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The Persistent Health Burden: Understanding Black South African Working-Class Men's Experiences of Living with Tuberculosis

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A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements of degree of Doctor of Philosophy (Health Sociology)

March 2024

Declaration

I declare that this thesis is my own unaided work. The thesis is submitted to the University of the Witwatersrand, Johannesburg, for a Doctor of Philosophy Degree. At no other university or institution has this thesis been submitted as a requirement for a degree or any other qualification.

Signature



4th day of March 2024

Abstract

This study is the culmination of ethnographic fieldwork on black working-class men's tuberculosis (TB) illness experiences, conducted during 2020 and 2021 in Modimolle Township, a non-mining, peri-urban community of South Africa's Limpopo province. The study examines ways men construct masculine identities and how this provides a lens through which to understand their health-seeking behaviours when beset with TB suggestive symptoms. Men's construction of masculine identities further helps shed light on their tuberculosis illness experiences and treatment outcomes. Tuberculosis scholarship in South Africa has justifiably focused on the impact of silicosis on men, and the subsequent oscillating labour migration as pathways through which the disease is contracted and transmitted to non-mining communities of the country and the southern African region. Men's experiences with tuberculosis disease in non-mining communities have however received little attention in South Africa's extensive tuberculosis research. Drawing from the African-centred theories of masculinity is a conceptualisation of men that I call masculinity in sociability. This thesis of masculinity in sociability manifests when men gather in spaces and engage in social behaviours and practices such as sharing cigarettes and beer within proximity of each other. I demonstrate that masculinity in sociability is informed by the socio-cultural values of *seriti* (dignity, integrity, and respect), *maitshwaro* (manners and conduct), and *botho* (humanness, *ubuntu*, the sum of human values), which engender a sense of belonging and community among men in specific masculinised spaces. I argue that masculinity in sociability illuminates the crucial and intricate interplay between masculinised, enclosed physical spaces and shared air as possible ways tuberculosis is contracted and transmitted among men. Considering that masculinity in practices of sociability is predominantly performed in masculinised spaces, I further argue that its manifestation concomitantly recedes when men experience TB illness in the private sphere of the home. The thesis demonstrates that men's exposure, infection, diagnosis, and response to tuberculosis treatment are influenced by their masculinity. In contrast to the public performances of masculinity for the purposes of sociability, the vulnerabilities brought about by tuberculosis create a significant disruption in individuals' life stories. This disruption is evident in men's experiences of losing their sources of income and becoming dependent on the care provided by mothers and spouses, which can be experienced by men as a return to a more childlike state. From health through to the continuum of TB diagnosis and illness experience, the thesis shows that masculinity exhibits a remarkable flexibility and adaptability. The thesis contributes to our understanding of masculinities by offering a condensed perspective on how

economically marginalised black men perceive and undergo the challenges of tuberculosis. Using metaphors, men depict TB as a debilitating and insidious illness condition which unmasks their vulnerability.

Keywords: Modimolle, tuberculosis, African centred theories of masculinity, masculinity in sociability, illness experiences.

Dedication

To the memory of my grandmother, Kokwani n'wa Ben (Notisa Elizabeth Madhuha) (1933-2021).

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Table of Contents

The Persistent Health Burden: Understanding Black South African Working-Class Men's Experiences of Living with Tuberculosis i

Declaration ii

Abstract iii

Dedication v

Acknowledgements vi

Table of Contents viii

List of Photos xii

List of Acronyms xiii

Chapter One 1

Bringing marginality to the centre of health research: tuberculosis and masculinities in South Africa 1

Introduction 1

Who said TB is not social? Foregrounding South Africa's TB burden within the global context 3

The research problem 8

The research argument and question 9

Thesis presentation 12

Chapter Two 15

An appraisal of knowledge contours on the social interpretation of tuberculosis 15

Introduction 15

Spotlighting conditions for TB infection and disease progression 16

Unpacking the social determinants of tuberculosis 21

The socio-political configuration of tuberculosis in South Africa 24

Tuberculosis and health inequalities in the democratic period 28

Does race matter in South Africa's research on tuberculosis? 31

Impact of social class on health and tuberculosis 34

The implication of structure/agency on healthcare access 36

Why gender matters in tuberculosis analysis 39

Conclusions 41

Chapter Three 44

Theoretical and conceptual linkages: Building on and towards African-centred theories of masculinity. 44

Introduction 44
Conceptualising gender 45
A brief review of masculinity theories 48
Not one but plural masculinities 50
Masculinities in Africa 54
Learning with and from African-centred theories of masculinity 58
Why African-centred theories of masculinity? 62
Men's health decisions in the context of medical pluralism 65
Sifting through the nomenclature of tuberculosis illness 69
Tapping into metaphors to explain TB illness experiences 74
Embracing African-centred theories of masculinities: concluding remarks 77
Chapter Four 80
Navigating the research site and conducting ethnography in the context of COVID-19 80
Introduction 80
Why ethnographic research design? 81
Research Approach 84
Unveiling the context: A glimpse into the research setting 85
Delving into the details of sampling, research population, and sample size 86
Sampling techniques and the processes of recruiting research participants 89
Negotiating access and traversing the research site in the context of COVID-19 pandemic 90
Employing participant and non-participant observation in fieldwork 95
Up-close with research participants: the interviewing technique 101
Formal ethical clearance processes 105
Navigating TB concerns: Reflections with research assistants and personal apprehensions 107
Conclusion 111
Chapter Five 112
Pathways of tuberculosis transmission: Exploring work environments and sociability among men 112
Introduction 112
What is a man? (*Monna ke eng?*) – Contextualising masculinity identity 114
The implication of living and working conditions on TB infections 125
Spaces of entertainment and the practices thereof as sites of TB infection 137

Concluding remarks 150
Chapter Six 153
The night side of life: Illness experiences and masculinity identities 153
Introduction 153
Tuberculosis gnaws at you (*Bolwetsi bja TB bja go kokona*) – men's experiences of the disease 154
Masculinities and the disclosure of illness 164
"My head was sinking into my shoulders…": TB Illness experiences and biographical disruption 169
The breadwinner role and TB illness 178
Social support amid TB-related infantilisation 183
Concluding remarks on men's illness experiences 191
Chapter Seven 193
TB diagnosis process in the context of medical pluralism 193
Introduction 193
Analysing tuberculosis illness in the context of medical pluralism 194
TB illness vis-à-vis cultural and religious belief systems 200
Men's health-seeking behaviours in relation to tuberculosis 209
Tuberculosis-suggestive symptoms and the challenges of diagnosis 218
Conclusion 225
Chapter Eight 227
Journey towards recovery and post-recovery from TB: Men's experiential reflections 227
Introduction 227
Health is an individual responsibility – it is about taking care of oneself 228
The 'soldiers of my body were weak' – syndemics and TB among men 234
The role of the state in TB management 244
Men's perceptions and experiences of the healthcare system 254
Traversing the recovery road: a concluding note 262
Chapter Nine 264
Conclusions on masculinity, TB diagnosis and illness 264
The conditions precipitating TB infection among men 265
Identity beliefs, men's health-seeking behaviours and illness experiences 267
TB diagnosis and medical pluralism 268

Men's perceptions and experiences of healthcare services.....269
Policy recommendations.....270
Appreciating the cultural and religious beliefs of the community 270
Re-engaging the community with health awareness campaigns.....271
Employing men as healthcare workers 271
Reconfiguring spaces of entertainment.....271
Social support structures.....272
National Health Insurance.....272
Limitations.....273
Conclusion and suggestions for further research 274
Reference list 277
APPENDICES.....312
Appendix One: Participant Profile.....312
Appendix Two: **Participant Information Sheet**.....324
Appendix Three: Informed consent 326
Appendix Four: Informed Consent for Audio Recording.....327
Appendix Five: Wits Ethics Clearance Certificate 328
Appendix Six: Limpopo Department of Health Permission Letter 329

List of Photos

Photo 1: A group of men playing dice and socialising outside a shebeen.

Photo 2: Men and women at a shebeen.

Photo 3: Drimia elata/Hyacinthaceae (locally known as *sekanama*)

Photo 4: Helichrysum caespititium (locally known as *mmetse*)

List of Acronyms

ART –	Antiretroviral therapy
ATM –	African Traditional Medicines
BRICS –	Brazil, Russia, India, China and South Africa
CHWs –	Community Health Workers
CHM –	Commercial Herbal Medicines
CSM –	Critical Studies on Men
DoH –	Department of Health
DOTs –	Directly Observed Treatment Short-course
FGDs –	Focus Group Discussions
GNP –	Gross National Product
HAST –	HIV/AIDS, STI's and Tuberculosis
LTBI –	Latent tuberculosis infection
MDR-TB –	Multidrug-resistant tuberculosis
M.TB –	Mycobacterium tuberculosis
NHRD –	National Health Research Database
PLWHA –	People Living with HIV/AIDS
PLHIV –	People Living with HIV
RDP –	Reconstruction and Development Programme
SASSA –	South African Social Security Agency
SDH –	Social Determinants of Health
SRD –	Social Relief of Distress
TCAM –	Traditional, Complementary and Alternative Medicine
TLB –	Tractor Loader Backhoe
TB –	Tuberculosis
TREATS	Tuberculosis Reduction through Expanded Antiretroviral Treatment and Screening for Active TB

TVET – Technical and Vocational Education and Training College

WHO – World Health Organisation

Chapter One

Bringing marginality to the centre of health research: tuberculosis and masculinities in South Africa

Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick (Sontag & Broun, 1977, p.3).

Introduction

My close encounter with tuberculosis (TB) was in 2011 in the wake of my brother's diagnosis. My brother led a campus-based religious organisation while he was a student at a university in Zimbabwe. Despite experiencing TB suggestive symptoms on campus, like unexplained weight loss and incessant coughing, he did not communicate these to anyone nor sought on-campus health services. Instead, he went out on a religious outreach for three weeks during the semester break. He however could not complete the outreach with the others because of ill-health. He was forced to return home prematurely to the presence of my wife and infant child. With persuasion, he agreed to check in at a local hospital where he was diagnosed with *Mycobacterium tuberculosis (MTB)* and was immediately initiated on treatment. For fear of household contagiousness which would have meant TB infection for my wife and child, I quickly arranged for my brother to come to Modimolle in South Africa where I was going to take care of him. My wife, her pregnant friend and our child underwent TB screening as a precautionary measure at the local hospital. My brother survived the disease and successfully completed his studies. A study on patient-centred care for tuberculosis in South Africa by Furin, Loveday, Hlangu, Dickson-Hall, le Roux, Nicol and Cox (2020) confirms that the socioeconomic, emotional, and social support provided to TB sufferers came from family members and almost always from females.

My positionality is interwoven into this research on men and their illness experiences of tuberculosis, with a set of questions arising in connection with the illness experiences of my brother: What were the conditions precipitating TB infection in my brother? Instead of being forced to return home due to ill-health, why did he not seek healthcare on campus? Why did he choose not to inform us or his friends about his on-campus condition? Despite TB suggestive symptoms, what prompted him to go on a religious outreach? Importantly, as a young man at

university, how did he experience and respond to symptom onset, tuberculosis diagnosis, and treatment processes? These are some of the questions that stimulated my interest as I pursued this study on men and tuberculosis. At the heart of this research interest was the need to understand the meanings, fears, and attitudes men had about living with the disease. The study sought to appreciate men's vulnerabilities resulting from their lived illness experiences of TB, a pursuit that is worth sharing.

A brief background of my familiarity with Modimolle deserves to be mentioned. As a migrant from Zimbabwe, I settled in Modimolle in the South African province of Limpopo in 2005. Throughout my stay in the area, I inadvertently and personally identified as an insider. Part of my integration process in the community included establishing a small business for my family's upkeep. In Modimolle, I learned the local Sepedi language, culture, and some of the customs of the area. These rich resources later helped me in the decision-making processes regarding a research site for my postgraduate studies. Modimolle local municipality comprises peri-urban informal settlements and a township. Due to its economic marginalisation, indoor pollution through high usage of firewood for cooking and heating is reported in the area and this is a risk factor for tuberculosis infection (Waterberg District Municipality Integrated Development Plan, 2017/2018, p.82). Modimolle is a peri-urban area with a high concentration of farming activities.

Intertwined with my positionality in relation to the tuberculosis disease, this study builds on master's-level research that I completed on the health-seeking behaviours of men in Modimolle (Madhuha, 2017). In the master's study, participants subscribed to a context-specific masculinity which I termed responsible masculinity (*maikarabelo* – Northern Sotho/Sepedi). This kind of masculinity transcended ethnicity and it enabled men not only to be providers to their families but to proactively take care of their health through different activities like the use of enemas and traditional medicines, as well as regular visits to healthcare providers (public and private). The interconnectedness between my master's research and my experiences of living with a tuberculosis-infected family member partially spurred me to undertake a research study of black working-class men's experiences of living with tuberculosis in a peri-urban setting of Modimolle. The mentioned factors, including the global burden of tuberculosis and its disproportionate effects on men, form a research puzzle that warrants investigation. Combining all the above issues, my research concerns masculinities, and their relationship to health. For clarity, the term "black South African" as used in this research study is borrowed

from Mayosi and Benatar (2014, p.1344) to refer to indigenous persons speaking an African language.

It is also worth mentioning that this research occurred in the context of COVID-19. Particularly, my fieldwork commenced in 2020 and continued through to 2021, the period in which COVID-19 struck the globe and affected life. As with many researchers, the emergence of COVID-19 affected my research in many ways. Primarily, I delayed fieldwork because of the state-imposed lockdowns and the personal fears that my participants and I had about the risks of COVID-19 infection. The context of COVID-19 highlighted the vulnerabilities of humanity at large and it precipitated the unprecedented pooling of resources in the production of vaccines. It also negatively affected access to healthcare services by some of my participants diagnosed with TB. For instance, in the research setting of Modimolle, a multi-drug resistant TB (MDR-TB) hospital was converted into a COVID-19 holding centre for Limpopo province, meaning MDR-TB patients were sent back to their homes where they started collecting their medication from local clinics. Before COVID-19, Modimolle MDR-TB hospital admitted people with MDR-TB, ensuring proper management of the disease for positive health outcomes. The conversion of the MDR-TB hospital into a COVID-19 holding centre disrupted TB service delivery. This broader framework is my entry point to the research on tuberculosis and men in South Africa.

Who said TB is not social? Foregrounding South Africa's TB burden within the global context

Tuberculosis is a communicable infectious disease contracted through the inhalation of airborne droplets containing tubercle bacilli released by persons with active TB (Barberisi Bragazzi, Galluzzo & Martini, 2017; Mishra & Surolia, 2018; Packard, 1989; WHO, 2021). Primarily, the disease affects the lungs in the instances of pulmonary tuberculosis, yet extrapulmonary tuberculosis exists where other parts of the body like bones, joints, brain, kidneys, spine etc. can be infected (Barberisi et al., 2017; Bynum, 2012; Davies, 2005; Dutt, 2006; Sontag & Broun, 1977; Zaman, 2010). While biomedicine helps us understand that TB is caused by a bacterium called *Mycobacterium tuberculosis*, disease occurrence and distribution are all context dependent and warrant sociological investigation. Following TB exposure, the prevalence of the disease in the community where an individual resides and works determines the risk of infection (Davies, 2005; Olaleye & Beke, 2018). Other exogenous

factors implicated in the risk of TB infection include a defenceless host (Bothamley, 2005), the source case's contagiousness, proximity to infectious persons, and social and behavioural risk factors including alcoholism, smoking, and indoor pollution (Narasimhan, Wood, MacIntyre & Mathai, 2013). Another risk factor to consider is the conduciveness of an environment that permits the "tubercle bacilli to survive transit from one host to the next" (Bothamley, 2005, p.527). In this case, issues of ventilation within spaces are also important. Thus, the routes of TB transmission are inextricably social.

South Africa is one of the 30 countries with a high tuberculosis burden and is also one of the 14 countries most affected by TB, TB/HIV, and multi-drug resistant TB (MDR-TB) (van der Walt & Moyo, 2021). Furthermore, the country is among the eight nations contributing two-thirds of the world's TB cases (Pillay, Mvusi, Mametja & Dlamini, 2021). In 2019, South Africa recorded an estimated incidence of 360 000 cases of active TB (World Health Organisation, 2020) and this figure dropped in 2021 to 304 000 cases (WHO, 2022). The country recorded a total number of 61 000 TB deaths in 2020 (WHO, 2022). With the outbreak of COVID-19, tuberculosis was the 13th leading cause of death globally and the second leading infectious killer disease after COVID-19 (WHO, 2021). The emergence of COVID-19 disrupted TB diagnosis and care resulting in the underreporting of TB in official statistics. In line with global best practices on disease surveillance, South Africa conducted its First National TB Prevalence Survey in 2018, a crucial step towards designing evidence-based interventions against the disease. While statistical figures are crucial in highlighting the magnitude of TB as a health burden, they mask the lives lived. In the same vein, a critique levelled against biomedicine is its emphasis on treating the person as the "site of disease" at the expense and neglect of the individual's subjective experiences with suffering (Good, 1993, p.70). This positivist perspective deliberately omits important issues in health, such as providing a voice to the person experiencing tuberculosis. Further, it neglects valuable insights about the socio-material conditions people live in. Health, disease occurrence and illness cannot be understood within a vacuum.

In South Africa, socio-political and cultural factors are implicated in overall disease distribution (Austin, Dick & Zwarenstein, 2004; Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Tuberculosis dominantly occurs within resource-constrained settings as these contexts generate conditions for its spread. For instance, a study conducted in the Eastern Cape province of South Africa found that TB prevalence at the household level was significantly correlated to poor housing quality and overcrowding (Cramm, Koolman, Møller, & Nieboer,

2011). TB is a disease that occurs within conditions of inequalities at individual, household, and national levels, making it a classic disease of poverty that perpetuates inequalities within and between countries. The disease is concentrated in poor countries and those with high inequalities (Hargreaves, Boccia, Evans, Adato, Petticrew & Porter, 2011; Maher & Raviglione, 2006). South Africa is one of the most unequal countries in the world with a 0.67 Gini coefficient (the measure of income inequality in a country) (The World Bank, 2018). The prevalence of tuberculosis in South Africa, stratified by race, gender, and class, reveals the fault lines of an unequal society. This situation positions the country as a social laboratory for studying the disease, highlighting the need for a sociological interpretation of tuberculosis. Income inequalities interplay with and are expressed in other forms of inequalities like health inequalities (Amzat & Razum, 2014). My research explores linkages between masculinity identities and tuberculosis occurrence among black men within a resource-constrained setting of South Africa. The thesis further explores men's practices of sociability and meaning making of TB and how gender identity influences their health-seeking behaviours towards TB diagnosis and treatment.

TB pathogenesis, disease progression, diagnosis, treatment, and treatment outcomes are all socially embedded (Hargreaves et al., 2011; Lienhardt, 2001) and gender is central to understanding its social embeddedness. This is the core argument I advance in this thesis. In 2020 approximately 10 million people worldwide became ill with tuberculosis; of this total, 5.6 million were men, 3.3 million were women and 1.1 million were children (WHO, 2021). Furthermore, global statistics show that the number of people that fell ill from tuberculosis in 2021 increased to 10.6 million, of which 56.5% were adult men, 32.5% women and 11% were children (WHO, 2022). Internationally, men constitute most tuberculosis patients, with a male-to-female ratio of 2:1 (WHO, 2019, p.7). The ratio is contestable and may need upward adjustment considering men's (precarious) interaction with healthcare services (see Baker, 2016). Furthermore, the World Health Organisation (2021) notes that globally, 53% of the HIV-negative people who died from tuberculosis in 2020 were men, with women and children accounting for 32% and 16% of TB deaths respectively. The disparities in tuberculosis prevalence rates between men and women are evident. Men have a higher burden of the disease, get diagnosed later and have worse outcomes than women (Horton, MacPherson, Houben, White, & Corbett, 2016; Horton, White, & Houben, 2018; Van den Hof, Najlis, Bloss & Straetemans, 2010). Men remain infectious in the community for a longer period than women do, and this causes more secondary infections (Chikovore, Hart, Kumwenda, Chipungu,

Desmond & Corbett, 2017; Horton et al., 2016). While there are biological explanations to this gender discrepancy in TB incidence rates, a sociological investigation paying attention to context and the underlying factors predisposing men to TB disease is appealing.

South Africa follows a similar global gendered pattern of tuberculosis distribution. The First National TB Prevalence Survey of 2018 shows that "the estimated prevalence of pulmonary TB in males 15 years and older was more than 1,000 per 100,000 population and was approximately 1.6 times that of women" (van der Walt & Moyo, 2021, p.17). As one of the structural factors, gender determines the risk of TB infection and progression to active disease (Chikovore, Hart, Kumwenda, Chipungu, Desmond & Corbett, 2014; Thorson & Garcia-Moreno, 2009). Seeking TB care is lower among men compared to women as evidenced in the 2018 South African TB Prevalence Survey. The survey found that of the 5 168 respondents who identified more than one TB symptom, 3 442 (66.6%) declared they did not seek medical care for the symptoms at the time of their participation in the survey. Of those, more men (71.36%) than women (63.4%) did not seek care (van der Walt & Moyo, 2021, p.18). This gendered difference in health-seeking behaviours is significant as it has implication in TB mortality rates. Closely connected with the issue of health-seeking behaviours is the problem of treatment interruption or defaulting, a precondition for multidrug-resistant tuberculosis (MDR-TB). Research indicates that MDR-TB is challenging and costly to manage due to the necessity of extended hospital stays lasting four to six months, and the high cost of medication (Department of Health, 2005 cited in Chauke, Netshikweta, Netshandama, Nyathi, Tshitangano, & Olaniyi 2018, p.56). The gendered distribution of TB mortality in South Africa shows that 18 153 men died of the disease in 2016 compared to 11 246 women (Statistics South Africa, 2018, p.34). An investigation into tuberculosis case detection in Johannesburg confirm that men were not keen on visiting healthcare facilities for diagnosis and treatment because of time constraints coupled with the masculine belief that it was 'unmanly' to visit a clinic (Mwansa-Kambafwile, McCarthy, Gharbaharan, Venter, Maitshotlo & Black, 2013). In the same vein, Chikovore, Pai, Horton, Daftary, Kumwenda, Hart and Corbett (2020) argue that another deterrent to men's health-seeking is their fear of losing immediate economic opportunities. Therefore, among men, health-seeking is mediated by pressing and competing challenges like livelihood pursuits, intricately connected to their preoccupation with identity.

Along with gender, race is also an important factor of analysis in tuberculosis. A 2016 detailed analysis of the top ten causes of death in South Africa by population group shows that compared to the white population in which TB had no impact, the disease was the leading cause of death

for black Africans, accounting for 24 886 deaths (Statistics South Africa, 2018, p.138). A comparative study of how black and white men experience the disease may not be ideal because tuberculosis does not constitute a major health burden among whites. As a factor, race is an important social fact in the social production of tuberculosis in South Africa. Similarly, the black African population bears a disproportionate burden of tuberculosis, evidenced by a death rate of 136.3 per 100 000 people. In comparison, the coloured population recorded a lower rate of 63.8 per 100 000 people during the period from 2005 to 2015 (Kibuuka, Mpofu, Neave & Manda, 2021, p. 4). This suggests that tuberculosis has a black man's face. It is against this background that I investigate the social practices and illness experiences of men living with tuberculosis to understand the meanings they attach to the disease within their own context.

This thesis is a qualitative study that examines how masculinity influences the incidence of tuberculosis. It also investigates how social interactions contribute to the spread of TB among men and explores men's experiences with the illness in a resource-poor, non-mining community. As evidenced in the South African TB Prevalence Survey of 2018, the majority of those presenting with TB symptoms and who downplayed the need for health help were men. What are the causes that explain the delays in health-seeking among men? What insights do research on masculinity and TB show us about men's health-seeking behaviours? Considering the above and writing on the contexts of high TB burden settings like South Africa, Chikovore et al. (2020, p.1) aver that "men's health and TB epidemiological situation have largely been overlooked, and men have been focused on mainly for their sexual practices and role in HIV/AIDS and gender-based violence." The literature further shows that globally and particularly in African countries, there are few targeted policies on men and TB, and these have limited reach in remedying the existing health disparities across genders (Daniels, Medina-Marino, Glockner, Grew, Ngcelwane & Kipp, 2021; Horton, et al., 2016; Medina-Marino, Bezuidenhout, Ngcelwane, Cornell, Wainberg, Beyrer & Daniels, 2022). This is despite research evidence demonstrating that, in the cases of Zambia and South Africa for instance, well over 50% of TB infections may be a result of contact with adult men (Dodd, Looker, Plumb, Bond, Schaap, Shanaube, & White, 2016). This study therefore builds on men and health scholarship with a deliberate focus on understanding the illness experiences of men diagnosed and suffering from TB. It is an attempt to bring men's illness experiences into the research agenda. Detailed space on masculinity theorisation as well as the conceptual framework undergirding this research is provided in Chapter Three of this thesis. But before then, the next section substantiates the research problem.

The research problem

In a systematic review of tuberculosis prevalence in 24 low-and middle-income countries, Horton et al. (2016, p.8) concluded that male TB prevalence was higher than that among females. In a similar vein, empirical evidence shows that in most countries tuberculosis is more prevalent in men than women among HIV negative individuals (Rhines, 2013; van der Walt & Moyo, 2021; Zaman, 2010). For instance, a 2013 South African study on TB mortality in rural KwaZulu Natal concluded that pulmonary tuberculosis and injuries among HIV-negative men contributed to a 16.5-year life expectancy drop in comparison to HIV-negative women (Reniers, Blom, Lieber, Herbst, Calvert, Bor & Hosegood, 2017). This glaring evidence calls for an in-depth investigation of what lies behind the disproportionate concentration of the disease among men. In South Africa, the question about the effects of tuberculosis among men arises retrospectively during autopsy reports around litigation matters for 'compensatable tuberculosis', especially among ex-miners (Ehrlich & Rees, 2016, p.452; Stuckler, Basu & McKee, 2010, p.1). In other words, the lived experiences of male TB sufferers are not well researched and documented. This research aims to fill the paucity by understanding tuberculosis illness experiences of black South African working-class men in Limpopo province.

In sub–Saharan Africa, an analysis of TB/HIV comorbidities helps us to gain a holistic appreciation of the TB burden among men. Studies show that people who are HIV-positive are more likely to contract TB, which progresses into active TB disease with adverse health effects (Matakanye, Tshitangano, Mabunda & Maluleke, 2021; Singer, Bulled, Ostrach & Mendenhall, 2017). In their investigation of TB epidemiology, Perumal, Naidoo and Padayatchi (2018, p. 2) conclude that the TB epidemic "has become increasingly feminised" because of the high HIV incidence among young women in sub-Saharan Africa. Important as the above point is, other scholars argue the urgent need to centre men in TB research as doing so helps in mapping strategies to address their barriers to TB care which are notably absent from the global research agenda (Chikovore et al., 2020; Horton et al., 2016). The omission of men as an "at-risk" population from the TB global research agenda and in public health initiatives is an academic prejudice that requires theoretical and empirical responses, precisely what this study offers.

Tuberculosis scholarship in South Africa is largely and justifiably skewed towards the effects of mining, with an emphasis on the heightened risk of infection among miners who acquired

silicosis (Packard, 1989; Rees, Murray, Nelson, & Sonnenberg, 2010; Williams, Campbell, Mqoqi & Kleinschmidt, 1998). Justifiably so, the gold mines of South Africa are hotspots for high TB rates. It is argued that among South African gold miners, the TB incidence rate is ten times higher than for the general population (Beinart, 2014). Although the trend in studying TB in South Africa is intricately linked to the mining sector, in particular gold mining, it is the circular labour migration (Collinson, Tollman & Kahn, 2007) which is to a greater extent implicated in the spread of the disease to other non-mining communities. The oscillating labour migrant system in South Africa is an important explanatory model to understand ways TB contracted in the mines is transmitted back to home regions where migrant labourers hail from (Coovadia et al., 2009; Rees et al., 2010). In similar vein, Lurie and Williams (2014) reinforce the notion that migration in South Africa and the southern African region has been central to the spread of tuberculosis and HIV.

Important as the mining trajectory is in the epidemiology of tuberculosis to other non-mining communities in South Africa, overemphasising it obscures other context-specific nuances exacerbating the disease burden among men. The tuberculosis burden in non-mining communities and particularly among men has not found much attention in the literature. Considering the high prevalence of tuberculosis in South Africa, scarcity of research about the disease in non-mining communities creates a blind spot to our understanding of how it is spread and experienced. It is crucial to note that there is no mining activity in Modimolle, the research setting. However, it is plausible that Modimolle's proximity to other mining areas in the Waterberg district, such as Lephalale and Thabazimbi might have a bearing on the TB burden due to oscillating labour migration. Nevertheless, none of the sampled participants for this study had a history of working in the mines. Therefore, this study contributes to our understanding of how TB is spread in non-mining communities through social practices that are enacted within poorly ventilated and masculinised spaces of entertainment.

The research argument and question

Considering the widespread prevalence of tuberculosis and its disproportionate impact on men, extensive research on the illness experiences of men was undertaken in this study. The research appreciates the meanings men attached to TB through their lived experiences and their own opinions of what made them susceptible to infection. Against the backdrop of the contagiousness of TB, men's sociability practices in this research provided a lens through which to examine ways the disease is contracted. In that regard, the study foregrounds

masculinity, and the way it is performed by men (Butler, 1988), in their understanding of TB within the continuum of health-seeking behaviours, TB diagnosis and post-diagnosis experiences. How do men living with TB identify, are identified, and define themselves? How does masculinity shape men's experiences of TB illness?

Our understanding of the way tuberculosis is spread, patterned, and experienced among men could potentially be enhanced by examining the concept of masculinity. In South Africa, masculinity has been well researched in relation to violence under the concept of hegemonic masculinity (Jewkes, Morrell, Hearn, Lundqvist, Blackbeard, Lindegger, Quayle, Sikweyiya & Gottzen, 2015; Morrell, Jewkes, Lindegger & Hamlall, 2013), men's sexuality (Ratele, 2017), male mortality (Ratele, 2008) and more widely in relation to HIV/AIDS (Hunter, 2005; Mfecane, 2012). Interestingly, there is pessimism around masculinity studies, with Ratele (2014) lamenting the lack of impact these studies have had in South Africa, which he claims relates to society's ignorance of men's gender. Men's studies in South Africa have underperformed, in Ratele's opinion, and have gone in the wrong direction (2014). This pessimism over the impact and scope of masculinity studies in South Africa should serve as a call for coordinated research on the subject in all its complexity. With the possibility of highlighting the gendered disparities in TB outcomes, there is a growing body of study on masculinity and TB in South Africa (Daniels et al., 2021; Makgopa, Cele & Mokgatle, 2022). While these studies examine men's health-seeking behaviours and illness experiences, they do not adequately theorise masculinity or investigate how men contract TB. My thesis addresses this gap by exploring the social norms and sociability practices among men in specific settings that potentially contribute to TB infection. By appreciating that men and the dynamics through which TB is spread possess gender-specific characteristics, society may better comprehend how vulnerable men are to health problems, particularly when they have tuberculosis. This may mark a positive turn in the direction of bettering men's health, which will subsequently benefit women's health.

The amount of research on tuberculosis in South Africa is substantial, but surprisingly, the literature addressing and illuminating the illness condition in men places an excessive amount of emphasis on male mortality (see Reniers et al., 2017). Added to the interest in male mortality is that surveys are the mainstay of studies on tuberculosis with the recent one being the 2018 South African First National TB Prevalence Survey (van der Walt & Moyo, 2021). Although surveys are a rich source of data for policy and research, they may not help us to comprehend men's subjective perceptions, understandings, and experiences of tuberculosis. This gap is a

limitation not only to targeted stakeholder interventions against the disease but on knowledge production itself. I therefore observe that there is a dearth of literature on 1) tuberculosis illness experiences of men, 2) how tuberculosis perpetuates health inequalities and vice versa, and 3) masculinity and its implication for men's health-seeking behaviours in the face of TB. Understanding how people with the disease perceive and experience it is important for TB control policies (Makgopa et al., 2022). This study therefore aims to contribute to our understanding of the relationship between masculinity and tuberculosis in the context of a non-mining community of South Africa.

Although theorisation around masculinity has gained traction when studying men, there is a lack of interest in researching men's health vulnerabilities. Men's health experiences are underrepresented in scholarship, which is a result of gender inequality. This gender blindness perpetuates the poor health status of men, which in turn degrades the health status of families and communities. Situated within the Critical Studies on Men (CSM), this thesis makes use of the concept of masculinity from the African-centred scholarship (Manganyi, 2019; Mfecane, 2018; Ratele, 2014). This aids in my examination of the gendered dominance of men (Hearn, 2004; Jewkes et al., 2015; Morrell et al., 2013) and how, in the face of TB illness, this power contributes to poor health outcomes for men. It is fundamental to mention that the CSM framework does not presuppose all men to be (all) powerful but it critically acknowledges that power asymmetry in gender relations is the basis for much of men's negative health outcomes (Hearn, 2004; Lohan, 2007). The paradox is that the pursuit of power by men ultimately militates against their own health (Courtenay, 2000). This is so on occasions when men portray invulnerability to pain and delay seeking health care services when ill from TB as some of the means to prove their masculine practices. Despite evidence that idealised versions of masculinity have a negative effect on men, Khunou (2013) contends that these ideals can, on occasion, result in beneficial experiences for other men. Khunou (2013) further adds that men derive social significance from their employment, which not only affords them the money and power that come with it but also a sense of wellbeing that contributes to their overall health. Masculinity is, therefore, a double-edged sword in the health outcomes of men. In other words, the relationship between masculinity and (ill) health among men is complex and context specific, requiring analysis through focalised studies.

The opportunities presented in terms of improving our grasp of African cosmologies on men's relationship to their health are what made African-centred theories of masculinities my theoretical source of reliance. It represents a break from importing masculinity theories from

the global North, which tends to generalise men's experiences and consequently disregard theories on masculinities from the global South. By theorising from an African-centred masculinity, this thesis explores how masculinities shape and are shaped by tuberculosis infection and illness experiences. The thesis further provides new insights into how masculine social practices such as smoking and beer drinking in male-dominated spaces of entertainment and recreation may contribute to the spread and infection of TB among men. All these practices are theoretically and empirically situated within the African cosmologies of what a man is. Importantly, this thesis reveals the ways men defined themselves even in illness and despite illness. In this thesis I advance the argument that tuberculosis among men, in non-mining settings, is a disease of sociability. From its spread, infection, and diagnosis as well as ways it is experienced in illness, tuberculosis is social, and as such requires sociological interpretation. The research question set for the study is:

How does the spread of tuberculosis and subsequent illness among men shape, and how is it shaped by masculinity identities in a non-mining community such as Modimolle?

Four auxiliary questions bolster the main research question as follows:

1. How do sociability practices in space affect tuberculosis infections among men in non-mining settings?
2. How do men's identity beliefs influence their perception of tuberculosis diagnosis and illness experiences?
3. How do men's cultural and religious beliefs impact their health-seeking behaviours regarding tuberculosis?
4. To what extent does being a man shape the perception and experience of health and anti-tuberculosis treatment?

To address the research question, the thesis made use of a qualitative methodology through ethnography conducted between 2020 and 2021 in Modimolle in South Africa's Limpopo province.

Thesis presentation

The thesis structure involves nine chapters beginning with this one in which I have fleshed out the sociological context of this study. This chapter provided the background and the focus of this research by highlighting the existing gap in research about TB and men. It then established the research argument and objectives of the thesis. It also includes a summary reference, on the

one hand, to the theoretical and conceptual frameworks underpinning the study and, on the other, to the methodological framework.

Chapter Two strengthens the sociological rationale of the thesis situated in historical processes. It argues that the tuberculosis epidemic was brought into southern Africa through colonisation and became entrenched through structural dynamics related to industrialisation. The chapter draws on extensive scholarship concerning the historical context of TB in South Africa, establishing connections to its current prevalence and impact.

In Chapter Three I present the theoretical frameworks and conceptual tools I use in this thesis. The chapter critically appraises the use of African-centred theories of masculinities, exposing its limits and detailing the ways I fill the gap exposed. It further engages with illness narratives, health-seeking behaviours, biographical disruption, and stigma as fundamental concepts that help illuminate the illness experiences of men suffering from tuberculosis.

The fourth chapter is a detailed overview of the ethnographic journey that I undertook during the years of COVID-19 between 2020 and 2021 in Modimolle. The COVID-19 context influenced this research: from ethical clearance application and access to the field, through to engagement with the participants. The chapter further discusses the study site, decision-making processes on sampling, data collection instruments and my positionality. In the fifth, sixth, seventh and eighth chapters, I present my research results.

In Chapter Five, the first findings chapter, I present participants' working and living conditions as pathways to understanding TB infections among men. I further unpack the views and perspectives of men on what they considered to have contributed to their tuberculosis infection. To that end, the chapter problematises the role of spaces that men frequent for entertainment and recreation. These spaces illuminate the kinds of masculinities performed by men through the practices of sharing cigarettes and beer, practices that engender belongingness. Inadvertently, these practices shed light on the spread of TB.

Chapter Six is a presentation and crystallisation of masculinity identity formation in the face of TB infection and illness experiences. Based on men's narratives, the chapter demonstrates the plurality of masculinity and how these are formed and performed in health and in illness.

In Chapter Seven I tease out the influence of culture and religious beliefs on men's health-seeking behaviours in face of TB. I do so within the context of medical pluralism and men's interaction with healthcare access for TB diagnosis and treatment.

The eighth chapter discusses the post-TB-diagnosis experiences of men in terms of their reflections and understanding of health and tuberculosis. It explores the use of metaphors by men in relation to their understanding of syndemics. In this chapter most of the men are on a recovery trajectory from tuberculosis: their deep insights of having lived with the disease reconfigures their understanding of health. Through these insights, the chapter untangles the complexities of tuberculosis and counterbalances this with the role of the state in managing the disease.

Chapter Nine is the conclusions; it captures the arguments raised in the thesis and the contributions made towards scholarship on health and men broadly, with a particular focus on TB and masculinities. It also presents the limitations of the study and offers suggestions for further research in the field of masculinities and tuberculosis.

Chapter Two

An appraisal of knowledge contours on the social interpretation of tuberculosis

'I've made all this money, and now I'm going to die'—he drowned in his own blood after a severe lung haemorrhage on 21 January 1950, aged 46, leaving a widow and an adopted son just under 5 years old (A quote from George Orwell cited in Bynum 2012).

Introduction

This chapter draws from existing literature on tuberculosis as a disease that disproportionately affects populations in the developing world, focusing specifically on southern Africa and, in particular, South Africa. The influence of capitalist extractivism through mining and the accompanying cyclical labour migration connected to most countries in southern Africa is at the centre of a large body of tuberculosis literature in South Africa (Coovadia et al., 2009; Lurie & Williams 2014; Rees et al., 2010). It is from this literature that I carved a research niche on black working-class African men's tuberculosis illness experiences in a non-mining community in the province of Limpopo, South Africa. By so doing I underscored the social determinants of tuberculosis to extend and deepen an analysis of health inequalities in the country. The chapter begins by defining tuberculosis and explaining how the disease is contracted and spread. Tuberculosis occurrence is contextual; thus, this chapter explores the structural conditions, cultural and religious factors, and individual behaviours implicated in the spread and infection of the disease. To that end the chapter problematises the social determinants of tuberculosis before historicising the connection between European colonialism and the occurrence and spread of epidemics in parts of Africa. Although this research focuses on the South African context, it is worth noting that tuberculosis knows no borders and as a socially contracted disease, it requires a contextual and localised perspective.

This chapter therefore makes the case for a sociological interpretation of tuberculosis, contributing to a multidimensional understanding of the disease. The strength of a sociological interpretation lies in the way social context, structure and agency are interlocked with tuberculosis disease and distribution among the population. A sociological interpretation points to how tuberculosis is social. As such the chapter demonstrates that the disease is mediated by specific structural factors. Research on the experiences of men with tuberculosis cannot be

covered in one chapter. Thus, the concept of masculinity – which has gained considerable attention in health – and men is succinctly explored in the theoretical chapter of this thesis, i.e. in Chapter Three.

The extensive and rich literature on tuberculosis overemphasises mortality at the expense of lived experiences of TB sufferers. How else can informed intervention policies to control TB be implemented if experiences of TB sufferers are not considered? There is little qualitative research on the meanings attached to the disease by the sufferers and what they understand to be the causes of infection and possible pathways by which it is transmitted. In addition, the literature on tuberculosis omits important gendered nuances of tuberculosis and the health inequalities the disease perpetuates. This lacuna is the basis upon which I crafted the research study on tuberculosis and men in Modimolle Town, Limpopo, South Africa. In the following section I analyse literature on TB disease and ways in which it is contracted.

Spotlighting conditions for TB infection and disease progression

Tuberculosis is a chronic transmissible disease. It is contracted through inhaling airborne droplets that contain tubercle bacilli released through coughing, sneezing, speaking, singing, or spitting by persons with active TB (Barberisi et al., 2017; Coleman, Martinez, Theron, Wood & Marais, 2022; Dutt, 2006; Packard, 1989; WHO, 2022). These processes of transmission and contraction of TB indicate that the disease is social. TB infection follows a two-stage process whereby a susceptible person is exposed to an infectious case which may result in infection (latent) and to the development of active disease (Lienhardt, 2001). When the TB germ is exhaled from an infectious person, it can remain in the air whereupon it may be inhaled by a susceptible person, leading initially to an asymptomatic condition called latent tuberculosis infection (LTBI) (Fox, Johnston, Nguyen, Majumdar, Denholm, Asldurf & Velen, 2021). As a major health burden, the problem of tuberculosis lies in its "infectious nature, complex immunological response, chronic progression and its uncompromising need for long term treatment" (Barberisi et al., 2017, p.E9). The processes and factors that are more likely associated with risk of infection include continuous exposure and proximity to a person with active TB disease, overcrowding, indoor air pollution, and poor ventilation. A TB sufferer traditionally displays visible symptoms such as progressive emaciation, coughing, languidness, and fever (Sontag & Broun, 1977). These are some of the prototypical symptoms of the disease. However, it frequently occurs that TB sufferers may not exhibit the archetypal symptoms (Coleman et al., 2022) and this presents diagnostic challenges as diagnosis is

largely based on what the patient describes to the general practitioner or to the nurse at a local clinic within a power-laced relationship.

Tuberculosis is dangerous and in its extrapulmonary form, especially the meningeal type in the brain, can rapidly become fatal (Bynum, 2012). When tuberculosis develops in its active form, the body's defence mechanisms are impaired, resulting in the destructive properties of the disease manifesting themselves over a much longer period (Bynum, 2012). Progression from Mtb infection to TB disease is influenced by a compromised immune system, which can result from comorbidities such as HIV and diabetes, as well as factors like malnutrition, stress, and lifestyle risks (Fox et al., 2021; Mathema et al., 2017; Ortblad et al., 2015; Tiberi et al., 2017). When accurate TB diagnosis is not performed and matched with subsequent anti-TB treatment, the disease can be fatal. Scholarship documents the prevalence of TB misdiagnosis and as defined by Houben, Lalli, Kranzer, Menzies, Schumacher and Dowdy (2019, p.150), a false-positive TB diagnosis occurs when an individual who does not have active TB "incorrectly receives a diagnosis of TB disease." In the same vein, Feng, Lin, Wang, Chien, Lin, Huang ... and Chiang (2022) argue that the issue of TB misdiagnosis has received little research attention, a pointer to how complex tuberculosis disease is.

The public health progress towards combating TB, as influenced by the World Health Organisation, has been accompanied by the systematic screening of active TB and LTBI among HIV-infected patients and the provision of appropriate treatment. Importantly, the WHO's End TB Strategy aims to halt the global TB epidemic by 2035. Adopted in 2014, the 20-year strategy aims at a 90% and 95% reduction in TB morbidity and mortality respectively, and to mitigate catastrophic TB expenses at household level by 100% by 2035 (Stop TB Partnership, 2021). As a preventable and curable disease, the fight against TB has witnessed improved diagnostic techniques of latent TB using "tuberculin skin testing (TST) or interferon gamma release assay (IGRA) tests" (Tiberi et al., 2017, p.e25). In addition, the four-drug regimen of isoniazid-H, rifampicin-R, Ethambutol-E and Pyrazinamide-Z are the first-line drugs used for people with drug-susceptible tuberculosis, except in cases where resistant tuberculosis is present (Tiberi et al., 2017; World Health Organisation, 2023). The WHO (2023, p.43) recommends the use of all the four drugs in the first two months of treatment, and this must be followed with isoniazid and rifampicin for the remaining four months. Due to its long-term treatment of more than six months, fatigue of ingesting medication is often a burden affecting one's treatment routines and outcomes. The long-term treatment demanded

of tuberculosis complicates the disease when treatment adherence issues are brought to the fore. Ramaliba, Tshitangano, Akinsola and Thendele (2017) conclude that treatment interruption is one of the risk factors associated with TB contraction and reinfection in the Limpopo province of South Africa.

Delaying TB diagnosis and treatment initiation are some of the central factors heightening the prevalence and onward transmission of infectious TB (Mathema et al., 2017). These factors are of major concern for the control of tuberculosis at the individual level where they can lead to death. At the community level, the mentioned delays contribute to continued transmission. The World Health Organisation (1999, p.10) notes that if left untreated "a person with active TB will infect on average 10 to 15 persons a year." The health challenge of treatment interruption is that it is associated with drug-resistant TB, which is difficult to treat, is expensive and "resistant to one or more anti-TB drugs" (WHO, 1999, p.31). Drug-resistant tuberculosis cannot be treated with the "standard first-line regimen" (Tiberi et al., 2017, p.e29). Consequently, second-line drugs are advised for extended durations of approximately 9-12 months (World Health Organization, 2022). However, longer regimens lasting 18-20 months remain an option for patients who are not eligible for the shorter treatment course (Tiberi et al., 2017; World Health Organization, 2022). This puts a strain on both the healthcare provider and the patients because of the need for hospitalisation.

It is important to mention that concepts and their usage evolve with time as witnessed in the contentious concept of 'defaulting'. In its definition, the World Health Organisation (2002, p.13) defines a defaulter as a "patient whose treatment was interrupted for 2 consecutive months or more." The concept of defaulting is not patient-centred, and instead signals health as an individual responsibility. The concept carries undertones of individual negligence and irresponsibility which, overall, are victim-blaming characterisations. The concepts that are replacing 'defaulting' are 'lost to follow-up' and 'lost from treatment' which are used interchangeably. To reflect the changes in lexicon, the World Health Organisation (2013, p. 6) defines 'lost to follow-up' as a "TB patient who did not start treatment or whose treatment was interrupted for 2 consecutive months or more." While the World Health Organisation (2013) includes among its definition of 'lost to follow-up' patients for whom treatment is not initiated after diagnosis, my study specifically targets TB sufferers who initiated treatment but interrupted. I relied on healthcare provider records for such individuals. In my study, I therefore borrow and use Moyo, Cox, Hughes, Daniels, Synman, De Azevedo... and Van

Cutsem's (2015, p.2) concept of 'lost from treatment' to refer to TB patients "who interrupted treatment for two or more consecutive months." The concepts of 'lost to follow-up' and 'lost from treatment' denote a more patient-centred focus that takes into consideration that TB treatment is a social process determined by various socioeconomic and environmental factors impacting an individual patient.

The advancement in diagnosis and anti-tuberculosis treatment was supposed to translate into possible eradication of TB, and so, one would ask: What could be making this ancient disease so persistent in developing countries? A sociological interpretation contributes to filling up some of these gaps in understanding. Against this backdrop of fleeting public health measures to counter tuberculosis, scholars have coined the concept of 'structural violence' to refer to the "avoidable loss of life from preventable and curable diseases such as TB during so-called peacetime" (Mason, Roy, Spillane & Singh, 2016, p. 211). In other words, a purely medical focus on understanding TB is important but must be recognised alongside sociological and anthropological perspectives. Structural violence in relation to preventable diseases helps us to appreciate the implication of socio-political factors in disease occurrence and poor health outcomes. In their articulations of structural violence, Farmer, Nizeye, Stulac and Keshavjee (2016, p.1686) aver that it refers to the "social arrangements that put individuals and populations in harm's way." In other words, individuals have no influence on the social arrangements that cause them harm as these are large-scale factors "embedded in the political and economic organisation of our social world" (Farmer et al. 2016, p.1686). The effects of structural violence according to Farmer et al. (2016, p.1688) are manifested through poor access and adherence to effective therapy.

The HIV epidemic is crucial to understanding the relationship between men and tuberculosis as it has exponentially exacerbated the incidence of TB in sub-Saharan Africa. As an opportunistic infection, tuberculosis lurks and manifests when the immune system is compromised by other underlying health conditions like HIV/AIDS. The routes of HIV transmission are complicated. The HIV-TB syndemic relationship is well pronounced within the sub-Saharan African population and is a common phenomenon in settings of poverty and constrained healthcare systems. HIV-positive status is argued to increase the annual risk of developing active TB by 10-30% together with the co-occurrence of factors like recent contact with an infectious person, homelessness, illicit drug use (Tiberi et al., 2017, p.e25). Furthermore, studies indicate that the risk of death among HIV-positive individuals with

prototypical TB symptoms is “about three- to seven-fold higher” than among TB infected individuals who are HIV-negative (Kibuuka et al., 2021, p.2). The largest population of people living with HIV is found in South Africa, and tuberculosis is the major cause of AIDS-related deaths (Zou, Liu, Hay, Basu, Belgaumi, Dhali ... & Huang, 2022, p. 11). Limpopo province within which the research setting lies is ranked among the worst-affected by TB in South Africa, with around 55 percent of TB patients being co-infected with HIV (Matakanye et al., 2021).

Another important factor fuelling tuberculosis progression among individuals is stigma, which is one of the social determinants of the disease. The concept of stigma is well researched in health studies and according to Scambler (2009), it is a social phenomenon marked by ostracism and blame arising from the actual experience, expected experience, or the perception of negative social judgments about an individual or a group. TB stigma is an important factor of analysis considering some of the TB symptoms like unexplained weight loss. TB stigma has a bearing on diagnosis, initiation to anti-TB treatment and treatment outcomes. Duarte, Lonnroth, Carvalho, Lima, Carvalho, Munoz-Torrico and Centis (2017) add that TB stigma is a social determinant of health and health inequalities which is inextricably associated with lack of social support potentially leading to non-compliance and poor treatment outcome. A study conducted in Tanzania confirms that TB stigma is accompanied by discrimination from healthcare providers, “fear, self-isolation, ostracisation, and loss of status in the community” which resulted in delaying seeking health care (Miller, Huston, Samu, Mfinanga, Hopewell & Fair, 2017, p.S43). Conceptually, I attend to stigma and its centrality to this study in the third chapter of this thesis.

Having provided an analytical overview of the structural conditions conducive for TB infection and transmission, the individual behaviours are equally important. However, individual behaviours are closely intertwined with the structural determinants of health regarding tuberculosis. Alcohol use disorder is one of the critical risk factors implicated in TB infection (Bynum, 2012; Lönnroth, Williams, Stadlin, Jaramillo & Dye, 2008; Parry, Rehm, Poznyak & Room., 2009; Rehm, Samokhvalov, Neuman, Room, Parry, Lönnroth... & Popova, 2009). Literature confirms there is a causal relation between heavy alcohol use and the incidence and outcome of TB (Duarte et al., 2017; Shukla & Chaudhary, 2019). Similarly, there are behavioural factors like smoking that are implicated in TB contraction and disease progression. Studies demonstrate that both active and passive smoking are risk factors in latent tuberculosis infection, progression to TB disease and poor treatment outcomes and higher TB-related deaths

(Duarte et al., 2017, p.117). Furthermore, discontinuing smoking has been linked with higher TB cure rates and the benefits of non-smoking are exponentially associated with positive health outcomes (Duarte et al., 2017). Tuberculosis infection and disease progression must therefore be understood within a complex set of social factors. As a social disease, the solutions to TB eradication cannot be understood in a social vacuum. Thus, Lonnroth et al. (2009, p.2240) argue for an appreciation of the social aspects associated with tuberculosis because the control measures involve socio-political, economic and environmental fixes. Tuberculosis infection is thus not a random process but is socio-structurally and behaviourally determined. In the next section, I present an analysis on the social determinants of health and tuberculosis.

Unpacking the social determinants of tuberculosis

Tuberculosis occurrence and spread is intricately shaped by structural factors. An appreciation of the socio-economic and political environment is important in our understanding of how one gets infected with TB, transmits bacteria and accesses diagnostic healthcare services. Duarte et al. (2017) argue that social, political and economic conditions within which people are born, develop, live, work and age determine population health. The World Health Organisation (2008, p.7) holds that the social determinants of health (SDH) are the material, ecological and psychological conditions that influence health outcomes. Expanding on the definition of the social determinants of health and TB, Craig, Daftary, Engel, O'driscoll and Ioannaki (2017, p.91) add that these include the range of social, political, economic, and environmental factors that shape the health status of populations and hence risk of TB and treatment outcomes. In addition, Duarte et al. (2017) conclude that tuberculosis epidemiology reflects a clear pattern of the influence of social determinants in all stages of TB pathogenesis that include the risk of exposure, susceptibility to progression of disease, time to diagnosis and treatment, compliance and successful treatment. Reinforcing an appreciation of the social determinants of tuberculosis, Dubos (1992 cited in Farmer, 1997, p.348) argues that the disease unmasks a complexity which confounds the conventional medical approach. Therefore, for a nuanced grasp that departs from a purely biomedical perspective, it is critical to dissect these social factors that are implicated in TB.

Ideally, the social determinants of health and tuberculosis can be split along structural and behavioural factors for a more distilled analysis. However, the difference between the structural and behavioural social determinants of TB is blurred. This is so because the behavioural risk factors are significantly determined by the socioeconomic and physical environment;

socioeconomic status, poor housing, environmental conditions, food insecurity and malnutrition (Duarte, Aguiar, Pinto, Furtado, Tiberi, Lönnroth, & Migliori, 2021, p.339) are all structural factors implicated in TB. These are broader social factors that individuals have little to no control over, yet they impact population health. Mason et al. (2016, p.211) add that the structural conditions "enact a violence against certain populations in ways that adversely affect their quality of life, healthcare outcomes and life expectancy." This speaks to the notion of structural violence that is associated with political neglect in combatting preventable and curable diseases.

Furthermore, an analysis of socioeconomic status as a social determinant of tuberculosis shows that education, income, occupation, opportunities and privileges afforded to people within a society are all integral for a nuanced understanding of TB (Duarte et al., 2021). Health and health outcomes are therefore not incidental issues but are socially patterned. Although every individual is susceptible to TB infection, the disease follows a clear social pattern of heightened risk to infection of the underprivileged, the malnourished, and those who endure poor working and living conditions (Bynum, 2012). As an opportunistic disease, tuberculosis infection is heightened by malnutrition which "compromises the robustness of the immune system, so latent infection is more likely to become active TB in the malnourished" (Oppong, Mayer & Oren, 2015). Therefore, TB is a social disease because of its intricate connection in a vicious cycle to poverty (Packard, 1989; Wingfield, Tovar, Huff, Boccia, Saunders, Datta... & Evans, 2016).

Furthermore, poverty is one of the many barriers to healthcare that compromise the treatment of active TB (Oppong et al., 2015). Being poor increases the risk of acquiring TB infection and having TB disease worsens poverty in TB-affected households (Wingfield et al. 2016). In South Africa for instance, access to public healthcare is socioeconomically configured along a dual system where 15% of the population have privileged access to well-functioning private healthcare compared to the overwhelming 85% – among them most TB sufferers – that rely on an underperforming public healthcare system. This dual and unequal system presents bottlenecks in accessing TB healthcare services. Paradoxically, while poverty is fertile ground for TB infection, the disease exacerbates poverty at household level when the mostly medically uninsured sufferers spend money buying over-the-counter medication and the basic food requirements for their recovery. Duarte et al. (2017, p.136) add that the money spent on transportation, co-payments for medication, and loss of work due to a medical appointment are all indirect costs associated with the use of healthcare services. Accessing TB care costs TB-

affected households approximately two months of their annual household income with half of the costs being incurred prior to the start of TB treatment and half consisting of lost income (Wingfield et al., 2016, p.s80). Considering that TB is largely prevalent among the economically active group of people, it impacts on an individual's productivity when infected and this worsens an individual's economic status. This further highlights the critical underlying issues that perpetuate health inequality and that are perpetuated by tuberculosis. The TB-induced catastrophic costs incurred at household level are part of the underlying factors the WHO is fighting against in its End TB Strategy.

In dissecting the social determinants of health, it is also important to consider people's living conditions. Housing is implicated in TB infection because of its association with overcrowding and poor ventilation, both of which are public issues in poor communities. A closer look at informal settlements in South Africa that are dominated by shacks crystallises the implication of housing for TB. Oppong et al. (2015, p.185) add that the connection between overcrowding and TB lie in the "frequency and intensity of interpersonal contact" a recipe for the amplification of inhaling aerosolised TB bacteria. The spread of tuberculosis is embedded within human interaction because of its contagious and infectious nature. Since tuberculosis transmission is airborne, understanding it from a sociological standpoint of human interaction within which infection happens is of value to its control (Allotey & Gyapong, 2008). Behavioural factors at the individual level include "alcohol consumption, smoking and drug consumption" while the underlying comorbidities that include HIV/AIDS, diabetes and mental disease are argued to heighten people's chances of TB infection and disease progression (Duarte et al., 2021, p.339). In addition to their immunological effects, alcohol consumption and smoking in this study are intricately social and this is an important finding that reinforces the social determinants of tuberculosis thesis.

The argument to locate tuberculosis in the social determinants discourse helps us to appreciate that in the developed world for example, decreased tuberculosis notification was a result of addressing the social context of the disease. Improving housing and habitat and access to clean water and ensuring better nutrition all contributed to achieving this (Lienhardt, 2001; Lienhardt, Glaziou, Uplekar, Lönnroth, Getahun & Raviglione, 2012). Jochelson (2001) adds that positive change in the population health of Europe was primarily due to the healthier environment and better nutrition, and not the result of scientific cures. To have impactful results against tuberculosis, Duarte et al. (2021, p.339) reinforce the importance of dealing with the social determinants of health and tuberculosis – improving housing, reducing over-

crowding, and securing “improved nutrition and increased economic and social resilience.” Other social determinants perpetuating TB in South Africa, such as race and gender, are attended to in the ensuing sections of this chapter. Before attending to such factors though, the next section historicises the tuberculosis disease in South Africa to nuance the social determinants of health argument.

The socio-political configuration of tuberculosis in South Africa

A historical overview of tuberculosis in South Africa provides a concrete premise on which to understand the current state of the disease. Colonialism, and the associated primitive accumulation through particularly the mining industry, sowed the seeds of tuberculosis in South Africa, and the apartheid system actively nurtured its growth. Its branches and fruits are all visible in the postcolonial state. This historical premise offers a bird’s eye view of the way the disease unfolded and continues to be a public health burden right through the contemporary epoch. This historical exploration is important as it reveals the social processes at the heart of how diseases manifested and became patterned in the population. Social apartheid was crafted through a host of legislation that separated residential areas and created “separate transport, recreational, educational, and health facilities” (Baker 2010, p.80). This architecture fomented inequalities with far-reaching implications for population health, particularly in relation to tuberculosis among black South Africans.

It is arguable that the origins of most epidemics that continue to affect the southern African region have historical roots outside of the region’s borders. Regrettably, these diseases are entrenched among the indigenous population because of structural factors such as the migrant labour system. A disease will not be confined to a geographical space. Phillips (2012, p.9) defines epidemics as “the unusually high prevalence of a lethal human disease in a town, country, or region.” According to De Beer (1986, p.3), evidence shows that tuberculosis “came to southern and central Africa with white colonisers. Written records left by traders and missionaries made it clear that there was no TB in these areas until about the middle of the nineteenth century.” By reasons beyond the region’s control, tuberculosis came into southern Africa from outside and though it clearly emerged as an epidemic, the endemic nature of the disease in most southern African countries was and is embedded in, among other factors, problems of inequality, poverty, and the HIV epidemic.

De Beer (1986) further claims that with the arrival of the colonists, tuberculosis became known among the African population. However, Fassin (2007, p.136) has a contrasting view about the emergence of TB in South Africa as he argues the likelihood the disease predated the arrival of Europeans. He however agrees that the intensity of the disease among the black populations became especially profound toward the end of the nineteenth century and in the early 1900s (Fassin, 2007). The discovery of gold on the Rand in the 1880s (McCulloch & Miller, 2023) provides an explanation for the intensity of TB among the black populations.

De Beer (1986) avers that the discovery of gold in South Africa in 1886 birthed a considerable change in the country's history, in tandem with the shift in the history of TB. This is so because of silicosis, a risk factor heightening tuberculosis contraction among mineworkers. Silicosis is a chronic lung disease characterised by fibrosis, and it is caused by inhaling respirable crystalline silica (Moran, Linch & Cocalis, 1994). Describing the working conditions of black African mineworkers which were instrumental in TB infection and transmission, De Beer (1986, p.5) remarks that,

> Underground, in poorly ventilated tunnels, these tuberculotic immigrants worked closely with the unskilled African workers from the reserves. Inevitably many black miners were infected as they encountered the two conditions necessary for the spread of TB. One involves the presence of TB bacillus which causes the infection. The other is the presence of people who are weakened by poor diet, physical strain, or other illnesses.

The role of the oscillating labour migrant system is significant in the processes of TB infection, and transmission to the reserves where the men hailed from. Added to the deplorable working conditions, the mineworkers were exposed to substandard living conditions in mine compounds. These twin factors contributed to TB infections. De Beer (1986, p.6) argues that miners were confined in the compounds' large rooms "housing twenty to fifty workers who slept on concrete bunks built one above the other like shelves…workers had to sleep on these damp floors." The working and living conditions for black African mineworkers were clearly a recipe for TB contraction with grave consequences that were felt in the rural areas from where miners were drawn.

De Beer (1986) argues that in the earlier period of tuberculosis' emergence in South Africa, isolated cases did not spread because the prevailing conditions were not favourable. This analysis is important as it gives credence to the importance of understanding the socio-economic and political processes implicated in the disease. Speaking of the black African

population in South Africa before the coming of tuberculosis, De Beer (1986, p.3) asserts the possibility that "the population as a whole must have been reasonably healthy." This is so because people owned their land and cattle, important resources for sustainable livelihoods that ensured food security. Commenting about smallpox between 1713 and 1893, Charles Darwin as cited in Phillips (2012, p.11) argued that "[w]herever the European had trod, death seems to pursue the aboriginal." In other words, the epidemics had a grave effect on the indigenous populations even though these diseases were brought from outside their shores. Added to the list of imported epidemics on the African continent, Jochelson (2001, p.3) argues that "sexually transmitted syphilis was introduced into South Africa by European settlers, sailors and soldiers." In describing the underlying factors behind the high percentage of Africans dying from the Spanish flu of 1918-1919 in South Africa, Phillips (2012) argues that the living conditions, poor physical condition, and a poor healthcare service delivery system were conducive to the spread of the epidemic. The social processes underlying the devastating force of the epidemics in colonial South Africa among the African population were similar and these conditions have largely found breeding ground in the democratic period.

The social processes through which tuberculosis unfolded in South Africa are intricately intertwined with the political dynamics of land dispossession in which the locals were stripped of their land by the 1913 Natives Land Act. Through this Act, the country's land availed for African residence and farming was reduced to about 12% (De Beer, 1986). Plaatje (1916, p. 21) graphically summed up the effects of the 1913 Natives Land Act thus: "[a]waking on Friday morning, June 20, 1913, the South African native found himself, not actually a slave, but a pariah in the land of his birth." The end goal of the colonists was to force the indigenous people into wage labour. To achieve this, they also imposed taxation on the locals (McCulloch & Miller, 2023). In relation to TB, De Beer (1986, p.4) posits that, "the mine owners got the labour they needed. The workers themselves got TB." The pariah identity imposed upon black South Africans through their deliberate political disenfranchisement and land dispossession meant they were left with no alternative but to turn to paid labour to obtain the cash required to pay the imposed taxes. Although these taxes served the political and economic purpose of forcing Africans into wage labour on the mines, the indirect consequence was that they became the conduits through which infectious diseases like TB flourished among Africans. According to De Beer (1986, p.9), "[t]axes also hastened the spread of TB in rural areas." Particularly, the hut tax meant that families had to do away with some of their huts as the taxes on them simply were unaffordable. This meant a change in living arrangements that translated into

overcrowding. De Beer (1986, p.9) further adds that, "[t]his tax (hut) had forced people to work in the mines. It also ensured that when they came back infected with TB, they would be more likely to pass the disease."

The magnitude of the impact of tuberculosis during the period of the discovery of gold in South Africa was devastatingly huge, such that multiple commissions of enquiry were appointed to get to the bottom of the problem (De Beer, 1986; McCulloch & Miller, 2023). The effects were racially patterned. While the findings of the numerous commissions were objective in terms of the social determinants, the mine bosses deliberately brushed aside implementation of the recommendations because it would have meant a loss of revenue. For instance, a 1905 committee summed up its findings by stating that the "spread of the disease amongst the African population in the towns was due to 'the unhealthy manner in which they live…overcrowding, poorness of diet and want of ventilation and sunlight are too often to be found in the town locations, compounds and barracks in which these people congregate'" (De Beer, 1986, p.5). The problem of tuberculosis and the inertia of the government of the day in ameliorating it was a lived reality for Africans. Contrasting some of the measures the government adopted in abating the effects of the Spanish flu for example, Phillips (2012, p.90) illustrates the implication of race as the government ended up building houses for the underprivileged residents, "especially if they were white." To effectively control infectious diseases, it is crucial to consider socio-political factors alongside biomedical solutions. This means that addressing the root causes within society and politics is just as important as developing medical treatments. However, acknowledging this does not diminish the significance of biomedical solutions in combating infectious diseases.

In the apartheid system, health inequalities became entrenched. The creation of Bantustans or 'homelands' for Africans heightened conditions that were conducive for the spread of infectious disease. Bantustan areas were acutely overcrowded such that despite Africans constituting "80 per cent of the population, the bantustans constitute only 13 per cent of South Africa and exclude all the wealthy industrial and mining regions" (Price, 1986, p.159). In other words, bantustanisation was never intended as a sustainable alternative for black Africans but was created as permanent labour reserves for 'white' South Africa. This despicable system condemned black South Africans to poor health for generations to come. Directly linked to population health under the apartheid system was the "deregulation of public healthcare" (Maillacheruvu & McDuff, 2014, p.11) which concomitantly ensured that the private healthcare system became dominant. The deregulation of the public healthcare system, which

primarily catered to the majority non-white population, was accompanied by simultaneous underfunding and understaffing. These factors collectively contributed to adverse health outcomes for non-white individuals. In addition, the private healthcare system was not only expensive, but it catered for the needs of the whites further entrenching white supremacy. Similarly, a 1970 survey projected that 13 residents occupied a township house and the figure rose to 17 occupants per house in 1975 (De Beer, 1975, p.33). These figures demonstrate how conditions for the transmission of tuberculosis like overcrowding were entrenched under apartheid.

The problem of tuberculosis has continued to be a pressing public health issue well after apartheid ended. Most of the disease's colonial and class vestiges have persisted. The apartheid engineering of spaces in South Africa has left an indelible mark on the postcolonial health status of the black population, the majority of whom continue to reside in urban townships. Fassin (2007) adds that not only is it difficult to access resources in the townships and homelands in South Africa, but the environment in these spaces is equally risky. The environment is indeed a key facet towards understanding population health, especially in relation to tuberculosis. The research for this study explored the entertainment spaces frequented by men in Modimolle Township. It helped illuminate the possible ways men contracted TB. Thus, the importance of dissecting social factors to understand the effects of tuberculosis among the general population cannot be over-emphasised. Therefore, the structural factors that have perpetuated the spread of tuberculosis among the African population are given attention in the next section, in which I appraise literature on health inequalities and tuberculosis in democratic South Africa.

Tuberculosis and health inequalities in the democratic period

As presented in the preceding section, the oscillating migrant labour system was central to the spread of the tuberculosis among the general population. Furthermore, the apartheid state systematically ensured this infectious disease became less of a problem among the whites. In apartheid South Africa, a bifurcated health funding system was put in place for rural and urban Africans. Price (1986, p.161) argues that in 1978, 0.23 percent of the country's gross national product (GNP) was allocated for health in the Bantustans where 40 percent of Africans were forced to live. This contrasted with the 2.3 percent of GNP allocated for the health of urban Africans (Price, 1986). The rationale for this differential funding system was premised on the fact that few Whites resided in the Bantustans, and those areas did not require serious health

investment. Considering that the Whites worked with Blacks in urban areas and employed Black domestic workers, the state was required to invest in the health of urban Africans to mitigate the transmission of infectious diseases to the Whites (Price, 1986). Overall, the living conditions for the African township residents and their homeland counterparts were not a major public health concern for their colonial masters and therein were the seeds of tuberculosis and other infectious diseases nurtured, right into the postcolonial state.

Jochelson (2001, p.3) posits that the migrant labour system and "social dislocation and poverty in the countryside and towns helped create environments in which diseases proliferated, a situation aggravated by the acute lack of medical facilities for Africans." Health inequalities were created through this system of spatial segregation, not only between racial groupings but between and within geographical areas. Having outlined the interlocking effects of geography on tuberculosis during the colonial and apartheid periods, it is evident that in the democratic era, townships have largely continued to experience similar patterns of contagious disease distribution among the African population. In that respect, Coovadia et al. (2009) contend that the health inequalities in South Africa are spatially stratified, from national to municipal level. In other words, place is deeply implicated in disease distribution. In Limpopo, tuberculosis ranked fourth among the underlying natural causes of death in 2016 (Statistics South Africa, 2018, p.40). In the same year, of the five districts of Limpopo province, only the Waterberg district had tuberculosis as the number one underlying natural cause of death (Stats SA, 2018, p.136). Mining areas in the Waterberg district could be a reason why tuberculosis is one of the major problems in the district. In an opinion piece in The Star newspaper (24 March 2016) the then Deputy President of the country, now President, Cyril Ramaphosa stated that government had launched a massive three-year TB screening campaign targeting communities with a high concentration of mining. Two districts of Limpopo province i.e., Sekhukhune and Waterberg were targeted for this campaign. It is instructive that there is no mining activity in Modimolle. However, it is plausible that Modimolle's proximity to other mining areas in the Waterberg district like Lephalale and Thabazimbi might have a bearing on TB distribution because of cyclical labour migration.

Limpopo is a largely rural province, and farming is one of the main economic activities that generates employment in Modimolle. A comment about working conditions and health inequalities in farms deserves attention. Mlangeni, Malotle, Made, Ramodike, Sikweyiya, Du Preez... and Zungu (2023, p.2) contend that some occupations, such as agricultural work, place employees at high risk for TB morbidity due to their poor working and living conditions,

migration, and challenges in accessing health services. Poor living and working conditions could offer a lens through which we can appreciate the problem of tuberculosis among men. In his research on migrant farmworkers in Musina in Limpopo, Bolt (2015, p.120) documents the inhospitable living conditions of male workers on farms. He records that "[r]esidents – men in most such rooms – sleep twenty or thirty to a room, and complain of lice and sick people coughing in confined conditions." The working conditions on farms some of my participants worked on have something in common with what Bolt (2015) describes. In commenting about the problem of overcrowding and tuberculosis, De Beer (1986, p.1) argues that "[i]f lots of people sleep in one room, or crowd into trains or buses, then they are more likely to breathe in the germs coming from people who are already sick." In the same vein, Mathema et al. (2017, p.S645) contend that "[c]loser proximity and longer duration of contact between an infectious source case and susceptible individuals increase the risk of transmission" of tuberculosis. The transition to democracy raised hopes for the elimination of the inhospitable living conditions fostered by apartheid, which were central to the spread of tuberculosis. However, these conditions have persisted despite the change in political landscape.

Unemployment is a feature of a largely rural province such as Limpopo, and closely intersects with poverty as a factor to consider when analysing the social conditions that give rise to the spread and distribution of tuberculosis. Employment is directly linked to income security which is considered a social determinant of health, and the lack thereof is implicated in adverse effects of ill health (Lonnroth, 2020). Bambra et al. (2019) posits that place is pivotal in population health as it exerts not only direct but indirect effects. Statistics for the fourth quarter of 2022 show the expanded unemployment rate of Limpopo province was at 49.6%, second only to the North West province (Stats SA, 2022, p.8). Unemployment in this case is a public issue affecting many people and by implication has a bearing on population health in terms of access to housing, sanitation, and nutritious food.

It is not coincidental that the province of Limpopo carried South Africa's severest burden of tuberculosis disease in 2016. Unless the reasons are natural or due to radioactive effects resulting from the detonation of atomic bombs as in the case of Hiroshima and Nagasaki in Japan, place is neutral to population health. It only becomes a factor of importance in population health when socio-political processes are interrogated. According to Fassin (2007, p.277) there are deliberate processes which insulate a territory from poverty, while other places "are left to the ravages of poverty, brutality, misery; in those places, acute material insecurity is people's daily lot." Political power determines a place's development and population health

through the distribution of resources and services. Fassin (2007, p.91) remarks that while health issues can be explored through a biomedical approach, the existing inequalities in South Africa show that "social interventions that improve living conditions and reduce economic disparities often have a much more decisive effect on health status." Similarly, Carter, Glaziou, Lönnroth, Siroka, Floyd, Weil... and Boccia (2018) aver that prospects of eliminating tuberculosis lie in reducing poverty and expanding "social protection coverage." The basic income grants and disability grants can be among such measures aimed at achieving these goals in South Africa. In other words, socio-political will and commitment targeting geographical areas have potential to address population health. Likewise, Bambra et al. (2019, p.37) argue that "[p]lace matters for health, but politics matters for place." To understand the intricate interlocking relationship between gender, place and health, Massey (1994) argues that places and spaces as well as the degrees of mobility by people are gendered. The next section problematises the race factor in population health.

Does race matter in South Africa's research on tuberculosis?

Race is a contentious and emotive subject matter in research on health in South Africa. Sociological research on tuberculosis and men in South Africa that does not come back to the issue of race would not have completed its scientific mandate. Moolman (2013, p.97) defines race as social practices which draw upon socio-legal discourses categorising people through the physicality of bodily attributes like skin colour, hair texture and body shape. Emerging from critical race theory's thesis on social constructionism, race is a category invented and manipulated by society (Delgado & Stefancic, 2023) which "governs access to power, resources, opportunities, and penalties in racially stratified societies" (Mannor & Malcoe, 2022, p.57). In the United States of America for example, race is a particularly important determinant of health which influences social class and economic position (Kawachi et al., 2005). Similarly, reproductive health among women in the USA is affected by one's race. Commenting on the USA, Andaya (2019, p.652) argues that "racial inequalities in birth outcomes affect Black women across all economic and educational statuses." In other words, race in the USA fundamentally determines population health. This important assessment similarly explains the interplay of race and health in South Africa.

By design, the system of apartheid carved and bequeathed the future of South Africa with a blurred distinction between race and class (Epstein & Morrell, 2012). While there is this fine line between race and class in South Africa, revisiting the history of the country makes race

an important factor with far-reaching implications for health in the post-apartheid context. Mills' (1959, p.6) notion of the 'sociological imagination' helps us "grasp history and biography and the relations between the two within society." In other words, we may not fully understand the health of an individual in South Africa unless we focus on the history of the country. Scholars like Seekings and Nattrass (2002) conflate race with socioeconomic status in South Africa and conclude that inequalities in health must transcend racial analysis. Both historically and in the contemporary South African context however, race has intricately and dynamically shaped population health in distinct ways. As such it needs to be seriously interrogated. As observed by Burgard (2004 in Charasse-Pouele & Fournier, 2006), race was pivotal in carving life chances and health outcomes among the population in apartheid South Africa.

