The dominant masculine discourse asserts that real men should play the provider role, when men are unable to fulfill this role they may feel that their masculinity has been compromised. If they are unable to work due to illness, this leads to ignoring of symptoms and delaying health seeking. The following sub-section looks at the health seeking process and what informs this process.

#### **4.6 Health seeking process**

This section looks at the health seeking process and its implication on health seeking. It looks at the commonly preferred service providers and the time frame for seeking health care and also touches on the health seeking process and its implication on delaying health care utilisation.

Health seeking behaviour is viewed as being part of a person's family or a community identity. This categorises health seeking as a holistic approach since it is influenced by social, personal and cultural experiences. As indicated in the literature review earlier in this study, health seeking and illness is understood as a complex interaction of different knowledge



sources which shapes local illness understanding and health seeking behaviours (Uzma et al, 1999). It is evident that “cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in mostly rural communities”(Shaikh, 2008:752). As outlined, there are diverse social factors which should be taken into consideration before seeking health care. It is also evident in the study that health seeking is complex as participants indicated that there are several processes that they follow before seeking health care.

These processes included consultation with peers or senior males where they discussed the illness and were advised on home remedies or they consulted a herbalist who prescribed certain herbs. They indicated that consultation with herbalists was the first step of seeking help before going to clinics. Elderly women also played a significant role as advisers in the health seeking process. It appeared that there is a consultation phase which takes place before the decision to seek health care. Health seeking is not viewed solely as an individual choice to seek help but rather as a complex intersection of different social and cultural norms which are commonly practised amongst the community/society.

In the health seeking process, it is evident that cultural practices and beliefs in fact do play a vital role in health seeking regardless of education and employment status.

The following section looks at the influence of peers on decision to seek health care.

#### **4.7 Peers**

Peers play an important and influential role in the health seeking process. Some participants indicated that before they seek health care they first consult their peers to get advice on how they should deal with the illness. This confirms Rahman’s (2000) study that identified the first step to seeking health care is the consultation with elders in the community. This consultation phase is therefore followed by self-remedy, which is finding your own cure for the illness after consulting with elders in the community, and this is the case with elderly men. In this study, the information given by peers before the decision to seek health care is crucial, as it determines when one is most likely to seek health care and where. The participants indicated that they would get a few opinions from their peers and evaluate which method they would try first before seeking health care. The 20 year old illustrates below

“Before I go to the clinic I first consult *amajita* (guys) and ask them if they know this situation and how I can help myself” [R6:20].

It appears that going to health facilities is the last option for some young men and is most likely to be considered after other methods of self-treatment have been explored and proved unsuccessful. The notion of being provided care seems to be the last option for most men. Peers were believed to provide reliable and useful advice which is embraced and deemed more reliable by participants. As the following respondent states,

“For me, I have my friends that I ask if I have a problem. My friends are older than me and they are my brothers so they cannot give me wrong advice. Someone in the group will know what I am talking about and they will help. I don’t have to go to the clinic unless *amajita* (guys) don’t know my illness [RM1:19]”

While other young males preferred consulting with *amajita* (guys), others felt more comfortable with consulting traditional healers and use of religious methods as highlighted in the section below. (Cessaly and Cheatham 2007) confirms that among other identified barriers to seeking primary health care, age and peer pressure insinuates that health seeking is a threat to manhood eg: Coronary screening.

Other factors include religion and traditional methods of healing. The following sub-section looks at how religion and traditional methods of healing influence health seeking behaviours.

#### **4.8 Religion and Traditional healers**

Literature supports the fact that religion and traditional healers are amongst the available alternative health seeking methods that people make use of and the study also reveals that people do indeed prefer these methods of health seeking. A majority of men in the study indicated that they would normally consult traditional healers before they would seek health care in clinics. This, according to them, depended on the nature of illness. Most men subscribe to the notion that there are African illnesses as well as western illnesses. Most men claim that what they consider African illnesses cannot be cured by Western medication and that before going to the clinics it is imperative to consult traditional practitioners then make the decision to seek health care in clinical settings. In instances where Western medicine is required, participants would consult traditional healers first before they considered Western medication. The delay in seeking healthcare in this case is therefore a direct result of unsuccessful preferred initial consultation.

Various reasons can be attributed to these preferred and initial methods of consultation.

Rahman's (2000) study asserts that the consultation of traditional healers and use of spiritual healing methods is commonly used when the illnesses is associated with super natural forces (witch craft,) which are conceived to be incurable by the biomedical approach. He indicates that the understanding of illness as associated with supernatural forces therefore results in the use of spiritual health care. This was used when the illness was associated with committing a sin and is as a result of punishment from God or dissatisfied ancestors.

Although the spiritual association of illness defines what respondents consider African illness, it is important to note that from this study some of the participants indicated that they make use of traditional healers regardless of association of illness as natural or supernatural, as they first consult traditional healers when ill. African illnesses therefore refer to general illnesses which do not necessarily need Western medical attention, but can be treated through traditional methods .It therefore becomes a norm for many to consult traditional healers for any illness before considering going to clinics. [RM13:18] states

“Before I can go to the clinic I consult my aunt who is a *sangoma* (herbalist), she can mix some herb for me so I don't have to go to the clinic,”

This indicates that traditional health care is not only a preferred method of health seeking but very trusted amongst African men as discovered in the study. This result in men purposefully delaying seeking western medical healthcare until traditional intervention has been fully proved ineffective for the particular illness. When asked if the herbs are unable to assist, one responded stated,

“unless I have an STI then I go to the clinic if I see that it is not going away, but also it depends there are something's that you cannot go to the clinic for you see” [R3:21].

