



'You are not yourself': Exploring masculinities among heterosexual African men living with HIV in London[☆]

Lesley Doyal^{a,*}, Jane Anderson^b, Sara Papparini^b

^a School for Policy Studies, University of Bristol, 8 Priory Road, Bristol BS8 1TN, UK

^b Centre for the Study of Sexual Health, Homerton Hospital, London, UK

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ABSTRACT

It is now clear that gender is an essential factor shaping the narratives of men as well as women. However, there have been few studies of the daily lives or sexual activities of heterosexual men. Hence, strategies developed to prevent the spread of the HIV virus are rarely based on detailed knowledge of the men whose behaviours they are intended to change; this is especially evident in the developing world where the epidemic is most severe. Nor do we know very much about those men who have already been diagnosed as HIV positive. Around 13 million men are now living with HIV of whom around 96% are in low or middle income countries. Migrants from developing countries also make up the majority of positive people in a number of developed countries. In the UK, for example, heterosexual activity is now responsible for about half of all new HIV diagnoses with the majority of those involved being of African origin. But almost nothing is known about the ways in which different constructions of masculinity affect their experiences of illness. This study used qualitative methods to explore the experiences of a sample of black African men who defined themselves as heterosexual and were receiving treatment for HIV and/or AIDS in London. It explored their feelings, their needs, their hopes and their desires as they negotiated their lives in the diaspora.

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Introduction: masculinities in a global context

The last few years have witnessed a growing recognition that gender shapes the narratives of men just as it does those of women. Much has been written about the social and cultural

construction of masculinity (Connell, 1995; Segal, 1990; Whitehead, 2002). But there are still few detailed studies of the daily lives of heterosexual men. Instead, they are sketched in as shadowy background figures against which women's lives are painted in much greater detail.

This is especially true in the context of their sex lives. The emergence of the HIV epidemic has brought the diversity of sexual identities and sexual practices into the open for the first time. However, most researchers working in this area have concentrated either on women or on gay/bisexual men. The sexual activities of those men who identify as heterosexual have been much less visible especially if they live in developing countries where the pandemic is most severe (Bowleg, 2004).

It is the 'feminisation' of the epidemic which has understandably drawn greater attention to the activities of women in heterosexual relationships, and to the implications this has for their vulnerability to HIV. This is especially true in Africa where heterosexual men appear in the literature mainly as the dominant partners in sexual relationships where their desires pose risks that women are often unable to avoid (Barker & Ricardo, 2005; Baylies & Bujra, 2000). Thus they are usually represented as conforming to the stereotype of what has been called the 'hegemonic' model of

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* Corresponding author. Tel./fax: +442076380232.

E-mail address: L.Doyal@bristol.ac.uk (L. Doyal).

masculinity (Connell, 1995). But few empirical studies have explored the sexual subjectivities of heterosexual men and their related activities across a range of African (or other) settings (Silberschmidt, 2005).

Gay and/or bisexual men on the other hand have received a great deal of attention in the HIV literature. This reflects in part the history of the epidemic itself with the virus first identified among gay men in the United States while sex between men is now the major mode of HIV transmission in Latin America. It also reflects the high levels of politicisation within gay/bisexual communities themselves. The emergence of new paradigms, particularly 'queer theory' and deconstructionist approaches to gender studies, have also contributed to this interest in sexual identities and practices among those who define themselves as gay/bisexual. But again it has generated little direct interest in the sexual lives (or the health) of heterosexual men (Campbell, 2004; Kaler, 2004; Robertson, 2007; Sorrell & Raffaelli, 2005).

Paradoxically, one of the main assumptions behind HIV policies in many parts of the world is that heterosexual practices play a major role in the spread of the virus. However, few preventive strategies are based on detailed or context-specific knowledge of those men whose behaviour they are intended to change. Again, this is especially true in parts of the world such as sub-Saharan Africa where the epidemic is at its most severe.