Detailed historical analysis of the development of tuberculosis and syphilis in South Africa proves that measures put in place at the beginning of the twentieth century to control these diseases were deliberately premised on exclusionary policies to keep the disease away from white South Africans (Fassin, 2007; Packard, 1989). In a similar vein, the final decade of apartheid, argues Steinberg (2011, p.5) witnessed the operating budget of the racially exclusive Johannesburg General Hospital outstripping the "combined health budgets of all seven of South Africa's Bantustans, home to a population of several million people, among whom the modern diseases of poverty were legion." Such was the policy of apartheid in shaping population health according to race. Although the democratic governments are addressing apartheid-inherited health disparities, Charasse-Pouele and Fournier (2006) argue the perpetuation of health inequalities according to race are evident where, for example, in 2001 only 8% of black Africans had access to a medical aid scheme as opposed to 83% of Whites.

In South Africa, race is arguably a 'social fact' which cannot be divorced from both the past and present population health realities. It is implicated in how diseases are patterned. Although writing in the apartheid era, De Beer's (1986, p.34) assertion cannot be far from reality when he argues that "to be born into the black working class is to be born to dangerous life." Apartheid created systemic discriminations in health outcomes along racial lines which were magnified through socioeconomic status, employment, education, residential location, and health services (Charasse-Pouele & Fournier, 2006). That there was and is a marked difference between races in terms of tuberculosis is indisputable. These differences cannot be explained away in terms of biology, but they are clearly socially manufactured. According to

McCulloch and Miller (2023, p.170), the Public Health Act of 1919 was not only created to curtail tuberculosis infection among whites but it also "introduced programmes for early diagnosis, treatment and notification, as well as improved housing, sanitation and education." Racially skewed as the Act was, no parallel programmes were designed for black South Africans (McCulloch & Miller, 2023) to ensure their protection from TB infection.

In the same vein, De Beer (1986, p.10) argues too that the 1932 TB commission stated that "[s]o far, the splendid climate, the high standards of prosperity and life in general, and the absence of overcrowding have combined to render the white population of South Africa in a good measure, secure from TB." These specific privileges which favoured the whites under colonialism and apartheid have continued in democratic South Africa, while the majority blacks live in impoverished conditions where tuberculosis is prevalent. The privileges further show how health inequalities were systematically created between the white and the African races in South Africa. As argued by Ataguba and Alaba (2012) race has continued to be a factor that divides black and white in relation to accessing education, health, and social services in democratic South Africa. In that breadth, Coovadia et al. (2009) argue that the glaring difference punctuated with impoverishment of the black population against the general affluence of the white population has always had an influential impact on the health of South Africans. Coovadia et al. (2009) further add that there are still acute differences in rates of disease and mortality between racial groupings in South Africa. This is typified by the mortality differentials caused by HIV/AIDS and tuberculosis wherein age-standardised death rates for black Africans in 2012 were 2.2 times higher than for whites i.e., 1 388 vs 631 per 100 000 population (Pillay-van Wyk, Msemburi, Laubscher, Dorrington, Groenewald, Glass ... & Bradshaw, 2016, p.e651).

A detailed report of the ten underlying natural causes of death by population group in 2016 shows that tuberculosis is the number one cause of death for black Africans at 24 886 deaths but does not feature at all among the White population (Stats SA, 2018, p.138). A comparative study of how black and white men experience the disease might be a futile exercise because tuberculosis does not constitute a major health burden among whites. Pointedly, the statistics provided give concrete impetus for this study's focus on black working-class men's experiences of tuberculosis in Modimolle. When analysed through the prism of apartheid history, race remains a distinct factor which independently influences how tuberculosis is distributed and experienced among men in South Africa. Having raised the debates around race and health in relation to tuberculosis among men, I further explore the entanglement of

socioeconomic class and tuberculosis in the next section.

Impact of social class on health and tuberculosis

Disentangling race from socioeconomic class is a complicated matter in the South African context as the two factors appear to be mutually constitutive. However, the two factors are independent of each other and the way they are implicated in tuberculosis among men is also different. The dominant view prevailing in the social production of tuberculosis is that socio-economic factors are closely tied with how the disease can be understood between and within countries, as well as within communities whereby the poorest remain at greater risk of contracting the disease (Ataguba et al., 2011). The South African healthcare system is described as a parallel one in which the public and private healthcare systems coexist. This parallel system is made to thrive because of the racialised capitalist system, and to a greater extent, by the large and acute differences in wealth and income between the rich and the poor. The parallel healthcare structure present in South Africa ensures that access to healthcare is fundamentally determined by social class whereby a high percentage of the poor and black African population congest the public healthcare system while the few with medical insurance make use of the world-class private healthcare sector (Delobelle, 2013; Neely & Ponshunmugam, 2019). According to the 2021 General Household Survey, 27% of households in South Africa rely on the private healthcare system for healthcare, while 71.9% of households use the public healthcare system (Stats SA, 2022, p. 23). Although there are various reasons for the use of either the private or public healthcare system, such as proximity to the point of care and perceived quality of care, socioeconomic class is a fundamental determining factor.

The national health inequalities in the use of healthcare systems are also reflected at provincial levels down to district and municipal levels. Inequalities in health access is a reality in most unequal societies like South Africa. Provincially, the 2021 General Household Survey found a stark contrast in healthcare reliance: in Limpopo, 85.4% of the population depend on the public healthcare system when ill, whereas only 52.1% of people in the Western Cape Province use public health facilities (Stats SA, 2021, p. 23). These disparities in healthcare access speak to the significance of socioeconomic class as a fundamental determinant of health between and within provinces as Limpopo is a largely rural province with constrained economic opportunities. Reinforcing the prevalence of health inequalities in South Africa requires a look at the population–provider ratio. Evidence shows that there are 204 healthcare professionals per 100 000 uninsured people in South Africa as compared to the World Health Organisation's

standard of 230 healthcare professionals per 100 000 (Neely & Ponshunmugam, 2019, p.218). This population–provider imbalance entrenches health inequalities for most of the people. In addition, Mayosi, Lawn, Van Niekerk, Bradshaw, Karim and Coovadia (2012, p.107) argue a strong and mutually reinforcing relationship exists between health and wealth. In other words, this two-way healthcare system in the country simply benefits the wealthy at the expense of the already marginalised poor who are the majority blacks.

The existing health inequalities in the country are evidence that the postcolonial state still exhibits colonial-era inequalities. This gives impetus and urgency for restructuring the healthcare system hence the call for the implementation of the National Health Insurance (NHI), which aims to provide universal health coverage for all South Africans. The NHI Bill clearly acknowledges these inherited health inequalities as it mentions in its preamble that it recognises, "the socio-economic injustices, imbalances and inequities of the past; the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights…" (National Health Insurance Bill, 2019, p.2).

With the glaring inequalities in South Africa, tuberculosis is considered a disease of poverty (Allotey & Gyapong, 2008; Coleman et al., 2022; Farmer, 1997), and like many other infectious diseases, it is more prevalent in socially and economically disadvantaged populations (Curtis, 2004). As one of the most unequal societies in the world, South Africa's burden of disease in relation to tuberculosis follows a clear pattern where it is largely concentrated among poor people (Burger & Christian, 2018; The World Bank, 2018). Socioeconomic deprivation in terms of poor access to basic services like water, sanitation, and income generating opportunities is associated with poor living conditions like overcrowding and undernutrition, which perpetuate the risk of exposure to communicable diseases (Curtis, 2004; Duarte et al., 2017; Hunter, 2010). Furthermore, socioeconomic status influences all stages of TB pathogenesis (i.e. from infection to disease development) (Duarte et al., 2017; Lienhardt, 2001), while the principal risk factor for not only acquiring tuberculosis but dying from the disease is nothing other than poverty (Farmer, 1997, p.355). To meaningfully address the tuberculosis disease burden in South Africa, a targeted focus on the social aspects of the disease offers better promise.

Although scholarship shows that socioeconomic class is fundamental to an understanding of TB occurrence, problematising this factor is crucial as it reveals some contradictions. This is so because the causal pathways linking poverty and low socio-economic status to increased

risk of TB are not fully understood (Lonnroth et al., 2009). Important as social class is to disease occurrence, its relationship with tuberculosis is complex. This is so because there may be some underlying conditions predisposing other individuals from better off socioeconomic classes to TB infection. These underlying conditions could be diabetes and HIV/AIDS, for example. However, this does not discount the forceful impact that poverty may have on tuberculosis. While the wealthy may also be susceptible to the disease, their access to nutritious food and private healthcare improves health outcomes, something the marginalised and poor might not possess. In an analysis on the social epidemiology of tuberculosis in South Africa, Harling, Ehrlich and Myer (2008) found the prevalence of tuberculosis to be associated with lower individual-, household-, and community-level socioeconomic status. As an important marker of social class, education is a protective factor against tuberculosis disease where every year of education completed corresponds with an increase in tuberculosis protection (Harling et al., 2008, p.496). The next section consolidates the sociological interpretation of tuberculosis through the structure/agency debate.

The implication of structure/agency on healthcare access

Having engaged most sociological debates central to understanding tuberculosis infection and distribution, it is equally important to devote space to the issue of healthcare access. However, I first concretise the concept of health before exploring factors around men's healthcare access as these two have interplay. While there are various interpretations around health, a fundamental point to note is that the concept finds meaning within socio-cultural contexts and at the subjective individual level. In other words, the definition of health may not find universal applicability though there are some common denominators undergirding the concept. Health can be understood at an individual level to mean one's own self perception of his or her physical, social and mental state. Within this framework is a definition by Raphael, Steinmetz, Renwick and Rootman (1999, p.200) who consider health as "the ability to have and reach goals, meet personal needs, and cope with everyday life." This definition emphasises the power of agency on the concept of health at the expense of the influence of socio-political processes.

At a structural level, health is determined by the environment in which one lives and to some extent this is captured in the World Health Organisation (1948, p.1) definition which holds health to be "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." In addition, health speaks to issues of happiness and wellbeing, and this has found traction through the work done by the World Happiness Report

that measures how happy a country and its population is. This measure is based on six key features that arguably are structural in nature, like the GDP per capita, social support, healthy life expectancy, freedom to make life choices, generosity and perceptions of corruption. According to Rowan (2022) South Africa occupies position 91 in the World Happiness Report, out of 146 countries surveyed. The above definitions on health are important in this study. I, however, take the middle of the road approach to health, embracing both the individual's self-perception and the social context of his/her existence (which is also cognisant of the supernatural). This definition of health adds impetus to the African-centred theory of masculinity central to this study of men's tuberculosis illness experiences. To this end, I borrow the definition of Helman (1994, p.108) who argues the existence of a holistic definition of health in what he terms the "non-industrialised" societies where health is understood in terms of a "balanced relationship between man and man, man and nature and man and the supernatural world." In other words, an individual's ability to achieve their planned goals and cope with everyday life must be looked at within the socio-political and supernatural belief systems of his/her existence. Chapter Eight of this thesis gives a reflective overview of how participants understood health and made meaning of tuberculosis.

Having highlighted the meaning of health at individual and social levels, I shed light on men's access to healthcare in the face of tuberculosis. On the individual level, healthcare access is intricately linked to health-seeking behaviours. A more biomedical view which premises healthcare access solely on the individual tends to blame the same individual when he or she does not make use of available healthcare services in times of illnesses. In his critique of biomedicine's individualised understanding of health, De Beer (1986, p.66) argues that "[t]he superficial truth that the body of an individual gets sick, is turned into the profound lie that health is an individual matter. If a person gets sick, it is his or her fault." Similarly, some radical political economists argue that medicine operates to obscure the influence of social and political determinants of ill-health by emphasising the individual's role in illness "thus supporting rather than challenging the capitalist status quo leading to much ill-health" (Lupton, 2012, p. 108). There is no doubt about the significance of biomedicine to our understanding of health. However, the socioeconomic and political contexts within which individuals are located must be critically considered for a more concise understanding of health, illness, and healthcare access.

It is worth pointing out that a hospital specialising in MDR-TB for the entire province of Limpopo is in Modimolle, the research site. The patients housed at the hospital come from far

and wide, such that distance is a deterrent for visits from family members (Chauke et al., 2018). In their study of policies to minimise multidrug-resistant tuberculosis in an MDR-TB unit in Limpopo Province, Chauke et al. (2018) capture the importance of family visits for positive treatment outcomes in hospitalised tuberculosis patients. The authors found that some of the patients felt neglected and lonely, which resulted in them not adhering to treatment (Chauke et al., 2018). In other words, health is contingent upon social processes and in this case, social support from family is important for a comprehensive understanding of health.

Drawing from Mohseni and Lindstrom (2007), Neely and Ponshunmugam (2019, p.215) argue that access to healthcare is "the ability to obtain health services when needed" and the "freedom to use" healthcare. Important as this definition is, I would hasten to mention that there are social factors that come into play when one considers accessing healthcare services. These include financial resources, gender constructions and distance to the healthcare centre. Is the freedom to access healthcare services guaranteed in environments with limited resources? Duarte et al. (2018) argue that poverty not only makes people more susceptible to tuberculosis infection and disease progression, but also raises barriers to accessing healthcare. In the same vein, the message by Dr Gluckman in 1942 is relevant in present-day South Africa the way it was back then when he remarked that "[u]nder the present system the majority of people are deprived of the advantages of the modern medical services. The service rendered is determined not by the individual's susceptibility to disease, but by his ability to pay" (cited in De Beer, 1986, p.15). Further still, Neely and Ponshunmugam (2019) argue that healthcare access in South Africa is interlinked with racial capitalism as this economic system influences life chances and livelihoods. Healthcare access is therefore determined by factors that include socioeconomic class and race.

Steps towards healthcare access are preceded by an individual and their social group's assessment of the symptoms, e.g., of tuberculosis in this case. This pertains to the meanings around illness. Lupton (2012, p.86) defines illness first and foremost as inherently a human process which is both social and an individual "lived experience of symptoms and suffering." This process involves acknowledging the lack of balance with one's body triggering health-seeking behaviours. In relation to illness experiences, Kleinman (2020, p.24) argues that these include "categorising and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those pathophysiological processes." Illness experience is an individual process that is intricately social as it must be deciphered and validated by the social group a sufferer belongs to. Helman (1994, p.110) adds that, "a person

is defined as being 'ill' when there is agreement between his perceptions of impaired well-being, and the perception of those around him." Illness experience is a process an individual sufferer, in this case a TB sufferer goes through in terms of the process of suffering from the TB symptoms as well as the meaning he attaches to that suffering.

When tuberculosis illness experiences are considered, it must be borne in mind that men are not passive actors in relation to negotiating access to healthcare services. Men pick and choose from a plural healthcare system when they consider healthcare access in the face of tuberculosis illnesses. I present a nuanced discussion of the concept of medical pluralism in Chapter Three of this work. I show that the use by men of any health system must be understood from a cultural basis. But before then, I complete this chapter with a look at gender as a social determinant of health and tuberculosis.

Why gender matters in tuberculosis analysis

Within a sociological interpretation of tuberculosis lies gender as one of the critical structural factors. What influence does gender have on health and particularly, on tuberculosis infections? Gender is an important social factor implicated in TB infection. Specifically, being a man is said to be a risk factor for late TB diagnosis (Chikovore et al., 2017; Meintjes et al., 2008) with the added challenges of treatment defaulting which compound the disease among male patients (Austin, Dick & Zwarenstein, 2004; Ramaliba et al., 2017). In other words, by presenting late for TB care as well as defaulting, men heighten the spread of the disease. Read and Gorman (2010) point to the differences in mortality in which women outlive men, regardless of when life expectancy is measured, as one of the areas where gender must be analysed. It is inferred that the differences in life expectancy between men and women is not solely biological. Gender is therefore a critical layer underpinning health and illness. Surveys conducted in Lesotho and South Africa show that compared to men; women have a better knowledge of tuberculosis in terms of its cause, symptoms, and mode of transmission (Luba, Tang, Liu, Gebremedhin, Kisasi & Feng, 2019; Shamu, Kuwanda, Farirai, Guloba, Slabbert & Nkhwashu, 2019). This gendered possession of accurate knowledge on TB is an important dimension in preventing infections and enhancing positive health-seeking behaviours.

Borgdorff, Nagelkerke, Dye and Nunn (2000) posit that gender differences on tuberculosis are intricately related to health-seeking behaviours between men and women. It is imperative to examine the reasons men delay presenting at points of care in face of suspected ill-health. The

underlying reasons men present late for care and in other instances 'default' or interrupt treatment are important factors that require exploring for evidence-based interventions. The health-seeking behaviours of black working-class men in Modimolle were problematised in this study to assess how they possibly had a bearing on treatment outcomes. Thorson and Garcia-Moreno (2009) argue that health-seeking behaviours, access to health information and ultimately TB treatment outcomes are moderated by gender. This study also empirically explored the cause for treatment interruption among men. Treatment interruption by men does not only contribute to drug resistance but bridging the gap in understanding the underlying reasons for non-adherence has potential to yield theoretically nuanced results. To that end, this research analysed the gap in understanding through ethnographic means, examining the reasons men in Modimolle presented for delaying seeking care.

A call for research investigating factors perpetuating and complicating tuberculosis among men is long overdue, hence Chikovore et al. (2015) argue against the marginalisation of men in health studies as is often the case. Stats SA (2018, p.34) confirms that tuberculosis in South Africa has a higher prevalence among men than women, with the disease being the leading cause of death among males in 2016. While this finding is important, it tells us little about the subjective nuances behind such high mortality rates among men, something this qualitative study addresses. According to Horton et al. (2018) there is a global systematic neglect of men as a key population in tuberculosis. It is therefore concerning that in much health research and policies formulated by global institutions like the World Health Organisation, and by extension in the South African health policy context, men, albeit heterogeneous, are not among part of the at-risk populations in need of urgent attention about tuberculosis. This is despite glaring evidence confirming, comparatively, that men suffer and die in disproportionately large numbers from the disease compared to women. Deliberate omissions of men in fundamental health policies, such as those in South Africa, arguably exacerbate the spread of tuberculosis at household and community levels. This is due to a clear deficit in intervention measures by the state to combat tuberculosis burden among this gender.

Reflecting on South Africa, Clowes (2013a) argues there is a tendency to neglect men's vulnerability not only to physical and sexual violence but also to health problems arising from patriarchal norms. This observation is noteworthy as it shows the trivialisation societies accord the health of men, something that has negative effects at household and community levels as well as on the country's overall development. The health of men and specifically tuberculosis

among men requires scientific investigation. Allotey and Gyapong (2008) emphasise that to control communicable diseases like tuberculosis it is imperative to understand the interplay of gender relations and the creation and sustenance of poor health outcomes among women and men. An approach to combat tuberculosis as an endemic disease in South Africa cannot be complete if it omits the gender dynamics that have perpetuated the unabated concentration of the disease among men. Broom (1998) suggests that improving men's health encompasses understanding what being a man means in a contemporary society. In the same vein, Griffith (2018) problematises discourses which take a skewed and individualistic analysis of men's health problems with no consideration for the larger social, cultural, and economic context within which men exist.

In my ethnographic journey, I visited some of the entertainment/recreation spaces frequented by men in Modimolle, such as taverns and shebeens, to observe and learn about men's social practices when they are together. Although taverns are gender neutral and are frequented for socialising, entertainment and beer drinking, men often spend lengthy periods in these spaces, especially at weekends. Associated with an individual's long stay in a tavern space is the challenge of accessing (healthy) food. Considering that tuberculosis is an opportunistic infection, the implication of a weakened immune system increases the risks of contracting the disease. The social practices in spaces of recreation – sharing beer between patrons (i.e., drinking from the same bottle), sharing cigarettes, (i.e., sharing the same cigarette) in confined spaces with no adequate ventilation – is one of the analytical lenses I use to analyse TB infection among men. In the case of South Africa therefore, the heterogeneity of men demands that the prevalence of tuberculosis among them be dissected against the multiplicity of social factors – race, socioeconomic class, gender, and men's social practices.

Conclusions

The chapter provided sociological insights and debates on tuberculosis disease. This was achieved firstly by defining the disease, predisposing conditions for infection and disease progression, and how the disease is transmitted among the population. Importantly, and in line with a sociological interpretation of tuberculosis, I examined the social determinants of the disease and argued these help us to appreciate that disease occurrence is not a random process. Through that analysis, I highlighted the usefulness of structure and agency in health and illness. The chapter further historicised how tuberculosis came into southern Africa with the advent of

colonialism, and it became endemic in the majority population. In South Africa, this was facilitated through social upheavals associated with colonial and apartheid state-crafted policies such as the creation of homelands for Africans under the 1913 Natives Land Act, the imposition of a hut tax and the system of labour migration. The architecture of primitive accumulation through large-scale extractivist mining was accompanied by harsh working conditions and substandard living conditions of overcrowding. These conditions were conducive for the spread of infectious diseases. I furthermore extended the debates on social determinants of health through dissecting the factors of race, socioeconomic class, and gender in relation to their implication for tuberculosis. The chapter argued that paying attention to these factors helps us to appreciate how tuberculosis is a social disease whose control invites multidisciplinary approaches.

Situated within a sociological lens, the chapter engaged and debated with extensive literature about the influence of social factors on TB distribution. Although the post-apartheid state has attempted to redress the ills of a skewed and unequal healthcare system inherited from the apartheid government, the neo-liberal policies adopted have not had a meaningful impact. As a result, the healthcare system in South Africa has largely remained unchanged as the well-functioning private healthcare system continued to operate in parallel to the poorly resourced public healthcare system. Healthcare inequalities have persisted along the same factors that prevailed during the apartheid healthcare system. Although the obscene racial health inequalities of the apartheid system were replaced, race has continued to be a fundamental determinant of health in South Africa as it influences social class. As a result, tuberculosis has continued to be a dominant disease among Africans, especially black men. In his analysis, De Beer (1986, p. 12) argues that TB is not spread randomly. Instead, it disproportionately affects the poor and marginalised, who "live in overcrowded conditions and work at hard jobs... These are the people who hold the lowest positions in the economy, and do not have the political power to improve their situation."

The next chapter devotes space to and critical analysis of what it is about men that make them disproportionately vulnerable to tuberculosis infections. The chapter borrows from critical studies on men and masculinities as it extends the African-centred theories of masculinity advocated by scholars like Manganyi (2019), Mfecane (2016, 2018, 2020), and Ratele (2021). In addition, the chapter crystallises fundamental concepts like medical pluralism, illness

narratives, biographical disruption, and stigma as these are central to the illness experiences of men with tuberculosis.

Chapter Three

Theoretical and conceptual linkages: Building on and towards African-centred theories of masculinity.

Central to African ontology is a recognition that in order to understand the status of an individual at any given time (be it in the areas of interpersonal relations, health or disease) attention should be directed at his existential situation in its totality. This means that the relationship among the interdependent vital forces (life forces), elders, ancestors and God have to be fully appreciated in each situation (Manganyi, 2019, p.53).

Introduction

In the previous chapter, I presented a comprehensive discussion arguing for a sociological analysis of epidemics in South Africa, and particularly a sociological diagnosis of tuberculosis. This helped me to underscore how tuberculosis ought to be interpreted through the social determinants of health lens which I connected to the structure/agency debates. I additionally historicised the emergence of epidemics in South Africa that coincided with the era of colonialism. I demonstrated how the apartheid system solidified disparities in healthcare among different racial communities. In this chapter I delve deeper, examining tuberculosis from a gender perspective by focusing specifically on the concept of masculinity. I dissect the genealogy of masculinity theories and their development in research on men, as well as their shortcomings. Some of the major shortcomings of masculinity theories, especially emerging from the Global North, concern the attempt at universalising men and their experiences and thereby blindsiding the importance of context. Suttner (2005, p.6) argues that scholarship on masculinity from the West is particularly different from that of South Africa and contexts that experienced colonialism, as the former do not appreciate a "situation where manhood has been denied in the sense that it has been in the history of apartheid or colonialism generally." The shortcomings of some of the theories of masculinity, especially the ethnocentric outlook, aid me in adopting the African-centred theories of masculinity as advocated and popularised by scholars like Manganyi (2019), Mfecane (2016; 2018; 2020) and Ratele (2021) among others. African-centred theories of masculinity have the capacity to help us understand African men and their historical, sociocultural, and traditional contexts.

In referencing Manganyi (2019) in the quotation above, I position this research within a uniquely African ontology, thereby invoking African-centred theories of masculinity to help explore the purchase or utility – or lack thereof – of their application to the TB illness experiences of men. My intention is to build upon these theories towards understanding men's health in general, and men's illness experiences of tuberculosis. Such theoretical engagement contributes to the advancement of knowledge. African-centred theories of masculinity presuppose that the immaterial elements of personhood, the ancestors and God influence the social conduct of Africans (Manganyi, 2019; Mfecane, 2018). These immaterial forces have an influence on the conduct of African men in their everyday lives and, by extension, in their health behaviours and experience of illness. To avoid generalisations, homogenising African men, and their experiences, I contextualise this study within the research setting of Modimolle Township in Limpopo province.

I therefore contend that among men, TB infection and the subsequent experiences of illness are both influenced by and contribute to the expression and intrinsic beliefs associated with masculinity. The process of masculinity identification occurs at the intersection of societal values, norms, and individual identity. Within this chapter, I also incorporate and explore significant concepts from the sociology of health, such as illness narratives, biographical disruption, and stigma, to gain a deeper conceptual and empirical understanding of how black African men in Modimolle experience tuberculosis in their daily lives. As these concepts are linked to men's health-seeking behaviours, I engage the concept of medical pluralism to appreciate the material and immaterial conditions men base their choices on about the healthcare systems for diagnosis and treatment of tuberculosis. I also engage the concept of "illness as metaphor" formulated by Sontag (1977), to better understand the contextual significance and interpretations of tuberculosis among men. Combining African-centred theories of masculinity with core concepts from health sociology can provide valuable insights into how men contract TB and experience the subsequent illness. Before offering a concise overview of the current state of knowledge regarding theories of masculinities, I conceptualise gender in the next section.

Conceptualising gender

It is important to foreground the concept of gender. Without doing so, we cannot fully grasp what masculinity entails. Usually, when the concept of gender is mentioned, people may associate it with women, as if men have no gender. Morrell and Swart (2005) agree that in

underdeveloped countries the emphasis on gender consistently centred on women, ironically resulting in the inadvertent invisibility of black men. This invisibility of black men is more acute in health discourses and policies. According to Reihling (2020, p.xi), there is a gap in health studies where "men's gender-specific vulnerability in its own respect" remains under-researched, especially "in less economically developed countries and cross-culturally." Likewise, Broom (1998, p.54) argues that the fundamental tenets of gender which are femininity and masculinity must be understood as fountains of risks and benefits at different levels of a person's individual and social life which can be "constraining and empowering." The relationship between gender and tuberculosis reveals the disease disproportionately affects more men than women. This makes gender an important analytic factor. Thorson and Garcia-Moreno (2009) add that gender is a key factor determining the risk of a person becoming infected and developing TB. In other words, health outcomes at an individual level cannot be fully understood without considering the interplay with gender.

Gender reflects societal expectations about how sexed bodies must behave and fulfil their roles. Conceptually, gender is comprehended at three levels: firstly, in how societies construct and regulate distinctions between sexes; secondly, in the cultural significance attributed to the roles of men and women; and finally, in the way individuals understand their own identities (Tsang & Wassersug, 2018, p.e29). Gender must therefore be understood at the continuum of society and individual. Gender is contextual and part of social stratification, which varies between and within societies. Explicit in the provided definition is that gender is hierarchical and closely tied to specific roles such as the stereotypes of 'man-as-breadwinner' and 'woman-as-caregiver', for instance. Societies prescribe these roles which become reinforced through socialisation. Connell (1987) adds that gender pertains to the ordered practices associated with and in connection to the reproductive categorisation of individuals into male and female. Men's understanding and experiences of tuberculosis must therefore be located within specific socio-cultural contexts which define what it means to be a man, their roles and how men understand these identities. While gender is argued to be a social structure (Connell, 2009; Russell, 2019) implicated in the health outcomes of populations, Butler (2004) contends that gender is a practice of improvisation within a scene of constraint. How individuals assume and enact the societally prescribed roles is clear from both definitions. In the same vein, West and Zimmerman (1987, p.129) agree that gender is the result of some social action made concrete through interpersonal relationships.

According to Butler (1988), gender is a performative aspect of identity, shaped by social interactions and historical contexts. The emphasis on performance of roles in context is important when discussing gender as this shows that gender is socially constructed and evolving. It is not a fixed or biologically determined characteristic. Gender is not something innate but rather a set of behaviours, roles, and expressions that individuals enact through interaction in their everyday lives. West and Zimmerman (1987, p.137) concur that as far as individuals do gender "the enterprise is fundamentally interactional and institutional in character…" Gender in this regard is a subjective expression and simultaneously a social structure. Gender is flexible and is an accomplishment of repeated performance of actions and behaviours enforced through "social sanction and taboo" (Butler, 1988, p.520). In other words, Butler's contention is that gender identity and expression are not predetermined but are constantly performed and reinforced through everyday actions and behaviour.

Connell, Hearn and Kimmel (2005, p.7) concur that as an identity, gender is a "constant process, always being reinvented and rearticulated in every setting, micro or macro." This performance occurs within the parameters of societal norms. However, Connell (2000, p.20) disagrees with Butler's idea about gender as performance because it does not consider things like work, taking care of children, life in institutions, violence, resistance, and material inequality. To put it differently, Connell (2000, p.24) argues that gender goes beyond being just performative; it is fundamentally a social practice. This implies that gender roles and identities are not isolated or unchanging entities but are closely intertwined with the complex web of social structures and interactions. At a personal level, gender influences one's behaviours, expectations and self-perception of their roles and identities. At the interpersonal level, gender shapes the way people interact with one another through communication style and power dynamics (Connell, 2000).

The communication level, as described by Connell (2000) as 'symbolism', highlights how communication serves as a site for gender practices to be expressed and observed. On a macro level, the impact of gender is evident in the social organisation of institutions, such as the disproportionate concentration of men in positions of state power and as chief executive officers in the corporate world and the formulation of policies that shape power distribution within society. Connell (2000) contends that the fundamental characteristic of the gender order in Western societies is the general subordination of women and the dominance of men, a structure commonly referred to as patriarchy.

In relational terms, the influence of gender is reflected in what Connell (2000) calls the production level where the division of labour shows benefits of social labour accrue to men than women. For example, a heterosexual couple with children might prioritise the education of the male partner first, leaving the female partner to attend to household labour for the family. This social practice is evidence of how gender influences institutions and ultimately, men are beneficiaries of the system. My study demonstrates how the gendered division of labour spotlights the care work by women when men are suffering from tuberculosis. Connell (2000) refers to this as the patriarchal dividend. Stemming from the core framework of gender are the fundamental concepts of masculinity and femininity. In the next section, therefore, I provide a brief and concise genealogy of masculinity theories as precursor to foregrounding the African-centred theories of masculinities.

A brief review of masculinity theories

Conceptually, masculinity is a form of social identity underpinned by socio-cultural expectations about roles and behaviours pertaining to different sexed bodies. According to Connell (2000, p.29), masculinity relates to male bodies – whether directly, symbolically, or indirectly – without being solely determined by male biology. In other words, masculinity can be expressed and performed by both male and female bodies. Fleming, DiClemente and Barrington (2016, p.1) argue that masculinity "is a social construct that depends on both social interactions and social expectations that judge men and their behaviours in each culture. That is, masculinity not only refers to what men do but also to what they are expected to do, it is a set of beliefs and practices." Like any identity theorisation, masculinity takes shape and solidifies at the intersection of an individual and the collective. According to Jenkins (2008, p.42) "[i]dentity is never unilateral" meaning that it is not one-sided. Similarly, Langa (2020) adds that, much like gender, masculinity is not set in stone and unchanging; instead, it possesses the ability to transform and metamorphose. This fluidity emanates from the ongoing entanglement between the individual and the collective. Thus, masculinity identity as socially constructed and as performed are not mutually exclusive.

While masculinity is largely expressed through biological male bodies, it can be performed by any gender: it is diverse and complex. Connell (2000) therefore avers that, the existence of masculine women or masculinity in women's lives as well as masculinity in men's lives is prevalent. If one understands invulnerability to be a marker of masculinity identity for instance, it implies that both male and some female bodies can express that feature. In defining

masculinity, Whitehead and Barrett (2001, p.18) argue that it is "something that one 'does' rather than something that one 'has', it's therefore appropriate to say that men 'do' masculinity in a variety of ways and in a variety of settings, depending on the resources available." More closely resembling Butler's definition of gender as performative, masculinity is equally performative: highlighting that individuals actively perform and enact masculinity within the context of societal norms and expectations. Masculinity is formed along the individual-societal continuum and this process of identity formation is closely linked with how men make meanings about their health. In this study, I employ the term 'masculinity' to analyse men's preoccupation with identity, shaped as it is by societal norms and values and manifested and enacted at personal, interpersonal, and macro levels.

A brief overview of the history of masculinity is warranted for insights on how the field of study has evolved. This helps to theoretically align this study with the trajectory of African-centred theories of masculinity. The emergence of masculinity studies since the 1950's shows the influence of various theories such as structural functionalism, Marxism, psychoanalysis, post-modernity, critical structuralism, and post-structuralism (Whitehead & Barrett, 2001). In other words, masculinity theories are shaped by different theories that emerged within specific contexts. Masculinity studies evolved along three waves since the 1950s. Connell et al. (2005) argue that scholarship in masculinity in its modern form started with psychoanalysis, through the theory of sex roles. This, as argued by Whitehead and Barrett (2001), was the first wave in masculinity scholarship. The initial understanding of masculinity placed emphasis on an "internalised role or identity" acquired through socialisation and guided by a particular culture's norms or values (Connell et al., 2005, p.5). According to Connell (2000, p.7) sex roles are seen as patterns of social expectations, the norms guiding how men and women should behave. These expectations are passed on to young people through a process of socialisation. Sex role theorisation tended to understand social behaviour only in terms of conformity and thus obscured the reality of gendered power and resistance. Messner (1998) finds fault with the terminology of sex roles as it suggests an untrue equality between the roles assigned to men and women, thereby concealing the oppressive power dynamics between the two genders. Similarly, Whitehead and Barrett (2001, p.15) critique the male sex role theory, asserting that it rigidly conforms to prevailing expectations of masculine ideology which was oppressive both to women and men. The women's and gay liberation movements also criticised the male sex role for its ethnocentrism, positivist outlook, and neglect of problems of power, violence, and material inequality (Connell, 2000; Connell et al. 2005). Some of the criticisms against the

positivist outlook of the male sex role theory revolves around the usage of quantitative Masculine/Feminine (M/F) scales researching how masculine or feminine one is. The problem with that theorisation is the presupposition that masculinity or femininity are intrinsic characteristics, neglecting just how gendered the categories are. The concept of masculinities succeeded the 'male sex role' theorisation, preferring rather the usage of men and masculinities concepts over manhood or manliness (Kimmel, Hearn & Connell, 2005).

The second wave in the development of masculinity studies arose in the 1980s and was not so much concerned with highlighting the cost to men of patriarchy as with the centrality of male power to dominant ways of being a man. Power is therefore implicated within the gender order in which masculinities and femininities are arranged. The concept of 'hegemonic masculinity' coined by Carrigan et al. (1985) surfaced during the second wave and underscores that masculinity is a political, multifaceted, contested, yet influential concept (Whitehead & Barrett, 2001, p.15). Linked to the shift away from sex role theorisation is the influence of feminist scholars from the 1980s. They advocated for moving beyond the tendency to universalise the male sex role, and instead embraced the idea of multiple masculinities (Messner, 1998, p.259).

Feminist post-structuralism as well as theories of post-modernity influenced the third wave in the trajectory of the sociology of masculinity (Connell, 2000). The emphasis is on how men's sense of identity is validated through dominant discursive practices of self, and how this identity work connects with gender power and resistance (Whitehead & Barrett, 2001, p.15). The third wave gave more impetus to defining gender as social construction. Fundamentally, the third wave – influenced by feminist analysis – understood gender as a "structure of social relations, especially a structure of power relations" (Connell, 2000, p.8). This analysis moved towards an appreciation of the interplay between gender and multiple categories such as race, sexuality, ability, and class. The third wave aimed to explore how definitions and discussions contribute to reinforcing gender inequalities. This includes portraying men as strong, rational, and disciplined while depicting women as fragile, emotional, and undisciplined (Whitehead & Barrett, 2001, p.17). A more detailed presentation of the plurality in masculinity follows in the next section.

Not one but plural masculinities

The transition from the study of masculinity to pluralised masculinities in research is a fundamental development which acknowledges heterogeneity in socio-cultural contexts as well

as the importance of power in the analysis of masculinities. Within a particular context, masculinities can therefore exist side by side, though the relationship is sometimes tumultuous. Connell (2001) argues that multiple masculinities emerge against the backdrop of the interplay between gender, class, and race. However, Breu (2022, p.588) cautions that while pluralising masculinities is an important development in researching men, the feat must avoid "a horizontal or flat conception of power, in which all masculinities can peacefully (and nonconflictually) coexist." Theories of masculinities should therefore always critically engage with power. Connell (2000, p.29) suggests that masculinities are patterns of behaviour within the context of gender relationships. These patterns extend beyond personal interactions to encompass broader aspects like institutions, economic systems, and sexuality. It bears emphasising that masculinities, like gender, are social structures. That would explain their influence in many spectra like personal relationships, and in macro-level institutions. In their articulations, Ammann and Staudacher (2021) argue that masculinities are norms and expectations related to what men say and do to be men. This resonates with Butler's (1988) definition of gender that it is not a stable identity but comes into existence only in time and space through repetitive acts. For these repetitive acts to conform to the display of masculinity, they must be "finely fitted to situations and modified or transformed as the occasion demands" (West & Zimmerman, 1987, p.135). The use of masculinities demonstrates they are contingent on historical and socio-cultural contexts.

Different masculinities that exist alongside and in relation to hegemonic masculinity include complicit, marginalised, and subordinated masculinities. The list of variants may not be exhaustive as the field of masculinities keeps evolving. Complicit masculinities are structured around the acknowledgment and acceptance of the benefits derived from patriarchal systems, even though they may not actively engage in defending or promoting patriarchy (Connell, 2000). Complicit masculinity is the least developed of Connell's concept. According to Buschmeyer and Lengersdorf (2016, p.193) complicit masculinity refers to masculinities that aim to meet the expectations of hegemonic masculinity but, for various reasons, falls short of satisfying them. Nonetheless, by aspiring to hegemonic masculinity, they inadvertently contribute to and reinforce the dominance of the group. It could be argued that complicit masculinity occupies a space of liminality except that, according to Connell (2001), it benefits men by virtue of the patriarchal dividend that accrue to them because of the universal subjection of women. Thus, Buschmeyer and Lengersdorf (2016) add that complicit masculinity is highly unstable: it consistently fluctuates between positions of subordination and dominance.

Referring to marginalised masculinities, Connell (2000) argues that they exist in circumstances marked by exploitation or oppression, particularly among ethnic minorities. These could include masculinities within migrant communities who experience, institutionalised racism or subtle forms of racial microaggressions, especially in predominantly White communities. Marginalised masculinities are to a greater extent muffled. Connell (2001) complicates the understanding of marginalised masculinities through factors like class and race. As an illustration, young Black African migrants in Australian workspaces that are predominantly White conveyed that they experienced racism in a manner that reflects assumptions about the racial inferiority of Black Africans, often associating them with notions of underdevelopment, backwardness, or tradition (Kalemba, 2023). It is in these contexts, for example, that marginalised masculinities emerge.

In addition, subordinated masculinities in European or American society, according to Connell (2001), come to light through the culture of heteronormativity that subordinates homosexual men. Buschmeyer and Lengersdorf (2016) argue that subordinated masculinities do not adhere to the established norms of what is considered 'masculine' in a specific social or contextual environment. These masculinities fail to meet the anticipated standards of acceptable masculine behaviour and the archetype of what is typically perceived as a masculine person (Buschmeyer and Lengersdorf, 2016). Subordinated masculinities comprise of gay masculinities especially in Western countries (Connell, 2000). Subordinated masculinities occupy the lowest rung on the hierarchy of masculinities because of oppression from hegemonic masculinity. The differentiation in masculinity is evidence that the concept is multiple, complex, and dependent on socio-cultural contexts.

Highly sought-after hegemonic masculinities top the hierarchy as they are argued to be cultural ideals of manhood (Jewkes et al., 2015). Adopted from Antonio Gramsci, hegemony extends beyond the exercise of physical power as it refers to societal dominance achieved through the interplay of social forces, and it shapes private life and cultural processes (Connell, 1987; 2001). Carrigan, Connell and Lee (1985, p.592) argue that hegemonic masculinity speaks to ways "particular groups of men inhabit positions of power and wealth, and how they legitimate and reproduce the social relationships that generate their dominance." In the context of Zimbabwe for instance, political elites with massive wealth and patronage systems may embody hegemonic masculinity. In qualifying hegemony, Connell (1987) adds that it thrives on a large amount of consent and not exclusively on brute force. Hegemonic masculinity is an analytical concept that explores ways gender inequality manifests and is reinforced by men

through attitudes and behaviours of domination over women as well as the exercise of power over other marginalised groups of men (Connell, 1987). Implicit in hegemonic masculinity is the utilisation of power through consent and at times through violence to ensure subordination and submission. Buschmeyer (2013) contends that hegemonic masculinity is the dominant, socially accepted model of masculinity in each society. While not all men experience equal advantages from hegemonic masculinity, Connell (2001) contends that most men benefit from its dominance, as they gain advantages from the general subordination of women. Some of the benefits men gain include "honour, prestige and the right to command" (Connell, 2001, p.43). Hegemonic masculinity represents the form of masculinity positioned at the apex of the hierarchical system of various masculinities (Buschmeyer, 2013) and is the one from which other masculinities gain legitimacy.

According to Connell (1987, p.186) hegemonic masculinity can simultaneously incorporate, with remarkable consistency, tendencies toward domesticity and inclinations toward "violence", prejudice against women and heterosexual attraction. It does not presuppose the elimination of alternative masculinities and as pointed out earlier, complicit masculinities accrue legitimacy through their benefit from patriarchy which is highly championed in hegemonic masculinity. In this regard, hegemony acknowledges that other alternative masculinities can exist in subordination to the dominant one. The premise of hegemony is the unquestioned subordination of women and subordinated masculinities. In Western societies the prototypical hegemonic masculinity is being White, heterosexual, and middle class as well as embodying stereotypes like assertiveness, control, and emotional strength (Evans, Frank, Oliffe & Gregory, 2011, p.8). In the same context Creighton and Oliffe (2010) add that hegemonic masculinity idealises men as robust, autonomous, and self-reliant rather than concerned with self-health, illness, or injury. Hegemonic masculinity evinces invulnerability which runs contrary to health seeking. Importantly as Connell (2001) asserts, hegemonic masculinity is not a static character type; it varies and is not consistently the same across all contexts and times.

Furthermore, Langa (2020, p.13) argues that hegemonic masculinity speaks to the existing "dominant cultural stereotype of masculinity in a society, community or group." Hegemonic masculinities are premised on the notion that "gender is not negotiable" (Langa 2020, p.13) but is binary, rigid and the failure to adhere to the expectations invites sanctions and ostracism. This is possibly so because the notion of hegemonic masculinity requires permanent assertion and maintenance of power not only over women but over other men. In Nigeria, a dominant

masculinity framed in traditional/heterosexual norms is epitomised through beer drinking among men in specific social spaces, leading to inebriation and engaging in rowdy behaviour to affirm their masculinity (Dumbili, 2022). In line with typical hegemonic masculinity which asserts control over women, Dumbili's (2022) study shows that in men's view, women indulging in men's practices as mentioned above do not idealise feminine practices. The dominant or hegemonic masculinities shape men and women's perceptions and behaviours, leading not only to the subordination of women but to the subordination of men who embrace alternative masculinities (Langa, 2020; Morrell, 1998; Russell, 2019). Having established the diversity in masculinities, I now turn to a discussion of masculinities in Africa.

Masculinities in Africa

To fully grasp masculinity identities and their expression requires an intersectional approach. Reihling (2020, p.4) argues that identity formation does not occur in a power vacuum but is determined by "race, sexuality, class, ability, and other markers." This reinforces the need for an intersectional approach in explaining the ways masculinities are formed and expressed in different contexts. Having been assigned its epistemic rigour by Kimberlie Crenshaw, intersectionality refers to the interlocking "ways that oppressed people experience multiple oppressions based on their multiple identities" (Tamale, 2020, p.65). Likewise, Lugones (2007) contends that the concept of intersectionality brings to light concealed elements that only emerge when gender, race and class are spotlighted for a holistic analysis. In relation to masculinities, it is important to highlight the interplay of age, socioeconomic class, geographical location, sexuality, ability, and race with men's identities (Hasso, 2019; Kimmel et al., 2005).

In southern Africa, the impact of regional history has shaped discussions on men and masculinities, concentrating on race relations and various forms of violence, including domestic and communal violence (Connell et al., 2005). Spall (2020) argues that in the context of Angola, masculinities are a historical product inasmuch as they are political or ethnic identities. When theorising masculinities, context and history are central. There is a convergence of thought among theorists writing from the global South about historicising masculinities. In relation to South Africa, Ratele (2021) advances the importance of locating masculinities in historical contexts, arguing that postcolonial masculinities cannot be understood without focusing on the colonial labelling of an African man as a (non)man. This labelling equates to what Shire (1994, p.149) demonstrates as part of the dehumanisation of

African masculinities in colonial Zimbabwe, especially in towns where "'Shona' men became the 'boys' of the colonisers." This process of labelling an African man as (non)man demonstrates the violence inflicted on African masculinities by the colonialists. Thus, Suttner (2005, p.6) argues that Western theories of masculinity or masculinities cannot be concretised in countries like South Africa and others that experienced colonialism. The Western conceptualisation of 'hegemonic masculinity' or 'gender orders' are weak due to their failure to analyse nuanced layers African men grappled with in attempting to reclaim manhood within the context of apartheid and colonialism (Suttner, 2005).

In her book *'The colour of disease: Syphilis and racism in South Africa, 1880-1950'*, Karen Jochelson (2001) demonstrates this labelling of an African man as a non(man) in medical care under colonial rule. In the book, the author notes that at Rietfontein in 1915, African male patients were compelled to undress for medical examinations in the presence of white patients (Jochelson, 2001, p.83). In other words, no human dignity was accorded to African men in medical care, an affront to their identity as men. Similarly, with reference to the context of the armed struggle against apartheid in South Africa, Suttner (2005, p.73) contends that African manhood was "*actually assaulted,* that is, where men are called boys, no matter what their age, where many whites never bothered to even know their actual names [Emphasis in the original]." Suttner (2005) argues that the infantilisation of African men in this regard was a means to justify political domination. Not only was political domination achieved through infantilisation of Africans and men, but equally damaging was the erosion of identity for many men who, in different contexts, were fathers, husbands, custodians and transmitters of important cultural and traditional values. The significance of a name in the African context and in relation to masculinity cannot be underestimated, as argued by Mfecane (2018, p.298) "[m]asculinity can be shaped by seemingly mundane things, such as a person's name." Intricately connected to the name are issues of personhood, and this might not carry significance in a different context like the West. A brief story about my uncle whom I will call George[1] will help to highlight how masculinity is tied to personhood in the African context.

Uncle George migrated from Zimbabwe to Britain in 1998 leaving his family consisting of his wife and two children – a complicated decision. His parents were still alive when he left in pursuit of better opportunities in Britain. He spent about 10 years without coming back to Zimbabwe to see his family as the processes of regularising his stay in a foreign country were

[1] Pseudonym. All names in this study are pseudonyms.

difficult. It happened that his fortunes in the diaspora did not turn out as expected and this affected his identity as head of household back home and as father to his children; he could not support them financially and emotionally. Uncle George was arrested and imprisoned for flouting immigration laws. Upon his release, Uncle George changed his name as he was eventually granted citizenship. When I met him in 2023, I still addressed him by his old name as that was the name most of us were familiar with until he asked me why I was doing that since he had changed his name. He shared with me that his father, my grandfather, named him George after a relative. Through some research, my uncle found out that his namesake, George, had delayed marriage, just as he himself did. Setting up an own independent homestead through marriage is something significant in the way my uncle defined his masculinity.

In our conversation, he told me he believed that his troubles in Britain, including his imprisonment, were supernaturally connected to his name. The seemingly commonplace matter of a name held great significance for my uncle as an African. He believed that the name given to him by his father was associated with a pattern of misfortunes that seemed to follow him. This realisation led him to change his name from George to Timothy. The story of my uncle demonstrates that even though he is in the diaspora in Britain, he is not disconnected from his masculine identity, one that hinges on African personhood emphasising the influence of the supernatural on his identity. My uncle was finally reunited with his family when they joined him in Britain. Whether his improved circumstances were a consequence of his name change is a separate matter. After the conversation with my uncle, I appreciated his reasoning and corrected the way I address him from then onwards. I now address him as Uncle Timothy.

In their discussions of indigenous knowledge within postcolonial settings, Morrell and Swart (2005) contend that this type of knowledge offers alternative ways of comprehending the world and finding meaning in life and death. The underlying principles of indigenous knowledge typically differ from those found in Western, individual-centred frameworks. For instance, the concept of human existence is interpreted in the context of communal and environmental connections, rather than being tied solely to an individual's birth (Morrell & Swart, 2005). The authors' articulations connect well with the lessons from my uncle's story in terms of his understanding of the influence the spiritual environment of his existence had in his life. It explains his change of name. Ratele (2021) further adds that as researchers, we must interrogate ways in which coloniality affects men in Africa, especially when they struggle to meet the criteria as complete human beings, for example in being the breadwinners, present fathers, and household heads. How must we create new liberating imaginaries on masculinity that speak to

history? To respond to the question, Motimele (2021) opines the need to extricate black masculinities from the clutches of whiteness. She argues that "[t]he exorcism required of black masculinities is that of its contact and construction through whiteness and its long history of dispossession and dehumanisation within black communities" (Motimele, 2021, p.63).

Different thinking and analytical tools are therefore required to understand black African men. In his ethnographic exploration of masculinities among the Shona people in Zimbabwe, Shire (1994) examines the impact of colonialism on how men perceived their identities in certain spaces. Traditionally, according to Shire, Shona masculinity was cultivated in the *dare*, a traditional meeting place for men where proficiency in using proverbs and metaphors was taught as indicators of masculinity. Shire argues that men who lacked "verbal prowess" were demeaned within this traditional gathering space. Differently put, proficiency in language within this context could be seen as synonymous with the idealised form of masculinity, while inadequacy might be associated with alternative expressions of masculinity. Interestingly, the emphasis on language, proverbs, and metaphors among the Shona studied by Shire highlights the significance of transmitting values and traditions from one generation to another. Shire (1994, p.150) further explains that the *dare* space, where the principles of manhood were taught, was a "space for talking rather than doing."

Connell (2012) argues that masculinities as social practices find expression within the biological properties of male bodies and are linked to their potential for work, violence, and fatherhood. As further asserted by Connell (2001, p.44), gender inequality is intricately linked with violence as "most members of the privileged group use violence to sustain their dominance." In the same vein, Wood and Jewkes (2001, p.134) assert that the relationship between women and men in South Africa is about power which manifests through sexual violence and assault. Important as the above formulations on power and gender inequalities are, the analysis is limiting especially in the context of Africa where the narrative on men and violence is uncritically perpetuated in public discourse. This is not to water down the endemic nature of intimate partner violence, not only in South Africa but also in Southern Africa. However, examining violence without considering proper socio-cultural factors is problematic. What are the underlying factors contributing to violence against women? How can this violence be addressed? Motimele (2021, p.65) expresses concern about the excessive focus on men and violence in South Africa. She laments the failure to extricate the affective aspects of black boys and men without primarily associating them with violence and deficiency. To respond to this dilemma, Motimele (2021, p.69) urges that more work should be done in which black men and

boys can disclose “the most intimate aspects of their emotional worlds in their own words.” Such a call is what this study on men’s TB illness experiences attends to.

While violence is an important public issue that must be responded to and dealt with in Africa, it is a complex issue that cannot be easily conflated with masculinity. In relation to the health of men, the pressure to subscribe to the idealised form of masculinity goes hand in hand with a tendency to mask vulnerabilities. Connell (2016, p.310) argues that the effects of neoliberalism on masculinity formation cannot be underestimated in the face of structural unemployment. The impossibility of meeting the idealised provider role for many men under a racial capitalist system exposes men’s vulnerabilities. In his book, *Affective Health and Masculinities in South Africa: An ethnography of (In)vulnerability*, Reihling (2020, p.3) argues that young men’s struggles to become invulnerable individuals is often associated with increased relationship problems, substance misuse, interpersonal violence and distress. At face value, the mentioned health-related problems may appear like ‘private troubles.’ Viewed alongside a 43.4% unemployment rate among individuals aged 15-34 years (Stats SA, 2022, p.10), these apparently private troubles transform into ‘public issues’ that play a role in shaping masculine identities. The point of an unrealised and unfulfilled identity becomes a process of rupture at the level of masculinity, leading to the display of men’s vulnerabilities. Beneath the ideal masculinity performance lies men’s vulnerabilities where they attempt to fit into what society defines and expects of men. The following section expands the theoretical understanding of masculinity by drawing insights from emerging scholarship that challenges the dominance of the global North in knowledge economies. It suggests the development of African-centred theories of masculinity.

Learning with and from African-centred theories of masculinity

That there are skewed power dynamics in the production and consumption of knowledge between the global North vis-à-vis the subordination of the global South is undeniable. Commenting on this global power imbalance, Connell (2014, p.218) asserts that scholars hailing from the global South frequently study the work of global North researchers, yet this is not reciprocated. This discrepancy in the way knowledge is created and consumed is a clarion call for researchers in the global South to do research differently, not only to make our voices heard but to actively ensure that our ideas are taken seriously in the global knowledge making enterprise. In her poignant critique of studies on women, the African feminist scholar Nnaemeka (2004, p.367) argues that,

> In the same way that Africa produced the raw materials that the *me´tropole* transformed into manufactured products, African women (as researchers/scholars and as the researched) are instrumentalised: as researchers/scholars they are the instruments for collecting the raw data with which foreign scholars manufacture knowledge; as the researched they are the instruments through which scholarship is produced and careers built.

This moving critique equally holds truth in masculinity studies from Africa, something that is however changing with emerging scholarship from the global South. Connell (2014, p.218) further argues for "a world-centred, rather than metropole-centred, approach to the study of masculinities and men's gender practices." Ratele (2021, p.780) adds that "[a] profound necessity, from an African-centred decolonial perspective, is to treat African countries not as merely sites of extractive data gathering but also as offering explanations." While this is an ideal, there is a need for proactive mechanisms to ensure practical realisation of these ideas. One such way is to rethink and open the curriculum to theories from the global South.

It is imperative to be cognisant of the power dynamics that perpetuate the hegemonic dominance of theories from the metropole. Such an awareness helps us to imagine and craft alternatives that are informed by the particularities of Africa. In her contention, Nnaemeka (2004, p.362) argues that "theory making should not permanently be a unidirectional enterprise—always emanating from a specific location and applicable to every location—in effect allowing a localised construct to impose a universal validity and application." In other words, theories emerge from specific socio-cultural contexts such that universalising them perpetuates ethnocentrism. Against that backdrop, studying men in Africa calls for specific context-driven theories like the African-centred theories of masculinity. Coined and promoted by Mfecane (2017, 2018), African-centred theories of masculinity enable us to comprehend the experiences of African men using local idioms and forms of expression. This offers promising alternatives especially in relation to men and health and holds the potential to generate context-specific interventions. Equally, Qambela (2021, p.593) seeks to promote awareness among researchers of the need to allow social actors to speak for themselves and in their own terms. In their diversity, the purchase of African-centred theories of masculinity is that they help us learn to unlearn what we have always taken for granted in terms of the universal reach of global North masculinity theories. African-centred theories of masculinity therefore help us to forge new imaginaries in understanding African men broadly, more specifically, men and health.

In line with African-centred theories of masculinity is the decolonising project emphasised by Ratele (2021, p.780). He advocates for African-centred decolonial projects, urging us to

confront and challenge the dominance of "colonialist research methods, theoretical models, analyses, and interventions." The value of theories originating from the global North is apparent and beneficial. Nevertheless, considering the context-specific nature of theories, it becomes imperative to formulate African-centred theories of masculinity. These theories are essential for explaining African realities. Ndlovu-Gatsheni (2021) shows how science was originally implicated with Empire for domination. This perspective is also echoed by Nnaemeka (2004, p.362), who critiques the "imperial nature of theory" and advocates for its thorough examination. Nnaemeka emphasises the necessity of questioning established theories to foster a more equitable process that allows for the inclusion of subaltern or marginalised theories. While knowledges created from the global South are at the fringes of the knowledge economy, Ndlovu-Gatsheni (2021) further demonstrates that postcolonial and decoloniality theorists from the Middle East, South Asia and South America are accorded special recognition at the expense of Black and African scholars who are the least recognised. The existing hierarchisation of knowledge places African theories right at the bottom, something that is disconcerting and proof that knowledge production is intricately and intensely political.

The thesis on the illness experiences of men forms part of the ways in which the alienated global South masculinity studies, particularly from Africa, can be brought into this new 'world-centred' imaginary, with a view to making theoretical and empirical contributions to the discourse of men and health. This attempt is integrated with a context-based appreciation of how black working-class men make meaning about health and TB illness. A thorough introspection is therefore required to undo this hierarchisation of knowledge. One approach to address this issue is to heed the call made by Mfecane (2018) for the establishment of African-centred theories of masculinity. It is an alternative which argues that knowledge created in the global North is as much context dependent as knowledge from the South is. Under the pressure for acknowledgment within the dominant global North scholarship, Connell (2016, p.304) asserts that gender scholars in the global South often find themselves resorting to an uncritical adoption of ideas from the North as the framework for their research. This research on men's TB illness experiences breaks away from that tradition and makes theoretical and empirical contributions to critical studies on men and masculinities by building, developing, and interpreting/explaining the illness experiences of men using the African-centred theories of masculinities. "[M]ore crucially," Ratele (2021, p.777) further adds "within studies on men and masculinities in Africa, the continent tends not to be thought of as a site of theory-generation for the world, if not for itself."

Mfecane (2018) contends that rather than unquestioningly and entirely adopting theories of masculinities from the global North, a more nuanced approach is needed. To comprehensively understand the intricate lives of African men, Mfecane argues that theories of masculinity grounded in African conceptions of reality must be developed. Such theories should treat masculinity as both socially constructed and as being influenced by unseen elements of personhood encapsulated in traditional African thought. In his detailed work on the concept of *seriti* among the Pedi or Northern Sotho speakers of Limpopo province, Rathete (2007, p.30) argues that a person is composed of "body/*mmele*, soul/*moya* and *seriti*. *Seriti* as shadow is not just a shadow but the supernatural form of shadow." In addition, Rathete (2007, p.30) further expands the analysis of *seriti* by arguing that it is also related to "personality and dignity." This conceptualisation of *seriti* in the context of the Northern Sotho ethnic grouping is important as it builds our understanding of what a human being is beyond corporeality. This helps to concretise masculinity from the vantage point of Africa. When I asked some of my interlocutors about their interpretations and definitions of man in the community of Modimolle, a 39-year-old, single and matric certificate holder named Timmy summed up his interpretation as follows:

> **Timmy:** In my own understanding a man in Modimolle is seen through (di ketso tsa gage – me diro ya gage) his deeds. We see him (ka di ketso tsa gage – me diro ya gage) we see him by his deeds/works, his dignity (seriti), and respect. Through these things you can say that man is a real real man.
>
> **(Interview with Timmy, 10 September 2020).**

What this interpretation of man entails is the material configurations of masculinity in terms of the visible, admirable works that the man does. This is captured in literature in terms of how gender is performative (Butler, 1988; West & Zimmerman, 1987). Central to the African-centred theories of masculinity as evidenced from the above quote are the unseen values that solidify the characteristics of a man in Modimolle, like dignity (seriti*)* and respect. Similarly, Morrell and Swart (2005) make use of the concept of *ubuntu* in their articulations of the importance of indigenous knowledge systems for masculinity. They argue that the concept of *ubuntu* champions "values such as universal brotherhood of Africans, sharing, and treating and respecting other people as human beings" (Morrell and Swart, 2005, p.99). Timmy's narrative above aptly captures how cultural values of *ubuntu* are building blocks of masculinity.

Likewise, Riesman (1986, p.74) contends that among the Dogon of Mali, the Tallensi of Ghana, and the Bambara of West Africa in general, their social conception of a person does not view

individuals as separate entities but rather as one who "participates in other beings (including persons) and is in part constituted by other beings." In other words, personhood is dynamically constituted within and between social interactions as well as through beliefs in the supernatural. Similarly, Morrell and Swart (2005, p.98) add the importance of the "idea of adhesion" which relates to communality in the traditional worldview of Africans. Furthermore, the Akan people of Ghana, for instance, do not distinguish between the natural and the spiritual in their conception of personhood. This plays a crucial role in their understanding of conditions such as mental illness (Opare-Henaku & Utsey, 2017). Thus, a personhood theorisation embedded within African cosmology provides a useful lens through which to understand men's interpretation of and existence with TB illness. Chapter Five dedicates a section to an in-depth examination of how men define themselves and are defined by society. But first I present arguments for employing African-centred theories of masculinity in the next section.

Why African-centred theories of masculinity?

In this study I join the call to theorise African masculinities in African conceptions, based on the articulations of men living with tuberculosis in a South African township. But what does an African-centred theory of masculinity entail? The critical tenets of African-centred theories of masculinity transcend the dominant definition of masculinity as performativity to include the influence of supernatural beliefs in the everyday. I argue that African-centred theories of masculinity offer a valuable framework for understanding the experiences of tuberculosis (TB) among black African men in Modimolle, South Africa. Ethnographic studies on health consistently show that diseases and illnesses are influenced by socio-cultural factors (Ashforth, 2000; Edginton, Sekatane & Goldstein, 2002; Lupton, 2012; Manganyi, 2019; Steinberg, 2011). Manganyi (2019, p.60), in relation to the black South African, articulates the view that the process of being ill is characterised by tension between the individual and the totality of his/her existence. Also, ethnographic work conducted by Comaroff and Comaroff (2001, p.275) on personhood among the Southern Tswana demonstrates that the "self was not confined to the corporeal body – it ranged over the sociophysical space-time occupied by the sum total of its relations, presences, enterprises – anything that acted on its traces might affect it for good or ill." As I present and discuss in Chapter Seven, the social universe within which men live influence their interpretation of TB illness.

Like Comaroff and Comaroff's 2001 ethnographic work, Steinberg (2011, p.138) observes in relation to his interlocutor's indecision about testing for HIV that "…it struck me that his

understanding of the pain in his stomach was crisply social; the somatic was simply an outcropping under which were layers upon layers of family and neighbours and the world at large." It is clear in this regard that illness speaks to the subjective experiences within a broader socio-physical and beliefs in the supernatural realm. To have a holistic understanding of illness among men within the African context, it is necessary to look beyond the socio-physical realm. Mfecane (2018, p.299) adds that "[i]f African masculinity is believed to be shaped by forces existing beyond the visible social realm, these should form part of our engagements with African men." Intricately connected with the notions of personhood transcending the corporeal is the importance of religion in the African cosmology. According to Xaba (2000), within African religions practised in South Africa a person is more than the physical body and is a personification of past, present and future relations between the living and the dead. Thus, ailments which seem to evade recognised forms of relief are considered to originate from the spirit world and would demand consultation with a *sangoma* (diviner) and *inyanga* (herbalist) (Xaba, 2000). These arguments cement the importance of using African-centred theories of masculinity to decipher men's interpretation of TB and how they live with the illness. A study conducted by Edginton et al. (2002) on the Tsonga and Northern Sotho patients' beliefs about TB in Tintswalo district of Limpopo located the aetiology of disease in both the spiritual and in biology.

An example of an African-centred theory of masculinity is an *indoda* masculinity in the Xhosa conceptions. The *indoda* masculinity as argued by Mfecane (2016, p.204) is premised on the practice of *ulwaluko* which is the central customary rite of passage from boyhood to manhood entailing "circumcision followed by separation from society" for a given period. However, *indoda* masculinity is incomplete unless aligned with public comportment in ways of dressing, "responsibility, respect and avoidance of violence" (Mfecane, 2016, p.207). Some of these values that co-shape an *indoda* masculinity resonate with notions of *seriti* as found in the study setting. Importantly, the public conduct precedes circumcision and, in that regard, Mfecane (2020, p.6-7) adds that "[i]zenzo (actions) on their own do not make a man because of the primary imperative to undergo ulwaluko in order to be considered socially to be a man." The hierarchy of masculinities in the Xhosa cosmology accords dominant status and honour to traditional male circumcision regardless of sexuality. Connell's (2012) argument that masculinities are not a preserve of and exclusive to male bodies is questioned in the Xhosa context.

While Mfecane (2016) argues that masculinity as defined among the amaXhosa is not about what one does but what one is by virtue of their ritualised circumcision, Qambela (2021b) questions this dominant conception, especially as it omits social class analysis in the configuration of Xhosa masculinities. In his study of masculinities in a rural and peri-urban area of Ngqushwa ('Peddie') in the Eastern Cape province of South Africa, Qambela (2021b, p.593) concludes that the economically marginalised men found "little meaning in terms of their ability to move their post-initiation lives forward." Although the "ritualised initiation (ulwaluko)" (Qambela, 2021b, p.591) was a significant marker of masculinity, it did not accord the men in the economic periphery the "hegemony in social context" (Qambela, 2021b, p.593). Therefore, an important dimension that is added to the Xhosa theorisations is that some men's possession of class status presented them with "various forms of social status in ways that sometimes superseded men who had undergone traditional initiation" (Qambela (2021b, p.593). While some of my participants were gainfully employed during the time of fieldwork in 2020 and 2021, it bears mentioning that most of them were on the economic fringes, like those found in Qambela's (2021b) study.

Consistent with sociological perspectives, TB infections and the experiences of illness are influenced by social interactions, the broader social context, and the individual's belief systems. In keeping with advancing African-centred theories of masculinity, Manganyi (2019, p.61) contends that an "African ontology conceives of reality as consisting of interacting, interdependent life forces." He explains that it is logical to explore the causes and potential treatments of an individual's illness by considering their connections with other vital forces in their environment. Similarly, Mfecane (2018, p.286) reinforces this by arguing that humans embody spirits of their ancestors and these shape "their temperaments and can account for aggressive behaviour among boys." Building on African-centred theories of masculinity, illness causation and other behavioural patterns among men cannot be entirely understood through biomedicine but are intricately tied up with belief in the supernatural. Manganyi (2019, p.62) adds that, "[o]ne of the factors which suggest the possible significance of African ontology in the lives of millions of Africans today is the noted resilience of traditional beliefs in the areas of health and disease." To comprehend the enduring influence of traditional beliefs on masculine identity formation and health, it is essential to consider the concept of medical pluralism. That is the focus of the next section.

Men's health decisions in the context of medical pluralism

In a study examining men's TB illness experiences, the concept of medical pluralism is important as it helps us to appreciate how men negotiate access to health, and under what material and immaterial conditions. The concept of medical pluralism originates from studies conducted in the global South, where the dominance of biomedical healthcare systems has been the exception rather than the norm. The term pluralism denotes multiplicity and the interaction of different alternatives in each context. However, medical pluralism is a nuanced and intricate concept. The umbrella concept of medical pluralism is plagued with contestations around what it encompasses – it is a conceptual minefield. For instance, Thornton (2017, p.36) argues against the use of 'medical pluralism' in his work on Ngoma tradition in South Africa, preferring to use 'medical *parallelism*' which refers to the "interaction of multiple medical systems." Medical pluralism is the reliance and use of more than one medical system for health and illness within a single society (Manganyi, 2019; Moshabela, Bukenya, Darong, Wamoyi, McLean, Skovdal... & Wringe, 2017; Winkelman, 2009). Important as this definition is, it does not problematise whether individuals rely on medical pluralism out of choice or constraint. In other words, the concept of medical pluralism must be contextualised and nuanced. Cant and Sharma (1999) argue the need to interrogate power when analysing the concept of medical pluralism. Critics of the concept of medical pluralism highlight concerns such as its tendency to favour the professionals' perspective over the patients', the creation of a 'false consciousness of choice,' downplaying the significance of political, economic, and structural power issues, and the implicit reproduction of a 'monolithic' concept of biomedicine (Penkala-Gawęcka & Rajtar, 2016, p.129).

Winkelman (2009) argues that in complex and modern societies, three overlapping healthcare systems often exist in relation to medical pluralism, and these comprise the popular (lay) sector, the folk sector, and the professional sector. In defining the popular sector within medical pluralism, Winkelman (2009, p.164) argues that it involves "what people mainly without recourse to specialists believe and do about health care, including ignoring symptoms, and decide whether biomedical care is necessary or whether recourse may be made to the folk sector." The health decisions made under the popular sector derive from family socialisation and other interpersonal relations and according to Winkelman (2009), these health decisions act as the first line of defence against maladies. The definition of 'popular sector' in the context of medical pluralism as provided in the above definition is important especially as it highlights

the choices made by people within constrained environments. However, one wonders how ignoring symptoms can be referred to as a health strategy in the popular sector. When men ignore symptoms of tuberculosis in the context of popular sector, it is important to highlight that these are decisions made in marginality. In that vein, a systematic review of the use of traditional, complementary, and alternative medicine (TCAM) in sub-Saharan Africa by James, Wardle, Steel and Adams (2018, p.12) concludes that resort to it is widely prevalent among people of "low socioeconomic class who are unemployed and unskilled." This is an important conclusion that underscores the importance of contextualising the concept of medical pluralism; in other contexts, the use of alternative medicine may be for its holistic advantages and not an indicator of class.

In a medically pluralistic context, individuals choose from a range of healing practices, which can include not only Western biomedicine but also traditional, complementary, alternative, folk, or indigenous medical systems. Manganyi (2019) shows that there are three categories of Africans in South Africa when it comes to interaction with existing healthcare systems. Manganyi (2019, p.62) categorises the first group as "hidebound purists" who exclusively rely on traditional African services and remedies. The second group comprises individuals who solely use Western remedies and services, completely excluding traditional services. The third group includes those who opt for a combination of traditional and Western services based on the circumstances. Interestingly, however, this picking and choosing is also determined by a diversity of factors, chief among them being socioeconomic status and religion. According to Flint and Payne (2013), the traditional healthcare sector in sub-Saharan Africa is one of the prioritised healthcare systems that services about 80% of the population with primary healthcare.

In their criticism of medical pluralism, Cant and Sharma (1999) argue that 'complementary' is suggestive of usurpation of autonomy of other forms of medicine that are not orthodox or biomedical. It reveals a subordinate role while 'alternative' signifies acknowledgement to the idea that these healing systems are separate, complete, and autonomous. Notwithstanding the contentions around complementary, alternative, folk, or traditional medical systems, the common thread is that these are culturally driven medical systems that are peripheral to biomedicine. Reliance on traditional medical systems in the context of medical pluralism vis-à-vis men's TB illness experiences is a crucial decision that is anchored in questions of identity. In the context of Angola, Spall (2020) demonstrates in his study how witchcraft beliefs are entangled with masculinity formations among men. Spall describes one of his interlocutors

bemoaning a witchcraft attack which shifted his breadwinner masculinity in significant ways. The author documents his interlocutor,

> Nando explained about a *feitiço*[2] attack he suffered, which resulted in a 'lack of blood', weakness and weight loss. It left him unable to work for over a year, wiping out his savings, requiring him to sell his motorbike, and only coming to an end when he consulted a diviner (*kimbandeiro*) (Spall, 2020, p.114).

The description unmasks important issues that are pertinent to this study of men's illness experiences. First is the interconnection between traditional beliefs and masculinity identity. Although the author does not show us other forms of medical systems the interlocutor relied on, the description that the attack 'only' ended after a consultation with the diviner shows the coexistence of plural health systems. The description also captures the interplay of masculinity, ill health, and belief in the supernatural among African men and their relationship with their social environment. Men's health decisions are therefore intricately connected with the supernatural realm.

Cant (2020, p.33) contends that classifying a system as complementary, alternative, or non-orthodox reflects a relation to biomedicine, a classification that inherently establishes a binary distinction implying a hierarchy. In their definition of alternative medicine, Cant and Sharma (1999, p.4) argue that these are other "forms of healing that depend on knowledge bases distinct from that of biomedicine and which, as such, do not share the special legitimation that the state has conferred upon biomedicine." Similarly, Winkelman (2009, p.164) argues that the folk sector in medical pluralism encompasses a range of "traditional cultural healing practices that are generally not part of an official medical system." Folk or alternative medical systems are not legally sanctioned and protected by the state. Thus, Cant (2020, p.41) argue in the context of the UK that complementary and alternative medicine (CAM) is "situated in the ambiguous position of 'mainstream marginality': popular, but not state sanctioned or funded."

James et al. (2018, p.12) argue that low socioeconomic status in the society influences the decision to use TCAM, given the fact that TCAM is a low-cost healthcare option compared with biomedicine. In the same vein, Ashforth (2000)'s book *Madumo, a man bewitched* unpacks how the period immediately after the end of apartheid in Soweto, South Africa became associated with disillusionment due to deep inequalities and poverty levels that fuelled witchcraft accusations. Being a victim of witchcraft accusations, Madumo, the main character

[2] Defined as witchcraft or sorcery.

laments that he was bewitched/cursed and made efforts to seek the cause of his problems in the spirit world of ancestors. Madumo retorts, "[y]ou see, for me, I'm relating this thing to the people that are called ancestors. I'm asking why can't they take me out of this trouble? Why can't they protect me?" (Ashforth, 2000, p.21). Madumo's narrative emphasises the connection black African men have with belief in the spiritual world if their social and health lives are under threat. Below is a quote drawn from Ashforth by Mfecane (2018):

> When black African men experience personal life problems, such as being violent, alcoholic, and unemployed *or becoming ill,* [*emphasis added*], their search for change goes beyond looking for tangible material things, like finding employment. Typically, they start by consulting family elders and spiritual healers to get some perspectives. An animal may be slaughtered, and traditional beer brewed to "cleanse" a person's spirit and remove obstacles (ukuvula indlela) which stand in the way of progress (Ashforth, 2000 cited in Mfecane, 2018, p.299).

In consulting elders or family in this case, a connection to what Winkelman (2009) calls the public sector in medical pluralism is made. Furthermore, consulting spiritual healers showcases how embedded medical pluralism is to the South African context. The significant reliance on alternative health systems by African men in this context underscores the necessity of analysing masculinity through an African-centred perspective. This transcends a narrow focus on the individual and delves into the supernatural for solutions to problems.

An appreciation of traditional beliefs and the construction of masculinity in an African context allows for a situated understanding of how men negotiate health issues in the context of medical pluralism. Mfecane (2018, p.298) argues that masculinity in the African context has a material and spiritual basis as it "can be shaped by the kind of ancestor that lives inside a person." While materiality is significant in the construction and performance of masculinity, the incorporeal is equally significant in the African context. It is crucial to emphasise that for African men, personhood is moulded by social structures, individual actions, and a belief in the supernatural. These elements are intertwined in how men navigate their health issues, particularly when confronted with tuberculosis illness in the context of medical pluralism. In the next section, I consider some of the fundamental concepts that help to concretise black African men's interpretation of TB, their access to healthcare and how they live with the disease.

Sifting through the nomenclature of tuberculosis illness

By virtue of being a subjective lived experience, illness is a social construct intricately connected with the concept of lay health beliefs which are important to the sociology of health and illness. Lay beliefs in health and illness emphasise ordinary people's interpretations and meanings of what they experience in their own ways, a shift away from the dominant medical explanation. Ordinary people's own experiences "are not only important for interpreting and making sense of signs and symptoms but also have a significant impact upon lay people's illness behaviour" (Shaw, 2002, p.291). Rooted in African-centred theories of masculinity, enabling laymen to share their tuberculosis experiences based on their everyday health beliefs contributes empirically to health and illness research. However, the premise of lay health beliefs reflects the dominance of biomedicine and the marginalisation of alternative perspectives. Thus, Shaw (2002, p.297) asserts that when a researcher formulates categories like layperson, it automatically means they are working on a biased premise "about the characteristics of those respondents and possibly even their knowledge base." To avoid such an 'epistemic trap' (Nguyen, 2022), my research focuses on black working-class men's lived illness experiences of TB in their everydayness.