This view is shared by most men who claim that one can only consult clinics for a few particular illnesses. Most men indicated that STI's in general are Western illnesses and therefore require Western treatment. Some, however, believe that not all STI's can be treated by Western medicine .When asked to indicate the type of STIs which do not require one to consult , a responded stated that

“For example *uma u bhajiwe* (swollen testicles) you cannot go to the doctors, they will not be able to help you. You need to goto a herbalist. Only the traditional people will

know which herb to mix with what. People die from *ukubhajwa* (swollen testicles) because they look for help in the wrong place” [RM5:20].

Similarly the following respondent echoes the importance of traditional medicines where Western medication is believed to be unable to cure certain illnesses.

“Once I got *izintwala* (lice infestation) but, I had used a condom because that girl moves with the dancers, so you can’t go to the clinic for that, they will tell you they can’t help you so you need to get traditional medicine for that. But sometimes if I have a problem (illness) I go and smoke weed or I drink with the boys and forget about the pain” [R4:19].

The notion of wanting to drink and smoke the pain away indicates a masculine identity. The idea of conceptualising illness as a problem that one could drink away is an indication of denial of sickness and not wanting to seek help from professional medical practitioners.

While other respondents believed in traditional ways of seeking health care, others stated religious ways of healing. They indicated the importance of religious methods to cure illness. Religion also plays a major role in the decision to seek health care as other participants indicated. Rahman (2000) asserts that health seeking decisions influenced by religion play a huge role in how societies define illness and the approach they take in addressing illness. In this study, religion came out strongly as an alternative method of cure. This included the use of the Shembe church Vaseline as the following respondent stated:

“If I am sick I don’t go to the clinic I use Holy Vaselline, if I feel pain somewhere I just rub with the vaselline” [R9:20],

So when asked whether Vaseline can be used for all illnesses and symptoms including internal pain such as chest pains stomach pains ,the respondent further states;

“If the pain is inside, I just swallow the Vaseline I use it for all illnesses, I never had to go to the clinic. Everyone in my family from my mother, father, brothers and sisters never go to the clinic, the Holy Shembe Vaseline [RM:29]”

The Shembe Vaseline, which is prayed for by the pastors and elders of the church, is believed to work for all types of illnesses. Church followers apply the Vaseline in parts of the body where they feel pain and believed that it has healing properties.

In support of religious methods of cure, participants from the Zion Christian Church emphasised the use of “the holy tea” which is believed to cure all types of illnesses as the respondent below indicate:

“If I am not feeling well, I use the holy tea, I have it at home and we also drink it on Sundays in church. I never feel sick, but if it does happen, I just drink the tea. I do not have to go to the clinic [RM: 25]”.

Members of Chibini St Johns church indicated that they make use of holy water to cure all sickness. As the holy water is used weekly, they believe that it keeps their immune systems strong, hence they never have the need to visit clinics.

“In my church we drink the holy water. We also have it at home and use it around the yard to protect our home from evil spirits, but we also take it for our health. We don’t get sick”.

Participants who leant towards African tradition medicine were open to exploring Western methods when their initial attempts had failed. Religious men, however, did not see the need to ever consult clinics for treatment or health scans and only visited health facilities under emergency, which has major health implications as some of the some diseases can be cured if diagnosed timeously. In addition to the consultation of peers, traditional healers and religion as influencing factors in seeking health care, men’s attitudes towards health promotion also plays an important role in utilisation of health care service.

#### **4.9 Severity of disease**

The most quoted reason for seeking health care was for sexually transmitted illnesses. Although participants indicated that they sought health care when they had STI infections, the identification of STI symptoms did not necessarily mean immediate health seeking. They indicated that they would delay seeking health care as they hoped that the illness would eventually disappear and visited the health care centre when the STI was severe and they could no longer bear the pain.

There is a general view that, as a man, you should delay health seeking and should be able to “take the pain like a man” [R10:25]. Participants, however, indicated that not all sexually transmitted illnesses could be cured by utilising western medication. Some STI’s were

perceived as associated with traditional spells as one would get the illness from having sexual intercourse with someone else's partner. The partner is believed to put a spell on his/her partner so that if they engaged in sexual intercourse with someone other than them, the person they engaged in the sexual act with will have (*izintwala*) lice infestation. The respondent below [R1:19] year old states:

“I just recently had *izintwala*, (lice infestation) and you cannot go to the clinic for that”.

The respondent indicates that visiting a health facility would not assist him and that he would receive the appropriate assistance from a traditional healer. This is attributed to the fact that even when one uses a condom during sexual intercourse, they would still get the lice infestation as it is associated with spiritual/supernatural powers.