Even less is known about those men who have already been diagnosed as positive (Schlitz & Sandfort, 2000). Current estimates suggest that worldwide some 13 million men are HIV positive, of whom around 96% live in low or middle income countries. Most of these are assumed to be behaviourally heterosexual (Doyal, Papparini, & Anderson, 2008). Similar patterns are evident in some developed countries with large migrant populations. In the UK, for example, heterosex now accounts for more than half the new HIV diagnoses with a majority of these being between people of African origin (UK Collaborative Group for HIV and STI Surveillance, 2007). Yet we know almost nothing about how these positive men live with HIV or die with AIDS and this constitutes a significant obstacle to the development of appropriate treatment and care policies.

The study presented here represents one of the first attempts to fill this knowledge gap. It describes the experiences of a sample of black African migrants from a number of different countries who were receiving health care for HIV in London. It examines aspects of work and parenthood as well as access to health care and other sources of support. The study differs from most existing research in that it was not focussed on the men's roles as the partners of women. Rather, it was directly concerned with their own experiences of illness and how this was linked to their sense of themselves as men. It explored their subjectivities, their needs, their hopes and their desires as they negotiated their lives in a diasporic context.

The men in the study were all migrants living outside their 'home' communities. Their physical and psychological health was already compromised to varying degrees and they were living with a diagnosis that would inevitably affect the rest of their lives. Not surprisingly, these realities had major impacts not only on their own perceptions of themselves as 'men' but also on the perceptions of the people around them. Hence, the study highlighted the fluidity of different masculinities and the ways in which they are shaped by changes in cultural and material circumstances and in bodily changes.

Research methodology

For the purposes of this study, the participants were identified as 'African men' and indeed most of the participants referred to

themselves in these terms at some point in their interview. But of course, this broad categorisation conceals diversity in characteristics such as countries of origin, ethnicity, religion, and immigration status (Aspinall & Chinouya, 2008). All of these differences could not be reflected in a study of this kind. However, the sample was chosen to reflect the country of birth of the wider group of African men receiving care in the London hospitals where the research was based. Hence, the findings can be assumed to be broadly representative of this group at least. The protocol was approved by the relevant ethics committee and all participants were fully briefed and great care was taken to obtain their informed consent.

The total sample consisted of 46 men, all of whom were over 18, had been born in Africa, diagnosed HIV positive for at least six months and lived in the UK for at least six months. They came from 12 different African countries with about half from either Zimbabwe or Uganda. The participants were recruited by one of two routes: either as patients in a specialist hospital unit providing clinical HIV services (37) or through their involvement with a support group: Organisation for Positive African Men (OPAM). Data collection began with a focus group of men from OPAM in order to clarify topics and develop emergent themes. Semi-structured interviews were then undertaken in which the men were asked about their experiences of HIV in the broader context of their life history and their current circumstances. The interviews were carried out between January and December 2004 (for further details of methods see Doyal, Anderson, & Apenteng, 2005).

Findings from the study: an overview

Twenty-six of the men were married or living as married and 38 had children but only 15 were living with them. Eight were working full time and ten part time with eleven undertaking some form of study, and the rest volunteering or not working. Twenty-eight had at least secondary level education while fifteen had either university level or post-graduate qualifications. This made them considerably better educated than the UK population in general.

The participants showed a wide range of responses to their illness and to the constraints that it placed on their lives. Some were currently able to carry on much as they had before but most had already been forced to rethink some of the most fundamental aspects of their lives. Illness itself was something that many found difficult to accept and the weakness and loss of capacity often associated with HIV was felt to be 'unmanly'. Many were socially isolated. While they had previously been part of a dense network of family and community, they were now more likely to be alone. Only about half were in relationships with women, many were childless and those with children were often living apart from them. Work was seen as central to a man's identity but few had full time jobs. Hence, they did not easily fulfil the expectations of adult manhood that are held in most African cultures (Barker & Ricardo, 2005; Lindsay & Miescher, 2003; Morrell, 2001; Sideris, 2005).

Beginning the journey with HIV: diagnosis and disclosure

Because they were in the UK, the men in this study had more opportunities than their countrymen 'back home' to be tested for HIV. But they did not take them up. None were diagnosed as a result of routine testing and some were only tested after their partners had already been diagnosed. Some reported that it was women in their lives who encouraged them to go. Most were already experiencing symptoms before they consulted a doctor.

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