To understand black working-class men's illness experiences requires paying attention to the socio-cultural context as it is central to how illness is expressed, interpreted, and understood. Blaxter (2010, p.65) suggests that narratives of illness experiences go beyond detailing the physical or mental state and its origins and outcomes. Instead, they express the individual's position or circumstances within the broader context of the world. In addition, Manganyi (2019, p.58) argues, "the meaning of illness is, like other social reaction patterns culturally determined." One does not become ill to him/herself alone, but their illness is socially validated. Illness is socially constructed, and as argued by Manganyi (2019), it affects the individual sufferer as well as their relations with other people. In the same vein, among the Akan people of Ghana, the emphasis placed on interdependent living is central to how illness is understood as an issue that affects not only the individual but also the entire social unit (Opare-Henaku & Utsey, 2017). This connects well with the African-centred theories of masculinity; focus is directed to the holistic aspects of personhood in terms of one's relationship with others and the supernatural. As argued by Charmaz (2002), chronic illness changes life and challenges previously unquestioned concepts of self. In other words, chronic illness causes one to reevaluate and redefine their identity. Similarly, Mfecane (2011) adds that

a chronic illness diagnosis not only produces facts about someone's state of health but it also directly (re)shapes subjectivity and identification and the choices one makes about life. In this way one's illness experience reconfigures one's masculinity identity.

In similar theme, Kleinman (2020) reinforces that as a process, illness must be defined as such by the individual sufferer and his family members and by extension, those in his social networks. In Chapter Seven I demonstrate instances where some men were reminded or forced by friends and relatives to seek healthcare against the backdrop of continued weight loss. Defining illness, Lupton (2012, p.87) argues that it is both a social and "lived experience of the symptoms and suffering which is innately human" while disease applies to every living organism. Illness is subjective and social as it encompasses how to live and respond to suffering. As an experience, illness is a process through which an individual explains the genesis of their illness, the cause of the illness, why it has happened, how it has affected their everyday life and strategies for health seeking (Helman, 1994). Illness experiences are not isolated from socio-economic and political influences. The specific material, sociocultural, and incorporeal context of men's existence plays a crucial role in how we comprehend this process. According to Pierret (2003), the concept of illness experience focuses on the sufferer's subjectivity in the meaning making process of what he or she is going through.

In researching the lived experiences of TB sufferers, illness experience is important because it brings to the fore how men use their situated knowledge to interpret and understand their suffering. Bury (2001, p.278) adds that in articulating their illness experiences, ordinary people are bounded by their cultural context through language and figures of speech that at times permit and constrain "what is said and how it is expressed." This further buttress the importance of ethnographic work for health and illness using African-centred theories of masculinity to unearth meanings attached to TB as well as the ways personhood shapes men's illness experiences. In the same line of thought, Lupton (2012, p.87) suggests that, through narratives, individuals experiencing illness can express their suffering in a manner that goes beyond the limited perspectives provided by biomedical accounts of illness. To concretise the argument by Lupton (2012), one of my interlocutors, Frank aged 32 who had been diagnosed with meningeal tuberculosis and was regularly in and out of hospital remarked the following to me at the end of the interview:

> **Frank:** I also thank you for coming to speak with me because, remember, at some stage you are our voice. If I had denied you the opportunity to hear our experiences of living

with TB, how would people know? I am sure your report will be a voice about us.
(**Interview with Frank, 22 September 2020**).

Indeed, this study is a voice about black working-class men's TB illness experiences. Thus, integrating African-centred theories of masculinity into men's TB illness narratives not only enhances the discourse on health and illness but also deepens the sociological interpretation of tuberculosis.

Inasmuch as illness is a subjective lived experience, it is also a social process attracting different meanings and moral judgments from society. Pierret (2003) argues that studies on illness experience cannot be complete without exploring issues of stigma, sense of shame and loss of self. In that respect, the seminal work of Erving Goffman (1963) on stigma is important in this study on black African men suffering from TB. In the context of South Africa, tuberculosis and the concept of stigma intertwine with race, something that finds resonance with Goffman's conceptualisation. Goffman (1963, p.14) argues that stigma draws from three different sources, namely physical deformities of the body, 'blemishes of character' and what he calls 'tribal stigma' which is linked to 'race, nation or religion.' Tuberculosis disproportionately affects black South Africans, and black men in particular. This disease patterning is not accidental. Consequently, by adding race and social class to our analysis, stigma becomes a lived reality for the TB sufferer in South Africa. Stretched further, the colliding effects of the co-occurrence of TB and HIV pandemics in individuals are aggravated by the social environment punctuated with the pandemics of unemployment and poverty in a racialised capitalist system. This results in syndemics that produce negative health outcomes for black working-class men infected and living with TB in Modimolle. Singer, Bulled, Ostrach and Mendenhall (2017, p.941) define syndemics as the clustering of two or more diseases or health conditions within a population, where there exists a level of harmful biological or behavioural interactions that intensify the adverse health effects of any or all the present diseases. As enunciated by Singer, Bulled and Ostrach (2020, p.943) syndemics are constituted of three components, namely: (1) sequential, co-occurring or clustering disease or other health conditions; (2) adverse biological interactions between those disease/health conditions and (3) social/political/environmental factors that cause or exacerbate the disease.

Although stigma originally refers to an attribute that is more personal and discrediting to the stigmatised, Goffman (1963) expands the concept to capture how it is a socially constructed identity. In this case, stigma is a social identity issue and not solely an attribute. According to

Goffman (1963), society ascribes stigma to an individual through assumptions that the individual is not fully human or normal and thus the individual becomes discriminated against. In the case where illness becomes visibly imprinted on the body of a TB sufferer or where it shifts the boundaries of the body, this attracts societal stigma that materialises in discrimination. The body plays a role in the successful performance of masculinities, and the disintegration caused by TB illness disrupts this balance, leading to the potential for stigma, which can be enacted, internalised, or anticipated. These three related conceptions of stigma emanate largely from literature on HIV (Earnshaw & Chaudoir, 2009; Pantelic, Sprague & Stangl, 2019; Quinn & Chaudoir, 2009). The emaciation of the body due to TB illness equates to what Comaroff and Comaroff (2001, p.273) describe as "*sefifi* [*sehihi*]" in Setswana which denotes a condition of "non-being" or "death pollution." This state "speaks of an erasure of self-determination; of empty shells of humanity…; of a slippage into the passive, past tense" (Comaroff & Comaroff, 2001, p.273). It crystallises and dismantles one's self-identity. Intricately connected with this understanding in relation to TB illness is the concept of enacted stigma which speaks to public prejudicial treatment against someone's health condition (Møller & Erstad, 2007; Pantelic, Ziauddeen, Boyes, O'Hara, Hastie & Alwan, 2022). TB symptoms and diagnosis can attract enacted stigma from the community which is discriminatory. Møller and Erstad (2007, p.108) conclude that enacted stigma is more pronounced where disease contraction is perceived to be "avoidable, where transmission of the disease is linked to sex or other morally sensitive issues, and where the disease is serious or terminal."

In addition, the conflation of TB symptoms with those of HIV/AIDS could be the reason TB attracts stigma. According to Møller and Erstad (2007) both diseases are closely related and this is demonstrated from the latest national data which suggest that 54-55% of individuals who develop TB are co-infected with HIV. That the connection between AIDS and death may have contributed to stigma similarly aligns with the potential stigma associated with TB illness, Niehaus (2007) observed. Similarly, the concept of internalised stigma describes the process by which individuals with HIV (Pantelic et al., 2019) – and by extension, individuals with TB – gradually adopt and endorse the negative sentiments associated with their health condition. Furthermore, internalised stigma is associated with feelings of shame/embarrassment, guilt, and worthlessness (Pantelic et al., 2022) possibly arising and associated with breaching certain taboos which attract moral judgments. Although the concept of internalised stigma was developed against the backdrop of people living with HIV, the fact that some of the symptoms of TB – such as continuous weight loss – are synonymous with HIV implies that those suffering

from TB can also share the same feelings of guilt. This is more so in instances of HIV/TB coinfection. The moral question of the association between HIV and promiscuity, for instance, feeds into TB stigma as the two diseases have a synergistic relationship.

Yang, Kleinman, Link, Phelan, Lee and Good (2007) add that stigma, as a socially constructed identity, occurs in the parameters of interpersonal communication and lived engagements, making it both a social and subjective process. Reinforcing the social construction of stigma as an identity, Yang et al. (2007) further argue that stigma occurs within social interaction between people through the exchange of words, actions, and the construction of meanings. Linked to this premise is the concept of anticipated stigma which speaks to the extent individuals with a hidden stigmatised identity expect others to stigmatise them once the "concealable stigmatised identity" is revealed (Quinn & Chaudoir, 2009, p.636). Regarding men suffering from TB, stigma becomes attached to their interaction and communication with their circle of friends and social networks as well as in their access to healthcare services. As the process of stigmatising is interactional and intersubjective, some male TB sufferers attempt to conceal illness when interacting. It is therefore noteworthy that as an identity, an individual who is stigmatised may decide not to live by the dictates of the stigma and invent strategies to manage it (Goffman, 1963; Pierret, 2003). The individual sufferer possesses agency in face of structural pressures.

As a chronic illness, tuberculosis causes biographical disruption in the realm of the-taken-for-granted mundane aspects of daily living. Originating with Bury (1982, p.169) biographical disruption is argued to be "the kind of experience where the structures of everyday life" and the associated knowledge are abruptly shattered. Biographical disruption severs the individual sufferer's normal day-to-day life routines and interactions with people close to him, leading to a process where family and occupational activities are rearranged around illness (Engman, 2019; Pierret, 2003). Similarly, Lupton (2012, p.87) avers that biographical disruption entails a "major assault to an individual's sense of identity and personal meaning." Barry and Yuill (2022, p.152) agree that biographical disruption compels individuals to restructure their lives on multiple fronts where different concepts of self and relationships with family, friends, and colleagues will be questioned and reassessed. Considering masculinities in the African context, it is of paramount importance to unpack how the disruption caused by TB illness reconfigures men's relation with their own selves, family members, their immediate social networks and, by extension, their sources of livelihoods. Commenting on the situation in Zambia's urban

communities, the TREATS project's Virginia Bond argues that the experience of falling ill with TB, which requires frequent visits to the health centre and being unable to contribute to the household, disrupts the lives of most residents given their impoverished circumstances (TREATS, 2022). In the study I demonstrate that being poor and unable to work is as disruptive as the TB illness itself. TB illness in this regard disrupts individuals' everyday lives. Pierret (2003) adds that the onset of an illness causes the sufferer and those immediate to them to ask questions about what is happening and to consciously interrogate taken-for-granted explanations.

In the context of this study, a few participants were hospitalised before and after a TB diagnosis. Associated with the disruption caused to their mundane lives of basic routines like "sleep, play, and work in different places, with various co-participants…and without an overall rational plan" (Goffman, 1961, p.17), the hospital became a critical institution for men suffering from TB. Through the process of "mortification of self", Jenkins, Burton and Holmes (2021, p.2) argue that a hospital is a total institution since it erases one's previous identity before conferring them with a patient identity. In line with Goffman (1961), a total institution is distinguished by the breakdown of typical divisions that separate fundamental social activities such as sleeping, playing, and working. Thus, Lupton (2012, p.95) argues that as in a prison, the hospital functions as a total institution where patients have minimal control over aspects such as meal and sleep schedules, clothing choices, exposure to noise or light, and the way they attend to bodily functions. For some men who experienced critical suffering resulting from TB, the hospital became an institution where new identities were formed, albeit temporarily. It is in the context of TB illness-induced biographical disruption that an African-centred theory of masculinity helps us to appreciate the renegotiation and reconfiguration of masculine identities. In line with the chosen theoretical framework, I now turn to a discussion of metaphor usage in illness experiences.

Tapping into metaphors to explain TB illness experiences

Health campaigns use metaphors for intervention purposes tailored towards behaviour change. In that regard, impactful metaphors emerge from ordinary people's experiences with illness. The usage of metaphors is important as it allows "social actors to speak for themselves and in their own terms" (Qambela, 2021, p.593). Metaphors in the discourse of health and illness are context specific. Speaking in relation to the doctor-patient relationship, Reisfield and Wilson (2004) argue that the physician's ability to pay attention to the patient's metaphoric

pronouncements is an important factor in determining treatment decisions by the health seeker. Metaphors work by association at the level of talking, thinking, or understanding one thing, often called the target, in terms of another which is the source (Jansen, van Nistelrooij, Olislagers, van Sambeek & De Stadler, 2010; Lupton, 2012; Semino, 2021). In my research on men's health-seeking behaviours in Modimolle in South Africa's northern-most province of Limpopo, men used a masculinised metaphor of a car in likening a human body. Men used this masculinised metaphor to demonstrate that, just as a vehicle requires regular service to operate efficiently, so does a human body (Madhuha, 2017). The target in that regard is the human body and the source is metaphorically the car. In that respect, the service spoken of by men in reference to the human body entailed regular use of enemas, traditional and over-the-counter medicines to keep themselves healthy (Madhuha, 2017). The way metaphors work is that they reorient people's expectations by stimulating them to engage – logically and emotionally – with the intended messages (El Refaie, 2015, p.5). Similarly, van der Geest and Whyte (1989), cited in Lupton (2012), observe that the use of metaphors in the context of illness helps people to make meaning and concretise pain.

The classic work by Sontag and Broun (1977) on illness as metaphors is relevant for understanding the use of metaphors in the context of men's TB illness experiences. Although their work on illness as metaphor is presented within the context of a historical analysis of tuberculosis in Europe, the relevance of this analysis is that it can be applied to the contemporary realities of TB in Africa where the disease burden is a public health priority, and more so in South Africa. It helps to underline that the analysis of illness as a metaphor by Sontag (1977) is meant to emphasise the significance of using metaphors when discussing illnesses. Paradoxically, the author also critiques the use of metaphors in such contexts. A classic example of illness metaphors is the war rhetoric where the sick person is representative of a nation under attack or invasion by an enemy (bacteria) (Kistner, 1998). Although this metaphor relates to the scientific discovery of bacteria, its usage is still common in relation to TB. Another important usage of metaphor is succinctly captured by Steinberg's (2011) book title *The three-letter plague.* The title is loaded with meaning about HIV and its devastating effects in the context of South Africa and according to Lupton (2012, p.59), comparing HIV/AIDS with plague conjures "centuries-old fears of incipient illness, spread mysteriously and striking down large numbers of people almost without warning."

According to Sontag and Broun (1977, p.32), "[i]llnesses have always been used as metaphors to enliven charges that a society was corrupt or unjust." In the same vein, Lupton (2012) adds

that metaphors are not politically neutral and in relation to disease metaphors, they are frequently used to describe disorder and pandemonium. Metaphors used in TB illnesses are important tools to interpret the broader issues of inequalities bedevilling South African society, especially considering the association between TB and poverty. It is no coincidence that TB ceased to be a pressing health burden in developed countries but persistently devastates South Africa, a pointer to how illness metaphors can help in highlighting issues of inequalities in the country. Emerging from participants' TB illness experiences, this research brings the import of metaphors to the discourse on health and illness. Considering metaphors as symbolic, their application in connection to TB illness gives tangible form to a disease based on individual experiences, with broader analytical connections to the South African state.

An example of the way metaphors linked to TB are used in South Africa is through children's comics intended to galvanise attitudes change about the disease (El Refaie, 2015). In one of the comics titled "Laduma! Stick to your TB game plan!" (No date, no pagination) the connection between Laduma, a popular cheer celebrating goals at South African football (El Refaie, 2015) and sticking with the "TB game plan" is illustrative of the drive towards TB treatment adherence and therapeutic citizenship (Mfecane, 2011; Nguyen, Ako, Niamba, Sylla & Tiendrébéogo, 2007). In defining therapeutic citizenship, Nguyen (2005, p.126) argues that it is an assortment of claims and moral expectations emanating from a combination of "techniques used to govern populations and manage individual bodies." This suggests that individuals within a society, as part of their citizenship, engage in activities or behaviours that are framed around notions of health, wellness, or therapeutic practices, which are influenced by broader societal norms and practices of governance. All the necessary ingredients towards health seeking considering TB symptoms and treatment adherence are summed at the end of the comic story with "[t]hat is how you win on the soccer field and how you beat TB too!" (El Refaie 2015, p.16). This analogy draws a connection between success in sports and success in managing TB, making the message relatable and memorable.

While the messaging in the metaphor is relevant to the fight against TB in South Africa, the target audience is urban and young children. This messaging might not apply to a rural context like Bushbuckridge in Limpopo province. In the context of Bushbuckridge, the people who were lost from TB treatment asserted they were not "suffering from TB but *Tindzhaka* or *Mafularha* [folk illnesses with similar symptoms as TB but attributed to witchcraft or sexual practices] …" (Zulliger et al., 2014, p.4). Other scholars argue that Tindzhaka and Mafularha result from the violation of social norms related to death, sex and using the belongings of

someone who recently died (Audet et al., 2023; Mfecane, 2010). In the case of Mafularha which is related to a breach of funeral taboos like ploughing before the burial of a corpse, the symptoms include “chest pains and profuse coughing” (Niehaus, 2002, p.193) and these are some of the classic TB suggestive symptoms. In the context of traditions and culture, the significance of metaphors is crucial for enhancing our comprehension of illness experiences. Thus, Reisfield and Wilson (2004, p.4027) argue for the need to find common ground by considering ill people’s metaphors as well as introducing other illness metaphors that may be more empowering. This study focuses on how men generate metaphors and employ them to construct meaning in the context of their TB illness experiences.

Embracing African-centred theories of masculinities: concluding remarks

This chapter is carved from an engagement with theoretical strands anchored broadly within the critical studies of masculinities as well as conceptual formulations embedded in the sociology of health and illness. The chapter began by centring gender conceptualisation and proceeded to script the genealogy of masculinity theorisation beginning in the mid-1950s. The genealogy of masculinity in the West was influenced by major theories from structural functionalism right through to critical structuralism and post-structuralism. Masculinity theorisation evolved through three stages, the first wave of which was more concerned with sex roles. The deficiency in this theorisation was its lack of appetite for interrogating power and material inequality between genders. These internal tensions within the development of masculinity thinking led to the second and third waves which argued for plural masculinities as well as the social construction of gender and masculinity. The concept of an idealised hegemonic masculinity was also elaborated in relation to alternative masculinities within a given society in time.

Furthermore, the chapter demonstrated that masculinity theorisation emerging from the West lacked a critical analytical grasp of the historical context of men in the global South who faced dehumanisation of their identities under colonialism. As with any theory, masculinity theories are context specific, and I argue with Connell (2014) that it is not a fruitful exercise to universalise masculinity theories emanating from the global North as they have limited application to the global South context. What is at stake, I claim, is that universalising global North masculinity theories only serve to perpetuate a hegemonic stranglehold and create a blind

spot on the complexities of men and masculinity studies. In that respect, I presented ways masculinity is understood by theorists from Africa. When studying black African men, Mfecane (2020, p.3) advises scholars not to be inflexible followers of a specific theory as we may fail "to truly hear African men's narratives", thereby allowing ourselves to be "blinded to the harsh circumstances to which African men are subjected on a daily basis." It is against this backdrop that I particularly trial the African-centred theories of masculinity as a lens through which to examine how black African men in Modimolle express and perform masculinities in the public spaces of work, entertainment and in private when experiencing TB illness.

Emerging as a new area of study on men, African-centred theories of masculinity appreciate both the corporeal and the unseen elements in shaping men's identities (Mfecane, 2018; Manganyi, 2019). I argued that masculinity is an identity that is mediated through social norms and values. It manifests and is enacted at a personal, interpersonal, and macro level. The importance of values and norms as bases of masculinity identification helped me argue for an African-centred theorisation of masculinity that emphasises how the immaterial foundations of personhood influence masculinity identity in the African context. Through men's enactment and embodiment of masculinities, I sought to understand how tuberculosis is spread among them. As presented in Chapter Five of this study, I argue that TB among men is a disease of sociability. Furthermore, the African-centred theories of masculinity helped me to appreciate the fluidity of masculinities when men are suffering from tuberculosis in the private sphere of their homes where vulnerabilities are manifested. The ordeal of TB illness in many men revealed the debilitating impact of the disease. This often led to a sense of dependency, sometimes even requiring care from their mothers, which could be seen as a form of infantilisation. In that respect, the sociological concepts of illness experience, biographical disruption, stigma, and illness metaphors helped me to make sense of how masculinities are reconfigured among men.

In the next chapter (Chapter Four), I take the reader through my fieldwork journey. The fieldwork was aided by my having settled in the research setting well before the commencement of my postgraduate studies. The rationale for selecting Modimolle as the research site, based on the prevalence of tuberculosis, has been considerably detailed in the first chapter of this thesis. However, my personal experiences as a resident of the area equally played a role in deciding to choose this research site. Furthermore, the research site was the same one within which I undertook my 2016 master's fieldwork on men's health-seeking behaviours. In all the methodological reflections that follow in the next chapter, I am also

guided by observation to triangulate interview findings on how masculinities are performed in the public spaces of entertainment and within the private spaces when men become ill from tuberculosis. The exposure to vulnerable men suffering from tuberculosis was a revealing experience that helped me think through the risks of infection from the disease.

Chapter Four

Navigating the research site and conducting ethnography in the context of COVID-19

Connected to politics of knowledge production, gatekeepers have the potential to influence the researchers' results. For instance, gatekeepers may allow only selective access to the research site, manipulate participant responses, or attempt to impose certain ideas on the researcher, thereby influencing how some knowledge in the field comes to be deemed more valuable, and the way in which researchers produce knowledge through their research and writing (Chaudhuri, 2017, p.134).

Introduction

While ethnographic literature offers guidance on how to successfully execute ethnography (Creswell, 2007; Vanderstoep & Johnson, 2009), each ethnographic work is peculiar as a rich exercise at the coalface of everyday life. Steeped within and informed by the cultural milieu of participants, a well-conceived and executed ethnographic work provides novel findings, contributing fresh theoretical and empirical knowledge on the studied phenomena. No matter how well-planned ethnographic research may be, the actual process of carrying it out is consistently marked by distinctive challenges that the ethnographer must overcome. To an inquisitive ethnographer, the challenges are the building blocks of knowledge production.

In this chapter I contend that in qualitative research, the selection of a research setting is influenced by a combination of factors, including scientific considerations and personal preferences, among others. I also argue, based on my ethnographic experiences, that the success of ethnographic research, particularly when it involves sensitive and contentious topics such as illness experiences, is significantly influenced by how researchers negotiate and manage their relationships with gatekeepers. Thus, everyday ethnographic work is inherently political.

Employing a qualitative research methodology, I adopt an ethnographic research design for this study. I examine the influence of my own prior experiences in Modimolle on the selection of the research setting. This reflexive and self-aware approach to the research process helps bring to the fore the impact my background has on the study design and context. In this ethnographic study, which examines men's experiences with TB illness in Modimolle, I also

use observation to help me examine men's expression and performance of masculine identities, not only in public spaces but also within the private sphere when they face illness. To access the research site and research participants, I used gatekeepers who at times played dual roles as gatekeepers and research assistants. These research assistants were an important resource of tuberculosis knowledge and as guides to accessing research participants. In the following section, I weave my positionality and justify the use of ethnographic research design to the study.

Why ethnographic research design?

I chose an ethnographic research design because of the empirical gap in knowledge about the lived experiences of tuberculosis illness among working-class men in non-mining communities. Issues of access to and my own position in the community also influenced my choice of an ethnographic research design. Precipitated by extended and active participation in the social life of the community, ethnography provides "holistic insights into people's views and actions, as well as the nature (that is, sights, sounds) of the location they inhabit, through the collection of detailed observations and interviews" (Reeves, Kuper & Hodges, 2008, p.512). In line with this principle, I used ethnography as a method to observe men's sociability practices which were informed by men's values and socioeconomic class. Such an attempt helped to unravel ways tuberculosis was possibly spread and distributed among men in the context of study. In the same vein, I employed ethnography to understand the perceptions and meanings that working-class men attached to TB and how these shaped their health-seeking behaviours and their access to healthcare when suffering from the disease. The basis for such understanding, argues Hammersley and Atkinson (1983, p.9) requires "that we learn the culture of those we are studying." Central to the premise of this definition is my immersion in the social and cultural context of men suffering from TB. Ethnography afforded me an opportunity to interact with my research participants in their natural settings as they engaged in their everyday social activities. The import of ethnography, argues Packer (2011), is that it considers not just what people say but what they do in their natural setting.

Ethnography helped me to acquaint myself with the cultural dynamics of the participants and these revealed deeper meanings related to masculinity and men's health-seeking behaviours. Arguing for the relevance of ethnography in health and illness studies, Savage (2000) stresses that the approach has been useful in accessing the underlying beliefs and practices of

participants that influence certain behavioural decisions. Furthermore, Rashid, Caine and Goez (2015) argue that health researchers who use ethnography often have a community orientation. Speaking of a 'community orientation', my entry into Modimolle was as an immigrant from Zimbabwe in 2004, long before I proceeded with my postgraduate studies in Johannesburg in 2015. My experiences as an immigrant residing in Modimolle are inseparable from my academic pursuits. During my stay, I established networks and explored business opportunities that not only supported me but also brought tangible benefits to my family. In this regard, I managed to create a collaborative business venture, specifically a *spaza* shop[3] with a friend using our savings. Inadvertently, the business served a dual purpose: it generated an income and granted me entry into the local community. Through interaction with my clients, I learned sePedi (Northern Sotho), the dominant language spoken in the area.

Additionally, I became aware of cultural dynamics in the community by participating in community events such as funeral gatherings and becoming a member of a local religious grouping. As a business owner, I joined the local small business forum, a lobbying group to urge the municipality to implement regulations for foreign-owned spaza shops in Modimolle's Phagameng Township. The proliferation of these shops had reached a point where they outnumbered and outcompeted locally owned businesses. As an immigrant, how did I fit into this business forum that was anti-foreign businesses in the area? A brief background would help. In 2012, there was a protest action against all foreign-owned spaza shops in Modimolle Township due to an alleged case of gender-based violence (GBV) involving a local woman and a foreign businessman. That incident triggered a wave of looting of foreign-owned shops in Phagameng Township. One of the foreign-owned shops close to mine was looted. Although I was a foreigner in the community, my shop was spared from the looting, possibly because I was perceived by the community as a local.

In one of the newly established settlements within the township, the community organised a mobilisation effort to dismantle recently constructed shop structures owned by Ethiopian nationals who had intended to operate businesses in the area. These new structures were constructed using zinc sheets. As some of the Ethiopian spaza shop owners knew me, they implicated me as one of the people who pulled down their shops and I was subsequently arrested together with one of the leaders of the local business forum in 2014. However, the man

[3] A spaza shop, also known as a tuck shop, is a small convenience store in marginalised communities and townships in South Africa often run from a shack or small room (Hare & Walwyn (2019). They primarily sell essential food staples like bread, sugar and non-alcoholic beverages (Mukwarami, Tengeh & Iwu, 2018).

who filed the charge against me and some of his countrymen withdrew the case. This was because of negotiations between the Ethiopian spaza shop owners and the locals. During my arrest in 2014, authorities did not detain me, and within a month, they dropped the case against me. My membership of the local business forum and the way the authorities handled my case effectively validated my insider status within the community.

My experiences in this community helped me to navigate the social landscape during fieldwork. In research, an insider is someone sharing personal affiliation with the group to which their participants also belong, such as in terms of ethnicity, sexual identity, and gender (Hayfield & Huxley, 2015). Conversely, an 'outsider' is someone who does not belong to that group. An insider identity is quite a fluid space which is socially constructed. For instance, some of the narratives that were emerging from community members were that the Ethiopian spaza shop owners did not allow them to buy goods on credit, something that I was practising in my business. It is possible then that this insider identity could be upended if I was not giving credit to my clients. The combination of these experiences became very useful resources in the way I conducted my ethnographic research for this study, and they also gave me an insight into the masculinities of black working-class men. Referring to scholars on masculinities in Africa, Ratele (2014, p.31) argues that "many of us appear to be dislocated from the cultural worlds of the subjects of our investigations." I managed to immerse myself within my participants' lifeworld.

While relocated to Gauteng province in 2015 for my postgraduate studies, my connection to Modimolle remained robust because my family resides there, making it a second home, akin to my original home in Zimbabwe. At the end of every month or during semester breaks, I always returned to Modimolle. For an ethnographic encounter, I returned and stayed in the research site of Modimolle for nine months between June 2020 and February 2021 as per the requirements of an ethnographic tradition. It was during this period that I acquainted myself with the everyday social activities of working-class men and how their interaction in spaces of entertainment provided an avenue through which tuberculosis transmissibility among this population group could be understood. I also conducted interviews with men suffering from tuberculosis to understand the meanings and experiences they attached to suffering from the disease. In this study, I relied on two main ethnographic methods which involved participant and non-participant observation as well as individual in-depth interviews. Before devoting space to these separate methods in the ensuing sections, a description of the setting within which this ethnographic study unfolded follows. As a reminder, I understand masculinity in

this study to mean men's preoccupation with own identity. This identity, I argue, is shaped by societal norms and values and is manifested and performed in practice at personal, interpersonal and macro levels. I reiterate that masculinities are embedded within specific socio-cultural notions of what it means to be a man and they are expressed and performed through social practices.

Research Approach

Maggs-Rapport (2001) argues that within most human sciences, qualitative research approaches may be adopted if they are in line with the research questions that are asked. The research approach and the research questions ought to have a congruent flow. The research question which guided this study was, "How does the spread of tuberculosis among men shape and become shaped by masculinity identities in a non-mining community such as Modimolle?" In qualitative research, "the researcher observes and records events and relationships through text, dialogue, participant observation, photography and video" (Maggs-Rapport, 2001, p.375). For purposes of collecting and analysing findings in this study, I relied on a qualitative research approach which gives insight into the ways participants construct meanings around their own lived illness experiences of tuberculosis.

I used a qualitative approach because it allowed me to understand the unique "social and material circumstances, experiences, perspectives and histories" of research participants (Ritchie & Lewis, 2003, p.3). This proved to be useful because the illness experiences of men in this study could not be divorced from their social and material circumstances. To put it differently, men's places of residence, workplaces, and the social venues they frequented for leisure and social interaction emerged as crucial factors for comprehending the transmission and infection of tuberculosis among them. A qualitative research approach not only revealed men's interpretations and understanding of their own tuberculosis experiences, but also illuminated the connection between masculinised spaces and socio-cultural practices of sharing beer and smoking in proximity as potential pathways for the transmission of the disease. In the performance of masculine identities within specific spaces, it is important to highlight that the social practices involved are influenced by certain socio-cultural values.

The research participants resided in the township of Phagameng in Modimolle. In the realm of healthcare provisions and services, the population of Phagameng township, which numbered 29 803 in 2016 according to Stats SA, primarily relied on two public clinics situated within the

township and in the town centre respectively. The research participants accessed the township government clinic and the public hospital for TB diagnosis and treatment. However, the healthcare landscape notably also included private facilities catering to individuals with medical insurance and those paying for services out-of-pocket. Within the parameters of a qualitative research approach, findings cannot be statistically generalised to larger populations (Babbie, 2004) of the Waterberg District, let alone to Limpopo province or to South Africa at large.

Unveiling the context: A glimpse into the research setting

Modimolle can be described as a resource-constrained setting. According to the town's Final Integrated Development Plan (2016/2017, p.35), the area comprises both urban and rural areas and is characterised by "informal settlements and farms." Before selecting a research site for data collection, researchers grapple with various factors. Lune and Berg (2017) delve into the considerations that researchers weigh, such as the size and complexity of the research site, as well as time and budgetary constraints. Fundamentally, the practical aspects of accessing potential male research participants with tuberculosis guided my choice of Modimolle as a research site. This was closely tied with how familiar I was with the research setting. As mentioned earlier, my time residing in Modimolle played a pivotal role in choosing it as a research site. My proficiency in the predominant languages spoken in the area, such as sePedi and Xitsonga, equipped me with the skills needed to navigate the data collection site with minimal difficulties. The stock of knowledge that I possessed about the area allowed me to conduct fieldwork for my masters' research, and this influenced my choice for the current research on men's tuberculosis experiences. Lune and Berg (2017, p.37) put forward different scenarios when considering the study site for research. These include that:

1. entry or access is possible;

2. the appropriate people (target population) are likely to be available;

3. there is a high probability that the study's focuses, and processes, people, programmes, interactions, and structures that are part of the research question(s) will be available to the investigator; and that

4. the research can be conducted effectively by an individual or individuals during the data-collection phase of the study.

In relation to the selected setting, statistical evidence shows a high concentration of tuberculosis in Limpopo province in which Modimolle is located (Mzobe & Loveday, 2017/2018). In addition, some of the participants in this study who had developed multidrug-resistant TB were referred to the multidrug TB (MDR-TB) hospital located in Modimolle. However, during the time of fieldwork, this strategic hospital had been converted into a care facility for COVID-19 patients. This complicated how some of my participants accessed their MDR treatment; they were referred to public clinics to collect their treatment. Importantly, this further justifies the choice of Modimolle as a research site because of the vulnerability of TB sufferers to sudden events and disruptions. In the next section, I unravel the nuanced intricacies of the sampling methodology employed in this study.

Delving into the details of sampling, research population, and sample size

The population in Modimolle from which I selected the eligible participants consisted of all black working-class South African men who had been diagnosed with tuberculosis. The selected sample was 30 men between the ages of 20 and 60 years suffering from tuberculosis and residing and working in Modimolle. Why the age range of 20 to 60 years? Evidence shows that tuberculosis was the highest cause of death for men between the ages of 15-44 as well as those between 45-64 years in Limpopo province (Stats SA, 2018, p.119). Clearly, tuberculosis disproportionately affects economically active persons in the province and that informed my participant selection.

Studying tuberculosis, specifically exploring the factors contributing to its elevated prevalence in the Waterberg District of Limpopo, alongside an exploration of the lived experiences of working-class men in Modimolle aged 20 to 60, enhances our comprehension of the disease within the broader context of South Africa. As a non-mining community, the TB illness experiences of men residing in Modimolle help to shed light on other important context-specific factors shaping the spread of the disease among men. Importantly, the provider role, household head, homestead formation *(umzi*) (Hunter, 2006), ideals pertinent for masculinities as well as the role of culture made it paramount to consider the men aged between 20 and 60 years. This aligns with existing literature, which asserts that adults –typically men in the economically active age range of 15 to 59 years – are predominantly affected by tuberculosis, as demonstrated by findings from Srivastava, Kant and Verma (2015). Coupled with the

theoretical lens of masculinity, the gendered nature of tuberculosis and socioeconomic class were therefore important factors that I considered in my sampling.

From the targeted population of male TB sufferers in Modimolle, I selected 30 participants diagnosed with the disease through non-random sampling. Vanderstoep and Johnston (2009) argue that non-random sampling ensures that participants are selected based on characteristics they possess or their availability to participate. A non-random sampling means that "each population member is not equally likely to be selected to participate" (Vanderstoep & Johnston, 2009, p.27). In this study, men were selected based on a tuberculosis diagnosis received after presenting for healthcare. This diagnosis was confirmed by the community healthcare workers as well as the participants. I also had the privilege of accessing some of the men's medical records at the clinic. The men had to be between the ages of 20 and 60 years. The male participants selected for the study accessed their healthcare services at the local Phagameng township clinic in Modimolle. I also selected two caregivers related to two of the participants in the study. Caregivers played a significant role in shedding light on the influence of masculinity in men's health-seeking behaviours and the strategies employed by men in coping with illness. I interviewed the two caregivers to fill gaps that emerged during interviews with their two male relatives. I also selected six healthcare workers as key research participants. Five of these participants were community healthcare workers (CHWs), and the sixth one was a nurse in charge of HIV/AIDS, STI's and Tuberculosis (HAST) unit at the clinic. All the community healthcare workers were women which illustrates how gendered the profession is. I selected the five based on their availability and willingness to share their work experiences with me. I selected them from a group of 28 community health workers (CHWs) working at the local clinic.

Out of the 30 main participants I interviewed, eight possessed a matric certificate, and among them, one had acquired a Technical and Vocational Education and Training (TVET) college qualification. Furthermore, 14 out of the 30 participants were high school dropouts, with eight having discontinued their education at the primary school level. As mentioned in Chapter Two, education plays a fundamental role as a buffer against tuberculosis (Harling et al., 2008). In 2016, the recorded educational attainment in Modimolle revealed that 45.1% of the population had completed primary education, while only 0.9% of the adult population held a tertiary qualification (Modimolle Local Municipality, 2016, p.38). Conversely, slightly more than 8% of the population holds a grade 12 qualification (Final Integrated Development Plan, 2021-2026, p.66). **Appendix One** contains a detailed participant profiling. Be that as it may, the

youngest participant was 24 years old. Among the participants, eight were in their 20's, 11 in their 30's, six in their 40's, and five in their 50's. Most participants identified ethnically as Pedi, with three participants identifying as Tsonga, three as Tswana, and one participant identifying as Ndebele. Half of the participants resided in government-subsidised houses, commonly referred to as RDP houses (Reconstruction and Development Programme). One-quarter lived in refurbished or extended houses while the remaining participants lived in informal housing. An interesting observation is that most of the participants living in RDP houses and refurbished houses lived with their parents or relatives, while those informally housed cohabited with their spouses and had formed own independent households. Setting up one's own independent homestead is an expression of masculinity.

The average household size for the participants was four persons which is consistent with the findings from the Modimolle-Mookgophong Local Municipality (IDP/Budget (2021-2026, p.61). Most of the participants self-identified as single and many of them relied on their mothers and aunts for caregiving during TB illness experiences. Those who were married or in cohabiting unions relied on the support of their spouses for care during their times of illness from tuberculosis. Eight of the participants were receiving disability grants of approximately R2 000 (US$ 105) per month. On average, the participants who were gainfully employed earned between R3 100 and R5 000 per month. Most of the participants relied on precarious piece jobs with no fixed monthly income. Six participants either lost their jobs due to illnesses induced by TB or the impact of the COVID-19 pandemic. They expressed a lingering hope of being reinstated in their previous employment.

Connected to the living arrangements is the significance of masculine identity. How does masculine identity manifest and how is it performed among men who reside with their parents or other relatives? This question emerged during my fieldwork, and I will briefly recount a scenario that transpired during my interaction with a 28-year-old participant, whom I refer to as Patrick to safeguard his anonymity. Patrick was one of the most eloquent participants that I interviewed. He was HIV-positive and was a former *nyaope*[4] addict who lived with his parents. After gaining consent to interview and audio record him, we mutually decided to conduct the interview in my car which was parked in front of Patrick's parental house. It is important to mention forthwith that we were putting on our face masks as was required under COVID-19 regulations. During our conversation, there was a palpable agitation from Patrick's mother who

[4] Nyaope is a drug defined as a form of black tar heroin, sometimes mixed with other substances that came into widespread use in South Africa in 2009.

was seated on the veranda. On two separate occasions, she demanded that Patrick come out of my car, for his own safety as he was talking to a stranger (myself). While in the middle of responding to one of my questions, Patrick's mother called aloud for him to stop the conversation:

> **Patrick**: [Showing agitation]. Let me talk to my mother now.
>
> **Eddie:** That is all right. (Patrick went out to have a conversation with his mother).
>
> **Patrick**: [After returning] My mother thinks that she can keep me under her skirt forever (Laughing).
>
> **(Interview with Patrick, 15 September 2020).**

Patrick's comment regarding his mother's influence was enlightening. On one hand, his mother was acting in his best interests, particularly concerning safety concerns. On the other hand, the mother's conduct demonstrates her control over her son though he was an adult. Multiple factors shape masculinity, and by living with their parents, men can sometimes be perceived as dependent children, irrespective of their actual age. Patrick's ongoing residence under his parents' roof meant that his mother could exert a certain level of control over him, a situation that Patrick found challenging to embrace. A closer exploration of the sampling techniques follows next.

Sampling techniques and the processes of recruiting research participants

In line with non-random sampling, I relied on purposive sampling for selecting participants. This sampling technique is premised on a subjective process of identifying and selecting individuals with characteristics relevant to the study and whose suitability to the research objectives can be ascertained (Smith, 2002). The criteria I considered to identify potential participants for the study included place of residence, existing TB diagnosis, gender, race, and age. The processes I undertook to establish the practicalities of participant recruitment were multifaceted. Following the receipt of ethical clearance from the Wits Human Research Ethics Committee (HREC Medical) in December 2019, I had to negotiate access to the research site. Towards the end of January 2020, I met the CEO of Modimolle Multi Drug Resistant (MDR) TB Hospital, which admits multidrug-resistant tuberculosis patients in the province of Limpopo. I furnished him with the ethical clearance certificate and the interview guide designed for healthcare workers, which I intended to incorporate in the key participant interviews for my research. After my engagement with the CEO, he referred me to the District

Health Manager on TB. However, on that day the district TB health manager was on leave. This was the first barrier stalling my fieldwork journey in terms of participant recruitment.

After email correspondence with the district health manager, we met on the 7th of February 2020 at 10:00 a.m. The district health manager played a crucial role as a primary gatekeeper for facilitating my fieldwork in Modimolle. We discussed my research interests and the targeted potential participants for interviews. True to the way bureaucracies operate, the manager took me through the protocols I was to follow before recruiting and interviewing participants in Modimolle. Understandably so, researching TB illness experiences of men is a sensitive topic that demanded meticulous adherence to ethical considerations at both the university level and within the Department of Health. After consulting her superiors, the district health manager informed me to approach the Limpopo Provincial Health Department research committee. I initiated communication with the provincial health department and was instructed to apply to the National Health Research Database (NHRD), along with all pertinent documentation, including my research proposal and ethical clearance certificate. I completed all the protocols as was required and I waited for clearance from the provincial health department before commencing the actual fieldwork processes. Coincidentally, following the receipt of the clearance certificate from the NHRD in March 2020, the COVID-19 pandemic emerged, compelling me to suspend my fieldwork itinerary due to the imposed lockdowns. **Appendices Five and Six** provide documentation of ethical clearance. The processes of participant recruitment cannot be complete without presenting the dynamics of COVID-19 pandemic, a section that I turn to.

Negotiating access and traversing the research site in the context of COVID-19 pandemic

COVID-19 disrupted the 'normal' routines of conducting ethnographic research and as argued by Ruppel (2020), while it is feasible for social scientists to work from home, it is a daunting task for those who rely on qualitative data collection, as they need to interact with other people. For my research, this interaction meant recruiting participants suffering from tuberculosis. With the relaxation of COVID-19 lockdown restrictions in South Africa in June 2020, I emailed the Waterberg district health manager in connection with resuming my fieldwork in Modimolle. Even though I had submitted the NHRD clearance letter from Polokwane to her office, she still needed to consult with management about the procedures since her office became the provincial centre dealing with all COVID-19 related cases. This meant that her

office became actively involved in addressing the COVID-19 pandemic in the province, leading to the temporary prioritisation of essential activities while other 'non-core' tasks were set aside. Significantly, the MDR Hospital in Modimolle, the site where I had hoped to get some of the key informant participants as well as potential main participants, had been turned into a COVID-19 holding facility for the entire Limpopo province. The conditions on the ground necessitated changes in my planned strategies to recruit participants.

When the country officially transitioned to Lockdown Alert Level 3[5] on June 1, 2020, the clearance obtained from the National Health Research Database in Limpopo allowed me inter-provincial travel from Gauteng for my fieldwork in Limpopo. I thus managed to travel from Gauteng to Modimolle, the research site. The NHRD clearance letter allowed me access into the healthcare facilities in Modimolle, and so my first port of call became the township clinic (Phagameng clinic) in Modimolle. Upon arriving at the clinic gate, I observed the COVID-19 screening protocols. Security officers captured my details, I underwent hand sanitisation, and while adhering to social distancing, I proceeded to the screeners for a temperature check. After this process, I was directed to the sister in charge of the clinic where I presented my clearance letters. The sister in charge welcomed me and she linked me with the leader of the community healthcare workers (CHWs) whose name was Ms. Lerato[6]. Ms. Lerato accompanied me to the team of CHWs where they were gathered.

I had an opportunity to introduce myself to the 28-member team of CHWs. This group of CHWs comprised only of women, and they were at first reluctant to welcome me. Ms. Lerato assisted me to integrate with the team members and on numerous occasions I accompanied the team members in the field on their home-based care visits. This is because my fieldwork and the community healthcare workers' work dovetailed, such that I managed to fit into their daily schedules. I gradually earned the team's trust. This whole process was a rich learning experience in my ethnographic fieldwork. Indeed, my access to the field would not have been possible without the help of the community healthcare workers. The work of CHWs entailed daily visits to the community to provide care to different patients. For instance, some of the CHWs monitored TB clients through their Directly Observed Treatment Short-course (DOTS) therapy.

[5] Lockdown Alert level 3 allowed for the movement of people between 4:00 a.m. to 10:00 p.m. When in public, it was mandatory to put on a face mask or cloth and to observe social distancing of one-and-half-meters.
[6] Pseudonym

Before I interviewed my main participants, i.e., men diagnosed with TB, I scheduled interviews with five CHWs. During an interview with Pauline, a community health worker who has been working in Modimolle since 2009, her comments regarding the nature of her work as presented below encapsulate the sentiments shared by many of her colleagues:

> **Pauline:** I look after those patients that are discharged from hospital or clinic especially those that are still not well. We attend to patients with various diseases like HIV, hypertension, diabetes, TB and those in need of palliative care. For those with serious illnesses who are not able to wake up from their beds, we bath them, and we dress them up. We also DOT those with TB. DOT is direct observed treatment where you give the patient his/her medications and watch him swallow directly in front of you so that he manages to recover. The problem is with the duration of TB treatment which takes six months to complete. Sometimes the patient just becomes weary about when he will complete his treatment because six months is a long period of time. But if you DOT and support him he manages to pick up quickly because we DOT every day, let me say from Monday until Friday. We don't work on weekends and that is where we talk with family to support the patient in taking his treatment.
>
> **(Interview conducted on 23 July 2020 with Pauline, a CHW**).

My fieldwork was made easier because it closely tied with what the CHWs were already doing. It is crucial to highlight that the DOTS strategy has undergone changes from its initial form, where TB patients visited the clinic for their daily treatment, to an evolved version known as DOTS-plus (Mason et al., 2016). Confirming Pauline's account, Mason et al. (2016, p.214) describe the DOTS-plus model as relying on the efforts of community health workers who offer patient treatment support, shifting the responsibility from doctors or nurses. Additionally, care is typically administered to the patient, reducing the necessity for constant returns to the clinic. As cited in Chauke et al. (2018, p.56), the Department of Health confirms Pauline's reflections on the DOTS process i.e. that it "involves an observer watching the patient swallow the tablets, in a way that is sensitive and supportive to the patient's needs." The DOTS strategy, as outlined by Pauline and affirmed by Chauke et al. (2018), aligns with the core principles of the strategy from its inception[7]. This is particularly so as regards the prolonged duration of TB

[7] The DOTS strategy originated in the 1950s in response to three pivotal factors: the challenges in ensuring successful completion of TB treatment; the complexities arising in individuals co-infected with TB and HIV; and the public concern sparked by multidrug-resistant TB (Bayer & Wilkinson, 1995). The concept of employing directly observed therapy short-course (DOTS) among TB patients originated from initiatives in Madras (India) and Hong Kong in the 1950s, aiming to ensure adherence to and completion of treatment (Bayer & Wilkinson, 1995; Moosazade, Jamshidi, Amiresmaili & Nezammahalleh, 2012). By the early 1960s, research on tuberculosis conducted in various locations such as Hong Kong, Madras, and London concurred that effective treatment necessitated direct supervision of therapy. This approach was recognised as essential to interrupt a prevalent tendency, not limited to individuals with tuberculosis, where patients tended to discontinue medication once they

treatment, which constitutes a significant barrier to treatment completion. In the same vein, Naidoo and Mwaba (2010, p.1324) affirm the role of DOTS by adding that as soon as one is microscopically identified to have infectious TB, relevant health workers observe the person swallowing the recommended course of "dosage of one of the anti-TB medicines."

With the passing of time, I began accompanying some of the CHWs on their daily visits to their 'clients' (patients). Because of the way my work neatly overlapped with the CHWs', there was no need for me to hire a research assistant for this sensitive group of participants (men) suffering from tuberculosis. The practical and efficient way for me to access men suffering from TB revealed itself as through the CHWs, and by default three of them became my main research assistants on different occasions. These research assistants knew the challenges and experiences of working with TB and other chronic patients in the community. In my fieldwork, their roles were multifaceted; they played a crucial part in participant recruitment, served as guides in navigating the research site, and occasionally took on the role of translators when assistance was needed. Their insights on tuberculosis in Modimolle were especially useful and all of them had more than ten years' experience working as community healthcare workers. During an interview with one of my main participants, my research assistant took the initiative to schedule another appointment with a potential participant for an interview. She came back into the house where I was winding up the interview and reported that the man next door told her that he was not interested at all to talk to her, neither was he keen on doing an interview with me. She then asked me, "Why on earth did you even choose to research on men and TB?" It was quite difficult at times to schedule interview appointments with some men, and, regardless of gender, this is a common phenomenon when doing research with human beings. My response to the research assistant was that the difficulty she experienced in convincing the man next door was one of reasons I decided to investigate men and TB. Men's TB illness experiences is an under-researched topic.

The sister in charge of the clinic and the team of the community healthcare workers were, therefore, central gatekeepers in how I recruited my research participants. My research topic on male TB sufferers was well received by the sister in charge of the clinic. As she mentioned

no longer felt unwell (Bayer & Wilkinson, 1995, p.1545). Evidence indicates that Directly Observed Therapy Short Course (DOTS) serves as a crucial standard of care in mitigating drug-resistant TB (Bayer & Wilkinson, 1995). In response to this, the Advisory Council for the Elimination of TB (ACET) advocated for the implementation of directly observed therapy for all patients in areas that did not attain a minimum 90% completion rate for treatment (Bayer & Wilkinson, 1995). Organised and championed by the WHO, this strategy is also implemented in South Africa.

in our conversation, as the male 'clients' tended to be hard to deal with in terms of complying with TB treatment. In addition, the community healthcare workers became important links for me to reach my targeted group of participants in Modimolle. It was through the team of CHWs that I was linked to the men diagnosed with TB or to the male "TB clients" as the CHW team members called them. Lune and Berg (2017, p.39) argue that in employing purposive sampling, "researchers use their special knowledge or expertise about some group to select subjects who represent this population." Engaging community healthcare workers to assist in recruiting men suffering from tuberculosis in the community of Modimolle was the practical approach for me to take, given their expertise in the subject. The participants' illness experiences are sensitive issues that are institutionally protected in public health; thus, my recruiting participants was through the community healthcare workers.

Since the CHWs possessed the database of all TB patients in Modimolle, I asked them to recruit men between the ages of 20 and 60 years as potential participants for the study. The community healthcare workers also conducted community-based care visits with persons suffering from other chronic diseases, and not only TB sufferers. They therefore made prior appointments on my behalf with male TB clients. This was the collective agreement that we reached with community health workers – that they ask their clients for consent to participate in the study. At no point was I supposed to visit a TB client without being accompanied by a CHW. My relationship with the CHWs was mutually beneficial in that I ended up providing some of them with transport when they visited their clients in their daily work. At the same time, the assistance from the community health workers was beneficial to my research because most potential participants felt they needed to accept the invitation to participate, more so because I was also a man. Nevertheless, some potential participants declined the invitation to take part in the research.

Doing fieldwork in the time of COVID-19 pandemic had its own risks because; as a researcher I exposed myself and the participants to infection as I interacted and observed them in their natural settings. Ruppel (2020) articulates succinctly that for us as social scientists, "[o]ur lab is the world, we study interactions and gather data from the world that surrounds us." As a researcher I had options to conduct fieldwork using virtual platforms like Zoom/MS Teams and/or WhatsApp for example. However, these platforms were constrained by issues of connectivity and by the social class dynamics of participants. My participants were from a working-class background with more pressing needs to meet than doing an online interview with me. In the next section I demonstrate the ways I practically employed ethnography for

purposes of observing how masculinities are expressed and performed by working-class men in Modimolle. I delved into this by examining the spaces that men frequent for entertainment and the connections to the incidence of tuberculosis among men.

Employing participant and non-participant observation in fieldwork

How are black working-class masculinities expressed and performed in Phagameng Township of Modimolle? In what spaces are masculinities crystallised? Masculinities constitute a complex research terrain, intricately tied to specific contexts, unique to defined settings. In Modimolle, shebeens, taverns/beer halls, and car washing spots are among the common spaces where men gather for entertainment and recreation. To gain insight into the ways black men expressed and performed masculinities, I used participant and non-participant observation in taverns and shebeens. This not only aided in comprehending the intricate dynamics of how men presented themselves in Modimolle but also lent credibility to the perspectives and views articulated by men in the interviews I conducted. Creswell (2007, p.68) argues that through participant observation "the researcher is immersed in the day-to-day lives of the people and observes and interviews the group participants." Below is an image of a group of men gathering outside a shebeen in part of the township on a Sunday afternoon.



Photo 1: A group of men playing dice and socialising outside a shebeen. **Source: Personal photos 7 February 2021**

The spaces men frequent and the associated social practices not only highlight ways men identify themselves, but they provide a lens through which we can understand tuberculosis transmission and contraction among this group. It was through observing the interactions in these spaces that I came to appreciate the construction of masculinities and how intertwined they were with the possible spread of tuberculosis. Employing participant observation, I recorded much of the data in a field journal that became a useful resource for notetaking in conversations and daily activities by participants. It is of significance that I conducted fieldwork during the context of COVID-19 where non-pharmaceutical regulations like wearing masks and social distancing were mandatory. The most important measure for protecting myself from TB and coronavirus infection was the face mask. I also adhered to social distancing from research participants and practised hand sanitising. Interestingly, during their congregating at shebeens as is shown above, men were not wearing face masks, nor was there any adherence to social distancing. As an infectious disease, it is possible that these gendered spaces become vectors through which TB infections and transmissions among men occur. While shebeens are accessed for entertainment by men and women, the picture above shows men congregating together in proximity. One group of young men in the image was playing dice, a social practice bringing these men together. By extension, this is how masculinity is performed within the context of the study. A game of dice can involve gambling, where bets are placed, as is the case in the image above. However, the game can also be played as a recreational pastime. As presented in Chapter Five, within these spaces of entertainment men exchange and share beer and cigarettes. By some men's own admission, it is possible that these practices contributed to them contracting TB. A nuanced dimension to understanding TB transmission and contraction as is presented in Chapter Five goes beyond the social practices. It problematises ventilation issues, time spent in proximity, dietary concerns and comorbidities as important factors for men contracting tuberculosis.

Towards the end of August 2020, together with my research assistant, we made a follow-up of a male TB patient who had missed his date for collection of TB medication. We arrived at the given address at around 10 am and the man was not at home. His brother told us that the man we were looking for had already gone to the tavern. We waited at the house while the brother went out looking for him at the tavern (about 100m from the house). When our 'client' was told by his brother that there were people from the clinic looking for him, he refused to come to us. We drove to the tavern, and directly opposite the tavern was a group of men drinking beer. By means of observation, this group comprised about 10 men, and they were drinking

beer together. I greeted them from a distance while my research assistant (CHW) disembarked from the car and walked towards the tavern. This was the group with whom my potential participant was socialising, and it explains why he declined to come when called by his brother. The potential participant approached my car, and we exchanged greetings. He mentioned that he was the person we were looking for. The CHW/research assistant asked him some few questions about the TB treatment process, and he agreed that he would come to the clinic the following morning to collect his treatment. He also agreed to have me interview him. To provide a graphic representation of the way spaces of entertainment are frequented by men, an image below shows patrons at a shebeen in Phagameng Township of Modimolle.



Photo 2: Men and women at a shebeen. **Source: Personal Photos, 7 February 2021**

In the above image the shebeen patrons are not wearing face masks, nor are they observing social distancing. Visible are the empty crates of beer and used Chibuku Shake-Shake (traditional opaque) beer cartons. While I sat down to have a chat with some patrons at this shebeen, I refrained from participating in beer drinking. An interesting observation I made at

the shebeen was that the patrons, both men and women, looked relatively young, approximately below the age of 40 years. In addition, these spaces were largely dominated by men. The importance of gender and space needs to be highlighted and reinforced in our understanding of how TB is transmitted among men. In a study by Ranade (2007, p.1522) on the gendered use of public space in Mumbai, India, the author observes that "men between the ages of 18 and 55 had the maximum access to public space." In this study, gender intersects with age in shaping how public space is accessed, and consequently, how it becomes intertwined with TB infection among men. Importantly, I visited these spaces during the afternoons and not at night, thus the gender dynamics could possibly change depending on the time of the day.

On the 8th of September 2020, I proceeded to the local clinic for an appointment with a male nurse in charge of TB records and files. Following the observation of all necessary COVID-19 protocols, the nurse assisted me to gain access to all the files containing information about current male TB patients who receive services at the township clinic. From a pool of the available 18 TB male patients aged 26; 28; 31; 28; 50; 32; 47; 24; 33; 34; 38; 35; 31; 44; 29; 45; there were 2 outliers i.e., one was 70 and the other 14 years. This was an important observation illustrating the way TB was distributed among men as it was concentrated among the economically productive age group. Another crucial factor I noted, as documented in the files, was that most of these patients had comorbidities involving both HIV and TB. All these patients were on self-administered TB treatment. I managed to follow up on some of these male TB patients while in the company of a team of community healthcare workers, some of whom at times also served as my research assistants.

As I immersed myself in the field, one of my interlocutors, a 27-year-old man, shared two pictures with me. These images were taken during his time on a hospital bed when his health had critically deteriorated due to tuberculosis. In the pictures, he was connected to a drip, portraying a narrative of suffering and pain. The images showed him as emaciated and weak, in stark contrast to his current physical state when I interviewed him. By storing these images in his phone and sharing them with me, my interlocutor was revisiting the illness experiences. As argued by Fassin (2007, p.238), in "serious diseases, suffering is inscribed in the body, in its material substance, in the most immediate and most elementary way." Through the photo images of his weak body, the materiality of TB illness was projected. We talked about the images in the pictures, and it showed how damaged the body had been due to tuberculosis.

The way some participants presented to me their ailing body images when they were laid low by tuberculosis illness was an important ethnographic resource. In most of these cases, the participants emphasised the contrast in their body images between those taken when hospitalised and critically ill due to TB illness, and their current states of improving health. TB illness leaves its mark on a human body; De Beer (1986) asserts that besides coughing incessantly, a person with TB of the lungs tends to drastically lose weight and become very weak. When one is suffering from TB, the body crystallises the disease.

On another occasion, I attended a pre-arranged meeting with a participant who lived in proximity to the township clinic. Adhering to our agreed-upon time, I visited the home of this participant. Upon observation, signs of illness were evident on the participant's face, marked by facial blemishes, and he appeared to be continuously scratching some sores. During our conversation, the participant presented to me the image on his identity document (ID card) to demonstrate the stages of suffering that he went through because of TB. When the ID picture was taken, the facial image was emaciated, with eyes sunken into the sockets. He presented his ID picture to signify how TB, as he mentioned in our conversation, "is a dangerous disease." Barry and Yuill (2022) argue that the experiences of chronic illness such as TB unmasks concerns with identity and self. By showing me the image on his ID, the participant was demonstrating the effects TB had on his identity. This is so when one considers that the physical body is a social body through which masculinities are expressed and performed in spaces. Images that participants presented to me forcefully emphasised suffering and pain caused by tuberculosis.

Observing the effects of TB illness on participants was itself harrowing for me as a researcher. I was able to see how participants physically lived with tuberculosis. In the company of two CHWs, I went to meet a TB client towards the end of August 2020. This was a 29-year-old man living with his mother in their RDP house. At first sight I perceived a man in pain due to TB. As he shared his experience with me, he revealed that he was also undergoing HIV treatment. His lips appeared red, and his complexion was dark, reflecting the effects of the sickness on his body. We arrived at his house around 8:00 am, catching him before he had a chance to wash his face. Intermittently, mucus dripped from his nose. It was evident that this was a man deeply in the grip of disease. He became uneasy during our conversation, and we had to end the discussion. As argued by Fassin (2007, p.238), illness in the context of persons living with HIV/AIDS "is a matter of pain and smell, of bodies not washed and festering wounds, of no longer being able to swallow food…" While Fassin (2007)'s case describes the

early days of HIV/AIDS when antiretroviral drugs were not yet widely available, his depiction of chronic illness resonates with the experience of TB suffering encountered by some of my participants. On another occasion during the fieldwork journey, I visited a participant at his residence, and I noticed that he looked physically frail. Seated with his back against the wall, his hands were trembling. When I greeted him, he shared that he had been startled by the little girl sent to wake him up for our conversation.

All these experiences highlight how masculine identities are influenced by chronic illnesses. Barry and Yuill (2022) confirm that chronic illness and pain lead to the reconfiguration of self and identity, necessitated by changes in health and wellbeing. TB illness unmasks the vulnerabilities of men and the fragility of masculinities, especially considering the statement by the above participant who was startled by a little girl waking him. Importantly, TB illness reveals a continuum within which masculinities are played out. On one hand, there are masculinities displayed and performed in public spaces, and on the other a transition toward a solitary life lived in the private sphere when one is ill from tuberculosis.

On the 1st of February 2021, I met my two research assistants at a local primary school where they were collecting food parcels given to school children as part of COVID-19 relief. As we were discussing the way forward for the day, I offered to carry their groceries in the back of my van to their respective homes. We agreed to visit our day's targeted participant, supposedly an 'interrupter' who had skipped his TB treatment during December. We attempted to call him on the phone number he had supplied at the clinic, only to receive the response that the number was in use in a different geographical location far away from Modimolle. This explained the kind of difficulty healthcare workers sometimes face when tracking patients on chronic treatment. There are cases where patients falsify addresses and cell phone numbers, an act of agency to run away from the state's gaze. In this instance, one of my research assistants suggested we drive to the area, an informal settlement, and after a few inquiries we managed to locate the TB patient. Though challenging, this exercise proved equally advantageous for the research assistants in terms of their own work, as it provided them with the precise residential location of the client and potentially facilitating later follow-ups.

I sat down with the 39-year-old participant who physically appeared very frail. Information retrieved from the patient's file at the clinic indicated that he had missed his treatment in December 2020. The green booklet that he kept showed that he was adhering to his treatment as it was appropriately ticked. This disparity is a cause for concern in cases where people on

TB treatment are left alone to self-administer treatment without proper monitoring through the DOTS strategy. In cases where there are no strong support systems in place at the household level, the chances of getting lost from treatment are higher. Towards the end, the man explained to me that he had received a South African Social Security Agency (SASSA) letter that he was supposed to fill and return to the clinic for a disability grant. As he appeared physically frail, I offered to give him a lift to the clinic after our conversation so that he could submit his letter. We drove and I left him at the clinic to facilitate his application. The next section pays detailed attention to the processes of interviewing participants. These yielded valuable data for this research which complement the observations detailed above.

Up-close with research participants: the interviewing technique

Another important data collection method I used was the one-on-one in-depth interview with my interlocutors. Interviews are described as professional conversations which help the researcher to respond to the research aims and questions (Gill, Stewart, Treasure & Chadwick, 2008; Kvale, 2008). To help me proceed to extract the intricate and personal illness experiences of participants, I used the interview guide (Braun & Clarke, 2013) with semi-structured in-depth questions which allowed respondents room to express the meanings and experiences brought about by suffering from tuberculosis. This helped in obtaining men's perspectives and understanding of their illness experiences. Through the help of one of the community health care workers, I was able to have a conversation with a 28-year-old man whose mother had died of TB in 2019. He was diagnosed with TB in 2020 and attributed the cause of infection to the living arrangements with his late mother. At the beginning of the interview, his girlfriend approached us to try and find out the purpose of the research. I gave her the participant information sheet, allowing her to acquaint herself, and eventually, she excused herself, enabling us to proceed with the interview. Most of my male respondents were comfortable sharing their illness experiences with me, possibly because of my gender.

Given the context of COVID-19 and the frail conditions induced by TB that some of my participants were experiencing, the interview processes were conducted and managed with empathy. I put in place contacts for trauma counselling in case some of my participants required such services. During the interviewing processes, adhering to social/physical distancing with my interlocutors sometimes resulted in conversations being inaudible for audio recording, with voices becoming muffled due to the use of face masks. In early September 2020, I arrived at

the clinic at about 9:00 am and two CHWs accompanied me into the field. On our way, one of the CHWs suggested that we make a follow-up on a man lost from TB treatment in another section of the location, a request I gladly accepted. As a researcher, I was flexible in the way I recruited participants, and this was largely determined by the advice of the community healthcare workers as they knew every TB patient on their database. We found the potential participant still asleep and although it was somewhat difficult to wake him, he later agreed to be interviewed by me. During the interview, he pointed out COVID-19 disruptions as one of the reasons he interrupted his TB treatment. He further disclosed the negative attitude of his white bosses at work who would not accede to his request for leave days as another reason he interrupted TB treatment; for the sake of keeping his source of livelihood. Added to these challenges, my interlocutor forcefully mentioned that the negative attitude of the nurse at the clinic who scolded him for 'defaulting' made him give up his medication. He however agreed to come to the clinic the following morning to get help. The effects of the COVID-19 pandemic and TB illness among the participants highlight challenges of doing health research in the context of colliding epidemics.

My fieldwork routines usually revolved around meeting my research assistants every morning at the clinic, except on weekends. With the targeted participants in place, we would leave for the field and return to the clinic after completing the interviews. Each day had its unique challenges, because some days I would fail to secure a single interview while on other occasions I would manage two interviews. On our return from interviewing the participant lost from TB treatment, I suggested to my research assistants that we stop at a spaza shop where we had previously missed a potential participant. As I was busy in the shop, the 28-year-old man approached me and confirmed that he was the man I had been looking for. During the interview that we conducted in my vehicle near his home, the man felt at ease to express himself. He told me that TB was a dangerous disease, and that on many occasions he had wished death because of his TB illness. He confided that he had been a *nyaope* addict, and that he had done worse things that even his parents did not know. Midway through the interview, his mother called him in protest about our conversation. He stepped out of the vehicle and went to explain to her the purpose of the conversation. It was understandable for a parent to be protective of their child who was in the company of a stranger. In hindsight, as a researcher, I should have heeded my interview subject's suggestion to conduct the interview far away from his house. The interview lasted an hour.

Towards mid-September 2020 I arrived at the clinic early in the morning, before 8:00 am. Unbeknown to me, the itinerary that was set was that I was going to be accompanied by a pair of CHWs to a 28-year-old potential participant who had already agreed to be interviewed for my research. The CHW pair planned to do their door-to-door COVID-19 screening. I conducted the interview with the participant in a relaxed manner outside his mother's house and the participant was free to share his experiences with me. During the interview, he mentioned that the medication he received made him gain more weight, much to his surprise. The participant was not expecting such a sudden and positive change in his body and as he explained, the medication was healing his lungs. He showed me the pictures on his smartphone to illustrate how his chest and biceps had become big. He was still undergoing TB treatment when I interviewed him. The narrative of this man was evidence enough of the efficacy of TB treatment when adhered to. He revealed that the first batch of medication given to him boosted his appetite such that he began to eat too much, and that the medication would make him want to rest. He added that he started eating three meals a day, much to the chagrin of his mother who complained about his eating habits. It should be emphasised that the man's health improved dramatically due to the combination of TB treatment and that he was food secure to the extent of eating three meals a day. When a TB sufferer is not food secure, medication alone is not sufficient for positive health outcomes.

In the middle of October 2020, I went into the field with one of my CHW research assistants. The appointment had been set and upon arrival at the man's informal dwelling, the potential participant was not available. His spouse told us that her fiancée had gone to his parents' house on the other side of the township. After calling him, he invited us to his parents' house, and we drove there. The 44-year-old man worked as a security officer at the local toll gate and was very welcoming and open to conversation. After observing all research protocols, he told me that he had been diagnosed with TB in April 2020 and that he had just completed his six months TB treatment on 3 October 2020. He was diabetic, and the support he received from his spouse, children, and parents made all the difference in both his experience with TB illness and diabetes. He explained that he spent about two months not going to work and during that time he had to be sustained with the grant money of his children. He was frustrated by the way he was treated when he wanted to apply for a disability grant from SASSA; he was told that the doctor handling such issues would only be available after the end of the coronavirus.

After taking a break from fieldwork to reflect on my work and to transcribe some interviews, I contacted my research assistant to meet for fieldwork in the middle of November 2020. We

visited a 53-year-old man (Tebogo) who was ill from TB. He was living alone in an informal dwelling, and he appeared physically frail. We sat down under the shade of a tree on his yard for the interview. This was after all the introductions and the signing of the consent form. After establishing rapport, the participant explained that this was the fifth time being diagnosed with TB. Although he explained that he had learned to accept his condition, he continued to wonder what made him prone to TB reinfection. He was also on antiretroviral treatment (ART) for HIV. The problem that he pointed out to me was that it was hard for him to quit smoking. There was a poignant acknowledgment from him that smoking was detrimental to his health, yet he felt trapped, without a way out of this situation. He acknowledged his addiction, confessing that given his solitary living situation, if he refrained from smoking it might lead him to engage in undesirable activities. Research indicates that chronic pain has a substantial impact on relationships and self-esteem and is correlated with elevated rates of divorce and suicide (Cohen, Vase & Hooten, 2021). It was not coincidental that he was living alone. When my participant expressed his fear of engaging in undesirable activities, it could imply involvement in drug abuse, criminal behaviour, or, worse still, it may allude to suicidal attempts. Thus, smoking for him is both a strategy to cope with chronic illness and as he pointed out, it makes him think soberly. In my interviews, I allowed participants to freely express themselves. The advantage was that the men felt at ease to bring out their detailed illness experiences in our interviews. Most of the interviews I conducted lasted for more than 50 minutes.

However, each interview was unique. On a different occasion, we approached a 58-year-old man for an interview as had been pre-planned by my CHW research assistant. The participant had just completed his TB treatment course. We proceeded to the man's house and were welcomed by his wife who gave us some chairs to sit outside the house. The man agreed to participate in the interview. It proved to be a challenging interview as he spoke inaudibly and provided one-word responses to the questions despite my probing efforts. Midway through the interview, a van carrying bricks arrived at the house, and he requested to attend to the men. The interview lasted about 20 minutes, and as we left the house, my research assistant asked me about its progress, and I conveyed that it was a difficult one. She reported that the wife confided that her husband was so secretive and that she had wished she could be part of the interview, as she knew that he would keep some information from me. It is possible the man was expressing his masculinity by offering passive resistance during the interview process.

I did not manage to interview all the women in my main participants' lives. While interviewing the women in these men's lives could have provided invaluable information for the study, it

was not a practical exercise due to time and resource constraints. However, I was able to interview two women who were related to two of my participants, one in the capacity of an aunt and the other as a spouse. On our way back to the clinic, my research assistant remarked matter-of-factly that men do not generally speak out about their issues. While these opinions from health workers were noteworthy, as a researcher, I learned to appreciate the heterogeneity of men and the uniqueness of their illness experiences during interviews. I unpack some important ethical considerations for the research in the following section.

Formal ethical clearance processes

It is important to observe all ethical protocols when doing research involving human participants as this ensures the credibility of research findings. By virtue of venturing into the personal lives of people such as their experiences of illness, social science researchers "must ensure the rights, privacy, and welfare of the people and communities that form the focus of their studies" (Lune & Berg, 2017, p.43). The principles of research ethics are broad but there are cardinal tenets a researcher needs to observe. These revolve around issues of harm, consent, privacy, and the confidentiality of data (Lune & Berg, 2017). I submitted the ethics clearance applications with the Wits Human Research Ethics Committee (HREC) Non-medical for evaluation in June 2019. My application was assessed, and I was advised that the Wits HREC (Medical) must handle research on men's tuberculosis illness experiences. I factored the feedback from the committee and proceeded to lodge my application with the Wits HREC (Medical). After meeting due requirements, I was cleared to do fieldwork in Modimolle.

Researching men suffering from tuberculosis is a sensitive topic. Before proceeding with the interviews, I thoroughly explained the contents of the participant information sheet. This detailed explanation aimed to ensure that the purpose of the research was clear to potential participants, providing them with an opportunity to make informed decisions before signing the informed consent forms. Appending one's signature to the informed consent form meant that the participant was agreeable to taking part in the research. However, participants were free to withdraw from the interview when they felt uncomfortable with anything during the interviewing process. I sought permission from potential participants to audio record the interviews, ensuring that I captured their views and experiences clearly and as comprehensively as possible. Only once – interviewing the nurse at the local clinic – was my invitation to audio record the interview declined. However, we proceeded with the interview through note taking.

On five occasions, potential participants turned me down when I asked permission to interview them. This underlines the importance of informed consent and voluntary participation. In two instances I could not interview potential participants, simply because they were in pain and too seriously ill to participate. I attempted to revisit them, without success. On two different occasions, I had to stop the interviews midway. This was because one of the participants had become uncomfortable with the questions while the other had received an urgent call about a job.

I conducted all the interviews with my participants in their homes, mostly outside their houses away from family members. I always wore my facemask and adhered to social distancing. The CHWs set up appointments for me with potential participants because they hailed from the same community. By virtue of their home-based care work that also involved administering the DOTS to people suffering from tuberculosis, the community health workers were better positioned to assist me in the recruitment of potential participants. The community health workers accompanied me to these participants and facilitated the necessary introductions before allowing me to take over proceedings. Although I personally knew some of the participants by virtue of my stay in the community, the CHWs introduced me as someone from Johannesburg and this made me an outsider. Because of their footprint in the community around home-based care, the CHWs' influence in securing appointments with potential participants cannot be understated. To avoid the CHWs influencing the interview proceedings, I allowed them to stay in my car after they introduced me. I ensured that I conducted the interviews away from the CHWs to limit their interference and ensuring the participants' views were confidential. Most participants did not know me, and so I went ahead to introduce myself. This helped in establishing rapport and building trust with potential participants. Importantly, my gender and that I was able to converse in the local language helped ensure rapport during the interviews. I alone had access to the audio recordings of the interviews, and I stored the data on a password-protected laptop. I did not make any promises of benefits to the participants. In the next section, I reflect on the community healthcare workers'/research assistants' fieldwork comments.

Navigating TB concerns: Reflections with research assistants and personal apprehensions

On one of my field trips in October 2020, my research assistant was surprised to see me returning to the car after having a brief interview with a research participant. The reality was that the participant was not in a condition to undertake an interview. This stimulated a discussion between the research assistant, Mapula, and I about why men were that vulnerable to TB. Interesting comments from my research assistant were that:

> Unlike women, men seem not to care about their health as they seem to be very fatalistic. Women make sure they consult immediately when feeling sick because they consider that if they die, who will take care of their children? Men seem not to consider a lot of factors when faced with a health problem. They seem to give up easily. **(Informal conversation with Mapula, a research assistant on 12 October 2020**).

These comments were insightful as they helped me to sharpen my observations and probing skills when interacting and conversing with men suffering from TB. The comments cast light on a wide array of topical issues like family, motherhood, and fatherhood in the context of Modimolle and to some extent in South Africa at large. Importantly, the comments by my research assistant, a community healthcare worker, reveals how masculinities are performed in the private sphere in the face of illness.

As we spoke, the research assistant told me that one of the potential participants we had tried to interview had been 'reckless' about his TB condition. The allegation was that the man caused his 9-year-old son to contract TB resulting in the boy becoming visually impaired. The case triggered some curiosity in me and on October 14, 2020, we went back into the field to visit the man who allegedly exposed his son to TB infection. The reality on the ground did not turn out that way. The supposed 9-year-old 'blind' boy was not a boy but a man who happened to be an in-law of the man in question. It turned out that the visually impaired man had experienced partial blindness four years ago (in 2016), and the doctors were unable to diagnose the cause until recently when they confirmed that the man had TB. The importance of this case was that it helped me to be alert to evidence rather than hearsay. I thus, managed to have an in-depth interview with the participant who was visually impaired because of tuberculosis.