Some participants indicated that they had gone to health care providers once their STI was so severe that they had difficulty walking. They also mentioned that the STI was so severe that they could no longer get assistance from the clinic and they were referred to a hospital where they were hospitalised for a number of days. As [R6:23] states

“I do not go to the clinic the minute I see something wrong, I have to see if I can't fight it myself first”,

When asked how severe the illness should be, he stated,

“I once had an STI and thought it would go away, so I did not go to the clinic. When I eventually went to the clinic, the sister told me I had to go to Prince Mshiyeni hospital because they could not help me as there was too much damage”.

Similarly, in a study conducted in the UK by (Mokdad et al, 2004), it was discovered that men who sought health care were those with severe prostate cancer and severe chest pain. Delayed health care until the illness is severe has been strongly linked with masculinity. The UK study of men with testicular cancer indicates that men interpreted health seeking as an unmasculine act and that real men solve their own problems (Mokdad et al, 2004). There is a need for policy advocacy that focuses on these detrimental masculine traits and more emphasis should be placed on encouraging men to seek health care in times of need. The following sub-section looks at men's attitudes towards health promotion and how it facilitates underutilisation of health care services.

#### **4.10 Men's attitudes towards health promotion**

This section looks at men's attitudes towards health promotion such as condom use amongst study participant, smoking and the use of alcohol and other drugs.

The general view on health promotion is a positive one, as participants indicated that they listened and appreciated health promotion efforts, but the main challenge was adhering to these promotions. These health promotion efforts included condom use, multiple concurrent partners, smoking and the use of alcohol and drugs. Some participants indicated having more than one sexual partner with whom they did not use condoms. Some were heavy smokers who smoked between (10-20 cigarettes per day) and consumed alcohol often (2-5 beers a day, but could not estimate their weekend consumption of liquor as they consumed more than they could account for) which displays the hegemonic masculine identity. These behaviours are aligned with the dominant masculine ideologies and values that have implications on men's health. The following section looks at multiple and concurrent partners and condom usage.

##### **4.10.1 Condom usage**

###### **Multiple and concurrent partners**

The practice of having more than one sexual partner is associated with the social construct of masculinity which define multiple partnerships as normal for men. The study confirms that ideas and beliefs about male sexuality are largely shaped by the notion of masculine identities. These masculinity constructs "create expectations among men that having 'main' and 'other' sexual partners is both natural and central to their gender identity as men" (Sonke Gender Justice, 2008: 14).

In the South African context, there is high prevalence of HIV/AIDS. Most of the respondents were aware of the prevalence and this was a barrier to their health seeking. Although they indicated their fear of being infected with HIV, the reported use of condoms as a preventative measure against infection still very low. This high prevalence did not deter some of the participants from having multiple concurrent partners and engaging in unprotected sexual acts. Hegemonic masculinity emphasises sexual prowess on men and this is often demonstrated through having multiple sexual partners (Foreman, 1999; Lindegger & Durrheim, 2002).

There are several reasons which have been outlined that facilitate the lack of condom use, and participants indicated that they only thought about the consequences of their actions after the sexual act. While another expressed a different view as stated below:

“I have a few girlfriends. I mean today you see a pretty girl, tomorrow you see a prettier one, so it is hard to have one (laugh). I know the girls from the neighborhood, so I know who I should use a condom with and who is clean [R4:19].

Even though [R4:19] indicates that he does not use a condom with some of the girls, he indicated that there are certain females who he cannot risk not using a condom with, as he states below:

“I mean you know the girls here. There are good girls and the girls who move with the sugars daddy. Those types of girls you have to use a condom with, because you don’t know where they have been” [R4:19].

It appears, from the participants’ statements, that there are certain circumstances which lead to condom use, as indicated by the respondent above regarding girls with sugar daddies. The respondent clearly indicates that there are good girls that he can risk engaging in unprotected sexual intercourse with, which is also alarming. The participant below attributes not using a condom to a different reason as he asserts [R2: 18]

“I did not use a condom because she was my first and it was also her first time so I did not feel unsafe, I trust her and she also trusts me she is my only one”

While other participants had a different experience as respondent [R1:19] states:

“If you ask a girl to use a condom, she will say "I’m clean" and she will ask you if you have AIDS if you want to use a condom, she says if you have AIDS then leave me, so you end up going *skoon* (sex without a condom)”.

The respondent indicates that the question of trust comes into play when he suggests the use of condoms. This is a major concern and raised questions whether women are in control of the sexual act. The dominant ideas of masculinity in this case would suggest that the man would not ask the women if they wished to use a condom, but would himself dictate the use or non-usage of condoms.



The issue of individuals engaging in unprotected sexual activity and alcohol consumption also came out strongly in the study. Alcohol consumption is said to play a role in the increased cases of people who are newly infected by HIV as well as the spread of sexually transmitted illness. Similarly, The World Health Report.14, on alcohol consumption as a risk factor for gender-based violence and for the sexual transmitted illnesses confirms that alcohol consumption contributes to the spread of HIV/AIDS. In addition, a study conducted in South Africa indicated that there is a “direct correlation between alcohol consumption and the likelihood of men and women engaging in unprotected casual sex particularly in spaces associated with alcohol consumption such as shebeens or taverns”(Sonke Gender Justice, 2007:6).