On another occasion one of my research assistants did not hold back in expressing concern about a 53-year-old participant, previously mentioned, who had been infected with TB for the

fifth time. My research assistant commented that the man in question deliberately and strategically exposed himself to TB so that he could access the disability grant. As I asked my participant during the interview what his source of livelihood was, he retorted that he used to do piece work as and when called by people. Nevertheless, because of his illness, he was not working anymore and preferred to stay at home alone for fear of infecting other people with TB. Literature shows that chronic illness is a leading cause of disability which "interferes with an individual's ability to work and can lead to financial ramifications, including homelessness" (Cohen et al., 2021, p.2083). That the man in question had been reinfected with TB for the fifth time influences his identity, hence the reason for stopping to actively look for employment. By stating that he chose to stay at home so that he does not infect other people, the man demonstrated a sense of responsibility. Indeed, he confirmed that he was accessing the disability grant of about R1 750 (about USD $92) per month. The other two CHWs in the car all concurred that they previously assisted this man to take his TB medication through DOTS since 2014. My research assistant stated that this was a common problem among many people in Modimolle; they use their TB status to access disability grants. This could be possible in the context of poverty and high unemployment. Literature shows assessment contestations towards disability grant eligibility as the processes are subjective and "open to bias and fraud on the part of both doctors and patients" (Kelly, 2017, p.110). The disability grant is accessed for about 4 to 6 months and one of the means test for accessing it is low weight of the TB patient. Notwithstanding the relief brought about by a R1 750 disability grant to the TB sufferer's personal health in terms of accessing food in the context of poverty and unemployment, De Paoli, Mills & Grønningsæter's (2012, p.8) study did not find evidence suggesting that "PLHIV taking ARVs sought to compromise their health in order to remain eligible for the grant." However, Kelly (2017, p.112) argues that the disability grant assessment, as is the case with all healthcare experiences, is influenced by "power, relative agency and emotions of social actors."

During the fieldwork phase, I engaged in interviews with men at different phases of their TB treatment journeys. As I delved deeper into my research on TB and men, concerns about potential exposure to infection arose. When engaging with TB patients, adopting protective measures is paramount. Fortunately, the widespread use of facemasks during the COVID-19 pandemic proved advantageous during fieldwork, significantly reducing the risk of contracting TB. Not adhering to this precautionary measure would have increased my risk of infection. Despite my diligence in taking necessary precautions, it was unsettling to observe that many

of my interviewees did not wear masks. This was particularly worrisome in the context of the ongoing COVID-19 pandemic. This is possibly because they felt safe as they were in their homes and not in public spaces. We talked through this personal dilemma with the community healthcare workers-cum-research assistants. During the conversation, one of my research assistants, Salome, revealed her fears of contracting tuberculosis. Salome told me that during her routine visits to a newly diagnosed TB patient, she later experienced some weaknesses in her joints. She said that she did not waste time to consult and test for TB. Fortunately, her results were negative. Salome was honest with me that visiting TB patients was a risky exercise.

As regards her strategy when visiting TB clients, Salome explained that she always ensures the client comes out of the house, something that I managed to negotiate with some of my interlocutors. She informed me that a proven method she had been taught when visiting TB patients at their homes is to pick up some loose soil from the ground and toss it into the air to determine the direction of the wind. In that situation, the healthcare worker should position themselves where the wind is coming from to minimise the risk of bacterial transmission. Salome's insightful experience taught me the need to be vigilant when doing my fieldwork with people diagnosed with TB. Precipitated by my own fears of contracting TB, I went ahead to do some radiological tests for TB in Modimolle. I was negative. Similarly, Salome, who was open to sharing her own experiences, provided advice on a precautionary measure she always followed when visiting TB patients. She mentioned that a principle taught during training was to have a healthy breakfast in the morning before visiting TB patients. According to her, this practice helps boost the immune system and provides a defence against the TB bacteria. When I first began fieldwork with men suffering from TB, I overlooked the significance of having a healthy breakfast. This perspective underwent a complete shift the moment my research assistant, Salome, educated me about the importance of taking precautionary steps against TB infection. It became important for me to implement these lessons as I began taking my breakfast every morning before going out in the field. This meant eating my breakfast before 8 am so I could meet my research assistants between 8 am and 9 am.

Like most researchers, the emergence of COVID-19 affected my research in many ways. Primarily, I delayed fieldwork because of the state-imposed lockdowns and the personal fears that my participants and I had about COVID-19 risks of infection. Furthermore, face-to-face interactions with fellow PhD colleagues at postgraduate centres ceased to exist. Under 'normal' conditions, these postgraduate centres are important hubs for cross-pollination of ideas among

colleagues. In-person meetings with my academic supervisor became replaced with virtual meetings. Although the COVID-19 context negatively affected my research, it also made me resourceful in managing my time and to work independently in the production of this thesis.

The research participants were equally and significantly affected by COVID-19; some had their treatment disrupted. One of my interlocutors aged 30 years, Klass[8], was diagnosed with MDR-TB. Klass lived in an informal dwelling with his girlfriend and children in a household of five members. Due to the COVID-19 pandemic, Klass faced challenges accessing his medication from the MDR-TB hospital in Modimolle. He had the following to report about the effects of COVID-19 on the way he accessed TB medication:

> **Klass:** Since the [COVID-19 induced] lockdowns began; I have been in danger because I no longer collect my medication through a scheduled routine like I used to. The supplies are no longer regular but erratic. It now takes time for me to receive the medication and sometimes it takes me three days without receiving my supplies and in other instances I spend five days without receiving my medication. I remember calling the clinic last week that my medication is running out and they reported that they will contact MDR Hospital to bring the medication but even now I am still waiting for that medication. And the problem is that if I don't get those tablets, my health deteriorates. If I miss the medication for three or four days, I feel like by the time I receive the supplies it stops working the same way it used to.
>
> **Eddie:** So, are you now getting the medication from the local clinic here?
>
> **Klass:** Yes, isn't it they have stopped us from accessing MDR Hospital? They have converted the MDR hospital into a centre for COVID-19 patients, so we no longer go there to collect our medication. I last went there in May 2020 and now we access the medications from the local clinic. The clinic calls me to come and collect my TB medication. **(Interview with Klass, 19 October 2020).**

A study reviewing data on the impact of COVID-19 on TB shows that the pandemic interrupted "treatment for TB patients due to limited treatment support and medication stockouts" (McQuaid, Vassall, Cohen, Fiekert & White, 2021, p.440). The above scenario from my research participant empirically demonstrates some of the ways in which the COVID-19 pandemic disrupted the healthcare service delivery system for TB sufferers. Although this was not a common experience for many of my interlocutors, it nonetheless helps to contextualise and heighten the COVID-19 pandemic effects on TB care.

[8] Klass is a pseudonym. In all naming of my interlocutors, I use pseudonyms.

Conclusion

As a foretaste of what comes in the ensuing chapters, this methodological chapter laid bare, in rich detail my fieldwork experiences of interacting with men in both the public and the private spaces. The chapter provided some important signposts that helped me tease out preliminary themes from my findings: the social practices that prevail within masculinised spaces and their implication to TB infection and broadly; the intricacies of experiencing TB illness. In the chapter, I argued that qualitative fieldwork can become entangled with the researcher's subjective position. From the conception of my research topic on men's TB illness experiences to the choice of the research setting and the processes of participant recruitment, my own positionality as a man who took care of a TB sufferer, and my insider status were revealed in this chapter.

The next four chapters are informed by the findings from the fieldwork that I conducted in Modimolle among men diagnosed with tuberculosis. The chapters are structured to demonstrate how tuberculosis among men is a disease that is largely mediated through the lens of space(s) and the associated social practices. Based on men's illness experiences, there is a clear continuum through which tuberculosis infection is patterned among men. TB infection is not coincidental but is a disease of sociability, largely contracted within public spaces frequented for entertainment. After diagnosis, men withdraw to their homes to receive care and support, mainly from women. During their recovery from tuberculosis illness, men re-engage with public spaces of entertainment, fostering a sense of belonging and conviviality through specific social practices. This further reinforces the centrality of space to understanding how tuberculosis is contracted and transmitted among men.

The next chapter, therefore, takes the reader through the process of ethnography where I stake claim to the centrality of masculinised spaces to TB infection and transmission among men. I focus attention on the public space of entertainment mainly frequented by men when in good health. It is through sociability enacted within public spaces of entertainment that tuberculosis transmission among men is crystallised. I demonstrate that the split between spaces is associated with a display of masculinity.

Chapter Five

Pathways of tuberculosis transmission: Exploring work environments and sociability among men

The other issue is lack of basic hygiene practices, and you will see that where men congregate or come together, they don't really wash their hands or even practice proper coughing etiquette and they go ahead and shake hands with others and by so doing TB is spread. The other contributing factor to TB cases here in Modimolle is the problem of squatter camps. ***(Interview with Dumisani, a nurse, 3 March 2021).***

Introduction

The quotation above is from a male nurse who led the HIV/AIDS, STI's and Tuberculosis (HAST) unit at the local clinic in Modimolle where I conducted fieldwork. At the core of his analysis on tuberculosis prevalence among men lies the influence of spaces frequented by men and the prevailing social conditions within informal settlements, both serving as pivotal factors shaping the distribution of tuberculosis in Modimolle. The highlight of his assessment is the intricate connection between poverty and the occurrence of tuberculosis. According to Duarte et al. (2017) it is often the case that people experiencing socioeconomic deprivation are at an elevated risk of meeting individuals affected by TB. Furthermore, the same people face a greater likelihood of residing and working in densely populated and poorly ventilated environments. Additionally, they have a heightened risk of malnutrition, engage in less healthy behaviours such as smoking and alcohol abuse, and encounter obstacles in accessing healthcare (Duarte et al., 2017, p.117). These are conditions that loom large in the local nurse's excerpt above.

Throughout my fieldwork in 2020-2021, the townships in Modimolle experienced intermittent water rationing. This must be considered against the background of COVID-19 regulations that required regular handwashing with soap. During this time, residents had access to tap water only two or three days a week, and some received water just once per week. There was therefore a clear disconnect between public health guidelines and the actual access to water in the townships of Modimolle. In certain cases, residents in specific township areas had to endure periods without water, resorting to municipality-filled public *Jojo* tanks. Simultaneously, some

residents relied on water wells they dug in their yards. In contrast, residents in Modimolle Town and those in surrounding suburbs had access to running water. The word on the ground was that Modimolle Local Municipality could not consistently supply water to township residents because they owed the municipality for water services. This resonates with the argument by Slater (2013, p.379) that the "unequal provision of public goods and unequal treatment by the state of the different areas" ensure perpetuation of inequalities. The structural inequalities that result from political decisions offer a lens through which to understand disease and health outcomes, as well as life chances. While inequalities exist between and within provinces in South Africa, they also manifest similarly between and within towns, highlighting the influence of politics on resource distribution among the population.

In addition, most of my participants lived in low-cost government-built houses commonly known as RDP houses. Nine participants were living in shacks in informal settlements. The living conditions in Modimolle's townships, compounded with erratic water supply, provide context to understanding the health of the population, especially in relation to men and tuberculosis. Langa (2020) confirms that townships in South Africa have continued to experience a shortage of essential services like housing, clean running water, and functional drainage and sewerage systems, even after the onset of democracy. These dire living conditions are prevalent in a significant number of black residential areas, and structural conditions are implicated in ill health among the majority black people that reside in the townships. Bambra et al. (2019) thus argue there is a relationship between health and place that manifests in place-based health inequalities. Informed by a political economy approach, Bambra et al. (2019, p.37) assert that "[p]lace matters for health, but politics matters for place." Health, and by extension TB occurrence, cannot be understood in a socio-political and economic vacuum; the socio-political context must be examined. In that vein, Amzat and Razum (2014) add that a society's health cannot be understood without understanding the intricacies of the community or society itself.

The dominant argument informing TB incidence, transmission, and infection, especially in Southern Africa, centres on the mining sector – gold mining and the attendant circular migration in particular. This is because of exposure to silica dust that leads to silicosis, itself a major cause of TB infections among miners (Moran et al., 1994; Packard, 1989; Rees et al., 2010; Rupani, 2023; Williams et al., 1998). In this thesis, I acknowledge the mining sector argumentation but further advance the need to consider how sociability in spaces frequented by men deepens and enhances analysis of this endemic disease in South Africa. The essence of

this argument centres on a distinct form of masculinity that I term 'masculinity in sociability' which manifests and is performed when men gather in environments for entertainment and leisure. The thesis thus explores alternative pathways through which tuberculosis is transmitted, especially in non-mining communities.

It is against this background that the chapter explores and argues the interplay between gender identification, place, and TB infection among men. I map and demonstrate how men's working and living conditions, along with their relationship to spaces of entertainment and recreation, are entangled with TB infections. The core theme of the presentation centres on the idea that masculinities are not only performed but are also lived and expressed in public spaces like workplaces, leisure, and recreational environments. The environment in which people live and work is an important site within which health and illness can be understood. To illustrate this, the chapter uses a psycho-social-environmental (PSE) model developed by Nettleton (2013) to argue that TB is a social disease. The model highlights the influence of individuals' behaviour and their social environment (such as their activities, living conditions, and locations) on their health status and disease outcomes (Kabudula et al., 2017). From the way TB is patterned (along gender, age, social class, geographical location, for example) to the way it is transmitted and contracted, the disease remains social. As this research focuses on men's TB illness experiences, it suffices to explore how men identify and are identified within Modimolle, the task I attend to in the next section. This helps in foregrounding contextual meanings of masculinity identities.

What is a man? (*Monna ke eng?*) – Contextualising masculinity identity

In this section, I discuss masculinity identification and the ways it mediates TB infection among men in Modimolle. At the heart of this section are the descriptive opinions and experiences of what participants think define the gender – man in Modimolle. I presented the question about masculinity identification to the participants in their own sePedi language, using the phrase *Monna ke eng?* What is a man? In the context of delineating what defines a man, the responses to the question underscore a fundamental theme: that masculinities are not rigid but flexible, and influenced by broader social structures, including factors like socio-economic status and life events such as illness. Let us look at the example of masculinity identification in the amaXhosa culture. Literature shows that masculinity is anchored chiefly in *ulwaluko* (Mfecane,

2016; 2020; Ntombana, 2009) and the establishment of autonomous households (Qambela, 2021b). Since masculinities exist within broader structural contexts, the challenge of economic marginality, as evidenced by elevated unemployment rates among young men in Peddie, Eastern Cape, has resulted in a transformation of the prevailing dominance of the respected masculinity linked to ulwaluko (Qambela, 2021b). In the case of Guinea Bissau for example, Vigh (2006, p.40) contends that young people find themselves living their lives at the "margins of power and resources flow" caused by the poor economic climate. Such conditions of economic constraints result in the reconfiguration of masculinity identification. Within the context of economic marginalisation, the onset of TB illness can result in biographical disruption which impacts men's identity conception.

In the third chapter of this thesis, I argued for the importance of African-centred theories of masculinity as a lens through which to comprehend men's experiences with TB illness. To illustrate this perspective, I presented evidence from a 39-year-old participant called Timmy who intimated the importance of *seriti* (dignity, integrity) as well as *di ketso* (works) as identifiers of man in Modimolle. Timmy is ethnically Pedi, unemployed and lived with his mother in a four-member household. The interlocutor's understanding of what defines a man is evident in both his stated values and the actions associated with men, emphasising that masculinity is an identity influenced by values and inherently performative. I further probed with Timmy what exactly he meant when he spoke about works:

> **Eddie:** Di ketso ke eng? What do you mean when you talk of works (di ketso) in relation to men?
>
> **Timmy**: I mean mediro like (works), dignity, and respect describe a man.
>
> **Eddie:** Okay.
>
> **Timmy:** (Seriti sa gage) It's about dignity and integrity.
>
> **(Interview with Timmy, 10 September 2020)**

To speak of a man in the context of Modimolle as provided by the interlocutor demonstrates the inseparability between socio-cultural values and performativity. This interpretation of what constitutes a man enables us to recognise that masculinity is indeed expressed through actions and behaviours but encompasses more than just those aspects. Masculinity also encompasses other intangible values such as dignity, integrity, and respect *(seriti*). In theorising African masculinities, Mfecane (2018) argues that theories must also account for the role that the unseen elements of personhood play in shaping the type of individuals men evolve into. This salient dimension contributes to our ability to construct a more refined understanding of

masculinities from an African perspective. Jean Comaroff's (1980, p.643) work on healing and cultural order among the Barolong boo Ratshidi (Tshidi) of South Africa and Botswana observes that their social environment understands self in relation to the "social, spiritual, and material context." The self in this regard does not exist as an individualised entity separated from the socio-spiritual and material connections. Important for this research and in connection with the African-centred theorisation of masculinities is the other meaning of *seriti* that denotes self and is associated with personality, dignity, respect, and presence (Comaroff, 1980, p.643; Niehaus, 2002, p.194; Rathete, 2007, p.30). This resonates with Mfecane's (2018) argument that masculinity theories grounded in African conceptions of reality must consider the invisible elements of "personhood" or, as Comaroff (1980, p.643) terms it, "selfhood" since these elements are inseparable from men's identity.

To reinforce the significance of non-material conceptions of masculinity, let us consider the words of 27-year-old Erick, who discontinued his education after Grade 9. Erick lived with his mother, ethnically identifies as Tswana and was single. When I met the interlocutor, he was in the process of establishing himself as a musical artist. Erick stated the following in relation to his conception of a man:

> **Erick:** A man; I understand that you can tell that there is a man ka maitshwaro [manners, comportment/behaviour, the way he conducts himself], seemo [the condition or the state], botho [humanness, ubuntu, the sum of human values]. These are the characteristics we consider when we say that someone is a man. This is my understanding of what a man is.
>
> (**Interview with Erick, 18 August 2020)**

The insights from Erick capture the values that define a man, and these nuanced qualities may not be eloquently captured in English. All the values he articulates are instructive of the intangible elements defining masculinity. *Maitshwaro* (conduct) is quite broad but at the heart of this conception are values like civility, politeness, good manners, good conduct and approachability. While the interlocutor professes maitshwaro values in relation to men within the specific context, it is important to mention these values transcend gender and cut across humanity. The *seemo* concept encompasses positive standing, influence, and impact that a man has in his household and in the community. During a funeral procession I attended in Modimolle in 2023, I observed Erick embodying the value of seemo. He appeared to hold a positive standing in the community, particularly in grassroots activities. Actively participating in the funeral procession, he led in singing songs and encouraged mourners to join in. During the 2020 interview I held with him, Erick, despite being unemployed at the time, shared his

plans to record some of his songs, showcasing his aspirations as a musician. After the burial at the graveyard, Erick requested to play one of his recorded songs as a marketing strategy. The singing and leadership roles he assumed in the funeral procession exemplify the values he professed when conceptualising his definition of man. With reference to the Sotho-Tswana man, Setiloane (1976 cited in Rathete, 2007, p.32) contends that, "[a] Sotho-Tswana man is one who follows the accepted pattern of social living, who shows equanimity and maturity. He is generous and kind, but also strong; not only physically but morally and spiritually."

In his articulation of the qualities that identify a man, Erick's mention of *botho* (humanness*)* speaks to *ubuntu* values and according to Ntombana (2009, p.76), the way African people live is through communion with each other through the expression of the saying "*umuntu ngumuntu ngabantu*", meaning that a "person is a person by other people." In a similar vein, Rathete (2007, p.43) sheds light on the defining characteristics of a man among the Pedi ethnic group that "[a] gentleman welcomes strangers into his house without inquiring or finding out what he could do for them." This evocatively deepens our understanding of man through the prism of African-centred theories of masculinity. The idea of communality configured around humanness is central to how we can understand tuberculosis, men, and masculinity in this research. The context of the study is of men coming together and enacting the practices of sharing cigarettes and beer without questioning who is buying or not. In the same vein, Rathete (2007, p.44) reinforces how things have not changed for Pedi men by arguing that "…a group of men could decide to watch a match on television without making prior arrangements with the owner of the house." It is these normative sociocultural values that define men's relationship with each other in their everyday lives. By extension, these values capture how masculinities in the African context can be understood in terms of the practices of coming together for sociability through ubuntu.

While some participants highlighted the important non-material conceptions of masculinity, others emphasised the significance of works (*mediro*) as signifiers of a man. At 24 years of age in 2020, Herbert was the youngest of my participants living in an RDP house. He headed a household of six members. Frank on the other hand was 32 years of age, living with his mother in a household of three. Both men were single, and they ethnically identified as Pedi. While Herbert dropped out of school in Grade 9, Frank completed Grade 12 and went on to acquire a diploma at a further education and training (FET) college. The two interlocutors expressed their opinions of what a man is as follows:

> **Herbert:** Okay. For us to conclude that there is a man, we see that ka mediro ya gage [through his works/deeds]. We see that through his deeds like for example that he can take care of his family. As men we tend to envy and say I wish I can be like that man. It is because we admire his deeds. It means that we view that man as our role model and would wish to emulate his deeds.
>
> **(Interview with Herbert, 21 September 2020)**

> **Frank:** You know what; I do not think a man is some trousers. I think a man is a person who can play a role of taking responsibility of his family if he does have a family. A man is a person who can be able to be a father to someone that is not his biological child. A man can be somebody who can look at a child as a child and not to look at that child as a woman for sex. A man is a person who understands his position when he is required to play a role, for instance, when he finds school children fighting after school, he must be able to stand and say, 'no, we don't do this.' A man is someone who maintains discipline to a child. A man is a man if he takes responsibility for his actions. I think that is a man. If he has done something wrong, a man does not blame somebody else. He does not make excuses for his own actions; he can take responsibility for his actions. I think that is a man. A man is a person who can discipline himself to say, no, I must not do this. I must not be a bully towards the community, but I must be a father figure to someone. That is what I believe in short.
>
> **(Interview with Frank, 22 September 2020)**

Herbert's interpretation signifies an idealised and admirable masculinity calibrated around deeds *(mediro).* The idealisation of such a masculinity resonates with Qambela's (2022) work on the *Anthropology of Boyhoods* in the Eastern Cape in which young men idolised and admired qualities like comportment or way of conduct and the qualities of dignity in their role models. Considering that Herbert, at 24, was heading a household closely connects with his admiration and envy of men who take care of their families. Herbert's definition of a man resonates with Mfecane's (2020) characterisation that defines a man through *izenzo* (works). Crucially, *mediro* or *izenzo* (works/deeds) as discussed here, encompass the entirety of a man's actions, character, conduct, and behaviours. In this context, it forms a comprehensive package that defines what a man is known for and identified with, rather than solely referring to his specific craft or profession.

There is a convergence of thought between Herbert and Frank above, and Erick who spoke about seemo (the condition), maitshwaro (manners and conduct) and botho (humanness) as characteristics constitutive of a man. The stated values of 'botho, maitshwaro and seemo' undergird Frank's understanding of a man and that manifest through performances of accountability, self-control/discipline, social fathering and more importantly, respecting and

not sexually exploiting young girls. This characterisation of a man dovetails with the responsible masculinity that obtains in the community of Modimolle (Madhuha, 2017). The usage of a metaphor by Frank that a man is not 'some trousers' deserves comment. This conceptualisation of a man emphasises the social identifiers of responsibility and respectability. It marks instead a significant departure from traditional notions of identifiers of a man that are centred around the phallus and biological fathering. Similarly, Qambela (2022, p.44) argues against emphasising the biological construction of masculinities, and rather reinforces the need to understand the formation of men's identities through "social relations and social structures…"

Some of the essential elements defining a man in a resource-constrained setting like Modimolle with its limited employment opportunities included persevering in the face of economic adversity and during illness. The traditional role of man as provider is idealised even when the economic climate is not favourable and in face of illness. At the time of the interview, 24-year-old Herbert and 32-year-old Silas, who was undergoing HIV and TB treatment, shared their perspectives on what it means to be a man as follows:

> **Herbert:** The way I see it, a man is someone who must hustle and not just stay idle and procrastinate on what he wants to achieve in life. A man does not procrastinate on what he wants but acts. Even if that which you hope for failed, at least you get the satisfaction that you tried. You know what they say in sePedi; "maleka ga se makgona, makgona ke maboeletša" [if at first I try something and fail, I should not give up because if I try again, I will succeed. Be persistent until you get it right – perseverance will be rewarded].
>
> **(Interview with Herbert, 21 September 2020)**

> **Silas**: You see, if I can say a person is a man, in my own opinion, a man does not give up in the face of anything that happens in his life. You are not supposed to give up in anything. For example, in the way that I was suffering from TB, I did not try to hide my condition by feeling embarrassed to go out to the spaza shop [tuck shop] or to go to the clinic for my treatment afraid of what people would say or that they will gossip about me. I just told myself that I would be okay and that I would be cured of TB even though I fully knew that I would remain on a lifelong treatment for HIV. That is what I told myself, that I must abide by the treatment for me to be okay and be able to return to work so that I may also be able to help my mother here and there, especially with the monetary contributions for burial society.
>
> **(Interview with Silas, 24 September 2020)**

Herbert and Silas underscored the importance of perseverance in whatever circumstances one is going through and not giving up. Aligned with this perseverance are key aspects of

masculinity, such as acknowledging one's illness and adhering to treatment, as exemplified by Silas who openly admitted to not hiding or feeling embarrassed about his condition. These elements play a crucial role in achieving positive health outcomes. This resonates with Talcott Parsons' concept of the 'sick role,' which functions to connect phases of incapacity by creating a unified role that encourages compliance within the context of illness-related deviance (Varul, 2010, p.76). While the sick role theory has faced criticism in health sociology, it serves to highlight the subjective nature of illness. In this context, individuals who are unwell are expected to temporarily set aside their regular obligations, such as going to work as is the case with Silas, and instead take on new responsibilities such as adhering to treatment. Thus, Varul (2010, p.77) adds that by loyally committing to the sick role and efficiently performing as expected, the ill person "compensates temporarily for general incapacity."

Hustling as a measure of not giving up, as presented by Herbert, speaks about the urge to seek a livelihood for oneself and the family within constraining conditions. By referencing a local proverb signifying the importance of keeping on trying, Herbert is making a statement about hopes and dreams that temporarily fail to materialise especially within conditions of constraint. He perceives that, notwithstanding these setbacks, a man is identified by the persistent effort he invests in attempting repeatedly, with the optimism of eventual success. Man as provider is here highlighted as an idealised masculinity identity. A similar observation is captured among the Mpondo men in Ithanga, Eastern Cape. In his analysis, Steinberg (2011) argues that the Mpondo adult men's lives which once revolved around owning land, cattle, and establishing a homestead through marriage disappeared with the collapse of the economy. This necessitates men that persevere and, as Herbert stated, a man must "hustle" and refrain from giving up.

A study conducted in South Africa regarding men's behaviours to TB care and treatment found that the incapacity of men to financially support their families during illness led to a reluctance to seek family support, as such actions were perceived as "shameful and unmasculine" (Daniels et al., 2021, p.12). Contrary to expectations, my research findings illustrate that men rely on the 'economy of affection,' and in doing so, they do not experience shame due to their inability to provide. But what does that tell us about masculinity? It demonstrates that as an identity, masculinity evolves as it is influenced by sociocultural and economic conditions. The "economy of affection" denotes a reliance on "family, friends, religious and ethnic networks" for food when in need…" (Vigh, 2006, p.47). Patrick who was 28 years old during the time of the interview concretises the import of the economy of affection by remarking:

> **Patrick:** I have good parents, you know. I have very, very good parents. I am what I am because of that *mdala* [dad] and that mama. They are the world's greatest parents anyone can wish for, you know. Even when times are tough, they are there. I am stable here at my parents you see.
>
> **(Interview with Patrick, 15 September 2020)**

At the age of 28, Patrick did not perceive himself as diminished in masculinity, despite depending on his parents for financial support. As a matriculant, Patrick's increased prospects for employment did not materialise, leading him to rely on his parents for sustenance. This runs contrary to Mfecane's (2011, p.132) findings in Bushbuckridge, Mpumalanga province where the male study participants adhered to a masculinity of living "independently from parental support…" While Patrick's case is a divergence from most participants who idealised the provider role as an important marker of masculinity, it is important to highlight that economic marginalisation forces some participants to rely on the economy of affection. It also demonstrates that masculinity is not entirely dependent on creating one's own homestead but can be enacted in subordination to the female household head who is often the mother. This observation is supported by Qambela (2021, p.596) who calls for the disruption of the dominant literature on Xhosa men which assumes as fixed that manhood is associated with homestead establishment.

I followed up with one of my interlocutors, Garry who was 42 years old, single, and living with his parents in a refurbished house to understand what he meant about a man taking care of himself:

> **Eddie:** If you say a man must take care of himself, how does he do that?
>
> **Garry:** You see these things like smoking. These are not necessary. Another thing is that you are not supposed to have sex without a condom. It is not safe. These are the things I have seen to be very bad for men. I used to tell myself that ladies love me not realising that hey, I am on a slippery slope. You see, sometimes you tell yourself that 'hai [no]! I am a celebrity' without realising that you are only fooling yourself. The effects of such behaviours are bad. I was not used to sticking to one girlfriend as I used to tell myself that girls love me, not knowing that hai [no]! I was wrong. It comes to that point of not taking care of yourself as a man. What I have realised now is that in a woman we only want one thing, yet you see a man wanting to have many girlfriends. Why? One woman can do everything that you want as a man. Why do you have to look elsewhere? **(Interview with Garry, 15 September 2020)**

Garry's narrative description of a man is instructive as it points us towards historicising masculinity. Garry effectively captures what it meant to live as a man before his encounter with

a biographically disruptive condition such as HIV/TB illness. In his account, there was a point in his life when he glamourised having multiple sexual partners. At one point in his biography, this was a marker of masculinity. In his work examining the anthropological perspective of medicine, rationality, and experience, Good (1994, p.119) posits that narratives of pain serve the purpose of shaping the experience of pain, assigning its origins in both time and space, and constructing a biography that imparts meaning to a life marked by suffering. This argument eloquently captures Garry's biography and the genesis of his illness which is closely tied to his past life of multiple sexual encounters without using protection. Expanding Frank's (1993, p.47) perspective, it is asserted that "all illness narratives are stories of self-change." This is succinctly illustrated in the interlocutor's realisation that activities once considered markers of masculine identity before the onset of illness, were in fact unnecessary. There is therefore a marked shift in his masculine identity embracing the narrative of "[o]ne woman can do everything that you want as a man." Masculinity is therefore not an innate identity, but it is subject to change.

While most of the participants focused predominantly on the impact of sociocultural values in defining a man, a few interlocutors underscored the significance of the provider role and the establishment of an independent homestead as crucial markers of masculinity. This understanding reinforces masculinity as an identity that is influenced by values and is also performative. Below are excerpts from three interlocutors emphasising the importance of the provider role as an identifier of a man. At the age of 40, Themba was employed, resided with his partner and two children in their self-owned shack, independent of their parents. On the other hand, at 30 and 39 years old respectively, Lawrence and Charles did not have their own independent homesteads but were living under the headship of their relatives. The three participants ethnically identified as Pedi. My engagement with the three participants in relation to their definition of a man in Modimolle went thus:

> **Themba:** Ahem, a man…if you say there is a man, it means he is someone, even though he might not be married. But let's say he has a wife and kids, that means he must take care of those kids and whoever he is staying with. A man takes care of those people.
>
> **Eddie:** By taking care of; what do you mean?
>
> **Themba**: Supporting them, like if they are kids, you must support them; you must see that they eat. When they are going to school you must know that they are going to school. You cannot just be a man in name and say I am a father, I have two kids, three kids; no it doesn't have to be like that. You must provide for the kids, for the wife and

in that way, it will make it easier for you and for the kids.

(Interview with Themba, 1 December 2020)

Charles: [Monna] a man must take care of his family. He must work. He must love himself. I do not know what I can say. He must work for his family if he has a family. He must take care of his family and he must be strong. When I say he must be strong I mean he must be well in his health like he must be physically fit and to walk, to gym and to exercise for health. **(Interview with Charles, 7 September 2020)**

Lawrence: [A very long pause]. A man is a man when he shows that he works. He is the one who is supposed to take care of the family by providing.

Eddie: But if I am not working, does that mean I cease to be a man?

Lawrence: The family looks up to me to provide, right?

(Interview with Lawrence, 7 September 2020)

While biological fathering is an important identifier of masculinity, the manifest roles of providing for the family is hereby emphasised. Charles and Lawrence were not gainfully employed but they relied on piece jobs – yet they highlight how the provider role is an important identifier of masculinity. The rhetorical question posed to me by Lawrence demonstrates societal pressures exerted on a man, and this resonates with Butler's (1988, p.528) argument that when one performs their gender incorrectly, they invite direct and indirect sanction and "performing it well provides the reassurance that there is an essentialism of gender identity after all." Ashforth (2000) observes a strikingly similar finding in Soweto among siblings in which the provider role comes out strongly as a marker of masculinity. This happens in the context of disillusionment brought about by a lack of employment opportunities in the newly-independent South Africa. In the observation made by Ashforth, one of the brothers remarked why he hated his elder brother, Madumo. The sibling expressed his hatred of Madumo because "he has never worked. Why doesn't he look after himself? Me, I don't have any education, but I'm a *man*" (Ashforth, 2000, p.218). Consistent with the results of my research, men expressed the belief that a man's responsibility is to take care of both himself and his family. In Ashforth's study, when the younger brother stated, 'I'm a man" (Ashforth, 2000), it symbolised his capacity to support himself financially through work, a task his older brother, Madumo struggled to achieve. Society expects men to live by these ideals and failure attracts some sanction even from family members. The significance of the 'provider role' as a defining marker of masculinity is fundamentally prevalent, even in the face of economic hardships. This is evident in Lawrence's rhetorical question to me, "[t]he family depends on me to provide, doesn't it?"

In Chapter Four, I briefly recounted the story of 28-year-old Patrick, whose mother insisted that he withdraw from an interview I was conducting with him. I presented the story to demonstrate the ways masculinities are also connected to individual independence, something obtainable through setting up own homestead. Although Patrick remarked that "[m]y mother thinks that she can keep me under her skirt forever", it was clear the mother had control over him mainly because he was still living with his parents and did not have his own homestead. Writing on the concept of social becoming through marriage and attainment of individual authority for the youth in Guinea Bissau, Vigh (2006, p.37) argues in Marxist terms that the "uneven distribution and access to resources and the ongoing period of decline has led to the social dynamics of the generational order being replaced by social inertia." In other words, failure to possess resources through job opportunities has whittled young men's attainment to societally expected masculinity ideals, not only in Guinea Bissau but also in Modimolle and South Africa as a whole.

When a man is dependent on their parents or relatives materially and otherwise, age might not be a masculinity-identifying factor but the ability to be independent in setting up an own homestead is what matters. Despite the mother's call for her son to terminate the interview, Patrick did not shout back at his mother; in a dignified and respectful manner reflective of *seriti, maitshwaro, botho and seemo,* he went out of the car to talk with his mother in private to explain the purpose of our interview. This demonstrates a respectful masculinity. Interestingly, by stating that his mother 'thinks that she can keep me under her skirt forever,' Patrick was demonstrating his agency even against parental control. Mfecane's (2011, p.132) study on therapeutic citizenship in Bushbuckridge of Limpopo found that "real men are free to do what they want and are not accountable to women for their actions." On the contrary, my findings show that men do account to women, in this case to their mothers when they live under their roof and even to their partners when they experience TB illness. My findings, therefore, build and expand the African-centred theory of masculinity, as they demonstrate how respectful men can be, even when they live under their parents' homesteads. Whether we discuss the performative provider role or the establishment of autonomous households as markers of masculinities, the fundamental source from which these roles derive their meaning is rooted and embedded within the sociocultural values of seriti, botho, maitshwaro, seemo, and mediro. In the next section, I illustrate men's relationship with space in terms of living and working conditions and how these mediate TB infections.

The implication of living and working conditions on TB infections

In this section, I empirically examine living and working conditions as key components of the social determinants of health to better understand tuberculosis infections among men. Through ethnography, I accessed men's living spaces where I not only observed their living conditions but also gathered rich information through interviews. During interviews with participants, we also traversed the scope of their working conditions. Taken together, living, and working conditions are crucial factors in a study on men's TB illness experiences because health is inseparable from socio-economic influences. Although the TB illness experience should be comprehended from the perspective of the individual sufferer, Pierret (2003, p.15) adds that illness experience provides significant insights into the socio-economic context in which patients have lived and continue to live. In the same vein, De Beer (1986) reminds us that to understand why someone is ill, we must not look at the individual as a mechanical body that is malfunctioning, but we must explore the person's social and physical environment as these have a strong bearing on the individual's health. In different terms, the sociological imagination's emphasis on the intricate link between 'private troubles' and 'public issues' (Mills, 1959) is crucial for a synthesised understanding of tuberculosis infections among men and their subsequent experiences of illness. While smoking and alcoholism are some of the social determinants of health at the individual level, the structural conditions like housing, unemployment and poverty equally deserve critical attention (Nettleton, 2013).

Most of my participants demonstrated an understanding of how TB is contracted and were aware that it is a treatable disease. Participants mentioned their working conditions as the underlying factor that predisposed them to tuberculosis infection. I again refer the reader to **Appendix One** for participants' profiles**.** Most participants worked as labourers on farms and in the construction industry. Participants' socioeconomic class was intricately connected to their poor living conditions when one considers the number of bedrooms a household resides in as a marker of poverty status. To provide context, the 2019 General Household Survey illustrates that, on a national scale, households residing in one-bedroom dwellings experienced the highest levels of poverty, reaching 39,6%, followed by those in zero bedrooms at 35,2% (Statistics South Africa, 2022, p.32). In comparison to the national levels illustrating poverty rates based on the number of bedrooms, Limpopo recorded poverty levels of 51,7% for zero-bedroom dwellers and 45,2% for one-bedroom households respectively (Statistics South Africa, 2022). An important observation from the General Household Survey is that Limpopo

exhibits the highest poverty levels in relation to two-bedroom households, standing at 50,7% (Statistics South Africa, 2022, p.32). The concentration of poverty among households with two bedrooms in Limpopo Province, significantly exceeding the national average of 27,1% (Statistics South Africa, 2022), can be attributed to the prevalence of RDP houses that typically feature two bedrooms. This suggests that the provision of government-subsidised houses does not translate to the reduction of poverty among RDP households.

To reinforce the interconnectedness of socioeconomic status and tuberculosis, the evidence from my participants demonstrates that, out of a sample size of 30, 15 resided in two-bedroomed RDP houses while nine participants resided in shacks. I therefore argue that tuberculosis infection follows a clear socioeconomic gradient affirming that there is a noticeable pattern in the occurrence of tuberculosis corresponding to differences in socioeconomic status. De Beer (1986, p.82) contends that "[t]he working class earns wages and lives in conditions which are either on the borderline or below the level of living standards required to maintain good health." Similarly, and evocatively, Engels' graphic description of the working-class condition in 19th-century England, in which he argues that "[a]ll conceivable evils are heaped upon the heads of the poor" (Engels, 1993, p.112), resonates with the findings of this study. Only six participants lived in refurbished or extended houses with more than three bedrooms. Exacerbating the poverty levels documented among households residing in two bedrooms and less are the reported incidents of participants sharing spaces with TB-infected family members. This further highlights the criticality of living conditions and arrangements as significant risk factors for TB infections among men.

Two of my interlocutors, namely 28-year-old James and 39-year-old Thuso, dropped out of school in Grade 10 and Grade 8 respectively. While James lived in an RDP house constituted of seven members, Thuso lived in a shack in a five-member household. Both participants were unemployed at the time of the interview in 2020 and were in cohabiting unions with their partners. Their explanations in relation to suspected TB predisposing factors went thus:

> **James:** At my previous place of work, I used to mix cement for building. I suspect that dust caused me to get infected with TB. The other thing is that since I was staying with [9]mamazala [my mum in this sense], it is possible that I was exposed to the disease, and it infected me because I used to get into her room [his mother suffered from TB and during the time of the interview, she had died]. I was so close to my mother, and we

[9] Usually used to refer to a mother-in-law.

stayed together most of the time.

(Interview with James, 24 August 2020)

Thuso: I used to work in construction where I would mix concrete. There was no one who could out-compete me when it came to mixing concrete at work. That was the work I was good at, of mixing concrete. I also used to live with my mother who was infected with TB. It was that TB which affects the bones. She used to smoke pipe tobacco. They asked me at the hospital whether there was anyone coughing at home, and I said yes, it was my mother. They advised me not to stay together with my mother.

(Interview with Thuso, 21 June 2020)

James and Thuso's explanations demonstrate a web of possible predisposing factors to TB infection in the form of previous work, living conditions and living arrangements. Their employment in the construction industry is a significant risk for contracting TB. Research indicates that excessive exposure to dust within the construction industry places workers at risk of inhaling respirable crystalline silica, leading to an increased likelihood of developing silicosis (Moran et al., 1994). While the stories above may seem less significant when compared to the mining industry and the issue of silicosis, it is important to note that the production of concrete involves the use of cement, sand, rock, and water. Sand is known to have a high content of crystalline silica (quartz), and most types of rock also contain silica (Moran et al., 1994). As a result, working in the construction industry can be a risk factor for developing silicosis, particularly with ongoing and sustained exposure to these materials. It is well established that a synergistic relationship exists between silicosis and tuberculosis, often referred to as "silico-tuberculosis" (Rupani, 2023, p.2).

In terms of the living conditions, an RDP house in Modimolle has two bedrooms, a dining room, and a bathroom. There are clear variations about the size of these houses, even within the same township. In some instances, the rooms are spacious, while in other residential locations the rooms are smaller. James' case raises three important factors that shed light on possible ways tuberculosis was spread at the household level and his subsequent infection. James' household consisted of seven members, all living in a two-bedroomed RDP home. There is clearly overcrowding in that instance, and this is a critical factor contributing to the spread of TB. Added to these conditions is that one of the seven members was TB infected, and she eventually died. James makes it clear that he was close to her TB-infected mother and would regularly visit her in the room. The conditions described in James' case help us to appreciate how tuberculosis is spread. Literature shows that acute transmission of

Mycobacterium tuberculosis (M. tuberculosis) occurs at the household level (Martinez, Shen, Mupere, Kizza, Hill & Whalen, 2017; Morrison, Pai & Hopewell, 2008).

While both James and Thuso attested living with their TB infected mothers in the same household, it is the emphasis on how close James was to his mother that presents an important layer in the analysis of how he predisposed himself to contracting TB. According to Morrison et al. (2008, p.359), "…people who are in close contact with an individual who has an infectious form of tuberculosis are at an increased risk of acquiring the infection and, once infected, of progressing to active tuberculosis infection." Equally important in the analysis is the way Thuso reports the TB-screening procedures that he underwent at the hands of the healthcare staff. Added to these important dynamics is the low educational level of the two participants, a factor that inversely works against tuberculosis protection (Harling et al., 2008). Thus, the working and living conditions as well as the living arrangements are risk factors for TB infection.

In another case, a plethora of factors contributed to Herbert contracting TB. As a former farm labourer, he used to sleep on the floor at his workplace. He describes his working conditions as follows:

> **Herbert:** I used to work on a farm, and we were planting some watermelons. You know when you are farming watermelons you need manure, and we would carry 50 kg bags of that manure. We would offload these bags from a truck… The other problem at work was that we were sleeping on the floor.
>
> **(Interview with Herbert, 21 September 2020)**

The work described by Herbert is tiring. The working and living conditions at farms are some of the worst faced and endured by the marginalised black Africans. In his study on the working and living conditions on South African farms that border Zimbabwe, Bolt (2015, p.5) argues how farms as "workplaces are lifeplaces", meaning that these spaces of work are also places of residence for farm workers. Through the work of Bolt (2015), we appreciate the intersection of socioeconomic class and gender in that men dominate these 'lifeplaces' where they are constrained to live in squalid conditions after performing hard labour in the fields. Living in numbers of "twenty or thirty to a room" (Bolt, 2015, p.120) is inhumane, and because of such overcrowded conditions infectious diseases like tuberculosis become concentrated among poor working-class men. The conditions for the workers in 19th century England as captured by Engels (1993, p.112) where they were enclosed "in dozens into single rooms, so that the air which they breathe at night is enough to stifle them" resembles the present-day working

conditions on farms, the 'lifeplaces' of people like Herbert. These poor working and living conditions on the farms are fertile grounds for the spread of and infection with TB. Literature shows that, occupationally, farm workers are at a heightened risk of contracting tuberculosis due to concomitant factors like low wages, poor education and generally poor living and working conditions (Clarke, 2003; Kootbodien, Wilson, Tlotleng, Ntlebi, Made, Rees & Naicker, 2018; Mlangeni, 2023). Between 2011 and 2015, TB mortality in South Africa was reportedly high at 15.3% among 'elementary occupations' (Kootbodien et al., 2018, p.4) which include agricultural workers, labourers in mining and construction (Statistics South Africa, 2012). Although the statistical information is outdated, the study by Clarke (2003, p.69) carried out in the Boland, Western Cape region of South Africa shows a TB incidence of 1 685 per 100 000 population of temporary agricultural workers. The incidence rate surpasses the district level's and is attributed to the economic marginalisation of temporary agricultural workers who, in addition to working long hours, face limited access to healthcare services (Clarke, 2003).

The living arrangements, as well as the working and living conditions of men in this study, cannot be disentangled as they are intricately intertwined with the possible acquisition of TB. Added to the working conditions, Herbert's family had a history of tuberculosis, itself a possible indicator of poverty. As previously indicated, Herbert lived in an RDP house and at 24 years, he was heading a household of six members – his mother died when he was in Grade 3. He described the history of the family and TB infections:

> **Eddie:** When you look at everything in your life, what do you think predisposed you to TB infection?
>
> **Herbert:** You know what happened with me, my mother became ill from TB, you see.
>
> **Eddie:** Oh, I see.
>
> **Herbert:** Yes. After my mother, it was my elder brother who got infected with TB and he died. After my brother, my sister's child [nephew] was also infected with TB. After my sister's child, TB infected this girl [his niece] you saw here with me and now the disease has infected me.
>
> **Eddie:** Oh, man.
>
> **Herbert:** Yes. So, I realised that these people that I know and that I have been living with have survived the disease not knowing what really transpired with the deceased [mother and brother]. Maybe it was God's time to take them, I don't know.
>
> **Eddie:** When did your niece become infected with TB?

Herbert: Erm, I think it was last of last year [2018] if my memory serves me well**.**

Eddie: So, is it because of the family members who went through TB experience or your smoking, or maybe it was your working environment which you think caused you to be infected with TB?

Herbert: You know what, I think this TB runs in the family and that is why I am also infected. It is because it started off with my mother back then and then my brother, my nephew, and my niece. I just don't know the circumstances in which my mother got infected but, in my case, it started by hitting me in my lungs, but I did not know anything about TB. But when they mentioned TB I accepted, and it dawned on me that in this family there is a history of TB illness among family members. I then told myself that I will also go through the experience and recover. I accepted the disease and strengthened myself by the assurance that if these two [nephew and niece] recovered then I was also going to be well. I then started my treatment journey until now. I am glad that now I am gaining weight and I am also able to eat food without any problems.

Eddie: But were you staying with your nephew who got infected with TB?

Herbert: Yes, at that time we were all staying together.

(Interview with Herbert, 21 September 2020)

As he narrates, Herbert lived with all the infected family members at different times, and that in an RDP house. An investigative study conducted in the Gambia, Guinea Conakry, and Guinea Bissau by Lienhardt et al. (2005, p.917) confirms that, "…the risk of TB increased with a reported family history of TB." Since Herbert lived with the TB-infected family members, it is clear this heightened his risk of TB infection. Lienhardt, Fielding, Sillah, Bah, Gustafson, Warndorff ... and McAdam (2005, p.917) further found that the risk of infection with TB "increased with the number of persons in the household having had TB in the past." Considering that Herbert had four close family members who suffered TB amply demonstrates his risk for contracting the disease. With the exposure to so many family members that lived with TB, the living arrangements were a critical factor in the spread of the disease, since the family lives in a two-bedroomed RDP house which has limited space. The central issue here is overcrowding in a small space. Some of the community healthcare workers who accompanied me into the field as my research assistants knew Herbert's family history with tuberculosis. This shows that families and households with well-known histories of TB infection require targeted state intervention for screening and monitoring, so that the spread is mitigated at household and community levels. Another important dimension would be to consider the living conditions like food insecurity issues; assisting with the provision of food parcels to such families can help reduce the risk to them.

Among my interlocutors, I engaged Dumisani, the male nurse responsible for chronic diseases. I wished to know from him what he thought were some of the critical factors at play in TB infection and spread among men in Modimolle. Besides the important issue of lifestyle, Dumisani mentioned that living arrangements have a role to play in the spread of the disease:

> **Dumisani**: You also look at the issue of living arrangements. You will observe that you will have multiple TB cases within one household, and this is due to the living arrangements where a lot of people share small rooms which have poor ventilation. Even at their spaces of work where they are away from their homes, sometimes eight to 10 men live together in a small room without ventilation. You will find a family of eight members sharing an RDP house or staying in mokhukhu [shack]. It is automatic that if one member has TB other members might also get infected with the disease. Recently there is a case of MDR (Multiple Drug-Resistant) TB that has been giving me problems. When I ask the guy how he feels he tells me that he is feeling well yet the problem is he continues to live together with his family members. I have on many occasions called the police to come and assist me and bring him to the clinic. MDR is very dangerous, and its management is very difficult and that is why we try by all means to make sure that when we identify a case he or she is initiated onto treatment and proper protocols are taken. MDR takes long to cure. If someone has been exposed to TB, we usually give them prophylaxis to prevent active TB.
>
> (**Interview with Dumisani, nurse, 3 March 2021)**

Dumisani's assessment of the predisposing risk factors to TB infection resonates with and reinforces the experiences of my participants in terms of their working and living conditions as well as the living arrangements in confined spaces with poor ventilation. The problems encountered by Dumisani in his official role with a male MDR patient is revealing. Due to his continuous contact with other family members, the man's refusal to initiate TB treatment automatically predisposes them to infection. A study in the Eastern Cape found that the risks for reinfection among those that were successfully treated for TB were high in instances where they continued to live with "family members with TB symptoms who refused to present themselves for treatment" (Møller & Erstad, 2007, p.111).

While the living arrangements with TB infected family members heighten someone's risk to infection, I furthermore explored two of my interlocutors' work in construction to understand more on the social determinants of health. At the time of the interview, James had been retrenched from work, while Themba was still employed. They described their experiences:

> **Eddie:** I remember you spoke about working with dust and your exposure to your mum who was infected. Is there anything else that comes to mind that you think could have put you at risk of being infected with TB?

James: Erm, you see, where we were working at Kokanje, we were renovating houses. You will see that for example, these Boer homeowners would ask us to replace a bathtub in their house. They would lock us in the workspace while they are off to the sitting room. They would not provide us with any dust masks. We were working under this other Boer who was full of apartheid [racism]. He would make you work very hard, and the problem is you have no choice but to work because you don't want to be idle doing nothing.

Eddie: When you started feeling weak, did your employer offer any form of help or you had already left work?

James: They actually ended up terminating our contracts telling us that the houses that needed renovations were finished. So, they cut down the staff compliment.

(Interview with James, 24 August 2020)

Eddie: But then, when you look at the environment you are working in and the conditions you live in, what do you think could have caused tuberculosis in you?

Themba: Erm, I would think of the dust. Yes, we do have the masks, but you know, some of the places you work, it's not like those masks will protect you 100 percent. No, no, I don't think so.

Eddie: Okay, but they do provide you with masks?

Themba: Yes, they do provide us with masks. The other problem is when it's seriously hot, it is impossible to keep putting on that mask. Maybe you are inside the roof ceiling for an hour or so, there is a lot of dust inside there, especially in the ceiling. There is just a lot of dust, and you can feel it and inhale it. And this is fine dust we are talking about**.** **(Interview with Themba, 1 December 2019)**

Hard and gruelling is the work; inhumane are the working conditions that James used to work under. Equally harsh are the working conditions for Themba, and in both cases their exposure to dust is a health hazard on its own. In his analysis of the state of health under apartheid, De Beer (1986, p.1) asserts with respect to TB that healthy people with access to nourishing food and who are not "overworked or emotionally strained" are able to withstand infection. It is safe to argue that the risk to TB infection among these men is high because they are overworked, and that in poorly ventilated spaces. In a resource-poor setting where employment opportunities are limited, the interlocutors highlight the importance of providing as men and not to be 'idle doing nothing.' This fits well into the masculinity framework of *mediro* (works/deeds). It again emphasises the interlocutors' pressure to perform their gender correctly in terms of providing; failure to do so invites direct and indirect sanction (Butler, 1988).

Despite the provider masculinity that James expresses and performs, it is important to historicise masculinity in the context of South Africa. Locking up men in a confined space to

work can be regarded as infantilising. This parallels what Suttner (2005) refers to in the context of South Africa's colonial encounter, where African males were treated as boys by the colonial authorities. While black African men's masculinity identities are driven by sociocultural values towards providing for their families, in James' case ironically the workplace becomes a site in which their masculinities are redefined and reconfigured by the White employers. In these workspaces, black African men assume and perform marginalised masculinities (Connell, 2000) within a racialised economic system because such masculinities occur within contexts of exploitation or oppression. It is within the context of performing marginalised masculinities that TB infections can occur as the working conditions are inhospitable. As one of my interlocutors, Timmy averred, **"…**the way I heard about this disease [TB] is that you cannot be aware that someone has it because it is not written on their forehead." Against such a backdrop, the transmission and contraction of tuberculosis bacteria cannot be ruled out among workmates who are confined within a workspace, sharing the same air for prolonged periods.

In addition, exposure to dust in a confined space as narrated by James poses risks of contracting other respiratory diseases like pneumoconiosis, and this heightens the risk of TB infection. Although Themba has access to a facemask, he is afraid that the dust he and his workmates are exposed to in the ceiling is too fine, making them vulnerable to TB contraction. A point to note about Themba is that his interaction with the private health care facility in the build-up to a positive TB diagnosis started with a mention about bronchitis, a respiratory infection, in the following manner:

> **Themba**: The doctors asked me whether I sweat at night, something I never experienced. I told him no, I don't sweat at night. So he took my sputum and did the test and then erm, he talked of bronchitis and said the lungs are infected and stuff because of the coughing. He asked me, "What exactly do you do for work?" This is because we normally do different kinds of work and there is also a whole lot of dust when you get into the ceilings and when you are building. So, he was talking of bronchitis, and I got treated and it just stopped for a while.
>
> **(Interview with Themba, 1 December 2019**)

The doctor's mention of the working environment in triangulating the aetiology of Themba's symptoms is revealing as it demonstrates that disease occurrence cannot be fully understood within a socio-economic vacuum. The working environment in this regard is as important a social determinant of health. Besides the problem of other respiratory diseases that are caused by continuous exposure to dust, TB is a "prototypical airborne pathogen that is transmitted,

almost exclusively, from person to person via shared air" (Morrison et al., 2008, p.359) in spaces where there is poor ventilation when the TB host coughs or sneezes.

The inhumane working conditions are complicated by high unemployment rates that stand at 49.6% in Limpopo (Stats SA, 2022, p.8) in terms of the expanded definition of unemployment. This scenario of high unemployment has a bearing on how working-class men access clinics, not only after a TB diagnosis when they routinely collect treatment, but even at the onset of TB-suggestive symptoms. In the case below, Lawrence became lost from TB treatment primarily because he had to make a choice between his health and his livelihood in a context of high unemployment, and so, he chose the latter. I therefore asked him whether he was willing to initiate back onto TB treatment and he had the following to say:

> **Lawrence:** Yes, I am interested because if I do not take my treatment, I am killing myself mos [right?]. … [A long pause]. You must understand that if I am working, there is no way that I can nag my employer to give me time off. If I ask for a day off and they refuse me that request, what must I do? If I ask and they decline my request I cannot force them and if I do not come to work, it means I get fired. What will I eat? [Rhetorically]. **(Interview with Lawrence, 7 September 2020)**

The finding from Lawrence on choosing between health or livelihood resonates with a study in South Africa on men and TB care retention by Daniels et al. (2021, p.12) which found that many "sick men continued to work until they were physically unable to do so or were fired from their jobs for underperformance or TB-related discrimination." Lawrence discontinued his TB treatment because of the constraining working conditions on the farm where he also resided. Lawrence's health-seeking behaviours are clearly shaped by the social structure of a poor economic climate in which unemployment is high. Even though he exercises his agency towards health-seeking, Lawrence realises the constrained economic opportunities. As such, he succumbs to the demands of the employer. According to Williams (2003, p.141), it is important to pay attention to people's narratives of their lives so that we appreciate the connection between "the personal troubles and the public issues, over time and in space, in relation to multiple facets of identity and social position." Thus, research confirms that access to healthcare services is a significant obstacle for agricultural workers in South Africa (Clarke, 2003; Mlangeni et al., 2023).

About his working conditions Lawrence emphasised that "…if you get a piece job, you cannot just miss work as and when you please. If the employer says no to your request, that is final. On top of that, I was not working nearby." A study by Mlangeni et al. (2023) on tuberculosis

screening among farmworkers in Limpopo Province found, many agricultural workers, particularly seasonal ones, encounter challenges in seeking healthcare due to the potential loss of income associated with taking time off work. Similarly, Daniels et al. (2021, p.12) further observed that men were trapped in a health-compromising cycle, juggling work, perceptions of masculinity and unhealthy behaviours which hindered their involvement in clinical care and adherence to treatment plans. Also, a study on structural barriers to men and TB-related healthcare revealed the fear of losing income opportunities outweighed men's decisions towards seeking healthcare (Chikovore et al., 2020).

TB treatment requires one to regularly go to the point of care for collection of medicine in the six-month period, to monitor whether the medication is compatible with the sufferer or not. Juxtaposed against the environment of piece jobs, it becomes untenable in the case of Lawrence to regularly collect his medication; this is one reason he became lost from TB treatment. Keeping his job over his health in this case relates to the provider role he performs in his family. Daniels et al.'s (2021, p.12) study on South African men's experiences with TB care further noted that men reported that their work schedules clashed with clinic hours and wait times, and this affected their access to care. Because of the conditions at work, Lawrence could not even tell his employer that he has TB for fear that he could lose his job. I asked him:

> **Eddie:** Did your employer know that you had TB? Did you tell them or not?
>
> **Lawrence**: I did not tell them either. I just told them that I was sick.
>
> **Eddie**: Did they support you or not?
>
> **Lawrence:** Do you know how the white foremen are?
>
> **Eddie:** How are they like?
>
> **Lawrence:** They are a big problem because they are the ones with the power to fire you. They just don't care. They are just interested in getting work done. They are the ones who sell us out by telling their boss that this man is not interested in work because he is constantly asking for a day off every week.
>
> **(Interview with Lawrence, 7 September 2020)**

Piece jobs, as in the case above, do not come with any job security – they are precarious. Lawrence understands that in his work situation, he can be disposed of at any time; therefore, he could not divulge his TB condition to the supervisor. A study on TB treatment adherence conducted by Skinner and Claassens (2016) in South Africa similarly found that respondents were afraid to disclose their diagnosis to the employers for fear they would lose their job.

Considering that TB is airborne, Lawrence's non-disclosure puts his workmates at risk of contracting the disease. Disclosure is important so that everyone takes precautionary measures when around a TB sufferer. In the context of high unemployment, coupled with the assumption of a provider identity, individuals may enter precarious work situations. When combined with the onset of a debilitating TB condition, these factors only serve to unveil men's vulnerabilities. Thus, men's health behaviours require contextualisation.

In the same vein, Herbert had similar experiences to Lawrence which did not favour health-seeking in the face of TB-suggestive symptoms at work. He had the following to say in our conversation:

> **Eddie:** Did you try to explain to your employer that you were unwell?
>
> **Herbert:** I could not tell them anything as I was trying to save my work. You know the problem of working these jobs where you have a foreman, the moment you begin to talk about your issues [like health] is the moment he tells you to go home and not come back again. You realise your situation that you badly need this job and so I forced myself to do the work. I came back home and stayed a bit and in December I went back to work. I then explained the symptoms I was experiencing to my co-worker, and he advised me to approach the employer and explain my situation. I was against that idea because I knew that the moment I talk with them about it they would immediately fire me, and it was in December. I was also considering the situation at home that life was difficult because most of the people were not working. I felt that I was supposed to do something by contributing to my family through working. I managed to speak with the foreman about my ill health and he told me to wait a little bit before he would talk with the employers. I told him that I did not want him to tell the employers because I knew that the way my experience would be presented would be distorted because as you know, we as black people do not really like each other that much. I only returned home after completing the work in January and I started explaining to family members how I was feeling.
>
> **(Interview with Herbert, 21 September 2020)**

For both Herbert and Lawrence, the process of disclosing one's illness is a difficult one considering the circumstances of working piece jobs and the societal mandate placed on the provider identity. The risk of losing a job after disclosure of illness to the employer is great and it outweighs the considered health needs of the two interlocutors. Necessitated by the family dynamics in which no one else was working, Herbert takes it upon himself to save his job by not disclosing his TB condition because disclosure was a sure way of getting himself fired. Primarily, Herbert was only biding his time before the signs and symptoms became apparent to everyone, a situation that would ultimately and inadvertently invite dismissal by the

employer. Among this marginalised class of men, the onset of TB presents competing challenges. My conversation with Matshepo, a home-based carer who has worked in Modimolle, further illuminates the challenges men face regarding TB and their employment:

> **Matshepo:** Eish! TB presents a lot of challenges indeed because if you are on DOT (Directly Observed Treatment short course) you have to be committed to the treatment, and if you are not on DOT that's when you will see a lot of faults because people will tell you that they are working. Sometimes our people are scared to tell their managers that they are sick because they are scared of being criticised and judged. Also, some are scared of losing their jobs after disclosing to the employers. It is a challenge for those who work because right now when we go there to DOT them, we don't find them at their homes as they are at work and even when they are at work, they still do not take their medication.
>
> **(Interview with Matshepo CHW, 22 July 2020)**

Matshepo's insights help corroborate the challenges faced by men who do menial and piece jobs. For these working-class men, their choices are constrained between choosing health over work or vice versa. In the next section, I elaborate on the permeability of gender on space and TB infection.

Spaces of entertainment and the practices thereof as sites of TB infection

In this section, I foreground the way masculinities are expressed and performed in public spaces of entertainment and sociability, as a possible pathway for understanding TB infection among men. I argue that behind the performance of masculinities in public spaces or masculinity in sociability, are the influences of sociocultural values and norms of maitshwaro, seriti, seemo and botho. Through employing non-participant observation, I sat with men in the spaces of entertainment like taverns and shebeens to observe the activities they engage in when they come together for beer drinking and socialising. The decision to employ non-participant observation in public spaces as a research method stemmed from findings obtained through interviews. Most interviewees asserted that they had contracted tuberculosis (TB) through activities such as sharing beer and smoking together. While these individual accounts provided insight into perceived modes of TB transmission, it is essential to recognise that the broader rationale for utilising non-participant observation lies in a comprehensive understanding of the gendered social interactions and environmental factors that may contribute to disease spread within communities.

Taverns and shebeens are deeply and dominantly frequented by men, a testament that spaces are always gendered (Cummins, Curtis, Diez-Roux & Macintyre, 2007; Gopinath, 2019; Ranade, 2007). Space, according to Bondi (2005), is relational rather than an absolute physical locality. This understanding of space is premised on the social constructionist perspective, which presupposes that space is continually shaped and redefined through the dynamic connections between places and social interactions (Bondi, 2005). Herein lies the importance of analysing TB and men through the social relations that occur when men come together in space. In other words, spaces acquire meaning through social practices. Space in this sense is social, and as argued by Massey (2005, p.9), "space is the product of interrelations" which is "constituted through interactions…"

It is important to mention as Butler (1988) avers that gender is performative while West and Zimmerman (1987, p.126) contend that gender is a "routine, methodical, and recurring accomplishment." Gender is relational within space and similarly, masculinity is expressed and performed within space and time. The performance of masculinity identities occurs at personal, interpersonal, and macro levels, crystallising within space. Crucially, these spaces are not pre-existing but emerge through the interactions of identities and entities (Massey, 2005). Men accessing spaces of entertainment and recreation occurs for various reasons and is not limited to the need for sociability and support systems. For most men in the study, the interaction occurs in public spaces such as taverns, shebeens and car washing spots. The spaces of sociability are intricately connected with how masculinities are performed in the public sphere. A study on gender and alcohol use among young Nigerians found that social gatherings in recreation spaces served to reinforce traditional masculine ideals. Within these public entertainment settings, the ability to consume large amounts of alcohol without displaying inebriation was regarded a marker of achievement and social standing in masculine hierarchies (Dumbili, 2022, p.6).

Beer drinking or cigarette smoking by an individual in his own isolated space does not provide the same meaning as that which occurs among friends within spaces of entertainment and sociability. When beer drinking and cigarette smoking are done among friends in taverns or shebeens, they become social and, in the process, relations are forged and cemented. In other words, the social relations prevailing in spaces of entertainment provide a lens through which masculinities and TB infections can be understood. But how do these sociability spaces help us to understand TB infections among men? My conversation with the nurse Dumisani and community healthcare worker Linda may help elucidate this. Linda's comment highlights the

group dynamics associated with men; Dumisani crystallises the social interactions and practices in poorly ventilated spaces. All these insights shed light on how TB is transmitted among men. Below are the responses of the two interviewees:

> **Eddie:** But are you saying there are no women that come together and share beer and cigarettes together with men?
>
> **Dumisani:** The spaces where men come together are taverns and shebeens and these spaces have no proper ventilation if you look at it closely. This increases chances for TB spread and infection. These are closed spaces and they expose the young men to TB. Women do come to these spaces but in few numbers than men and they also leave these taverns earlier before men. A man might visit a tavern at 9 am and leave at 12 midnight. Although women come to these taverns or shebeens, sometimes they just loiter outside these spaces that are dominated by men, and they leave early. You will also find that some of the women frequent these spaces on weekends while men are there most of the days. Another thing is that women remain behind at the houses taking care of children and might only find time to visit a tavern at night when their parents are back from work for example. As a result, men are more at risk of contracting TB at these spaces of socialising. Look for example at car washing facilities here in Modimolle, you will find most men there socialising in large numbers and they automatically get the TB from there. Men have another problem of not eating enough when they visit these taverns. For example, where does a man find time to cook a proper meal if he spends most of his time at a tavern? Men who drink beer do not have enough time to eat a proper balanced diet and this compromises their immune system making it more prone to getting TB. Men become prone to develop TB because they don't eat balanced diet.
>
> **(Interview with Dumisani, nurse, 3 March 2021)**
>
> **Linda:** When it comes to the problem of TB, many of the men drink beer and they smoke, and they like to be in a group. For some, even if they are working in the construction where they are building, they don't put on protective gears like face masks. That is why most of them become ill with TB.
>
> **(Interview with Linda, CHW, 20 July 2020)**

Dumisani and Linda's excerpts provide a detailed overview of TB infection among men in the context of Modimolle; they articulate the shebeen culture and the associated social practices of alcohol drinking and cigarette smoking. Studies in South Africa show that poverty and social inequality are among key factors influencing acutely high levels of heavy drinking among adults (Trangenstein, Morojele, Lombard, Jernigan & Parry, 2018). Similarly, alcohol serves to give some fleeting relief to people experiencing the structural violence of "poverty and dehumanising living and working conditions" (Ndaba, 1984 cited in Ramphele, 1993, p.55). Furthermore, Dumisani crystallises the ways in which space is gendered, and this resonates

with the study carried out in India which reinforces that "[w]hen comparing men and women of the same class and community, men have better access to public space at all times of the day" (Ranade, 2007, p.1525). This is critically laid bare in the above excerpt where women's access to taverns is intermittent while men's access is unfettered.

Reinforcing the social practices of beer drinking in space is the conversation that I had with 39-year-old Terry who was in a cohabiting union with his partner. Terry lived in a shack and narrated his life experiences with smoking, beer drinking and how these related to TB infection:

> **Eddie:** But let us look at TB again and its causes among us men. What do you think is the problem here?
>
> **Terry:** For us men, I think TB infects us through different ways. I smoke cigarettes. On Fridays, there is need for brandy and whisky, you see. There is no way that TB will not infect me. It is easy to get TB from even somebody because of smoking and beer drinking. As men, we are rough because we work with heavy stuff and drink heavy stuff like brandy and smoking. Some of us smoke marijuana [cannabis]. On weekends, you will find a man drinking beer and smoking without even eating any food. I used to do that myself. When I would come from work on Fridays, I would take out my braai stand and start to braai some meat and we eat with friends before starting to drink beer. When I start to drink beer I would not stop and the following morning I would buy a live chicken but that would only be for my wife because I would be drinking beer. I spend the whole of Saturday drinking beer without eating anything. On Sunday, I would be preparing to go back to work. I would not even feel hungry. On the other side my partner would complain about me leaving her to eat the food alone.
>
> **(Interview with Terry, 1 February 2021)**

Terry worked as a tractor loader backhoe (TLB) operator and used to earn around R6 000 (USD$320) per month and was comparatively among the highly paid of my interlocutors. Like most of the participants, Terry suspected cigarette smoking as a cause of his TB contraction. A study in China corroborates the finding above by demonstrating that there are heightened chances of active TB among current cigarette smokers and "heavy drinkers of at least 2 drinks a day" (Soh, Chee, Wang, Yuan & Koh, 2017, p.9). According to Duarte et al. (2017, p.117) global evidence demonstrates that approximately 17% of tuberculosis cases and 15% of TB-related deaths could have been avoided if there had been less alcohol consumption. In the same vein, Louwagie, Wouters and Ayo-Yusuf (2014) add that alcohol use is a risk factor for acquiring TB, and continued use of alcohol and tobacco products once a person has contracted TB lowers the chances of successful treatment. Interestingly, and probably because he could afford to, Terry's choice of alcohol was, as he termed it, 'heavy stuff', which included brandy

and whisky. This consumption of heavy stuff occurs in the company of friends and other men, a sure way of performing his identity of masculinity. Arguing in the context of Nigeria, Dumbili (2022, p.3) claims, "alcohol is one of the resources that men and women use to perform, (re)produce or assert masculinity and femininity." That Terry does not have time to eat a proper meal when he starts to drink beer is exactly what Dumisani stated about men. It is possible that the abuse of alcohol suppresses one's appetite and this eventually compromises one's immune system, making it easier for TB infection.

The social practices of sharing beer and cigarettes, intricately linked with physical proximity, are central to men's social interactions. Taverns and shebeens are associated with overcrowding and they are poorly ventilated. Considering the aforementioned factors, along with the extended duration that men spend in these social spaces, it is important not to overlook the risk of tuberculosis infections. While the mining environment is the dominant analytical lens through to understand TB infections, the social space of entertainment plays a role in the analysis of the prevalence and incidence of TB among men. The assertion by the nurse Dumisani that a man can arrive and stay in a tavern from the time it opens in the morning – anytime between 9 am and midday – till when it closes is a critical observation for the analysis of men contracting TB in space. It is noteworthy however that the South African National Liquor Act 59 of 2003 stipulates taverns' operating hours as between 10:00 and 00:00, Monday to Sunday, though these may vary by province. This helps to explain Dumisani's stressing how men frequent spaces and the associated practices.

During fieldwork, I had the opportunity to engage one of the tavern owners, Mr Thapelo (pseudonym) in Modimolle, for insights on how taverns operate. On other occasions I observed how patrons interacted at different taverns. In my informal engagement with Mr Thapelo, he told me that his liquor license provides for him to operate his tavern from 10:00 am to 02:00 am, and this is applicable to taverns in Modimolle and the province of Limpopo as a whole. The other provision on his liquor license is that the tavern must have a kitchen where food is prepared and sold to customers. However, Mr Thapelo did not have an operating kitchen facility in his tavern for preparing food intended for sale. Outside his tavern were small entrepreneurs who put up braai stands to roast chicken feet for sale to the tavern patrons. These braai stands are usually set up in the evenings on weekdays and early afternoons during weekends when many tavern goers frequent the space. While conducting ethnography, I visited another tavern in a different section of the township owned by Mr Mashego (pseudonym). I noted that the tavern owner cooked pap (soft porridge) and meat outside of the tavern, under a

shade. My informal engagement with one of the patrons who frequents Mr Mashego's tavern revealed that this food was given to the tavern patrons for free in the afternoons. Through further investigation, I ascertained that Mr Mashego does so to outcompete other tavern owners for customers for his liquor business. While the food incentive is designed to tap into the market for customers, Mr Mashego's practice comes with health benefits for beer-drinking patrons: they get a proper meal. This helps to contextualise Dumisani's assertion that most men frequenting taverns have no time to prepare a decent meal, something that weakens their immune systems to fend off TB infection. The WHO (2022) confirms that there is a higher chance of developing TB disease among people affected by undernutrition, smoking and alcohol consumption.

More than three-quarters of my participants self-reported they smoke cigarettes and by extension, the majority pointed that smoking and beer drinking caused them to contract the disease. While literature shows that cigarette smoking and alcohol consumption are risk factors in TB infection (Gegia, Magee, Kempker, Kalandadze, Chakhaia, Golub & Blumberg 2015; Louwagie et al., 2014; Soh et al., 2017; Wessels et al., 2019), the findings of my study extend and deepen this understanding by demonstrating that sociability among men heighten TB transmission and infection. In particular, the social practices of sharing cigarettes and beer are central to the epidemiological understanding of TB among men. The practices of sharing beer between patrons involve drinking from the same bottle and sharing of cigarettes entails smoking and exchanging the same cigarette. As presented in Chapter Four, a synoptic ethnographic overview of a shebeen illustrated how patrons engaged with space for entertainment and sociability. Shebeens and taverns tend to be overcrowded, especially during weekends and at the end of the month when patrons receive their wages and salaries. Below are excerpts from Timmy and Charles summing up most men's sentiments on factors they suspected put them at risk of contracting TB:

> **Eddie:** But what do you think made you to contract TB?
>
> **Timmy:** Erm, eish, I cannot say because I meet and mingle with a lot of people. Serious, I am not sure. But actually, let me be honest with you maybe it can be a result of sharing cigarettes. I think so because as men we share cigarettes a lot and TB is very prevalent among men. A lot of men have gone through TB treatment. In my case I did not hide my TB status to the people I hang out with. After disclosing my status, a lot of my friends came forward to disclose that they also went through TB treatment. Had I not disclosed my TB status I tell you; they would have just kept quiet about their status.
>
> **Eddie:** Is this your group of friends or what?

Timmy: Not really my group of friends but people that I know, and we just hang around and talk and then you hear another confessing that I also went through TB treatment, and you hear another saying the same thing that he passed through the process of TB treatment some time back.

(Interview with Timmy, 10 September 2020)

Charles: I remember that I was living with two people that I know very well. The other one died, and the other was still on TB treatment. I used to smoke and drink with them, and I suspect that they are the ones who contributed to my contracting TB. I used to be so close with them and we would share almost everything.

(Interview with Charles, 7 September 2020)

'…I meet and mingle with a lot of people', as asserted by Timmy, is a statement demonstrating sociability within specific spaces. By extension, the sociability involves practices of sharing cigarettes and beer together and within that context Charles suspected he could have contracted TB from his peers. These sharing practices among men occur with no obligation on whoever is next in line to buy a beer bottle or cigarette, for instance. These performances of masculinity are driven by certain sociocultural values. There is a shared sense of communality, togetherness, and Ubuntu among men when they gather in taverns and shebeens. It is not an understatement by Charles that 'we would share almost everything.' While the sharing practices manifested around masculinity in sociability cannot be detached from the economic climate of unemployment and poverty, it must be emphasised that this masculinity is deeply embedded in sociocultural values and practices that emphasise sharing. This is summed up in the Sepedi proverb that states "*Bana ba motho ba ngwathagana hlogo ya tšie"* (loosely translated to mean that sharing is caring regardless of how little you have).

Inadvertently, this sharing of almost everything extends to sharing TB. Evidence shows that smoking is a risk factor for TB, fundamentally when it acts to heighten "the susceptibility of the human host or the probability of transmission by encouraging infectious individuals to cough (this requires smoking to be a social as much as an individual pursuit)" (Bothamley, 2005, p.527). In addition, Wessels, Walsh & Nel (2019) argue that TB sufferers who smoke have a nine times higher risk of mortality than those with the disease who have never smoked. Timmy's interview clearly demonstrates that cigarette smoking is a social activity, as he mentions the sharing that occurs among the people he 'meets and mingles with.' It is also important to mention the purpose of narrative in the sense provided by Timmy. Narratives, according to Blaxter (2010, p.67), serve multiple purposes which include transforming "individual experience into collective experience." In his narrative, Timmy tended to

homogenise his smoking practice as a common experience among men, and among whom he concedes TB is highly prevalent.

When men gather in spaces of entertainment and leisure for sociability, the social practices permeating the relations are identity markers of masculinity. These identity practices occurring in physical proximity are consequently implicated in the transmission of infectious diseases, particularly when they occur in poorly ventilated spaces where men share the same air for prolonged durations of time. This resonates with literature that "[t]ransmission of M.tuberculosis from an infectious source case to people with whom they share air is governed by several factors, among which are the closeness of contact and duration of exposure" (Morrison et al., 2008, p.364). Arguing in the context of Nigeria, Dumbili (2022, p.6) further asserts that there are some control measures governing men's practices when they come together for alcohol drinking because "most men valorised heavy drinking." Thus, refusal to partake in beer drinking with social networks is automatically sanctioned where one is told not to occupy these leisure spaces (Dumbili, 2022). Another critical and overarching layer of information on the complexity of TB infections among men is the non-disclosure of TB status, considering men's venturing out into public spaces and the quest to belong. Men's behaviours in this regard are paradoxical. This is so because their masculinities revolving on communality, cohesiveness, and belongingness in sharing cigarettes and beer wane as they fail to share and disclose their TB status within their social networks, as demonstrated in Timmy and Charles' accounts above. It is possible that this reluctance to disclose TB status to friends is driven by the fear to appear vulnerable. This resonates with Motimele's argument (2021, p.61) that African men's identities continue to be overly dominated by interpretations that "insist on black male vulnerability as aberration and an intuitively untrustworthy space."

A study conducted by Edginton et al. (2002) on TB beliefs in Tintswalo district of Limpopo found a third of the sampled TB patients attributing the disease to smoking or beer drinking. My findings, on the contrary, emphasise the social practices of cigarette and beer sharing as the routes participants ascribed to TB infection. Importantly, these social practices occur in proximity among and between men within specific spaces. A reflection on my ethnographic experiences takes me to Monday, 7 September 2020 during fieldwork where two of the community health workers were tasked with following up on 30-year-old Lawrence and 39-year-old Charles who had been lost from TB treatment. This mandate to follow up on the two men resonates with the concept of 'therapeutic clientship' that borders on surveillance techniques extending from the clinic into clients' homes to produce "responsible and adherent"

men (Zhou, 2019, p.633). According to Mason et al. (2016, p.211), "[t]uberculosis is an excuse to co-opt the poorest classes into participating in global networks of consumerism."

I accompanied the CHWs to Charles' house in the morning but could not find him at his place of residence. With the help of his brother, we managed to track Charles to a house directly opposite a tavern where he was seated among a group of men who were drinking beer. This was well before 10:00 am, the time by which taverns are permitted to open for business. This explains why men were gathered in a space opposite the tavern. Although it was a Monday morning, the men were already drinking beer. Important questions arise as to how and where these men managed to access alcohol before the opening of the tavern. In support of my observation above, a study conducted in a South African village in Mpumalanga province by Mfecane (2011) confirms that beer consumption is a marker of masculinity construction. It is important to mention forthwith that Charles' brother knew exactly where to find him, an indication that this was Charles' regular space for socialising. As previously argued, space is gendered and the social practices within space crystallise gender identifications.

As mentioned above, Charles was lost from TB treatment, through treatment interruption. Although he was seated among beer drinkers, my interview with Charles indicated that he was not drinking beer at that moment. This finding contradicts Dumbili's (2022) assertion that non-participation in beer drinking among beer drinkers invites a sanction of exclusion from spaces where men gather. At one point during fieldwork, I managed to have an interview with Tracey, who was Charles' aunt and his caregiver. Tracey had the following to say about her nephew:

> **Tracey:** Every morning, upon waking up he [Charles] would go to the tavern. By that time, he had since stopped drinking alcohol because his body was so weak to allow that. He would visit the tavern just to hang out with friends.
>
> **(Interview with Tracey, 5 October 2020)**

The crucial finding from my study is that spaces where men gather serve various purposes, chief among them being sites for masculinity performance. While beer drinking is associated with masculinity construction, some men access these spaces for purposes of belongingness as stated by Tracey that Charles would frequent the tavern 'just to hang out with friends.' Although Charles had become weak in his body as stated by Tracey, he still felt a sense of belonging among his beer-drinking friends within a tavern or in a separate space where men coalesce. It is through accessing these spaces that relations are created, cemented and the latest local or international soccer matches and results are discussed. Notwithstanding that Charles was not drinking beer, the physical proximity with each other punctuating the gathering of

these men is an important dimension to our understanding of how TB, an infectious disease, is spread among men.

Similarly, Timmy and James, both unemployed and diagnosed with TB, preferred hanging out with others than staying indoors, believing it to be beneficial for their health. Timmy and James shared their experiences as follows:

> **Timmy:** You see, in situations like mine where you are just idle without doing anything [unemployed] you end up thinking too much if you just sit alone at home. So that is why in most cases I take my time and go to hang out with other people and share issues together and people laugh and have fun. From there I come back home feeling better. But if I keep to myself, I end up watching TV all the while without concentrating. My mind will be far away [absent-minded].
>
> **(Interview with Timmy, 10 September 2020)**

> **James:** I am one person who would not lie in bed because of TB. I would force myself to walk away from the house to be with other people. I would make sure I leave the house just to go and mingle and talk with other people. I avoided sitting alone because if you always isolate yourself from other people that is when the disease affects you a lot because you will be thinking about your condition a lot.
>
> **Eddie:** Oh, you mean you end up thinking about the disease?
>
> **James:** Yes.
>
> **Eddie:** But how did that process of moving out to be with others help you manage your condition?
>
> **James:** Nna, [I] used to keep company with guys older than myself. Mostly, these are people like your traffic officers and police officers. We would drink beer together. They would ask me what was going on with me and I was open to disclose that I was on TB treatment. They used to encourage me to stick to my treatment schedule and to be patient with the process for my own health, you see.
>
> **(Interview with James, 24 August 2020)**

To manage their illness experiences, both Timmy and James took decisions to go out and be among other men (and women). This urge for belongingness as men is crucial in the context of a debilitating and stigmatising disease. Fundamentally, being unemployed and having TB is a double burden among working-class men, contributing to negative health outcomes. Despite this double burden, Timmy and James found a sense of belonging among other men. In the process, they fulfilled their need for beer in addition to receiving social support. Timmy eloquently shows how this belonging among men within specific spaces was a beneficial process, alleviating TB suffering and ensuring he returns 'back home feeling better.' By

hanging out in the company of other men at a car-washing space, James managed to involve himself in washing people's cars for income. Therefore, men access sociability spaces for belongingness, communality, sharing and socialising to cope and manage the psychological burden of having TB.

The social practices of beer drinking and smoking generate solidarity, belongingness, and cohesiveness among members of the social network. While some men access space as a coping mechanism against TB illness, these spaces become vectors of the disease. Furthermore, during our conversation with Timmy, he received a phone call when he was responding to my question on the process of TB treatment. He responded by saying that "Yes, I skipped treatment [Timmy's phone rings and interrupted the flow of his response]. Sorry, can I please answer this phone?" **(Interview with Timmy, 10 September 2020).** After finishing with the phone call Timmy urged me to hurry up with the interview because the phone call was from a friend who asked to meet him in relation to a work opportunity. After finishing our interview, I gave Timmy a lift to a house where a group of men and women were gathered outside playing dice. This space served as a meeting place for Timmy and the caller, highlighting the critical role that sociability spaces play for men in terms of information-sharing, conviviality and – ironically – as channels for the spread of TB.

To reinforce and crystallise the interplay of space, social practices, and TB infection among men I had a conversation with 36-year-old Richard who lived with his sister and niece in an RDP house. Richard had completed Grade 12 and was employed as a cleaner at a garage. I asked him about his understanding of TB, to which he responded as follows:

> **Richard:** You know what I realised with TB; the way I see it is that TB infects you especially if you are not careful about the people that you hang out with. For us youths, TB attacks us too much because we play indoor games like TV games and PlayStation together. In my case I became aware that I had TB immediately when I started playing the PlayStation game with my friends… After being diagnosed with TB I did not keep it as a secret to myself but went back to my friends and I disclosed to them that I had been diagnosed with TB, only to find out that there was someone in the group we played with who was also taking TB medicine but was afraid of disclosing his status to us. Since he kept his illness a secret, we kept smoking cigarettes and drinking beer together with him. The guy then disclosed how he had been on TB treatment but defaulted/discontinued because as he said, he was ashamed about what we would say because of his condition and the treatment he was taking… I then went ahead to talk with all the group members we used to hang out to say, 'guys, I see we are having fun playing the games but I don't think it is beneficial for us to continue playing the games

in this room. I think we need the room to be cleaned and because of lack of proper ventilation, we must stop using it.'… Now we are playing our games in an open space. We no longer play in the room. The reason we were playing in the room was that we wanted to keep to ourselves as a group and stop other guys from joining us not knowing that we were actually killing ourselves. I told them that now we are in the midst of coronavirus, what if it had been COVID-19? We would have infected each other, you see.

Eddie: But tell me about the room you were playing the PlayStation and TV games.

Richard: It was a mokhukhu [tin room or shack]. The place which we now use is just an open shelter and there is a free circulation of air.

(Interview with Richard, 8 February 2021)

Richard is knowledgeable about the mode of TB transmission possibly because of his educational status. At the core of his narration is the gendered access to space for entertainment and the social practices of playing games, smoking, and drinking beer together. All these practices cement belongingness among friends to the extent that the group members created mechanisms to exclude outsiders from joining them. In addition, the social practices that occur among men and within spaces of entertainment reinforce the purchase of masculinity in sociability. The articulation by Richard resonates with research conducted in Zambia on the transmission efficiency of TB where it was found that women were on average spending most of their time at home while men frequented spaces of recreation to watch movies in "small makeshift tented 'theatres'" (Murray, Dodd, Marais, Ayles, Shanaube, Schaap... & Bond, 2021, p.6). From Richard's narration, the shack did not have proper ventilation. Although I did not physically see the mokhukhu Richard was referring to, his story illustrates that the space was poorly ventilated, and the group members understood the need to change the space for their social practices of entertainment. The shack accessed by Richard and friends sounds like the makeshift 'tented theatres' of the Zambian study which "were darkened as much as possible to enhance viewing, by closing gaps in the tarpaulin, which in turn limited ventilation" (Murray et al., 2021, p.7). In addition, closed indoor spaces with "limited air circulation and minimal UV light exposure" provide a fertile environment for "airborne particles containing *M.tuberculosis* to remain viable and infectious" (Mathema et al., 2017, p.S645). The fact that one of Richard's friends had been diagnosed with TB and interrupted treatment puts every group member in danger of TB infection. The Zambian study further concluded that, as a form of routine leisure activity, watching video shows carries "high presumptive risk for *M.tuberculosis* transmission because of the darkened, poorly ventilated and contained space in which it is conducted (Murray et al., 2021, p.8)."

TB is a social disease and among men the disease is clearly mediated by the social practices that occur when men gather in spaces of entertainment and sociability. Considering that I carried out my fieldwork during the COVID-19 pandemic, access to space and the associated social practices did not comply with social distancing. At the centre of an analysis of TB infections among men are masculinities that are generated in sociability spaces. These masculinities revolve around the importance of communality, belongingness, and cohesiveness among men, with clear boundaries being enforced against outsiders. It is this important notion that I term masculinity in sociability, driven by the values of ubuntu (botho), seriti (dignity and integrity), seemo (positive standing) as well as maitshwaro (conduct and manners), that fosters belongingness when men come together in spaces of entertainment. The social practices of sharing cigarettes and beer reinforce masculinity in sociability among men. The common denominator binding these men as evidenced above include entertainment, social practices of sharing beer and smoking together in closed spaces.

While men come together as a group for entertainment, the problem of non-disclosure of TB status is common and it emanates from fear of ostracisation linked to the stigma associated with the disease. The fact that a friend from Richard's circle did not disclose his TB status is revealing, as it highlights the concept of anticipated stigma (Earnshaw & Chaudoir, 2009; Pantelic et al., 2022; Quinn & Chaudoir, 2009). Anticipated stigma pertains to the expectation held by individuals with a concealed stigmatised identity that others will stigmatise them once this identity is revealed (Quinn & Chaudoir, 2009). The friend from Richard's circle "was ashamed about what we would say because of his condition and the treatment he was taking." Anticipated stigma fuels treatment interruption among men, and in this case, it exposes not only the individual TB sufferer to developing multidrug-resistant TB but heightens TB infection among the group members. The group members welcomed Richard's TB disclosure, and this earned him respectability rather than ostracisation. A study conducted in Bushbuckridge by Mfecane (2011), which centred on therapeutic citizenship among males living with HIV, found that disclosing their HIV positive status allowed some men to redefine their masculinity, become role models, and earn respect.

The architectural configurations of taverns, shebeens, makeshift movie/game theatres, and other entertainment spaces lack adequate ventilation, making them potential incubators for the spread and infection of TB among men. Elsewhere in Zambia, a sociological analysis of TB transmission provides evidence of overcrowding in bars and taverns and that these spaces are poorly ventilated. Small windows serve as a precaution against theft (Murray et al., 2021). The

spaces of entertainment and sociability as shown in this section often connect with practices of sharing cigarettes and alcohol among patrons and this provides a bird's-eye view of TB transmission and infection among men. The tobacco industry is implicated in the TB spread and infection among men. Global estimates show that up to 20% of TB cases are attributed to tobacco exposure (Gegia et al., 2015). Drawing from Oni et al. (2012), Wessels et al., (2019, p.2) argue that smoking suppresses the immune system, thereby heightening TB infection and progression.

Concluding remarks

In this chapter, I provided a contextual mapping of what participants believed to be masculinity identifications in Modimolle. I also examined the social determinants of tuberculosis by unpacking the structural conditions within which masculinities are formed and manifested through the kinds of work men do. I demonstrated the inseparability of the working and living conditions for an understanding of the ways men contract tuberculosis. I emphasised the connection between socioeconomic class and the gendered contraction of the disease. According to Singer (1995, p.90), disease should not be solely viewed as a pathological occurrence in nature but rather as the result of social processes situated in historical contexts. Singer's (1995) argument helps us to analyse TB and the spread thereof among men through the political economy and social production of health. The argument implies that understanding tuberculosis goes beyond its mere biological or pathological aspects. Additionally, it emphasises the importance of considering the broader social, economic, and historical factors that contribute to the emergence and spread of diseases. This perspective suggests that health outcomes are influenced by social inequalities, economic systems, and historical contexts, highlighting the interconnectedness between health and broader societal structures. Therefore, addressing health issues effectively requires analysing and addressing the underlying social determinants of health within specific historical and socio-economic contexts. Against the backdrop of high unemployment in Modimolle and in the country, men are forced to make hard choices between access to healthcare services and their paid work, often choosing the latter. This has implications for the spread of tuberculosis. As I demonstrate in this chapter the poor living arrangements in the home context are closely linked to limited space in two-bedroomed RDP houses and in shacks. The limited and limiting space within RDP houses and shacks is associated with overcrowding where men's interaction with other TB-infected household members heightens the risk of infection.

Through adopting an African-centred theory of masculinity, I deepened and stretched its application by revealing the important sociocultural values that define a man within the given context. I emphasised the centrality of the concepts of seriti (dignity, personality, and respect), botho (humanness), maitshwaro (manners and conduct/behaviours), seemo (the condition), and mediro (works/deeds) as masculinity identifications. These conceptual strands are the fountains upon which masculinity in sociability is configured, expressed, and performed within the context of this study. Masculinity in sociability engenders the ethos of sharing, communality, cohesion, and belongingness when men come together in spaces of entertainment. Working-class men's access to spaces of recreation like shebeens and taverns for beer drinking is contextually connected with a resource-constrained environment of limited employment opportunities. In more or less parallel ways to the condition of the working-class man in Modimolle is the evocative description of the working-class in nineteenth century England which, for purposes of the reproduction of labour, were "deprived of all enjoyments except that of sexual indulgence and drunkenness, are worked every day to the point of complete exhaustion of their mental and physical energies, and are thus constantly spurred on to the maddest excess in the only two enjoyments at their command" (Engels, 1993, p.112). While this chapter did not discuss men's sexual relations, it is the social practices of beer drinking in taverns which, to a greater extent, is men's clearest source of entertainment.

I further reinforced that the social relations of smoking and beer drinking are important for understanding TB infection and spread in Modimolle. This distinction is crucial in ensuring specific TB control measures are sensitive to the sociability of alcohol use and smoking. Architecturally, taverns and shebeens do not have adequate ventilation making these spaces and the associated practices vectors for TB transmission and infection among men. The time spent in spaces of entertainment and sociability deprives men from eating healthy meals, further predisposing them to opportunistic infections like TB. In the same vein, Engels (1993, p.117) argues that "[a]ll possible temptations, all allurements combine to bring the workers to drunkenness. Liquor is almost their only source of pleasure, and all things conspire to make it accessible to them." While Engels' context is nineteenth century England, his conclusions resonate with the context of twenty-first century South Africa where access to liquor taverns – with more than 15 operating hours per day – are easy because these spaces are situated in residential areas. Engels further argues that because of the exhausting nature of the working-class man's work and the comfortless condition of his home, the public space or tavern in this case becomes the best space for recreation. This, as Engels (1993, p.117) asserts is because he

desperately “demands some external stimulus; his social need can be gratified only in the public-house, he has absolutely no other place where he can meet his friends. How can he be expected to resist the temptation?” It is this ‘temptation’ to belong in space and the associated social practices that occur therein that holds an important key to our understanding of ways TB is spread among working-class men in non-mining communities like Modimolle. The next chapter extends masculinity theorisation through an analysis of men’s TB illness experiences.

Chapter Six

The night side of life: Illness experiences and masculinity identities

I also ask myself why we as men do not want to talk about our situation when we are in serious problems. I do not know or maybe it is because of what we used to hear growing up that monna ke nku o llela teng in sePedi [literally means a man is like a sheep he does not cry or simply, men don't cry] because when they slaughter a sheep it does not make noise. It is quiet; it is silent. It would be in pain, but it will not make any noise. Therefore, as men, we are like sheep. ***(An interview with 27-year-old Erick recorded on 18 August 2020 during fieldwork on men diagnosed with tuberculosis).***

Introduction

Premised on African ontology, the preceding chapter illuminated masculinity identifications in context. The chapter highlighted that gender and socioeconomic class intersect in raising men's risk of TB infection. This I did through exploring the social determinants of tuberculosis. I analysed the implications of working and living conditions in predisposing men to TB infection. Through a masculinity lens, I demonstrated that the resource-poor setting of Modimolle does not overwhelmingly reflect the traditional ideals of men as independent homestead makers and providers. I thus demonstrated the formation of masculinity in sociability among men. Masculinity in sociability is conceptualised and underpinned by sociocultural values of seriti, seemo, botho and maitshwaro and is expressed and performed in public spaces of entertainment where men congregate. The chapter demonstrated how masculinity intertwines with sociability, highlighting how gender shapes the use of space. It illustrates how specific social practices, like sharing beer and smoking cigarettes in close physical proximity among friends, actively express and perpetuate masculinities. These sociability practices occur within poorly ventilated spaces where men stay for extended periods of time. All these factors conspire in the creation of a fertile environment that enable the spread of and infection from TB. Through notions of masculinity in sociability I deepen and expand on African-centred theories of masculinity in a study about men and TB. While acknowledging that mining and the oscillating labour migration are important analytical lenses for the spread and infection from tuberculosis, I argue the need to investigate social relations in spaces

frequented by men as important pathways to the spread of tuberculosis in non-mining communities.

In this chapter, I delve into men's encounters with tuberculosis, tracing their journey from expressing masculinity in social contexts to navigating their interactions with health systems for TB diagnoses. In this chapter, I explore men's experiences of TB as they transition from a performance of masculinity in sociability into the private sphere of the home. At home, men's focus on maintaining their masculine identity shapes their experiences with TB illness. This occurs even though the TB illness experience is a significant life event that disrupts men's established values of masculinity and their associated performances. Russell (2019) argues that the possession of physical capital in masculinities through a healthy body is integral as it mediates accrual of other forms of capital – social, cultural, and economic. Through men's detailed accounts of living with TB illness, I argue for the need to historicise masculinities. I do this by thinking about and through sociological concepts such as illness narrative, illness as metaphor, stigma, and biographical disruption. This helps me to showcase the fluidity of masculinities. In essence, this analysis reveals that as gendered beings dealing with tuberculosis, men require social support when appropriating an illness identity to achieve positive health outcomes. Along the process of assuming and accepting an illness identity, how does a man adjust and accommodate this new identity and remain a man? The next section takes the reader through ways men experienced TB illness.

Tuberculosis gnaws at you (*Bolwetsi bja TB bja go kokona*) – men's experiences of the disease

Considering the high prevalence of tuberculosis among men, understanding the disease from their perspective is important; not only to deepen knowledge of men and health but also to help develop targeted intervention strategies. This would result in relevant and evidence-based measures to close the identified knowledge gaps about the disease at community, provincial and possibly the national levels. In addition, and as argued by Makgopa et al. (2022, p.2) "[f]or TB control efforts to succeed, it is important to understand the way of living with the disease from the infected persons' perspective." This section unpacks the ways men described their experiences before and after TB diagnosis. It also establishes the suspected causes of the disease.

There was an overwhelming understanding from participants that TB is a curable disease. The healthcare workers impressed this stock of knowledge upon participants after a TB positive diagnosis. Diagnosed with meningeal tuberculosis, Frank had the following remarks when I asked for his understanding of the disease:

> **Frank:** You know as they say, they usually tell us that TB is not dangerous because it can be cured. It just needs you to take your medication and that is all. That is how they educate us. It will not kill you if you properly take your medication. My understanding is that TB only requires you to follow the procedures of taking medication properly and then that is it, you will not be in danger of it. That is the understanding that we have, that TB does not kill. TB is curable. Treatment takes only six months then you will be fine. That is the knowledge we have.
>
> **(Interview with Frank, 22 September 2020)**

Having set out the basic understanding that TB is curable, there emerged a continuum related to participants' general knowledge of tuberculosis. As a researcher I was not interested so much in how accurately respondents understood the biomedical definitions of tuberculosis. I follow the argument of Fassin (2007) that social scientists working on sickness are shifting their gaze from a purely biomedical analysis towards the value of narratives and meanings. I was therefore interested in the meanings the participants attached to the tuberculosis disease through their own narratives. This is important because health and illness are context specific. In the same way, tuberculosis elicits different meanings and experiences from participants. In my study, few participants on one side of the continuum expressed no knowledge of tuberculosis except how they experienced the disease. Nevertheless, this lack of TB-related health literacy does not minimise their contribution to the discourse on men and health as they possessed nuanced experiences. In the middle of the continuum are participants who expressed that the disease is airborne but could not actualise what possibly predisposed them to infection. They expressed shock at how they discovered they were infected with the disease, to the extent they asked the important question "Why me?" On the other end of the continuum are participants who had an adequate biomedical understanding of how TB is spread, and how they possibly contracted the disease.

Although he acknowledged a positive diagnosis, TB and HIV-co-infected Silas could not attach a definition to tuberculosis except graphically describe how he experienced the disease and what it did to his body. This is crucial because he experienced and suffered the disease in his own body – and these illness experiences form the basis of this thesis. The meaning that Silas

attached to TB is that it is insidious as it gradually gnaws at one's body. My conversation with Silas occurred thus:

> **Eddie:** I am interested to find out what your understanding of TB is. What is TB?
>
> **Silas:** I am not so sure what kind of a disease TB is, but I see that bolwetsi bjo bja TB bo a kokonanyana mo mothong [TB gnaws at your body]. Bo a kokonanyana [It gnaws at you]. [Laughing]. (**Interview with Silas, 24 September 2020)**

That Silas could laugh amid his gloomy description of TB is a way he attempts to make light a weighty and horrendous illness experience. It is a way to manage the illness experience. Even though he accepted the illness, Silas does not lose his identity and this he demonstrates through the way he laughs off the illness. In addition, Silas' reliance on the metaphor of 'gnawing' is "partly due to the lack of linguistic expressions for effectively conveying bodily feelings" (Lupton, 2012, p.56). Sontag and Broun (1977, p.72) add that "[d]isease imagery is used to express concern for social order…" By metaphorically expressing that tuberculosis gnawed at him, Silas was making a statement about his longing for balance, social order and harmony of the masculine body with its associated relationship to other forms of capital. Although Silas could not pointedly describe what TB is, his description of how it impacts the body is crucial; it summarises what most of the participants in the study felt when they described the effects of TB. The description by Silas shows the debilitating and ravaging nature of the disease as it makes one lose weight. Silas did not attempt to hide his experiences with TB, and he voluntarily showed me his TB clinic card to illustrate the gravity of TB. Silas was 32 years old during fieldwork. He was still taking his TB treatment. As I looked at his clinic card, there was a point when his weight dropped to 45 kg, an indication of how the disease gnawed at his body. In the same vein, Patrick and Timmy describe their experiences of TB through weight loss in the following manner:

> **Patrick:** I lost almost half of my weight during the time when I was suffering from TB. I became underweight. You know the lungs are the respiratory organs and are the main engine of the body, you know. If they are attacked, it means you lose weight and other symptoms follow. A healthy person feels good about himself or herself.
>
> **(Interview with Patrick, 15 September 2020)**
>
> **Timmy:** But I was not coughing repeatedly, I was becoming skinny, and my face was also getting skinny [losing weight]. (**Interview with Timmy, 10 September 2020)**

As with Silas who showed me his clinic card, Timmy similarly showed me the picture on his ID card taken at the Department of Home Affairs immediately before a TB diagnosis. The

picture showed him with sunken eyes. In his thesis on seriti (dignity) among the Pedi in Limpopo, Rathete (2007, p.44) argues that besides making someone weak, illness "attacks not only the body of a person, but also affects a person's dignity (seriti)." When one considers that masculinity in sociability as previously discussed is embedded, among other norms, within the sociocultural values of seriti, tuberculosis illness in this case destabilises such identifications. In other words, the concept of seriti (dignity) which is attacked by illness as argued by Rathete (2007) is illuminating in this section as men revealed not only how their bodies were gnawed by tuberculosis, but metaphorically also their dignity. When one suffers drastic weight loss from illness, one's dignity is threatened. In addition, the metaphor of illness 'attacking' the lungs as the 'main engine of the body', as stated by Patrick is important because it brings out images of war that found resonance with most of the interlocutors. They presented metaphors of 'weakened body soldiers' (weakened immunity) when they described how they became infected with TB. The metaphor of 'attack' conjures up images of physical strength in line with traditional norms of masculinity that valorises strength and invulnerability.

According to Sontag and Broun (1977), TB is a disease of the lungs, and Patrick crisply shows how pulmonary TB 'attacked' his lungs and made him lose weight. This connects with the metaphor of 'gnawing' induced by the disease, as raised by Silas. At a point I engaged a Pedi colleague for some deeper reflections and meanings of *go kokona* (gnawing). To illustrate the metaphor, he used the example of a dog biting and chewing a bone. In the process of gnawing a bone the dog persists in drawing out the marrow to the point where the bone is left with no marrow at all. It is important to mention that context about the kinds of dogs that can gnaw at a bone differ. A dog that gnaws a bone in this regard is indicative of a particular context of scarcity and marginality. Having grown up in rural areas and in townships, the colleague's example resonated with me and made me understand what TB does to a human body. Most participants reported the persistent and gradual gnawing away at a human body that TB inflicts, leading to weight loss. Similarly, and aptly, the metaphor of a dog captures that TB is a disease of poverty. Literature shows the importance of metaphors in that people "who have experienced illness or disease have often reverted to metaphorical discourse to conceptualise and articulate their experiences to themselves and to others" (Lupton, 2012, p.56). In addition to manifest weight loss, men experienced TB as a dangerous disease, as reflected in the words of 27-year-old Erick:

> **Erick:** This thing of TB is more dangerous than HIV and AIDS, I am telling you. This thing is dangerous. TB is very, very dangerous. Once you cough, you cough the blood

> and that means there is a piece of meat that is coming out from the lungs. Your lungs are getting hurt [O kwiša mafahla bohloko]. As you cough blood, there is a piece of meat that is coming from your lungs. Your lungs are being damaged. It is very painful.
>
> **(Interview with Erick, 18 August 2020)**

Erick's comparative conclusion of TB and HIV illness experiences was experiential as he was co-infected. In their study in Malawi, Nyasulu, Phiri, Sikwese, Chirwa, Singini, Banda... and Munthali (2016) confirm similar findings where participants expressed the devastating and serious effects of tuberculosis. In a graphic manner, the description that a 'piece of meat …is coming out from the lungs' is testimony to the damage the disease inflicts on the body. Writing on chronic pain, Good (1994, p.124) argues that "pain has agency...Pain is an 'it'…a force which streaks around the body" in a similar way to how Erick describes the pain caused by TB as 'this thing.' Erick accords agency to the pain caused by tuberculosis. Sontag and Broun (1977) argue that the social order is implicated in the imagery of disease. Disease occurs in a social context and since TB is a social disease, the metaphor of *go kokona* (gnawing) can be equated to the South African state's insidious, corrupt activities that tend to rob the already marginalised; they do not enjoy proper healthcare delivery services. It speaks to the state's neglect of its citizens when it fails to address the social conditions that foment the spread of TB in black communities. In the same vein, De Beer (1986, p.77) argues that any form of (ill) health explanation that does not come back to the implication of "social structures on the health of the population, is helping to keep those structures intact, and prolonging the creation of unnecessary illness."

Considering the above participants' graphic presentations of the debilitating nature of TB in relation to acute weight loss, is the association with stigma. The underlying issue connecting TB illness with stigma in the community seems to be the conflation of the disease with HIV/AIDS. Both diseases bring out seemingly identical symptoms. However, the dominant sexual route of HIV transmission seems to bring out the stigma that bears on TB. This resonates with Conrad and Barker (2010)'s constructionist assertion that there is nothing intrinsically stigmatising about a condition except the social response to the condition, its manifestation and the types of individuals that suffer from the condition. In my conversations with the community healthcare workers for instance, they emphasised that TB is highly likely to occur among HIV positive individuals. In addition, the inaccurate understanding about TB and its transmission is to blame for some of the stigma. My interlocutor, 39-year-old Thuso who dropped out of school in Grade 8, remarked as follows about TB transmission:

Thuso: To be honest, I can say TB goes hand in hand with diseases like AIDS because they even mention that if you are not taking good care of yourself, TB turns into HIV/AIDS. On radio, they tell us that TB can turn into HIV. That is what experts say. Is it not that ourselves we know nothing?

(Interview with Thuso, 21 June 2020)

Literature on TB beliefs in Tintswalo district in Limpopo confirm that both TB and HIV/AIDS were strongly related and stigmatised illnesses, and that the beliefs in the sexual origin of TB aggravated the stigma (Edginton et al., 2002). In the excerpts below from Herbert and Timmy, the participants demonstrate the stigma they experienced during TB illness. In both cases, the weight loss induced by the illness and its association with death attracted stigmatisation. They both recounted the following when I asked about people's reaction during their illnesses:

Eddie: What was the reaction from people during your illness?

Herbert: It was very bad because even as I would walk around, word in the street was that at any time I was going to die. People also later confessed to me that, 'hey bro [friend] you once became so ill that everybody was sure that you were leaving us [dying].' People had concluded that ke bolwetsi bo bogolo [the big disease – HIV/AIDS], you see. They were already telling themselves that they would be coming to my funeral. **(Interview with Herbert, 21 September 2020)**

Timmy: Somehow, friends are not the same. Some gave me support and others talked behind my back. A friend who really loves you would come and tell you that they are speaking negatively about you, saying that you are sleeping with many blankets during the day and that you have lost so much weight and that you are thin like this paper [demonstrating with a participant information sheet he was holding]. They are even saying you are dying. I would respond and say that okay, it is fine, I can lose weight and become as thin as this paper but what remains is that the medication that I am taking will assist me. There is no way I must take their negative gossip to heart because I would be killing myself for sure. I would be killing myself instead of recovering, you see. That is the way it is in this world. Some will talk bad and some will talk good about you.

Eddie: How did you manage to cope considering such words from people?

Timmy: I believed what I was told by the father up there (pointing to the sky in reference to his belief in God). He told me that your ancestors are strong, and they do not allow you to go [die] now. Just go and drink your treatment, you will be well. That is why I had strength, and I was able to respond to anyone the way I wanted, saying that no, I am taking my treatment, and it will help me.

(Interview with Timmy, 10 September 2020)

The articulations by both Herbert and Timmy are indicative of enacted stigma that in its classical interpretation originally related to the extent "PLWHA believe they have actually experienced prejudice and discrimination from others in their community" (Earnshaw & Chaudoir, 2009, p.1163). Due to the acute illness that manifested in weight loss, people concluded in metaphorical ways that Herbert was suffering from that 'big disease' (HIV/AIDS). What brings stigma from the community seems to be the moral dimension that one acquired the disease through their own doing, as well as its consumptive nature that leaves a man 'thin like this paper.' The disease gnaws at someone in a similar way HIV/AIDS does. Similar findings on stigma are corroborated in a study on TB by Makgopa et al. (2022, p.9) in Gauteng province where interlocutors stated they experienced discrimination from the "community, family members, friends and their significant others including people at the healthcare facilities." Notwithstanding the stigma that he faced in the story above, Timmy managed to harness some strength from his belief in the ancestors – a clear indication that personhood in the African cosmology goes beyond the physical body and influences masculinity identifications. This finds resonance in Triebel's (2002) articulations that ancestors in African thinking are ubiquitous, and impact lives in relation to individuals' well-being or misfortune.

The second category of participants demonstrated a clear understanding of tuberculosis in terms of its infectious nature. However, what they had been informed to be some common risk factors for infection did not correspond with their lived realities. This created some confusion as to what possibly made them contract tuberculosis. Themba and Fannie, 40 years, and 51 years old respectively, made the following remarks to articulate their understanding of tuberculosis:

> **Themba:** Ahem, for now, ahem, eish, I do understand that it is an airborne transmitted disease but erm how it starts is not clear to me, and I have many questions about that [laughing]. Yah, I do understand it is airborne but if you go to the clinic and stuff, they will ask you if you drink beer or smoke. So, on both of those aspects, I do not qualify because I do not smoke nor drink beer. So, where the disease comes from is what I don't understand. How exactly is one infected?
>
> **(Interview with Themba, 1 December 2019)**

> **Fannie:** They just said it is what by the way? They said these are particles [bacteria] that are just hanging in the air, they just wait for someone to pass by, and they infect the person. I do not know how one is infected. That is how I understand it. However, I just do not know how one is infected. Were those particles just waiting for me? Why

did those particles not infect other people? Why me? Am I the weakest?

(Interview with Fannie, 6 November 2020)

Both participants completed high school and they understood that TB is airborne. However, the biomedical explanation of tuberculosis contraction was not a satisfactory explanation for either, leaving them with more questions than answers. While Themba does not drink beer nor smoke, Fannie indicated that he was a smoker but had since stopped drinking beer for three years. Beer drinking and smoking are some of the behavioural risk factors for TB infection. Closely connected with the aetiology of tuberculosis is the question "why me?" as it goes to the heart of the experience of illness. The two participants asked this question because they were not wholly predisposed to the mentioned risk factors. Pierret (2003) agrees that illness intrusion causes patients and those close to them to question everyday explanations in their pursuit of meaning. Both participants expressed some confusion as to how they contracted the disease:

Themba: It is not that simple to hear about something you did not even expect, like to hear that you are TB-infected. However, the real problem involves failure to have an explanation as to where exactly the disease came from and stuff. It does affect you.

(Interview with Themba, 1 December 2019)

Fannie: It surprises me, to tell you the truth. In my life I never imagined myself being infected and to suffer from such kind of a disease [TB]. Do you know what it means to take care of yourself? Maybe in the process of taking care of myself there is a point I lost focus. Ahem, nna [I] know how to look after myself because I used to work and getting paid R1 000 per month. On top of that, I used to get a disability grant after every three months and you would find me having about five, six or R7 000. I would afford to buy some food for the children as well as putting some money away for savings. The money was able to cushion me somehow… I just told myself to stop drinking beer. That is why I said I take good care of myself. I smoke cigarettes and maybe through sharing cigarettes I contracted TB but the thing that surprised me is why the people that I used to smoke with did not get TB?

(Interview with Fannie, 6 November 2020)

Baffled as my participants were about what predisposed them to TB infection, a study of the health-seeking behaviours of men diagnosed with TB in Gauteng exposed similar findings: participants expressed shock and disbelief as to where they got the disease from (Makgopa et al. 2022). To some extent, the confusion leads people to use alternative health systems for meaning. Through specific health literacy campaigns, key stakeholders can help fill some of the TB knowledge gaps that abound in communities. Other participants like Trust who was a Grade 5 dropout also expressed uncertainty of the causes of TB. He said that:

> **Trust**: Eish, I was surprised when I was infected with TB. I do not know what really caused it in me. However, I am sure this does not apply to me alone but to many people: we do not know what causes TB in us. You just get surprised when you are told that you have TB, but you wonder how it infected you.
>
> **(Interview with Trust, 25 August 2020)**

There are some clear information gaps around TB infection and its transmission, as expressed by Trust and most other participants. According to Ntenda, Mussa, Gowelo, Sixpence, Bauleni, Simbeye...and Nkoka (2021), possessing accurate knowledge about disease transmission and associated symptoms correlates with preventive actions and appropriate health-seeking behaviours. There appears to be inadequate information dissemination to those infected with TB about how the disease is transmitted. This runs contrary to a South African study by Naidoo, Simbayi, Labadarios, Ntsepe, Bikitsha, Khan ... and Rehle (2016) which found close to two thirds of their respondents accurately distinguishing that TB is airborne and transmitted when a person sneezes or coughs. Most of my interlocutors as reflected above could not tell what possibly predisposed them to TB infection. Does this failure to comprehend possible pathways of TB transmission not perpetuate reinfection among the population if predisposing conditions are not changed? The study conducted by Naidoo et al. (2016, p.2) on predictors of knowledge of tuberculosis in South Africa further found that for those with active disease, being knowledgeable and aware of the "infectiousness of TB as a disease was the basis for individuals taking protective measures to avoid becoming infected or transmitting it to others."

On the other end of the continuum are participants who understood that bacteria caused TB and that it mainly affects the lungs. The following is a conversation I had with 28-year-old Patrick on how he understood tuberculosis:

> **Patrick:** You know what, tuberculosis is just a disease caused by bacteria that affects the lungs when your immune system is down. When your immune system is down, erm cannot fight easily transmitted diseases, that is when you contract tuberculosis. These bacteria live in the atmosphere, but it is the bacteria that attacks the lungs. Simple explanation. The illness attacks the lungs when the immune system is at its weak point.
>
> **Eddie:** Okay, but how is one infected with TB?
>
> **Patrick:** You know what, by inhaling the air in closed spaces with another person who is infected with TB and then I can say when the immune system is down, they actually call them easily transmitted diseases [opportunistic infections]. When the immune system is down or is low, such diseases attack, you know.
>
> **(Interview with Patrick, 15 September 2020)**

Patrick completed Grade 12 and compared to his fellow participants in the study, he was more knowledgeable about health and tuberculosis. A study conducted in Lesotho by Luba et al. (2019) found that only a few respondents correctly identified the bacteria behind TB, and this resonates with my study where a few participants like Patrick accurately articulated disease transmission and infection. That tuberculosis is caused by bacteria inhaled because of shared air comes out so clearly from Patrick confirming what is prevalent in literature (see Barberisi et al., 2017; Dutt, 2006; Packard, 1989).

Like the sentiments revealed by Patrick, both Timmy and Frank had completed their matric and they had some clear knowledge of tuberculosis in terms of its infectious nature and the possible conditions for infection like inhaling bacteria-infected dust. This finding concurs with a study by Naidoo et al. (2016) which found that completion of high school was among some of the TB knowledge determinants. Below are the extracts from Timmy and Frank. Timmy was infected with pulmonary tuberculosis (TB of the lungs) while Frank had contracted extra-pulmonary tuberculosis, in his case meningeal TB (TB of the brain) (Bynum, 2012).

> **Timmy:** Oh, the way I heard about this disease is that you cannot be aware that someone has TB because it is not written on the forehead. Make sure you are not too close to anybody so that they do not exhale onto you. The other thing is dust where people spit their phlegm on, when the wind blows, and you inhale that dust you might get infected with TB. It is too dangerous. TB is spread through the air… That is the way I understand TB. **(Interview with Timmy, 10 September 2020)**

> **Frank:** The experience that I have is that we have got erm, three or four types of TB. There is the one you get when you communicate in proximity with a person who is having TB. This TB I am having is that of meningitis [Tuberculosis meningitis] and I have no knowledge of how one gets infected with it because they failed to explain it to me. My knowledge is about the type of TB which infects you because you are communicating in a closed place with someone who already has the disease. The place must be poorly ventilated, and it would be very easy for someone to contract TB. That is the only knowledge that I have. I have never inquired about the other types of TB. I just know about the TB that affects the lungs.
>
> **(Interview with Frank, 22 September 2020)**

Most participants were aware of pulmonary tuberculosis as they constantly referred to its target as the lungs. For instance, Tracey, a caregiver, had said that "[t]uberculosis [ke bolwetši bja mafahla] is a disease of the lungs." **(Interview with Tracey, 5 October 2020)**. In the above extracts, closed spaces, poor ventilation and dirty environments are conducive to the spread and infection with TB. This finding contrasts sharply with a study by Edginton et al. (2002,

p.1077-1078) in Limpopo where the locals understood the disease to be a result of "*tindzhaka (or mafulari* or *makhuma)*, indistinguishable in presenting features from, western' tuberculosis." Members premised this local understanding of TB infection on the infected person breaking societal taboos, such as family members not abstaining from sexual intercourse when a death has occurred (Edginton et al., 2002). However, Edginton et al.'s (2002) study is two decades old; a lot has since changed about TB information. Although some of my participants did not have accurate scientific knowledge about TB, it is interesting to note that their descriptions emphasised tuberculosis is dangerous as it gnaws the human body. In line with medical humanities, Fassin (2007, p.237) calls for the subjectivisation of illness, something this section has sought to do. The importance of this section is that it demonstrated the subjective narratives of how men understand and interpret TB. The next section discusses masculinity identities and the processes of TB illness disclosure.

Masculinities and the disclosure of illness

Regarding the formation of masculine identity in the context of health and illness, most participants expressed the view that a man should prioritise the well-being of both himself and those in his immediate circle. There are however instances in which some men struggled to live up to this standard. Like 28-year-old Patrick, Thabo, also 28 years old in 2020, lived with his mother in a household of four. I asked him his definition of a man and he said that '[f]rom the way I see God designing him, a man is a protector. A man must always be there to protect.' During the onset of symptoms suggestive of tuberculosis and his illness experience, Thabo faced challenges confiding his condition to his mother, opting instead to share his situation with his uncle who resided approximately 105 kilometres away. I inquired about the reason he felt it unnecessary to communicate openly with his mother about his illness:

> **Eddie:** I heard you speak about your uncle who helped you, how did your mum help you during your time when you felt unwell?
>
> **Thabo:** I never shared my health condition with my mother. My mum would only see me coming to the house and just being at home. She is one person that I never explained my situation to. Even when my health deteriorated, I never told her anything, not knowing whether my uncle told her. There are times when I would rather go speak my issues to the sister next door. I would explain to her that I have this and that problem and she would in turn take the issue to my mother. I am not used to sharing my issues with my family here at home.
>
> **Eddie:** But why are you not able to share your health issues with family?

> **Thabo:** Eish, I am just not used to that. I do not know why. It is like when I tell my issues to an outsider, I feel sharp-sharp [feels good]. For me to go straight to a parent with my issues; eish it is hard for me. **(Interview with Thabo, 11 September 2020)**

While talking to Thabo, I observed his open and confiding nature as he shared with me most of his experiences during his illness journey. It came as a surprise therefore when he pointed out that it was 'hard' to share these issues with his mother. He felt greater ease sharing his health challenges with his uncle who lived far away, and with a neighbour, rather than expressing his vulnerability to his mother with whom he lived. Due to the intensity of the symptoms, there came a point when Thabo could not keep his condition from his family:

> **Thabo:** I could not hide the blood from anyone anymore as it became uncontrollable, such that everyone ended up seeing for himself or herself. I started coughing incessantly ke tlatsa madi [vomiting blood]. That is when I realised that there was a problem with my lungs. My brother called for an ambulance.
>
> (**Interview with Thabo, 11 September 2020)**

Could it be that Thabo held the belief that sharing his health problems with his mother was a display of weakness? Could it be that he was attempting to 'protect' his mother from the pain of seeing her son suffer? Considering his statement that, 'a man is a protector'? Thabo's decision not to communicate his illness to his mother, with whom he lives, serves as a clear statement about the type of masculinity he embraces. During acute pain, which Good (1994) argues extends beyond the physical body into the social realm, it follows that men can maintain their identity even amid such pain. To some degree, Thabo's perception of masculinity was that a man must not display vulnerability. This belief contrasts with the importance of illness disclosure to family members, which is crucial for receiving timely help to protect against the debilitating consequences of TB.

In contrast to Thabo, James' ability to disclose his health to other men ensured him access to important advice on TB, a resource that helped him manage the illness experience with positive health outcomes:

> **James**: Yes. I used to congregate among men who are older than I am [majita a magolo mo go nna] at the car wash [which is about 500m from where he stays]. I socialise with the men that bring their cars there and many of them are lawyers and police officers by profession. The other guy who comes there works at the hospital and he used to help me with advice on dealing with my TB condition. I did not take the advice for granted or despise it. I would listen attentively to their advice and follow through until I managed to recover. **(Interview with James, 24 August 2020)**

When James began suffering from TB illness, he did not alienate himself from others. Besides reinforcing a masculinity identity fashioned around belongingness, the process of sharing issues with others acts as a support mechanism through which one gets encouragement and advice necessary to manage illness experience.

While Silas' TB illness experience 'gnawed' at him to the extent of alienating him from others, he did not hesitate to disclose his illness to family members. Added to his illness disclosure, Silas also cautioned family members against getting close to him for fear of infecting them with the disease:

> **Silas:** I have my sister's child living in Phomolong and he was one person I was free to share my health issues with. He used to visit me some time here especially when I call him if I wanted to send him to town. He would not spend a lot of time with me, and we would always keep a distance and that was during the time when I used to stay indoors because I was so weak. I used to tell him that 'eish, my nephew, do not enter into my room because I have TB and I do not want to end up infecting you with TB, stay outside.' He would not stay here for more than 30 minutes before leaving.
>
> **Eddie:** Oh, so you did not hide the illness from your family?
>
> **Silas:** No, I did not hide anything about my condition from family. I was able to tell even my little nieces to keep a distance from me until such a time I was okay. I did not want a situation where I would put them at risk of TB infection. They once told me at the clinic to tell my sisters to bring their children for some TB screening. They indeed went with the children, and they were all clear of TB.
>
> **(Interview with Silas, 24 September 2020)**

The fact that Silas was open about his condition to the extent of alerting his loved ones to enforce social distancing and to tell his sisters to take their children for TB screening is a marker of responsible masculinity. While Silas and James were comfortable disclosing and sharing their health issues with other people, Patrick reveals that disclosing and sharing such sensitive information is for the select few, especially in a township setting. Although he reveals that he had difficulties sharing his health issues, Patrick later felt comfortable sharing with those close to him, his loved ones, which is contrary to Thabo who was not at liberty to share his experiences with his mother:

> **Eddie:** But as a man, how free were you to disclose your health issues to your close friends, or family members or your girlfriend?
>
> **Patrick:** To tell you the truth, we do not share health issues with everyone. It was a hard decision for me to disclose my health issues even to close people, but it was a hard

decision to make, you know. I took a leap of faith and shared my health issues with the people that I feel safe around and with the people that I trust, you know.

Eddie: But why was it a hard decision?

Patrick: You know with the ghetto [township] life, you can never predict a human being. That is why it was hard for me to share with anyone, you know. People are like shadows; they are here during the day and during the night they are not here, you know. It is difficult to find people you trust besides your own family. You just have to be careful because the ghetto life is the University of Life. It is rough and is the worst experience in life. It is hard to find people you can trust in the township. I only share my health with the people I trust, and I love, you know.

(Interview with Patrick, 15 September 2020)

Patrick, like Silas, endured both TB and HIV comorbidities. The overlap of TB symptoms with those of HIV contributed to his hesitation in disclosing his condition. His metaphorical assertion that 'people are like shadows' was Patrick's way of safeguarding himself from stigma by not sharing his health issues with people. This is consistent with studies on HIV and stigma demonstrating nondisclosure to be one of the most common stigma management strategies (Daftary, 2012). Thus, Patrick could only disclose his condition to those that he feels safe around and those that he loves – his family, as these constitute a support system.

Erick expanded on his nondisclosure of illness experience in terms of society's expectations of men. I asked him why men seem reluctant to share their health issues when not feeling well:

Eddie: Again, why do you think, we as men have a problem of speaking out and share our health issues when in need of help?

Erick: I do not know. I also ask myself why we as men do not want to talk about our situation when we are in serious problems. I do not know or maybe it is because of what we used to hear growing up that monna ke nku o llela teng in sePedi [a man is like a sheep he does not cry] because when they slaughter a sheep it does not make noise. It is quiet; it is silent. It would be in pain, but it will not make any noise. Therefore, as men, we are like sheep. **(Interview with Erick, 18 August 2020)**

To provide context, Erick was diagnosed with comorbidities of tuberculosis and HIV back in 2015. This came out in the interview I held with him in 2020 as he had interrupted his TB treatment. Erick confided in me that he could not accept the TB diagnosis back in 2015. He refused to take the prescribed treatment. The following conversation we had provides more context:

Eddie: Tell me Erick, what made you not to take the TB treatment in the first place in 2015?

> **Erick:** Erm, I did not take the diagnosis seriously. I was just saying this thing is not on me. I was just saying this sickness is not on me and I will not take the medication. It was because ga se ke amogele [I did not accept the diagnosis]. That is why I did not drink the TB treatment. Even when they gave me the ARVs, I never drank it. They made sure they gave me the medication every month. I remember the whole of 2016 I did not go to collect my medication, they tried to call me, and sometimes they would come here to the house to beg me to come collect my medication. They would tell me that you would die if you stopped taking the treatment. Sometimes I would go and collect the treatment but when I came home, I would just not drink it because I had not accepted my illness. I kept the condition to myself without disclosing to my mother.
>
> **(Interview with Erick, 18 August 2020)**

Erick's first TB diagnosis came as a shock possibly because of the underlying HIV condition. In this instance, the process of being diagnosed with TB/HIV presented a challenge to Erick's masculine identity, making it difficult for him to disclose the diagnosis to his mother. A qualitative study on TB treatment adherence conducted by Skinner and Claassens (2016) in South Africa similarly found that non-acceptance of TB diagnosis was a major hindrance to treatment initiation, causing initial loss to follow-up. Despite initiating TB treatment, Erick did not adhere to it, nor did he disclose his condition to his mother. His reference to the local idiom that 'a man is like a sheep' must therefore help us to understand his actions in relation to the first diagnosis he kept to himself. This finds resonance within a study conducted in Bushbuckridge where it was common for men to enact a stoical masculinity – they preferred to deal with own problems without involving other people (Mfecane, 2011, p.132). During the second round of TB infection in 2019, there was a change in the way Erick enacted his masculinity as he both adhered to treatment and disclosed his condition to family.

In a similar way, Garry, like Erick did not accept a positive HIV diagnosis back in 2017. The HIV-positive diagnosis preceded a TB diagnosis. He had the following to share about his experiences:

> **Garry:** Before the TB diagnosis, I had previously visited the clinic for a HIV test. That time, I denied my HIV positive results. I visited the clinic with my friend who lives not far from here. We influenced each other to go and test for HIV. When we arrived at the clinic, he encouraged me to go in first for the test and I braved the challenge and went in. They tested me and told me, 'you are positive.' I did not disclose to my friend the accurate HIV status at first. I then said to him, 'your turn, please get in and get tested.' He came out smiling and told me his results were HIV-negative. We came back home. I remember that on our way back I then disclosed to him and said, hey mfowethu [my brother], things are not good with me, and he said to me, please go ahead and get treatment. I told him, 'no, they are mad' [referring to the healthcare staff]. I refused to

> go on treatment. I remember last year [2019], that friend of mine was telling one of my siblings here that you know what, 'your brother is hot-headed. That time when I went with him to the clinic was the exact time he was supposed to have started with his ARV treatment. Not all this could have happened' [the stress, stroke, and the TB infection].
>
> **(Interview with Garry, 15 September 2020)**

Garry's description of life events shows the connection between masculinities and one's health condition. Garry's labelling of the healthcare staff as 'mad' was an assertion of his masculinity, challenging the biomedical interpretation of his identity. In other words, masculinity is not defined solely when someone is in good health, but men define themselves even in illness. It was a refusal then to act on and adhere to the responsibilities expected in 'therapeutic citizenship.' Garry rejected his HIV-positive result and chose not to disclose it to his family members, a pivotal decision that led to a cascade of other negative health conditions, including a stroke and ultimately a diagnosis of tuberculosis. The series of illness experiences transfigured Garry's masculinity identity, leading him to embrace a view that men must take care of themselves by sticking to one sexual partner. This points to the importance of historicising masculinities. The next section discusses men's TB illness experiences in relation to the concept of biographical disruption.

"My head was sinking into my shoulders…": TB Illness experiences and biographical disruption

In this section, I employ the concepts of illness experience and biographical disruption to highlight men's vulnerabilities to tuberculosis. Using these concepts, I also distil and develop the ways men define themselves in sickness. Illness experience highlights the subjective process through which the TB sufferer interprets the effects of the disease on his body. As a concept, illness experience helps the TB sufferer to make meaning of the illness and to verbally and non-verbally articulate and project it to those close to him. The concept of illness experience facilitates the creation of shared meaning between the individual TB sufferer and their immediate social circle. As a subjective process, illness experience involves listing and delineating in layperson's terms the suffering caused by illness (Pierret, 2003; Kleinman, 2020). Similarly, Lupton (2012, p.86) adds that meaning making in illness experience involves using a plethora of discourses about the body and illness, ranging from folk knowledge, biomedicine and alternative medicine to mass media and the internet. For men suffering from tuberculosis, their illness experience reveals, through laypersons' language, ways to make

meaning of the disease. By expressing their illness experiences, TB sufferers in this regard take us through ways to understand masculine identities.

Retrospectively and subjectively, Thuso remembered how the onset of TB made him lose weight:

> **Thuso:** I can only tell from my own experiences, ne ke fela, ke ota [I was losing weight]. My head was sinking into my shoulders, my complexion changed, and it became very dark, and I could not recognise myself [coughing].
>
> **(Interview with Thuso, 21 June 2020)**

Through first-person narrative, Thuso's illness experience reveals the intricate subjectivities of suffering from tuberculosis. His interpretation invites empathy and understanding the significance of what he went through suffering from disease. Thuso's use of metaphors to depict his experience with illness engages one's senses, allowing the formation of visual images that concretise the suffering he endured. Besides helping one share the meaning of suffering, Thuso's description adds weight to just how insidious tuberculosis is: it led to significant weight loss to the point he could not 'recognise' himself. Concretising the conceptual significance of illness experience, Das (2015, p.33) affirms that, "[t]he lexical terms employed to refer to illness or to abnormal bodily sensations are the linguistic means through which illness acquires a social existence." Thuso's illness experience, as conveyed through his choice of words to describe weight loss, such as 'sunken head' and 'change of complexion,' makes it easier for listeners to grasp and empathise with the meaning of his suffering. Although my encounter with Thuso occurred right towards the completion of his TB treatment course, he was still visibly frail, confirming the metaphor of his head 'sinking into my (his) shoulders.'

In recounting their illness experiences, the stories of Timmy and Terry below reveal the subjective interpretation of suffering from TB. As pointed out earlier, Timmy showed me the emaciated picture on his identity document taken just a few days before a TB diagnosis, while Terry shared how he felt like a dead man walking:

> **Timmy:** I went there [to the prophet] with my younger sister. O'lady [mother] was at work in town. We hitch-hiked and I was very, very, very, very weak. From here to Hammanskraal I was asleep in the taxi and when I arrived at the pastor's place I went straight to sleep on the chairs, until my turn to be called for consultation and my facial appearance was clearly showing that I was really sick. I was even scared to view myself in a mirror, a mere mirror, just imagine. Eh, it was bad. However, through my belief, I soldiered on and so I told myself to follow my treatment and I would be fine.
>
> **(Interview with Timmy, 10 September 2020)**

> **Terry:** When I first presented at the clinic, I was setopo, ne ke sena bopelo [I was like a dead body]. There was no life in me. I could feel it on my own that whatever hopes people have mo ke a tsamaya mo [I am dying here]. I was so skinny, ke we tshe [emaciated]; these fingers [*demonstrating*] were like foroko [a fork]. These eyes, erm, you know I was even scared to look myself in the mirror, ke ba sehlare [I was very skinny], ke le mphukudu [zombie]. A relative of mine came to visit me from Pretoria and he literally fainted when he saw me. His sisters called him on the cell phone to inquire about my status, and he responded that, 'no, it's not the person that I came to check on. This one is someone else, not our relative that I know.' Even the neighbours were scared to come and check on me and some had already started to talk that da man [that man] is going [he is dying]. **(Interview with Terry, 1 February 2021)**

Due to the weight loss resulting from their TB illness, both interlocutors hesitated to look at themselves in the mirror. They felt uncomfortable with their bodies. The illness was debilitating and according to Lupton (2012, p.88) "[s]erious illness can redefine social relationships and become an occasion for questioning the direction of one's life, including confronting one's own mortality, perhaps for the first time." Terry's vivid description encapsulates the devastating effects of TB illness. In short, Terry confronted his own mortality. His use of metaphors like *setopo* (corpse) and *mphukudu* (zombie) conjures and enhances graphic pictures of liminality – a dead man walking. The liminal state disrupted his social relations as family members and neighbours were frightened to look at him. Terry's illness experience helps us to appreciate masculinity identity formation in health and in sickness, especially when we historicise his experiences. Terry used to embrace the masculinity in sociability performed in the public space and involving sharing beer and 'heavy stuff' like 'brandy and whisky' with friends. Timmy too was clear that he possibly contracted TB because of sharing cigarettes. As I argue, these practices occur in gendered spaces where masculinity identities of belongingness manifest. Like Timmy, Terry's masculinity identity transitions from the public space into the private space, mediated by illness where relatives and even neighbours became frightened to look at him. Thus, tuberculosis illness disrupts the identity of masculinity in sociability and reconfigures one's masculinity so that one embraces vulnerability and fear of mortality. This is crystallised through men's fear to look at themselves in the mirror as they go through TB illness experiences. Kleinman (2020, p.24) would call the experiences of Timmy and Terry, especially their apprehension to look at themselves in a mirror, as 'illness problem' where one grieves "over lost health, altered body image, and dangerously declining self-esteem."

TB illness experience closely interlinks with the concept of stigma that most participants experienced in the community. I engaged Erick on how he managed to cope during his illness experience:

> **Eddie:** How did you manage to cope with all these difficulties in the treatment experience, like the sweating, change of complexion?
>
> **Erick:** Like, it would embarrass you because once you come out of the house, the people that knew you do not recognise you because you are different. They would remember that hai maan, this guy is a yellow bone [light in complexion] but now he is so dark and is losing weight. Once you see such reaction from people, you feel disappointed and embarrassed. Even when you are outside there and you see people walking in the streets, you sometimes feel the pressure to come back into the house so that you can just stay inside for the whole day. It is very painful. I just had to accept. Even if I am walking from here to the clinic to collect my treatment, people would stare at me and start talking and this thing causes embarrassment, you understand. People would talk in hushed voices that he is dying. You can easily see when you pass the people in the street that these people are talking about me. You might not hear them, but their body language would tell you that they are talking about you then how are you going to feel? Pain. However, you will just have to leave them and focus on your treatment. **(Interview with Erick, 18 August 2020)**

It is important to reiterate that illness experience is both a subjective and social process. Because of the changes caused by TB illness in the body, like a darkened complexion, people easily see and attach stigma to the sufferer. As concluded by Goffman (1963), stigma compounds suffering. The way Erick describes his experiences seem to straddle enacted and internalised forms of stigma. Erick experienced the co-occurrence of two types of stigmas – enacted stigma compelled him to embrace internalised stigma. This internalised stigma is related to "the degree to which PLWHA endorse the negative feelings associated with HIV/AIDS about themselves" (Earnshaw & Chaudoir, 2009, p.1163). Based on Erick's description, it is clear the burden of stigma was heavy on him: he isolated himself. Erick's observation of feeling like an object of public stigma when collecting medication from the clinic aligns with findings in Nepal. Harper and Rawal (2016) noted that TB sufferers in Nepal chose to purchase their own medicines and take them at home rather than visit the DOTS clinic, due to the stigma associated with clinic visits. While Erick further stated how he ended up eschewing going out of the house, Thuso's experience of stigma was subtler and institutionalised:

> **Erick**: I was not going anywhere; I was just staying inside the yard. When I felt I needed to get some fresh air nyana [a bit], I would just go sit on the ground in the yard. I would

not go into public spaces. I was not comfortable.

(**Interview with Erick, 18 August 2020)**

> **Thuso:** They invited my children to come to the clinic where they were going to give them some tablets since I used to share the same spaces [house] with them before I diagnosed with TB. It was only after the diagnosis that I stopped sleeping in the same house with my wife and kids, but I moved to stay alone in my own tin house. The nurses also told me that my children are not supposed to eat my leftovers. That is why they advised me to always carry a bottle of water so that I do not use any utensils in the house for drinking water. I had my own plate and my own cup, and I still use these up to now. (**Interview Thuso, 21 June 2020)**

The interlocutors' narratives resonate with Møller and Erstad's (2007, p.104) study on tuberculosis stigma in the Eastern Cape province of South Africa which shows that "[s]tigmatised individuals are variously shunned, isolated, ridiculed, and cold shouldered." Erick adopts withdrawal from public visibility as a strategy, fearing embarrassment due to the visible effects of the disease on his body. Similarly, the Tuberculosis Reduction through Expanded Antiretroviral Treatment and Screening for Active TB (TREATS) project in Zambia and South Africa found that "[s]tigma caused social isolation associated with TB, such as people not wanting others to know they had it, as well as the fear of infecting their family and others" (TREATS, 2022, p.20). Like Thuso's institutionally ascribed stigma, the TREATS study shows that isolation-related stigma in Zambia was perpetuated through health education where "TB nurses would say you must isolate yourself, you must have separate utensils at home, you must stay away from others, sleep in a different room" (TREATS, 2022, p.20). While the strategy above has the apparent intent to control the spread of TB, it is loaded with stigma that negatively affects the stigmatised. Therefore, it suffices to state that stigma in this context serves as a social determinant of health, exacerbating negative health outcomes.

Intricately intertwined with illness experience and stigma is the concept of biographical disruption. The concept of biographical disruption speaks to how the onset and unfolding of a chronic illness impacts upon personal identity and social experience. The masculinity identities most participants expressed and performed include respectability, being outgoing, sharing together and performing the role of provider. This, as I demonstrated, is captured through masculinity in sociability. It must be borne in mind that most participants did not fulfil the ideal of home making that the literature suggests is the hallmark of masculinity in the African context. Most participants lived in households headed by their parents, their mothers in particular. This living arrangement benefited men in terms of care when they became ill from

TB. It however put a financial and emotional burden on female carers who would sometimes stay awake throughout the night offering care to male TB sufferers. Many of the parents depended on state older persons' grants. The biographical disruption caused by TB illness proved to be a double-edged sword, impacting both the male TB sufferers and their mothers. This was so because some of the men ceased going to work and instead relied on their mothers' grants, thus redirecting household income intended for purchasing basic food items to covering medical expenses instead. Put differently, TB illness caused biographical disruption among men and at the same time eroded the parents' income since *they* assumed the provider role for their ill sons.

Through the interruption of everyday bodily functions, most of the men expressed how they experienced a disruption in their life stories. Frank, 32, diagnosed with meningeal tuberculosis, concretises the application of biographical disruption. His experiences capture the effects of tuberculosis:

> **Eddie:** Could you please describe to me the onset of TB symptoms and the period you stayed at the hospital. How serious was the experience?
>
> **Frank:** Yoh [Hey], you see when it started, it was very serious because I could not walk on my own, I could not stand on my own, I could not eat; when I ate, I always vomited. At the hospital I was admitted for almost a month and then after a month I went back again for a week. Every time when I ate some food, I would vomit. At that time, I was not eating at all. Sometimes the headache would be very severe such that I would end up just shutting my eyes. I could not see properly. My sister would normally advise that I be put on intravenous drip, so I went for the second time to the hospital… You must also bear in mind that TB was a new thing to me, and my understanding was that I could die anytime. When you look at me, I have lost a lot of weight, lot of weight. I am thin and I am no longer my old self. My clothes no longer fit me the way they used to. **(Interview with Frank, 22 September 2020)**

Often when in good health we take for granted bodily functions like standing up, walking, and eating. The concept of biographical disruption therefore highlights how TB illness severed the taken-for-granted bodily functions that Frank used to enjoy before the onset of tuberculosis. Conceptually, Engman (2019, p. 124) elaborates that "biographical disruption begins with a breakdown at the level of embodiment (specifically, the introduction of novel physical limitations that make familiar behaviours and habits inaccessible)" as occurred in Frank's instance. Critically, Frank's hospitalisation highlights biographical disruption. As a total institution, a hospital, and the process of being hospitalised for a month creates biographical disruption through isolating the TB sufferer from his everyday environment. Jenkins et al.

(2022, p.1) confirm that a hospital has the totalising practices of a total institution which involve the process of "mortification of self" in which a person is stripped of autonomy and is made to serve the needs of the institution. In the same vein, Lupton (2012, p.95) agrees the hospital is like a prison where "patients have little or no control over when they eat or sleep, the clothes they wear, the level of noise or light to which they are exposed, and the manner in which they defecate or urinate." The hospital strips away individual autonomy and enforces disciplinary power over the patients.

I visited Frank for the interview in the company of a community healthcare worker who spoke highly of him – someone well known in the community as a pastor and a singer. Frank's illness experiences further reveal the profound disruption to his biography:

> **Frank:** You must understand that in the first instance, around June [2020], I could not do anything on my own. I am the only son in this house, I am the only boy child; the rest are women. So, I could not bath on my own. My mum bathe me while I am sitting in bed. My mum would wake up in the middle of the night just to come and check if I am okay… When I need to go to the toilet, they [mum and his sister] would come and give me some balance so that I go to the toilet…This thing [TB] was a new thing to me. It hit me hard and fast such that it did not give me chance to prepare and fight back. When it hit me, it hit me hard and it made me to be helpless... When it hit me, I just became helpless. I only remember an ambulance coming to pick me here at home and when I arrived at the hospital according to the information that my parents later told me, they said I could not do anything at all on my own. I am a person who likes to be jolly with people, I am a person who likes to visit people now and then but during that time I could not walk and talk with people, I could not go and laugh with people, no. The only thing was for me to sit in bed. Even now, you see I am still in pyjamas; it is not that long that I woke up.
>
> **(Interview with Frank, 22 September 2020)**

It is interesting to observe how Frank describes TB illness in metaphorical terms as an enemy that invaded him without warning and leaving him helpless. Frank juxtaposes his identity of masculinity in sociability and the illness attack that left him helpless. His framing of TB as an invading enemy clearly shows his capitulation, the capitulation of a fortress (his body) as opposed to a resilient and a masculinity in sociability. He was an outgoing man, but his TB illness immobilised him. TB illness infantilised him, leaving him at the mercy of his mother and sister for care. The feminisation of care work resonates with a study by Furin et al. (2020) who found that compared to men, women disproportionately offered socioeconomic, emotional, and social support to drug-resistant TB sufferers in South Africa. Important to Frank's illness narrative is the concept of 'core narrative' as discussed by Bury (2001, p.279)

who argues that the use of such forms of narratives help people to account and to give meaning to events "they feel they relate to self and others." An illness narrative as presented by Frank is his way of making meaning of his TB experience. Consequently, the biographical disruption he attests to "involves a disruption at the level of identity" (Engman, 2019, p.124). In addition, biographical disruption caused by tuberculosis illness impacts masculinity identity, especially as in Frank's case where he is reliant on his mother's care. Biographical disruption reframed his masculinity identity that was constructed around access to public space and meeting people and laughing, to a new identity of confinement in the private space of the home and at times the hospital. From Frank's illness experience, it is apparent that gender is relational. His articulation is instructive as it demonstrates how masculinity is positioned at the top of the gender order. His emphasising that his position as the 'only boy child' in the household implies that when he is ill, everyone must take care of him. In illness, Frank positions his identity as a man.

Frank's story encapsulates how he experienced biographical disruption:

> **Frank:** Many of my activities were affected. Firstly, there were awareness campaigns that I was participating in at schools; I discontinued. My job also got affected where I was involved in route patrols to prevent crime. Many activities got affected. I could not go to church to pray with others or to preach to people. I would just go to church just to observe, and I started to go to church recently. If I could have gone to church in my previous condition [of frailty], it would have been to unnecessarily attract people's attention because when I come out, I would have to be balanced. I could not sit properly on my own. It is like when I sat, I was supposed to be lying down. So, a lot of my usual activities got affected and my life got affected in terms of not doing the things that I was used to do. I could not sing; I could not walk. Remember, I also used to get some of my income from musical gigs done outside my own church for example when the other churches were having functions or even someone was having a function, they would hire me to come and sing. So, I could not do that anymore till now.
>
> **(Interview with Frank, 22 September 2020)**

Frank's story comprehensively captures the areas of his life that suffered disruption due to TB. Like Frank, most participants experienced inhibited walking, problems with toileting and disruption of income. Barry and Yuill (2020) contend that disruption is not primarily caused by illness itself but rather by how the encounter with illness intersects with an individual's pre-existing life narrative and, crucially, their embodied connection to the world. Considering how he was active in the community before the onset of the disease, Frank's narrative crystallises the disruption he encountered when he faced TB illness.

Although TB illness caused biographical disruption in most of the participants, TB illness was inadvertently a source of biographical restoration or a 'restitution story' according to Lupton (2012, p.88) as it emphasises "regaining control, focusing on becoming well and 'doing something' about the illness." The narratives of restoration helped some of the participants to reconfigure their masculinity identities resulting from TB biographical disruption. In my engagement with Patrick, he reflected that he was a former drug user before TB infection. Although he was HIV-positive, the fact that he was a previous drug user possibly contributed to TB infection. We conversed as follows:

> **Eddie:** Is there anything in your life that has changed when you started suffering from TB?
>
> **Patrick:** You know what neh, life changes every day. My life changed a lot. First, I was a drug addict and I changed from that.
>
> **Eddie**: Was it because of TB that you changed?
>
> **Patrick**: Yes, I realised that drugs and TB will kill me you see [laughing]. Already the drugs were killing me, so the TB was there to finish me off [laughing]. You see, that is when I realised, I need a change in my life. That is when I realised how special I am, how important I am. I am a goal-getter, I know myself. I always get what I want in life. I told myself that I am the best. I am unique; I am special in my own ways. That is what awakened the feelings of resilience inside me as I was battling with TB. Tuberculosis made me realise that life is precious. The TB illness experience is not good, and it is something that I cannot wish on anyone. It taught me that I must stand up for my life. I need to love myself. I told myself that every living soul must reach its destiny, but I realised my destiny was not yet close and that the book of my life was in the middle rather than in the end. That is when I realised that I must take steps and man up. I must pull myself up, stand up, and walk tall, you know.
>
> **Eddie:** And you did just that?
>
> **Patrick**: I did just that and I did it brilliantly. If I show you a picture of myself when I was doing drugs, you will not want to have a conversation with someone like me. I used to be a drug addict; you know. I used to look like someone hit by a plutonic (sic) bomb. I used to be fucked up. My life was messed up. TB almost finished me off. After the onset of TB, I realised that if drugs could not kill me and if TB could not kill me, then I have a chance at life and I told myself that I would make it I know. I have been through worse. The things that I have been through are not good. But for now, I am fine.
>
> **(Interview with Patrick, 15 September 2020)**

Instead of becoming despondent amid a life story wrecked by drug abuse and TB illness, Patrick demonstrates agency in masculinity when he mentions that 'I have to take steps to man

up.' In illness, men assert their identity, as demonstrated by the rhetoric, 'man up.' This is indicative of an active and agentic character of masculinity in the face of a difficult situation, i.e., both a life of drugs and overcoming TB illness. From the way he expressed himself, Patrick used to be a nyaope addict and in his own words, '… that drug neh, you know 99% of the people who are using the drug I was using [nyaope] never come out of it. The rehabs can help other people using other drugs but the person using the drug I was using [nyaope] is not easily rehabilitated.' Instead of biographical disruption, Patrick's encounter with TB illness brought about a positive change in his life as it helped him reorient from a previous life of drugs. Amidst TB illness experience, Patrick managed to summon himself towards positive health outcomes. This projects a resurrection of a positive masculinity, thus TB in this sense presents a path towards restoration. Of turning around his masculinity, Patrick declared 'I have now been thinking of opening an organisation that helps those people who are discriminated because they are on drugs. I want to open that organisation; it is something that I can do for my community. As confirmed by Bury (2001, p.277), "[o]ut of the badness of illness comes some good, as people attempt to rescue valued life, against the onslaught of symptoms and their effects on self and others." Against the background of biographical disruption and restoration, the next section brings to light the fluidity of masculinity amid a TB illness.

The breadwinner role and TB illness

The findings of this study reveal some tensions and contradictions that men experience as they strive to balance their livelihoods and breadwinning responsibilities in the face of TB illness. The research area of Modimolle is a resource-constrained setting with an unemployment rate of 34% (Modimolle-Mookgophong IDP, 2021-2026, p.64). For men suffering from TB, the precarious nature of their work complicates health outcomes, particularly regarding treatment adherence in the face of a widely practised no-work-no-pay convention. TB illness worsens the precariat's work and health. In his definition of the precariat, which fits well with most of my participants on the periphery of economic labour, Standing (2014, p.10) argues that it is characterised by "so called 'flexible' labour contracts; temporary jobs; labour as casuals, part-timers." Against this backdrop of precarity and the breadwinning identity, how do men experience TB illness? A TB diagnosis forced men to make some difficult decisions towards their families at the expense of their own health. In the case of 40-year-old Themba, the tumultuous period preceding a successful TB diagnosis was associated with loss of weight. Themba used to earn between R5 100 and R10 000 per month but due to the onset of

tuberculosis illness, could not go to work for a week. This disrupted his income flow and caused some tension within him as it meant failure to provide for the family. During his illness, 39-year-old Terry, who worked as a TLB (tractor loader backhoe) operator earning about R6 000 (US$318.24) per month, was worried that his employer might have already replaced him at work. Similarly, 44-year-old Mthuli, who was earning between R3 100 and R5 000 per month, stopped going to work for three months due to TB illness. This resulted in no income during that time:

> **Eddie:** But when you look at that period when you were suffering from tuberculosis, what happened then to your duties as a man?
>
> **Themba**: Yah, it did set me back because some of the duties I could not do, like going to work.
>
> **Eddie:** Oh, so there was a time when you could not go to work because of the illness?
>
> **Themba:** Yes, I think it was for a week or so.
>
> **Eddie:** Oh, I see. How did it affect you when you could not go to work?
>
> **Themba:** Erm, it did affect me because I was used to be out most of the time and come home late. However, being at home the whole day, hai [no], it is something else. It is not that easy. It is not easy just to be home the whole day and you are not doing anything. What you will be doing is you just have to eat, and you are not able to do most of the stuff, hey, it is hard. **(Interview with Themba, 1 December 2020)**

Themba's life revolved around his paid work, which was essential for maintaining his identity as a provider. The onset of TB temporarily disrupted this routine, and it was the hardest thing for him. Although Themba was one of the highest paid among all my participants, he worked as a casual worker with no job security. The tension for Themba stemmed partly from his establishment of an independent homestead and his role as the sole breadwinner. Therefore, the inability to work for even a short period became a significant challenge as it meant a failure to support his family. However, establishing an own independent homestead as a masculinity identifier does not automatically mean the man assumes the provider masculinity; it is both a societal expectation and individual choice. Because of the pressure to live up to this provider role, Themba did not give himself enough time to rest. He resumed work in his state of weakness. Themba's demonstration of masculinity resonates with Evans et al.'s (2011, p.8) theoretical study on masculinity and illness. Like Butler (1988), they argue the performative essence of gender in which manliness is appreciated "by continual proving of manhood." Themba's case demonstrates that staying at home 'doing nothing' as he describes it,

undermines his sense of masculinity. Thus, Evans et al. (2011, p.8) add: "men are only as masculine as their last demonstration of masculinity." For Themba, that demonstration of masculinity was providing for his family, hence the pressure to assume the same role even before fully recovering from TB illness. This finding resonates with a study by Daniels et al. (2021, p.11) on South African men's behaviours of TB care and treatment which found a strong expression by men to keep working and to maintain "access to material and financial resources to support their households."