Similarly, the respondent in the study also expressed how alcohol facilitates unprotected sex as the participant expresses the following:

“When you are having drinks and then you see a girl that you want, a condom is always the last thing you think of as it kills the mood”

The use of alcohol in most cases results in unprotected sexual intercourse and puts the respondent at risk of infectious diseases. This engagement in unprotected sexual intercourse exposes the participants to sexually transmitted illness including HIV/AIDS. The following respondent indicates the difficulty of using a condom when he has been consuming alcohol.

“It is difficult to use a condom after you have been drinking. Everything just goes so fast and there is no time to be looking for a condom. Imagine if the girl wants to give it to you and you busy looking for the condom, what if she changes her mind? (laugh). You know things are moving fast” [RM18:17].

As these sexual acts are usually ‘one night stands’ (random sex) it appears that the respondent, as he states above, would not risk missing the opportunity of having sex with the girl that he ‘wants’ because of a condom. The following respondent confirms his peer's statement about condom use under the influence of alcohol:

“When you are having a good time and you find a girl. You don’t think about a condom. Sex is not the same too with the condom. It’s better to go *skoon* (sex without a condom) (laugh) [RM9:20]”

In Courtenay (1998) study, he reports that among college students in the USA, men have an earlier age of initiation into sexual practice and are in excess of 10 sexual partners. They are also more likely to have sex under the influence of alcohol or drugs. Similarly, Vitellone (2000) findings indicate that only 1/3 of sexually active American college men use condoms. The use of alcohol and unprotected sexual intercourse came out strongly in the study and raises concern as that particular informal settlement has a relatively high HIV/AIDS prevalence.

After touching on factors such as financial implication for health seeking, geography, knowledge and education of participants amongst others, the following section looks at the shift from the dominant masculine discourse of being the provider and showing no fear and weakness to that of fear of the “unknown”.

#### **4.11 Notion of fear verses the notion of masculinity**

The participants indicated that they fear visiting health care facilities as they are unaware of what the cause of illness could be. This fear indicates a rather unique and new dynamic to the commonly known dominant masculine discourse which is socially constructed and adhered to by men.

The question is, has HIV/AIDS become the greatest barrier to the already concerning health seeking behaviour amongst males? It is evidence from the study that, particularly young males, fear seeking health care as they fear the “unknown”. The unknown in this case is the cause of illness (the disease). This fear has been largely associated with the high HIV/AIDS prevalence in their societies. The participants feared that they could have been exposed to HIV/AIDS during their unprotected sexual intercourse. Most studies indicate that males are less likely to utilise health care due to their masculine identity. The study uncovered that the fear which is attributed to knowing one's HIV status is associated with the notion that a sick body is weak and knowledge of disease will threaten the core ideology of masculinity. The feeling of hopelessness and weakness will dent one's status in the society as they will no longer be able to perform male duties due to ill health or be viewed as ‘the man’ in society. Men highlighted that illness was associated with loss of independence and the invasion of privacy due to being provided care.

The fear of visiting health care facilities was also associated with the HIV/AIDS stigma amongst their community. Males in this study asserted that it is difficult for them to seek health care as they would be perceived as being HIV positive or having AIDS if they

regularly visited the health care centre. This potentially threatens masculinity as respondent [R2:18] states:

“I do not like going to the clinic because people will start asking questions and saying what is wrong with Sam maybe he has *Iqhoks* (township slang for HIV/AIDS). People can talk and they see”.

It is evident in the study that the stigmatisation of HIV/AIDS has also had a tremendous impact on health seeking amongst young men. The fear of friends and community members knowing that one is frequently visiting the clinic appears to be associated with being HIV positive or fully blown AIDS. The stigma attached in seeking help associated with STDs also facilitates non usage of health services because of embarrassment and shyness of infected people. Hence, young males fear visiting health care as they may be suspected to be infected with the virus.

In the South African context, there seems to be a major shift from the commonly understood notion of masculinity as it has now been associated with fear of stigmatisation as well as fear of knowing one's HIV status which contradicts the core notion of masculinity of Macho not showing fear or weakness.

The participants indicated that they feared getting tested and knowing their HIV/AIDS status as they would be unable to cope with knowing their status.

The participant below [R4: 20] indicates how he wanted to be circumcised but the fear of knowing his status prohibits him from visiting health providers as the prerequisite of circumcision is an HIV test:

“ I want to go and get circumcised, but the problem is that I have to get an HIV test and I am scared, it's better not knowing because when you know then you get stressed. Even when you are with your friends, you will laugh but you will know that you are not clean”.

The notion of fear came out strongly amongst the research participants as well as the implications on their daily lives after discovery of being infected. Respondent [R25: 30] also confirms this notion of fear and stigmatisation as he further elaborates:

“If I keep going to the clinic, people will start talking and saying uMtee has *iqhoks*”.

He elaborates why he felt people might question his HIV status and also touched on an important element of stigmatisation and privacy in the public health care centres.

“I once went to get my neighbour's ‘medication’ as he was working, but people were asking me what is wrong with me? You know at the clinic there are separate doors for women and children and those coming to get “medication ARVs” so they were asking me are you sick? So I had to show them the clinic card”.