Although Mthuli had established an own independent homestead, he did not overwhelmingly feel pressured to return to work after he initiated on TB treatment. Mthuli thought it wise to give himself time to recover despite the lack of income from the employer. His understanding of tuberculosis was that '[s]ince TB affects the lungs; the problem with it is that it comes with exhaustion, and it does not allow you to do hard labour. You get tired too easily.' Coupled with the fact that the employer understood the infectiousness of TB, Mthuli decided to take sick leave although the decision had consequences for his provider role in the family:

> **Mthuli:** The only thing that gave me stress was the fact that I had to stop working for a while and I have a wife and children that I take care of.
>
> **Eddie:** Pardon me, you were saying?
>
> **Mthuli**: I was saying that the challenge that I experienced involved work, as I had to stop working for a while. My employer made me to stop coming to work for a while, as they did not want me to infect others with the disease. I was also wise enough to tell my boss that I need to stay at home for about 2-3 months. So, I stayed for a while here at home and after 2-3 months, I told my boss that I am ready to go back to work.
>
> **Eddie:** Were you paid for the time you were off sick and not working?
>
> **Mthuli:** No, I was not receiving any wages from my employer, but the child support grant is what helped us financially. **(Interview with Mthuli, 15 October 2020)**

Mthuli had to grapple with balancing competing and important issues like livelihood and health. On one hand, taking time off work with no pay meant that his family would suffer a loss of income crucial for daily living. On the other, he needed to recuperate as well as protect his workmates from TB infection. He enacted a responsible masculinity by taking care of himself and the health of others. As Mthuli narrated, taking time off came with stress in terms of meeting his role as provider. A study on the social determinants of tuberculosis in the shantytowns of Callao, Peru found that "accessing TB care cost TB-affected households approximately 2 months of their annual household income with half of the costs incurred prior

to the start of TB treatment and half consisting of lost income" (Wingfield, Tovar, Huff, Boccia, Saunders, Datta... & Evans, 2016, p.s80). This observation is reflected in the loss of income incurred by Mthuli. It demonstrates the inextricable relationship between poverty and TB, forming a vicious cycle in which the economic challenges posed by the illness contribute to and perpetuate the cycle of poverty. Like most of my participants, Mthuli belongs to the precariat class of workers. The precariat fundamentally relies on their cash income, as they have no claim to non-wage benefits like pensions, paid time off or health insurance (Standing, 2014).

Added to the loss of work-related income, Mthuli tried to apply for a disability grant with the South African Social Security Agency (SASSA) during the height of the COVID-19 pandemic but could not access it. The doctor responsible was not available to assess his application. Out of frustration, Mthuli gave up applying. During the period of TB suffering and loss of income, Mthuli relied on the child grant to support his family. Thus, the precarious situation in which no benefits accrue to someone when they are off sick is one of the fundamental inhibiting factors for men's disclosure of their TB status and adherence to treatment while at work. This evidently emanates from the need to satisfy the provider identity which is influenced at the individual and societal levels. Men's balancing of livelihood and health is therefore crystallised. To illustrate the challenge of the precariat when faced with a debilitating illness like TB, I asked Terry how his employers were assisting him and he responded that, '[t]hose ones do not give a damn about me. Those employers did not register us.' Terry's candid response shows the extent to which a precariat is easily expendable when beset with illness.

While setting up an own homestead is an important marker of masculinity, men who were living with their parents defined their identity differently. Due to the onset of TB illness, 32-year-old Silas, who lived with his mother, could not go to work to earn an income. His illness coincided with the COVID-19 lockdown, and he became part of the staff that had to stay at home. He was hopeful however that he would be back on his feet, his health sufficiently restored to enable him to resume work. He illustrated how important it was for him to recover and assume his role as a breadwinner:

> **Silas:** Yes, I have to be okay so that I may be able to assist magogo [mother] because she is only getting an old age grant and when I look at it, that money is too little to cover the needs of the household. So, even the money they were giving me during the lockdown I was able to give some of it to my mother to pay for the burial society and

she would use her grant money to buy groceries for the family.

(Interview with Silas, 24 September 2020)

Silas was fortunate that his employer was able to pay him some money during the COVID-19 level 5 lockdown in early 2020, when he was ill from tuberculosis and not working. Although he lived with his mother and experienced TB illness, Silas did not abdicate a provider masculinity. He knew that he had a role to play in the household in terms of paying the funeral policy. The case of Silas demonstrates the complementary role he had to play under the household headship of his mother.

For Thabo, however, TB illness reconfigured his masculinity identity. Thabo used to do some contract work – laying pavements, painting, and carpentry. During fieldwork in 2020, Thabo had been out of work for a month. Although he used to earn approximately R7 000 (US$ 368) per month, it was clear that it was precarious work. He could go for some time without being hired. This is typical of the precariat who, according to Standing (2014, p.10), "have no secure occupational identity." This transient class position disrupts men's identities, especially when confronted with TB illness. Just like Silas, Thabo lived with his mother. The double burden of lack of work and TB illness put pressure on Thabo's masculinity identity, to the level of relying on his mother for financial relief:

> **Eddie:** During that time when you were unwell, how were you able to support your family, and especially your child?
>
> **Thabo:** Erm, eish it became so hard. Yah, it was hard because I was that person who was used to having my own money. I would make sure that I have my own money. Hey, during that time when I was diagnosed with TB it became so hard because I was always staying at home and my mum ended up assisting me through the money from the child grant that she gets for the children. She would at least give me something like R200 and I would then be able to give my child at least R100. When sometimes the situation is desperate for my child where he stays, I would ask him to come over here so that he could be able to have something to eat. In times when they have no toiletries, my brother is that kind of a person who buys these in bulk for the family and it meant that I would take some of the toiletries and support my child. I would also get assistance from family in terms of my child's lunchbox to school. I was only stressed by the fact that I was no longer financially independent the way I used to be. These are some of the challenges that I faced during TB suffering.
>
> **(Interview with Thabo, 11 September 2020)**

The colliding epidemics of precarious employment and TB infection took their toll on Thabo, who used to be financially independent and able to provide for his child. During his period of unemployment and while suffering from TB, Thabo relied on the 'economy of affection' (Vigh,

2006), which allowed him to fulfil the role of provider to his child, albeit in a limited capacity. In a sense, this invaluable social support made all the difference for men in managing their TB illnesses and coping with the loss of their provider identity, a topic that I will discuss in the next section on infantilisation and masculinity.

Social support amid TB-related infantilisation

Considering the masculinities constructed around sociability in public spaces and the provider role that some men adhere to, illness poses an existential threat. During TB illness, men depend on family members, friends, and those around them for social support. While the feminisation of caregiving perpetuates patriarchal domination, men acknowledge that without care and support from women, mothers, sisters, or spouses their health outcomes from tuberculosis would be dire. This is so especially in view of biographical disruption and infantilisation caused by TB. Illness is social; one does not get ill to him/herself alone, but the family at large experiences the emotional, social, and financial effects of the illness. Thus, Pierret (2003, p.13) affirms that for a patient to manage the disruptions caused by illness, "family represents the first line of affective and material support." Infantilisation occurs within partial or total institutions and refers to a "behavioural pattern in which a person of authority (social workers, medical personnel, etc.) interacts with, responds to, or treats an elderly person as if he or she were a child" (Marson & Powell, 2014, p.144). Precipitated by TB illness, infantilisation intricately connects with biographical disruption in which men lose their autonomy and are at the mercy of caregivers and their social networks in the home for positive health outcomes.

In their study on TB treatment adherence in South Africa, Skinner and Claassens (2016, p.7) confirm that family, friends, and community support was crucial in ensuring that TB sufferers remained adherent. How do men define themselves in illness? While men construct their masculinity identities in health, for example through sociability as argued in Chapter Five, men continue to define themselves even in illness. Social support came in different forms; it was multi-layered according to marital status and one's social networks. Participants who had established own homesteads relied on their spouses – and to some extent on their parents – for support, especially when their income stream from work stopped. Participants who were single relied on emotional and material support from friends and siblings. However, the main support and care for this category of men came from parents, especially from mothers.

Having established his own homestead, Themba's spouse and child were central sources of social support during TB illness. At one-point Themba's spouse accompanied him to a medical doctor for a consultation, which greatly facilitated the diagnosis process and the treatment outcomes. I asked Themba about the support that he relied upon during TB illness:

> **EM:** But do you have any support system in terms of any help that you get so that you are able to stick to the treatment routine?
>
> **Themba:** My wife is there and even my daughter usually asks, 'Daddy, did you drink your tablets?' These two support me. I have a good support system.
>
> **EM:** So, how important is this support system for your health?
>
> **Themba:** Erm, I think their support is making me recover so well for now.
>
> **(Interview with Themba, 1 December 2019)**

TB illness experience is social and managed socially through available support structures. For Themba, his three-year-old daughter (during fieldwork) played an important role in her father's TB treatment adherence. I went further to establish how Themba, assessed the social support that he received from his family during TB illness. I also inquired on this topic from Charles whose aunt forcefully took him to the hospital. The participants shared the following:

> **EM:** But let us say for example and for interest's sake, you were alone with no family, how were you going to handle your illness experience?
>
> **Themba:** Erm, it was not going to be easy because eating was hard. I was not eating that well. The appetite was not that good during the week that I did not go to work. The family gave me support to eat and even going out of their way to get me some other special kinds of foods. Sometimes, you would feel that no, I do not want to eat this kind of food, and if you are alone, it is not that easy to even go and buy the food because I was not even fit to walk. It was not that easy.
>
> **(Interview with Themba, 1 December 2019)**
>
> **Charles:** As men, we need support from family, or relatives or even from friends. If they give you support, then you will be able to manage even to go and get your treatment and even to get the much-needed food when you are not well. If you are alone, you cannot manage to do those things. But if you have people that support you and give you encouragement, they can even accompany you to the clinic if possible. What you need to do is to get support from people and from family.
>
> **(Interview with Charles, 7 September 2020)**

Themba's description of biographical disruption manifested through inhibited walking resonates and is intertwined with what Kleinman (2020, p.24) terms illness behaviour that involves "initiating treatment (for example, changing diet and activities, eating special foods,

resting, engaging in exercise…).” As gendered beings, men require social support to be able to manage illness experiences, including treatment adherence. This support is an important resource to ensure positive health outcomes. This aligns with a South African study by Daniels et al. (2021, p.11) which found that “access to tangible and mental resources within their social networks engendered retention in care, while loss of these resources increased disengagement” for men suffering from TB.

During fieldwork, I interviewed Patricia, Themba’s partner. My conversation with Patricia occurred when she had just returned home from collecting her partner’s TB treatment from the local clinic, a clear indication of the support she was offering. The fact that Patricia went to collect the treatment for her partner reveals how Themba defined his masculinity even during illness, i.e. he was the provider. This is so because Themba prioritised livelihood for his family over missing work to collect his treatment. I asked Patricia how she was coping with the role of caregiver to her partner:

> **EM:** So, like right now, if I would ask about your condition, how are you feeling?
>
> **Patricia**: Erm, how do I put it? [*Rhetorically*] I do not know. My health status sometimes is mixed up because, erm, actually, I sleep less these days. Therefore, I will not say I am the healthiest person, but yes, I am physically healthy but mentally I am a little bit stressed out and tired. This is especially so ever since this TB thing started at home. So, it had been putting strain on me. For me personally, that’s how I am now. I am not balanced. I won’t say I am totally healthy because I am tired. I am not sick, but I am just tired. I am tired. I am healthy, I am not sick, I am not coughing, I am not erm, sweating. I am just normal, but I am just tired.
>
> **EM:** And is it because of the walking that you did from the clinic [She had come back from the local clinic about one-and-a-half kilometres away] or is it just general tiredness?
>
> **Patricia:** Generally, you know what it’s like? It is like…as I said I do not sleep that well. Like I do not get a normal eight-hour sleep. It is not about walking. I can walk and come back and rest a little bit. It is just, let us just say I am mentally tired. Not physically. I can walk around; I can do normal stuff that I do every day, but I am just mentally tired.
>
> **EM:** I am still interested to find out more about you saying you are mentally tired. What could be the reason?
>
> **Patricia:** Erm, you know…ever since Themba started being sick, it was basically like…I have to take care of two kids and at the same time take care of him [fiancée]. In addition, well, with this one [referring to her toddler present during the interview], he

> is on formula…drinking formula. Therefore, I get up normally in the middle of the night to make it for him and after that, I must also get up and check up on Themba. His sleeping positions. That is the thing. When I am saying I am tired it is just that I need a full eight-hour sleep then I will be fully recharged. That is what I mean.
>
> **(Interview with Patricia, 2 December 2019)**

Patricia's description of her experiences in caregiving crucially demonstrates the effort it takes providing care to an infantilised man as his 'sleeping positions' require constant checking. Balancing her role of caregiver to her fiancée and meeting the toddler's needs strain Patricia's health and she clearly does not have the luxury of resting which would ensure she recovers. It bears mentioning that while social support from caregivers is critical for a positive health outcome among men, the caregivers themselves have no one to take care of them in the process. This 'emotional labour' done by Patricia takes a toll on her health. Studies show that "[w]here gender roles and relations are concerned, the care roles fulfilled by women are significant as women frequently take on the majority of the burden and risk of providing health care in the home, often with little external support" (Smith, 2019, p.356). That Patricia had just come from the clinic to collect Themba's TB treatment adds weight to the support caregivers render in relation to men's treatment adherence.

Silas and Frank, who lived with their parents, relied on family support from their mothers and sisters during episodes of infantilisation resulting from TB illness. The support rendered included caregiving such as preparing food, and emotional and moral support. The two describe the following in relation to the support they received:

> **Silas:** To be honest with you, for me magogo [mother] was always by my side. She used to accompany me to the clinic. Even at the hospital, she would always be by my side when the doctor would be explaining things to me. She is one person who supported me, and she would say to me 'my son, o se ke wa lahlela toulo [do not lose hope], I will be here with you. Just drink your pills, you will be fine'. She is the one who was supporting me in everything. She cooked for me. She gave me strength. You see, sometimes I would be seated all by myself in my room and she would call me outside and sit with me and she would tell me a lot of things to encourage me. She would talk to me like she is talking to a little child, and I would not mind. I would then consider that I also have a child in Phomolong, he is 8 years old, and it would hit me hard thinking how my son would survive if I died. My mother would even talk to me about my son, and she would always encourage me that I would be fine and that I must take my treatment. I accepted my illness. She supported me a lot if I would be honest with you and I took heed of her advice, and it helped me to recover quickly. She would sit by me when I was eating because when she was not around, I would not eat my food. If ever she would dish for me and decide to leave me alone then she would just find the

food the way she dished it. She would encourage me to eat my food and always assuring me that I would be okay.

(Interview with Silas, 24 September 2020)

Frank: My mum was not well. She was always crying that my baby must be fine. My sisters were worried as well because my condition was also affecting their love lives, their relationships. My sisters used to sacrifice their relationships only for me; they would leave their own families to attend to me. My mum stopped going to any gatherings saying that she cannot leave me alone. It really affected them but seeing me now erm, on the mend, has brought joy to them. It brought joy to them. As I said that sometimes I could not sleep; they would sit here with me until I sleep then they would also go to sleep. They would pick me up from this couch and take me to bed.

(**Interview with Frank, 22 September 2020)**

Considering that the two interlocutors were both 32 years old, key words like 'talking to a little child', 'my baby' 'pick me up from this couch' highlight the process of infantilisation caused by TB illness. By not eating the food provided, Silas highlights the process of infantilisation leaving the mother to urge him to eat. Despite the alienating nature of illness where Silas would sometimes sit alone in his room, the fact that he accepted his condition was an important step towards reframing his illness experience for positive results. This is because Silas had HIV/TB comorbidities. Equally important was the quality of care provided by his mother, which helped Silas construct a positive masculinity identity focused on his son's well-being. This engendered a fighting spirit in him, driving him to achieve a positive health outcome.

Frank's condition required his mother and sisters to provide basic care, as he was unable to take care of himself. Similarly, a study on South African men's behaviours in TB care by Daniels et al. (2021) found that where men could not secure food, money, or emotional support on their own, mothers, partners, sisters, and aunts became central support systems. Frank required care in terms of bathing, going to the bathroom, being lifted to go to bed etc. and all these are part of the unpaid work many caregivers perform. These care giving activities demonstrate how illness as the 'night side of life' infantilises men. Chronic illness is hard work, for the mothers and sisters and the men in the account provided. This is so because the "routines encompass various forms of work. This work is labour that is not regarded as 'work' in terms of paid employment" (Barry & Yuill, 2022, p.152). The account of Frank shows graphically the social aspects of illness in that it affected his immediate family. Illness affects all family members, and, in this case, they sacrificed their own relationships and their own health, as their own sleeping was disrupted by taking care of Frank. Pierret (2003, p.13) confirms in the case of chronic illnesses that when one family member becomes ill, the impact on the family or

household is drastic as members are forced to reorganise activities. Frank's assertion that his sisters sacrificed their relationship and love lives demonstrate the rearranging of activities in the family to manage his illness experience.

A further highlight of the importance of family support came from Silas whom I engaged as follows:

> **Eddie**: In other words, we as men need support?
>
> **Silas:** Yes, and you only get the best support from your family. You have to get support from family especially from your parents.
>
> **Eddie**: But in the event, you have no parents where will the support come from?
>
> **Silas:** Eish, in that case you will be in a very difficult situation because if you look at people like your sisters, they are not the kind of people that can stick with you when you are ill. They can tell you hurtful words that might cause you to give up. I was honestly lucky because magogo [mother] was around when I started to be ill because she supported me and did everything for me. She supported me with encouraging words and things like that. I am now feeling much better because of her support, and she is no longer worried because now I am able to wake up and return to work. I am still able to confide in her and even the treatment that I am taking now, I was able to ask her to go and collect it for me as I was going to work. It was not difficult for her. She just took my clinic book, and she went to the clinic and when I knocked off, she gave me the medication [TB pills]. There was no problem at all. You see, things like staying with sisters or your fathers; these people cannot take good care of a suffering family member. They will tell you to your face that, "I am not the one who caused this sickness in you. Go after the person who made you sick." They will hurl painful words at you to a point where you will end up entertaining bad thoughts. You will end up not having positive thoughts that are beneficial to you. I am telling you the truth. My mother was supportive, and she accepted my condition the way I was. Even now when I have managed to return to work, she is supporting and telling me not to give up. It gives me courage to say that the remaining three months is just a little time before I complete my treatment. That is why I am comfortable to ask her to collect medication for me if I am pressed at work. If they really need me at the clinic to check on my weight and things like that then I have to ask for permission from work.
>
> **(Interview with Silas, 24 September 2020)**

Silas helps us to delineate and profile social support for TB sufferers at the family level. An important observation from his articulation is that family support is not uniform. Silas is clear that when beset with TB illness, one's sisters are not the best source of social support and care to rely upon. This observation contrasts with Frank's situation whose sisters rearranged their life activities to care for him. Equally so, fathers according to Silas are not able to offer

meaningful social support and care to their sons. Siblings and fathers according to Silas can worsen one's health outcomes as they tend to victim blame a TB/HIV sufferer. It is important to point out that social support intertwines with mental health for positive or negative outcomes. The way Silas documents how sisters may hurl painful words speaks to discrimination based on moral judgments. Elsewhere in Zambia and South Africa, a study on TB and HIV found that the association between the two diseases resulted in a TB sufferer having to face the "assumption that you may also have HIV and everything that goes with the assumption that you've done something you shouldn't have, that's immoral" (TREATS, 2022, p.20). Although Silas was HIV-positive, TB exacerbated his condition. He attracted stigmatisation from his sisters instead of positive support. According to the findings of this study, the social support provided to men with TB overwhelmingly indicates that maternal care and support were paramount and had the greatest impact – they were the most valued by participants.

Besides family support, participants showed that friends were an important resource required during TB illness. For instance, Frank relied upon friends for social support in addition to the care given by his family. This is in sharp contrast to Garry whose friends deserted him during TB illness. In highlighting the importance of social support men relied upon during illness, I juxtapose Garry and Frank's extracts below. I introduced the topic on social support to Garry as follows:

> **Eddie:** In your opinion, what is the support that men require for them to continue with their medication during TB illness?
>
> **Garry:** I think that as men, if we give each other advice we will be able to pull through and stick with our treatment. The only challenge is that as men we have no time for each other. We are not able to visit each other. If I will tell you the truth, I used to have many friends but since I started to be wheelchair bound, they no longer come to check on me. This place used to be full of cars and we would chill and do car washing outside there with friends. These days, hai [no], it is no more. There is only one man who usually phones me, he is a paramedic... All the friends I used to associate with do not even call me at all. Like yesterday, he [the paramedic friend] called me to say that he will be off duty this coming Wednesday and he promised me that he would visit me.
>
> **Eddie:** To check on you?
>
> **Garry:** Yes, just to come and check on me. So, the problem with us men is that we do not give each other support. People like you when you are well but once you become grounded the way I am then there is no one who cares. When we become sick, we need support groups where we can encourage each other to adhere to our treatment.
>
> **(Interview with Garry, 15 September 2020)**

> **Frank:** Hey, my friends were very worried. They used to call every time to check how I was doing. They used to visit me as well and they would come and inquire about the things I needed because, here at home, it is I and my sister that were working. My mum is a pensioner. So, they would come and check on me to find out what else I needed and on whether I was eating. They were a bit worried because they were funding everything that I needed…They always asked for an update about my condition. I remember this other woman once said, 'he cannot die now, we still need him more.' She would say to my mum, 'no matter what Frank need, do not hesitate to call me. If you have no airtime, send me call backs and I will call you.' They also used to send my other sister airtime and tell her that if she needed anything, they would come and assist. They normally used to assist, because, sometimes at night when the lights are left switched on, I would feel dizzy. The only thing that would calm me down was for me to go to the hospital so that they would inject me with this other injection that would calm the dizziness in me and would be admitted for two or three days in the hospital. So, my friends would come with their cars and take me to the hospital... I do not want to lie to you; these people played a huge role in my life. There is another woman I work with; she is paying for my medication and a lifestyle meal that I am taking from the chemist. This prescription helps me to get my body back. That woman is contributing R300 every month from her salary towards the purchase of that medication. Sometimes she would take me to a doctor and use her own medical aid. These people are still assisting me even now. They are supporting me in this journey until I am cured. Remember, I lost weight, and I was no longer visible to the public as was previously the case because I used to attend many public events like funerals in the community. **(Interview with Frank, 22 September 2020)**

Garry's longing for social contact from friends is palpable. On the contrary, Frank is well integrated into his circle of friends, and their social support during his illness proved crucial for achieving a positive health outcome. When I met Frank during fieldwork, he was two months away from completing his TB treatment. Considering biographical disruption, the financial and moral support from friends and workmates made a difference in the way he managed the illness. This holds with the findings of a study by Naidoo and Mwaba (2010) where participants identified family members as the most important sources of social support during illness, followed by friends and neighbours. While social support from friends involve material provisions, as is the case with Frank, moral support through rendering advice is a key issue that Garry required from his friends. Garry's articulations show that in the private space of the home where TB illness is experienced, men 'have no time for each other' and this sharply contrasts with the performance of masculinity in sociability with friends in public spaces like car washing spots, taverns and shebeens.

While illness alienated Garry from his former circle of friends, leaving him with no social support, TB illness galvanised Frank's friends to offer him tangible support. Illness experience as demonstrated in both instances is social; by assuming and appropriating the TB illness identity, men expect support from those around them – family, friends, and significant others. This is similarly captured in Helman's (1994) study where, regarding the sick role, he argues that the cooperation of other people in the identification of who is ill is imperative if the sick person is to assume some rights and benefits associated with the role. Helman (1994, p.110) further argues that the socially identified ill can withhold various obligations to their social groups while his social groups like friends and family "often feel obligated to care for their sick members while they are ill." Thus, family and friends are societally obligated to offer support to the TB sufferer. However, as demonstrated in Garry's instance, social support is a vital yet scarce resource, easily withheld among and between men. Elsewhere in South Africa, a study by Medina-Marino et al. (2022) on men's engagement and retention in TB care found most men yearned for a peer-to-peer support structure in places men gather. When men render each other social support as friends then, as is the case with Frank, positive health outcomes are possible.

In illness, men express and define their place in the gender order. During illness-induced incapacity where he was relying on care from his mother and sisters, Frank retorted that, 'I am the only boy child; the rest are women.' It is an identity claim for social support. Similarly, Themba and Silas' interaction in the private space of the home indicate a construction of masculinity in that it was the women – Themba's spouse and Silas' mother respectively – who went out to collect TB treatment for the two men. This was on the pretext that the two were at work. The care provided by women ensured the men adhered to treatment that was important for recovery in order to assume their provider masculinities. Therefore, in illness, men define themselves transitioning from infantilisation in the private spaces of the home into their roles as breadwinners.

Concluding remarks on men's illness experiences

This chapter extended the space-TB illness continuum argument by highlighting that the private space of the home represents a site in which TB illness is crystallised when men, in their vulnerability, rely on care. Due to the biographical disruption and stigma induced by TB illness, the public performances of masculinity in sociability within spaces like taverns and shebeens are sharply contrasted as men retreat to the private confines of their homes. In

bringing out the utility of key concepts like biographical disruption, the chapter demonstrated how men's TB illnesses became a social experience disrupting the taken-for-granted everyday flow of events. However, in the confines of the private space of the home where illness is experienced and care is provided by support structures, men do not go through these experiences passively, but continue to define themselves in terms of projecting a positive resilience towards recovery. Against illness experiences, I have demonstrated that masculinity is fluid and contingent upon space and time.

Although some participants correctly offered a biomedical understanding of tuberculosis and the ways in which it is transmitted, I demonstrated that this clear understanding was largely determined by the level of education of the participants. Importantly however, men who dropped out of school before Grade 12 possessed concrete and unique knowledge about tuberculosis based on their own lived experiences of the disease. Rather than offering a biomedical understanding of tuberculosis, the narratives of men with no matric qualifications became central to nuanced understandings of tuberculosis as a disease that gnaws at the body. These nuggets of experiential information empirically expand knowledge of tuberculosis from a section of the population often peripheral to and marginalised in the discourse of health and TB.

In concretising masculinities, the chapter disrupted the oft homogenising characterisation of men found in literature which is centred on the establishment of own homestead and the provider role. As the chapter argued, the departure from the dominant theorisation of men stems from the socio-economic class of participants who live in a resource-poor setting. This pivot ensures a leaning towards the 'economy of affection' (Vigh, 2006) that speaks to men's reliance on family for material support. While there are forms of masculinity centred on establishing independent homesteads and provider roles, the context of TB illness reveals that men exhibit other forms of masculinities. In the next section, I examine men's health-seeking behaviours in the context of medical pluralism.

Chapter Seven

TB diagnosis process in the context of medical pluralism

One of the factors that suggest the possible significance of African ontology in the lives of millions of Africans today is the noted resilience of traditional beliefs in the areas of health and disease. (Manganyi, 2019, p.62).

Introduction

In the previous chapter I explored ways men interpreted and made meaning of tuberculosis based on their lived experiences of the disease. By providing graphic descriptions of how men experienced TB illness, I showed, not only the insidiousness of the disease, but I empirically contributed to novel ways of understanding tuberculosis in context. Against this background, I argued that TB illness sharply affects masculinity in sociability performed in public spaces as men experience illness in the private sphere of the home. The concepts of biographical disruption, illness experience and stigma helped me to crystallise men's vulnerabilities leading to infantilisation, a situation in which they come to rely on social support and care from family and friends for their mundane needs. Biographical disruption manifested in the interruption of taken-for-granted bodily functions, causing men to reframe their masculinity identities. When taking on the identity of illness, which is isolating and stigmatising, I further argued that working-class men primarily define and construct their identities through words that portray resilience. I further demonstrated that TB illness does not always cause disruption in men's life stories but in certain instances, TB illness facilitated biographical restoration for some men as they reoriented their lives.

Turning to this current chapter, I proceed to employ the African-centred theories of masculinity to appreciate ways men negotiate health and illness before and after a TB diagnosis. What are the factors that influence men's decisions to seek health help in the face of TB-suggestive symptoms? What are the sources of healthcare men relied on when faced with TB-suggestive symptoms? These questions set the tone for appreciating the concept of medical pluralism in the African context. There is widespread acknowledgement in literature of the existence of multiple and competing health systems relied upon by people in sub-Saharan Africa in relation to health and illness (Manganyi, 2019; Moshabela et al., 2017; Van Rensburg, 2012). While TB diagnosis is scientific, the cultural and religious milieu of men mediate how they choose

from the available health systems to attend to their health needs. The processes leading to TB diagnosis and the attendant health-seeking behaviours of men occur within the context of medical pluralism. This plural healthcare system involves 'switching or shopping' from diverse healthcare systems that include traditional and faith-based healthcare systems (Moshabela et al., 2011; Moshabela et al., 2016). The context of choosing from multiple healthcare systems reinforces the importance of understanding men's TB illness experiences through a theoretical framework that is contextually contingent. That objective is achievable through the lens of African-centred theories of masculinity.

To appreciate the health-seeking behaviours of men, African-centred theories of masculinity shed light on men's engagement with health systems other than western medicine. Health and illness are subject to religious and cultural interpretation and similarly, Mfecane's (2011) study on men's notions of masculinity in Bushbuckridge, South Africa found that men perceived health in broader terms of culture and identity; they used other therapies to maintain good health. Similarly, my study on responsible masculinity in Modimolle found that men engaged with a plural healthcare system. They utilised traditional medicines, religious prescriptions, over-the-counter medicines, and various kinds of enemas for their health (Madhuha, 2017). Through the lens of masculinity, the nexus between health and illness vis-à-vis culture and religion is explored and this helps to better inform and deepen an African perspective on masculinity. Therefore, understanding and addressing TB involves pluralism as an ontological process for diagnosis among men.

Analysing tuberculosis illness in the context of medical pluralism

When faced with illness or a problem out of the ordinary, men do not engage with the issue on a blank slate, but their cultural and religious stock of beliefs are relied upon in response to the perceived challenge. The reliance on the incorporeal in search of the cause of their problems is embedded in the African social universe, and as argued by Manganyi (2019, p.59), "the meaning of illness is, like other social reaction patterns, culturally determined." In this study, men rely on their sociocultural beliefs when responding to health challenges. For instance, 28-year-old Patrick remarked, '[t]here is more to human life than what science can prove. Whatever you believe in spiritually and mentally affects our health as well' **(Interview with Patrick, 15 September 2020).** The efficacy of science for health is clear, but in this case, Patrick demonstrates that belief systems are also important when interpreting health. This line of thought is captured in Lupton's (2012) argument that the dissatisfaction with the

mechanically alienating biomedical emphasis of health has seen a shift towards a more holistic understanding that considers the individual's biography as well as the psycho-social and spiritual elements. An inclination towards such an understanding of health opens the space for medical pluralism when investigating the aetiology of disease among men.

By way of definition, medical pluralism refers to the reliance on competing ethnomedical traditions within a single society (Manganyi, 2019; Moshabela et al., 2017; Winkelman, 2009). To wit, a plural healthcare system is akin to an open market where one can choose a single or a combination of systems for their health needs. In their study on local beliefs and TB in Ghana, Tabong, Akweongo and Adongo (2021) confirm that the local people situate the cause of the disease in both the spiritual and the physical realms. Winkelman (2009, p.164) corroborates this finding by asserting that "all cultures have ethnomedical systems" which are societally established to deal with health disorders. The culture and traditions people hold are part of their identity and these mediate how men relate to diagnosis and treatment of TB. Medical pluralism is anchored in the assumption that the different healthcare systems "coexist and form distinct health subcultures with unique beliefs, practices, and organisations" (Winkelman, 2009, p.164). However, the dominance of biomedicine in most modern societies weakens the assumption of coexisting health systems because biomedicine is professionalised and legislated, thereby giving it more authority.

The biomedical model of health presupposes that health and disease are biological while the "psycho-social-environmental" perspective places health in a "social context and advocates a multidisciplinary approach" (Gilbert, Walker, Cooper, Lewins, Matshedisho, Nunez-Carrasco & Selikow, 2019, p.3). In the research context, men draw upon diverse medical systems like Western medicine, traditional medicines as well as spiritual (religious) systems for interpreting TB. From Western medicine, bacteriologically inhaled aerosolised droplets in a random process cause TB. Interestingly, Steen and Mazonde (1999) aver that the traditional healer interprets the same disease through witchcraft causation while a religious healer may interpret it as God's punishment. The connection between witchcraft beliefs, misfortune and ill-health is common among my interlocutors, an entrenched belief that influenced their access to disparate medical systems. One of my interlocutors, wheelchair-bound Garry told me that his neighbours were jealous of his thriving transport business, and they bewitched him. As such, he interpreted that witchcraft caused him ill-health:

> **Garry:** I used to work hard. I was able to earn about R15 000 because I used to transport more than 90 schoolchildren in a day. The least numbers I was carrying were 75 schoolchildren per day. I used to make a lot of money back then. I even thought baagisane ba nloile [my neighbours had bewitched me] when I started to feel unwell.
>
> **(Interview with Garry, 15 September 2020)**

Steeped in an African cosmology, Garry's interpretation helps us to appreciate that people's cultural beliefs are crucial to their understanding of health and illness. Just as Ashforth (2002) noted the prevalence of witchcraft beliefs in post-apartheid Soweto were a result of jealousy amid inequalities. Garry felt that his neighbours were envious of his success, which is why he suspected they bewitched him. This jealousy-precipitated witchcraft must be understood in the context of high unemployment and poor service delivery in Modimolle. In other words, Garry's interpretation of his illness was not isolated from his socio-cultural context where witchcraft beliefs exist in a sea of poverty and unemployment. These belief systems find corroboration in Steinberg's (2011) work in Lusikisiki in the Eastern Cape province; the villagers believed that by virtue of being materially better off a person can be a target of witchcraft attack, even from family members. The witchcraft-caused afflictions invite engagement and a reliance on different medical systems within the context of medical pluralism.

In relation to the context of East and Southern Africa, Moshabela et al. (2017, p.1) argue that delays accessing HIV testing and anti-retroviral treatment among people living with HIV has been consistently found to be a result of utilising "fragmented medical systems" like traditional and faith healers. With reference to TB, a study conducted in Limpopo by Pronyk et al. (2001) shows that among other factors influencing patients' delays presenting for biomedical care was their practise of first consulting spiritual or traditional healers. Likewise, research conducted in Botswana highlighted the pivotal role of the plural health system in prolonging the delay period for TB diagnosis among TB sufferers. This delay was attributed to factors such as reliance on self-care through over-the-counter remedies, irregular attendance at healthcare facilities, and in some cases, seeking assistance from traditional healers (Steen & Mazonde, 1999). The existence of a plural health care system sheds some light on how men in this study interpret and negotiate the process of TB diagnosis.

During my conversation with 32-year-old Silas, it became clear that his delay in presenting at the clinic for TB care was rooted in witchcraft beliefs. Similarly, 24-year-old Herbert took his time engaging different medical systems before presenting at the local clinic, because he thought the cause of his illness was witchcraft-related. Such interpretation reinforces the

importance of the incorporeal in shaping men's identities and their interaction with healthcare systems in this context. The two interlocutors shared the following with me:

> **Eddie:** But why did you leave the decision of going to the hospital until such time when you were incapable of walking?
>
> **Silas:** [Laughing]. To tell the truth of what was going on in my mind; I was thinking that ke dilo tša batho or maybe ke dijeso[10] or something like that [I was thinking that maybe I was bewitched]. A lot was going on in my mind by that time such that it never crossed my mind that it could be TB troubling me.
>
> **(Interview with Silas, 24 September 2020)**
>
> **Eddie**: Who advised you to stop smoking and drinking?
>
> **Herbert:** It was my father. I then stopped smoking and drinking beer. Nna ne ke nagana gore ke tša batho la bona. [All along I was actually suspecting that what I was experiencing was a result of some witchcraft, you see]. I personally wanted to do my own findings about my health condition whether there was somebody who was bewitching me. It is because I was thinking a lot of things as I was in acute pain. I was hurting and so I was thinking that there was someone o a ntekang [who was testing me] and so I decided I rather try these faith-based healers because they have a gift of seeing in the spiritual realm. I wanted to know what was really happening with me. Instead of confirming my initial suspicions that there were people bewitching me, the prophet did not do that but prescribed me some taelo [religious prescription]. He told me something completely different and I then realised that he was telling me lies because I was taking pain block as well as Lerumo La Madi and Stametta [commercial herbal medicines] but they were not assisting me at all. How would his taelo [religious prescription] help me? From there I just stopped going back to him. I stayed like that with no change in my health until I eventually decided to go to the clinic to consult.
>
> **(Interview with Herbert, 21 September 2020)**

Both interlocutors firmly believed that their ill-health was because of a malicious hand of witchcraft – *ke dilo tša batho* (caused by witchcraft). Their interpretation of what they were going through was firmly rooted in cultural understandings of their bodies and health. The two participants reveal a belief that the aetiology of their ill-health was supernatural – an important basis that bolsters the utility of African-centred theories of masculinity to health and illness. The participants' culturally informed suspicions led them to seek healthcare from various sources, including folk healers, over-the-counter medicines (such as pain blockers), and

[10] *Sejeso, isidliso, idliso* (singular), dijeso (plural) refer to a disease or diseases inflicted by the witch mainly through the means of ingestion. *'Sejeso'* is similar to what Ashforth (2002, p.121) calls "*'isidliso'* in isiZulu or "Black poison", an evil work of the people called witches." Ramphele (1993. p.46) calls this *idliso* which refers to "disease attributable to having been 'fed' or 'made to eat' a harmful substance by evil-doers."

commercial herbal remedies like Lerumo La Madi and Stametta. Eventually they presented themselves at biomedical healthcare facilities where they were diagnosed with tuberculosis. A study on men and TB in Gauteng province by Makgopa et al. (2022) found that some male participants regarded witchcraft as the source of their TB illnesses and this belief necessitated concomitant health-seeking behaviours.

To understand the use of alternative medicine, the wider sociocultural meanings of health like belief in the supernatural causation of illness must be considered. In a typical representation of medical pluralism, 24-year-old Herbert opted for faith-based healers among the available alternatives because they purportedly 'see in the spiritual realm,' allowing them to identify the root cause of his illness. The alternatives included commercial herbal medicines and biomedical healthcare systems. Cant and Sharma (1999) argue that alternative medicines represent some kind of counterculture or resistance. The presence of and dependence on commercial herbal medicines, herbalists, and faith-based healers in South Africa exemplify resistance to the dominance of biomedicine. Herbert's consultation with the faith-based healer occurred after using commercial herbal medicines as a first alternative because he suspected he had 'clotted blood.' However, his condition did not improve; neither did the consultation with the diviner yield any positive health results. A study by Madhuha and Carrasco (2020) confirms the common use of Stametta by men for detoxification in Modimolle. Commercial herbal medicines as reported by Mothibe, Kahler-Venter and Osuch (2017, p.51) are widely used in South Africa as "immune boosters or tonics." At stake is the importance of understanding health and illness in the context of medical pluralism in South Africa; this explains some of the reasons men confronting ill-health delay seeking biomedical help.

In this context, men's perception of health is embedded with their cultural and religious belief systems. These belief systems play a significant role in shaping their ideas of what it means to be man and their involvement with alternative health systems. Informed interventions that target TB among men must therefore pay attention to these belief systems. The importance of these belief systems is that they offer meaning to men in terms of what they think to be the real cause of the disease, i.e., these belief systems help them come to terms with the philosophical question, 'Why me?' This important question evades biomedical interpretation. Ethnographic research helps us to appreciate the meanings interlocutors attach to everyday events without judging their interpretations and decisions. The vernacular terms used by the interlocutors like "*ke dilo tšabatho*" and "sejeso or *dijeso*" allude to suspected external and supernatural causation of ill-health. There is therefore a close relationship between men's understanding of

illness causation and their preoccupation with the incorporeal in identity formation. The language of *sejeso/dijeso* is associated with evil people who feed their enemies for evil intent. The delay in seeking biomedical help is therefore not disconnected from the context of traditional beliefs around illness causation.

Against the background of searching for the cause of illness within medical pluralism, I asked 54-year-old Gift about the medical systems he engaged with amid deteriorating health. He underscored his suspicion in the supernatural causation of his ill-health and the need to consult a diviner:

> **Eddie**: But before you decided to go to the clinic, are there any other health sources that you accessed first?
>
> **Gift**: I first went to some prophet before going to the clinic. I went there in August this year [2020]. I went to a prophet who told me some strange stuff. He is the one who actually made me to end up going to the clinic because I could not trust what he was saying. He first told me about sejeso. He said "you have sejeso and that the person who fed you sejeso means harm as he wants you dead. The evil person who fed you sejeso is meaning to have you dead before November [2020]."
>
> **Eddie**: But why did you first go to consult with the prophet?
>
> **Gift**: Eish, I was so, so weak until one of my relatives who lives close to these prophets called me and said let me take you to these prophets because your health does not look good. Let us go together so you can find out what your problem is. I straightaway went with him to consult. Immediately as we entered the shrine, they told me that 'your days to live are very few' and they started to tell me about sejeso in his presence. They prayed for me, and they told me that, the woman who fed you sejeso wants you dead before November. I began to wonder what kind of message that was, but they insisted that, 'yah, just know that in November you will be dead.' I was so frightened and to tell you the truth, the fear of the impending death in November forced me to go to the clinic. I then inquired from a neighbour who advised me that if it is sejeso, it might also be difficult for the prophets to take it out. Rather, go to the clinic. It later dawned on me that it is possible that I had been carrying this TB for a while before even the consultation with the prophets. I think I must have been infected with this disease since last year [2019].
> **(Interview with Gift, 22 October 2020)**

Although Gift states that his relative influenced him to consult the prophet, he had the agency to refuse or accept even when he was weak. More closely mirroring the consumptive and debilitating manner of TB is the argument by Ashforth (2000, p.167) that the affliction of *isidliso/sejeso "*devours the person from inside*"* where it "slowly consumes its victim…" Considering the way TB consumes an infected person's weight, witchcraft beliefs and

particularly *isidliso/sejeso* become relevant to how men interpret their condition at the onset of TB. This explains their delayed presentation at biomedical healthcare systems. In other words, TB symptoms and those induced by *isidliso* are blurred. A study in Ghana by Tabong et al. (2021) confirms that delays in health-seeking at hospitals among TB sufferers were associated with the dominance of local beliefs within contexts of medical pluralism. Likewise, a study by Makgopa et al. (2022, p.6) on health-seeking behaviours of men with TB in Gauteng province, South Africa found it a common practice for men to first seek health help from faith-based healers before presenting at clinics in critical condition. The fact that there is widespread use of alternative health systems is evidence of medical pluralism. This evidence calls for mutual coexistence and collaboration among these disparate health systems, to achieve positive health outcomes for men infected and suffering from TB. In the next section, I explore how traditional beliefs intersect with TB diagnosis and treatment.

TB illness vis-à-vis cultural and religious belief systems

It is through culture that people relate to others, and with the material and invisible world. Culture forms part of a people's identity. In Manganyi's (2019, p.50) articulations, "culture may be understood as constituting the most concrete medium for the structuring of the dialogue between man and the universe." In addition, culture mediates how people relate to health and illness. In my interview with Herbert, I further probed why he became dissatisfied with the faith-based healer's diagnosis:

> **Eddie**: So, he [faith-based healer] told you that you slept with a girl with dirty blood?
>
> **Herbert:** Yes, he told me such things asking me, 'isn't there a girl you slept with o a ntšhitšheng mpa [who had aborted]? Did you not have sexual intercourse with a girl who was on her monthly periods?' Then it dawned on me that yes it was my girlfriend the mother of my child. As you are aware as men, sometimes we force matters and end up doing certain things like having sex with your girlfriend even if she is on her periods. So, I told him that yes, I had sex with a girl on her periods, but I ended up not going back to him [diviner] again because I thought he was only interested in my money.
>
> **(Interview with Herbert, 21 September 2020)**

Although he decided not to return to the faith-based healer, Herbert's cultural beliefs about the perceived pollution from women are part of the cultural stock of the community and this resonates with literature (see Madhuha & Carrasco, 2020; Niehaus, 2007). The locals believe that having sexual intercourse with a 'polluted' woman can cause an affliction. A study of responsible masculinity in Modimolle unpacks four scenarios in which sexual intercourse with

a ‘polluted’ woman can cause illness (Madhuha & Carrasco, 2020, p.109). Similarly, a study in Bushbuckridge by Niehaus (2007, p.853) found the community believed that “such *(polluted*) women are in a dangerous state of heat (*fiša*)” and a sexual encounter with them was believed to cause fatal afflictions in some instance. Elsewhere, in Botswana, a study by Steen and Mazonde (1999) confirms the widespread belief in the ‘pollution’ of women whereby a sexual encounter with a pregnant or menstruating woman is believed to cause illness.

Herbert’s admission that as ‘men, sometimes we force matters and end up doing certain things like having sex with your girlfriend even if she is on her periods’ demonstrates the power dynamics at play in heterosexual encounters. In such situations, women often lack the ability to negotiate safe sex with their partners. However, power is ubiquitous and, paradoxically, the ‘polluted women’ wield power that poses ill-health to men, something that impinges on masculinity identity. Despite using the concoction prescribed by the diviner, Herbert’s condition did not improve. Upon his eventual visit to the clinic, he was diagnosed with TB. Nevertheless, this does not diminish the significance of traditional beliefs regarding sexuality and its perceived risks. Like Herbert, Terry also engaged with a traditional healer and a diviner and found no efficacy in the prescribed remedies. Here they narrate their experiences:

> **Herbert:** But then I asked myself that, since he is telling me about my kidneys and my dirty blood and I have bought Lerumo la Madi and Stametta to clean my blood without any improvement, why was he insisting on me coming to him again? I then decided to stop going back to him for help.
>
> **Eddie:** How much did he charge you for the consultation?
>
> **Herbert:** He only told me that he would give me a container with water that he would mix with methylated spirits for R50. He also told me that he would give me motlamo [a waist or wristband worn to protect oneself from evil spirits or illness or to get luck]. He then said to me that the process would also involve him cleansing me and overall, he wanted me to pay R150.00. It was a taelo [religious instruction] but in the end, I decided not to honour it because I did not believe him. The problem is that the pain I was experiencing was too much. That is why I ended up not trusting him because I used different things hoping that I would get well. I used to tell myself that all these pains were caused by clotted blood that was blocking certain body parts. That is why I used different remedies to try to break those blood clots in my body only to be told that I have dirty blood, what-what, ‘you slept with girls, and you drew dirty blood from them.’
>
> **(Interview with Herbert, 21 September 2020)**
>
> **Eddie:** Whom did you consult?

> **Terry:** I consulted both a prophet and a traditional healer. In Pretoria, my cousin took me to a prophet who gave me a 2-litre full of some concoction for my stomach. It made me to constantly run to the toilet to relieve myself. There were no changes to my condition and when I came here to Modimolle, I went to a traditional healer somewhere in Extension 8 and he told me that ke sejeso and he advised me against going to the hospital. He said I must not go to the hospital because if I do that I will die. He gave me some herbs that he said are for sejeso and that he would want me to pay him R4 000. Because I was desperate due to the illness I took the herbs and he recommended I eat soft porridge mixed with his herbs three times a day. I was having a problem of a running stomach so he said the other medicine was for ensuring the running stomach stops. On the contrary, the herbs meant to stop the running stomach worsened my condition as I continued to experience the running stomach without signs of abating. My wife then decided to stop going to work for a week and she insisted that I go to the hospital. She then took me to the clinic where they transferred me to the hospital. The doctors did their tests and confirmed I had TB. They asked me whether I was taking traditional medicines to which I confirmed in the affirmative. They then said the medicines had caused damage to my kidneys. I refused to pay that traditional healer the R4 000 he charged me because I was only assisted at the hospital. I only paid him R250 for consultation and R500 for the herbs, and R500 for o thlapisiwa senyama [cleansing of bad luck]. Overall, I paid him R1 250.
>
> **(Interview with Terry, 1 February 2021**)

True to its form, medical pluralism is a space in which one engages with a multiplicity of medical systems to enhance one's health. Both Herbert and Terry suspected witchcraft as the cause of their ill-health. During their consultation with folk and traditional healers, the interlocutors help us to appreciate the importance of sociocultural beliefs in the interpretation of illness. The vivid case of Terry who engaged with three disparate health systems in the form of faith-based healer, traditional healer and biomedicine demonstrates the prevalence of medical pluralism in the community.

Men's attempts to rid themselves of *senyama* (bad luck) and illnesses through *taelos* (religious prescriptions) hinge on their firm beliefs that health is intricately connected to the supernatural. By extension, these beliefs reinforce the argument that masculinities in the African context are shaped by the incorporeal. The tension between traditional medicine and western medicine peaks when Terry mentions the express instruction from the traditional healer not to consult biomedicine. This is an indictment of identity construction in the African context, a further demonstration of the dominance of biomedicine. In the same vein, the tension between and within plural medical systems is heightened with the remarks from the healthcare staff of the toxic nature resulting from the continuous use of traditional herbs as reflected in Terry's statement. This aligns with Ashforth's (2000) research on witchcraft in Soweto. In the context

of the research, biomedical practitioners concluded that individuals who delayed seeking biomedical care because of their reliance on traditional herbalists exhibited chemical poisonings due to their extended use of traditional herbs. This underscores the competing and tumultuous relationship within plural medical systems. Regardless of the efficacy of alternative health systems, disease causation among men has supernatural origins.

Consistent with a study in Limpopo by Pronyk et al. (2001) where only 15% of TB sufferers had used traditional healers as the preferred source of care, very few of my study participants consulted traditional healers when they started experiencing TB-suggestive symptoms. The majority of those who engaged with plural medical systems used faith-based healers and over-the-counter medicines. During his engagement with the faith-based healer, Herbert was using commercial herbal medicines to cleanse his blood, which he suspected to be 'clotted' while Terry underwent *o thlapisiwa senyama* (cleansing of bad luck) from a traditional healer. This fixation with 'cleansing' is corroborated in a study by Ramphele (1993, p.47) where she argues, "the preoccupation with 'cleansing' is also a significant indicator of the acute awareness of living in a polluted environment." Similarly, a study in Zambia on TB and HIV stigma found an association between TB, a dirty environment and moral contagion (TREATS, 2022). The prevailing perception was that one gets TB in a dirtier environment and that morally, one contracts the disease because of doing something that ought not to be done, like smoking or drinking too much or having sex with multiple partners (TREATS, 2022, p.20).

Epidemiologically, tuberculosis is associated with poverty and symbolically, the contaminated and defiled environment epitomises the fractures and inequalities prevailing in the South African society where tuberculosis is concentrated among the marginalised population. Herbert and Terry discontinued the religious and traditional treatment because they realised nothing was changing for the better and they went instead to the clinic. It is in this regard, that Ramphele (1993, p.45) concludes that "…people employ a hierarchy of resort in search of healing and that this hierarchy is developed in relation to available healing resources with evidence of a facility to adjust to changing realities." It is therefore clear that when one presents to an alternative health system, it is because of suspicions about the cause of the affliction, just as when one presents at a clinic or a hospital. The frustration becomes clear when one's suspicions are invalidated. This results in distrust, and the client pulling out of the healing process altogether.

Health is dependent on the sociocultural context; that illness is both a subjective and societal process lends credence to the importance of analysing tuberculosis through medical pluralism or 'medical parallelism' to borrow from Thornton (2017). While some participants initially sought solutions for their illnesses through alternative health systems like faith-based healers and traditional healers, Timmy's first source of medical assistance was the public clinic. He stated the following about his interaction with the local clinic:

> **Timmy:** When the nurses completed checking me, they gave me medication for flu and my condition did not improve at all. Erm, I then went somewhere-somewhere, and they told me that you have TB; you must go and take your TB treatment because TB is hidden in you, and it cannot manifest itself.
>
> **(Interview with Timmy, 10 September 2020)**

Timmy's first interaction with the local clinic did not yield an accurate diagnosis and he opted to go 'somewhere-somewhere' in a bid to understand the aetiology of his symptoms. The point he was told that 'TB is 'hidden in you' must not be construed as dormant TB because Timmy was already ill and emaciated. I followed up with a question on where exactly he went when he referred to 'somewhere-somewhere':

> **Timmy:** Oh, I had to go to another Moruti [a pastor] to consult on family matters. We went together as a family somewhere. The pastor checked me, and he said, no man…Because for me to go there I had realised that I had many diseases checked at the clinic but was found to be negative. I then assumed that it could possibly be a result of witchcraft, you understand. It was because the clinic could not diagnose me with anything. The pastor told me that only one thing was not checked at the clinic and that was TB. He told me to go back to the clinic, be tested, and initiate onto treatment. He assured me that I would be okay.
>
> **Eddie:** Wow. Serious?
>
> **Timmy**: The pastor told me exactly that. He is a pastor and not a witchdoctor. He is a Moruti. He told me that there was no problem with me but only that I needed to initiate onto TB treatment at the clinic and I would be okay. Then I went back to Modimolle because I had hitch-hiked with my younger sister to visit this pastor. When I got back, I went to the clinic same time, and I gave them my sputum like today and the following day they called me to come and take my TB treatment.
>
> **(Interview with Timmy, 10 September 2020)**

At the onset of deteriorating health, Timmy presented at the local clinic but could not get an accurate diagnosis of his condition. This prompted Timmy to suspect witchcraft causation, and this reinforces the point that personhood in the African context is also transcendental. This resonates with Comaroff and Comaroff's (2001, p.275) argument on personhood that it

transcends the corporeal body as its essence can be impacted for good or ill. In similar vein, Ashforth (2002, p.126) found that in Africa, "untimely illness…are almost always attributed to the action of invisible forces, frequently those described as witchcraft." Timmy's matter-of-fact statement to me, 'I then assumed that it could possibly be a result of witchcraft, you understand,' is noteworthy and informative. The statement demonstrates a taken-for-granted assumption in which Timmy expected me, as an African man myself, to appreciate his interpretation that his illness had other supernatural causes.

Timmy's story illustrates that relying solely on biomedicine for interpreting illness is insufficient. It highlights the absence of a universal medical system capable of addressing all health problems in this context. In a manner similar to how Timmy was referred by the pastor to the clinic, the prophet whom Silas had consulted referred him to the clinic possibly after realising that the illness was beyond his expertise:

> **Eddie:** What did you do then when you suspected that witchcraft was behind the illness? Did you consult?
>
> **Silas**: Ke e le ka dira denyakesiso kgo bolela nnete [I made my own consultations] and the prophet told me that no, go back to the clinic.
>
> **(Interview with Silas, 24 September 2020)**

In a culturally diverse society like South Africa, health remains a cultural issue deeply intertwined with people's belief systems. To harness the health benefits within this cultural diversity, different health systems must work and complement each other for population health. A study by Galvin et al. (2023) on religious and medical pluralism among traditional healers in Johannesburg confirms the occurrence of cross-referrals between traditional healers and medical practitioners. The authors offer evidence indicating that in certain cases, professional nurses also serve as traditional healers, advising their patients to seek consultation for ailments perceived to have supernatural origins (Galvin et al., 2023). While these instances are limited, where a traditional healer takes on the biomedical role of a nurse, they illustrate the coexistence of distinct health systems within this context. In line with the experiences of individuals like Silas and Timmy, who grappled with cross-referrals between disparate health systems for positive health outcomes, Galvin, Chiwaye and Moolla (2023) confirm that traditional healing practitioners often advise patients they perceive to have natural illnesses to seek treatment from doctors.

In a scenario somewhat akin to Timmy's, Silas initially visited the clinic for consultations and was diagnosed as HIV positive. However, a critical communication error by the healthcare staff led to conflicting messages: while one healthcare official informed him of his HIV-positive status, another mistakenly told him that his 'blood was clean.' This contradictory information caused Silas to miss a crucial opportunity to begin antiretroviral therapy (ART) and exercise his 'therapeutic citizenship' rights, as conceptualised by Nguyen et al. (2007). His cross-referral experiences proceeded as follows:

> **Silas:** After having been instructed by the prophet, I went to the clinic where they told me that, 'you have a disease [HIV] and you were supposed to come here at such-and-such a date.' I told them that I came on the exact date and found a certain man who told me that 'your blood is clean; go back you are okay.' In my clinic book, I showed them the date that I was there at the clinic. They then told me to sit outside while they looked for my file. When they found it, they directed me to a container where they gave me some tablets. I started taking those tablets but as time went on, I felt that ke felelwa ke maatla [I was losing strength] and that was the time magogo [mother] took me to the hospital. When I arrived at the hospital, they put me on a drip, and I remember that I stayed there for quite some time.
>
> **(Interview with Silas, 24 September 2020)**

Silas experienced a decline in his health due to the unintentional delay on his part in enrolling for antiretroviral therapy (ART). By the time he began ART, tuberculosis (TB) had developed, leading to his hospitalisation. The crucial aspect is that both Timmy and Silas sought assistance from folk healers when their initial visits to the clinic did not yield favourable outcomes. This underscores how the interpretation of illness is influenced by cultural and religious contexts, further reinforcing the importance of medical pluralism. As I delved deeper into conversation with Timmy, he revealed his struggles to get employment. Consequently, his visit to consult the pastor was more than just seeking spiritual guidance for his illness; it was a comprehensive journey to seek holistic solutions. This is inseparable from identity. I have shown that within African cosmology, personhood is profoundly influenced by the supernatural. About his visit to the pastor Timmy, remarked: 'I went to consult with that pastor because he helps people. He attends [name supplied] church, but he is more powerful, *o tshwere maatla* [he is powerful], you see.' Therefore, alternative healers have a holistic approach to the health problem, a fundamental reason why men consult them in line with African personhood.

To the participants, the role of religion connects not only to health but also to other social issues. The search for meaning in life circumstances that transcend the physical domain is,

according to Timmy, what drives people to this 'powerful' pastor. Timmy accords the pastor much respect:

> **Timmy:** The pastor is gifted; I am telling you. He is powerful. There are many people that I know who lost their government positions because of fraud and they stayed home for a long time without working. They went to consult with that pastor there in [name of city provided] and now they are back at their work. That place is always full. He is in [location name provided] … or somewhere there. People in need of help flock to that place. The pastor then told me that after getting through with your treatment you must come back for your other issues that you needed consulting with.
>
> **Eddie:** Oh, so you will still go back to the pastor?
>
> **Timmy:** Yes, I am still to go back to him.
>
> **(Interview with Timmy, 10 September 2020)**

As Timmy was still searching for employment, the confidence he showed in the pastor demonstrates his belief that what happens in the material world ties with the incorporeal. Even amidst his illness, Timmy remained focused on his need for employment. This highlights that in illness, men's preoccupation with masculinity identities is not lost hence the quest to return to the pastor for further consultations.

While Herbert, Silas and Timmy consulted folk healers, Thuso's knowledge of African traditional medicines (ATMs) was a cultural resource that he relied upon as he experienced TB-suggestive symptoms of coughing. In his assertion, Thuso stated that he did not suspect that the continuous coughing was something to worry about. To manage the coughing, Thuso resorted to the use of traditional medicines first:

> **Thuso**: I started coughing in January 2019. That is when I started coughing, but I could feel that my body was not okay, and I would just explain it away as flu, hoping and planning that I would treat it with drinking traditional herbs.
>
> **EM:** Oh, so you did use the traditional herbs?
>
> **Thuso:** Yes, I used them but not right through. I used only one leaf of sekanama [Drimia elata] because it is too bitter, and I mixed it with mmetse [Helichrysum caespititium]. I would drink the concoction to clean my blood. As soon as I would finish drinking these medicines I would feel better and immediately, I would leave to go and drink beer. I quit smoking cigarettes in January 2019. The time I eventually became very very weak was in 2020, in January.
>
> **(Interview with Thuso, 21 June 2020)**

Below are the pictures of traditional medicines that Thuso used in attempting to manage the symptoms he was experiencing before a TB diagnosis:



Photo 3: Drimia elata/Hyacinthaceae (*sekanama*) (*mmetse*) (Source: Personal photos).



Photo 4: Helichrysum caespititium (Source: Personal photos).

Thuso used the mentioned herbs for cough management and as an enema to cleanse his blood – a practice commonly adopted by men as discussed in my 2017 study conducted in Modimolle (Madhuha, 2017). This self-medication is evidence of 'medical parallelism'. Thuso's exercise of agency helped him to maintain a sense of health security which enabled him to continue with his everyday life. A study on *Ethnobotanical knowledge of the lay people of Blouberg area (Pedi tribe)* in Limpopo province of South Africa shows that people use the bulbs of the herb Drimia elata (s*ekanama)* to "treat sexually transmitted infections and as a blood purifier" (Mongalo & Makhafola, 2018, p.10). An interesting observation is that Thuso is ethnically Shangaan and is the only participant who attested to using 'traditional' medicines based on his own knowledge. As confirmed in Mfecane's (2011, p.133) study, "[t]he use of traditional medicines also emerged as a significant feature in the constructions of masculinity in Bushbuckridge and as part of a Shangaan identity in general." Thuso's familiarity with and dependence on traditional medicines is a direct and powerful statement of his ethnic identity and masculinity. While Thuso's personal use of the traditional medicines may reinforce the individual responsibility over health and a sense of empowerment, it is important not to overlook the unequal access to biomedical healthcare. His health-related behaviours reflect how medical pluralism as a concept is not simplistic but is foregrounded within the broader socio-economic and political context.

The fact that men rely on complementary healthcare systems highlights the importance of collaboration with biomedicine. Edginton et al. (2002, p.1080) argue that holistic patient care

requires communication between all care providers to accommodate patients' cultural needs and to avoid conflicting messages. It is necessary to acknowledge that when men take their time to present for care at the hospital or clinic for TB, they would not be idle, but explore the necessary means possible to establish the cause. Additionally, it is important to recognise the effectiveness of other complementary or alternative systems in referring sufferers for TB diagnosis. The lessons learned from the collaboration between religion/traditional systems and biomedicine in combating TB and other diseases are significant because these alternative health sources are deeply rooted cultural practices that people rely on for healthcare assistance. Having established the rich context of alternative health systems for TB illness, I follow this up with a specific analysis of the health-seeking behaviours of men.

Men's health-seeking behaviours in relation to tuberculosis

Men's health-seeking behaviours occur at the individual-structural interface. Preceding steps towards their health, men undergo the processes of meaning-making of the TB-suggestive symptoms. The meaning-making processes that prompt men's health-seeking behaviours are influenced by various factors such as educational status, socio-economic class, culture, healthcare system, and family structure. Chikovore et al. (2020, p.4) argue "[t]he prior focus on women in TB research, policy and funding has meant little research exists on men's TB care access barriers, and most of this has come out of the African continent." My study emphasises the importance of understanding the TB illness experiences of men in a non-mining community of South Africa. Overwhelmingly, all the participants were diagnosed with TB after presenting themselves at either a public or private healthcare facility. The meaning-making processes preceding a TB diagnosis involved complex trial and error. Men interacted and consulted pharmacies while presenting with flu-like symptoms where they purchased over-the-counter medicines. In other instances, they utilised traditional medicines, both as enemas and for their medicinal properties, to cure the symptoms. As presented in the preceding section, some men consulted religious healers and prophets when they experienced illnesses. In all these initiatives, the agency of men in health-seeking is clear.

To elicit participants' health-seeking behaviours, I first asked them the question, 'What do you do when you feel that you are not in good health?' I followed up on this general health behaviour question with a more pointed prompt, asking participants what steps they initiated when they started experiencing TB-suggestive symptoms. This was Themba's explanation:

> **Themba**: Firstly, I normally go to the pharmacy where I just explain whatever I am feeling and stuff. If that medication I take does not help, I will just go to the doctor. Normally I do not go to the public clinic. [Laughing].
>
> **(Interview with Themba, 1 December 2019)**

Themba's response demonstrates a patterned health behaviour when he experiences symptoms of illness. The initiative towards seeking health help from pharmacies at the onset of illness-suggestive symptoms was shared by a few participants. Makgopa et al. (2022) in a study on men and TB in Gauteng note a similar common practice of men, when unwell, to first either self-medicate or seek healthcare from community-based healers, before visiting health facilities. Importantly, Themba had a job guaranteeing him a regular income. Although he did not have medical insurance, he could afford out-of-pocket payment of his medical expenses at private healthcare facilities. As Herbert was digesting and trying to make meaning of the pain that he was experiencing before a TB diagnosis, he recounts the other sources of health help that he interacted with:

> **Herbert:** Let me say that in the month of October [2019] was the time I was coming from work, and I was starting to experience some pain in my back, and I was thinking that these were just some ordinary back pains since the work I was doing was too hard and strenuous. I was thinking that the back pains were a result of that kind of work. I began to be surprised when I bought and started using Lerumo Lamadi [over-the-counter medicine] and there were no changes to the back pains. The medicine temporarily eased the pains and after two or three days, the pain would resurface. Because I used to smoke, I would feel something in my lung and when exhaling, I would sense a whistling like sound of dust coming out. When coughing, my phlegm would be mixed with blood. However, I did not know that this was TB. Therefore, I just stayed with those symptoms. In December [2019], I remember as I was drinking beer, the beer affected my throat, and my lymph glands became badly swollen, le fahla le gana ka thoma go thibana [and my lungs started having problems when breathing] and they advised me not to smoke or drink beer again. I stopped those things.
>
> **(Interview with Herbert, 21 September 2020)**

Herbert's narrative is significant for his deep understanding of his body. He attributed the back pains he experienced to his strenuous job. Proceeding accordingly, he purchased over-the-counter medicine, Lerumo Lamadi, readily available at pharmacies and retail outlets. This medicine is used for various ailments, and Herbert utilised it to alleviate the pain he was enduring. Since he was aware of the way his body functioned, Herbert noticed negative changes occurring in his body after smoking and beer drinking. Health-seeking behaviours are structurally mediated issues as demonstrated in the way Herbert mentions people's advice to

him to stop beer drinking and smoking. At the same time, the decision to stop these practices was ultimately an act of agency on his part.

Most participants turned to the public healthcare system when they required assistance for symptoms suggestive of TB. Thuso's knowledge of traditional medicines was a crucial resource he relied on when faced with incessant coughing. However, upon the coughing persisting he made a personal decision to seek help from the public clinic:

> **Thuso:** So, it was a year and a month since I started feeling that no, I am not feeling well. It was in January 2020 that I felt that hai, ga e sale nna, gore ke bokoa [I am no longer the person I used to be, I was weak]. I was now so weak to the extent that even if someone would slightly push me, I would fall down. People close to me were beginning to wonder what was happening to me. That is when I came with a plan on that Sunday to go to the clinic alone without telling my family.
>
> **(Interview with Thuso, 21 June 2020)**

Although health is an identity issue that is self-validated, the people around us play an important role in the validation process. In Thuso's case this manifested when his friends became concerned about his deteriorating health. For the 13 months before finally presenting at the clinic, Thuso used traditional medicines to manage his illness. As I argued earlier, Thuso's utilisation of traditional medicines was not only a practical choice but also a deliberate performance of his masculinity and an embracing of his Tsonga ethnic identity. Concerned to establish why Thuso visited the clinic without informing his family, I followed up with him:

> **EM**: Okay, the other time I heard you say that you privately went alone to the clinic without telling your family members, why did you do that?
>
> **Thuso:** I was afraid to tell them because I knew they would talk me out of that decision, as they would not believe me. I knew they would say I was drunk. So, I went alone to the clinic without disclosing anything to them. When I came back, I had a letter from the clinic. That is when I told them that I would go back to the clinic the following morning. As usual, they did not take me seriously. So, I went back to the clinic on Monday, and I was then referred to the hospital. Since I did not have money for transport I came back home, and they gave me R50 which would also cover food expenses. I was so fixated on finding the underlying cause of what was troubling me such that I did not even bother to eat anything at home but immediately left for the hospital.
>
> **(Interview with Thuso, 21 June 2020)**

The prolonged delays in seeking biomedical healthcare and initiating TB treatment by individuals like Thuso and Herbert align with findings from a systematic survey review conducted by Horton et al. (2018, p. 249), which indicated that the duration from disease onset to treatment initiation is a year longer for men compared to women in Vietnam and Malawi. In

a similar vein, a study conducted in Ghana by Tabong et al. (2021, p. 10) revealed a significant delay of "several months, sometimes a year or more" between the onset of symptoms and the initiation of TB treatment. This finding is corroborated by Pronyk et al. (2001, p. 624) in their study conducted in rural Limpopo, South Africa, which also identified a considerable delay between the onset of illness and the commencement of treatment among pulmonary tuberculosis patients. It is not coincidental that comparatively more men than women delay seeking biomedical healthcare in the face of TB-suggestive symptoms. As Thuso highlighted, societal norms, particularly within the family institution as in his case, frequently instil doubt when men exhibit vulnerability. Men are generally expected to embody resilience and conceal any signs of vulnerability within this societal framework. However, the core reason behind men delaying seeking biomedical healthcare services lies in their reliance on alternative healthcare systems within the framework of medical pluralism. Their inclination towards alternative health systems, including traditional medicines and faith-based healers, is driven by a belief in the supernatural causation of illness. This belief, deeply rooted in their cultural and personal beliefs, becomes a performative aspect of their identity, which crystallises how masculinity is shaped by the incorporeal.

Health-seeking behaviours are mediated at the individual and structural levels. While Thuso claimed that his use of traditional medicines temporarily alleviated the coughing, it was evident that his friends remained concerned about his condition. This highlights that while individual agency plays a crucial role in determining health-seeking behaviours, external structures are equally significant in shaping an individual's healthcare decisions. The findings of my study show how some caregivers exerted pressure on men to seek biomedical health assistance amid persistent delays in doing so:

> **Erick:** When I was eating, I would puke. Same applies when I would drink something, I would vomit it until my grandmother said no; this is serious. It was because now when I was coughing the sputum was contaminated with blood. It was too much. Even when I was vomiting, I was vomiting some blood. It was then that my grandmother said you must go to the clinic. I think it was at 5:00 on a Thursday evening**.**
>
> **(Interview with Erick, 18 August 2020)**

> **Charles:** That is the reason I mentioned that I was losing appetite and I was not eating. I ended up becoming so weak and failing to walk on my own. I had become very, very weak. This TB thing happened so fast to me. Let me just say within one or two weeks it had caused me to lose so much weight and appetite. However, I still thought that I was okay yet the people seeing me were telling me otherwise. This place [demonstrating by touching his face] had fallen inside, and my eye sockets had sunken

> but, in my body, I would feel like I was strong. The people who knew me started to tell me that I was sick. My aunt forced me to go to the hospital to check what was happening with me. I went to the private doctor first and they put a drip on me and gave me some tablets. I felt like I had improved after seeing the private doctor but after four or five days, I then started feeling worse. I then ended up going to the hospital for medical consultation. That was the time they then told me I had TB.
>
> **(Interview with Charles, 7 September 2020)**

There are similarities between Herbert, Thuso, Erick and Charles's health-seeking endeavours in that they admitted that something was amiss with their health, yet they did not take the necessary steps on their own to seek biomedical healthcare. Herbert states that 'my lungs started having problems when breathing' and people around him 'advised me not to smoke or drink beer again,' while Thuso remarked, '[p]eople close to me were beginning to wonder what was happening to me.' For Erick who was coughing and vomiting blood, reports that 'It was then that my grandmother said you must go to the clinic', while Charles, who appeared sick to those close to him, admits that 'My aunt forced me to go to the hospital to check what was happening with me.' There is a consistent behavioural pattern among these men not to seek biomedical healthcare, and this clearly borders on masculinity identification and performance; a man is resilient and cannot show vulnerability. That embracing of masculinity of resilience is societally reinforced emerges in Thuso's case – he shares that he feared his family would doubt him if he told them of his need to consult at the clinic, and hence he went alone. Be that as it may, the extracts above evince that family and friends form an important social structure relied upon by men for health-seeking. This demonstrates that health-seeking behaviours are mediated at both the individual and societal levels.

Dumisani, the nurse, provides insights into some of the factors contributing to men's delays in seeking health assistance from biomedical facilities. His views add to the complexities of men's health-seeking behaviours. A deeper understanding of what would be happening with the men in their own lived context is an important premise upon which to base conclusions on why men sometimes present at points of healthcare in wheelchairs or in situations of emergency. Dumisani had the following remarks to make:

> **Dumisani:** Many men that I see coming to the clinic are cases of leaving it until very late before visiting the clinic and in some cases, they will come here with the aid of someone and in others, they come in wheelchairs because they are no longer capable to walk on their own due to different illnesses. When they come here, their immune systems are already very weak and, in some cases, their CD4 count would be very low. … Men always want to go and access healthcare when they really feel down and so

> weak, in much pain and when they cannot do anything. They wait until someone close like family members force them and say, 'now I am going with you to the clinic.'
>
> (**Interview with Dumisani, 3 March 2021)**

Considering that Dumisani regularly interacts with people who are chronically ill, his observations about men's health-seeking behaviours are important. His observations indicate that men presenting late for biomedical healthcare is a common phenomenon. But why do men delay presenting themselves at biomedical facilities for TB diagnosis? Although Dumisani does not state the reasons behind this delayed health-seeking by men, evidence from my study shows that men interact with alternative health systems when faced with illnesses and this is inseparable from identity constructions. This is in line with their community's socio-cultural understanding that the aetiology of disease is connected to the supernatural. Similar observations in a study on men's barriers to TB care-seeking in Malawi show that men had a "pattern of waiting and seeing if their condition worsened before they sought care and only going to formal healthcare when illness was at an advanced stage" (Phiri, Makepeace, Nyali, Kumwenda, Corbett, Fielding ... & MacPherson, 2021, p.5). Considering the argument that masculinity identity is shaped by the corporeal and beliefs in the supernatural, it follows that men's understanding of their bodies and health is also incorporeally influenced. Men's engagement with complementary health systems explains the delays in presenting for TB diagnosis at biomedical facilities.