The issue of privacy in public health facilities is a major concern and perpetuates the stigmatisation of people living with HIV/AIDS. The fact that there are distinct rooms for those with HIV/AIDS which separates them from all other health care users further facilitates underutilisation of health care. This separation of patients hinders health screening for HIV and health seeking. The participants strongly felt that seeking health care would raise a number of questions, such as their HIV status and they would also be perceived as weak. This contradicts the common masculinity norm as fear is a sign of weakness.

Most young males expressed their discomfort with seeking health care as they often asked to do a blood test when they visited health care centres as expressed by respondent [R7:27],

“I don’t feel comfortable with going to the clinic because they will want me to do a blood test and I know I have been doing many things, so I’m scared to do a blood test so I avoid going to the clinic”.

Similarly, research conducted by Sonke Gender Justice (2008) reveals that men use voluntary counselling and testing (VCT) services less than women. A recent national study of VCT services found that men accounted for only 21% of all clients receiving VCT (Sonke Gender Justice 2008:3). A study conducted on the uptake of antiretroviral therapy (ART) in Khayelitsha reveals that 70% of those accessing treatment were women, they further state that women accessing ARVs outnumbered men by a ratio of 2 to 1.2 men are also said to be likely to access antiretroviral therapy (ART) later in the disease progression than women, and consequently access care with more compromised immune systems (Sonke Gender Justice 2008:3). Research indicates that “gender discrepancies in ART uptake are not a function of the higher infection rates amongst women” (Sonke Gender Justice 2008:3), but the fact that men do not utilise health care facilities until severity of disease. This leads to the question of whether participants would seek treatment if they discovered that they were HIV positive.

As much as participants were not fond of seeking health care, they indicated that there were circumstances which would force them to go to hospitals after suffering for weeks on end after their illness had become severe. The following section provides an overview of men's experience in health care centres and how this affects health seeking.

#### **4.12 Men's experience in health care centres and how it hinders access to health care facilities**

##### **Nurse attitudes**

There were several challenges which the males indicated to have faced during their interaction with health care providers, including their ill-treatment at the hands of nurses during their consultation which discouraged them from accessing health care. The respondent [R18:27] expresses his view below,

“When you go to the clinic and you have an STI, the nurse will just demand that you show it to her and shout at you. This is a female, and the way she says it you doesn't feel right”.

It appears to be a challenge for males to show their private parts to female nurses and the manner in which the nurses address their patients during consultation is not favourable to these young males.

The issue of privacy during consultation also was indicated as a barrier to health seeking. The participants mentioned that on arrival at the clinic, they would be questioned by the receptionist as to what was wrong with them with all other patients in the waiting room listening. As indicated, participants mostly visited the health care facilities because of sexually transmitted illness. It made them feel uncomfortable to give out this kind of private information in the presence of other health care users. The respondent felt that the health workers were passing judgement on them as they would ask them in a harsh manner why they did not make use of condom. One could argue that this is a logical question for the health workers to ask knowing the HIV/AIDS prevalence in their area, but the manner in which the question is asked plays a major role in determining whether patients seek health if they are ill as well as shapes their perceptions of health workers. They also mentioned that the nurses would be harsh to them and ask them what they wanted from the clinic. One of the participants mentioned that they felt as if the nurses thought they were coming to rob them when they visited the clinic as he states:

“Sometimes when you are still outside the clinic, the nurse will come outside and shout what are you doing here as if *sizobahlukanisa* rob them” (laugh).

Conversely, some of the participants expressed the following

“I do not have problems when I go to the clinic. If you tell the nurse the truth and tell her what your problem is, they understand it, but if you keep hiding from then you have a problem; you need to be open with them”.

He further states,

“When I first had an STI I was scared but once you talk the nurses will help you”

Gathering from the respondent’s positive responses, one could assume that nurses are impatient due to their workload and hence are highly frustrated by patients who are not upfront with them. It is important to note, as stated earlier in the literature review, that men view the clinic as a gendered space hence they need to feel comfortable with sharing private information with a female they perceive as a stranger. Nurses need to be both gender and culturally sensitive. They need to be trained on how to interact with males and need to take into consideration cultural factors such as how to address male patients during their consultation.

#### **4.13 Concluding remarks**

The study demonstrates that there is a pathway to seeking health amongst communities and whether the illness is viewed as a natural or super natural illness. There is an initial stage which is the identification of symptoms and condition. Seeking information and advice was preferably obtained from peers and local elders as they are viewed as having information, experience and are more approachable and trustworthy. As highlighted in the Theoretical framework of this particular study, there are cultural and socio-demographic factors which determine health seeking as found in the study. Health advice given by women plays an important role in the decision to seek health care the service provider. These factors result in delayed treatment seeking. Lack of awareness and knowledge amongst males on their own health also plays a major role in men not accessing health care services.