Dumisani's reflections concur with findings from several of my participants, especially those who ended up in hospital. To back up this claim, I refer to Charles' aunt, Tracey who was once his caregiver. I asked her at what point she realised that her nephew's health was deteriorating and that he needed help. She responded:

> **Tracey:** At first, I saw him losing weight and he had stopped eating food the way he used to. His health had taken a turn for the worse as compared to the way I knew him. I started telling him to go to the clinic for consultations, but he would refuse.
>
> **(Interview with Tracey, 5 October 2020)**

Tracey approached her elder sister who owned a tavern Charles liked hanging out at, hoping that she would intervene in influencing Charles to seek health help:

> **Tracey:** I would at times ask my sister who owns the tavern why she would keep up with Charles in his ill condition without telling him to go to the clinic. My sister told me that she had unsuccessfully tried to encourage him to go to the clinic. At one point, I told him to bath so that we could go to the hospital. I then drove with him to the hospital. **(Interview with Tracey, 5 October 2020)**

The information from Tracey demonstrates how important a family is for helping shape men's health-seeking behaviours. I reflect below on Silas and George's experiences before they finally presented at the clinic and hospital. Like Silas, 29-year-old George was co-infected with TB and HIV, and he lived with his mother in an RDP house. Both participants admitted they only turned up at the healthcare centres in critical condition after the intervention of their mothers. They shared the following experiences around health-seeking:

> **Silas:** So, when I was here at home during the first COVID-19 lockdown, I realised that no, ke a fela, ka fela, ka fela [I am gradually losing weight] and Magogo [mother] then said, 'no, tomorrow we must go to the clinic.' So, we went to the clinic, and I was carrying that small book that I used during my first visit [two years before].
>
> **(Interview with Silas, 24 September 2020)**

> **George**: I used to sweat a lot at night, and I would not even wear blankets. I used to sweat especially when I cough; then the old lady [the mother] took me to hospital. I did not realise what it was because I never went to the clinic to check on my health when I was experiencing the symptoms at first.
>
> **EM:** So, you didn't go to the clinic at first?
>
> **George**: No, I did not but now I go regularly, I do not want problems.
>
> **EM**: So why did you not go to the clinic before?
>
> **George:** I did not think it was TB I thought it was a bad flu, sometimes you get a bad flu for about 2 weeks, and you cough. **(Interview with George, 20 August 2020)**

Despite experiencing symptoms such as swollen feet, coughing, and sweating, George did not feel compelled to act regarding his health nor did he see the need to seek help from a clinic. A study in Ghana on local beliefs about TB confirms that the symptoms experienced in the early stages of the disease are not very straightforward as they conflate with symptoms of asthma (Tabong et al., 2021). The blurred relationship between TB symptoms, asthma and in this case, George's 'bad flu' explains men's delays seeking biomedical healthcare. As evidenced in both accounts above, it was at the intervention of their mothers that Silas and George ended up going to the hospital for healthcare. This was after the parents realised that the health of their sons was deteriorating.

Overwhelmingly, it is evident that a family is an important social structure mediating men's health-seeking behaviours when faced with TB-suggestive symptoms. While in many cases families can support and encourage men's health-seeking behaviours, they can also hinder these attempts, particularly when they doubt or question men's efforts to seek help for their health. To manage the pressures from doubtful family members, especially from caregivers,

men sometimes request their spouses to accompany them to healthcare facilities for consultation. This demonstrates that men's delays in seeking biomedical healthcare are not innate behaviours but rather socially influenced. The case of Themba below illustrates how frustrated he had become because of not getting his illness accurately diagnosed. He made more than three visits to a private health care facility in addition to his over-the-counter purchase of medicines from a pharmacy before an accurate TB diagnosis was made:

> **Themba:** But erm, when I went to the doctor, I had been tested a whole lot of times and it [tuberculosis] did not show up for a while maybe until…erm, I went in for three tests, I think. **(Interview with Themba, 1 December 2019)**

Themba, who previously indicated his health-seeking behaviours revolve around consulting the pharmacies first when not feeling well, tried thrice to seek healthcare help from a private doctor without success. This lack of progress in the matter took its toll on his spouse, such that he finally asked her to accompany him to the doctor:

> **Themba:** I can just add that when you are sick, as long as you have support from someone and as long as you have someone by your side to go through the situation with you, like who can go to the doctor with you, or someone who will be there to listen with you, that will also help. Because it is not easy to report to someone and say, 'I was at the doctor and he said this and that' when the person [his partner] was not there to hear it with you. It is not that easy for that other person to believe and trust what you say when you report what the doctor said.
>
> **EM:** So, in your case, you went with your partner, or you went alone?
>
> **Themba**: We did go together to the doctor. Yes, she was there. That is why I said I did get all the support I needed from my family. However, if you are alone, when you come out and try to explain to your partner that the doctor said this and that, it will not be easy for the partner to believe you. It will not be easy [laughing]. As partners, you just have to go together. This helps her to know how to help you.
>
> **(Interview with Themba, 1 December 2019)**

The decision to persuade his partner to accompany him to the consultation with the doctor was pivotal in allaying doubts Themba's spouse could harbour about the cause of her partner's ill-health. It also helped the couple in terms of fostering transparency and accountability on health matters in their relationship. These positive values bring the family together instead of the alienating consequence of keeping secret one's health condition. The joint consultation ensured that Themba received the necessary care from his spouse and children. I had the privilege of interviewing Themba's partner, and she corroborated her spouse's version of events when they

went together for consultation. She confirmed that Themba initiated the joint consultation in line with health-seeking:

> **EM:** But why was it important for both of you to go together to that private doctor when you did?
>
> **Patricia:** Erm, I do not know exactly. I think I just needed to hear what exactly was wrong with him. For me I needed to hear what is wrong with him because it is stressing to be with someone who is sick and then you do not understand what is wrong. He is actually the one who said OKAY, it is fine, you know what, let us go together so that we help each other to understand the problem and to voice out our questions. So, that's why we went together because we are in this together, whatever is troubling him; if it's…, you know TB is infectious. We have kids so we needed to know exactly whether his coughing is not going to affect the kids, everyone, or myself. You know it is weird if you all get sick at the same time; who is going to take care of the other? So, we needed to find out what's going on and he actually said you know what, this time let's go together. **(Interview with Patricia, 2 December 2019)**

The events preceding the couple's joint consultation show the amount of stress they were subjected to, a demonstration that illness experience is both subjective and social. Pierret (2003) concurs that illness prompts both patients and those in close proximity to them to reassess commonplace explanations as they seek meaning. It further demonstrates how complicated TB as a disease is. Literature confirms that in India, China, and Kenya, "most primary care providers are unable to diagnose TB" (Reid & Goosby, 2020, p.1). While family mediates men's health-seeking behaviours, equally important is the role of social class because Themba continued to go to the private doctor until he got a TB-positive diagnosis. Furthermore, the arduous and painful process preceding Themba's eventual TB diagnosis at the private doctor help to counter the often-trumped-up narrative that men leave it until very late to show up at the healthcare facilities. This narrative is often ahistorical. It is important, therefore, to guard against the temptation to oversimplify the complex issue of men and health-seeking behaviours because various diseases invite different health-seeking initiatives, all entangled with multiple structural factors. The next section unpacks men's experiences with suspected TB symptoms and the complexities leading to a TB diagnosis. While these could explain men's engagement with medical pluralism, the processes shed light on the reasons for men's delaying initiating TB treatment.

Tuberculosis-suggestive symptoms and the challenges of diagnosis

To gain participants' understanding of tuberculosis, it is useful to discuss the symptoms experienced before and after presenting at healthcare facilities. To comprehend men's decisions and behaviours regarding tuberculosis healthcare access and outcomes, it is essential to contextualise the complexities of the disease and the meaning-making processes men grapple with. Most participants reported undergoing TB screening measures and ultimately getting their sputum tested. Without production of sputum, participants show that it was difficult to get a diagnosis. It is important to state this because for one to present at point of care they start by a process of making meaning of what would be happening in their bodies – a process that is mediated by socio-cultural conditions. Most participants experienced common tuberculosis symptoms, including fever, fatigue, night sweats, and persistent coughing, before seeking care. These symptoms are consistent with those identified in prior research (Bynum, 2012; De Beer, 1986; Sontag & Broun, 1977). These symptoms are quintessentially associated with pulmonary tuberculosis. However, tuberculosis-suggestive symptoms differ because of the variants, as is demonstrated in this section. Below are two extracts from Timmy and Thabo that help to concretise the common TB symptoms experienced by many of the participants:

> **Timmy:** I became weak, having a fever where I felt cold even when it was hot. I used to cover myself with many blankets while sleeping. My body became skinny.
>
> (**Interview with Timmy, 10 September 2020)**

> **Thabo:** It was around February [2020] that things changed and now the sweating had increased from what I used to experience before, such that my blankets would become wet. Eish, the bed I slept on was always wet because of the sweat and it was a sign that the body needed to release something from my lungs. I felt like it was acid. The experience was like when you take Eno [an anti-acid substance used to treat a stomach upset] and pour it into a glass of water, that shhhhhhhh sound [sound of Eno when dissolving in a glass of water]. **(Interview with Thabo, 11 September 2020)**

While health professionals describe a disease condition from a pathophysiological perspective, Thabo's description of the TB-induced sweating indicates the subjective experience of illness informed by ethno-cultural conceptions. The disparate interpretations between health professionals and lay people are "explanatory models recognised as the cultural difference between how groups of people understand illness" (Ho & Sharf, 2021, p.280). Thabo's description of the sweating is something that is widely shared by the participants. Besides sweating, participants talked of experiencing fever and tiredness, as recounted by Timmy.

A few participants mentioned a seemingly divergent symptom: the association of TB with mental health decline. Thungana, Wilkinson and Zingela (2022) confirm that there is a gap in understanding the prevalence of mental health disorders among individuals with TB in South Africa. The following extracts highlight the connection between mental health and TB among men:

> **Herbert:** Even if someone would talk to me, I used to ignore them because tlhaloganyo ya ka ne e tšabile [I had lost my mind]. I had completely lost it [mind] such that I did not know what was happening with me. Whenever people talked to me, I would respond in whatever way I felt liking because I had become so impatient as I did not know what was happening with me.
>
> **Eddie:** Was it because of TB that your mental health deteriorated?
>
> **Herbert:** I think TB had made me to lose my mind. When I look back, I can tell that TB had wreaked havoc in me. It had gotten the worst of me. It is only that I do not have my pictures when I was in that critical condition; my phone is broken down. I was going to show you. My eyes had sunken into their sockets like someone who was dying. **(Interview with Herbert, 21 September 2020)**
>
> **Thuso:** I came to understand what TB does to someone's health. It started to feel like your mind is no longer functioning properly when around people, o ka re ke thoma go gafa [as if I am losing my mind]. When speaking to someone I would say things that do not make sense [Ke mmotsa ditshila]. I would speak rubbish through and through. In my case, the way TB affected me resulted in me talking rubbish through and through. I would not mind speaking vulgar, and I realised that I was likely beginning to lose my mind. However, since I started to take my medication, I gradually started to regain my mind until now. **(Interview with Thuso, 21 June 2020)**

In hindsight, the participants made the connection between their mental health deterioration and TB illness. Mental health is a complex issue, and its interpretation and diagnosis are dependent on socio-cultural context. The association of mental health and supernatural causation is something common in the African context. Braathen, Vergunst, Mji, Mannan and Swartz (2013) contend that complex belief systems intricately intertwine with mental disorders, where culture-specific syndromes and events play a significant role in both understanding and treating mental disorders. For instance, Xhosa-speaking individuals commonly utilise traditional healers in managing mental disorders (Braathen et al., 2013). This adds weight to the argument that black African working-class men's interpretation of disease is closely tied to their beliefs in the supernatural. Consequently, this translates to health-seeking in the alternative health systems and thus delaying presenting at biomedical facilities.

Thuso heightens and interweaves TB illness experience with mental health deterioration, something shared by other respondents. According to the TREATS project (2022, p.20), there is little research on how TB affects mental health and there are "few options for accessing mental health care in the communities most affected by it (TB)." However, other studies show that people with TB are disproportionately at increased risk of having mental disorders compared to the general population (Kastien-Hilka et al., 2017; Sweetland, Jaramillo, Wainberg, Chowdhary, Oquendo, Medina-Marino & Dua, 2018; Sweetland, Galea, Shin, Driver, Dlodlo, Karpati & Wainberg, 2019). Although the experiences shared in the above excerpts are from a few participants, it is evident that tuberculosis affects mental health. Based on their experiences, Herbert and Thuso describe how they suspected that TB was at the root of their mental health challenges. They both share similar experiences of mental health deterioration, including lapses in concentration during conversations, impatience, use of vulgar language, and difficulty in selecting appropriate words. While this finding aligns with the study conducted by Theron, Peter, Zijenah, Chanda, Mangu, Clowes, and Dheda (2015), which identified a strong connection between psychological distress and individuals seeking care for tuberculosis in Southern Africa, it underscores the necessity for a collaborative healthcare approach. This approach should involve the participation of psychologists and psychiatrists in healthcare centres when addressing the needs of tuberculosis patients. Thus, Naidoo and Mwaba (2010) call for a more holistic approach to health care programmes, one that would include mental health services.

Another TB-suggestive symptom that participants experienced was incessant coughing, which in some cases became associated with the production of bloodstained phlegm. Garry and Thabo shared the following in terms of the symptoms that they experienced before getting a positive TB diagnosis:

> **Eddie:** What kind of symptoms did you experience before the TB diagnosis?
>
> **Garry:** I was coughing too much, and the coughing continued for weeks on end. I knew that I had a problem, but I did not know what it was because flu does not continue for a long time. Sometimes my phlegm/sputum would be bloodstained. I was wondering why I was coughing for such a long time. I am not sure whether it was my being hot headed or what because I just continued with my life as usual without consulting about my condition. **(Interview with Garry, 15 September 2020)**
>
> **Eddie:** Were there any other symptoms that you experienced before a TB diagnosis?

Patrick: Yeah, the symptoms are coughing more than two weeks, lack of sleep. I used to struggle to sleep before I noticed that something was wrong. Even waking up in the morning, eish, I used to feel like a nine-month pregnant woman (laughing).

(Interview with Patrick, 15 September 2020)

Participants' presentation of the above symptoms is representative of what most of the other interlocutors experienced. Garry acknowledges that the coughing was not typical of the flu. In reflecting on his narrative, he questions whether his decision not to seek consultation was due to his stubbornness. Garry's refusal to consult at a healthcare facility contrasts with findings from a South African study on TB treatment adherence (Skinner & Claassens, 2016), which identified poverty, stigma, and treatment fatigue as common reasons for non-treatment initiation. Instead, Garry's refusal to consult and initiate TB treatment suggests a stoic identification with masculinity. Added to the symptom of coughing, Patrick, like other participants, experienced sleeplessness at night. His description of his experiences with symptoms is graphic though sexist. In the description, Patrick is performing gender.

Besides the common and typical TB-suggestive symptoms described above, two participants experienced unique symptoms before a positive TB diagnosis. Frank, who diagnosed with meningeal TB, stated his experiences 'I was having symptoms of heart failure. I collapsed at one point' **(Interview with Frank, 22 September 2020).** It only emerged after hospitalisation that he had tuberculosis meningitis. Scholarship shows that by its nature, extrapulmonary TB is commonly associated with delays in diagnosis, "with an increased morbidity and mortality" (Ramirez-Lapausa, Menendez-Saldana & Noguerado-Asensio, 2015, p.9). All these reasons underscore the complexities behind men's delays in seeking biomedical healthcare. In another case of extrapulmonary TB 29-year-old Thomas, who experienced visual impairment before a successful diagnosis, had this to say:

Eddie: So, what was really happening with you?

Thomas: You know how it started. It started with a headache, a strong headache. It was a persistent headache always. Always a strong headache, always a strong headache. I struggled for about a few weeks with that strong headache that my left eye began to have some problems. During that headache, the eye started to be red. Gradually, the eye began to lose sight. I started to have problems seeing distant things. At the end, the eye could not see faraway objects but only those closer. I began to be worried, and I visited the local hospital trying to find out what was really happening with me. When I was going back and forth to the hospital trying to find the underlying cause of the eye problem as well as the migraine headache, the other eye [right one] also started to experience some problems. It also went through the same gradual process of diminished

vision in 2018. I then lost sight in both eyes. It was total loss of sight. At times, I would be able to see but the vision would be so blurry that I would not be sure of what I was seeing. I would struggle to see, and, in the end, it became a total blackout where I ended up not seeing at all.

(**Interview with Thomas, 14 October 2020)**

Thomas' experiences leading up to a TB diagnosis show how complicated TB symptoms can be, especially in its extrapulmonary form. Ramirez-Lapausa et al. (2015, p.9) assert that the symptoms and signs of extrapulmonary TB can be "relatively vague", which is why it took Thomas four years of suffering before a successful diagnosis.

During the period of four years, Thomas had his eyes operated with minor improvement, as the underlying condition was not established. It was only around January 2020 that a positive diagnosis was conclusively established confirming that he had TB of the eyes. Our conversation went as follows:

Eddie: But then how do you understand TB?

Thomas: I cannot say I understand what TB is; I do not have any understanding. That is why I only realised that I have TB of the eyes just recently. It is because they only told me that I have TB of the eyes after they operated on me.

Eddie: But when did they finally find out that your problem was not just eye-related but was TB-related?

Thomas: Erm, I think it was this year [2020], the beginning of this year around January. That is when they clearly found out after researching. Even before this year, they were still researching about my problem, but they were not finding anything at all, you see. So at least they finally managed to find the underlying cause of the problem, and it is something that also gave me strength and it made me happy that they found the underlying cause of the problem. Is it not that all along they were checking me but finding nothing? Therefore, when they started to realise my problem, it really made me happy. I then assured myself that when the doctor would be busy with my eyes, he would be well aware of the underlying cause. The TB diagnosis freed me.

(Interview with Thomas, 14 October 2020)

It is noteworthy that the delay in establishing a TB diagnosis in Thomas only serves to exacerbate TB transmission at household and community level. At the time of the interview, Thomas' household was four-strong, and all were at a heightened risk of contracting the disease. The complexities surrounding TB symptoms create conditions for people to engage a plural healthcare system for solutions. Considering the precarious nature of TB-related health literacy in the community, what actions must be taken to ensure that both men and women seek

care as early as possible? Furthermore, how can we actively equip the healthcare system to efficiently diagnose all forms of TB to prevent continuous transmission of the disease in the community?

Underlying the complexity of an accurate TB diagnosis is the variation in symptoms experienced, with some not conforming to the common catalogue. Although Silas reported that he had lost a lot of weight, he presented at the healthcare facility with diarrhoea (running stomach) and recounted the following in our conversation:

> **Eddie**: I see that you went to the hospital in July (2020); but what were you feeling in your body when you decided that it was time for you to consult?
>
> **Silas:** The time I went there ne ke bolawa ke mala [I was experiencing a running stomach]. I was not eating at all; actually, I was not eating at all. Dijo ne di sa tsene ke bolawa ke mala [I did not have appetite for food, and I was experiencing a running stomach]. I would only drink water here and there.
>
> **Eddie:** Any other symptoms that you remember?
>
> **Silas:** I was experiencing those symptoms. It is only now that I am able to produce sputum. It was a problem for them to get my sputum at hospital because my cough was just dry.
>
> **Eddie:** But how did they realise that you had TB?
>
> **Silas:** Erm, I am not so sure about that because they used to take my blood and they gave me some injection until another doctor eventually came and treated me so that I could produce some sputum. **(Interview with Silas, 24 September 2020)**

Silas' journey leading to a positive TB diagnosis demonstrates a lengthy process during which his health did not improve while waiting for the diagnosis. Before a TB diagnosis, Silas recounts that he could not produce sputum that is essential for TB testing. The other complex issue is that Silas was having a running stomach, and this symptom does not come anywhere close to the well-known TB-suggestive symptoms. After a process of induced sputum production, Silas was finally tested and diagnosed TB-positive. It is not an overstatement that the process of accurately diagnosing TB is arduous and complicated.

After getting a referral from the clinic, Erick admitted at the hospital, and he had to undergo X-ray tests to obtain a positive TB diagnosis. Erick had the following in terms of the process he went through:

> **Erick:** While sleeping, I would sweat and experience fever with shortness of breath and when coughing I would feel something on the throat. That thing would keep me awake the whole night. That is when they [healthcare workers] realised, I had a problem, and they took me to the X-ray on Saturday morning I remember. When I got to the X-ray, they checked me only to realise that I had a lot of infection on my lungs, and they concluded I had TB. That is the time I realised I had tuberculosis. It was the end of October 2019. **(Interview with Erick, 18 August 2020)**

While some participants underwent sputum testing, others like Erick received their TB results through X-rays. All participants went through medical TB testing before a positive diagnosis was determined. However, the variations in experiences depended on the number of times they sought care before an accurate TB diagnosis was established. This factor contributed to delays in initiation of TB treatment for some participants.

During my conversation with Themba about his health-seeking behaviours, he expressed a preference for the private healthcare system over the public system. When he began feeling unwell, Themba sought medical attention from the private healthcare system, as was his usual practice. However, to his frustration, the doctor concluded that he had bronchitis. Consequently, Themba's health continued to deteriorate. The frustration stemming from the inaccurate diagnosis was evident in the way Themba described his experience at the private healthcare facility. I asked Themba what his feelings were about this whole process of inaccurate diagnosis:

> **Themba:** Erm, my first reaction, I got angry about it because they did two tests before and nothing came out of them. They were not able to clearly explain to me what exactly was causing whatever they were saying is happening with me. Indeed, I collected the results on the 14th of October [2019], but I had been coughing for a while and I had been going to this doctor for five months if I am not mistaken before the TB tests confirmed a positive result**.**
>
> **(Interview with Themba, 1 December 2019)**

Themba's account might look like an outlier but the important contribution it makes to our understanding of tuberculosis is that it is a complex disease, which continues to confound both public and private healthcare providers. Harper and Rawal (2016) who found that the process was sometimes associated with wrong results at times leading to delays in getting someone initiated onto TB treatment corroborate this complex process underlying a TB diagnosis in a study in Nepal. Similarly, a comparative study conducted among the BRICS countries on TB mortality demonstrates that private healthcare providers in India produced flawed TB diagnostics resulting in inappropriate treatment (Zou et al., 2022, p.10). Delays in diagnosis

and treatment initiation are not always solely attributable to individual behaviour but may also stem from the failure to obtain an accurate diagnosis from the biomedical healthcare system. This explains men's engagement with a plural healthcare system in the face of illness.

Conclusion

In this chapter, I established the foundation for understanding men's health behaviours through the concept of medical pluralism. In line with the African conceptualisation of masculinity that acknowledges the role of the incorporeal in shaping personal identity, I argued that men's understanding of illness intricately intertwines with belief in the supernatural causation of disease. It is against this background that I highlighted men's engagement with alternative health systems like traditional medicines and faith-based healers, which provided options of access to men when beset with TB-suggestive symptoms. This understanding enables us to appreciate why men delay healthcare seeking at biomedical facilities. Men's engagement with alternative health systems is inseparable from the cultural and religious systems of their community and it is a means through which they assert their identity. I have argued that the process towards TB diagnosis among men involves meaning making of a disease and its aetiology, and these are issues embedded within the cultural milieu of participants. In that respect, the witchcraft belief systems around '*sejeso*' permeated men's understanding of disease causality and their engagement with alternative health systems.

It is important to note that the family is not merely a bystander in the individual's experience of illness; rather, it actively feels the impact of the affliction. This interconnectedness between the individual and the family shapes health outcomes during the illness experience. Equally crucial is the role that families and friends play in shaping men's health-seeking behaviours. Men's approaches to seeking healthcare are dynamically shaped by both individual and structural factors, rather than solely relying on personal agency. Just as women crucially provide care when men are ill, they also significantly influence men's health-seeking behaviours by encouraging them to seek medical advice and treatment. Furthermore, I have demonstrated that the symptoms of TB are complex because the disease does not manifest in clear-cut symptoms, but as Sontag and Broun (1978) observe, TB manifests itself in very gradual, subtle, and harmful forms – it is 'insidious.' Not only does TB manifest in subtle ways, but also instances of inaccurate TB diagnosis occur as evidenced in literature (Feng et al., 2022; Houben et al., 2019). This explains the challenges in diagnosis leading at times to men delaying

treatment initiation. The complexities of the disease intertwine with the intricate health-seeking behaviours of men, shedding light on the reasons men delay presenting for TB diagnosis.

Since the processes towards a TB diagnosis were not monolithic or straightforward, instances participants obtained inaccurate diagnoses inadvertently meant continued spread of TB at household and community levels. Based on men's lived experiences of tuberculosis, I argued that the supposed delays in seeking biomedical healthcare after manifesting TB-suggestive symptoms must be contextualised within the complexities of the disease. Compounding this problem are the different types of TB ranging from the common pulmonary type to meningeal and extrapulmonary TB that often affects the bones and the spine (Barberisi et al., 2017; Bynum, 2012). The associated suggestive symptoms of such types of TB vary and this further complicates men's health-seeking behaviours. These experiences deepen our understanding of TB symptoms beyond the classic and commonly documented ones like coughing, fevers, and loss of weight. Having analysed men's health-seeking behaviours within the framework of medical pluralism and considering the African conceptualisation of masculinity, the subsequent section explores men's reflections of their path to recovery from TB.

Chapter Eight

Journey towards recovery and post-recovery from TB: Men's experiential reflections

Health has to do with a human's wellbeing. It is about taking care of your body, psychologically, physically, mentally, and emotionally. That is health. You see, that is who we are. Health is about making sure that people meet their needs to quality medication, reducing malnutrition; that is health… ***(An interview with 28-year-old Patrick recorded on 15 September 2020 during my fieldwork among men diagnosed with tuberculosis).***

Introduction

In the previous chapter, I examined and argued that, in the context of a plural medical system men's health-seeking behaviours are informed by their social universe as Africans. The cultural and religious beliefs mediated men's interaction with specific alternative health systems like traditional healing systems and traditional medicines. As I have demonstrated, this highlights the incorporeal influences of masculinity, and men consequently express and perform their identities through their interaction with alternative health systems. They attribute the cause of illness and disease to the supernatural. This African ontological understanding of personhood helps us to appreciate the perspective that disease causation and illness are a result of witchcraft manifesting through *sejeso/dijeso* and 'women's pollution.' I argued that men's engagement with specific alternative health systems intricately connects with identity preoccupation at personal and societal levels. This leads to the observation that men's delay in presenting at biomedical facilities for TB diagnosis and treatment initiation is influenced by their prolonged use of alternative health systems. Through African-centred theories of masculinity, I have demonstrated that men's beliefs in the influence of the non-physical aspects of their identity shape their behaviours towards their health.

In this chapter, I present a descriptive discussion of the concept of health as understood by men, alongside existing literature. This discussion extends our appreciation of men's preoccupation with masculinity identity as argued in the previous chapter. The concern with identity permeates men's perceptions and lived experiences of health and this discussion offers a contextual basis upon which to interpret men giving meaning to tuberculosis. It also helps to strengthen the argument about the influence of the supernatural in men's understanding of

disease and illness. In the chapter, I therefore argue that health is an identity issue mediated at the intersection of the individual and the social structures. Through the concept of therapeutic citizenship, I demonstrate the connection between the individual and the state in the management of TB. I further unpack the implication of syndemics for a clearer understanding of men's illness experiences in relation to tuberculosis. Before concluding the chapter, I also dissect men's perceptions and experiences of the healthcare system to provide a holistic understanding of their health behaviours regarding TB. The next section takes the reader through men's interpretation of health.

Health is an individual responsibility – it is about taking care of oneself

Overwhelmingly, participants emphasised the role of the individual in ensuring good health. In my conversations with the research participants on the broader meanings of health, I started by posing the question: "What is your understanding of health in general?" I followed the question with another: "What does health mean to you?" Based on these questions, I elicited participants' opinions, perceptions, lived experiences and interpretations of the concept of health. The meanings of health were important because the concept does not lend itself to universal application. It is not monolithic but fluid and dependent on contextual particularities, such as beliefs in the supernatural aetiology of disease and illness. In my engagement with the participants on this concept, I further inquired about the state of their health during the time of the interview. I asked this question to establish whether participants were under any distress that could possibly affect the flow of the interview, since most of them were on TB treatment. This approach ensured that as a researcher I adhered to ethical principles, prioritising the commitment to do no harm. Additionally, it provided participants the flexibility to withdraw from the interview process if they felt uncomfortable.

To appreciate the meanings attached to the concept of health, I asked the question in the local language, sePedi or Northern Sotho understandable to all participants. When talking of health in sePedi – it is *tša maphelo,* (literally, something that pertains to issues of life). For instance, when I asked 32-year-old Frank about health, he responded that 'health is something that concerns the life of a person' (**Interview with Frank, 22 September 2020**). To reinforce this interpretation about health, 42-year-old Garry, who is wheelchair-bound, emphasised that health is fundamental to human existence, stating 'Eish, health is important and without it erm,

I cannot live' (**Interview with Garry, 15 September 2020**). Added to the notion that health speaks of a person's life is the interpretation by 24-year-old Herbert who believes that 'When we talk of health, we are talking about life' **(Interview with Herbert, 21 September 2020)**. These reflections demonstrate how easily the concept of health finds practical concretisation with the participants in Modimolle; health simply speaks about life, and it concerns human existence. This resonates with Blaxter's (2010, p.68) assertion that at the minimum, health involves sustaining daily activities, while at its peak it represents a complete "psychosocial or spiritual state of well-being."

Premised on the common understanding that health relates to a person's life, most of the participants went on to describe health as an individual responsibility marked by a personal initiative related to taking care of oneself. 27-year-old Erick elaborated on the notion of taking care of oneself:

> **Eddie:** But if you are talking of taking care of yourself, what do you mean? Like how do you take care of yourself?
>
> **Erick:** What I mean by taking care of yourself is about issues of sexual relations. You must use protection when engaging in sexual intercourse. Being healthy in your body also involves that you must eat well. That is how I understand it.
>
> **(Interview with Erick, 18 August 2020)**

Abstractly, Erick begins at a general level where he understands health to be an individual initiative. Interestingly, he concretises his understanding of self-care for maintaining health by emphasising the importance of using protection during sexual intercourse. It is important to acknowledge that the biomedical perspective influences the way Erick frames health, particularly within the context of HIV and AIDS and its connection to tuberculosis. The mention of using protection during sexual intercourse reveals the impact of the HIV discourse. As argued by Nguyen (2005, p.125), this discourse has conceptually expanded our comprehension of various phenomena, such as "sexual responsibility" and adherence to drug regimens. As my interview with Erick progressed, it emerged that he developed TB because he did not adhere to his antiretroviral therapy after testing HIV-positive. Therefore, Erick's understanding of health derives from a public health discourse.

In addition, Charles and Thuso further reinforced the theme of individual responsibility to health. They both eloquently spoke of the importance of the minute and taken-for-granted, everyday practices and bodily functions as the cornerstone of health. In Charles' understanding, the inability to maintain and fulfil everyday routines signals the need to pay attention to his

health. This understanding aligns with Charmaz's (2002) argument that through illness, one may be forced to make minor changes to routines, to drastic changes in habits. Charles and Thuso set out their understanding of health thus:

> **Charles:** Speaking about myself, each morning when I wake up, I am used to going to the toilet. It's either I go and defecate or urinate at a certain time. Because I drink water even at night, I understand that after one or two hours I must visit the toilet to urinate. And then at a certain time, let's just say for example at 9:00am, I begin to get hungry and that means it would be my time to eat and drink my medication. From there I can start to take a walk. But if I feel that I am struggling to do those activities then I would know that there is something wrong with my body. It is because I am used to doing those kinds of things. **(Interview with Charles, 7 September 2020)**

> **Thuso:** I know that when I was fit, I was able to carry two 25-litre containers of water at once. When I was infected with tuberculosis, I began to struggle to carry those two 25-litre containers of water. From there I realised that there was something wrong with my health. **(Interview with Thuso, 21 June 2020)**

Charles interprets health as the accomplishment and meeting of everyday activities while Thuso emphasises health in terms of fulfilling menial tasks for his household in a resource-constrained setting of insecure access to piped water. According to Blaxter (2010, p.70), working-class people regard "fitness of the body" as the markers of "healthiness." The descriptions by Charles and Thuso corroborate Raphael et al.'s (1999) definition of health as the ability to cope with everyday life. This also resonates with the notion of health as function or "being able to do things" (Blaxter, 2010, p.8). Failure to fulfil everyday mundane routines signifies to the participants that their health is not optimal.

Central issues emerging in the description of good health by most of the participants is optimal bodily functioning, one that closely intertwines with working-class definitions that fitness of body for purposes of commitment to work is a marker of health (Blaxter, 2010). Men further described good health as being free from bodily pain and having balanced mental health, with an emphasis on being stress-free. In this context, health is seen as a comprehensive concept, aligning with the definition put forth by the World Health Organisation in 1948. This definition of health emphasises not only the absence of disease but also encompasses physical, mental, and social well-being. For instance, Erick and Patrick defined health in holistic terms, sharing the following sentiments:

> **Erick:** When your health is good, you feel good. Everything is good; you possess lots of energy and appetite; your state of mind is good; you do not stress and think about

many things. You are always happy, and everything is always fine in your body.

(Interview with Erick, 18 August 2020)

Eddie: But as a man, what does it mean for you to be healthy? How important is it for you as a man to be healthy?

Patrick: So that I can be able to take care of myself, the people I love. It also means nourishing my body, feeding my soul. When you are healthy, you feel good mentally, spiritually, psychologically, and physically in terms of the body that is when I can say I am healthy. You know what? A healthy person is a happy person. You cannot be happy if you are sick. Now I feel good about my health because I feel well, you know.

(Interview with Patrick, 15 September 2020)

During the fieldwork, both Erick and Patrick were progressing toward recovery from tuberculosis. The interpretation of health as put forward by Erick – that good health translates to lots of 'energy and appetite' – resonates with Blaxter's (2010, p.72) assertion that working-class people view health "more in physical and functional terms." However, it is important to note that Erick's mention of having 'lots of appetite' contrasts with the diminished appetite typically experienced due to tuberculosis illness. Like Erick, Patrick underscores that being healthy is associated with happiness. When one has good health, there are feelings of pride and confidence, something that shapes their outlook to life in positive ways. According to the World Happiness Report of 2022, South Africa ranks 91st out of 146 countries surveyed on the happiness index. The population's level of happiness is reported to be 5.194 points on a scale of 0 to 10 points (Rowan, 2022, p.18). The country is averagely happy.

As demonstrated by Patrick, good health encompasses the quality of life. It is holistic, involving not only physical well-being but also mental and spiritual aspects. The holistic conception of health resonates with Rathete's (2007) finding among the Northern Sotho or Pedi people of Limpopo province whose understanding of health and illness emphasised wholesomeness and well-being. This perspective aligns with the social model of health, as described by Blaxter (2010, p.19), which emphasises a "positive state of wholeness and well-being." Health encompasses the body, soul, and spirit, an understanding that connects with an African perspective of personhood which is an important premise undergirding African-centred theories of masculinity. In expressing the importance of maintaining good health for both self-care and the well-being of his loved ones, Patrick is highlighting that masculinity is performative and intertwined with health.

Health is a concept that elicits diverse interpretations, and the common thread from my findings is that it has to do with individual agency. Linked intricately with the notion that health entails individual responsibility, Timmy, and Patrick, both of whom have completed their matric, expand this interpretation by emphasising the significance of adhering to basic hygiene practices for maintaining good health:

> **Timmy:** You are supposed to eat healthy food and then after coming from using the toilet, you must always wash your hands clean…And another thing is that the place you stay must always be clean. That is how I can summarise my understanding of health.
>
> **(Interview with Timmy, 10 September 2020)**

> **Patrick:** Health is about hygiene, ahem, eating nutritional foods. It also relates to the spiritual and mental elements of a person, you know. Health is about feeling good about your body, your life and everything around you. Good health is a good thing you know; it is the opposite of not being well [laughing].
>
> **(Interview with Patrick, 15 September 2020)**

The interpretations of health presented by the two interlocutors are rooted in the public health discourse that underpins the aetiology of tuberculosis. The concept of basic hygiene, exemplified by practices such as handwashing, highlights individual responsibilities in disease prevention and health maintenance. This understanding demonstrates the influence of the public health discourse, considering that tuberculosis is an airborne disease that is social and associated with poverty, poor hygiene, and dirty environments (Bynum, 2012; Packard, 1989; Sontag & Broun, 1977). Importantly, the perspectives offered by the two participants above cannot be divorced from their educational background, as they both completed high school. In their view, health involves proactive measures taken by individuals, especially personal responsibility. Furthermore, they underscore the holistic nature of health by acknowledging the importance of spiritual and mental well-being.

Viewed as an individual responsibility, good health represents a valuable resource that bestows various benefits upon its possessor, as Timmy and Thabo illustrate:

> **Timmy:** Yeah, for me good health means that e tlo nhlokomela [health is wealth – it will take good care of me] and ensure that I am not infected with many different diseases, in short.
>
> **Eddie:** When you are in good health, how will you be feeling?
>
> **Timmy:** When you are in good health you feel proud of yourself, and you feel good. Obviously if someone is sick their heart beats faster and they are not at ease but will be wondering when they will get well. However, when you are in good health you feel

> good and happy. Good health means that even your mental state is happy because things like stress are also a big problem. You see in situations like mine where you are just seated without doing anything [unemployed] you end up thinking too much.
>
> **(Interview with Timmy, 10 September 2020)**

> **Thabo:** Good health protects me. I must always stay clean and the environment that I live in must be clean. It means that for example as I live here at this house I am not supposed to say because I do not use that other room then I must not clean it up. What will come out of that room will affect all of us. I must make sure that if it is a house, I clean all the rooms and not my room alone.
>
> **(Interview with Thabo, 11 September 2020)**

The interpretations of health by Timmy and Thabo portray it as a valuable, utilitarian, and comprehensive asset. They view health as synonymous with wealth, recognising its possession as yielding positive returns. This perspective reinforces the notion that maintaining good health is an individual responsibility. Additionally, their understanding aligns with the concept of health-related quality of life, as discussed by Phaladze, Human, Dlamini, Hulela, Mahlubi Hadebe, Sukati ... and Holzemer (2005), in turn closely associated with access to meaningful employment as emphasised by Timmy. In other words, the definition of good health intricately connects with being employed and this lends itself to a successful performance of the provider masculinity which is idealised by most participants. Here Blaxter's assertion (2010, p.68) that "[g]good health has qualities that go beyond the simple absence of disease or illness and is logically independent of them" comes into play. Rathete (2007) further confirms the significance of work for an individual's dignity, particularly as a marker of masculine identity, where the role of provider is still widely expected among men. The significance of dignity (seriti) in shaping the conceptualisation of masculine identity among men in this study cannot be gainsaid.

Silas, undergoing treatment for both TB and HIV, responded in the following manner concerning his understanding of health:

> **Silas:** I think that health is about taking my treatment daily, eating, and drinking lots of water. I have since stopped drinking beer so I might be able to complete this [TB] treatment. I am undergoing treatment for both TB and HIV…
>
> **(Interview with Silas, 24 September 2020)**

Due to treatment fatigue, interruption of treatment is a common challenge associated with chronic illnesses (Ramaliba et al., 2017). Silas is emphatic about his dedication to treatment adherence, a demonstration of his understanding of health. Literature shows that

disproportionately more men are lost from TB treatment than women (Austin et al., 2004), a health behaviour that complicates their health outcomes. As part of health, treatment adherence is fundamental. Silas' account of stopping beer drinking demonstrates a personal undertaking of self-transformation found in therapeutic citizenship. His account further highlights the 'quest' story associated with illness experience. Within the context of the illness journey, a quest story reflects the optimism that is rooted in the positive transformations brought about by the experience of illness on individuals and their lives. This would include recognising and appreciating the significant aspects of life (Lupton, 2012, p.88). In his journey of personal transformation, Silas redefines his life story by abstaining from alcohol consumption, prioritising a crucial behaviour that supports treatment adherence towards positive health outcomes. Studies confirm that alcohol use is associated with worse TB treatment outcomes because of behavioural issues associated with non-adherence to medication (Ragan, Kleinman, Sweigart, Gnatienko, Parry, Horsburgh ... & Jacobson, 2020). In the following section, I interrogate the syndemics theme, examining the connection between TB and HIV among participants.

The 'soldiers of my body were weak' – syndemics and TB among men

Empirically, this section discusses tuberculosis as an opportunistic infection that lurks and manifests when the immune system is compromised by other underlying conditions. To comprehend the interplay between men, masculinities, and tuberculosis, it is essential to consider the HIV epidemic as a pivotal factor. The HIV epidemic has significantly exacerbated the incidence of tuberculosis in sub-Saharan Africa (TREATS, 2022). HIV and AIDS suppress the body's immune system, enabling latent tuberculosis to progress into active disease (Oppong et al., 2015, p.186). Limpopo province is ranked among the worst affected by TB in South Africa, with some 55% of TB patients being co-infected with HIV (Matakanye et al., 2021, p.2). In other words, there is a synergistic relationship between the two conditions that leads to poor health outcomes for the TB-infected. Singer et al. (2017, p.941) assert that these diseases, which interact negatively, represent a syndemic due to the disproportionately high occurrence of co-infections in poverty-stricken and marginalised populations, especially in developing nations with limited access to healthcare. HIV/TB coinfections, poverty, corruption, and unemployment produce syndemics among individuals infected and ill from TB, leading to poor health outcomes.

In endeavouring to understand the perspectives of participants regarding their beliefs about what made them susceptible to contracting tuberculosis, HIV emerged as a prevalent underlying health condition in the narratives of men. While some participants openly acknowledged HIV as an underlying health condition, a few hesitated to express the condition directly, resorting to metaphors, while others became inarticulate in their responses. When describing their experience with tuberculosis, most of my interlocutors emphasised that they were 'attacked' by the disease when 'the soldiers of their bodies' had weakened (*mashole aka ammele ne a le fase* in sePedi). This highlighted that a weakened immune system became vulnerable to TB infection. Importantly, the immune system does not abruptly become weak but gradually deteriorates because of other underlying conditions like poverty and undernutrition. To provide context, Patrick who had a good support system cushioning him from the ravages of TB illness, commented the following in relation to other factors that can worsen health outcomes:

> **Patrick:** This thing of TB: if you do not have people who care about you then you are going to die from it. I am telling you because you cannot only rely on the Department of Health (DoH). You know even this period [COVID-19 period] starting from March [2020], you know the social grants [Social Relief of Distress grants] for COVID-19 and those for TB and everything; I do not depend on that myself. I am stable here at my parents, you see. However, for other people, I am just thinking you know; other people do not even have two slices of bread on the table. Imagine having just water in your house and you have TB. You know you are going to die [laughing].
>
> **(Interview with Patrick, 15 September 2020)**

The Social Relief of Distress (SRD) grant mentioned by Patrick was a social safety measure implemented by the South African government in response to the impact of COVID-19 on the livelihoods of the unemployed. During the peak of the pandemic, beneficiaries received a monthly payment of R350 or USD$18.39. While this grant was welcome relief for many individuals who did not receive other social grants, Patrick emphasised that he did not require such assistance because he had a strong support system to help him during tuberculosis illness. As discussed in Chapter Six, having a strong social support system is crucial for achieving positive health outcomes when dealing with tuberculosis. Additionally, the role of the state in providing social security to people that are ill from TB is equally important. However, for impoverished individuals, coping with TB illness becomes even more challenging. This situation is particularly dire for those in the precariat and unemployed men who lack any form of social support. Poverty plays a significant role in compounding the syndemic relationship between HIV and TB to co-produce negative health outcomes for men with TB.

Participants were explicit about the factors contributing to a weakened immune system, which rendered them more susceptible to tuberculosis infection. While HIV and AIDS are the underlying conditions towards TB infection, so are certain masculine behavioural tendencies where men forgo eating proper meals because of beer drinking practices. Chapter Five demonstrated that this behavioural pattern weakens men's immune system against TB infection. In my methodology chapter I documented how community health workers advised me to eat a good breakfast before going out to meet with my participants. The reason was to ensure my immune system was strong to fend off TB attacks. In the interview with Garry, I asked him what he thought predisposed him to TB infection:

> **Garry**: When I look at it, I think many diseases are caused when the soldiers of your body are down [when the immune system is weak]. That is when many diseases hidden in your body manifest. That is how I understand it. My CD4 count was very low; it was 61 [a normal CD4+ T count is between 500 to 1400 cells per cubic millimetre of blood]. That was my main problem.
>
> **(Interview with Garry, 15 September 2020)**

> **Eddie:** But what did they explain to you when you went to the clinic the first time when they diagnosed you with TB?
>
> **Lawrence:** They told me that [mashole a ka a mmele] the soldiers of my body are weak. You see, I was also taking treatment for, what is it by the way? [Lawrence does not pronounce the condition. The community healthcare worker who used to DOT him confirmed Lawrence was on ART]. They just told me that my immune system was weak and that was the reason I became infected with TB. My immune system was very weak. (**Interview with Lawrence, 7 September 2020)**
>
> **Eddie:** But in your opinion, what could have predisposed you to contract the disease?
>
> **Terry:** Eish, I think it might have been caused by these other diseases that I am having. I realised at one point that I am like this and that and I went on treatment [does not pronounce the condition he is talking about].
>
> (**Interview with Terry, 1 February 2021)**

Like Garry, Lawrence and Terry were also HIV-positive. Garry's solid grasp of his low CD4 count prompts a consideration of his biography before the HIV/TB coinfection. Garry previously operated a successful taxi business, primarily transporting schoolchildren. During our interview, he reflected on his past, recalling engaging in multiple sexual encounters, and viewing himself as a 'celebrity.' This was his lived identity before he experienced a stroke and became co-infected with HIV and TB. Garry mentioned that during the period he was operating his successful business venture, a friend accompanied him to the clinic for an HIV test, which

returned positive. In refusing to accept the positive diagnosis, Garry labelled the health practitioners 'mad'. Garry was not prepared to forego his masculinity identity of multiple sexual pursuits performed within public spaces as he confided 'I was not used to stick to one girlfriend.'

Accepting the HIV-positive diagnosis would have required Garry to acknowledge a sense of vulnerability and potentially compromise his masculine identity, a step he was not yet ready to take while still enjoying the public attention and his 'celebrity' status. His reluctance to accept the HIV-positive status led to delays in initiating Antiretroviral Therapy (ART) and which consequently resulted, as he points out, in a low CD4 count and increased susceptibility to tuberculosis infection. Studies confirm that individuals infected with HIV, especially those with lower CD4+ T cell counts, are at heightened risk for developing TB compared to HIV-negative individuals (Duarte et al., 2017, p.117). When I encountered Garry, he was in a wheelchair, and his situation serves as a classic illustration of how more than two diseases co-occurred in his body, exemplifying the concept of syndemics. The low CD4 count was a clear indicator of how vulnerable he became to TB infection. By definition, a CD4 count is a "blood test measuring the strength of the body's immunity" (Steinberg, 2011, p.11). Because Garry had a low CD4 count, his susceptibility to TB infection increased. According to Tiberi et al. (2017, p.e24), this heightened risk begins when the body starts producing detectable HIV antibodies and worsens as CD4+ T cell counts decline. In view of Garry's low CD4+ T cell count of 61, Phillips (2012, p.113) confirms that a drop from the normal "1200 cells per microliter of blood to 222" signifies the HIV-infected person's immune system is compromised to fight against any opportunistic infections. Garry's immune system had weakened to withstand any opportunistic infections.

While Lawrence and Terry hesitated to disclose their HIV statuses during the interview, their weakened immune systems increased their susceptibility to TB infection. Their explanations highlighted the opportunistic nature of TB in exploiting compromised immune systems. Studies show that among people living with HIV (PLWH), TB is the most common opportunistic disease (Charoensakulchai, Limsakul, Saengungsumalee, Usawachoke, Udomdech, Pongsaboripat... & Piyaraj, 2020; Tiberi et al., 2017). Dumisani, the nurse who specialises in chronic illnesses at the clinic, supported the interpretation provided by my interlocutors regarding how a weakened immune system becomes vulnerable to tuberculosis infection. His observations mentioned the co-occurrence of TB and HIV among men:

> **Dumisani:** Everyone has TB but, in most cases, it is passive [latent] but when the CD4 count is low then TB manifests. It manifests when the soldiers of the body are weak. In most cases in a sample of 5 to 10 male TB cases you will find one patient who is HIV-negative, and the rest are HIV-positive.
>
> **(Interview with nurse Dumisani, 3 March 2021)**

At the heart of Dumisani's evaluation of TB is the recognition that HIV and AIDS are the underlying conditions among most men diagnosed with the disease. Dumisani's metaphorical usage of 'weakened soldiers' permeate men's understanding of TB infection as reflected in Garry and Lawrence above. The healthcare practitioners' metaphorical use of 'soldiers' to define antibodies against diseases simplifies a complex biological process, and this metaphor resonated with most of the HIV-positive participants. HIV/AIDS and TB are therefore synergistic, HIV boosting the incidence of TB so that the two diseases "in effect constitute two intertwined epidemics that complement each other" (Phillips, 2012, pp.113-114). In the same vein, Van der Walt and Moyo (2021, p.6) argue that in 2019 the HIV co-infection rate among TB cases in South Africa was 59%. This highlights the impact of HIV on the TB epidemic. Additionally, Hopkins, Doherty and Gray (2018, p.2) identified tuberculosis as the foremost cause of mortality in South Africa, with 63% of TB cases affecting People Living with HIV (PLWH), representing the highest number of HIV-related TB cases worldwide. The intersecting syndemics of HIV and TB, coupled with conditions of poverty and unemployment, contribute to adverse health outcomes among men with tuberculosis.

The mandatory testing for HIV when one presents with TB-suggestive symptoms at a healthcare facility demonstrates the strong relationship between the two diseases. The WHO (2016 as cited in Tiberi et al., 2017, p.e24) recommends the availing of HIV testing to patients with a diagnosis of TB. Although Thuso and Herbert were HIV-negative, their presentation with TB-suggestive symptoms called for HIV screening. They reflected the following processes as they presented at the point of care:

> **Thuso:** They took my sputum and my blood for testing. When they took my blood, they checked for HIV and they showed me that I was negative, but they told me that I had tuberculosis. **(Interview with Thuso, 21 June 2020)**

> **Herbert:** I then went to the clinic, and they tested me and at first, they were suspecting that ke bolwetsi bo bogolo [the famous or big disease, HIV], but they found that I was HIV-negative. **(Interview with Herbert, 21 September)**

Thuso's remarks reinforce the mandatory testing for both HIV and TB, an indication of the syndemic relationship of the diseases in settings like South Africa's with its high HIV burden. Similarly, Herbert's reference to the metaphor 'bolwetsi bo bogolo' 'the famous or big disease' to describe HIV and AIDS illustrates the magnitude of the disease in terms of human suffering. Similarly, the context of the Agincourt region of Mpumalanga demonstrates the localised term for HIV and AIDS as "*mavabyi ya masiku lawa*, 'nowadays diseases'" and this denoted the ways residents made sense of the epidemic in terms of periodisation (Mojola, Angotti, Schatz & Houle, 2021, p.970). Herbert's use of a metaphor, the 'famous disease' is a euphemism like the 'nowadays diseases' used in the Agincourt region which normalise and make common a disease.

During our interview, 48-year-old Trust metaphorically disclosed his HIV-positive status to me without any difficulty. Trust disclosed that as for 'bolwetsi bo bogolo bo ba HIV [this famous disease of HIV] is caused by sleeping 'o sa apara di overalls' [literally translated to mean sleeping without wearing overalls] – having sex without protection (**Interview Trust, 25 August 2020)**. Trust's use of metaphor is a significant means of expressing a disease whose transmission is largely private and sexually contracted because of not using protection. Similarly, Trust's reference to overalls symbolises a worker's identity and the necessity for protection from various types of dirt encountered in the work environment. Moreover, this statement suggests that masculinity is performative. Drawing from Feng and O'Halloran (2013), El Refaie (2015, p.4) argues that the purpose of many metaphors is not to make an abstract concept easier to grasp, but rather to defamiliarise it for poetic or persuasive purposes. The worker in this case takes the necessary precaution of wearing protective clothing (overalls) before entering the work environment. Citing Searle (1979), El Refaie (2015, p.5) contends that the use of a metaphor as a form of language "requires people to first reject the literal meaning as a violation of semantic rules and then search for an alternative meaning that makes sense in context." Thus, Trust's reference to the 'overalls' metaphor not only captures the worker's identity but extends to the transmission of HIV and masculinity identities in relation to multiple sexual partners.

Unlike Lawrence and Terry who were hesitant to disclose their HIV status, Trust was forthcoming:

> **Trust:** You know what, I was also getting HIV treatment [Pause: the sister interrupts us, as she wants to sweep the place where we were seated]. I used to get my TB

> treatment here at the clinic. However, I am still getting my ARVs from the hospital at the containers. **(Interview with Trust, 25 August 2020)**

The ease with which Trust expressed his HIV status is commendable considering the stigma associated with HIV and TB. Although he had completed his TB treatment, Trust continued with his responsibilities and duties concerning adherence to ART. An interesting observation in the above interview is the performativity of gender (Butler, 1988) in space as evidenced through the act of cleaning by Trust's sister. There are clear gender roles enacted in space – with women performing and administering their roles in private spaces while men display theirs in public spaces of sociability. Symbolically, the sister's cleaning signifies the eradication of dirty within spaces against infectious diseases like TB.

Possibly because of age, participants like Trust voluntarily disclosed their HIV status, in contrast to 29-year-old George who was also HIV-positive but left it to me as the interviewer to insinuate his status. Either way, George's HIV-positive status was the underlying health condition that rendered him susceptible to TB infection. The syndemic nature of TB/HIV was evident. During my interaction with George, he appeared physically unwell, with mucus running from his nose. As I interviewed him on what he thought could have made him susceptible to contracting TB, HIV did not come out until halfway through the interview. This is what he had to say when I asked whether he received his TB test results the same day that he was tested:

> **George**: No, they cannot give it to you same time, they first take your sputum and test it, but one sister told me that I have TB because she first looked at my fingernails before she tested me. She also took my blood sample and found that I had HIV.
> **(Interview with George, 20 August 2020)**

As I sat down with George for the interview, his complexion was very dark, the kind resembling an imprint of a disease. It was about 8:30am when I met him at his mother's RDP house, and he had not yet washed his face. It took George some time to disclose his HIV status. The process he underwent at the healthcare facility shows that the healthcare practitioners simultaneously tested for TB and HIV. Commenting on the materiality of illness, Fassin (2007, p.238) argues, "in AIDS as in other serious diseases, suffering is inscribed in the body, in its material substance, in the most immediate and most elementary way. Illness is a matter of pain and smell, of bodies not washed and festering wounds, of no longer being able to swallow food and of relieving oneself in one's bed." TB/HIV comorbidities had aggravated George's illness to

the extent that the discomfort he displayed during the interview led us to discontinue the interview.

Similarly, Patrick who demonstrated a good understanding of tuberculosis by describing it as a bacterial infection that occurs when the immune system is weak, took a considerable amount of time before revealing that HIV infection could be the possible underlying cause of his contracting TB. I asked him what weakened his immune system to TB infection:

> **Eddie**: So, what happened with your immune system for you to contract tuberculosis? What made it to be weak for you to contract TB?
>
> **Patrick:** You know the, the, the, the, [stammering], I was diagnosed with human immunodeficiency virus, you know. I think that is what caused the problem of TB in me. **(Interview with Patrick, 15 September 2020)**

Patrick was one of the more articulate participants in the series of interviews conducted for this study, expressing himself eloquently and demonstrating knowledge of the tuberculosis disease. This was likely due to his completing high school. Although he managed to disclose his HIV-positive status as the underlying cause of his TB infection, it came with much difficulty. He mumbled. It is worth noting that Patrick did not focus at any great length on the issue of HIV, despite being typically outspoken during the interview. Patrick did not discuss the process of his HIV diagnosis or how long it took him to initiate antiretroviral therapy.

Delaying initiating ART was what culminated in TB infection for 27-year-old Erick. This is even though he previously tested for HIV and TB. Erick discovered that he was positive for both HIV and TB. Yet, he could not accept his HIV-positive results; he refused to take both TB treatment and ART:

> **Eddie:** Okay, but what do you think was the main cause of you being infected with TB?
>
> **Erick:** If I remember correctly, in 2015 or 2016, I went to test for HIV, neh [right]? And I found that I am HIV-positive. Then after that, they said to me I must take the treatment for TB for six months before starting HIV treatment. They said to me that they would only initiate me onto HIV treatment after completing the six months of TB treatment. I agreed and said there was no problem. Therefore, I took the TB treatment, but I did not ingest it. I did not drink this TB treatment for those six months and then I went back to the clinic and they [nurses] asked me, 'are you done with your treatment?' and I said yes. They said okay and then they gave me the antiretroviral treatment. In addition, this treatment, I did not drink it. This was until last year [2019] when I was at the hospital that they told me that because you are a defaulter, that is what made the TB

to attack you again. They told me that once you are HIV-positive and you are not adhering to your treatment, you would end up getting many opportunistic sicknesses. This is because the HI virus is multiplying in your body, and it compromises your immune system and making it vulnerable for attacks from any kind of sicknesses. That is when I realised what made me to contract TB.

Eddie: Tell me Erick, what made you not to take the treatment for TB and HIV as advised in 2015?

Erick: Erm, I was not taking it seriously. I was just saying this thing is not on me. I was just saying this sickness is not on me and I will not take the medication. It was because ga se ke amogele [I did not accept] that I am HIV-positive. That is why I did not drink the TB treatment. Even when they gave me the ARVs, I never drank it. They made sure they gave me the medication every month. I remember the whole of 2016 I did not go to collect my medication, they tried to call me, and sometimes they would come here to the house to beg me to come collect my medication. They would tell me that you will die if you stop taking the treatment. Sometimes I would go and collect the treatment, but I would just not drink it because I had not accepted my illness.

(Interview with Erick, 18 August 2020)

The first positive step towards managing illness is accepting the diagnosis, something Erick refused to do, saying 'this thing is not on me.' There is a clear sense of co-occurrence of TB and HIV in Erick, hence the decision by the healthcare practitioners to initiate him for TB treatment before ART. In illness, Erick defined his identity by refusing to accept the HIV and TB diagnoses. Back in 2015/2016, the period Erick first diagnosed with HIV/TB, he worked as a security guard and lived alone. It is possible Erick framed his masculine identity around his work. His subsequent refusal to initiate treatment after diagnosis, commonly known as loss to follow-up (LTFU) (Skinner & Claassens, 2016) catapulted him to TB reinfection that led to his hospitalisation. This further demonstrates the ways syndemics manifest among men with TB.

The point of accepting or refusing the results of a diagnosis is central to one's health outcomes and intricately connects with disclosure/non-disclosure dynamics. Some men find it challenging to disclose their tuberculosis status, let alone being HIV-positive, to their circle of friends. This lack of disclosure deprives them of the crucial social support needed to cope with their condition. Despite repeated confirmation at healthcare centres that he was HIV-positive, Garry could not accept the results. His version of experiences is that he wanted his partner to test for HIV so that he could (in)validate his own status. I asked Garry a follow up question:

Eddie: So, you spoke about your wondering whether it was because of your hot-headedness that made you not initiate ARVs, why was it like that?

Garry: I went to the clinic before I became weak, and I tested positive for HIV. That is when I was still fit and able to do anything. In the end I realised that I was in fact fooling myself, I was sick. It is not really because I was in denial of my HIV test results, the only thing that I wanted was for my girlfriend to go and get tested so that she could be able to see whether she was HIV positive or not and that would have helped me with a confirmation that I was truly HIV-positive. Now, when I started telling her about testing for HIV, she started ducking and diving. She eventually deserted me.

(Interview with Garry, 15 September 2020)

Dumisani: Actually, men test for their HIV by virtue of their pregnant women since it is mandatory that pregnant women test for HIV. You will observe for example where men gather and discuss issues like HIV and disclosure of statuses that those with pregnant partners will often boast that they are negative because their wives tested.

(Interview Dumisani, 3 March 2021)

Dumisani, the healthcare practitioner, corroborates Garry's dilemma about men's HIV testing, in that although Garry tested positive, he still required his partner to do the same for his own validation purposes. It is a manifestation of the gender order in heterosexual arrangements in which unequal power relationships are a feature. Interestingly, power is ephemeral, as Garry experienced when his partner not only spurned his request for HIV testing but also abandoned him altogether.

A study elsewhere in rural South Africa by Mojola et al. (2021) confirms evidence of proxy testing where some men in heterosexual relationships requested their partners to test for HIV, assuming their partner's status would apply to them. Dumisani claims that men procrastinate testing for HIV and opt instead to wait for their sexual partners to alleviate their fears and provide reassurance. To test or not to test for HIV is the question that runs in Steinberg's (2011) *Three letter plague*. Documenting the testing campaigns that were conducted by the NGOs working on HIV and ARVs in Ithanga village of the Eastern Cape, Steinberg (2011, p.185) concludes that most of the people that came for HIV testing were women while "[m]en confined themselves to watching and talking." In other words, men were spectators who because of fear did not participate in HIV testing. This is a similar situation described by Dumisani, a slippery trajectory towards TB infection among men when they delay initiating ART. Dumisani's explanation feeds into Garry's experiences who felt the need to have a validation of his HIV-positive status through proxy testing by his partner. Therefore, masculinities are not static but change over a life's course. In my conversations with both Erick

and Garry, their reflections on their past lives brought them to the realisation they could have handled their HIV/TB diagnoses in different ways, instead of refusing to accept the unfavourable results. Evidence presented in this section demonstrates men's understanding that a weakened immune system is vulnerable to attacks from opportunistic diseases like TB. It is at the interface of TB and HIV that syndemics are crystallised, the point at which community health workers become pivotal as a support system and in relation to the DOTS system among men. It is to that topic that I turn in the next section to address the role of the state in TB management.

The role of the state in TB management

Healthcare provision is the responsibility of the state, aligning with the objective of ensuring universal health coverage (UHC) for the population. This objective is in line with Sustainable Development Goal (SDG) 3.3, which aims to "[e]nd the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne, and other communicable diseases" by 2030 (WHO, 2022). My analysis of the state's role in the management of TB is two-pronged: first is the role of the directly observed treatment short course (DOTS) strategy; second is the state's social security in the form of the temporary disability grant system for TB sufferers. Conceptually, I infuse these roles with therapeutic citizenship which encompasses a range of activities or behaviours related to physical or mental health, wellness, self-care, or other forms of personal improvement (Nguyen, 2005). South Africa's National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 ambitiously targets a future where the three infectious diseases (HIV, TB, STIs) cease to be public health problems (SANAC, 2019). This is an acknowledgement of the implication of syndemics for population health. In pursuit of these targets, the NSP's number one goal is to accelerate prevention of new HIV, TB, and sexually transmitted infections (STIs). The fact that TB remains the leading cause of death in the country from an infectious agent means a lot of effort is required if the NSP objectives are to be achieved.

It is important to emphasise that, while the state's management of tuberculosis is commendable, addressing the fundamental structural issues surrounding the disease requires holistic interventions to achieve the objectives outlined in the National Strategic Plan. As discussed in Chapter Four of this thesis, the community health workers are important agents of government policy for managing and at times providing care to people suffering from chronic illnesses like tuberculosis. Similarly, an article by Nicole Ludolph (24 January 2023) of the Bhekisisa Centre

for Health Journalism found the involvement of the CHWs in "task shifting", where they shoulder the time-consuming roles of professional health workers like following up on HIV or TB patients to ensure they correctly take their medication. Closely associated with this task shifting is the DOTS strategy for individuals suffering from TB. After declaring TB a global health emergency in 1993, the World Health Organisation promoted "a management and patient support strategy" called Directly Observed Treatment Short course (DOTS) (Otu, 2013, p.228; Serapelwane, Davhana-Maselesele & Masilo, 2016, p.1). While DOTS rests on five important pillars (Otu, 2013), my focus is on the ingestion of anti-TB medications under the supervision of a community healthcare worker. Despite its shortcomings, such as low coverage (Ershova, Podewils, Bronner, Stockwell, Dlamini & Mametja, 2014) and disempowerment of TB patients (Atkins, Biles, Lewin, Ringsberg & Thorson, 2010), when effectively implemented, the DOTS strategy shows promise in terms of treatment adherence and contributes to the reduction of drug-resistant TB instances and associated mortality. Studies show that the effective implementation of the DOTS strategy improves TB cure rates (Serapelwane et al., 2016). In the same vein, a study conducted in Iran demonstrates a 92% treatment success for people suffering from TB under the DOT strategy as compared to 83,2% treatment success in the "Non-DOTS group" (Moosazade et al., 2012, p.877). Criticism of the clinic-based DOTS led to a system called DOTS-plus which, according to Mason et al. (2016), revolves around the role of community health workers in administering anti-TB treatment. Mason et al. (2016, p.214) argue that the DOTS-plus model "incorporates a range of psychosocial, financial and structural supports to help patients during treatment and after they are cured…"

In my engagement with the community health workers, they emphasised the importance of monitoring individuals undergoing treatment for TB to ensure they take their anti-TB medication. When narrating their experiences of doing their work, CHWs Matshepo and Pauline pointed out the following in relation to the DOTS system:

> **Matshepo:** When we get a person with TB, we do not tell him directly that he has TB. We start by getting a referral from the clinic. From there, we take the referral to the affected individual, explain to them the situation, and give each other dates and the times when I should come and DOT them.
>
> **(Interview with Matshepo, 22 July 2020)**

> **Pauline:** We greet the patient and inquire from him/her whether they are receiving any treatment from the clinic. If he says yes, it is TB treatment, we then go ahead to tell him that we have been sent by the clinic so that we can work together with you in terms of

properly taking your treatment. If the client agrees, we then discuss the appointment time for our daily visits so that when we arrive, we give him the medication. If he agrees to have his meds at 9 am for instance, then that means every day at exactly that time he must adhere to taking the treatment under my supervision.

(Interview with Pauline, 23 July 2020)

Matshepo and Pauline had more than 10 years working in Modimolle as community health workers. Community healthcare workers do not impose themselves on individuals suffering from TB when providing DOTS services. To some extent, community health workers consider the vulnerability of the person with TB and the family structure when conducting home-based care visits. Participants with supportive family structures opted not to have the CHWs come to provide DOT services. Importantly, most of the employed participants did not require CHWs' support. Considering that community healthcare workers are well known in the community, there is some stigma attached when community members see them visit households. CHWs are after all recognised for their work helping persons living with HIV and AIDS or those that are chronically ill and bedridden. I followed up on the CHWs to establish their roles in the DOTS strategy:

Eddie: Okay. So, what do you mean when you say you DOT them?

Matshepo: When I say I DOT, I mean that I will be giving them their treatment. I make sure that they have indeed swallowed the pills. You know how patients behave; sometimes, you might give them their medication and they will end up not drinking it and hiding the pills under their tongue instead. We do this because sometimes you think the patient is drinking their medication, but they are not and as time passes by you see that they are getting worse and not better.

Eddie: So, they can really put the pills under their tongues and not swallow them?

Matshepo: Yes, and when you leave, they would spit them out.

(Interview with Matshepo, 22 July 2020)

Pauline: DOT is directly observed treatment where you give the patient their medications and watch them swallow directly in front of you for their own recovery and survival. Isn't it the patient is supposed to take the treatment for six months? The problem is that a patient can become weary and hopeless as to when they will complete their treatment because six months is a long period. However, if you DOT and support them they manage to recover quickly because we DOT every day, let me say from Monday until Friday. We do not work on weekends and that is where we talk with family to support the patient in taking their treatment. In directly observed treatment, I ask the client to bring the water and the medication and then I take out the required pills and hand them over into their hands for them to swallow. After that, I write on the patient record, 'direct observed treatment' meaning that I have seen them swallow the

> treatment. After they swallow the pills, I must initiate conversation with the patient to make sure that they have swallowed the pills. Other clients hide pills underneath their tongues. You must ask them a question where they cannot easily nod in agreement with their heads; they must answer you back so that you can observe that there is nothing in their mouth. **(Interview with Pauline, 23 July 2020)**

Notwithstanding the disempowering nature of the surveillance mechanisms enforced under the DOTS model, it is important to highlight the existence of a sense of agreement obtaining between the individual with TB and the community health worker. Additionally, as confirmed by Mason et al (2016), a DOTS-plus model involving the community health workers emphasises structural support as crucial elements for TB treatment adherence. This is supported by Pauline's account, where family members collaborate on weekends to ensure the TB patient continues with treatment when the community health worker is unavailable.

While the DOTS-plus strategy fosters patient support, Mason et al. (2016, p.213) contend that the demand for rigorous patient management has often been accompanied by moralistic judgments that attribute the "persistence of TB on the therapeutic infidelity of patients." In other words, the strategy is driven by moralistic judgments that blame the patient for the disease burden at the expense of structural issues that perpetuate TB transmission. Considering that TB stigma is a social determinant of health, the expectation that patients attend at a TB clinic or have healthcare staff supervise treatment ingestion in the community perpetuates existing stigma (Craig et al., 2017). In the Eastern Cape, a study on TB stigma found that TB patients complained about TB pills being sour and big; some pretended to be taking the pills only to spit them out later (Møller & Erstad, 2007). The acknowledgement by the CHWs that they initiate conversations to ensure there are no pills hidden under the TB patients' tongues shows how invasive and disempowering the directly observed strategy can be. Given that masculinity in this study is shaped by values such as seriti (dignity), the DOTS strategy can be perceived as eroding and infantilising that identity. This suggests that TB control policies and research need to critically examine ways that address the social determinants of TB, including the aspects of TB control that perpetuate stigmatising practices.

Therapeutic citizenship, which combines a political assertion of global belonging to treatment for the ill, with personal commitment and self-transformation (Nguyen, 2007), falls short in addressing the challenges of tuberculosis given the backdrop of patients spitting out medication. Therapeutic citizenship embraces participation in support groups for people living with HIV (Mfecane, 2011). The absence of support groups among individuals with tuberculosis

in my research differs from the support networks observed among people living with HIV (PLHIV). This, coupled with the lengthy duration of TB treatment, leads other TB patients to non-adherence and spitting out medication, as reported by community health workers. A qualitative study conducted in South Africa on delays to initiate and adhere to TB treatment confirms that the challenges of staying on treatment for a prolonged period inhibits treatment adherence (Skinner & Claassens, 2016). Furthermore, a quantitative study of the effectiveness of DOTS as a TB control strategy in developing countries found that it had ethical loopholes resulting from lack of privacy and stigmatisation (Otu, 2013). There is a power-skewed relationship staked against the TB patient who may be constrained to accept the support of the CHW in the DOT strategy. Nevertheless, the CHWs' experience in administering the DOT strategy is crucial to ensure treatment adherence and is a support mechanism for TB patients who for varying reasons struggle with treatment fatigue.

More than half of the participants in this study agreed to have visits from the community healthcare workers for care and support through DOTS. The work of the CHWs is critical because not all families are able to support and care for their chronically ill relatives. These extracts from Garry and Thuso emphasise the role of the CHWs:

> **Garry**: As soon as they [healthcare workers] found out that I had TB, they initiated me onto treatment. Even here at the clinic, they used to send me another sister [CHW] and she would come here every day to watch me take the tablets. Erm, I remember I agreed with that sister [CHW] for her to come here at around 9 am in the morning. I would only drink the tablets in the morning upon her arrival here [at the house]. I used to go and collect the TB medication on my own from the clinic, but she would come here to make sure that I am swallowing the tablets. When I was about to finish my course, she came to take me, and we went together for my check-up.
>
> **(Interview with Garry, 15 September 2020)**

> **Thuso**: She [CHW] would come and sit with me to observe that I take the tablets. I would always wait for her and at exactly 8:00 am, she would come by. I would take the tablets in her full view and then swallow them while she was watching me. She would give me a paper to sign. The paper contained the date of her visit.
>
> **(Interview with Thuso, 21 June 2020)**

Added to the physical monitoring done by the CHW under DOTS to ensure medication is taken, the system tended to delegate some responsibility to the TB patient where he would mark a TB green book after the daily intake of the medication. This came out clearly in Trust's account when he said '[t]hey [CHWs] would come every day to see whether I was doing the right thing. They gave me a green book where I tick after drinking the pills' **(Interview with Trust, 25**

August 2020). While there are claims the patient makes in therapeutic citizenship, equally so the patient has responsibilities to fulfil as demonstrated by Trust; he had to record his daily routine of ingesting anti-TB treatment in the presence of a CHW.

Although a few participants complained about the side effects of TB treatment, the majority experienced improved health outcomes after initiating treatment and this enhanced their dignity. It was interesting to observe that while a few participants were lost from treatment, those that adhered to treatment had good remarks on anti-TB treatment efficacy as they experienced positive changes in their bodies, leading to recovery. Thabo recounted the positive results from the TB medication:

> **Thabo:** When it came to that [TB] treatment, I can say that within the first two weeks after initiation to the medication, I then stopped coughing at night and the sweating decreased because I used to sweat heavily at night. After that, I started gaining weight, I gained a lot of weight ka shushumoga le mo sefahlegong [even my face became chubby]. [Laughing]. Isn't it that was my first-time taking medication into my body? I became scared of the weight I was gaining. I started wondering to myself about the sudden weight gain not knowing that the medication was strengthening the damaged lungs. The pores on the lungs were closing off. But then I was becoming scared. The weight I gained was scary my brother.
>
> **(Interview with Thabo, 11 September 2020)**

On his recovery journey from TB illness, Thabo experienced weight gain on the back of the anti-TB treatment, to the point he became shocked to see the changes. An interesting remark from Thabo is that the TB medication was his first instance of ever taking medication into his body. Such a statement is a masculinity claim like Courtenay's (2000, p.1389) argument that in bragging "I haven't been to a doctor for years" a man is projecting his identity. Equally so, 32-year-old Silas whose weight once dropped to 45kg during illness remarked that he saw some changes in his health including a growing appetite:

> **Silas:** But since I started taking my treatment, I have been witnessing some positive changes. I am gaining my weight. They used to give me some vitamin pills at the clinic, and I used to eat too much food. Magogo [mother] ended up complaining that haowa monna oja kudu [hey, you are eating too much]. I used to eat a lot and that is why I gained weight quickly. They are still giving me the same pills for appetite.
>
> **(Interview with Silas, 24 September 2020)**

> **Timmy:** After a week, I started gaining weight because the first tablets they gave me increased my appetite a lot. I used to eat a lot. I used to eat a lot.
>
> **(Interview with Timmy, 10 September 2020)**

Timmy is the interlocutor who once was afraid to look at himself in the mirror because of his emaciation, while Silas' weight once dropped drastically due to illness. As they initiated TB treatment, both interlocutors reported positive recovery stories because "the treatment of TB is identified with the stimulation of appetite" (Sontag & Broun, 1977, p.15).

While CHW monitoring is evidently a mechanism to police bodies of TB patients, TB treatment adherence is an important way of mitigating transmission and development of multidrug-resistant tuberculosis at community levels. As Erick and Garry put it, without the help of the CHWs, they could not imagine completing the TB treatment course on their own:

> **Eddie:** How was it feeling like to take the medication in the presence of your CHW dotter?
>
> **Erick:** For me, I think it was very good because I know that if she [CHW] were not around, I possibly would not have completed my course. There are high chances of forgetting to take medication with the easy option of brushing it aside not knowing that this would cause me some problems later. Therefore, I thank her because she would make sure that I drink the medication in her presence, and she would always encourage me to drink it. I would therefore drink the medication in front of her. She would always check my green card because I was supposed to tick it whenever I took the medication. If I skip the schedule, I am supposed to mark X to indicate that I had not taken my medication for that day. Therefore, she was the one who was helping me through that process. **(Interview with Erick, 18 August 2020)**
>
> **Garry:** Eish, I am not sure whether I would have been able to complete my medication without her monitoring me. She indeed helped me because she used to encourage me to drink the medication. She also used to tell me positive words that I would be fine, and I am grateful because now I am okay. I can see that I am okay.
>
> **(Interview with Garry, 15 September 2020)**

Both Erick and Garry refused to accept their TB and HIV diagnoses, and their refusal led to their hospitalisations. With the help of the CHWs, they managed to adhere to TB treatment which ensured positive health outcomes. Besides observing and monitoring TB patients take their medication, the CHWs provided counselling services to the men as well as offered moral support, the key ingredients for TB treatment adherence. In considerable measure they evince that the work of the community healthcare workers in administering the DOTS service made a difference between TB treatment adherence and non-adherence among men.