## CHAPTER FIVE

### CONCLUSION AND DISCUSSION

This study adds to the existing body of knowledge about men's health seeking behaviours and the determinants that affect health seeking. It aims to generate an understanding of how Black or African men, specifically in the South African context of cultural diversity, high unemployment rates, and high levels of inequality, understand their masculine identity and how this impacts on health seeking. The study uncovered that health choices and knowledge of low income men highlighted as the contributing factor to men's underutilisation of health care services. As indicated earlier in this paper, in South Africa the life expectancy for White, Asian, and Coloured males is significantly higher than Black men which is currently the lowest at 52 years of life. This highlights the fact that therefore, there is a greater need to focus on African men's health. The primary objective of this study was therefore to investigate the reasons behind men's underutilisation of health services and how masculinity facilitates underusage of health services. The study sought to answer these questions:

- What are the possible barriers behind men's underutilisation of health services?
- How masculinity facilitate underusage of health services?

The study presents how hegemonic masculinity such as being strong, robust, fearless and its socially constructed ideologies such as drinking, drug use and multiple concurrent partners and sexual behaviour influence health-related behaviours. Their low life expectancy reflects their health seeking behaviours and underutilisation of health care services as it is also proven that the majority of them die from curable illnesses which could have been avoided had there been early detection of symptoms and health seeking. This section will synthesize the empirical findings to answer the study's research question:

What are the possible barriers behind men's underutilisation of health services?

The main empirical findings are summarised within this chapter and reflect how the findings were organised in chapter four.

## **5.1 Men's awareness of their own health**

Men's lack of awareness of their own health proves to be detrimental and highly impacts on health seeking behaviours. All the men in the study had very little information on illness that particularly affects men. For example, urinalysis screening is imperative. It screens for cholesterol, diabetes, and kidney or thyroid dysfunction and colorectal health which is the screening of cancer at treatable stages is not under taken by men. Due to lack of information and knowledge about such screenings, men in the study had never accessed these services. Health screening was not viewed as necessary as visiting health care facilities were for the severely ill. The study uncovered that there is a great need for educating men on their own health and the importance of health screening to avoid preventable deaths. This finding supports the theoretical position of the study which indicates that knowledge translation is imperative in seeking health care.

## **Socio-economic status and geographical location**

Socio-economic status and geographical location are critical determinants of health care utilisation. These factors determine the time frame and the frequency of seeking health care. As the research took place in an informal settlement, the research participants came from low income families. The unemployment rate was significantly high and participants who had part time employment indicated that it was not ideal for them to stay away from work so they could go to the clinic. If they could still walk and work, health seeking was delayed until the illness became severe. In terms of health care affordability, unemployed people are able to access free health care in public health facilities. With this in mind, participants in the study indicated not visiting public health services even though they were free and geographically accessible. The only instance when financial implications came into play was when an individual was severely ill and they could no longer walk or make use of public transportation which is more affordable than hiring a car to take the sick to the hospital as ambulance services are highly unreliable.

## **Health seeking process**

The study uncovered that there are preferred health seeking processes which the respondents indicated to follow, including peer consultation, traditional healers and religious methods of healing. The study uncovered that before the participants sought health care in clinics, they



would first consult peer, traditional healers or make use of religious methods to cure various ailments. The concern with this pre-consultation phase is that it delays health seeking from clinics in the case where traditional medicines and spiritual methods are unable to assist. Another concern is that in the case where participants are infected by HIV/AIDS, they delayed seeking health care while they tried other methods. This delays early diagnosis and initiating their ARV uptake and could potentially spread the virus. Men in the study indicated that they would first explore their own remedies with the attempt to provide self-cure. The preferred methods raise concern as they facilitate delayed health seeking and may result in preventable deaths. The notion of consulting peers with the aim of providing self-help is strongly tied with masculinity. The theoretical framework utilized in the study also confirms that cultural factors do indeed play a role in health seeking amongst males.

### **How masculinity facilitates under usage of health services.**

How men define manhood, health as well as their view on health proves to be detrimental to their health. Men in the study defined being a man as being a provider. Manhood was understood as the ability for one to solve their own problems which also spans to health related problems. The definition of a man as being strong and not showing weakness also influenced men's underutilisation of health services. The socialisation of men as strong and fearless as well as their provider role impacts health seeking.

### **Men's attitudes towards health promotion**

Health promotion efforts are crucial in order to improve and promote health seeking. Men generally appreciated health promotion efforts and the only challenge they expressed was adherence to these health promotion campaigns. Men in the study displayed some masculine traits as they expressed drinking and smoking excessively, including cannabis. The participants in the study indicated not using protection when they engaged in sexual activities and the use of alcohol was also associated with engaging in unprotected sexual intercourse. Some of the participants indicated having more than one sexual partner. The issue of multiple and concurrent partners and unprotected sexual intercourse came out strongly in the study. There is a great need to dismantle masculine identities which impact negatively on men's health as well as to change societal understanding and interpretation of manhood as this

impacts men's perception of manhood and their daily lived lives. This confirms the dominant masculine discourse and the societal understanding of manhood in relation to masculinity.

### **Notion of fear verses the notion of masculinity**

Contrary to the norm of men being viewed as strong and fearless, the era of HIV/AIDS has unveiled new forms of masculinity and there has been a shift towards fear. Males in the study indicated that they feared visiting health care centres for fear of finding out they were unwell. As the participants indicated that they had engaged in unprotected sexual intercourse, they also feared knowing their HIV status. This is due to the fact that their neighbourhood had significantly high HIV/AIDS statistics. They feared being ill, as illness is associated with weakness and powerlessness. The perception on illness was that when one is sick they are unable to take care of themselves, which contradicts the dominant masculine discourse of being the provider and a problem solver. The association of illness with weakness is also an indication of why men delay health seeking until the illness becomes severe.

### **Men's experience in health care centres and how it hinders access to health care facilities.**

Men's experiences in the public health facilities also proved to be a barrier for future use of public health care facilities. The lack of privacy and the nurse's attitudes were reported as one of the reasons for men not visiting health care services. They expressed their dissatisfaction with the services provided. There also seem to be cultural barriers which hinder health seeking, and men expect to be treated in a certain culturally acceptable manner. The way in which they are addressed in health care centres made them feel disrespected and they felt as though they were being judged by the health workers. The tone used by the nurses to address them is undesirable and hence results in them not wanting to visit the health care centres. Culturally there are certain health topics which men cannot discuss with women, but this is not possible in the health facilities as most of the staff members are female.

The clinic setting does not cater for men and one could attribute this to the lack of knowledge and awareness about men's health. The clinic should create a conducive environment where men are able to share their health related problems and medical practitioners should be trained to be culturally sensitive when mostly dealing with African men. Cultural sensitivity includes how the professionals address their male patients and the issue of privacy and

confidentiality. There is a need for cultural sensitivity regarding health seeking. How the health service providers interact with males and whether they meet the expectations of how men feel they should be treated, has a profound impact on men's health care utilisation. It is puzzling though, to find this cultural difference as most health workers are African women who are aware of the cultural dynamics and subscribe to African cultural values and norms. One could assume that when these health workers are at their work place, they no longer feel they should adhere to the African cultural norms. It is imperative for providers to be aware of the needs of their stakeholders to ensure adequate use of health care services. Service providers should be aware of the cultural norms, values, and should be culturally sensitive to the traditions of the society they serve. This is essential in order to provide health services that are accepted and utilized by men.

In conclusion, there needs to be a change in attitudes by health providers in order to be able to provide a good service to the communities they serve. There needs to be good communication between the service providers and the recipients of medical care. The manner in which this information is channelled is vital in order to ensure a user friendly environment. Information dissemination and education campaigns on men's health will enable men to be active participants in health care and will empower them to achieve good and sustainable health outcomes. There is also a greater need to educate communities on men's health and the fact that men should not be viewed as super beings who never show weakness.

This study looked at the health seeking behaviours of men through the lens of the health, illness, men and masculinity framework. The framework is about masculinity and socio-demographic factors which affect health seeking and health related behaviours among men of different age groups. The framework aims to link masculinity and demographic factors to men's health seeking and health related behaviours. The framework highlights that there are unexplored health disparities among men, which are associated with age, employment, education, socio-economic status, ethnicity and sexuality. In addition to the factors highlighted by the framework, the study uncovered dynamics such as the notion of fear of the "unknown", which is largely attributed to the stigmatisation of HIV/AIDS. The study also uncovered that religion plays a major role in health seeking which has not been highlighted in the theoretical framework.

## **Concluding remarks**

Masculinity, coupled with socio-economic, demographic and cultural factors prove to be detrimental to men's health and affects their decision to seek health care. The findings of this study support the theoretical framework used in the study and indicates that masculinity plays a fundamental role in men's underutilisation of health care. The framework also states that one's socio-economic background, demographic factors as well as their culture indeed play a fundamental role in health seeking. To ensure appropriate health care services utilisation by men in the developing country context, there needs to be policy advocacy focused on improving men's health. Most attention has been placed on the health of women and children and not many efforts have been put on men's health. There needs to be a focus on health education, to educate men as well as communities on the importance of health seeking. As most African societies are largely traditional, with community norms and culture, this usually results in health care from clinics being viewed as contrary to traditional methods. Currently, the use of primary health care is viewed as opposing traditional medicine. There needs to be collaboration between what is viewed as "western medicine" and "traditional medicine", as both methods seek to improve the health status of societies. There need to training that is provided to both "western medical practitioners" and "traditional medical practitioners" on how they can collaborate to improve health care utilisation. Collaboration and educating communities could result in transforming and improving men's health care utilisation.

## **Recommendations**

Advocacy campaigns, lobbying for a policy shift which focuses on men's health is of paramount importance. It is important to implement programmes that focus on improving men's health care through health promotion campaigns and campaigns that focus on disease. There need to be programmes which focus on behavioural change and shift from masculine identities which facilitate negative health behaviours and outcomes. Policy makers need to take into consideration social determinants influencing health not only just medical research.

There is a need for qualitative research which considers social and personal factors as well as cultural factors which affect health seeking. There is a need for more scrupulous research focusing on how societal understanding of masculinity can be reconstructed in a manner that is not detrimental to men's health and wellbeing. More research should focus on how western health methods could be collaborated with traditional methods to improve health care.

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## Appendices I

### Interviewer Guide

#### Demographic Characteristics

##### Gender

- Male

##### Age Group

- (15-39),
- (40-70)
- (75+.)

##### Marital status

- Married
- Divorced
- Widow
- Widower
- Never been married

##### Race

- African

##### Level of education obtained:

- Never attended school or only attended kindergarten
- Primary school
- Secondary School
- Some college of technical school
- College graduate

##### Employment Status

Are you currently:

- Employed



- Self-employed
- Unemployed
- Retired
- Unable to work

**What is your main source of income?**

**Current Place of residence**

- Township
- Informal settlements
- Place where you lived most of your time as a child?