Furthermore, the state's role in TB management is also manifested in the disbursement of temporary disability grants. Findings from this study show that the provision of the temporary disability grant ameliorated suffering among men diagnosed with TB and this ensured

adherence to TB treatment. The sampled men were from a working-class background which was disproportionately affected by the COVID-19 pandemic as their jobs did not allow remote working. Some of these men were unemployed and only the safety net of the temporary grants prevented their descent into absolute poverty and negative health outcomes. This was welcome relief enabling recipients to afford basic foodstuffs in the face of a 'dangerous' disease. However, a study on social constraints to TB and HIV healthcare in South Africa found that suffering from tuberculosis does not automatically guarantee approval to government-issued temporary disability grants (Daftary & Padayatchi, 2012). In my conversation with both healthcare worker Dumisani and 51-year-old participant Fannie, they both emphasised the following in relation to disability grants and tuberculosis:

> **Dumisani:** TB treatment demands a lot of eating, and you cannot take that treatment without food. That is why it is important that we give disability grants to TB patients for those six months when they are on treatment. Disability grants also work as motivation for our clients to adhere to treatment.
>
> **(Interview with Dumisani, 3 March 2021)**

> **Fannie:** My only challenge was in terms of money for food. I would sometimes ask my sister to buy me apples and she would tell me to my face that you must make a plan and get your own money. That was the issue that would cause a lot of stress in me. Eish, if you don't have money, it is difficult. Now I have my own money [temporary disability grant] and I can acquire the basics that I need. I no longer have any stress or depression. You know, they tell us that if you have TB, you must eat healthy foods like fruits and veggies, and that time when I didn't have money, I would be stressed a lot.
>
> **(Interview with Fannie, 6 November 2020)**

In corroborating Dumisani's sentiments, participants expressed how TB treatment stimulated their appetite for food, as reflected in Fannie's yearning for 'healthy foods.' Men reported they lacked appetite prior to a TB diagnosis in which they manifested marked weight loss – a demonstration of the gnawing nature of the disease. For instance, Charles shared how he lacked appetite in the period before his TB diagnosis. He stated that, 'let me just say within one or two weeks it [TB] had caused me to lose much weight and appetite' **(Interview with Charles, 7 September 2020).** This sharply contrasts with the rejuvenated appetite brought on by the anti-TB treatment. The burden of TB is exacerbated by the lack of income to access basic food intake needed for positive health outcomes when treatment is initiated. In their research on the social determinants of tuberculosis and COVID-19, Duarte et al. (2021) underscore the role played by food (in)security and malnutrition in the health outcomes of people suffering from TB. In other words, one's ability to buy food and the absence of access to healthy diets are

crucial factors that crystallise health inequalities in the prevalence of the TB disease. Therein lies the importance of the temporary disability grants. A study conducted in the Eastern Cape province confirms that besides boosting "patients' self-image as financially independent persons in society", disability grants for TB patients enhanced "nutritional intake" which ensured the efficacy of anti-TB medication (Møller & Erstad, 2007, p.116). The statement by Fannie that '[n]ow I have my own money [temporary disability grant] and I can acquire the basics that I need. I no longer have any stress or depression' demonstrates how the disability grant reshaped his identity and dignity as a man in terms of financial independence. Before being granted a temporary disability grant, Fannie lived with his sister, and it was difficult for him to receive financial support from her. This observation strengthens the point that quality support comes from mothers and not sisters or fathers as Silas claimed in Chapter Six. As soon as he started accessing the disability grant, Fannie moved back to his own RDP house.

A means test is performed to determine who qualifies for a temporary disability grant based on the TB illness. This created some tension among those that did not meet the criteria. Although unemployed and initiated on treatment for TB, Charles could not qualify for a temporary disability grant:

> **Charles:** When I was at the clinic, they told me to apply for a disability grant at SASSA [South African Social Security Agency] and when I went to SASSA, their doctor told me that I was not sick. They denied me modende [disability grant] and I was frustrated. They refused to give me a grant and they gave me an application form to resubmit again in November [2020]. I of course realised that I cannot just sit idle without doing anything. So, I decided to do some piece jobs.
>
> **Eddie**: But what are the reasons they gave for not giving you the grant?
>
> **Charles:** The person that I saw said you are well, and, in his assessment, I was physically fit to work. I completed the form with their doctor at SASSA and I submitted it. The doctor looked at it and just said you do not qualify for a grant.
>
> **(Interview with Charles, 7 September 2020)**
>
> **James:** As for the disability grant money, when I went to apply for it, they told me that I was well [healthy] and could not qualify for it as my body was already recovering. Therefore, they denied me the disability grant.
>
> **(Interview with James, 24 August 2020)**

Charles' sentiments speak to Whyte's (2009) biological citizenship created by medical practitioners as the gatekeepers to social security access. While temporary disability grants are an important ingredient accompaniment to therapeutic citizenship, the patient's social class,

gender and disease condition are equally crucial factors that help us analyse the utility of the concept in TB treatment. According to Standing (2014), the precariat is often reduced to the status of beggars, needing to plead for benefits and services from local bureaucrats represented in this case by the SASSA doctors. Therapeutic citizenship seems to suggest uniformity among the citizens as they embrace availed therapies, and this presents challenges when analysing the study's working-class men and tuberculosis. With no social support groups and the denial of temporary disability grants, the male-precariat TB sufferers find it difficult to exercise the rights and responsibilities enshrined in therapeutic citizenship.

While some participants were able to access temporary disability grants, the state's availing of this facility must be looked at in the context of unemployment. In that light, participants – Garry was among them – reported instances where tuberculosis sufferers use illness as a resource to access and to stay on the disability grant, something documented in literature (Kelly, 2017; Leclerc-Madlala, 2006):

> **Garry:** The man [Garry's neighbour] used to live three houses from here and was on TB treatment. He was told by the nurses at the clinic to finish the 6-month course of TB treatment. I am sure he was also getting a disability grant for those six months. Whenever he would realise that he was about to finish his TB treatment and that they would cut his disability grant, he would stop taking the treatment so that he continues being on TB treatment.
>
> **Eddie:** Really?
>
> **Garry:** He would do that so that his immune system goes down again. He was taken back to the hospital and enlisted back to the disability grant scheme.
>
> **(Interview with Garry, 15 September 2020)**

What Garry speaks about reflects the agency that men exercise against a bureaucratic system in the face of TB illness and limited employment opportunities. His observation echoes Kelly's (2017) discovery, wherein social workers at a psychiatric hospital observed frequent relapses among disability claimants just before their grants expired. This is also confirmed in a study by Møller and Erstad (2007, p.110) in the Eastern Cape where the respondents "were also outspoken about the temptation among their age-peers to get infected with TB in order to be eligible for a temporary disability grant." I raised this issue with my key informant, Dumisani. He emphasised that the Department of Health concentrates rather on the benefits of the disability grant, and not on the few cases of people exploiting the facility for their own selfish ends:

> **Dumisani:** We are more interested in positive outcomes, and I am sure the positive benefits of these disability grants outweigh the negative side where a few people try to take advantage of the system for their selfish gains. It is the same with the child grants. There are a lot of people that take the grants and put them to good use and that is what we are more interested with as the department.
>
> **(Interview with Dumisani, 3 March 2021)**

Every system has its weaknesses, and, in this regard, the positive outcomes experienced by participants who accessed the disability grant, and the DOTS strategy are noteworthy. These positives helped ensure men recover their identities that were damaged by TB illness. The DOTS strategy and the disability grant system clearly indicate the important role played by the state in TB control and management. However, the remarks by the key interlocutor do not deepen an appreciation of the social determinants of tuberculosis like inequality, poverty, gender, and race. These important factors tend to be peripheral to the state's management of the disease. In other words, by managing tuberculosis, the state is sugar-coating the symptoms of the problem whose source lie elsewhere. In the argument of the World Health Organisation (2022) under SDG 10, TB remains a disease of poverty where proper mechanisms of decreasing "income inequalities combined with economic growth should have an effect on the TB epidemic." The next section reflects men's perceptions and experiences of their interaction with the healthcare system on their recovery journey.

Men's perceptions and experiences of the healthcare system

Along the journey to recovery, men's interactions with and perceptions of the healthcare system are important analytical issues that influence health outcomes. These experiences and perceptions shape men's health-seeking behaviours, and by extension crystallise masculinity and health. To some degree the perceptions and experiences of men in their interaction with the healthcare system provide lessons for ways to improve healthcare service provision. During the time of fieldwork in 2020 and 2021, Modimolle Town had two public clinics: one located in the township and the other in the town centre, providing participants with access options between the two. A taxi commute to town then cost R10. Participants who lived in the township elected to rather access health care at the township clinic in Phagameng. Participants had mixed perceptions and experiences of the public healthcare system. During the fieldwork period, individuals with the means had the option of private healthcare services, which charged consultation fees ranging between R350 and R400.

While the private healthcare system is preferred over the public healthcare system, evidence from this study shows that accurate TB diagnosis was at times elusive for both systems. Although Themba preferred private healthcare to public healthcare, he was frustrated when the general practitioner did not establish a proper diagnosis until his third visit. Such experiences shape men's health-seeking behaviours in the face of TB. On the contrary, Mthuli, who like Themba was employed, preferred consulting public clinics when he was not feeling well in his body:

> **Mthuli:** I prefer clinics and hospitals because they check for everything before they give you medication. I can know about by blood pressure and my temperature. Hospitals and clinics check everything such as diabetes and other health issues. But private doctors don't check such things, my brother. When I went to the doctors, they asked me what the problem was without properly checking me. After that, they gave me medication. **(Interview with Mthuli, 15 October 2020)**

> **James:** Erm, at the clinic when I used to go and collect my medication, they would take my weight first and take the blood pressure and perform other tests. They treated me good. **(Interview with James, 24 August 2020)**

Mthuli was diagnosed with both diabetes and tuberculosis. His detailed experiences of the screening processes in public healthcare facilities shape his opinion towards the system and to some degree influence his health-seeking behaviours. Mthuli and James made experiential assessments of both systems and concluded their preference for the public healthcare system because of its attention to pre-screening services. Both interlocutors report good experiences in their encounter with the public healthcare system.

When Silas became critically ill, he could not access emergency services to carry him to the hospital. His mother who was reliant on an older person's grant had to hire a private car to get her son to treatment. Despite the setback of the unavailability of an emergency service when he needed it, overall, Silas was impressed with the treatment he received from the hospital. Similarly, Erick, who did not accept his initial HIV and TB diagnosis resulting in loss from follow up and hospitalisation, was happy with the treatment he received at the hospital. The two had the following remarks:

> **Silas:** To tell the truth they [hospital staff] were taking good care of me [Smiling]. The only one who scared me was that one who would come very early in the morning to give me a drip. The drip was so cold because it was in winter. The blankets were also very few for warmth and the windows in the ward were left open [possibly for ventilation]. Remember this was in June and it was very cold. I ended up calling home

for some blankets. Other than that, the treatment from the healthcare staff was okay.

(Interview with Silas, 24 September 2020)

Erick: Once they realised that I had TB at the hospital, they transferred me from the general ward that I was in to the one with TB patients. They separate you from those uninfected with TB so that you do not infect them. They treated me nicely, eh, friendly; they would talk to me and tell me to ask if there is anything I want so they can give me. Honestly, they did not give me any problems. They were very, very friendly.

(Interview with Erick, 18 August 2020)

It is worth pointing out that the treatment from the public healthcare system is multi-layered according to whether one is interacting with the hospital or the clinic staff. As shown in the above excerpts, both participants reported receiving positive treatment at the hospital after hospitalisation even though they had delayed seeking health help. Although instances of unpleasant experiences occur at public hospitals, participants who accessed the hospital were overwhelmingly happy about the service they received.

Perceptions and experiences are both important in shaping how men interact with the healthcare system for TB diagnosis. In the extract below Frank, who reportedly said that he was a health ambassador, had the following perceptions of the public health care system:

Frank: ... The second aspect is about the treatment we get from the clinic if I may put it that way. For example, you will find that I have missed my appointment day with the clinic for collection of my treatment and when I get there, the healthcare workers become rude. They will shout at you, 'Why ne o sa tla maabane? [Why did you not come yesterday?] I think that is the other thing that we need to look at when we talk about men and their access to healthcare facilities. If you look at a man, he has his own pride and immediately you start to talk to him in those rude words you are damaging him. By the way, if you look at it these days, people who are dominating in government institutions are children [youngsters or the youths]. A child [young nurse] calls an old man of maybe 47 years or 57 years that 'Ga wa a tla maabane, hee eng eng eng' [shouting – why didn't you come yesterday?] The man will obviously feel disrespected by this child [young nurse] and in the end he will just give up on his treatment course.

(Interview with Frank, 22 September 2020)

Men's interaction with the healthcare system, even in their vulnerability, does not occur in an identity vacuum. As I underscored in Chapter Five, respect and dignity are values undergirding masculine identity in the research setting and as highlighted by Frank, ill-treatment such as being scolded by the health practitioners affects that important identification. Frank's statement that '[i]f you look at a man, he has his own pride and immediately you start to talk to him in those rude words you are damaging him' is a clear reminder of seriti identity that most men embrace. In interacting with the healthcare system, men's masculinity identities are projected.

In the same vein, the experiences at the healthcare facility can modify men's identities and impact their health outcomes. Being scolded in public, for example, could have the effect of inhibiting men's continued interaction with the healthcare system such as collecting their medication. True to Frank's perceptions of the negative treatment at some healthcare facilities is the example of 51-year-old Fannie who had an unpleasant experience at the hands of the clinic staff until another *abuti* (male nurse) assisted him:

> **Eddie:** But how was the attitude of the clinic staff when you went for consultation?
>
> **Fannie**: The day I went to consult, erm, let me tell the truth. [11]Bosesi [female nurses] that I found at the clinic, erm, they did not treat me well. No, they did not. There was a certain abuti [a respectful term to address a brother – a male nurse in this sense] who saw the misunderstanding between us and then he intervened and called me aside. I was actually assisted by that abuti because bosesi [female nurses] did not want to assist me.
>
> **Eddie**: Why do you say they did not want to assist you?
>
> **Fannie:** You see; I think I arrived at the clinic around 11 in the morning. I told them in sePedi that ke tlo tšea diteko tša sehuba [I have come to do some tests for TB]. We were all putting our facemasks [context of COVID-19] and I slightly removed mine so that I could be able to speak audibly. Therefore, I said to them, I have come to do some sputum tests. They asked me, 'are you sick?' and I said to them ke a gononwa [I am suspecting so]. They asked me, 'when did you start to have the cough?' I said this is the second week and I told them, 'I am in extreme pain. Can you please test my sputum?' Hey, right at that moment, another sister said to me, 'no we don't take sputum at 11.'
>
> **Eddie:** Really?
>
> **Fannie:** I looked at her and by the way, I actually know her from around. I thought maybe it's because I am putting on a mask that is why she does not recognise me. The other one said, give him the sample bottle so that when he produces the sputum at his own time, he can bring it and that other nurse handed the sample bottle to me. Remember I was coughing badly as I told you. It did not take me time to cough and produce the phlegm and I spat it into the bottle and came to hand it over to the nurse. The first nurse responded to me saying, 'did you hear what I said? We do not take sputum at 11. Throw it in the dustbin.' She gave me a plastic to put the sample bottle with my sputum. She told me to put the bottle in the plastic and I was thinking maybe she is going to take the sputum for testing but no, she handed it back to me and said throw it in the dustbin. I took the bottle and threw it into the dustbin. I came to stand there in front of the nurses and asked, 'why are you doing this to me? Why are you telling me to throw that bottle away?' I then realised that I was wasting my time talking with them and I just said to myself they would meet their match one day when they face

[11] Bosesi refers to sisters and abuti refers to brother.

someone who will confront them. As I was leaving, that abuti [male nurse] called me and I went to his consulting room and he inquired what the problem was. I told him 'I had come to do a sputum test for TB and bosesi [female nurses] said they don't take sputum at 11. They told me to throw the sputum away in the dustbin and I did just like they asked.' He then told me to remain behind in the consulting room. As he went out, I peeped through as he engaged with the female nurses and he asked them, 'where is Fannie's sputum?' and they told him 'it is in the dustbin.' Abuti went to take it out from the dustbin, and he asked for the papers then he came back to the consulting room. I asked abuti, 'but is that a proper way to treat a patient? These are bosesi [sisters], I am afraid of being accused that I shouted at them.' Abuti then told me to leave it like that.

(Interview with Fannie, 06 November 2020)

The titles Fannie uses to address the male nurse as *abuti* and the female nurses as *bosesi* are important markers of identification defining the identifier as someone embracing the value of respect. In illness and in the face of unfriendly treatment from the female nurses, Fannie held on to the value of respect towards both the unfriendly female nurses and the friendly male nurse. The use of the titles *abuti* and *bosesi* shows the interlocutor's modicum of deference to the nurses. This is significant given the gender order and to some extent their status as health professionals. The contrast to *abuti* is *moshimane (boy)* and to *bosesi* (plural) is *banyana* (plural – girls), terms that in this context would denote disrespect considering that the identified addressees are adult and professional people. At 51 years, Fanie was older than the male nurse, yet he addressed him as *abuti* (brother).

In facing up to the female nurses, Fannie showed respect and chose the non-confrontational route as he gave up and left them alone. Fannie's experiences at the hands of bosesi were unprofessional and unexpected considering the infectiousness of TB. There is a sense that Fannie was older than the female nurses, yet he respectfully addressed them as bosesi. This overlaps with Frank's comment that 'children' (youths) are the ones employed in government departments with a knack for disrespecting patients, elders included. The disrespect Fannie experienced from the female staff was dehumanising and damaging to his seriti. This resonates with a study conducted in Tintswalo district of Limpopo province that confirms occurrences of health workers' displays of disrespect to TB patients (Edginton et al., 2002). The study further found that the ill-treatment by the health workers negatively shaped the patients' health behaviours to the extent they thought of not going back to the healthcare facilities for their reviews (Edginton et al., 2002). However, nurses who are predominantly female, are constantly negotiating competing relations with physicians in addition to managing "sexism and paternalism on the part of both doctors and patients" (Lupton, 2012, p.123). As such, when

interpreting nurses' behaviours, we must understand these occupational relations and conflicts. It is not an exaggeration to say that the public service is hiring young graduates. The main concern is how to navigate the sometimes-difficult relationships caused by the generation gap between healthcare providers and elderly patients, without disrespecting each other's dignity. How can both parties maintain professional conduct?

Most men in this study delayed health-seeking from the clinics when they started experiencing TB-suggestive symptoms. It is commendable that Fannie took the initiative to visit the clinic in the second week of continuous coughing when he suspected (*gononwa*) that his health was not okay. This initiative to take care of himself extends an appreciation of a responsible masculinity. The fact that Fannie was assisted by a male nurse whom he respectfully called abuti is telling. Could it be that the nurses do not tolerate an individual presenting with certainty that he is suffering from a particular disease? The power relations between the healthcare staff and the interlocutor were acute and manifested through the infantilisation of Fannie. However, Lupton (2012, p.124-125) further helps us to understand the complexities of the social position of nurses who are called upon to do traditionally unclean and highly feminised work "including washing 'patients' genitalia…dealing with symbolically contaminating and emotionally revolting bodily fluids such as blood, saliva, phlegm, vomit and faeces…" It is in such light that the nurses interacted with Fannie.

During a visit to the same clinic attended by Fannie, Patrick recounted how he infuriated a nurse when he suggested to her that the symptoms he was experiencing were the same as the ones displayed on a TB information chart against the wall:

> **Eddie:** When you first noticed that you were not feeling well, what did you do?
>
> **Patrick:** I went to the clinic [Patrick lives in a street that I termed a TB hotspot street because of the number of TB sufferers that I came across – six in total]. I told them how I was feeling in my body and the symptoms I was experiencing. You know what neh, I was turned away and given pain killers on three different occasions. I would for instance go today and explain the symptoms and everything neh, they would give me painkillers three times on different visits. Here at the clinic, they didn't even notice anything with me even when I was telling them I feel like this in my body. You know what, there was a chart on the wall that I observed when I entered the clinic. It was a tuberculosis chart and I told them no, the symptoms I am experiencing are exactly the same ones described in that chart [laughing]. Hey, I made them very angry. They gave me painkillers and told me to go and that I will be fine. I told them I will be back within a few days' time. It was after that when I felt very, very weak that I decided to go to the hospital.

Eddie: But what do you think caused the nurses to be angry after you showed them the TB information chart depicting what was going on in your body?

Patrick: They feel angry because they realise that if that person can read that chart it means he is a bit literate than other people. I could tell the symptoms on the chart were what I was feeling in my body. I could relate with what was on the chart that if I feel like this for more than two weeks it means I was supposed to consider consulting at the clinic. That is when I made the nurse angry. On the fourth time in seeking help, I just went straight to the hospital without going to the clinic for a referral letter.

(Interview with Patrick, 15 September 2020)

The role of power in the relationship between healthcare staff and the client is evident here. Power in this instance manifests in the possession of cultural capital (Bourdieu, 1986), specifically in the form of scientific knowledge by the healthcare practitioners. Frequently, healthcare staff cite time constraints when explaining things to patients. However, Nguyen (2005, p.138) contends that this reasoning reflects healthcare providers' fear that by "explaining and demystifying medical knowledge, practitioners will lose some of their status and prestige." Patrick's account demonstrates the unequal power relations as the healthcare worker felt challenged at the mere suggestion that the TB symptoms displayed on the information chart were like his own experiences. Due to the complexity of the diagnosis process, the state becomes complicit, albeit inadvertently, in the spread of tuberculosis at community levels when healthcare seekers are turned away at facilities of healthcare with no proper TB diagnosis.

Furthermore, the nurses' negative exercise of power influences men's health-seeking behaviours. A study of TB patients elsewhere in Limpopo found that inasmuch as there existed a relationship between patient delay and TB diagnosis delays, "the failure of recognised clinical services to diagnose tuberculosis among symptomatic individuals" contributed to TB transmission in the community (Pronyk et al., 2001, p.624). The fact that Patrick was not properly diagnosed at the clinic on three occasions, until his presentation at the hospital, helps to understand just how TB transmission is exacerbated in the community. In the same vein, Nyasulu et al. (2016) confirms that delaying initiating TB sufferers onto treatment perpetuates transmission of the disease at household and community levels. However, a commendable aspect from the state is the availing of TB information to the public in terms of the charts; this is important as it helps improve awareness of the disease. Considering the illiteracy levels in the community, the dissemination of this information through word of mouth when people

present themselves at healthcare facilities is important. This can be done as part of random TB screening.

While the creation of 'men only' health facilities may be desirable, this is not a panacea to the challenges of men's access to public healthcare facilities. What is possibly required is the involvement of communities and government in proactive and sustainable community engagement forums for a shared understanding of mechanisms to improve relations between the healthcare staff and the population and assuage acute concerns such as Patrick's:

> **Patrick:** I think the nurses working at this local clinic seem to have chosen a wrong career. You know a career is like a path, it is a calling, and you cannot say you will work with people if you know very well that you cannot accommodate them. You must know that illiterate people will come for your service, sick people, and old people. You know what, they [nurses] even shout at old people here at the clinic. At times, you can arrive at the clinic and there are not many people to be attended yet you will be made to wait for five hours while the nurses are seated inside.
>
> **(Interview with Patrick, 15 September 2020)**

At the heart of these perceptions is a major breakdown in public healthcare service delivery at clinics. I hasten to reiterate that the negative reflections on healthcare staff is centred on the experiences at the local clinic as opposed to the hospital. The working relationship between the government, healthcare staff, and the population has broken down. Corroborating Patrick's perceptions is an incident that occurred in Rethabile Clinic in Polokwane, Limpopo province. Limpopo province's health member of the (provincial government's) Executive Council (MEC) Phophi Ramathuba was recorded shouting at the healthcare staff for dereliction of duty. She is seen disallowing the clinic supervisor from going out to lunch because patients were seated in long queues waiting to be served (Gounden, 24 January 2023). While this incident elicited mixed reactions from society, it demonstrated the tip of an iceberg in terms of poor public healthcare service delivery prevailing in the country. Paradoxically, the shouting meted out by the MEC against the clinic management is exactly what most healthcare staff do to the healthcare seekers as presented in this study, an indication of poor professional conduct and lack of respect.

In his encounter with the healthcare practitioners after missing an appointment for collection of TB medication, 48-year-old Trust narrated his experiences:

> **Trust:** Erm, there were times they would shout at me. It was not always the case though but at times ne ba go omanya [they would scold me]. Let us say for example I am supposed to go to the hospital on the 28th and I fail to honour the appointment for that

date, in that case, it would be ntwa nyana [a mini war]. [Laughing].

(Interview with Trust, 25 August 2020)

As a human right, health speaks to one's dignity. Ill-treatment through scolding from a healthcare practitioner is a double burden for a TB sufferer as it gnaws at one's dignity or seriti, self-respect and to some degree compounds the social suffering inflicted by the state. The rationale here is that TB is a social disease, manifested through the state's slow pace of addressing the living conditions of the marginalised. Shouting at an elderly man infantilises and damages his dignity and identity.

Traversing the recovery road: a concluding note

This chapter reflected on the concepts of health, syndemics, directly observed treatment short course (DOTS) strategy and therapeutic citizenship in analysing men's experiences in their recovery from tuberculosis. It rounded off with an analysis of men's perceptions of the healthcare system and the implications thereof for their health-seeking behaviours. Premised on the African conception of personhood that transcends the physical dimension, the chapter demonstrated the holistic concretisation of health among participants. In deepening our appreciation of African-centred theories of masculinity, I have argued in this chapter that seriti (dignity) which is an important value that defines men in the research context is connected to ways men define health and their interaction with the healthcare systems. This was important to tease out because health and the meanings attached to tuberculosis are context dependent. Appreciating context-based meanings of health and tuberculosis can help us stimulate intervention mechanisms against the disease. I argued in this chapter that health is individually contingent and structurally constrained or enabled.

As a reflective chapter situated on the trajectory of recovery from illness in which participants shared their TB experiences, this chapter provided a comprehensive argument for understanding TB in its syndemic relationship with HIV and AIDS that which complicates men's health outcomes. Although it was difficult for some men to disclose the underlying HIV condition as a factor, TB is embedded within the discourse of syndemics. In that respect, men graphically and metaphorically revealed that the weakened 'body soldiers,' precipitated largely by the underlying HIV condition, predisposed them to TB infection. This was in reference to the biomedical notion of weakened immune systems.

The chapter further highlighted the usefulness of the concept of therapeutic citizenship, aligning with the state's role in managing and controlling TB to support treatment adherence among TB patients. It is important to point out that structurally and in relation to the health of men, the state plays a fundamental role in the management of TB through its DOTS strategy and disability grant system. As presented in this chapter however, the role of the state leaves the deep structural factors implicated in TB unaddressed. The slow efforts to address deep inequalities prevailing in the country mean the perpetuation of tuberculosis as a disease of poverty. While appreciating the concept of therapeutic citizenship in TB, its limitations are mainly centred on the lack of social support groups for TB sufferers. Against the backdrop of a masculinity constructed through the values of seriti/dignity and respect, the chapter argued that the negative treatment experienced by men from healthcare providers frames their healthcare-seeking behaviours. While some participants mentioned negative treatment from healthcare providers, most participants experienced positive treatment from the healthcare staff. Consequently, they reported experiencing treatment efficacy from the anti-TB treatment. Addressing the somewhat tumultuous relationship between nurses at local clinics and men has potential to alleviate the disproportionate burden of TB, not only among men but in the population at large. The following chapter is a recap of this thesis.

Chapter Nine

Conclusions on masculinity, TB diagnosis and illness

In concluding this thesis, I emphasise the key findings and contributions by revisiting the story of my brother presented in the preamble of this study. While personal detachment in scientific research is a worthwhile ideal, I agree with Ritzer (2011, p.5) that intellectual fields are influenced by their social settings and in relation to sociology, the social setting is its subject matter. In that respect, the personal cannot be divorced from the conceptualisation of the study and its execution. To limit biases, I distilled my positionality throughout the work because researchers are influenced in their research decisions, including choice of theoretical perspectives, by their cherished values and commitments (Singer, 1995). The personal is therefore, both academic and political. My brother's story connects with the overarching themes that emerged from the engagements with my interlocutors and as presented in this work. In the preamble to this study, I grappled with a few questions about my brother's reluctance to seek healthcare while studying at a local university in Zimbabwe, in the face of TB-suggestive symptoms. These decisions occurred against his roles as member and leader of a religious grouping on campus. These roles framed his identity and by extension, shaped his health-seeking behaviours. Herein lies the importance of men's engagement with alternative health systems.

Considering his identity as member and leader of the religious grouping, my brother's situation called him to make a choice between going to a religious outreach or seeking healthcare in the onset of TB-suggestive symptoms. He chose the former. However, the TB-suggestive symptoms – continuous coughing and unexplained weight loss – forced him to prematurely abandon the outreach and go home, at the insistence of his co-participants at the outreach. On his arrival at home, my brother's emasculated physical appearance shocked everyone, and my wife encouraged him to seek healthcare at the local hospital where he diagnosed with TB. In this study I recount the experiences of men who, despite facing health issues like continuous weight loss, only sought biomedical healthcare after being encouraged by family and friends. Does delayed diagnosis and treatment of TB contribute to a decline in mental health, leading to a diminished awareness of one's suffering? How does knowledge of TB influence men's decisions regarding their health? Is it possible that men's adherence to masculine identities, characterised by invulnerability and stoicism, contributes to them delaying seeking medical

attention at biomedical facilities? Men's concern with masculine identity shapes their health behaviours and the use of alternative health systems.

My brother was not forthcoming when I asked about the conditions that led to his TB infection while at university. However, my mother revealed to me that due to the university's limited accommodation, my brother had to share a rented room with multiple students since the institution was new and lacked sufficient housing facilities. TB occurrence and transmission must therefore be understood in a social context where social determinants of health are analysed. I restate the main argument that shapes tuberculosis scholarship in South Africa and the southern African region: it is dominantly and understandably centred on mining, especially gold mining, and its association with silicosis (Moran et al., 1994; Packard, 1989; Rees et al., 2010). This risk factor predisposes miners to TB infection. Connected to this is cyclical labour migration, which serves as a pathway for the transmission of the disease to rural areas. This insight forms a fundamental argument that aids our understanding of the tuberculosis burden in South Africa. However, there exists a gap in understanding the disease within non-mining communities. It is within this gap that my research is positioned to explore the factors influencing the spread of the disease and the experiences of illness among black working-class men in the non-mining community of Modimolle, South Africa. The contribution of this ethnographic study is its focused attention on the experiences of a sample of men who diagnosed with tuberculosis and were either undergoing anti-TB treatment or had recently completed the treatment. Accessing male TB sufferers would have been a challenging task without gatekeepers like community healthcare workers. Their day-to-day interactions with chronic patients in the community of Modimolle were instrumental in enabling my access to all the participants of this study.

The conditions precipitating TB infection among men

Gender plays a significant role in the risk of TB infection, as demonstrated by the disease disproportionately affecting men compared to women. However, men often remain overlooked as a non-risk population in health policies, an oversight that perpetuates the spread of TB in the community. This gender blindness does not bode well for reining in its spread, not only among men but also in the population at large. In my thesis, I contend that TB occurrence is not accidental, but rather intricately connected to the socio-historical processes of colonialism and apartheid that plagued South Africa. Persistent health inequalities, particularly evident in diseases of poverty like tuberculosis, have deep historical roots in colonialism. These

inequalities are crystallised in contemporary South Africa through social determinants of health such as gender, socioeconomic class, and race.

After historicising tuberculosis in South Africa, I have further demonstrated that men's working and living conditions strongly influence tuberculosis contraction. This is particularly evident as most of the participants occupied the economic margins as a precariat, relying on the 'economy of affection' (Vigh, 2006) when they became ill. Closely connected with the precariat were conditions of exploitation in men's workspaces like farms and the construction sector. Besides the physically draining work men did, the conditions of work did not permit them to seek healthcare, forcing them to choose livelihoods over health. These exploitative conditions perpetuated a marginalised masculinity (Connell, 2000) which prevails in conditions of exploitation and oppression. Furthermore, I presented evidence demonstrating that most of the participants lived in two-bedroomed reconstruction and development programme (RDP) houses and informal dwellings. The number of bedrooms a household occupies is related to socioeconomic status. A 2019 General Household Survey found a strong relationship between poverty and a household living in two-bedroomed houses, and that this poverty was highest in Limpopo (Statistics South Africa, 2022). Evidently, most of my participants lived in RDP houses and shacks, making the connection between poverty and tuberculosis clear. There is therefore an intricately intertwined relationship between the political economy of health and the social production of tuberculosis, which in this regard links to gender constructions. The conglomeration of these factors culminates in social determinants influencing tuberculosis infection and spread.

Moreover, I have argued towards employing an African-centred theory of masculinity as a lens through which to understand masculine identities in context. African-centred theories of masculinity place emphasis on local idioms and expressions. Borrowing from scholars like Manganyi (2019) and Mfecane (2018), I show that masculinity pertains to men's concern with identity, which is socially constructed through norms and values. Masculinity is manifested and enacted at the individual, interpersonal and macro levels. This helped me conceptualise a context-specific notion of 'masculinity in sociability' which men in this study framed themselves along. In that respect masculinity in sociability, I argue, is constructed, and undergirded by sociocultural values of seriti (dignity, integrity, respect), botho (Ubuntu, humanness), maitshwaro (manners, comportment/aura, conduct/behaviour), and seemo (positive standing, influence). These values influence ways men perform other roles. Thus, masculinity in sociability is shaped by values and is expressed through performativity like

mediro (works/deeds). Masculinity in sociability is clearly highlighted when men come together in public spaces of sociability like taverns, shebeens and car washing spots. This notion of masculinity further engenders values of sharing, belongingness, and communality among men. The common products shared in proximity when men come together in spaces of sociability and entertainment include beer and cigarettes, where questions of who is next to buy beer or cigarettes are rarely asked.

Identity beliefs, men's health-seeking behaviours and illness experiences

In my definition of masculinity, I have emphasised that it involves men's preoccupation with identity, which is shaped by societal norms and values and is manifested and enacted at personal, interpersonal, and macro levels. This concern with identity frames men's perception and lived experience of TB illness. Despite many participants being unable to fulfil the societal masculine ideal centred on providing, I demonstrate that providing remains a core identity at a personal level. This societal script places pressure on men to prioritise livelihoods over health. I have demonstrated this through evidence where some participants would not divulge their TB illnesses to their employers for fear of losing their jobs. In this case, illness disclosure must be understood in the context of marginality that is precipitated by high unemployment. This forced some of the men to be lost from TB treatment.

Through the concepts of biographical disruption, stigma, and illness experiences, I highlighted the insidiousness of tuberculosis on men's identity as breadwinners. Even at home, some participants grappled with the tensions of disclosing their illness to parents, a further demonstration of men's preoccupation with identity concerns of invulnerability. In graphic terms and using metaphors, men describe TB as a disease that 'gnawed' at their bodies resulting in drastic weight loss. These experiential insights empirically enhance our understanding of tuberculosis, shedding light on a section of the population often peripheral and marginalised in health and TB discourse. It was at the stage of incapacitation and biographical disruption that men became needful and reliant on care and social support from women as caregivers, further highlighting the way gender is performed. For instance, Thabo lost his job and became dependent on his mother, to whom he previously was not willing to disclose his illness. Ultimately, his mother became the source of support for care and the provision of necessities. This demonstrates the fluidity of masculinity. I have shed light on men's need and quest for social support during illness experiences.

The biographical disruption and stigma induced by TB illness lead to a contrast in the public performances of masculinity in sociability within spaces like taverns and shebeens, as men retreat to the private confines of their homes. In this regard, men's TB illnesses transform into a social experience, disrupting the otherwise taken-for-granted everyday flow of events. However, within the private confines of their homes, where illness is experienced and women provide care, men actively engage in defining themselves, projecting a positive resilience towards recovery rather than passively going through illness.

TB diagnosis and medical pluralism

Men's health seeking decisions require a holistic analysis where culture and religious beliefs must be explored in line with an African-centred masculinity. Behind masculinity constructions influenced by beliefs in the supernatural, men's understanding of illness becomes intertwined with the idea of supernatural causation. In this regard, I presented evidence of participants suspecting that the symptoms they were experiencing before a TB diagnosis were a result of witchcraft as manifested through sejeso or dijeso. Other participants explained their symptoms as being the result of sexual encounters with 'polluted women.' It is against this backdrop that we can appreciate men's delays in seeking biomedical healthcare services as they first interact with alternative health systems within the framework of medical pluralism.

I also highlighted the complexities participants experienced before an accurate tuberculosis diagnosis. While most participants presented with prototypical TB-suggestive symptoms such as incessant coughing, unexplained weight loss, and languidness, others spoke of experiencing visual impairment, while yet others mentioned mental health deterioration before an accurate TB diagnosis was established. On another occasion, a participant underwent three tests at a private doctor without a clear TB diagnosis. All these examples illustrate that TB is a complex disease and as such, men's interaction with alternative health systems to establish cause of their illnesses must be contextualised.

Men's inclination towards the use of alternative health systems, including traditional medicines and faith-based healers, is driven by a belief in the supernatural causation of illness. Deeply rooted in their cultural and personal beliefs, this belief becomes a performative aspect of men's preoccupation with identity, crystallising how masculinity is shaped by the incorporeal. It is therefore critical to mention that when men take time to present for care at the hospital/clinic for TB they would not be idle but explore the necessary means possible to establish the cause.

I presented evidence of ways men engaged with faith-based healers and traditional medicines in the face of TB-suggestive symptoms. These alternative health sources are deeply ingrained cultural repertoires that people rely on for their health. Men's engagement with alternative health systems is premised on a holistic quest to find solutions not only for illness but also for the entirety of life. An example of this is Timmy, who shared that the pastor he consulted suggested further consultations for other issues, including his job search, after completing his TB treatment. It is important to acknowledge the efficacy of other complementary/alternative systems in guiding individuals toward a TB diagnosis. The lessons derived from the collaboration between religion/traditional systems and biomedicine in combatting TB and other diseases are crucial if properly harnessed.

Men's perceptions and experiences of healthcare services

Men's understanding of health in this study is premised on ways they identify themselves. I have sharply contrasted men's masculinity identity, framed through sociocultural values of seriti (dignity, respect, integrity) and botho (ubuntu, humanness), with the somewhat infantilising and humiliating treatment from some healthcare workers. I presented the narrative of Fannie, who, after experiencing incessant coughing for two weeks, personally suspected that it could be related to TB. While I have provided evidence that most men initially sought help from alternative health systems when experiencing TB symptoms before turning to biomedical facilities, Fannie's case was different. He went directly to the local clinic when suspecting TB. Fannie exemplified the values described by most men as the epitome of masculinity – seriti, maitshwaro, seemo, and botho – as he presented at the local clinic. The way he interacted with the nursing staff reflected the respect and dignity he accorded them, serving as an expression of his identity. However, the treatment he received from the staff was humiliating as he was told to throw away his bottle of sputum into the dustbin because he ostensibly came at the wrong time. Considering that health encompasses issues of dignity, the treatment was an affront to that value. While this incident could be viewed as an isolated case, most participants reported that the treatment from healthcare staff, especially at the clinic, was humiliating and lacked respect. However, at the local hospital, participants shared positive experiences with healthcare staff. These perceptions and experiences influence men's health-seeking behaviours. Upon initiating anti-TB treatment, participants overwhelmingly shared positive stories, highlighting the efficacy of the treatment. This positive outcome, including improved appetite and an increase in body weight, further contributed to the restoration of men's dignity.

In discussing men's interaction with the healthcare system, I explored the concept of therapeutic citizenship, examining the state's role in TB management to promote treatment adherence. It is important to highlight that structurally and concerning men's health, the state plays a fundamental role in TB management through initiatives like the DOTS strategy implemented by the community healthcare workers. Despite the alienating nature of TB illness, participants welcomed the role of CHWs in the DOTS-plus strategy. However, it comes with disempowering and infantilising effects on masculine identity, as men are required to ingest TB medications in front of CHWs. This results in passive resistance by some men where they hide the medication under their tongues so that they spit them out later. Furthermore, the state's role includes the disbursement of temporary disability grants to TB sufferers. How did the disability grant system shape masculinity? The impact of the state's role in social security within the contexts of unemployment and illness experiences is an important issue. The grants helped men reconstruct their identity amid unemployment and TB illness, providing a temporary sense of financial independence. However, the state does not address the deep structural factors such as poverty and inequality implicated in TB. The slow efforts to address deep inequalities in the country perpetuate tuberculosis as a disease of poverty.

Policy recommendations

Appreciating the cultural and religious beliefs of the community

Health and illness are socio-culturally defined and understood, and as such, there is a need for healthcare workers to have knowledge of the cultural context they work in. Through culture, people make meaning of their identities, their bodies, and their health. Healthcare workers operate within culturally specific contexts and as such they need to understand how men interpret identities and health. By appreciating the social context and the values that define what it means to be a man, healthcare workers' interaction with healthcare seekers like men would be mutually beneficial. In this thesis, I have demonstrated that men's identities are constructed through notions of seriti, maitshwaro, botho and seemo. Some of the cultural issues prevalent in the community revolve around the supernatural causation of illness e.g. witchcraft beliefs and women 'pollution.' Healthcare workers must embrace these values with an open mind to ensure successful interventions for population health. In that regard, there must be mutual respect for the prevailing cultural beliefs. In the same vein of mutually understanding people's beliefs, my study demonstrated how faith-based healers referred their patients to seek

healthcare at biomedical facilities. The reverse can also apply when biomedicine works hand-in-hand with traditional healing systems for population health.

Re-engaging the community with health awareness campaigns

I conducted fieldwork during the COVID-19 period when health awareness campaigns had been suspended. The local MDR-TB hospital had been repurposed as a holding facility for COVID-19 patients and this demonstrates how attention had been shifted from other infectious diseases. In my engagement with community health workers, they indicated that they used to conduct health campaigns at taverns and spaces where men come together. This is noteworthy: my findings demonstrate that a few participants were able to aptly define tuberculosis and ways it is spread and contracted. Possession of accurate knowledge about TB and its mode of transmission are crucial in shaping health-seeking behaviours and treatment adherence (Ntenda et al., 2021). There are instances participants reported receiving inadequate basic information of tuberculosis from the healthcare workers during diagnosis. This does not help participants to appreciate the possible conditions precipitating infection, which makes TB reinfection possible as there is a dearth in knowledge about the disease. The Department of Health needs to embark on health awareness campaigns where emphasis is placed on what tuberculosis is and how it is spread. This approach will be another way to prevent TB infection among the population and it will enhance the health-seeking behaviours of people.

Employing men as healthcare workers

Another important recommendation is that the public healthcare system proactively work towards the purposeful and deliberate employment of male healthcare workers as nurses and as community healthcare workers. While this study highlights the role of community healthcare workers, some men expressed difficulty in being open when interacting with them due to the overrepresentation of women in this profession. This explains why some men preferred not to get the DOTs services from the CHWs. One of my interlocutors, Mthuli, stated that 'the clinics must also send male healthcare workers to make things easier because some of the diseases *require a man-to-man talk*' (emphasis mine).

Reconfiguring spaces of entertainment

Evidence provided in this thesis shows the importance of taverns and shebeens in the formation of masculinity in sociability, an important contribution that departs from the common negative

narrative that vilifies these spaces. Based on the evidence of poor ventilation due to the architectural configurations of taverns, I recommend reconfiguring them to include wider, more spacious windows. This would facilitate better air circulation and improve overall ventilation. In addition, I suggest enforcing rules regarding the compulsory availability of food at taverns to ensure the health and wellbeing of patrons. In the thesis, I consistently demonstrate that masculinity in sociability revolves around the shared practices of smoking and drinking alcohol together. This practice of sharing permeates men's interactions in masculinised spaces and could possibly extend to sharing food sold at taverns. Given that taverns are small businesses, the South African government could introduce incentives such as subsidies for taverns that comply with regulations requiring food availability. This approach not only alleviates concerns about potential business losses but also promotes the health of patrons by reducing the risk of TB infection, which can sometimes be exacerbated by poor nutritional behaviours.

Social support structures

This study shows that social support is crucial for positive health outcomes in men experiencing TB. While support from family and community healthcare workers is essential, these structures often lack the empathetic dimension that can be provided by individuals who have experienced TB themselves. I therefore recommend forming social support groups for individuals suffering from TB. The men in this study have shown that, in addition to sharing cigarettes and beer, they are also willing to share their TB experiences with other men in such groups. Social support groups are valuable resources where men can openly share their illness experiences and receive advice from others who have had similar experiences. Importantly, in line with the theory of masculinity in sociability, social support groups can serve as significant intervention strategies for TB prevention and treatment among men.

National Health Insurance

Although there are concerns about how South Africa's National Health Insurance will be funded and fears of corruption, the NHI stance on addressing the past injustices that manifest through healthcare inequalities is a just cause. If the NHI is managed and implemented properly, the benefits may outweigh the weaknesses considering that health is a basic human right and as such, healthcare services must cease to be commoditised and be accessed on need.

Limitations

Methodologically, the study could have benefitted a great deal from the use of focus group discussions (FGDs) especially on the use of traditional medicines, traditional and religious healers as part of the alternative health systems relied upon by men. For instance, a study in Tintswalo, Limpopo province emphasised the strength of focus group discussions as they allowed participants to candidly ventilate their opinions and beliefs about tuberculosis as compared to individual interviews (Edginton et al., 2002). Ideal as FGDs are in data gathering, I could not use them because of the context of COVID-19. It was not feasible to hold focus group discussions because of the public health guidelines on social distancing. For fear of COVID-19 infections, I therefore left out the use of FGDs as a method of data collection.

A study on men's experiences of TB should have included individuals with tuberculosis who both accessed and did not access biomedical care. However, due to the complexity of TB and the associated stigma, reaching such a population without gatekeepers would have been an immense challenge. Considering the ethical issues involved in researching individuals with certain health conditions, the only feasible way to access this population was through health workers. This introduces a potential bias in the study, as the research only included individuals who sought TB treatment. Consequently, those who did not visit public healthcare facilities for TB diagnosis were excluded, leaving their illness experiences silent. In the same vein, the study possibly excluded individuals who did not survive long enough to seek treatment or who succumbed to the disease before accessing care, leading to an overrepresentation of individuals with less severe illness experiences.

Additionally, by selecting a study population consisting of individuals who accessed TB treatment, the research introduced a health system bias. The selected individuals likely had better access to healthcare services in Modimolle compared to those without access, who may have experienced different disease progression, complications, and outcomes. This bias could have skewed the research findings.

My insider status in the research setting led to interviewing participants who knew me. Additionally, I involved healthcare workers in the selection of research participants. These two factors potentially introduced biases into the research. Participants who knew me might provide responses they believed I expected or that were desirable, rather than being completely honest. This could lead to social desirability bias (Bispo Júnior, 2022), where participants tailor their

answers to please the researcher. Furthermore, the dual role of healthcare workers as caregivers and researchers can create conflicts of interest, where participants may feel obligated to participate in the study or to respond in certain ways due to their relationship with the healthcare workers.

Another potential bias relates to the limited selection of caregivers, particularly mothers as research participants. These caregivers played a crucial role in assisting individuals suffering from TB, especially in terms of health-seeking behaviour, diagnosis, and treatment. Their omission from the study creates a blind spot regarding invaluable experiences that could have significantly enriched the study's findings on masculinity and illness experiences.

Conclusion and suggestions for further research

Men are a neglected population in the study of TB (Daniels et al., 2021; Horton, et al., 2016; Medina-Marino et al., 2022) and this is despite evidence showing the disease disproportionately impacts them, and with negative health outcomes as well. As a neglected population in TB research, this study argues for bringing the marginality of men to the centre of health scholarship, considering the risks of disease transmission at household and community levels. Since men are not a homogenous group, the study makes a claim towards understanding black working-class men and TB illness experiences. Against the background of bringing in men as a marginalised group in TB scholarship, the study contributes to scholarship through the concretisation and expansion of the African-centred theories of masculinities. The study expands on the theory by unravelling what I term 'masculinity in sociability' which I have argued is framed through sociocultural values of seriti, maitshwaro, botho and seemo. These are values that underpin personhood within the African social universe. Masculinity in sociability is expressed through sharing practices within public spaces where men gather for entertainment, and it fosters a sense of belonging and communality among men. The values shaping masculinity in sociability further influence men's enactment of mediro or works/deeds (mediro). Through the local Sepedi proverb *Bana ba motho ba ngwathagana hlogo ya tšie* (meaning that sharing is caring regardless of how little you have), I have demonstrated the influence of values in the formation of masculinity and how this translates into performativity. Masculinity in this regard encompasses sociocultural values and is performative.

The purchase of masculinity in sociability lies in the practices of sharing when men come together in spaces. The social practices of sharing cigarettes and beer occur in physical proximity, and this is a crucial prism through which to understand TB infection, because the disease is airborne. While men argued overwhelmingly that they suspected they contracted TB through sharing beer and cigarettes, a nuanced interpretation is that masculinity in sociability enhanced TB transmission and contraction among men because of sharing the same air in closed spaces with poor ventilation. This is because TB is a prototypical infectious disease that is transmitted in poorly ventilated, confined spaces through aerosolised droplets when individuals engage in social activities such as talking, speaking, or singing. These activities commonly occur when men gather in sociability spaces. This contributes to what is known about the spread and infection from TB. The concept of masculinity in sociability extends African-centred theories of masculinity, not only in theory development but also in terms of disease epidemiology. Therefore, the central argument of the study is that TB is a disease primarily associated with sociability among men in non-mining communities.

This thesis contributes significantly to scholarship on men and TB by challenging the prevailing notion of men as perpetual delayers in seeking health care. It highlights the complexity of TB symptoms and the diagnosis process, which in turn complicates health-seeking behaviours. To comprehend men's health-seeking behaviours in the context of TB, it is essential to discuss the complexity of the disease and men's preoccupation with identity, as this shapes their interaction with alternative health systems within the framework of medical pluralism. The thesis demonstrates instances of biomedicine misdiagnosing TB, suggesting the need to complement it with health alternatives that are informed by culture and religion. This explains why some men resorted to searching for the aetiology of disease within religious sources before returning to western medicine. Emanating from the masculinity in sociability is the importance of cultural and religious beliefs that inform the ways men define themselves in context, and how they interact with plural healthcare systems.

Further research could explore a comparative study on the illness experiences of men and women with tuberculosis as well as their access to health care. This could help us deepen our understanding of the implication of gender for health-seeking behaviours in relation to tuberculosis. The added advantage is that appropriate intervention strategies against the disease can be explored, instead of a blanket approach that is assumed for both men and women. In addition, there is a lack of knowledge regarding the interconnection between tuberculosis and

mental health. While my thesis ventilated this important topic, it remains a novel research area and this is an opening that I put forward for further research.

To address the limitation of excluding individuals who did not visit public healthcare facilities for TB diagnosis, future research could partner with non-governmental organisations (NGOs), traditional healers and community health organisations that work with underserved populations. These organisations often have access to individuals who might not use public healthcare facilities.

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APPENDICES

Appendix One: Participant Profile

This appendix profiles participants based on key biographical identifiers. I begin by profiling the main participants of this study, namely men diagnosed with and suffering from TB. I conducted interviews with these participants after they had already been diagnosed with TB, and they were at different stages of living with the disease. Some were newly infected, while others were nearing completion of their TB medication. A few participants had recently completed their treatment, while one had been lost from TB treatment. These identifiers provide a brief background on age, ethnicity, residence, education, and employment status. Additionally, some useful biographical information included relationship or marital status, household size, and the type of fuel used in the household for cooking and lighting. All these key identifiers provide readers with important context regarding living and working conditions, demonstrating how the social environment shapes men's health in relation to tuberculosis.

Themba (40)

Themba's wife was acquainted with my wife. In conversations between Themba's wife and my wife, it emerged Themba was not feeling well. Themba's wife then disclosed that Themba has been diagnosed with tuberculosis. As I was in Johannesburg, my wife was involved in assisting with research participants for my study. During one of our conversations, my wife mentioned that I could interview Themba. Through the help of his partner, we managed to secure an interview with Themba. Themba lived in a household of four members in an informal dwelling in Modimolle. In terms of access to water, Themba's household had dug a well on their stand and they used the water mainly for domestic use. Themba would always buy bottled water from town for drinking. Themba worked in construction doing maintenance and he had completed Grade 12. He used to earn between R5100 to R10000 per month. He is one of the participants who was skilled in his trade. His household uses gas for cooking.

Thuso (39)

Ethnically, Thuso identified as Tsonga and was 39 years old when I met him for the interview. Thuso used to carry a bottle of drinking water as this was one of the recommendations from the health providers. He lived with his partner in a cohabiting union in an informal dwelling in Modimolle. Thuso lived in a household of five. Due to TB illness, Thuso was out of

employment though he used to work in the construction industry. The main source of energy for his household was firewood and paraffin. His household relied on a well for water. Thuso dropped out of school in Grade eight. Thuso is the participant who showed me the traditional medicines that he used when he started feeling unwell. Although I had intentions to try the medicines as he had indicated that they work as enemas, we did not have time to prepare the medicines together.

Erick (27)

Erick ethnically identified as Tswana and he dropped out of school in Grade nine. Though he was not working during our time of the interview, Erick was exploring the music career as he was preparing to launch his album Erick had been diagnosed with TB and HIV. He was single and lived with his mother in a household of five. They lived in an RDP house where they used gas and electricity of cooking and lighting. Erick is the participant who revealed that he was reinfected with TB because, during the first diagnosis, he did not accept the results. Erick's household had access to piped water although the water supply was erratic during the period of the interviews.

George (29)

George is ethnically Tsonga, single and dropped out of school in Grade nine. He lived in a household of four members with his mother. They resided in an RDP house. George was unemployed and receiving a disability grant of R2130. For lighting and cooking, George's household used both electricity and firewood. Although the supply of water was not constant in the township, George's household has access to piped water.

James (28)

Ethnically identifying as Pedi, James was 28 years old and was in a cohabiting union. He lived in an RDP house in a seven-member household. James dropped out of school in Grade 10. He used to work in 2019 and when I met him for the interview in 2020, he was no longer working but relied on piece jobs. The household used electricity and firewood for lighting and cooking. James' household had access to piped water.

Trust (48)

I met Trust for an interview at an RDP house where he was living with his sister. On the residential stand, Trust had his own backyard informal dwelling where he lived. He however

was living in a household of four members which include his sister. Trust was a divorcee aged 48 years when we met for the interview. He identified as Pedi and had dropped out of school in Grade five. The household had access to piped water, and due to the area being low-lying, they enjoyed uninterrupted water supply. Trust was unemployed and relied on a disability grant. He used to work in a carpentry firm where they manufactured wooden doors.

Lawrence (30)

Lawrence dropped out of school in Grade three. He identified as Pedi. He was 30 years when I met him for the interview that we held outside the RDP house where he stayed with his mother. He was single and lived in a household of six members. He revealed that he has a girlfriend who did not trust him whenever he visited the clinic for TB treatment, and this bothered him a lot. The household had access to piped water for drinking and they relied on firewood as their source of energy for cooking. Lawrence was unemployed having been laid off work at the height of COVID-19. He however does piece jobs. He was diagnosed with TB and HIV, and at one point, he was lost from treatment for both conditions. I accompanied two CHWs to Lawrence's home as part of a follow up strategy so that he could be re-initiated back onto TB treatment. Lawrence confirmed that he used to work at a farm and could not disclose to his employer that he had been diagnosed with TB for fear that he would lose his job.

Charles (39)

Identifying as Pedi, Charles was 39 years old. I met him after a follow up process with the community healthcare workers because he had been lost from TB treatment. Charles was single and he completed Grade 12. He lived with his brother at a family subsidy house. The household relied on electricity for lighting and cooking. They had access to piped water. Charles relied on income earned from piece jobs having been denied a disability grant. At one point, Charles' aunt played a crucial caregiving role when she forced him to go to the clinic after realising that Charles' health was deteriorating. I met Charles at a tavern where I interviewed him.

Timmy (39)

Timmy ethnically identified as Pedi and had completed Grade 12. I met Timmy at his mother's RDP house where he had been living after a TB diagnosis. He however owned an RDP house that he was renting out. Timmy was 39 years old and was single. He lived in a household of four members which included his mother, sister, and the sister's boyfriend. Timmy was unemployed but used to be a municipal employee working as a plumber. He relied on his

mother for financial support as he did not qualify for a disability grant. He stated that he was now doing piece work as and when called. During our interview, he received a call regarding a job opportunity, and I accompanied him to the caller. Timmy's household relied on gas and electricity for cooking and lighting. They had access to piped water.

Thabo (28)

Identifying himself as Pedi, Thabo was 28 years old and lived with his mother in a refurbished house. He was single and dropped out of school in Grade 10. The participant was unemployed when I met him. He previously worked in the construction industry where he earned R7 600 per month. Thabo's household used electricity for lighting and cooking in addition to having access to piped water. During my interview with Thabo, he spoke at length about his experience as part of a team of entertainers who would visit taverns as a comedian. However, TB illness caused his friends to isolate him. Thabo was the participant who revealed that he was not comfortable sharing his TB symptoms with his mother. He stated how he felt at ease sharing his illness experiences with strangers.

Garry (42)

Ethnically, Garry identified as Pedi and was 42 years old when I met him for the interview. Educationally, Garry dropped out of school in Grade nine. He lived with his parents in a refurbished house. He was diagnosed with both HIV and TB when I met him. Garry was single and used to cohabit but was deserted by his girlfriend when he insisted that she tests for HIV. He was wheelchair bound having suffered a stroke. He used to be a taxi driver ferrying children to and from school – an occupation that earned him R15 000 per month. He suspected that the neighbours were jealous of him because of the house his family owned and that was the reason he was bewitched. During the period of my fieldwork, Garry was relying on a disability grant. His household of five relied on firewood and electricity for lighting and cooking. The household had access to piped water, and they had installed a Jojo tank at the yard.

Patrick (28)

Patrick was 28 years old when I met him for the interview. He ethnically identified as Pedi and had completed Grade 12. He was a former drug (nyaope) abuser and was living with his parents in a refurbished house. The household owned a spaza shop that was being rented out to Ethiopian business owners. This was another form of income for the household. Patrick was diagnosed with both TB and HIV. The participant was one of the outspoken interlocutors who

was very eloquent on many issues that we discussed. He was single and belonged to a five-member household. Like most of the participants, Patrick was unemployed, and he appreciated the support he received from his parents. The household relied on electricity for cooking and lighting and had access to piped water. The household had a Jojo tank for water storage.

Herbert (24)

Like most of the participants, Herbert was ethnically Pedi, and he was the youngest of my interlocutors. He dropped out of school in Grade nine. He was single and lived in an RDP house consisting of six household members. He was the household head even though he was not working. Herbert was close to his mother who died of TB. The participant used to work as a farmworker in 2019 where he earned R2500 per month. The household had access to piped water and relied on electricity and firewood for cooking and lighting.

Klass (30)

Klass lived in an informal dwelling with his girlfriend in a household of five members. He self-identified as Pedi. It took me and my CHW-cum-research assistant some time to locate Klass as he seemed to have different addresses. Klass was 30 years old at the time of the interview, and he dropped out of school in Grade seven. The participant was diagnosed with multidrug-resistant TB. He was unemployed and he relied on a disability grant. The household relied on firewood and paraffin for cooking. They accessed water from a municipal public tap. Klass' condition necessitated hospitalisation at Modimolle MDR-TB hospital. However, COVID-19 changed everything such that he was asked to stay at home and collect his medication at the local clinic. The anti-TB medication for Klass was no longer consistently supplied to him.

Tshepo (31)

Tshepo identified himself as Pedi. He was single and lived in a refurbished house consisting of five household members. Tshepo did not complete high school but dropped out in Grade 11. The participant used to be employed earning between R800 and R1000 per month but stopped work because of TB illness. Tshepo's household relied on electricity for cooking and lighting. The household had access to piped water.

Frank (32)

Frank was the only interlocutor who had furthered his education by enrolling in an FET college. Frank was single. He lived with his parents in a household of eight members. He ethnically

identified as Pedi and due to TB meningitis, Frank was forced to stop working. He used to earn R2500 per month. The participant's household relied on electricity for cooking and lighting. They had access to piped water. Among many of the roles he was involved in, Frank was a pastor, a musician, a health ambassador and was also involved in the local policing forum. Due to this close bond with the community, Frank had good social and financial support when he became ill from tuberculosis. This social support came from friends in addition to the support from his mother and sisters, who sacrificed a lot towards his care.

John (47)

47-year-old John used to work at a brick making factory in Modimolle. Due to the COVID-19 context, he was asked to stop coming to work. When I met him for the interview, he stated that he was in the process of taking his case to the labour tribunal so that he could be reinstated back at work. John was single and dropped out of school in Grade eight. His ethnicity is Pedi and he lived in a household of five members**.** John lived in an informal dwelling but had access to electricity and piped water which was not consistent during the time of fieldwork.

Silas (32)

I met Silas for an interview after 7pm at his RDP house where he lived with his mother. This was after he had returned from work at a game lodge. He was earning R3500 per month. Silas' home was directly opposite a tavern. He was 32 years old and lived in a household of two members. He dropped out of school in Grade three. Silas was diagnosed with TB and HIV. He was single and he self-identified as Pedi. The household had access to piped water and relied on electricity and firewood for lighting and cooking. It was Silas who revealed that siblings are not capable of providing quality care when one is ill. He said that the mother's care is the best. Evidence from his clinic card showed that at one point, Silas' weight dropped to 45kg when he was ill from tuberculosis. It was during those times that Silas relied on his mother, whom he affectionately called 'magogo,' for financial and social support.

Thomas (29)

In my conversations with the community healthcare workers, they insinuated that Thomas was a child whose TB infected father had predisposed him to infection because of recklessness. As it turned out, Thomas was 29 years old and lived with his partner in a four-member household. Thomas lived in an informal dwelling and dropped out of school in Grade eight. Starting off with a serious headache and visual impairment, it was after a period of about four to five years

before Thomas was successfully diagnosed with extrapulmonary TB. The participant was unemployed and used to do piece jobs working for his brother-in-law. The interlocutor ethnically identifies as Tsonga and used gas for cooking. Thomas disclosed that he was happy when he finally received an accurate TB diagnosis because the visual impairment he had been experiencing had caused despair for him and his family. He could not work because of the challenges with his eyesight.

Mthuli (44)

Identifying as Ndebele, Mthuli completed matric and managed to set his own independent household. He was engaged to his partner and was living in an informal dwelling in a household of four members. He was diabetic in addition to being diagnosed with TB. I conducted the interview with Mthuli at his parents' home, and he was confident that he would have a positive health outcome after TB because his parents had once lived with the disease and were cured. Due to his TB illness, Mthuli, who was gainfully employed and earning between R3100 and R5000 per month, was forced to stop going to work. This resulted in a loss of income during the period he was not working, forcing him to rely on child grants for survival.

Gift (54)

Gift was single and I met him at his informal dwelling where he lived alone. This was after several failed attempts to locate his dwelling. It is typically difficult to locate informal dwellers, especially during visits by the CHWs, for purposes of following up and collecting their treatment. Ethnically, Gift identified as Pedi and dropped from school in Grade five. He was unemployed and relied on a disability grant. Besides relying on the disability grant, the participant depended on the support of his nephew, with whom he lived in an informal dwelling. Before finally accessing medical care for TB, he initially consulted a prophet when he started feeling unwell. Gift used firewood for cooking and relied on a municipal public tap for water. During the interview, the interlocutor revealed how he depended on certain family members who would come to fetch water and cook for him because he was very ill.

Fannie (51)

On my first visit to Fannie's sister's place, we could not locate him as he was reportedly said to be at his own house. Upon arrival at his house, Fannie was not present either. It was on a second attempt that I finally managed to interview Fannie, who was ethnically Pedi and lived alone in his RDP house. Fannie completed Grade 12 and used electricity for cooking and

lighting. He had access to piped water and maintained a small garden where he planted spinach and other vegetables, particularly liking spinach. Before becoming eligible for a temporary disability grant of R1860, Fannie stayed with his sister when he started feeling unwell. He used to work at a crèche but lamented the low wages he received. Fannie, at 51 years old, was among the oldest in my sample.

Tebogo (53)

In the company of two community healthcare workers, we visited 53-year-old Tebogo who lived alone in an informal dwelling. Tebogo identifies as Pedi and dropped out of school in Grade five. He was unemployed but relied on a temporary disability grant. At the time of the interview, Tebogo reported that he had been reinfected with TB for the fifth time. The CHWs shared with me that Tebogo deliberately exposed himself to TB infection for the sole purpose of accessing disability grants. Although Tebogo lived in an informal dwelling, he had access to electricity and piped water. This is because he was living in a backyard informal dwelling.

Terry (39)

Terry stopped working when his health deteriorated. He used to work in Pretoria and during the time of the interview, Terry was living with his partner in an informal dwelling. He was both HIV and TB positive. He showed loss of weight, and I gave him a lift to the clinic where he wanted to apply for a disability grant. Terry reported that he did not receive any formal education and had only started to attend evening classes. He self identifies as Pedi. I had the interview with Terry in his informal dwelling.

Richard (36)

I held an interview with Richard at his sister's RDP house. Richard was Pedi like most of the participants, and he was very open in sharing his experiences with me. He was gainfully employed as a cleaner earning between R3000 and R5000 per month. He was single and he is the one who shared his passion for playing PlayStation games with his friends in a poorly ventilated informal dwelling. Richard completed grade 12 and he lived in a household of three members. The household had access to electricity and piped water.

Sammy (54)

Sammy self-identified as Tswana and was 54 years old during the time of the interviews in 2020. He lived in an RDP house with relatives in a household of three members. Sammy

dropped out of school in Grade three. He was separated and unemployed. The household used both electricity and firewood for lighting and cooking. Although the household had access to piped water, the supply was erratic. Sammy's home was closer to a tavern.

Brian (43)

Brian self-identified as Tswana and dropped out of school in Grade seven. At 43 years, Brian lived with relatives in an RDP house. Brian was unemployed and this was precipitated by TB induced illness. Brian used to work as a garden serviceman where he was earning R2000 per month. Brian's household relied on electricity for lighting. The household had access to piped water which was not consistently supplied during the fieldwork period.

Kennedy (35)

My interview with Kennedy occurred at his RDP house where he was living in a household of three members. Kennedy was not married though he lived with his girlfriend and some friends. The RDP house Kennedy was residing in belonged to his late mother, and it was now being contested by his uncle, who wanted him out of the house. He disclosed that he was currently not employed though he previously worked as a petrol attendant. He now earned irregular income from repairing appliances like TVs and microwaves. Kennedy used electricity for lighting and cooking. He also had access to piped water. He ethnically identifies as Pedi, and he dropped out of school in Grade eight.

Toni (58)

Toni lived with his wife in a household of two members. Toni is the only participant who resided in a different location of the township from the rest of the participants. His TB diagnosis was established at the clinic in town. Toni self-identified as Pedi and did not have any formal schooling. Toni lived in an RDP house and was unemployed but relied on some piece jobs. He used electricity for cooking and lighting as well as having access to piped water. He was on a temporary disability grant because of TB illness. My interview with Toni occurred at his RDP house.

Ralph (29)

Ethnically, Ralph identified as Pedi and he dropped out of school in Grade 10. He was single and he lived in a four-member household. The household relied on electricity for cooking and lighting as well as having access to piped water. Ralph lived in a refurbished house. When I

met him for the interview, Ralph was not employed. He previously worked as a driver for a courier company. Ralph is the participant I spoke about in my ethnographic chapter who was startled by a little girl who had been sent to wake him up for our interview.

Dumisani

Dumisani was the key participant, a male nurse who worked in the HIV/AIDS, STIs, and Tuberculosis (HAST) unit at the local clinic in Modimolle. He gave me access to the current files of men diagnosed with TB and who were on anti-TB treatment at the clinic. I managed to have an interview with Dumisani at the local clinic. He did not consent to me audio recording the interview, but he allowed me to write down his responses. He was very open with me during the interview, and he was patient with my note taking. Dumisani is the male nurse who is referred to by Fannie (male participant) as the one who intervened after Fannie had been told to throw his sputum sample into the dustbin by the other nurse. His expert knowledge on tuberculosis and how it affected men in the community was reflected in our interview. He also spoke at length about the efficacy of the DOTS strategy.

Linda

The first among the community healthcare workers to allow me opportunity to interview her, Linda had more than ten years working in Modimolle. Linda was passionate about her work and was the one who provided the DOTS services to Thabo (the 28-year-old participant who was not willing to disclose his TB symptoms to his mother). As my interview with Linda was the first in the series of interviews with both the CHWs and my main participants, my audio recorder malfunctioned because I had placed it in direct sunlight. It was an awkward moment for me. However, Linda was patient with me and allowed me to restart the interview. This time, I had to use my smartphone for recording. During the period of the interviews, Linda and other CHWs were actively involved in community screening for COVID-19. While Linda mentioned that it would have been ideal if I had made prior arrangements for her to research the questions I would ask, her responses were informative regarding the work she and her team do as CHWs.

Matshepo

Matshepo is one of the community healthcare workers I interviewed for this study on 22 July 2020. She started working as a community healthcare worker in Modimolle in 2009. She agreed to have the interview at the clinic immediately after all the team members had left to go to the field. Matshepo wanted me to visit one of her clients who was using the drug, nyaope.

Subsequent to the request, I accompanied her into the field, hoping to schedule an interview with the said client/potential participant. As we arrived at the RDP house where the potential participant lived with his brothers, he refused to do an interview, insisting that we give him some money before agreeing to participate. We could not comply with this demand and therefore did not conduct the interview with the potential participant. Additionally, as he had discontinued TB treatment, he also insisted on assurance of a disability grant before resuming treatment. Among the CHWs, Matshepo emphasised the issue of stigma in the community. The problem of stigma, according to Matshepo, leads people to deny their illnesses.

Pauline

On 23 July 2020, I sat down for an interview with Pauline and as was the case with all the CHWs that I spoke to, we hosted the interview at the local clinic. Pauline spoke in greater detail about her work as a CHW in relation to the directly observed treatment short course strategy. With more than 10 years of experience working as a CHW in Modimolle, Pauline disclosed that the process of administering the DOTS strategy was based on voluntary participation. If the client was not comfortable with CHWs assisting in the process, they were free to decline. Pauline emphasised the importance of adhering to the set time for taking anti-TB treatment with the client. In the strict DOTS strategy, Pauline stressed that as the 'dotter,' she would supervise the client taking the treatment. She also noted that the six-month duration of treatment was lengthy, making adherence crucial, which underscored the importance of the DOTS strategy.

Patricia

Patricia is one of the two caregivers interviewed in this study. She is Themba's spouse and was unemployed at the time of the interview. I conducted the interview with Patricia at my house since she and my wife were colleagues. Patricia had been deeply affected by her spouse's illness, leading her to confide in my wife as part of her support system. The interview took place just after Patricia had collected anti-TB treatment for Themba, who was at work during the interview. Patricia's narrative highlighted the toll her spouse's illness had taken on her, leaving her vulnerable without anyone close to share her burden with. At the time of the interview, Patricia had a young daughter, approximately four years old, and a toddler. She shared how she accompanied her spouse to the doctor to understand the root cause of his illness, especially after two previous visits to the same doctor without a clear diagnosis.

Tracey

Tracey is the other caregiver I interviewed for this study. She is Charles' aunt, as her sister was Charles' mother. Tracey took on the role of caregiver for Charles as his mother had passed away. I visited Tracey's family house, a subsidised one, accompanied by two community healthcare workers. These workers were assigned by the clinic to follow up on Charles, who had been lost from TB treatment due to treatment interruption. Upon our arrival, Charles was not present as he was in the company of friends at a nearby tavern. During our interaction, Tracey expressed deep concern for her nephew. In the interview, Tracey shared the challenges she faced while caring for Charles. She recounted having to insist that Charles go to the hospital when he began losing weight. Despite her caregiving efforts, Tracey noted that Charles was not cooperating, and eventually, she gave up the caregiving responsibilities. This was against the backdrop of her attempts to persuade him to stop drinking beer, considering he was on anti-TB treatment.

Appendix Two: Participant Information Sheet



Edmond Madhuha
1 Jan Smuts Avenue,
Braamfontein 2000,
Johannesburg,
Email: Edmond.Madhuha@wits.ac.za
Phone number: 076 587 0088.

Dear Sir,

My name is Edmond Madhuha, and I am a PhD student at Wits University in Johannesburg. As part of my studies, I have to undertake a research project and I am investigating men's experiences of living with tuberculosis. Research helps us to understand problems better. The aim of my research is to understand your experiences of living with tuberculosis.

I would like to invite you to take part in an in-depth face-to-face interview that I expect will last approximately 45 minutes to an hour. Participation involves making yourself available at a time and place of your preference. If you are interested and available, a further one to two interviews of similar duration would be helpful to me, but only if you would like. To make it more private, the only requirement would be that the interviews be conducted when your partner, friends, family members are not present. I would like, with your consent, to record the interview. This is for ensuring that I capture your responses as accurately as possible.

Your participation in this project is voluntary. You will not receive any direct benefits for participating and there are no disadvantages or penalties for not participating. You are free to decline to participate in the study without any consequences. If you experience any distress or discomfort, we will stop the interview or resume another time. If you need support or counselling services following the interview these are available free of charge at the Department of Social Development (Modimolle) contactable at boinette@gmail.com or (014) 717 2637.

If you choose to participate, you will be assisting me, and I really appreciate it. The interview will be completely confidential and anonymous, as I will not be asking for your name or any identifying information. I will ensure that no one will know that you participated in this research, and I will not use your real name in reporting the results of this research. You will therefore not be identifiable in any way. The information you give to me will be securely stored in a password-protected computer.

If you have any questions afterwards about this research, feel free to contact me on the details provided above or to contact my academic supervisor (Lorena Nunez Carrasco) at Lorena.NunezCarrasco@wits.ac.za : 011 717 4427. A final product of this project will entail a written research report, which will be available online through the Wits University library website. If you have any queries, concerns or complaints regarding the ethical

procedures for this study, you are welcome to contact the Wits University Human Research Ethics Committee (medical), telephone +27 (0)11 717 1234/2656/2700, email Zanele.Ndlovu@wits.ac.za.

Yours sincerely,

Edmond Madhuha

Appendix Three: Informed consent

Project Title: The persistent health burden: understanding black South African working-class men's experiences of living with tuberculosis.

1. I have been given a Participant Information Sheet which explains the nature and processes involved in this study;
2. I was given time to read it, or had it read to me, in the language I best understand;
3. I was given time to freely ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate and direct benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time;
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained;
7. I was assured that the information I share will be kept confidential and can only be accessed by the researcher and his supervisor;
8. I was satisfied with the explanation that no one will be able to identify me when the results of my interview are reported and that my name will not appear anywhere in the written report or other write ups of research;
9. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study I am free to speak to any of these contacts.

Contact details:

Edmond Madhuha: Principal Investigator. Telephone no. 076 587 0088, or by e-mail at Edmond.Madhuha@wits.ac.za

Lorena Nunez Carrasco: Supervisor, on telephone no. 011 717 4427, or by e-mail at Lorena.NunezCarrasco@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.

Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____
Date: _____
Place: _____
Signature or mark _____

Witnessed by:

Name of Witness: _____
Signature: _____
Date: _____

Appendix Four: Informed Consent for Audio Recording

Project Title: The persistent health burden: understanding black South African working-class men's experiences of living with tuberculosis.

I hereby consent to audio recording of the interview,

I understand that:

- The recording will be stored in a secure location in a locked cupboard and a password protected computer with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within five (5) years of the publication of the research findings,
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.

Name of Participant: _____
Date: _____
Place: _____
Signature or mark _____

Witnessed by:

Name of Witness: _____
Signature: _____
Date: _____

Appendix Five: Wits Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Mr Edmond Madhuha

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190951 MED19-08-059

NAME: (Principal Investigator)	Mr Edmond Madhuha
DEPARTMENT:	Sociology Modimolle Municipality, Limpopo Province
PROJECT TITLE:	The persistent health scourge: understanding black South African working-class men's experiences of living with tuberculosis
DATE CONSIDERED:	27/09/2019
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof Lorena Nunez Carrasco
APPROVED BY:	Dr C Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	03/12/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 301, Third floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed September and will therefore be due in the month of September each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

20/12/2019
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix Six: Limpopo Department of Health Permission Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref	:	LP- 202002 - 006
Enquires	:	Ms PF Mahlokwane
Tel	:	015-293 6028
Email	:	Kurhula.Hlomane@dhsd.limpopo.gov.za

Edmond Madhuha

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

The persistent health scourge: understanding black South Africa working –class men's experiences of living with Tuberculosis.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
    b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
    c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    e. The approval is only valid for a 1-year period.
    f. If the proposal has been amended, a new approval should be sought from the Department of Health
    g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department **Date** 12/03/2020

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!