**Manhood and Health**

1. What do you think it means to be a man?
2. What would you consider to be a healthy man?
3. What is your understanding of illness?
4. What are things you consider before you seek help when you are not feeling completely healthy?
  - a. Probe: what do other men your age consider?
5. Do you think women make different decisions about when to seek health care? How?
6. Where do you usually seek help when you are not feeling completely healthy?
  - a. Probe: where do you think other men your age seek help?
7. When and how often do you use health care services such as doctors and clinics? How accessible are these health care services?
8. How would you describe your relationship with health care providers?
9. What are the possible barriers to health seeking for men?
10. How can these barriers be eradicated?
11. Do you think it's important to encourage men to seek health care?
12. What do you think should be the role of the health provider towards improving men's health seeking behaviours?

## Health promoting activities for men

1. Is health promotion such as condom usage, screening for cancer, AIDS prevention, TB screening and other illnesses important or not for men? Why?
2. Do you exercise regularly? Why / why not?
3. Why do you think men are encouraged to stop smoking and / or limit their alcohol intake?
  1. How seriously do you take this advice? Why? Why not?
  2. How seriously do you think men your age take this advice? Why? Why not?
  3. When last did you have your blood pressure, your cholesterol, your blood sugar tested? Why .Why not?
  4. Under what conditions would you seek help if you were depressed?
  5. What effect does stress have on men's health? What do you do to deal with stress?
  6. Would you say men your age are more likely than women your age to take risks, be more likely to have an accident? Why?

Older participants: when last was your prostate checked? Your eyes checked?

Older men: do you have a chronic condition? Do you go for regular checkups? How do you manage your condition? How do other men your age manage their condition? Why?

## Health promotion activities

Diet and exercise
Sufficient sleep
Smoking, alcohol and drugs
Driving safety
Accidents and risk taking
Occupational health & safety procedures
Testicular self-examination
Condom use
Dentist visits
Mental health / depression
Stress

## Health screening

<b>Physical Exam</b>	Reviews overall health status, perform a thorough physical exam.
<b>Blood Pressure</b>	High blood pressure (hypertension) has no symptoms, but can cause permanent damage to body organs.
<b>TB Skin Test</b>	Test used to determine if someone has developed an immune response to the bacterium that causes tuberculosis. Should be done on occasion of exposure or suggestive symptoms at direction of physician. Some occupations may require more frequent testing for public health indications.
<b>Blood Tests &amp; Urinalysis</b>	Screens for various illnesses and diseases (such as cholesterol, diabetes, kidney or thyroid dysfunction) before symptoms occur.

<b>EKG</b>	Electrocardiogram screens for heart abnormalities.
<b>Tetanus Booster</b>	Prevents lockjaw.
<b>Rectal Exam</b>	Screens for hemorrhoids, lower rectal problems, colon and prostate cancer.
<b>PSA Blood Test</b>	Prostate Specific Antigen (PSA) is produced by the prostate. Levels rise when there is an abnormality such as an infection, enlargement or cancer.
<b>Hemoccult</b>	Screens the stool for microscopic amounts of blood that can be the first indication of polyps or colon cancer.
<b>Colorectal Health</b>	A flexible scope examines the rectum, sigmoid and descending colon for cancer at its earliest and treatable stages. It also detects polyps, which are beginning growths that can progress to cancer if not found early.
<b>Chest X-Ray</b>	Should be considered in smokers over the age of 45. The usefulness of this test on a yearly basis is debatable due to poor cure rates of lung cancer.
<b>Bone Health</b>	Bone mineral density test.
<b>Testosterone Screening</b>	Low testosterone symptoms include low sex drive, erectile dysfunction, fatigue and

	depression. Initial screening for symptoms with a questionnaire followed by a simple blood test.
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Source: [www.menshealthnetwork.org](http://www.menshealthnetwork.org)

## Appendix II: Informed Consent

(to be read out by researcher before the beginning of the interview. one copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

My name is (Mbali) NtokozoNzama (student number 207526239). I am doing research on Men's health seeking behaviours and the factors that facilitate or hinder men's access to primary health care in uMlazi W section Durban, KwaZulu Natal

This project is supervised by Dr Kerry Vermaak in the School of Development Studies, University of KwaZulu-Natal, in Durban, South Africa.

Should you have any questions or concerns my contact details are:

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Cell no: 072 599 8344

Email address: 207526239@stu.ukzn.ac.za or ntokozo.nzama1@gmail.com

Thank you for agreeing to take part in the project. Before we start I would like to emphasize that:

- Your participation is entirely voluntary;
- You are free to refuse to answer any question;
- You are free to withdraw at any time.

All interviews will be recorded. The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report. Do you give your consent for: (please tick one of the options below)

Your name, position, and organisation, or

Your position and organisation, or

Your organisation or type of organisation (please specify), or

None of the above

Please sign this form to show that I have read the contents to you.

----- (signed) ----- (date)

----- (print name)

Write your address below if you wish to receive a copy of the research report: