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“The (human) body is like a car – it needs service”: Exploring the factors influencing the health seeking behaviours of working class men in Modimolle Town, Limpopo Province.

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A research report submitted in partial fulfillment of the requirements for the degree Master of Arts in Health Sociology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg.

Declaration

I declare that this research report is my original, unaided work and that, to the best of my knowledge, it has neither been previously submitted nor currently being submitted to any other University for a degree or an award. Where someone else's work has been used, due acknowledgment has been given and reference made accordingly.

_____

Edmond Madhuha

Date: 15 March 2017

Dedication

To my sons Caleb and Casper be inspired to follow your dreams.

Acknowledgments

To God my Father, thank you for giving me this opportunity, your love has carried me throughout this work.

A great thank you to, Associate Professor Lorena Nunez Carrasco, my supervisor for bringing that aha moment in me throughout our numerous discussions. Your invaluable insights and support spurred me to critically think through this work, your guidance was spot on.

To my wife, Emildah Madhuha, thank you for holding on when the going was tough. Your support, understanding and encouragement are immense. To my boys Caleb and Casper Madhuha, we did it; we are going to do it again!

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Abstract

This study is founded on the argument that the health of a population is dependent on both structural factors and human agency. Literature shows that men are generally poor at attending to their health needs as compared to women, with statistics confirming higher mortality rates and lower life expectancy among them. This research study aimed to explore the factors influencing the health seeking behaviours of black South African working class men in Modimolle Township, Limpopo Province (South Africa). The study followed a qualitative approach where semi-structured face-to-face interviews were used for data gathering. A snowball non-probability sampling technique was used to select 15 black working class men between the ages of 29 and 50 years. All the interviews were conducted and audio recorded in Modimolle Township between two residential locations. The interviews were transcribed verbatim. Thematic content analysis was employed for data analysis in which emerging themes bordered around the identities of men, their relationship to their bodies and their perceptions of health care systems. The construction of masculinities among men created multiple and varied ways to their health seeking behaviours. Men engaged in multiple practices ranging from preventive medical check-ups, the use of various types of enemas as well as the use of traditional medicines for the maintenance of their health. These practices were associated with the construction of a responsible masculinity among the participants which challenges the notion that masculinity is associated with negative health seeking behaviours among men.

Key words: Responsible masculinity, *maikarabelo*, working class, health-seeking behaviours, men, Modimolle

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Chapter 1: Introduction

Introduction

This study is founded on the argument that the health of a population is dependent on the structural factors within which people exist. Notwithstanding the above assertion, individual agency is also significant to how people maintain their health. Underlying people's health or lack thereof lie their health seeking behaviours, and these form the cornerstone on which this research report is situated. The study sets out to explore the factors that influence the health-seeking behaviours of working class men in Modimolle Township, Limpopo Province of South Africa. This study was crafted against the overly stated observations in men's health literature that there is something about men that makes them poor to take care of their health. Men, for example, are said to view health seeking behaviours as a sign of weakness (Peacock, Redpath, Weston, Evans, Daub and Greig 2008:3). Chief among this deficiency on men's part towards their health is the notion of masculinities (Connell, 1995). In contrast, men are clearly not homogenous but are diversely affected by multiple factors in their health seeking behaviours, thus, the need to be specific about the kind of men being talked of. Not only is there a problem of generalising about men in relation to health, but what men do to keep themselves healthy does not receive enough attention. In this study, I therefore explore the health-seeking behaviours of black working class men in Limpopo. To achieve its aims, this research used a qualitative methodology with face-to-face semi-structured interviews as the data collection method.

The social sciences have posed a critique to the dominant perspective of biomedicine in explaining health and illness. Schuster, Dobson, Jauregui and Blanks (2004:350) argue that the sociology of health and medicine is concerned with understanding the perceptual and social processes by which individuals and groups understand and experience health in a holistic manner. In relation to the sociology of health and illness, socio-cultural factors determine people's perceptions and experiences of health and illness (Nettleton, 2008). Due to social stratification, the state of being healthy and the resulting access to health services is inevitably gendered, classed as well as racialised.

As Leon and Walt (2004:3) postulate, the health of individuals within a society is largely dependent upon the way that society is structured; the way in which resources are invested as well as the interests these resources serve.

Rationale

Social stratification creates gender differences which are linked to marked disparities toward health services (World Health Organisation, 1998; Courtenay, 2000); just as class and race are implicated in health inequalities (Nettleton, 2008; Cockerham, 2013; Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios and Onoya, 2014). Literature abounds on a global scale as well as in South Africa about the health concerns of women; however, the health related literature on men is comparatively small. Within the discourse of health and gender, there is a tendency of conflating gender-related inequities as being uniquely particular to women (Okojie, 1994; Afifi, 2007), denying the fact that men are gendered and are also faced with diverse health inequities. The overemphasis on women's health and the significant marginalisation of men's health issues in gender and health literature has been singled out for criticisms (Courtenay, 2003; Connell, 2012). In the literature on gender and health, not enough is written on men's health in general and in particular, on their health seeking behaviours. Interestingly, men are a heterogeneous category enmeshed in structural conditions which have a bearing on their access to health. Diverse as men are, this research sets out to understand the health-related behaviours of a specific racial and cultural group of men within a certain socioeconomic category in South Africa. This study makes a contribution to the existing literature on men's health in general and in particular to the South African context.

A review of the literature on the public's health beliefs by Hughner and Kleine (2004) reveal that most of these works examine illness-specific beliefs and behaviours within specific populations afflicted with a particular illness. For South Africa, some of the studies done on health seeking behaviours (Pronyk, Makhubele, Hargreaves, Tollman and Hausler, 2001; Case, Menendez and Ardington, 2005; Leichliter, 2011) have focused on specific health conditions like tuberculosis (TB) and HIV/AIDS. In contrast,

fewer reviews according to Hughner and Kleine (2004:398) have clarified the undiagnosed general sentiments and meanings about health from the public's perspective. This observation applies to the context of South Africa. Notably, the study done by Letsela and Ratele (2009) has explored the link between masculinity and men's general health seeking behaviours in South Africa. The study population in the aforesaid work varies from professional men to those with no income at all. Building on the above study, this research work aims at understanding the lived experiences and perceptions of the black working class men in Modimolle Township towards their own health seeking behaviours and the underlying reasons behind these behaviours.

Using education as one of the indicators of human development, the population of Modimolle shows the area lags behind with 45.1% having primary education while only 0.9% of the adult population has a tertiary education (Modimolle, 2016:38). Important to this study is access to health services in the municipality. There is one hospital in the town and two clinics each located in Phagameng Township and another in the town centre and these facilities are not able to meet the community's needs (Modimolle, 2016:73). With South Africa having the highest number of people living with HIV and AIDS on the globe (Blecher, Chiu, Abdullah, Daven, Tavanxi, Meyer-Rath, Pillay, Kollipara and Borowitz, 2016), the Department of Health (2015 cited in Modimolle, 2016:73) reveals that HIV prevalence rate in Modimolle stands at 25%. Set against this backdrop, the findings in this research study point out to a responsible masculinity in which working class men engage in diverse practices for the sake of their health.

Background of the study

I grounded this research study on the sociology of health and illness which accepts that health seeking behaviours do not occur in a vacuum, but rather, within specific "sociocultural and sociohistorical environment" (Schuster et al, 2004:350; see also Batisai, 2016). This study explores factors that have a bearing on the general health-seeking behaviours of black working class men and the practices they engage in to promote their own health. Consensus in the literature is that women are comparatively better at taking care of their own health and that they have a higher life expectancy than men (Blaxter, 2004; Cockerham, 2013; Shisana et al, 2014). On the other hand, diverse

reasons are behind men's avoidance of health care as well as their refusal to take treatment which results in the worsening of their condition (Shavers, Shankar and Alberg, 2002; Whetten, Leserman, Whetten, Ostermann, Thielman and Swartz, 2006). A noteworthy observation around literature on men's health is that traditional beliefs about masculinity are to blame for their health behaviours (Connell, 2000; Peacock et al, 2008). However, this assertion is overstated in literature as this research study evinces that besides masculinity, other factors like social class, geographical location, the health care system, occupational as well as living conditions have an effect on men's health behaviours.

This study recognises the fluidity around meanings and definitions of concepts. Just as there are diverse definitions around concepts; health, which is principal in this study, is a multifaceted concept. The social constructivist approach defines health as being determined by the social structure around which individuals exist, and the meanings these individuals assign to health. Within this framework, the World Health Organisation (1948:100) views health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition of health stands for a holistic approach in which social causes and the individual physiological determinants play a part. In a follow-up to its earlier definition, WHO (1986 cited in Schuster et al, 2004:350) further clarify that to reach a state of health "an individual or a group must be able to realise aspirations and satisfy needs, and to change or cope with the environment". This elaboration is important as it can be used to explain how the black working class men in Modimolle Township navigate barriers to their health so as to satisfy family, work and community roles.

Health seeking behaviour is a complex concept which is open to different interpretations. The micro level lens sees the primacy of the person at taking care of his/her health through access to health care services. On the other hand, a macro-level analysis of health seeking behaviours notes the pre-eminence of structural factors to how populations negotiate health concerns. In psychology, MacKian (2003:7) argues the inclination of people towards making or not making healthy choices is determined by outside factors. Although an individual's agency is important in this regard, various

conditions which are outside of the individual's control are fundamental determinants of how different people respond to their health concerns. Interestingly, MacKian (2003) further argues that health seeking behaviour varies for the same individuals or communities when faced with different illnesses. It is important to point out that in other sources; health seeking and help health seeking behaviours are interchangeably used. Health seeking behaviours is the concept which is consistently employed in this study to show how working class men within their specific context understood health and what behavioural practices they engaged in to stay healthy.

Health seeking behaviours for this research study is defined as "personal actions to promote optimum wellness, recovery and rehabilitation" (Nursing Outcomes Classification, 2010 cited in Cornally and McCarthy, 2011:282). From this definition, health seeking behaviours are personal choices which are shaped by the individual awareness of an actual or a potential ailment. Significant as it may, personal choices alone do not offer nuanced explanations to health seeking behaviours, thus, the definition above will be balanced up with MacKian's (2003:23) assertion that health seeking behaviour is not just a separate result but is an essential component of a "person's, a family's or a community's identity which is the result of an evolving mix of social, personal, cultural and experiential factors". Although the individual makes the personal choices, the larger social context needs to be factored in. As wellness is intertwined with health seeking behaviours, its definition is suitable. Thus, Schuster et al (2004:351) conceptualise wellness as the generalised self-perception of health.

Further still, in defining working class, the study adopted the definition by Scambler (2001:90) who defines it as "those who have no command over the means of production, the labour power of others, or their own means of realising their own labour". For purposes of operationalising a strict definition of working class in South Africa suitable for this study, I borrow from Seekings (2003:17), who splits the broader category of working class into subcategories of core working class comprising of semi-skilled and unskilled workers and the marginal working class composed of farm and domestic workers. In the core working class category, my research participants included security guards, alarm system installers, truck assistants as well as bricklayers. In the

marginal working class category, I included gardeners. For this study, the nature of work (involving physical strength, impacting the body in any specific way), the resources by which members of the working class use to preserve health (e.g. food, physical exercises, access to health care and preventive check-ups) as well as their lifestyles are all relevant.

Aim and objectives of the study

This study aims to contribute to literature by sociologically researching the factors that influence the health-seeking behaviours of working class men in Modimolle.
In pursuance of the broader aim, the study sets itself to address the following objectives:

- To investigate how notions of masculinity held by working class men influence their health seeking behaviours.
- To explore ways in which working class men uphold their health and respond to illness.
- To explore the views of working class men towards the use of the health care system.
- To examine participants' views on how the care provided by the healthcare system helps or inhibits their search for health-related help.

Research questions

This study sets out to answer the following research question:

What are the factors that influence the health seeking-behaviours of black working class South African men in Modimolle Township, Limpopo Province?

Subsequently, the study looks into four main research questions which inform the interviews as well as the analysis of the data. These research questions include:

- How does masculinity relate to men's health-seeking behaviours?
- What are the various health related resources men have to maintain health and respond to illness?

- How do men perceive and use the health care system?
- Does the healthcare system in South Africa inhibit or promote men's access to health services? Either way, in what way(s) does it promote or inhibit men's access to health services?

Outline of the research report

Following from this Chapter which introduced the research study, Chapter 2 is the bedrock through which the study is anchored. The chapter engages with the literature on health, masculinities, and embodiment as well as on health seeking behaviours.

Chapter 3 is framed under a qualitative methodology which informed the use of semi-structured in-depth interviews to bring out participants' perceptions. In this chapter, I address the research setting as well as the criteria for selecting research participants. I spell out the process of data analysis and ethical considerations. Under reflexivity, I explain my positionality as a researcher before highlighting methodological limitations.

In Chapter 4, I take the reader through data analyses. I present this chapter in such a way that my findings and discussion run simultaneously for purposes of ensuring coherence of arguments. I embed the overall presentation within existing literature.

Chapter 5 summarises and discusses the central findings of my study and relates it to the set research question. In concluding this chapter I also present recommendations.

Chapter 2: Literature review

Introduction

In the present chapter, a detailed review of literature is taken up at length to locate men's health-seeking behaviours. I explore the debates around gender and the ways in which masculinities are implicated in men's health. Taking its cue from the sociology of health and illness, this chapter further explores other social factors which are implicated in men's health-seeking behaviours. I use the theory of intersectionality as a lens through which to analyse working class men's health seeking behaviours before concluding the chapter.

A brief review of the interplay between structural factors and health

The social conditions within which people live and work are implicated in health outcomes across and within countries. Health inequities are not attributable to biological determinism but are largely social outcomes resulting from the way societies are stratified. According to Marmot, Friel, Bell, Houweling and Taylor (2008:1661), the immediate structural conditions in which people are born, grow, live; work and age are linked to the high burden of illness which causes premature loss of life. Apartheid created much of the current health inequities in South Africa (Coovadia, Jewkes, Barron, Sanders, and McIntyre, 2009). These inherited health inequities continue to exist in the contemporary period in which differences are magnified across and within provinces. As the richest province in 2007, the Western Cape had 60 private hospitals and 55 public hospitals compared with 6 private and 44 public hospitals in Limpopo, the poorest province (Stuckler, Basu and Mckee 2011:168). These imbalances in health infrastructure investment show that health is shaped by social class.

Many factors contribute to the disparities that exist among people towards health care access. For South Africa, Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich (2011: S117) argue there exist institutional barriers that impede access to health care by the poor and uninsured. The social conditions defining people's health

outcomes include housing, access to clean water and sanitation, access to education as well as the working conditions. Statistically, in 2000, an estimated 13 368 deaths which translated to 2.6% of the overall mortality rate in South Africa were found to be caused by unsafe water and sanitation (Lewin et al., 2007 cited in Govender, Barnes, Clarissa and Pieper, 2011: 341). In this case, socio-economic status is implicated in the overall health outlook of people. Further still, employment conditions according to Marmot et al (2008:1663) as well as the work people do are important to health. Therefore, the types of jobs done by the working class men in this study as well as their living conditions cannot be separated from their general health and wellbeing. These conditions are also directly related to men's health-seeking behaviours.

The plurality of the South African health care system

Building upon the work of the World Health Organisation (2002, 2008), Flint and Payne (2013:48) argue that the traditional healthcare sector in sub-Saharan Africa provides primary healthcare service to about 80 percent of the population. This figure should be juxtaposed with the pre-eminence of biomedicine, thus most of the black people use both systems for their healthcare needs. Although the relationship between biomedicine and traditional medicine in South Africa is fraught with tension, most of the black population pick and choose from the two systems in face of any health condition (Flint and Payne, 2013; de Roubaix, 2016). Medical pluralism according to Helman (1990 cited in Kahn and Kelly, 2001:41), is a tendency to subscribe to disparate healthcare systems. By outlining the context of the healthcare in South Africa, I am arguing that, people are either influenced by structural forces or they practise their own agency on which medium of healthcare system best serve their needs. Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood and Flisher (2010) argue there is interplay between western biomedical health services and traditional practitioners in South Africa. Statistically borrowing from Liddell et al (2005) and the South African Department of Labour (2008), Flint and Payne (2013:51) argue that in South Africa, there are an estimated 300,000 traditional health practitioners versus 33, 000 biomedical practitioners. These figures serve to illustrate that the traditional healthcare sector has an important role to play in the South African healthcare system.

In their study of stroke sufferers in the Agincourt sub-district of Limpopo province, Hundt, Stuttaford and Ngoma (2004) describe the ways in which stroke patients navigate different barriers by visiting healers, prophets and doctors to preserve their health status. This picking and choosing from multiple systems is corroborated by Batisai's study (2016:119) on HIV/AIDS and alternative medicine in Zimbabwe. Batisai (2016) found that HIV-positive participants made calculated choices on using western medicine, faith healing and herbal cures as this was motivated by the need to augment their chances of regaining health. In line with the argument that structural factors are critical to understanding health seeking behaviours, the following section illuminates on the debates between gender and health.

Gender and health

Of particular interest in this section is a focus on gender to men's health-related behaviours. Since men are not a homogenous category, their health status is differentially influenced by race and class. In defining gender, Courtenay (2002:8) argues that it "is a dynamic process that is produced and reproduced daily through social interactions". Important in this definition is that gender is not a fixed classification but is simultaneously formed and reshaped in time and space within social relations. In the same vein, Kumpula and Ekstrand (2014) argue that gender must be understood within the processes of power relations between men and women in social interaction as this shape the symbols people use in their actions as well as in the way they talk and in their dressing.

Gender is not an independent factor influencing health behaviours but is enmeshed with other factors in shaping the health outcomes of individuals. Thus, Schofield (2012) sees gender as a process played out symbiotically with other factors like class and ethnicity causing barriers to health and well-being among some groups of men. It is important to highlight the interplay, not only of gender with socio-economic status and race but also how age, religion, residential location and education intersect with gender to create health inequalities.

Commenting on gender and health, the World Health Organisation (1998:12) argues that, “women as a group tend to have longer life expectancy than men in the same socio-economic circumstances as themselves”. While this could be partially attributed to physiological differences between men and women, social factors are of greater importance. For developed countries, Rossi (1992 cited in Courtenay, 2000) remarks that women engage in far more health-promoting behaviours than men and have healthier lifestyle patterns. Corroborating the predisposition of women towards healthy patterns, Courtenay (2000) attests that, besides being well adapted to seeking social support, women employ more effective coping strategies and are more effective to provide support than men. Paradoxically, Blaxter (1990 cited in the WHO, 1998) argues that despite their greater longevity, women in most communities are beset with more illness and distress than men. The way gender is implicated in the health of men and women is complicated since it does not uniformly shape health outcomes.

On disease outcomes; Cockerham (2013) argues that women have higher incidents of ailments that are not a leading cause of death while men have more health problems that result in death. It is recognised there are clear gender differences that translate to health inequalities between men and women. While there are marked differences in mortality and morbidity between men and women, Arber and Cooper (2000 cited in Nettleton, 2013:170) add that, there are also differences among women when it comes to health inequalities. The reason for these disparities among women could be located in their different material circumstances. This serves to show that in as far as women are generally perceived to have better health seeking behaviours than men; they are a varied category with different life chances. Thus, the way gender shapes health behaviours of women and men can be understood when it is interlinked with economic status.

Drawing on the work of the Department of Health and Human Services (1996), Courtenay (2000:1385) argues that, on average, men in the United States die 7 years younger than women and have higher death rates for all 15 major leading causes of death. In South Africa, the National HIV survey by Shisana et al (2014:37) shows that females have a higher overall HIV prevalence rate of 14.4% compared with 9.9%

among their male counterparts. Therefore, gender discrepancies in health-related behaviours are complex. An interesting observation from Statistics South Africa (2015:4) is that after discounting HIV/AIDS, life expectancy for males in 2015 was estimated at 65.2 while that for females was estimated at 72.7 years. However, the reality on the ground shows the decimating effects of HIV/AIDS on life expectancy, thus Stats SA (2015:5) shows that in 2015, life expectancy at birth was estimated at 60.6 years for males and 64.3 years for females. The overall assessment is there are complex contradictions between gender and health in that men in South Africa as explained above have lower rates of HIV prevalence compared to women, yet men have a lower life expectancy in comparison with the higher life expectancy of women. This study will add to the literature as it provides a sociological investigation of the underlying factors behind the marked discrepancies in men's health outcomes. To this end, Comaroff (1980 cited in Manglos and Trinitapoli 2011:119) argues that health seeking is neither purely practical nor culturally determined but is a result of a complex interplay of individual experiences, social interactions, structural constraints and cultural flows.

To examine gender and health, context is important. On England, MacFarlane (1990 cited in Nettleton, 2013:168) notes that when conditions associated with reproduction are excluded, the differences in admissions of men and women between 15 and 44 years almost disappear. This disputes the common assumption that men do not consult as much as women do. Similarly, in their quantitative study on health seeking behaviours in Northern KwaZulu-Natal, Case et al (2005) found no significant difference in health seeking patterns between men and women except that women take non-prescribed medication. This observation contradicts the general view that women are more predisposed to having more positive health seeking behaviours than men. In a study aptly titled, '*Clinics aren't for men'*, Leichliter et al (2011) note that for HIV-positive men in Gauteng, the high numbers of female staff and the daytime clinic hours created a barrier for men to get health care. The gendered environment of health care facilities thus creates gender discrepancies in relation to health seeking behaviours.

Gender roles as societally expected can either positively or negatively affect the health of men and women. I argue that the provider role prescribed on men in various societies shapes their health outcomes. The World Health Organisation (1998) argues that, in instances where societies expect men to be the breadwinner, some men will feel obligated to work long hours resulting in damage to their physical and mental health. Reflecting on the work of Sabo and Gordon (1993), the WHO (1998:11) remarks the social expectation of what it means to be a 'real' man makes it difficult for men who are ill to admit weakness and seek medical help. In the same vein, Mfecane's (2012) study found that men were reluctant to do an HIV test, neither were they comfortable disclosing their status as they viewed help seeking as a weakness which subjected them to the control of young women who were health providers. Therefore, gender dynamics are important to understanding health-related behaviours.

Different societies control and reinforce men to behave within specific gender roles and this, in turn, has a bearing on how men navigate health seeking concerns. Drawing from the World Health Organisation (2008), Bates, Hankivsky and Springer (2009) remark that gender is intricately tied to the high burden of disease and disability related to substance use and intentional and unintentional injuries among men. According to Peacock et al (2008), the effect of gender norms on men's health-seeking behaviour must inform policy on men's health and on gender equality. In analysing why from certain age men start to 'disappear' faster than women in the population of South Africa, Ratele (2008:22) finds the missing puzzle in what he terms 'ruling masculinity'. In other words, the ideals of being a real man are related to both disease and injury which result in high mortality rates among adult men in South Africa (Ratele, 2008). Following from gender and health, the next section looks specifically to give detailed debates on men and health.

A background review of men's health

Health is an abstraction and it lends itself to different interpretations and meanings. Although it is important to analyse health at an individual level, sociologically, the structural factors within which people exist are more important. Fox and Ward

(2006:476) dispute the idea of a single master theorisation of health and instead argue that "…health must be acknowledged to be a highly contextualised outcome of the lived body/self and its relations with its material and psychosocial environment". In his argument about men's health, Lloyd (2001) supports the importance of paying attention to the specificities of context and the wider belief systems and practices. As a result, the concepts of health and men's health, in particular, do not lend themselves to universal definitions that cut across all societies. Batisai (2016:113) agrees the definition of health cannot be limited to the absence of disease but that sociologically, health must include a sense of well-being which concomitantly is reflective of the sociocultural, economic and political order of a specific context. The specific context of the study is important so as to get nuanced expositions on men's health, therefore the choice of Modimolle Township as a research site.

In defining health, Aggleton (1990) argues that it is a reserve of strength or energy. Health, in this case, is perceived to be a commodity that can be drawn upon and used for personal and societal roles. In reviewing earlier works on men's studies, Broom and Tovey (2009) conclude these reify monolithic conceptions of masculine identity thus paying little or no attention to significant differentiation in masculinities according to ethnicity, sexuality, class and culture among other factors. The main weakness in early studies about men's health is the uncomplicated assumptions of lumping masculinity to ill health among men as if men are a homogeneous group faced with similar health related challenges. This explanation I contend denied the critical interplay of 'history and biography, personal troubles versus public issues' to borrow from Mills' (1959) sociological imagination. In their assessment of early works on HIV/AIDS, Shefer, Ratele, Strebel and Shabalala (2005) remark the literature has excessively painted a negative picture of masculinities and their impact in men's lives.

Rather than portraying masculinities as rigid and static, Hunter (2004 cited in Mfecane 2012) argues that early literature on men's health overlooked the fluidity of masculinities which should be explored in light of challenges faced by men like unemployment and AIDS. On men's health, Lloyd (2001) admits the role played by individual risk taking but argues that reasons like a man losing his job, the messages he received about growing

up to be a man, where he lives and with whom he lives are equally significant. The importance of structure-agency debate is thus drawn upon in the analysis of men's health. This complicated convergence of factors in relation to men's health helps to discount the notion of an overarching and dominant factor in the debates. This links into the importance of intersectionality as a theory to explain the health of men. This theory, as shall be addressed in the course of this literature review unravels the interconnectedness of factors in men's health and their health seeking behaviours.

The discourse of men's health largely stems from the global North. Notwithstanding this fact, men's health is an important concern to all societies because of high mortality rates among men. In a critical appraisal of the literature on men's health, Crawshaw and Smith (2009) argue the practical lens adopted by men's health scholars has been driven by epidemiological data examining rates of mortality and morbidity among men, or specific phenomena linked to men's health practices like risk-taking or delayed help-seeking behaviours. The emphasis placed on such narrow conceptualisation masks the underlying causes that are at the core of men's health and their health seeking behaviours. This gap in literature gives impetus for this study to research the broader health seeking behaviours of working class men in a specific context of Modimolle Township.

Debating the definitions of men's health the New South Wales Health Department (1999 cited in Karoski, 2011:53) views it as, "any issue, condition or determinant that affects the quality of life and/or for which different responses are required in order for men to experience utmost social, emotional and physical health". The definition is influenced by the sociological theory of functionalism in which the health of men is viewed mechanistically for purposes of optimum functions. The World Health Organisation (cited in Karoski, 2011) further adds men's health to include the impact on a man's health of accommodation, income, employment, family circumstances, education, sanitation and pollution, factors which are often ignored by health providers. This definition proves that even though human agency is important at explaining men's health, the external factors are as well significant. As pointed out in the criticisms

against early literature on men's health, masculinity negatively influences the health seeking behaviours of men. The next section picks up from this debate.

Masculinities and health

Courtenay (2000:1389) argues that 'when a man brags, "I haven't been to a doctor for years"; he is simultaneously describing a health practice and placing himself in a masculine arena'. This observation shows that some of the taken for granted behaviours of men have deep-seated roots in specific cultures and these become tied in with men's health. Thus, the concept of masculinity becomes relevant to examining men's health-seeking behaviours. It is worth mentioning that masculinity needs to be understood not as a neatly packaged concept, but a plurality in which various forms of masculinities converge in space and time. Connell (2015:40) argues that masculinity is the pattern or arrangement of social practices linked to the position of men in the gender order, and socially distinguished from practices linked to the position of women. Similar to gender, masculinity is socially constructed.

Broader socio-structural forces influence men and women to conform to certain gendered roles which in turn have a bearing on their health. However, this influence is not uniformly exerted. Thus, Williams and Best (1990 cited in Courtenay, 2000) argue that men and boys experience greater social pressure than women and girls to endorse gendered societal prescriptions like the strongly supported health-related beliefs that men are independent, self-reliant, strong, robust and tough. In addition, Williams (2003:726) argues that men are socialised to project strength, individuality, autonomy, dominance, stoicism, and physical aggression, and to avoid demonstrations of emotion or vulnerability that could be construed as weakness. Intertwined with factors like race, class, age and education, masculinity can be an impediment to the health seeking behaviours of men. Interestingly, Connell and Messerschmidt (2005) argue that decreased health care seeking and higher engagement in risk behaviours are two decisive health-damaging displays of masculinity ideals. From the above illustration, one gets the impression that masculinity is a negative structural force to men's health-seeking behaviours.

However, the enactment of masculinity produces contradictory health-related behaviours. For some men, masculinity can be an ideal worth aiming for with positive health fortunes, yet at the same time; it can yield disastrous health results. Khunou (2013) remarks that in so far as idealised forms of masculinity have been shown to impact men negatively, on occasion, they also lead to positive experiences for other men. To illustrate the complexity of masculinity negotiation in the face of HIV/AIDS for men, Mfecane (2012) documents the dilemma of HIV testing and status disclosure for men who were suffering from the epidemic. In the end, those that managed to go through the process of HIV disclosure restored their own masculinity identity and even became 'role models' in the Bushbuckridge community (Mfecane 2012: S111). It is, therefore, evident that masculinity shapes men's health-seeking behaviours in varied and complex ways.

Masculinities are socially constructed therefore they are not reducible to male bodies alone. Nevertheless, male bodies are fundamental to the production of masculinities just as some female bodies can equally perform societally prescribed masculinity actions. According to Connell and Messerschmidt (2005:836), "[m]asculinity is not a fixed entity embedded in the body or personality traits of individuals. Masculinities are configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular social setting". The fluidity of masculinities should be emphasised to mean that they are not a stable phenomenon that is cast in the immutability of biology. Thus, Halberstam (1998 cited in Connell, 2012:1677) believes that since masculinities are examples of social practice that alludes to the natural properties of male bodies, manly characteristics can be sanctioned by individuals with female bodies. It is the performances that male and some female bodies practise which define masculinities. Skovdal, Campbell, Madanhire, Mupambireyi, Nyamukapa and Gregson (2011) add that men's health beliefs and behaviours are set within social boundaries of what it mean to be a man and are thus consciously performed by men in an attempt to show their manhood, thereby erecting the idealised norms of masculinity.

As highlighted above, masculinities are plural and varied and they can be expressed in various ways. The display of masculinities has a bearing on the health seeking behaviours of men. Reflecting on the work of Connell (1983), Jewkes and Morrell (2010:3) attest to the existence of multiple forms of masculinity that are hierarchically organised along lines of gendered domination of men over women, of powerful men over less powerful men, of adult men over younger men. In explaining a uniquely traditional masculinity in the isiZulu culture of South Africa, Hunter (2005:389) notes the existence of the *isoka* masculinity where a Zulu man dabbles with multiple and concurrent sexual partners. Although the practice of *isoka* was mostly performed by men, Hunter (2005:391) does highlight that "unmarried women could also enjoy limited sexual relations with more than one boyfriend". This analysis of *isoka* masculinity serves to illustrate the elasticity of masculinities in shaping the health behaviours of both men and women, especially in light of HIV/AIDS. In support of the changing boundaries of *isoka* masculinity, Leclerc-Madlala (2003:214) argues that many women in South African urban areas exchange sex for financial or lifestyle rewards. In other words, the *isoka* masculinity has been reconfigured in light of the cash economy and women are now practising it in the form of transactional sex.

In their analysis of normative masculinity, Bates et al (2009:1003) show that it dictates that men should be confident, powerful and impervious to health problems. Through embracing these masculine ideals, men brush aside pain and ignore health related concerns, let alone asking for health help. It is within such a background that Bates et al (2009) argue that health care seeking for men becomes akin to voluntary emasculation. However, I would hasten to point out that men cannot be uniformly categorised as their health seeking behaviours are not the same. There is, therefore, a need to look at a particular racial group of men occupying a specific socio-economic category because masculine tendencies cannot be generalised to all men.

Among an array of masculinities is what Connell (1995) calls hegemonic masculinity, defined as the enactment of an idealised form of masculinity i.e., being 'the real man' in a particular time and place. For Ratele (2008), hegemonic masculinity is a mesh of social practices productive of gender-based hierarchies which include violence that

supports these hierarchies in the unequal relations between females and males as groups. Mostly, it is the expression and practice of hegemonic masculinities that spell negative results to men's health-seeking behaviours. However, Connell and Messerschmidt (2005) caution and argue that most accounts of hegemonic masculinity do include such actions as bringing home a wage, sustaining a sexual relationship, and being a father. This picture is illustrative of the need for a critical engagement when analysing masculinities with the health seeking behaviours of men.

In the same vein, Courtenay (2000) holds the view that hegemonic masculinity and traditional beliefs about manhood are the strongest predictors of individual risk behaviour over the life course. In line with the argument, Ratele (2008:517) remarks that masculinities should be understood as a creation at both the social and psychological levels, something males do and prove constantly towards females, other males, but also to their own inner lives. It becomes clear the embracing and enactment of masculinities affect the health seeking behaviours of both the performer and those to which these practices are enacted, that is other men and in most cases women. In describing ruling masculinity in South Africa, which is akin to Connell and Messerschmidt's (2005) hegemonic masculinity, Ratele (2008) argues that it is a position which males and some females strive to occupy "discursively and materially and from where they interpret their world, behave and interact with others". From within this interpretation of ruling masculinity is the important theme that masculinity can be enacted through both male and some female bodies. It follows that ruling masculinity is visible through performance, i.e. what the individual man and some women do to others and to themselves. Ratele (2008) thus, argues the performed acts resulting from ruling masculinity include swearing at strangers, abuse of intimate partners and violence.

For men, the expression and rigid constructions of masculinities are associated with the display of delays in seeking medical help when ill, not asking for help, reckless driving, road rage, drinking and driving. With specific reference to South African masculinities, Jewkes and Morrell (2010:5) stress these approve courageous attributes of physical strength, hardness and they embrace authority and the capacity to exercise domination over women and other men. In the same vein, Wood and Jewkes (2001 cited in

Coovadia et al, 2009:821) argue the control of women is a central part of present day constructions of South African masculinity and the use of physical and sexual violence against women is legitimated when the goal is to secure such control or to punish resistance to it. To some extent, the traumatic experiences of women which are a health concern arise from the exercise of masculine behaviours by men and other women.

The dynamics of embodiment and health

Human bodies, I argue are first and foremost sites of health and illness. As human beings, embodiment represents the inseparability of the biological and the social aspects of our existence. Male embodiment cannot be disconnected from social class. To emphasise the importance and distinguishing power of social class to the debates on embodiment, Stainton-Rogers (1991 cited in Williams 1995:592) argue the common metaphor of the 'body as machine' was characteristic of working class men and women's conceptions of health and illness in developed societies. In contrast, the middle-class people felt a greater sense of control over their health and lifestyles (Calnan, 1987 cited in Williams, 1995:592).

Embodiment according to Krieger (2005:350) entails three key viewpoints namely, "bodies tell stories about – and cannot be studied divorced from – the conditions of our existence; bodies tell stories that often – but not always – match people's stated accounts; and bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell". Embodiment becomes relevant to a comprehensive understanding of the health-seeking behaviours of men. In light of the above argument, Vaccaro (2011:70) contends that men's socialised habituation of certain bodily practices makes the body an ideal resource representing manhood. It is thus within the socio-structural factors that the male body can be understood in relation to health.

In his analysis of embodiment, Bourdieu (1984:190) argues that "the body is the most indisputable materialisation of class taste". In line with the argument is the idea that the human body represents the social class within which it is brought up. Although research participants can tell their own lived experiences about health seeking behaviours, the

importance of the body is that it can qualify or disqualify the narrated story. In this case, the health seeking behaviours of working class men cannot be separated from the material conditions of their existence. Making food choices is a complex process set in social relationships that have short- and long-term health outcomes (Bove, Sobal and Rauschenbach, 2003). Bourdieu (1984) further elaborates that, the working-class habitus produces a taste for cheap, filling and fatty foods, free consumption of alcohol and tobacco, while the middle-class habitus is defined by valuing dietary restraint, bodily fitness and slimness. Although Bourdieu's context (Europe) differs from the research setting for this study, his theoretical framework is nevertheless applicable to the findings of this research. In a comparative study of working-class and middle-class women, Calnan (1990 cited in Williams, 1995:579) showed that in contrast to middle-class women's emphasis on a 'balanced diet' and 'everything in moderation', the working-class women were more concerned about meals being 'substantial' and 'filling'.

In his study on therapeutic citizenship in Bushbuckridge, South Africa, Mfecane (2011:132) observes two consumption patterns which he associated with constructions of masculinity and these were drinking alcohol and taking 'traditional' medicines. In other words, alcohol consumption becomes a way of proving 'embodied manhood'. This on its own is connected with health outcomes especially when risk factors are considered. Further still, Vaccaro (2011:69) argues that for males to be considered men they must uphold the principle of referring to their bodies as always strong, capable, and healthy, even if this entails not disclosing signs of serious health problems to others. For members of the working-class, Bourdieu (1984) further argues that the body is a means to an end since they have little leisure time to indulge the body, thus developing instrumental orientation.

A male embodiment is linked to food consumption. Sobal (2005) argues that food stands for varied meanings in accordance with ethnicity, nationality, class, culture and gender. In addition, Jensen and Holm (1999 cited in Vaccaro, 2011:71) argue that in contemporary society, the type and quantity of food consumed are considered important signifiers of manhood. Men consume a greater quantity of food than women, and they avoid food items that are linked to inferior statuses like femininity and childhood

(Vaccaro 2011). How far this holds true to the South African working class is up for investigation. For instance, through primary socialisation, boys become predisposed to the male embodiment where they are expected by parents to consume all the food on their plates while girls are not encouraged to do the same. The way male embodiment is closely tied to the health-related behaviours of men becomes evident when analysed in the long term as Vaccaro (2011:72) puts it "[i]n late adulthood, males paradoxically pay for their earlier embodiments of manhood in the form of their general health and life-expectancy. As they grow older, their bodies – once symbols of their masculine status – begin to betray them". Letsela and Ratele (2009: unpaginated) further contend the conditions of diabetes, hypertension, ischemic heart disease, tuberculosis and cancer among African men and women "emerge in middle age after long exposure to unhealthy lifestyles involving tobacco use, alcohol…, and consumption of diets rich in saturated fats, sugars and salts". In other words, these kinds of foods consumed by black South Africans are unhealthy as they have long term health effects. Added to the burden of disease associated with age especially for African men, their comparative lower life expectancy vis-a-vis women could be explained in the particular behaviours that men do.

As argued before, male embodiment is inseparable from the external environment within which bodies, both female and male exist. Thus, Cornell (2012:1677) holds that bodies can be recognised as being involved in social class processes when differences in income create different levels of nutrition, or when factory and mine workers suffer injury because of the design of machines and the speed of production. Thus the working class male bodies become affected with what happens in the bigger social structure of employment, albeit differently. Referring to other examples of gendered practice like sporting, eating, working and education Broom and Tovey (2009) argue that these produce bodies that have particular muscular development, cardiovascular vulnerabilities and injury risks. Important as the body is, it is largely unnoticeable in the day to day interactions. It is often not until illness or pain is encountered that the body becomes recognised, hence illness may be conceptualised as the body assuming control, as an outer environment separate to the self (Lupton, 2003:23). This analysis brings some common and general perceptions that men usually engage in health

seeking behaviours when it is often too late or when the body can no longer withstand illness. To what extent does the analysis given apply to working class men in Modimolle? These are some of the questions the researcher empirically ground the study.

The health seeking behaviours of men

The individuals' health seeking behaviours are context dependent. As already pointed out for South Africa, healthcare is accessed through plural and interlocking channels. There is, however, the predominance of biomedicine alongside traditional medicine. Health seeking behaviour does not occur in a social vacuum, thus history and biography always have interplay. In their study about health seeking behaviour in Northern KwaZulu-Natal, Case et al (2005:9) found a pattern in which spending on medical help increased slightly with age until late middle age, after which spending on treatment declined significantly. Individuals who were aged 20 to 59 at death spent R964 on all treatments following an illness, while those aged 60 or above spent R612 on average. Case et al (2005) further point out that care-seeking declined for all types of traditional care above age 60 while, age, education, asset ownership and length of illness were significant predictors of health seeking behaviour. Another study done by Pronyk et al (2001) on health seeking behaviours among tuberculosis patients in South Africa found that household composition was a determining factor shaping the time frame members take to seek medical help, thus family played a role in the health seeking behaviours of the other members. In another illustration, Lloyd (2001) points out the experience of unemployment, for example, has been shown to destroy men's personal and social identities especially the breadwinner identity, often resulting in a life crisis, with the unavoidable increase in stress and illness.

Taking a more biomedical approach to health seeking behaviour, Chinn and Kramer (1999 cited in Poortaghi, 2015:2) define it as an individual's actions toward promoting maximum well-being, recovery and rehabilitation, and this could happen with or without health concerns. In as far as the given definition is centred on the individual's actions; the argument in this research study is that the actions to seek or not to seek any health help are influenced by the structural forces. Health seeking is, a multifaceted concept

shaped and reshaped by various factors. Commenting on the effects of working conditions on health status, Ncho and Wright (2013:1) argue that work-related stress increases the risk of disease. In addition, the findings by Letsela and Ratele (2009: unpaginated) show that among other reasons for not going for health check-ups, the male respondents cited "lack of medical aid; distrust of public services; the view that visiting health services are a waste of time…and the idea that health check-ups are for others who are weaker…" The bases for the reasons forwarded by men in the mentioned study are largely structural and these demand an investigation.

Critiquing the methodologies used in the debates on men's health, Galdas (2009) contends that studies of men's health-seeking behaviours are mostly quantitative and they confound and collapse variables. It is arguable then that, the result is the masking of the rich, thick experiences that affect men's health-seeking behaviours. Comparatively, Galdas (2009) notes that evidence from the United States of America (USA) and the United Kingdom (UK) shows that with regard to physical health, men use primary health care services less often than their female counterparts. Because quantitative surveys are largely advantageous for representing the sample to larger populations, the underlying factors shaping some individual behaviour are often left unexplored. In contrast, this qualitative study intends to contribute to ways that explore men's health seeking behaviours through establishing among other issues, the practices men engage in to preserve their health. Documenting the experiences of African American men to issues of health, Leininger (1991a cited in Plowden, 2003) observes that education; economics, religion, philosophy, family/kinship, and politics are factors that motivate health seeking behaviours.

The interplay of social class and health seeking behaviours

By default, a study on the health seeking behaviours of working class men cannot be disconnected to the influence of social class. The claim I put forward is that access to health services and the maintenance of healthy behaviours are all interlinked to social class. Marmot et al (2008:1661) argue that health and illness follow a particular pattern in which the lower the socioeconomic position of an individual, the worse his/her health is. I concede that that the relationship between class and health is a complex one. It is

however a relationship that demands critical engagement. Giddens (2006:300) defines class thus, “a large scale grouping of people who share common economic resources, which strongly influences the types of lifestyles they are able to lead”. The choice of the research population (working class men) is therefore premised on the assumption that due to more or less similar life chances for these men, their health seeking behaviours warrant a sociological investigation which eventually offers a contribution to the discourse of men’s health at large. The argument by Seekings (2003:4) of the existence of a relationship “between class and household income, living conditions, health and the intergenerational reproduction of inequality through the education of children” finds resonance in this project. Because of their working class status, it is likely the working and living conditions that these workers are exposed to have a bearing on their health status. Courtenay (2003:10) argues that “[p]atterns of social relations related to class or caste systems and to the structure of economic markets expose working-class men performing manual labour to a range of occupational health and safety hazards”. In their study on occupational health in Denmark, Brendstrup and Biering-Sørensen (1987) found out that fork-lift truck driving caused low back trouble among the drivers. Truck driving is associated with known health risks (Apostolopoulus, Sonmez, Shattell, Gonzales and Fehrebacher, 2013; Caddick, Mato, Nimmo, Clemes, Yates and King, 2017). As chapter 4 reveals, the working class position of the participants has far reaching effects on their health.

The social class one occupies in a society is critical in determining one’s health status as well as the associated health seeking behaviours. In addressing the relationship between social class and health condition, Marmot (2004:23 cited in Cockerham, 2013:87) contends that, “the lower the social position, the higher the risk of heart disease, stroke, lung diseases, diseases of the digestive tract, kidney diseases, HIV-related diseases, tuberculosis, suicide and other ‘accidental’ and violent deaths”. The influence of social class cannot be overemphasised when it comes to health outcomes. Complementing the central role of social class in health seeking behaviours, Winkelby, Jatulis, Frank, and Fortmann (1992:816) observe that among other factors, a person’s socioeconomic status is the strongest and most consistent predictor of his or her health. It is objectionable that social class can be a significant factor when it comes to

HIV/AIDS because the relationship is contradictory. In South Africa, on one hand, low-income or level of employment is associated with a greater exposure to risky sexual experiences (Fassin and Schneider, 2003:495). On the other hand, due to extra income at their disposal to engage in transactional sex, those in the middle class are all the more vulnerable to contracting HIV/AIDS. Marks (2002) agrees the contemporary patterns of HIV/AIDS dispel the notion that the disease is concentrated among the poor because many professionals, teachers and nurses, as well as high-profile politicians with notable education and affluence, have also been victims and these cannot be described as malnourished or health compromised. Further still, Sekhejane (2013) argues that the current health system in South Africa is inequitable and undermines the rights of some citizens, especially those in the low-income class or the unemployed. In the same vein education is arguably an indicator of a person's skills for acquiring positive social, psychological, and economic resources. Mixed, all these factors show how working class men grapple with their health seeking behaviours.

Hunter (2010:28) draws upon the work of the Health Systems Trust (2004) and argues that in the ten years after elections in South Africa, 15% of the population had access to private health-care facilities while the remainder, most of whom were poor and black, depended on an overburdened public health service. In the same vein, Bosch et al (2010 cited in Padayachee and Bordiss, 2016:674), argue that "South Africa's GINI coefficient (the international standard for measuring the distribution of income and wealth in a country), has been shown to be very high, at over 0.70, where 1.0 measures perfect inequality, i.e. one individual receiving total national income". This high inequality in income and wealth between the poor and the rich serves as an indicator of how health inequalities are entrenched in the country. Thus, housing as a signifier of social class is arguably interlinked with the health outcomes of people as well. Commenting on the failure of the new government to intersperse Reconstruction and Development Programme houses with former white areas, Desmond (2008 cited in Hunter, 2010:28) concludes that the system of apartheid in South Africa has not died but that it has had a makeover. This signifies the social inequalities which prevailed under the old apartheid regime have continued into the contemporary South Africa with marked class and racial differences.

How race ties in with health

As pointed out in Chapter 1, health is gendered, classed and racialised not only in South Africa but globally. Race is a social construct seized by race supremacists to entrench racial inequalities. Cockerham (2013:153) defines race as a person's observed physical characteristics, with skin colour the single most important determinant of an individual's racial status. To some extent, racial inequalities have permeated the health system of South Africa hence Coovadia et al (2009:823) are of the opinion that "[o]ne of the most important influences on the health of South Africans has been the impoverishment of the black population in the face of general white affluence". Closely tied to the race factor is the health seeking behaviours of the working class men.

Although black South Africans have socially moved upward into the previously white-dominated social classes like the middle and the upper classes, race is still a factor that represents health inequalities. I argue that through the interplay of race and class a clearer picture of the health-seeking behaviours of working class men in South Africa can be illuminated. Charasse-Pouele and Fournier (2006:2898) believe that race remains a clear indicator of individual income, educational attainment and individual health care demand, community health care supply and of the quality of medical treatment. Summing up the findings of the General Household Survey in 2001, Charasse-Pouele et al (2006) conclude that 68% of Whites had access to medical aid scheme, followed by Indians/Asians at 29%, and then coloured at 19% medical aid access, while only 8% of African population had medical aid access. Attached to these statistical representations to medical aid access is the quality of health care. Interestingly, the General Household Survey (2014:30) follows the same skewed pattern showing a jump to 76.9% of Whites having access to medical aid compared to a small 10.6% medical aid access for black Africans.

The relationship between race and health is contentious. That relationship is complicated because of the way race and class simultaneously cause health inequalities to the extent the difference between the two factors becomes blurred. Commenting on the context of the United States of America, Farmer and Ferraro (2005) argue that there exist racial health inequality between whites and blacks in which black

Americans experience poorer health than white Americans. For South Africa, Shisana et al (2014) report a 15% overall HIV prevalence among black Africans compared with 0.3% HIV prevalence among the white population. Nettleton (2013:177) aptly sums up the relationship between racial inequality and health in the United States of America by concluding that, "[t]he racial patterning of health and illness cannot be understood without an appreciation of the wider experiences of black people, which are shaped by a society which has been historically, and indeed remains, inherently racist". Although this description is context specific to America, similarities can be made about the apartheid legacy of black marginalisation in the contemporary South African society in relation to the health outcomes of the black population. In light of the view that race largely explains class dynamics in South Africa, this research study intends to examine how these different factors intersect to produce different health seeking behaviours among working-class men. Interestingly, the study by Charasse-Pouele et al (2006:2905) conclude that in South Africa, the "care provided to Whites allows for a better management of structural health risk factors such as low education, ageing or gender". The analysis is clearly illustrative of the racial effect and class dynamics in health thus Charasse-Pouele et al (2006:2905) remark that "higher coefficients estimated for Whites for income suggests that the South African health care system is profoundly segmented between low price-low quality public facilities and a high price-higher quality private sector". Needless to mention that it is the public health sector to which the majority black South Africans get medical attention.

Linked to race, class and health is the geographical location which shows that informal settlements, chiefly occupied by blacks in South Africa are enclaves of high disease burden. In his ethnographic study of Mandeni an informal settlement in KwaZulu Natal, Hunter (2005) shows high incidences of HIV prevalence among the population because of what he terms the phenomenon of "transactional sex". A difference is clear in literature between prostitution, survival sex and transactional sex (Leclerc-Madlala 2003). For many women in the context of urban South African communities, Leclerc-Madlala (2003:214) argues that transactional sex is more about exchanging sex for financial or lifestyle rewards rather than a result of poverty per se.

Theoretical framework

As a theoretical lens for this study, intersectionality as coined by Black feminist scholar Crenshaw (1989) was originally meant to examine the myriad layers of marginalisation and oppression experienced by women of colour in feminist discourse. Although it was originally crafted in feminist circles, intersectionality has been adopted for use in different studies including men and women's health (Griffith, 2012; Hankivsky, 2012). The choice for this theoretical framework in this study is therefore premised on the fact that there is no single overriding factor that can adequately address the health seeking behaviours of black working class men in South Africa. It is the contention of Hankivsky (2012:1712) that "intersectionality challenges practices that privilege any specific axis of inequality, such as race, class, or gender and emphasises the potential of varied and fluid configurations of social locations and interacting social processes in the production of inequities". As clearly pointed out in the literature review, men are not a homogeneous category with uniform behaviours towards their health. Even when the factor of race is incorporated and black working class men are selected, as is the case in this study, other factors like geographical location, marital status, education, religious beliefs still intersect to produce different health seeking behaviours among men of the same social class.

Intersectionality focuses on examining how social locations and structural forces interact to shape and influence human experiences (Hankivsky, 2012:1713). One needs to admit the above depiction of an intersectionality approach is overly skewed towards the influence of structures to the marginalisation of human agency. In light of the above fault line, an appreciation of the fundamental importance of the structure – agency debate in relation to health would be required. Thus, the objective of an intersectionality approach is to simultaneously examine the social and health effects of several key aspects of identity and context in ways that create a new understanding of these factors and that are a more accurate reflection of the lived experiences of the populations of interest (Griffith, 2012).

Criticisms against intersectionality include the point “that it does not have any methods associated with it or that it can draw upon” (Phoenix and Pattynama, 2006:189). However, the fundamental importance of intersectionality is that it does not set itself to be a grand theoretical framework in research, thus it does not “insist on any particular research design or way to conduct research” (Hankinvisky 2012:1715). Since the choice of this research study is to gain the lived experiences and subjective interpretations of the health-seeking behaviours of black working class men, it is my contention that the multiple marginalisations of this particular class of men in South Africa can best be explored using an intersectionality lens. An ‘intersectionality shift’ according to Hankivsky (2012:1715) encourages researchers to reflect on the complexity of their own social locations, how their values, experiences, and interests shape the type of research they engage with, including the problems they choose to study, and how they view problems and affected populations. Relevant in this analysis is the fact the researcher who is guided by the intersectionality theory is self-reflective and cannot be delinked from the topic and question of the research study. Studies on intersectionality and men’s health include Griffith’s (2012) work which highlights that the theoretical framework helps to locate the socio-cultural factors like race/ethnicity, gender, age and others as determining the health status of men. From this standpoint, this study recognises the multiple factors that inextricably shape the health of working class men. However, it is the fundamental factors like gender, race, class, education and geographical location which are empirically explored to find out how their interplay shape the health seeking behaviours of working class men in the township of Modimolle.

Conclusion

The literature reviewed in this chapter formed the basis on which the research study was established. In this chapter, the main argument raised is that the health seeking behaviours of working class men are dependent on the social factors within which men live and work. The chapter unfolded by detailing the context of the South African health care system which is punctuated with medical pluralism. By debating the importance of

gender and health, the literature reviewed showed that there are health disparities across and within the respective gender categories. In the ensuing sections, the chapter focused on men's identities of masculinity and the relationship to health. Through understanding male embodiment, the significance of the male body was examined in literature and this is important as it reveals how working class men relate to their bodies and health. The chapter has debated the critical factors of social class, race and men's health before recapping with the theoretical lens through which working class men's health seeking behaviours are analysed. In the next chapter, I take the reader through the methodological approach for the study.

Chapter 3: Research methodology

Introduction

This chapter gives a step-by-step breakdown of the research process. It begins with an outline of the paradigm chosen and the rationale for that choice. In this study, a qualitative methodology was preferred for use as it allowed the researcher to explore the subjective, "social and material circumstances, experiences, perspectives and histories" of research participants (Ritchie and Lewis, 2003:3), thus giving a richer understanding of the study topic. The chapter follows up by detailing a non-probability sampling strategy used as it informed the choice for a snowballing technique used for selecting research participants. I employed semi-structured, in-depth interviews to gather data from 15 working class men in Modimolle. A concise data analysis process involving thematic analysis will be discussed before detailing ethical considerations that were followed in the study. A discussion on reflexivity follows as it reveals how the researcher's biases were laid bare and the ways in which these were addressed. The chapter progresses with a discussion on the limitations of the research design before rounding off with some closing remarks.

Research design

In defining a research design, De Vaus (2001) argues that it is a structure of inquiry which is put in place before data collection or analysis can take place. The work of a research design is to ensure the evidence got enables the researcher to answer the research question and the sub-questions as unambiguously as possible (De Vaus, 2001:9). This research study set out to explore factors influencing the health seeking behaviours of working class men in Modimolle Township. To obtain the subjective experiences of the research participants on their health seeking behaviours, a qualitative approach was used.

The researcher takes into consideration the fact the knowledge produced in this study is not generalisable to other towns in Limpopo or to all of South Africa (Babbie, 2004). The findings are therefore specific to the context of Modimolle. It is important to mention that

as a researcher under the qualitative approach, detachment from the study is not possible because the research involves an interpretive as well as a naturalistic approach to the world (Denzin and Lincoln, 2000). Important to this research study was the use of field notes, interview recordings as well as photographs which according to Denzin and Lincoln (2000:3) are important practices through which the world can be represented. A qualitative approach is interpretivist; therefore the meanings research participants attached to phenomena were given attention in the study. Further still, this study is exploratory and is premised on the basis there is limited knowledge or information about a particular subject (Bless, Higson-Smith and Sithole, 2013) which in this case entails the health seeking behaviours of working class men. It is important to highlight the study sought to look at the general health and wellness of participants and not on a specific illness condition.

Research studies demand intricate planning hence Braun and Clarke (2013) argue that a research design should be thought of as a blueprint for the research. As this study is qualitative, the research design is set in an interpretive phenomenology which draws on the work of Edmund Husserl and Martin Heidegger emphasising a “shift from the thing and nature toward human beings and their worlds” (Giorgi, 2005:76). This serves to distinguish a qualitative research design from a quantitative one because the focus in this research design is to look at the lived experiences, views, as well as the meanings research participants, attach to phenomena within their natural setting. In addition, the basis and purpose of phenomenology in health research is to unearth an individual’s lived experience and the meaning that they place on that experience (Giorgi, 2005; Lopez and Willis, 2004; Stark and Trinidad, 2007). It is important to highlight that multiple subjectivities form part of a qualitative research design and it is these subjectivities that give rich detail to the whole study. Therefore this research design takes into perspective a qualitative methodology with a specific phenomenological approach affording the researcher an opportunity to explore different subjectivities, experiences, meanings and perspectives as is possible (Willig, 2008).

There are two key approaches that emanate from a phenomenological health research, namely descriptive and interpretive inquiry (Lopez and Willis, 2004). For this research

design, the interpretive phenomenological inquiry is adopted as it emphasises an understanding of the relationship between an individual and their "life world" (Lopez and Willis, 2004). Central to this framework is the individual's lived experience as well as that individual's meaning making of the subjective experience within his specific socio-cultural and political contexts (Crist and Tanner, 2003; Lopez and Willis, 2004). The researcher, therefore, considers this approach to be the most relevant way of exploring participants' lived experiences to their health seeking behaviours. Due to the complexity of the topic of men's health, a qualitative research is the most fitting approach for this study as it provides thick rich data with a unique potential for unmasking the underlying nuances, further yielding descriptions that are insightful (Miles and Huberman, 1994).

Research setting and target population

Modimolle town as the research site for this study is located in the Waterberg District Municipality within the Limpopo Province. It is situated 130 km to the north of Pretoria along the N1 road and 155 km to the south-west of Polokwane (the provincial capital of Limpopo Province). The town shares borders with Bela-Bela Local Municipality, Mookgopong, Thabazimbi, Lephalale, as well as with Mogalakwena. The area is characterised with townships, informal settlements and farms (Modimolle, 2013:11). Modimolle is the administrative capital of the Waterberg region, which means that all government district offices are situated in Modimolle town including the Waterberg District Municipality. In this study, all the participants that were interviewed work and live in Modimolle with eight of them living in RDP[1] houses while seven are living in an informal settlement. Access to housing, let alone quality housing is implicated in the health status of the population (Krieger and Higgins, 2002; Coovadia et al, 2009; Mathee, 2011). Thus, a place of residence is an important signifier of the health status of men. There were differences between the two places sampled although they fall under the same town. Extension 10 was better serviced and there were RDP houses and piped water despite the erratic water supply at the time of interviews. This was due to the fact there was a national water crisis resulting from the drought. There were no refuse collection services at the time in Extension 10 and the roads were not paved. In

[1] Reconstruction and Development Programme houses

Extension 13, the place was still to receive proper service delivery like water and proper sanitation, let alone RDP houses and electricity. The area was demarcated to receive services from the municipality. The images below show a reflection of the spatial disparities existing in Modimolle. The pictures depict the residential structures between Extension 10 and Extension 13.



Figure 3.1: Image of a RDP house where participant lives



Figure 3.2: An example of a RDP house in Extension 10

(Source: Researcher's own photographs)



Figure 3.3: Shack dwelling for participant



Figure 3.4: Image of a shack in Ext 13

(Source: Researcher's own photographs)

The labour force in Modimolle town is mainly unskilled resulting in most of the population being employed in semi- and unskilled occupations (not high income occupations) (Modimolle Local Municipality, 2013/2014:69). In this research study, the above picture mirrors the participants' jobs in that, of all the jobs done by the research participants, few if any were of a skilled nature. Only in two cases involving Chris[2] (CM) who is a security guard possessing a competency certificate in handling a firearm as well as Pitso (PM) whose job involves installation of alarm systems does one appreciates the levels of skills held by these two in comparison to most of the participants who are largely in unskilled work.

[2] Pseudonym

In its document, Modimolle Local Municipality (2013/2014) recognises that education is an indicator of human development. The Modimolle Municipal document further adds that education provides a set of basic skills for development, creativity and innovative abilities within individuals. In this characterisation, social upward mobility is one of the benchmarks which show the importance of education. This can be ascertained through gainful employment in skilled work as well as venturing into entrepreneurship. Interestingly, the municipality in its document acknowledges that 43.3% of people in the town have a primary school level education (Modimolle Local Municipality, 2013:56). It further points out that approximately 11.6% of the population has no schooling and only 2.8% have grade 12 exemptions (ibid). The picture painted in the document holds sway for the sampled men who were interviewed in this research study. It is not surprising that of all the 15 working class men interviewed for the study, only 4 of them reached grade 12. Of the four, only Tony (TN) had a matric exemption as he managed to advance to do a diploma in chemical engineering.

The sampling technique

A sample is a population of interest through which a researcher gets the needed research results (Neuman, 1997; Coleman, 2005). Thus, the sample of this study was 15 black working South African men staying in Modimolle. In line with the philosophical origin of interpretive phenomenology adopted in this study, the goal was to gain rich data from 15 participants to fully understand their experiences and life worlds. For purposes of selecting participants, the researcher used snowballing which is a non-probability sampling technique. In a non-probability sample, units are purposively selected to reveal particular features of a sampled population. However, the aim was not to be statistically representative, as the chances of an element being selected were not known (Ritchie, Lewis and Elam, 2003).

With particular regards to snowball sampling, participants are selected based on social networking (Artkinson et al, 2001 cited in David and Sutton, 2011). As part of snowballing exercise, Mpho who works for a beverage company as a truck assistant referred the researcher to Tony who is his work colleague. For Buti who runs a tuck shop in his yard in the informal settlement, his networks came into good use for the

researcher as he referred me to one of his clients who works in a mining company that makes bricks. Snowball sampling makes use of participants' referrals to other potential participants holding the same attributes as they do (Berg, 2009). Most of the working class men who were identified using non-probability sampling were interviewed and were also asked to provide as referrals their colleagues whom they deemed suitable to participate in the study. However, in other cases to which the researcher was referred, some potential participants gave excuses for not wanting to take part in the study. Reasons ranged from being too busy, to others asking for a cash payment to take part in the research study.

Participants

To set up the inclusion criteria for study participants, black South African men between the ages of 29 years to 50 years living and working in Modimolle were selected. Besides, the working class criterion was designed using Seekings' (2003:17) typology to include the core working class as well as the marginal working class. Seekings' (2003) definition of a core working class in South Africa is characterised by both semi-skilled and unskilled workers. In the marginal working class, Seekings argues that this is constituted by farm workers and domestic workers. Drawing from this typology of working class, most of the core working class participants are represented by truck assistants, brick manufacturers as well as bricklayers. The marginal working class, on the other hand, is represented by gardeners. Below is a table giving a breakdown of the participants by age, mother tongue (a proxy for ethnicity), education, occupation as well as residential location.

Table 3:1: Participants' demographics

NAME: PSEUDONYM	AGE	MARITAL STATUS	MOTHER TONGUE	EDUCATION	OCCUPATION	RESIDENCE
THABISO (TS)	38	MARRIED	SETSWANA	MATRICULATED	TRUCK ASSISTANT	RDP HOUSE
CHRIS (CM)	47	DIVORCEE	XITSONGA	MATRIC	CIT SECURITY	RDP HOUSE
SHIMANI (SM)	39	COHABITING	XITSONGA	STANDARD 10	BUILDER	RDP HOUSE
MPHO (MM)	34	COHABITING	XITSONGA	STANDARD 9	TRUCK ASSISTANT	RDP HOUSE

PITSO (PM)	34	SINGLE	SEPEDI	GRADE 10	ALARM SYSTEMS INSTALLER	RDP HOUSE
TONY (TN)	39	MARRIED	SEPEDI	GRADE 12 AND HAS DIPLOMA	TRUCK ASSISTANT	RDP HOUSE
SHAKES (SH)	29	SINGLE	SEPEDI	GRADE 11	PAINTER	RDP HOUSE
STEVE (ST)	38	COHABITING	SEPEDI	FORM 1	FORKLIFT DRIVER	SHACK
BUTI (BN)	36	MARRIED	XITSONGA	GRADE 7	BRICK LAYER	SHACK
JIMMY (JM)	31	COHABITING	SEPEDI	GRADE 10	BRICK PACKER	SHACK
TRUST (TZ)	37	MARRIED	XITSONGA	GRADE 4	GARDEN BOY	SHACK
SIPHO (SN)	36	COHABITING	XITSONGA	GRADE 4	PACKING BRICKS	SHACK
PIET (PS)	29	SINGLE	SEPEDI	GRADE 11	TOLL GATE MAINTANANCE	RDP HOUSE
NGWAKO (NP)	29	COHABITING	SEPEDI	MATRIC	COURIER	SHACK
JAPIE (JL)	45	SINGLE	ISINDEBELE	GRADE 10	GARDEN BOY	SHACK

Table 3:1 above shows the composition of the 15 working class men who took part in the research study. The oldest participant interviewed is a 47-year-old who is a cash-in-transit security guard while the youngest are aged 29 years old. Among the participants, seven of them ethnically identified themselves as Pedi, while six are Tsongas. Thabiso (TS) and Japie (JL) complete the sample identifying themselves as Tswana and Ndebele respectively. Of all the men in the sample, Tony has the highest level of education as he holds a matric and a diploma in chemical engineering while Trust and Sipho occupy the lowest rung in education as they both are grade 4 dropouts. Four participants in the study identified themselves as single while four were married with the majority cohabiting. The difference between the men who identified themselves as cohabiting and those saying they are married is blurred as they all enjoy the benefits enjoyed by married couples. On the health status of all the participants during the interviews, they reported that they were enjoying good health except Piet who said he was still recovering from a flu bout.

Data collection method

To respond to the research question, the interview which is a professional conversation was used (Kvale, 2008). The face-to-face interview method was employed with the goal of getting participants to talk about their experiences and perspectives, and to capture their language and ideas about the health seeking behaviours of working class men (Rubin and Rubin 1995 in Braun and Clarke 2013:77). To get the intricate, personal and interpretive meanings the participants attach to health seeking behaviours, the researcher used semi-structured in-depth interviews or what Braun and Clarke (2013:78) call the interview guide approach (*See Appendix A for the interview guide*). In this approach, the "researcher has a list of questions but there is scope for the participants to raise issues that the researcher has not anticipated…" (Braun and Clarke 2013:78). The semi-structured, in-depth interviews gave room for manoeuvrability by the researcher thereby allowing respondents to express their meanings and experiences about their health seeking behaviours.

After making the interview guide, I first piloted the instrument on one participant to check for efficacy or lack thereof on the scope of the topic as "'piloting' a topic guide is a critical part of research" (Ritchie and Lewis, 2003:134-135). The pilot interview was audio recorded and some questions on the interview guide were refined while other questions were completely removed in accordance with what the objectives of the study were. Before each interview took place, I made appointments with potential participants. The interviews were done between the 10th of September to the 11th of December 2016 and the duration allowed the researcher time to reflect on the whole interview process.

All in all, 15 interviews were conducted and these were done in phases. The researcher started off with the participants staying in RDP houses. Most of these interviews were conducted at the participants' houses and this was done without their partners or their children. For participants in the informal settlement, some of the interviews were conducted inside my car and this was for purposes of ensuring privacy and quality of the audio recordings. In the last phase, three respondents were on different days identified at a local shebeen in the informal settlement. In consultation and in agreement

with interviewees, we did the interviews in my car to ensure good quality of audio recordings as this was a public place where people were drinking beer.

As the researcher, I conducted the interviews in Sepedi, a language all the participants in the study were comfortable and familiar with. Through establishing rapport and trust with the respondents, it became easier to make follow-up questions and asking for clarification on some words which the researcher was not clear about. In one particular incident, the researcher had difficulties in understanding the words used by Sipho to describe the methods he used for keeping his body healthy. For instance, Sipho practices steam inhalation (*go aramela in Sepedi*) as well as detoxification through induced vomiting (*go phalaza*). Due to the fact that the researcher had gained trust with the respondent, clarification was sought and the meaning became clearer. The researcher went on to ask for proper translation on some Sepedi words from a trusted colleague in the community. However, sometimes, the meaning could be lost in translation. After providing the data collection method in the form of in-depth interviews, the following section sets the tone for how the collected data was analysed before discussing ethical considerations.

Data analysis

All the 15 audio recorded interviews conducted for this study were translated and transcribed verbatim from Sepedi into English thereby producing large amounts of data. In a qualitative research design, data analysis is not a linear but a constant, back and forth process where one looks for patterns in the beginning of data collection through to the end. Data analysis is a process where the researcher makes sense of the data, breaking it down, studying its contents, exploring its importance and understanding its meanings (Lacey and Luff, 2001; Taylor-Powell and Renner, 2003; Bailey, 2007; Berg 2009). As data analysis unfolds, the researcher keeps in mind the bigger picture of how the data responds to the research question. Qualitative data analysis is as scientific a process as is a quantitative one because it involves a systematic, thorough reading and re-reading of the transcribed data in their totality. In line with the exploratory nature of this research study, the researcher chose to use thematic content analysis (Bailey,

2007) which involves transcribing the tape-recorded interviews into readable text. Through adopting thematic content analysis, the researcher read and analysed transcriptions repeatedly and carefully, drawing out common themes, concepts and emergent categories (Crist and Tanner, 2003; Ritchie and Lewis, 2003; Chadderton, 2004).

Weber (1990) argues that thematic content analysis involves classifying of textual material to relevant and manageable data. As a first step in analysing data for this study, the researcher familiarised and immersed himself in the data in a bid to come up with ideas about men's health. As a follow-up step, the researcher kept an eye on what the emerging and recurring themes were. The researcher did this by comparing and contrasting ideas from different participants. The next step involved indexing to which Ritchie and Lewis (2003:224) argue shows how a theme or concept is being mentioned or referred to in a particular section of the data. An example of a question asked to the participants was: "[w]hat does to be a man mean to you as an individual?" One respondent had this to say: "[t]o be a man... *(Laughing*), we will see by the responsibilities how responsible you are, that now this is no longer a boy but a man. Responsibilities will show us that this one is a man; he has passed on from the stage of being a boy". In the ensuing data analysis, the recurring theme that emerged is that masculinity is viewed as *maikarabelo* (Sepedi term meaning that one is a man because of the responsibilities he carries) and one of the sub-themes was that masculinity is about (assuming the provider role).

A theme, according to Braun and Clarke (2008: 82), "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set." The above theme and sub-theme recurred in most of the responses from the study participants. As chapter 4 outlines, the theme of masculinity as responsibility was shared by most of the respondents and the researcher tried to make links on how it relates to the health seeking behaviours of the men in the study. In the final step of data analysis, the researcher sifted the themes to make interpretations and meanings of the data (Weber, 1990). The advantages of employing thematic analysis according to Braun and Clarke (2006) are that it sums up

core features of a large body of data. Because one is dealing with large portions of data, thematic analysis is disadvantageous because it is time-consuming and the emphasis on taking the uniqueness of a case makes the coding of themes a difficult exercise.

Ethical considerations

As with any research project using human subjects, ethical considerations are important especially when individuals are asked to share their personal stories and experiences. Some of the ethical guidelines kept in this study include informed consent, voluntary participation and confidentiality. After getting ethical clearance from the University of the Witwatersrand's Ethics Committee, a participant information sheet (*Appendix B*) detailing the purpose of the study was given to most potential participants for them to read, while to others the contents of the participant information sheet were explained in detail. In addition, participants were informed that participation in the interview process was voluntary; thus, all participants had a right to withdraw or not to answer questions that they felt uncomfortable with. This was followed by extending an invitation to potential participants for their participation in the study. Where potential participants agreed to take part in the interview, an informed consent form was handed for them to read and in other instances; the contents were read out and explained to them. The consent form was twofold in that the first section was an invitation to take part and the potential participant would sign it. The other part was a request for consent to audio record the interview. In both instances, the participants' signatures gave me the green light to continue with the interviews. For informed consent form (*see Appendix C and D*).

Since this study is grounded in a qualitative approach, the more open-ended the questions in the interview guide were, the more ethically and empirically useful they became as it gave the research participants a stronger voice and say towards the research (David and Sutton, 2011:117). As a researcher, I was responsive and conscious of the need to protect the confidentiality of the research participants in the study. Assurance was given to all the participants that their identities were not going to be disclosed or accessed by other people. All the transcribed interviews and the quotes

used in this study carry pseudonyms for purposes of anonymity. Since the participants were sharing some of the intricate details about their lives, the assurance not to disclose the identities allayed their fears. In one case where the researcher was referred to a potential participant, the man aired his fears on whether I was going to request for his identity document. On further assurance that there was no need for his identity document and that his identity was going to be anonymous, the potential participant declined to take part and this was well within the ethical considerations for this research study. For purposes of audit trail, audio records of the interviews are only accessible to the supervisor on request. The researcher also assured the participants that after the write up of the project, those interested could access the dissertation on the University's website.

Reflexivity

In the pursuit of knowledge creation, a researcher is implicated in how he/she represents his/her story. Drawing on postmodern and feminist theorists, knowledge creation is not as objective as portrayed under positivism. The researcher brings his or her preconceived ideas and assumptions, interests, place and biography in the research process and these ought to be commented on (Macbeth, 2001). In defining reflexivity, Macbeth (2001:35) argues that it is a "deconstructive exercise for locating the intersections of author, other, text, and world and for penetrating the representational exercise itself". The researcher in this research study is not an independent investigator but is closely enmeshed with the research process through to the research results. Creswell (2009:192) asserts that openness and honest self-reflection of the researcher are paramount to the trustworthiness of the research so it can 'resonate well with readers'.

There are multiple layers through which my research position could bear on the whole research process. As a foreign student, the language barrier cannot be overemphasised. My 'outsider' position could affect the interview processes because there were some Sepedi words that I could not fully grasp. However, through establishing rapport and ensuring trust, I managed to seek clarification on such words.

Having stayed in Modimolle for more than eight years ensured a certain degree of understanding and communicating in the dominant language spoken in the area. Linking my gender as a researcher, the fact that I have my family in the area and the participants were black men meant that I became an insider and this helped smother the research process as the participants felt at ease to share their experiences. In one instance, a participant had this to share about the way he felt as the interview process unfolded: “Like as I am speaking to you right now, I am feeling like I am talking to someone special right now when we are speaking like this. I am just relaxed, I am calm, I don’t know why. You know when I am speaking to you right now I am feeling good. I am feeling good like I am speaking to my brother, or to my father, I am feeling good. You know sometimes I can speak to somebody but I feel I am not connected. You see how I am talking to you, my head is good, and I am feeling good. You see I am feeling good. I don’t know why, but I am feeling good (*laughing*)”. This sense of feeling good could only be ensured because the participant was comfortable conversing with me as a researcher.

In my research experiences, an instance arose where my prejudices as an “expert” crept into one of the interviews I had with a participant in the informal settlement about how safe the water from the well in his yard was. There are power dynamics at play in the research process and usually, this power is contested. Although other participants mentioned that the water from their wells was not safe for drinking, one particular participant insisted the water was safe despite the fact the well was not properly protected: “From my own opinion, I think the water is safe because we covered the opening with some material so that nothing can fall into the well. Since we started having the water, we have never complained about the water. If the water was not safe, by now we would have closed these wells and there were supposed to be complaints of stomach pains and stuff but there is nothing like that since these wells have started two years ago”. Although this was a scenario where I unconsciously tried to impose my own judgments on the participant, I had to come to the reality the participant’s worldview deserved to be respected.

Strengths and limitations

The strength of face-to-face interviews lies in that it allowed me as the researcher to build rapport and trust with research participants. Semi-structured interviews allowed me to probe and to clarify issues where necessary. It also allowed participants to explain in simpler terms the meaning of some terms that they used in the interview. Although a qualitative approach was a methodology of choice for the research process, its limitation is that the research findings emanating from it cannot be generalised to other contexts outside of Modimolle (Babbie, 2004). However, the findings may produce important information for other studies researching men's health in general and with health seeking behaviours among working class black men in a different context.

Another limitation of employing in-depth interviews is that it is time-consuming. The processes of scheduling interviews, conducting them, transcribing and data analysis needed a lot of time. As this study was part of the overall Masters Programme combining course work and a research report, time and budgetary constraints limited the study as the researcher had to travel to and from Modimolle. It surely would have been interesting to do a comparison between men and women's health within the same context.

A brief summary of the chapter

This chapter has discussed the motivation for a qualitative approach that was employed in the research design. Stemming from this approach, the interview as a data collection method was elaborated on as it enabled the researcher to collect data from a sample of 15 black working class men in Modimolle. A non-probability sampling technique using snowballing was employed to get research participants. The chapter gave a detailed discussion of thematic content analysis which guided the process of analysing data. Ethical considerations were given a special attention in this chapter as this informs research protocols on human participants. The experiences of the researcher were summed up under reflexivity before the chapter wrapped up with a snapshot of the strengths and limitations of the methods used.

Chapter 4: Findings and discussion

Introduction

This chapter is a discussion and interpretation of the findings emanating from the interview material. The findings are presented as themes that emerged from the face-to-face, semi-structured recorded interviews. In analysing these findings, the chapter starts from the basic level of descriptions, through to explanations (Ritchie and Lewis, 2003). The interview material forms the founding basis through which the discussion is anchored. In this chapter, I present the findings and discussion basing them in the existing literature. The main themes are condensed to respond to the research question: *What are the factors that influence the health-seeking behaviours of black working class South African men in Modimolle Township, Limpopo Province?*

The chapter begins with a snapshot description of structural factors under which the participants work and live. This is important because it aligns with a qualitative paradigm which emphasises the importance of context in research. The first theme proceeds by shedding light on men's understanding of what health is. The second theme to be discussed in this chapter is the *motto* being a man comes with being responsible. In line with this theme, a man shows his masculinity by establishing his homestead and moving away from parents. For men who set aside time to go for medical check-ups, their perceptions are that this signifies responsibility on their part. In the third theme, men's lived experience of multiple sexual partners is brought to the discussion. The reasons brought forward for practising or not practising concurrent multiple sexual relations are used to shed light on what masculinity is. The fourth theme touches on men's understanding of the body. In the final theme, participants' perceptions and experiences of the health care system will be analysed in line with men's health-seeking behaviours. The applicability of the theory of intersectionality to this study is presented before concluding the chapter.

General structural factors defining participants

The common denominators defining the participants in this study are gender, locale, race and their working class position. These working class men are individually defined by age, ethnicity, marital status, educational level, the jobs they do as well as the particular location they reside in. General working and living conditions of the participants have an effect on their health. Although Ncho and Wright (2013) admit that having a job is beneficial to health, they further argue that the working conditions are also significant determinants of good health. The following section unpacks the working conditions faced by the participants and it explores how these conditions have an effect on men's health.

Working conditions and men's health

Although the findings in this chapter cannot be generalised to all of Modimolle, let alone to the whole of South Africa, it is useful to have a glimpse of what makes up a working class man from the participants' experiences. Thabiso (TS), a truck assistant works delivering meat products from Modimolle to Johannesburg, a distance of about 185km. He describes the way he starts his job and what is involved:

> TS: Okay, firstly when we reach the firm you find that the truck is already loaded and then you check the invoices whether everything is fine, you check diesel and after that you leave maybe you are going to take two hours or one and half hours to arrive to a first client and when you arrive there, you go there you talk with them that you are coming to deliver your (their) stock. You give them the invoices and then you can offload, you see.

On recounting his experiences of the job and its health-related effects, Thabiso adds that:

> TS: …Truck, truck harms you. Truck is not good, if you drive it for five years, you feel it yourself…your kidneys. You see the main problem is on the kidney, that's the worst part of a truck …

When asked how he is able to tell the work affects his kidneys, he added that "[y]ou feel it when you sleep…" For Thabiso, there exists clear occupational health risks associated with being a truck assistant. In his reflections about the hardships associated

with the job he does, Steve (ST) a forklift driver at a brick manufacturing mine had the following to share about his work experiences:

> ST: My work is heavy because we also work night shift. I don't have lunch, I work twelve hours. Sometimes you just work but the body will not be feeling alright, it will be tired because we work so fast to meet the targets. Everybody there has to work to meet the targets so I must work fast to remove the bricks and create space for new bricks.

After he got admitted to the hospital when he was not feeling well, the following is what, according to Steve the doctor's diagnosis revealed about his condition:

> ST: He said that the cause could be the work I do because where I work there are a lot of humps when I drive the forklift and that was the cause for the pains in my body.

After the medical examination, the X-ray results according to Steve showed that "…one of my lungs has a problem and they gave me some medication for it". The work done by most of these working class men is strenuous and has damaging health outcomes. This must be understood in the context of the broader economic climate of the country as well as at the municipal level where for example unemployment in Modimolle stands at 22.2% (Modimolle Local Municipality, 2016:39). Both Thabiso and Steve share similar experiences when it comes to occupationally related health effects. In a study done about the effects of forklift driving in Denmark, Brendstrup and Biering-Sørensen (1987) concluded that fork-lift truck driving was a contributing cause of the low-back trouble. Although the contexts are different, Steve's experiences of fork-lift truck driving show similarities to the Denmark study as the doctor's diagnosis confirmed. In a similar vein, Jimmy (JN) works in the same mining company as Steve and his experiences of work are as follows:

> JN: ….the work involves a lot of dust and the place itself is not healthy. If there is wind, that dust can affect you and the bricks have dust and we continuously inhale that dust so you are supposed to drink milk... (*Interruption*). You are not supposed to take more than a week without drinking Ultra-Mel[3] so that the milk can unblock

[3] Long life milk

> your lungs from the dust so you can breathe properly because otherwise the dust will make you sick and bring you TB.

Through exercising his agency, Jimmy's reflections show that the knowledge he holds is experiential and he uses this resource proactively to keep his health in check. It is interesting at this point to problematise the lay views about how the intake of milk is commonly understood to have health benefits in dealing with dust inhalation that causes respiratory disease. This understanding came strongly from those participants who work for a brick making company. According to Murape (2013), respiratory exposure to dangerous dust can cause pneumoconiosis, an incurable disease. Murape further argues that workers in Zimbabwe who work in dusty environments have for long been hoodwinked by employers that taking a pint of milk per day can prevent pneumoconiosis, which is not true. This observation by Murape holds true to the context of this study as all the participants who work in the mining company that makes bricks reported taking milk on a regular basis as a way of preventing dust from settling in on their lungs. They also reported that the company provides milk to those workers that are highly exposed to the fumes where bricks are burnt. The shared view among participants that milk intake helps them against the dangerous dust fumes shows the underhandedness of capital against its employees. The company in this case emphasises on profit at all costs at the expense of working class men's health, hence the deception that comes wrapped in the 'efficacy' of milk gets easily accepted as beneficial by the employees. The health of working class men is therefore multilayered and complex.

It is evident that the nature of the jobs done by the majority of the participants has got some negative outcomes on their health as they report experiencing pain in their kidneys, lungs or feeling tired in their bodies. Although the excerpts suggest that occupationally, the participants' experiences of work come with negative health effects, Trust (TZ) who has worked for six years as a gardener has a different story to share about his job:

> TZ: The fact that I have had six years at work means that there is nothing stressful at my work, they don't give me any problems because as I enter the yard I know

> where to start and where to finish my work. They showed me what must be done in the beginning and now I just do my work on my own.

Good health does not only result from having a job but is also directly influenced by the whole social organisation of work (Ncho and Wright, 2013:1). While sometimes participants experience pain and stress caused by work, some of the men have turned these experiences into good health as they equate their work to physical training. Both Tony (TN) and Mpho (MM) are truck assistants for a beverage company and their work involves delivering cold drinks to different clients. Although their work demands physical strength and perseverance, the two equate their experiences of work to those people exercising for health reasons. In his reflections, Tony said that "[o]ur work demands a lot of strength and you can compare it to somebody who is weight lifting for exercising, it also builds your muscles". While it is more understandable that some of the participants do exercise their agency to stay healthy in face of constraining work conditions, this has to be understood within the context of limited opportunities for these men. Against the backdrop of working conditions, the research participants' general living conditions are also important as they unmask underlying nuances to their health seeking behaviours, and to this, I turn to address.

General living conditions of participants

A sociological investigation of the health-seeking behaviours of men critically pays attention to the context within which the participants live. According to Krieger and Higgins (2002) quality of housing and the associated accessibility thereof are significant determinants of health status. A picture of spatial differences about housing in the research setting has been outlined in chapter three of this research study. During data collection period in the informal settlement of Extension 13 in Modimolle, there was no service delivery except public taps placed at different spots in the area. The taps were reportedly dry and this was blamed on the 2016 drought which according to Hemson (2016:29) was the worst drought since 1933. In explaining the conditions of general service delivery like housing, water and electricity, Jimmy who is a resident in Extension 13 states:

JN: It is a must that those things (*municipal services*) should be available because this is a township and not a rural area. That is the responsibility of the municipality. When I look here, there is no electricity and no refuse collection, no paved roads but these should be made available you see. They are also supposed to build people RDP houses so that people stop living in shacks.

On all the homes visited for the interviews in the informal settlement, there were mushrooms of wells for water as well as the existence of pit toilets. From my conversations with the participants, it emerged the wells were 3 to 5 meters deep, with one participant saying that he dug for about seven meters deep to get some fresh water. From the accounts of the participants, the wells had been in existence for two years, i.e., since 2015 to 2016. To protect the wells, the participants used different materials like zinc sheets, car tyres and rubber mats as depicted in **Figure 4.1** below.



Figure 4.1: Well from where household draws water

(Source: Researcher's own photographs)

During my interview with Steve (ST) on the state of water supply in Extension 13, his response was as follows:

ST: For water we dug some wells.

EM: So the same water from the well is what you use for drinking?

ST: We use the water for everything...we also drink that water.

EM: In your opinion, is the water safe for drinking?

ST: The truth is the water *(from the well*) is not safe but because we are struggling we just have to drink it. We drink that water because we are poor.

EM: But so far has the water caused any health problems to you?

ST: No, we haven't had any problems with the water as yet.

In reflecting on poor housing conditions, lack of safe drinking water and overcrowding, Mathee (2011: S37) argues that these have been linked to increased risk of morbidity from pneumonia, diarrhoea, chronic illness, injuries, poor nutrition and mental disorders. From the participant's account, there were no confirmed health related conditions arising from drinking water from the wells. However, the participant's analysis of the link between his poverty and unsafe drinking water is enlightening as this is a pointer to how class intersects with residence to produce health inequities in Modimolle. Interestingly, though, the participant reveals a lack of agency towards improving the state of the water he drinks. In contrast, Buti (BN) is actively conscious of making the water from the well safe for drinking. He regularly pours some jik bleach into the well so it kills the germs. During the period of interviews, it was a rainy season such that the research participant felt that this might cause some health problems since both the wells and the toilets were dug in the same yard. Buti's concerns are a reality since it is common cause that with the rising of the water table due to rains, seepage occurs such that fresh water in the wells can get mixed up with waste materials from the toilets leading to water-borne diseases. Buti's concerns are:

BN: We only get consolation in that you don't dig the pit for a toilet to be so deep. The problem is that we don't know how deep the neighbours' toilets are and how deep is my well, there is rain now and the earth gets wet and the water gets down. That's why I use jik because they say it kills germs if you constantly use it because boiling the water is a big job, besides, the fuel to heat it is expensive as well.

Even though most participants from Extension 13 raised serious concerns about the unsafe state of the water from the wells, Trust was insistent that it was safe for drinking. He stated thus:

TZ: From my own opinion, I think the water is safe because we covered the opening with some things so that nothing can fall into the well. Since we started having the water, we have never complained about the water. If the water was not

> safe, by now we would have closed these wells and there were supposed to be complaints of stomach pains and stuff but there is nothing like that since these wells have started two years ago.

When asked how he treats the water from the well, Trust stated that he neither uses any water treatment agent nor boils it but drinks it directly from the source. At one point when asked whether he visits chemists or pharmacies for non-prescribed medications, Trust said that he once visited when he had stomach pains to which the researcher further probed whether it was not related to the water problem. His response was as follows:

> TZ: Up to now people are complaining about that problem. Yesterday there is a boy I work with and he was complaining about stomach pains and a woman next door was also complaining about this same problem. I also heard reports from the clinic that there is a problem of stomach pains around.
>
> EM: But looking at it closely isn't the problem related to the water you are drinking in any way?
>
> TZ: No, it's not because of the water because it's not in this extension alone but the whole township is complaining about it.

While the researcher could not prove the claims by Trust, there were no general concerns of stomach pains reported during the interviews in Extension 10. This is so because when asked about the last time they visited any health care system for any specific condition, the participants in Ext 10 reported that the conditions ranged from those related to dental care, kidney problems to sexually transmitted infections.

In another case, Sipho (SN), a resident of Extension 13 combines boiling the water and adding bicarbonate of soda as methods of water treatment before drinking it. In as far as the health seeking behaviours of working class men in this study are dependent on the agency of the participants, their specific working and living conditions are connected to the overall health outcomes of these participants. Some of the participants show their capacity to turn harsh working and living conditions into positive health outcomes. However, the experiences of the majority show that the working and living conditions create negative health results for them. Commenting on structural violence, Scott-Samuel, Stanistreet and Crawshaw (2009:290) argue that the concept explores issues

as diverse like poverty and income inequality, unacceptable living and working conditions to show how they act on individuals, as well as communities and societies. Further still, Hunter (2010:30) argues that "[p]overty and poor living conditions affect the spreads of infectious diseases in many ways; for example, they drive malnutrition and health-sapping parasites". In this study, the suffering experienced by the participants is to a greater extent a result of the working and living conditions which are mostly beyond their control. As the study explores the dynamics of black working class men's health-seeking behaviours, their representation of good or bad health is useful to ponder.

Insights on what health mean to men

In this research study, participants have a clear understanding of how important their health status is. When asked about the value he attaches to his health, Thabiso was forthright:

> TS: I really feel excited to be what I am because sometimes you see people, that are sick and they are in pain, so as long as you feel that yourself you are still good, it is important to me.

In this case, the value of good health is revealed in comparison to the experiences of bad health in others. Because of his working experiences against a question about the health of his body Jimmy was forceful in his response:

> JN: It is important because my work demands me to work very hard so I give myself some targets at work. Sometimes I give myself some tight targets and work very hard and some days I slow down so I give myself some rest at work so that I listen to the health of my body … My health is important as it determines my work. For example I can tell myself that today I want to work very hard than yesterday you see. I do this so that I can reach my target.

For respondents like Jimmy, health is a functional prerequisite needed for carrying out work related duties. Health is fundamental to the fulfilment of deliverables at work.

The meaning of good health for men

There were various ways men expressed their own lived experiences of what good health meant. The common thread among these expressions is that good health is

always a useful resource. In the words of Pitso (PM), good health means long life and he expressed it in the following words:

> PM: When I am fit and healthy it means I am gonna keep on living. It's what everybody dreams of, to live long, to see children growing and to see my grandchildren. I dream of that.

Tony agrees with the above sentiments but adds that: "…you are respected when you have good health". On having a higher life expectancy as part of good health, Buti agrees yet he also reveals that:

> BN: If I say I feel alright, it's like if I can get somebody who says lets lift this heavy thing, we can do it and people will see that there was real work done there. I can feel it that I am a man and I am okay.

In Buti's understanding, one can show that he has a good health status through the strength he uses in carrying out manual and hard workloads. This understanding of good health is enlightening because it shows the worldview of a manual worker. As a reminder, Buti's job is a bricklayer and much strength is demanded of him. Similarly, Sipho's opinions of good health have a lot in common with Buti's sentiments. Thus, Sipho expresses his views:

> SN: You will be seen because of the energy you possess…If you are healthy, everything you do you do it with speed and you are tough. Even in bed you have strength. Everything that you do you feel that you are yourself and you feel good. Even in the way you eat your food, you show appetite so that you gain the strength. …Everything that you do when you do it with some energy it means that you are alright in your body.

For working class men, the account by Sipho sheds light on the significance of good health. One who possesses good health exudes much energy which is useful for the fulfilment of societally mandated duties for men. This links well with Aggleton's (1990) understanding that health is a reserve of strength or energy. On the other hand, it is also important to explore what working class men understand by ill health.

Men's representations of what ill health is

Most participants associate ill health with pain in the body. The presence or absence of physical pain best describes whether these respondents are experiencing ill or good health. However, statements from other respondents show how diverse ill health is experienced and understood. While ill health is a subjective experience which is felt at the individual level, the outcomes of illness have a wider impact on social relations as Thabiso recounts:

> TS: … Remember that if you are not feeling healthy, you begin to be a burden to somebody else; you can't even go to the shops by yourself to buy some stuff. Eish, it's not good.

In the extract, ill health is not a good experience as it disables oneself by making him be a liability to other people. Further still, illness is a subjective experience which can be understood from the vantage point of one experiencing it. While a disease involves a medically defined pathology, on the other hand, Blaxter (2010) argues that illness is the subjective experience of ill-health. Mpho's statement below makes clear the distinction of ill health as he emphasises that it is a lived experience:

> MM: You see if for instance I am in the process of waking up in the morning and I feel lazy to wake up the first time, I will ask myself but force myself to wake up. If I feel lazy to do small things like thinking I will know that I am not okay and I look closely in myself to find why I am like this. In the end I will get the cause regardless of whether it is a true diagnosis or not because I am the one who is experiencing the feelings of bad health.

Ill health is subjectively experienced from one individual to the other. It brings both the physical and the supernatural worlds to bear upon individuals. In his understanding of bad health, Chris (CM) says that it slowly eats away one's life expectancy and is associated with misfortune since the sufferer of bad health is automatically polluted. There is a strong inseparability between bad health and pollution such that the two simultaneously create each other. The other way around is that the polluted person has all the conditions that attract bad health and misfortune, i.e. something like *umnyama* (Zulu and Wilhelm-Solomon, 2015). However, Chris' understanding of pollution and bad health need to be understood in the context of multiple sexual relations in which men

are involved, hence the metaphor of men creating a ‘bomb’ in their own bodies as highlighted in the following extract:

> CM: Bad health reduces your life on earth… Bad health also causes bad luck for example you enter at a firm they say get out because you are polluted. Bad health is also caused by this thing of having many sexual partners, you take bad luck from this one and that other one and that's why I told you that some do a bomb in their own lives and when you go out looking for a job you find that they don’t hire you but they hire me.

The extract illuminates on the concept of health that it is not only physical but includes mental as it affects even a man’s shade or what surrounds his body. This conceptualisation of health speaks to the cultural notions of the body through which a person is perceived by others to the extent that he gets rejected and denied employment because he is polluted. The observation in the extract is for example supported in the literature by Niehaus (2002) who concludes that the informants in his study believed that there was exchange of blood during heterosexual intercourse. It is that exchange of substances in sex which the respondent aptly concludes to be the cause of the ‘bomb’ in many men. Drawing from the work of Ngubane (1977), Helman (1990:27) argues that among the Zulu, the virility of men could be weakened after having sexual intercourse with a menstruating woman. Supported on this observation from Helman (1990), the above finding on pollution which is equated to a bomb and bad luck finds resonance in Niehaus’ (2007) study in which he found that men got polluted due to engaging in sexual relations with many women as it resulted in the absorption of different substances. This exchange of substances is a recipe to what Chris above sees as the making of a bomb. This also needs to be juxtaposed with Tony’s assertion that when one is in good health he is respectable.

In expressing how he feels when in bad health, Buti reveals that his first symptom of illness experience is when he wants to be intimate with his partner:

> BN: Most of the time when I am not feeling well in my body, I feel it when I want to be intimate with my wife...when I don’t perform the way I did in the previous day, and the following day it’s the same, I would wonder why I am losing power… Myself I get worried when I slacken in bed and that’s when I sit down with my wife

to tell her that I don't know what is happening, could it be the food that we ate or what?

Through experiential knowledge, a slackening in sexual performance is Buti's yardstick to gauge ill health. Although most of the participants generally agree that physical pain is an indicator of ill health, their experiences reveal the complexity of the phenomenon. Thus, health which is characterised as good or bad health should be understood in its subjectivity. In this regard, the following section takes the reader through an understanding of what masculinity entails and its implications on the health of men. It responds to the first sub question set in Chapter 1: *How does masculinity relate to men's health-seeking behaviours?*

Masculinity means *maikarabelo*[4]

What does to be a man mean to you as an individual? This is the question asked to all men who took part in the research study to ascertain their constructions of masculinities. In the configuration of what describes a man, the theme of responsibility loomed large across the responses from participants. A man is a man because of the weight of responsibilities that he carries, like having a wife and children as well as taking care of them. Rather than classifying a man according to physiological characteristics, the respondents in this study are clear that masculinity is socially constructed. As advanced by the participants, responsibilities separate men from boys. For other participants like Jimmy, being a man was a societal mandate involving responsibilities like establishing a homestead. To emphasise the weight that comes with being a man, Buti's understanding is that a man is the figurehead of his family and does not shy away from his familial responsibilities. Buti puts it thus:

> BN: When they say, there is a man; it means there is a nation that he is representing. He is able to represent his family in order for them to eat; as a man you have to make a plan. They actually say he is a family man (*ke monna wa lelapa*)…. A man minds his own business through taking care of his family …He is able to handle all the business of his family. He does not run away from his family

[4] Sepedi word meaning responsibility or to be responsible

> responsibilities no matter what. A man perseveres in his duties of taking care of his family. A man who runs away from his responsibilities is not a man.

From conversing with participants, responsibility is the hallmark of what a man is and this is manifested in various ways like taking care of the family and even in personal decisions of an intimate nature like using protection during sex. In line with being responsible, independence from parental care emerges as a subtheme that defines a man.

Masculinity as provider

Most of the participants interviewed for this study were living outside their parents' houses, either in RDP houses registered in their names or as owners of shacks in Extension 13. Through socialisation, men learn what is societally expected of them, thus, masculinity is socially constructed. Thabiso understood masculinity to mean:

> TS: The way I understand it in South Africa if they say this one is a man, you will see him moving out and doing things for himself like starting his own family out there. You start your own things aside from the family you grew up in. In the end you are also supposed to provide for your own family.

Participants in this research study understand that one can be called a man because of the ability to start his own family. Masculinity in this regard is a process that a man learns and can be fully adopted through starting one's own family thereby asserting his independence from parental care. In actual fact, the man assumes the headship of his newly established nuclear family. In assuming this headship, a man has to show his ability to provide. These sentiments are shared by most of the participants like Trust, Thabiso and Steve. Summing up the views on the provider role, Steve suggests that, "[w]hen there is a man in the house, he is there to make things happen in the home, not a lazy man". The provider role is something held in high esteem as a significant characteristic defining working class men in this study. It ties in with the broader theme of masculinity as responsibility. The association between masculinity and responsibility finds a special place in the analysis of men's health-seeking behaviours in this study.

To complicate what masculinity entails, Chris states that being a man was not biologically determined but rather socially constructed and that it comes with power. His sentiments are as follows:

> CM: To be a man is not easy, it goes with how you approach your life as a man. For some, we are men because we put on trousers but lacking the power that other men possess. Being a man is being the head in the family, not like other men that go about beating people in the family because somebody tells himself that he is a man. Being a man is not to be abusive to other people but you are supposed to be a protector of those that you live with…

Chris' illustration is suggestive of the multiplicity of masculinities as put forward by Connell and Messerschmidt (2005). There is an ideal masculinity encompassing possession of power as suggested in the above extract. At the same time, there are other kinds of masculinities which manifest in violence and abuse of other men, women and children. Most of the participants in this research study do not ascribe to such forms of masculinities as they trample on the highly regarded ideal of responsibility or (*maikarabelo*).

Some of the participants emphasise that being a man means one has to be self-reliant and that even in difficult times, he has to learn not to bother his parents for help. These views were shared by Mpho and Pitso as they argued that by assuming the headship role, the ideal of self-reliance becomes important. Pitso succinctly put the point forward when asked whether he is able to solicit help from his parents even when ill:

> PM: I don't tell them because I don't want to stress them like I said they depend on me boss. I am the life saver so when I get sick they are all stressed and when I see them stressed like that, eish it breaks my heart so I rather keep quiet. If I die they will just cry once.

From the above quote, a man is defined by virtue of him being self-sufficient and being there for his family. However, the kind of self-reliant masculinity espoused in the quote becomes a deterrent to health seeking among men. The extract from Pitso unmasks society's demands on men to the extent that some men feel that they are the ones to provide all the help to their families and not vice versa. This finding is noted by Williams

and Best (1990 in Courtenay, 2000) who argue that there is a greater societal pressure for men and boys to adhere to attributes of independence, self-reliance and toughness.

Rather than the self-reliant kind of masculinity which is held by some respondents, others hold different opinions on how a man must conduct himself. For Tony and Sipho, a man cannot be self-sufficient but is dependent upon the advice and help of neighbours and elders in the community for him to develop. Thus, Sipho states, "…Where I see that I am failing I seek advice from the elders so that they also teach me how to live as a man and as a father". Because of the weight of responsibilities societally entrusted on men, self-reliance as a yardstick of masculinity is not an ideal held by the majority of participants hence a man is not an island but he needs guidance and help from others in order to fulfil his mandate in the family and to the society at large.

Preventive medical health checkup - a sign of responsibility

In line with the main theme of masculinity as being responsible, most of the participants expressed the view that they took general medical checkups as a practice for good health and this contradicts the widely held beliefs that men are illiterate at taking care of their health. In two cases, the participants recounted that their respective companies instituted mandatory medical checkups annually for them. When asked about his last visit to the hospital and the purpose of that visit, Thabiso narrated that he last visited the hospital in September 2016 and added that, "I had gone there just for general checkup". This decision is triggered by an awareness from the participant of his vulnerability and by the fact that he considers his job as one of the co-factors affecting his health as a truck assistant. The visit to a public hospital or clinic by the participant was not necessarily precipitated by any specific medical condition but was part of a proactive way of taking good care of one's health. Sipho and Trust's accounts showed that they were also in agreement on taking routine medical checkups as part of staying healthy. Narrating his last visit to a clinic, Sipho shows that it was intended as a proactive measure for the greater good of his health:

> SN: Yes, it was for check-up alone, there was no specific condition that I was concerned with for consultation…

In this context, there are no clear medical conditions that push men to pursue preventive medical checkups. However, men pick and choose between western and traditional paradigms to health. Some participants are clearly pushed by the general pressures of life to seek guidance from traditional healers. In his choice of traditional practitioners as a source for general consultation, Buti states:

> BN: I do sometimes go to traditional healers to consult about my life. Sometimes you find things are not well like bad luck, I do consult and get help but I don't like them… (*traditional healers*). In my case, I just consult while I am in good health for life in general…

Notwithstanding the fact that Buti consults while in good physical health, the illustration above shows that he is pressured to seek help from traditional healers because of a spiritual need. There is an intertwining of the physical and the supernatural for the participant as he perceives the onset of bad luck to be a cause for things not going smoothly as he anticipated. This speaks again to the notion of the effects of *umnyama* which according to Zulu and Wilhelm-Solomon (2015:138) is perceived to be a hindrance to good health, peace and upward social mobility. Thus, health is a multidimensional concept which is co-constructed by an array of factors; be they physical, spiritual or social. In describing his health, Mpho stated that:

> MM: …I am somebody who does not fall sick often, I don't get headaches or stomach pains. This is the result of me taking those things (*traditional herbs*) that I told you about… Those things (*traditional herbs*) help me and make me live a good life.

The above excerpts serve to highlight that working class men in Modimolle are not passive when it comes to their health. This feeds well into the broader theme in which masculinity in this research study is equated to being responsible.

Many studies concur that masculinities, in particular, hegemonic masculinity can be an impediment to men's health (Courtenay, 2000; Connell and Messerschmidt, 2005; Bates et al, 2009; Jewkes and Morrell, 2010) through delaying to seek healthcare when

in need. The findings in this study illustrate the complexity of masculinities vis-à-vis men's health-seeking behaviours. To a larger degree, the construction of a kind of masculinity which embodies responsibility shows that working class men do take care of their health as evidenced through preventive medical check-ups as well as visits to traditional healers. This finding concurs with Mfecane's (2012) study on HIV testing and disclosure among men where they restored their responsible masculinity identity by turning the stigma associated with HIV disclosure into a resource where they finally became role models. Caution is taken that Mfecane's (2012) study was for HIV positive black men in a South African village while this current study is about working class black South African men in a township setting. However, the similarities on the findings call for a comment.

Lived experiences of men on multiple sexual partners

It is the general view among all the participants in this study that although the phenomenon of multiple sexual partners is common, it has both social and health effects on men. It is, however, the reasoning behind the causes of the phenomenon that is of interest and how this affects the 'masculinity as responsibility' theme that was discussed above. In articulating a uniquely traditional kind of masculinity in the isiZulu culture of South Africa, Hunter (2005:389) observes the existence of the isoka masculinity wherein it was part of societal norms for a Zulu man to have multiple concurrent sexual partners.

However, this unidimensional understanding of multiple concurrent sexual relations is obsolete as evidenced by the phenomenon of transactional sex (Leclerc-Madlala, 2003; Hunter, 2005; Gilbert and Selikow, 2010). Transactional sex according to Gilbert and Selikow (2010:216) involves the exchange of sex for either a subsistence resource or for conspicuous consumption. In the same vein, Leclerc-Madlala (2003:214) argues that young women capitalise their desirability in an effort to attract men who can provide them with expensive products defying the long-held notion that poverty is a push factor for such behaviours.

Men's perceptions and lived experiences of multiple sexual relations

Men's views about the practice of having multiple concurrent sexual partners are interesting yet complicated. Although the question was asked in a way to obtain information on their perceptions, interesting nuances emerged about their lived experiences which become useful for this study. For some participants, having multiple sexual partners is simply a wrong thing while others argue that it actually serves a purpose of strengthening their intimate relationships in the family. Reflecting on his personal experiences, Thabiso had this to say about having multiple sexual partners:

> TS: It is something that happens but on my side eish it does not work for me, it does not because I am not good at having secrets. *(Both laughing*). Even my phone, I just put it on the table or leave it you see. That means if there is somebody aside life will change. I am not able to do that myself. If I focus on somebody, I become committed.

In the above instance, having multiple sexual partners takes a lot of work as it demands that a married man has to be discreet at keeping secrets, an effort Thabiso is not able to go through. In relation to his health, Chris had this comment about the practice of multiple sexual partners:

> CM: I don't like running around with women because they say if you are a man you are supposed to have seven girlfriends. You cannot be healthy if you are like that because even if you get sick, you will not know the woman who caused the sickness to you because they are seven.

Several accounts from men in the study show that they feel it is not good to go around engaging in concurrent sexual relations and this augurs well with the ideal masculinity espoused in the community in which a working class man has to be responsible. However, there are accounts of other men in the study showing that it is common practice for a man to have multiple sexual partners. Through sharing their experiences, it is clear that the practice has some negative health consequences as some of the men reported having been infected with sexually transmitted diseases. Although married, the following extract is a pointer to Trust's reasons for having at least one girlfriend:

> TZ: We don't deny that as a man you must have a girlfriend but if you are responsible, you are not supposed to have more than one girlfriend. There is no man that doesn't have other sexual partners, but as a man with family responsibilities at heart, just have one girlfriend. That girlfriend is important for you as a man because in the house, there is no way that you will always be happy. So if you want your relationship with your wife and your family to be strong, you must have one girlfriend. That one girlfriend is the one who will strengthen your marriage do you know that?

In their study on masculinity and HIV in Zimbabwe, Skovdal et al (2011:7) found that it was normative for men to have extra-marital relationships. That finding is supported in this study because many of the participants share Trust's sweeping generalisations that all men engage in multiple sexual relationships. The practice of engaging in multiple concurrent sexual relations is envisaged as a fallback strategy; a resource that men use to strengthen their intimate relationships or marriages. However, striking a line between a responsible masculinity and the phenomenon of concurrent sexual partners is complicated because the participants acknowledge that the practice has social consequences as well as personal effects on a man's health.

For Buti, the practice of having multiple sexual partners is both good and bad and his reasoning is that sometimes a man might suffer depression or might end up killing himself when his wife divorces him because he would have been too committed to her to the extent of neglecting to have a 'spare wheel', i.e. a separate girlfriend. Morally basing his reasoning that the practice is bad, Buti says that a man needs to stick to his wife whom he had been with through difficult times. Interestingly, Buti recaps his perceptions of engaging in multiple sexual relations by stating:

> BN: … sometimes we just do these things for practice so that we don't forget to date. If you stay for many years without dating, you will end up forgetting how to do it especially when you get separated from the person you are with. You will end up buying sex and it's not good, and sometimes you have no money to spend so how will you manage? As a man you are supposed to know how to speak and date.

It is important to mention that the phenomenon of multiple sexual partners should not be understood as sex work or prostitution but as a kind of relationship with long term benefits not only materially but socially as well (see Leclerc-Madlala, 2003). The central

point underlying Buti's narrative is that, by having multiple sexual partners, a man is creating a safety net for himself to fall back on during emotional breakups between long time partners. However, it is also clear that the practice of multiple sexual relations is a masculinity endorsement, hence the point by Buti that a man has to stay on top of the dating game regardless of his marital status. This finding resonates with what Lynch, Brouard, and Visser (2010) found in their study in Tshwane on the constructions of masculinity and HIV/AIDS among heterosexual black South African men. In the study, they found that participants drew on the normative notion that men must have multiple sexual partners (Lynch et al, 2010). The consequences of Buti's actions in engaging in multiple sexual relations resulted in him contracting herpes, a sexually transmitted disease. The following is Buti's account of what transpired when he went to a pharmacy for medical help:

> BN: I remember it was in 2008 when I was in Pretoria and I had developed some rash like a belt around my stomach. So I went and showed them to the pharmacist and they gave me some medication and I drank it. Some people told me that if that belt comes twice you will die or if it makes a complete circle then you die. I got help immediately and I was well until now.

Similarly, Mpho states that engaging in multiple sexual relations is a common and acceptable norm. However, because he engaged in the practice, he also recollects how he suffered a sexually transmitted infection: "… [t]he only serious illness that I suffered is drop (gonorrhoea) which I got from sleeping with girls…" Although the practice of multiple sexual relations is accepted for men, the consequences are far and wide. Considering that some of the participants are married, it becomes complicated to define what responsible masculinity is within the community. Due to the acceptability of the practice of multiple sexual relations, Jimmy's story below shows his narrow escape from death after engaging in unprotected sex with a girlfriend. He reports his visit to the hospital:

> JN: The problem I had was, ummm, actually this issue of women. I had sex with a woman who had aborted you see and it caused me a great deal of a problem so I had to go to the hospital so they could help me. That is the problem I had…

This finding speaks to the problem of pollution which is associated with engaging in unprotected multiple sexual relations. In his study in Bushbuckridge, Niehaus (2007:853) found that engaging in sexual intercourse with pregnant or women who had recently aborted resulted in afflictions in which the man's body "swell up and his groin to ache so badly that he might be unable to walk". The cause of all these afflictions according to Niehaus (2007) is associated with the aura of the dead baby in cases of women who have had recent abortions. Though pleasurable, sex is a dangerous minefield, especially where one engages with a woman who has recently aborted or who has had a miscarriage without using protection. Niehaus (2007) further adds that where sexual intercourse occurs between a man and a woman who has aborted, a man's blood would be poisoned thereby creating complications when he wants to urinate. This is further supported by Semenya, Potgieter, and Erasmus (2013:253) who argue in their findings of STI treatment in Limpopo that there is a consensus among traditional healers that chlamydia results from having sexual intercourse with either a menstruating woman or a woman pregnant with another man's child.

From the general conversations with participants, the affliction caused by these kinds of relations is life threatening thus, the participant named above had to be admitted to the local hospital. Chris succinctly explains the act of engaging in multiple sexual relations by adding that the transmission of blood between the couple in sexual intercourse is what explains the afflictions so dreaded in the community:

> CM: …You see when we sleep with women, we exchange blood, I give her mine and she gives me hers … problem is us men sleeping with women who are sometimes having their monthly periods. Sometimes, even if a woman is on her MPs[5] you want to sleep with her, so when that bad blood enters into me, what will it cause? That blood will condemn me because in me there is no outlet for that blood, it means it will settle in a place where it is not needed and in the end you cannot live a long life because you take that which is bad into your body…

In most instances, the practice of multiple sexual partners is associated with unprotected sex. Sharing his sentiments about engaging in multiple sexual relations without protection which he labels as being irresponsible, Buti states:

[5] Menstrual periods

> BN: …The problem with other STIs is that they can cause you to fail to wake up in the morning or when you have sex with somebody who has aborted or who is pregnant, you will fail to wake up because that sickness can be so worse… it's because of failing to look after yourself. Taking things for granted thinking that you are strong.

The findings show the mixed opinions of participants toward the phenomenon of multiple sexual partners. There is a consensus that the phenomenon has health related consequences for men, which in some instances can be fatal if not properly and timeously attended to. Although participants share the view that masculinity is reflected through the weight of responsibility, the cultural edict where it is acceptable for men to engage in concurrent sexual relations creates a form of hegemonic masculinity. In sharing his perceptions about the phenomenon of concurrent sexual partners in Modimolle, Mpho states that:

> MM: In Modimolle, I arrived here and I saw that … it's like fashion. For example let's say you have your wife and you go out with your friends to places and you don't act because you have a wife, they will say you have been given a love potion or they say she is controlling you with a remote. In my own opinion, it is acceptable; it is a norm that a man can have as many partners as possible as long as you have the self-control that you put some limits on how many you need. Culturally, it's not acceptable as a man to have only one wife…

The findings by Lynch et al (2010) in which they point out that society puts some sanctions on men who do not conform to the ideals of masculinity set out by culture are also reflected in the above extract. In other words, men who do not involve themselves in multiple sexual relations are lampooned and this is done as a form of social control to make them align to certain forms of masculinities. In the next theme, I take the reader to gaze at how working class men view their bodies and the various intricate practices they deploy to maintain good health.

How men keep themselves healthy

There exist various ways in which societies view the human body. Helman (1990:22) argues that the lay conceptualisation of the body in Western society is commonly

typified by the metaphor of body as machine and engine. In the same Western societies, Stainton-Rogers (1991 cited in Williams, 1995:592) emphasises that working class men and women use the 'body as machine' metaphor when conceptualising health and illness. In Modimolle's working class men, the common metaphor that resonates across many of the participants is that of 'body as car' which requires regular service for it to perform optimally. By referring the body in instrumental terms, men in this study are making a statement about their social class which dictates the importance of the body in relation to work. Associated with this thinking is the regular use of enemas by participants in the study as part of servicing their bodies.

The history of enemas indicates that they have been used for general purposes of detoxification since ancient times (Gerson and Walker, 2001:157). In the context of South Africa, Segal, Tim, Hamilton, Lawson, Solomon, Kalk, and Cooke (1979) argue that there is a widespread use of enemas by black South Africans. It is important at this point to mention the diversity of the participants in terms of their biographical details. The common factors defining the participants are their working class position as well as their gender. Significantly, the majority of the men in this study use enemas for the maintenance of good health. On the other hand, though slightly insignificant, some differences in terms of marital status, residential location and ethnicity are worth exploring in the participants' opinions and health practices. In South Africa, rural-urban migration witnessed a change in the ingredients of enemas from traditional herbs to modern products like Dettol, vinegar and soaps etc. (Segal et al, 1979). In this study, enemas range from over the counter products like laxatives and *Stameta*[6] to traditional herbs as well as special teas or coffees prescribed by churches, in particular, Zionist churches. Various uses of enemas are documented in the literature and these are meant for ritual purposes, treatment of impotence, abdominal pains and for aphrodisiac and emetic purposes (Segal et al, 1979). Below are two extracts from Thabiso and Trust illustrating how the male body must get 'serviced':

[6] A natural product with multiple active ingredients and is said to strengthen the immune system and relieve various conditions.

> TS: You wait first and when you feel that you are no longer flexible then that's where you do service, because you cannot do service when you are still feeling that you are well. It is the same with a car, when it starts to cough, it needs service. (*Both laughing*). You cannot service the car when you see that it is still alright.
>
> TZ: You know what; a human body is like a bicycle or a car. When you buy it you know how its performance is, right, and when you see that it is giving you problems you can tell that it is no longer performing the way it used to do. Same as a body, just as you grow in that body, you are the person who knows exactly what happens when your body is feeling okay or not…

In the context illustrated above, men possess a finer understanding of their bodies and they pay attention first to see whether their bodies are still functioning optimally before they induce any kind of 'service'. Participants in the study show clear differences on the types of enemas they use, with Thabiso and Trust preferring Western over traditional herbs. Trust had this to say about how he views enemas as an important resource for his health:

> TZ: … and sometimes cleaning my bowels in case I have constipation problems. I grew up doing that, so if I stay for a while without cleaning my bowels my body tells me so I clean the bowels again. That's what I think helps me to stay well in my body. I am sure of that…

The use of enemas in the above context can be understood as a useful resource the participant holds. In the case of Thabiso, the usefulness of enemas to his health is pointed out when he states: "[i]t helps a lot, you really feel relieved after you have cleaned yourself, you become strong again, and the appetite comes back again". In light of the fact that participants are working class men whose value is assessed in selling their labour and in providing for their families, maintaining a healthy body is fundamental. The two participants named above are different in terms of ethnicity, their residential location as well as educational status. However, both of them are married and they hold strong opinions against traditional medicines. On the other hand, one respondent (Jimmy) who works in a brick manufacturing mine states he uses body boosters which he buys from pharmacies to give strength to his body when he goes to work. For him, the work he does is strenuous because of the need to meet the targets.

He reports instances where he feels weak because of the work, hence the practice of taking body boosters to gain strength. It is important to mention that for this participant, enema use does not clearly feature in the activities he employs to keep healthy. His other resource which is significant to him is the drinking of milk to clear off the dust from infecting his lungs, a practice which is based on experiential knowledge with no clear health related benefits.

The metaphor of body as a car comes out strong among the participants. However, the 'service plan' which includes the use of enemas brings out complex nuances because, on one hand, enema use for internal purging of the body is a common health practice among Africans (Cocks and Moller, 2002:394), on the other hand, enema use predates the invention of cars. To say the body is a car on the premise of enemas which are regarded as methods of servicing it must, therefore, be understood at a more critical level. The study conducted in the Eastern Cape by Cocks and Moller (2002:394) found that the respondents used traditional medicines to "cleanse the blood". As argued by Cocks and Moller (2002), 'purgatives' or enemas are routinely used as a type of preventive health measure or for abating the onset of an illness. From the informants' experiences, the use of enemas in this study is a regular practice which is closely linked to the maintenance of good health and this corroborates Segal and friends' (1979:195) observation that among the Zulus, a member may use enemas as often as three times per week.

For participants like Pitso, Tony and Mpho, the use of traditional herbs for purposes of bowel cleansing is illuminating as it points out to the fact that men's health-seeking behaviours are a dynamic and complex phenomenon. It is affected by one's socialisation and his individual agency. The health seeking behaviours of men are embedded in multiple practices through which men pick and choose from a variety of resources to maintain their health. Tony aptly sums up the rationale for using traditional medicine as enema:

> "[i]t cleans my internal system, body, everything; my blood and I drink it after three months. It always keeps my body strong and healthy and fast".

The participant's use of traditional medicine as enema is part of a cultural tradition he was socialised into. Besides the fact that the three participants holding strong opinions towards the use of traditional medicines as enemas reside in RDP houses, there are no shared factors making them more predisposed to hold those views. The positions they hold could possibly be understood in the way they were socialised.

While Chris takes some time to consult a doctor about the state of his health, equating it as he does to servicing a car, he also uses teas that are prescribed by the church as enema to clean his bowels and sometimes to induce vomiting to clear bile *(nyoko*). This is supported in the literature by Anderson (1999:307) who argues in the context of Zion Christian Church (ZCC) that they use salt for cleaning the stomach and excess bile through vomiting. In the same light, Sipho who is a religious man brings another important metaphor of 'soldiers' of the body in illustrating his body and health:

> SN: As a man I must always have *taelo*[7] from church in my house that can save my life for example one for cleansing my blood and enemas which I use to induce vomiting so I remove the dirty in my bowels and these are always helpful in keeping my body healthy. This always helps the soldiers of my body to be healthy. I live with the teas from the church as I seek to save my body by that, I also use the method of inhaling hot steam from boiling water while covered in a blanket, and through sweating, the viruses from the body like flue gets destroyed. That prescription from the church makes you to live a healthy life and you can be tough like anybody else.

The role of the church in relation to health is illuminated when one puts the above extract into context. In as much as the above quote illustrates the important role played by the church in relation to health, it also shows the complexity of health both in terms of the physiological and the spiritual aspects. Different churches hold different positions to health, disease and sickness. Building on the work of Comaroff (1985), Oxlund (2014:83) argues that good health is defined in ZCC belief systems as the free flow of body fluids which is associated with an excessive consumption of cold tea and water. Similarly, Anderson (1999:305) adds that the water is seen as a symbol of "cleansing and purification from evil, sin, sickness and ritual pollution, concepts familiar to

[7] Sepedi term for strict instructions given by the church leader to a church member to perform

traditional religion". It is striking to observe that after using church prescribed teas as enemas, Sipho recounts feeling 'tough' again. This fits in well with the way a car performs after having been serviced. It is significant to mention that, there are no rigid demarcations on whether one follows the Western, traditional or religious paradigm when it comes to enemas. For some participants, these paradigms are fluid and one can straddle and choose from all three for better results as and when necessary. The bigger picture for using enemas is that the body ought to come to its full operational capacity to satisfy work related duties in line with the participant's working class position.

Although enemas are used as a health resource for various ailments and for the general well-being of the body through cleansing; there is a sense from one participant that the body has its own natural means of regenerating itself apart from inducing enemas. In other words, the participant in question refutes the body as car metaphor as he suggests that the body does not need enemas for it to function optimally. To put his point across, Buti states:

> BN: …Myself I am not the kind of person who uses sex pills to boost my performance in bed; I am still 100 percent strong. I don't drink any special teas or Stameta but I see some of my colleagues using it and I tell them that stuff damages your life because some people just want to use these boosters for no apparent reason or because somebody says it works for him, some traditional herbs end up damaging us… The problem is if you immediately run to take medicines, you will fail to understand your own body…

From his understanding, some men use various enemas for boosting their sexual performance (Segal et al, 1979), something which he does not adhere to. Due to the fact that he understands his own body, Buti leaves the natural process of regeneration to take its course. He is suspicious of traditional herbs which some men hold in high esteem as methods by which they keep themselves healthy. The challenge that can be encountered by the participant above is how to strike a balance between taking the time to listen to the body and when it would be time to seek health help. In light of the enemas used by men in this study for the well-being of their bodies, there are other important physical activities that are employed.

In spite of their limited access to facilities like state of the art gyms or stadia, the research participants in this study engage in various bodily exercises like going out to makeshift gyms, jogging, push-ups, playing soccer and dancing. Other participants use their mode of transport like bicycles as a form of bodily exercises. Push-ups are the commonly reported form of body exercise done by the participants in this study, while in some instances others mentioned that they sometimes use skipping ropes for exercising. Three participants, mention push-ups as part of exercising. Thabiso pointed out: “I can do twenty push-ups and then change exercise”. In all cases, the push-ups are done in the confines of the participants’ homes. In view of the fact that the work done by most of the participants demands a lot of physical energy, it becomes important to analyse physical exercises in such light. Chris states that after knocking off from his job as a security guard, he feels tired and often times he fails to have time for exercising. According to Shilling (1993 cited in Williams, 1995), having spent their bodily energies all day in what often amounts to physically demanding work, the working classes may have little time or inclination for exercising. In this case, the structure of the society wherein there is lack of proper facilities for exercising intersects with hard and menial work to prohibit working class men from involving themselves in health benefit exercises.

Williams (1995:595) argues that working classes are more inclined towards sports that cultivate physical strength and a high degree of energy or pain like weight lifting. Two respondents, namely Pitso and Buti mentioned going out to gyms which are largely equipped with weight lifting equipment as part of their physical exercising. Considering that Pitso is single, he states that he tries to go to the gym every day to lift the weights. In the case of Buti the demands of being a family man come with some constraints to his routine of going to the gym especially in the evening:

> BN: …There is a place around with the gym equipment; I sometimes go there to exercise. In a week I go there twice or thrice to lift the weights. Sometimes I don’t have time because we usually lift them in the evening and the family would want you home in the evening as well. I usually do one hour at the gym.

Although there is no conclusive relationship found in this study between marital status and physical exercising, it could be an area worth exploring in the case of working class men. The responsible masculinity which is highly valued by the majority of participants means that men are supposed to take care of their families and to be there when needed and in some instances, personal physical exercises may be relegated to the periphery. In the same vein, the fact that Piet who works at the toll gate is single and is able to play soccer as well as being able to tour around neighbouring towns as a dancer speaks to the way marital status of men can be a co-factor to their health seeking behaviours. Being married or single has both positive and negative effects on men's health in general and in their health seeking behaviours in particular. Piet maintains the health of his body in the following manner:

> PS: You see when I am playing soccer, I feel that everything else in my mind disappears and I concentrate on soccer only. When the game is over I can feel that I am tired in my body and my muscles will be painful you see.

On the part of dancing which forms part of bodily exercising, Piet had this to express, "…when I am dancing I forget everything". It is, therefore, important to point out that dancing and playing soccer form part of a psychosocial mechanism by which the respondent keeps his body healthy and fit. It is interesting to observe the emphasis he puts on having painful muscles after the soccer match and how this is a benefit to his body. It can be equated to the cliché, 'no pain, no gain' and this feeds well into what Williams (1995:595) states about the working classes that they engage in activities and sports which emphasise physical strength and pain. In so far as the various activities mentioned kept men's bodies healthy, it is important to mention that food intake is equally critical to the maintenance of a healthy body for the participants.

The male body and food

According to Krieger (2005), the body is able to tell multiple stories of its situated existence. Through the body, a related social class position is depicted and this positionality determines the food consumed. Food according to Helman (1990:31) is more than just a source of nutrition as it can work to create and express the relationships between people as well as being a symbol of social status. There is a lot of

meaning attached to food and this varies according to contexts. Jensen and Holm (1999 cited in Vaccaro, 2011) argue that the kinds and volume of food are important signifiers of masculinity where meat eating occupies the top of the rung. From the interviews in this study, the majority of participants favour eating pap (*soft porridge*) and vegetables as well as different kinds of meat. If vegetables are largely construed to be feminine foods, men in this study contradict that perception. However, context is important to such an analysis.

Food choices according to Bove et al (2003) are shaped by socialisation and are affected by social, physical and economic factors. The main reason pap emerges as the preferred meal among the research participants in this study is that, in addition to giving physical strength which is an essential resource for work, it is an embedded part of socialisation among the black working class men. The participants take it as 'matter of fact' that as black people they grew up eating pap; it is the staple food. However, the cost that comes with buying a bag of mealie meal cannot be discounted as a factor in the preference of pap by the working class men in this study. Building on the work of Department of Health and UNICEF South Africa (2004 to 2007), Mchiza, Steyn, Hill, Kruger, Schönfeldt, Nel and Wentzel-Viljoen (2015) argue that the large consumption of staple foods like maize and bread may be fuelled by the low prices due to government subsidies in which large and smaller millers are reimbursed for reinforcing compliance with fortification legislation. The health seeking behaviours of individual men in the study are therefore intricately tied to the larger social structures of government policies at national level.

The participants' work demands a lot of energy and eating pap comes with the desired results for the majority of the working class men in this research study. Intertwining the male body and social class, Bourdieu (1984) argues that the working classes are more attentive to the strength of the physical male body than its shape hence the tendency to go for cheaper and nutritious foods. To remind the reader, four participants in this study identified themselves as single and age was not a significant factor related to marital status as there was a 45-year-old man who was single. On the other hand, the majority of participants self-identified as married and cohabiting. The difference among and

between the members of this category was not clear and for purposes of this section, they will be treated as married because they essentially enjoyed similar benefits. Of the four respondents self-identifying as single, three were Pedi by ethnic background and the 45-year-old was Ndebele.

Interestingly, all single men in this study are less likely to cook their food opting rather to eat ready-made foods. Pitso is single and he says that: “I eat once a day when I am hungry. I can buy some bread and eggs, atchar (*spiced mango dish*) and a cold drink then I eat”. Further still, the participant’s food basket is totally different from those in cohabiting or marriage unions as it comprises: “[p]lenty of things, eggs, tinned fish, tinned beef, beans, macaroni they are the fast foods.” There is no mention of vegetables in the list of a single man because it requires time to prepare. However, although he is single, Piet suggests that being single does not mean one lacks time to prepare his food.

> PS: I have plenty of time to cook but I just don't like to cook. If I say I have prepared my food then I would have made some macaroni. When my partner comes she is the one who tells me that you are hungry and then she prepares pap and vleis (meat), and that's when I can eat pap. I am not somebody who likes cooking.

However, the fact that it is his partner who sometimes comes to prepare the food contradicts Piet’s assertion that he has time to prepare his food. The cooking of food is a time-consuming process which is often sidelined when a man is single. However, even though a man can be single, the fact that he stays with his siblings like Shakes mean that food preparation could be done in the house for the health benefit of all members. The other three participants who were single stayed alone and this could explain why they did not take the time to eat home prepared meals.

Cohabitation according to Bove et al (2003:28) leads partners to pay particular attention to meals than when living apart as single and this necessitates changes in eating patterns. For married participants and those in cohabiting unions, home cooked meals emerged top of the list. Both Chris who is a divorcee and Thabiso; a married man state their preference for pap and spinach. When asked whether these were the main kinds

of food he liked to eat, Thabiso stressed, "…yah, you see things like spinach are healthy foods". From the stories shared on what kinds of food the respondents eat, vegetables like spinach and cabbage frequently emerged as the most preferred and their consumption was based on health reasons. It is important to mention that across the residential divide between RDP and informal settlement dwellers, the majority of respondents, especially the cohabiting and married men cited vegetables as one of the main foods they eat in their homes. This could also be attributed to the point that vegetables are readily available and sold in the streets as the town is essentially surrounded by farms. Mchiza et al (2015) argue fruit and vegetables are regarded as good sources of vitamins and minerals and contribute to the fibre intake. While it is significant that the participants in the study prefer eating vegetables, the finding contradicts the national survey which according to Mchiza et al (2015:8243) shows that South Africans are consuming fewer vegetables which contribute to the burden of diseases in which low fruit and vegetable intake account for 3.2% of total deaths in the country.

In spite of limited capacity to afford a variety of foods; the respondents considered food intake as a health practice and it becomes crucial to their general health seeking behaviours. Food consumption is perceived to be influenced by factors as diverse as gender (Sobal, 2005), social class and ethnicity. One married participant living in the informal settlement had this to share:

> TZ: In my family, we don't have that much variety on the food we eat because we are poor. We eat pap, rice, bread and tea and that's all. We use vegetables like cabbage, tin stuff, beans sometimes potatoes and meat.

It should also be borne in mind that general food security is largely dependent on social class. Red meat according to Temple (2009 cited in Mchiza, 2015) is among the most expensive food items in South Africa such that it is mainly unaffordable to poorer communities. As such, chicken becomes the preferred source of protein. The social class of men in the informal settlement intersects with the unavailability of electricity meaning that there are no means to preserve perishable foods like meat. While there

are positive outcomes of eating vegetables, meat as a source of protein is also required and this is one product that most of the participants lack adequate access to.

Risk factors associated with men's health

Alcohol and tobacco use have clear risks to men's health. However, the relationship between substance use (alcohol, tobacco and dagga) and health seeking behaviours for working class men in this study is a complex one. It produces contradictory outcomes as analysed through the lived experiences of the respondents. The majority of the participants express that entertainment and simple cravings are some of the reasons for drinking alcohol and smoking tobacco. Chris's extract below captures the majority of the participants' sentiments on why they drink:

> CM: … So I cannot tell you what I feel when I smoke, it's just a cigarette habit that lures me to smoke. The same with alcohol, as we were growing up we would see people drinking and we would pick the bottles to drink that which was left and that thing became a habit (*Interruption-pause*). With beer, I don't know why I drink, if the body gets alcohol it becomes used to it. You cannot know why you drink, just for entertainment you see…

In defining the term 'risk factor', the World Health Organisation (2016:4) argues that it denotes individual or social factors that can be used to gauge an increased risk of a disease or an undesirable health condition. In this regard, alcohol, tobacco and dagga use can be said to increase the risks of undesirable health conditions. Drawing on the work of Rehm et al (2003), Seedat, Van Niekerk, Jewkes, Suffla and Ratele (2009:1015) argue that South Africa has one of the highest alcohol consumptions in the world per head for all individuals who drink alcohol. In the report on World Health Statistics, the WHO (2014:290) shows that South Africa's alcohol consumption rate is at 11.0 litres per capita per year making it Africa's number one beer drinking country. It is the associated health consequences at personal and social levels that an analysis of risk factors is important in this section.

Two of the participants aged 29 years and 34 years illuminate the picture of how alcohol drinking can be a risk factor for men's health-seeking behaviours. The 29-year-old is single and works at the toll gate while the 34 year is cohabiting and is a truck assistant

at Coca-Cola Company. Their stories show that they were both under the influence of alcohol when they got injured and ended up going to the hospital. According to Seedat et al (2009), young men are caught as both victims and perpetrators of violence in South Africa and in most cases; they are under the influence of alcohol or drugs. During the interview with the 34-year-old respondent, I could see the scar on his face which prompted me to ask what had happened to him since the wound was still healing. After admitting that he is an alcoholic, Mpho had the following response about his injury:

> MM: …We sat and enjoyed the beers and we smoked dagga in the tavern. We all began to be intoxicated. I was the one buying and he (*a friend*) wanted to take the beer away with him to his place but I refused. When I refused, I don't know what he thought but he managed to pick that beer *(beer bottle*) from a distance and when I tried to approach him he brought it back onto my face and it took me about 2 minutes to fall down. Because I had lost a lot of blood I sat down and the people around asked if they should call an ambulance but I refused and I stood on my feet and went away to my place…

The picture above shows the indulgence of the participant in two substances which are highly intoxicating. His personal health was at risk and his refusal to let the bystanders call the ambulance is illustrative of his health seeking behaviours. Interestingly enough, it shows that alcohol abuse inhibits men from seeking help even when in need. My encounter with 29-year-old Piet was at the shebeen in the informal settlement. He admitted that if her partner does not find him at his RDP house, she would automatically come to the tavern. From his account, Piet is a regular beer drinker at the shebeen. The participant volunteered to show me the scars on his chest and at his back as proof of the injuries inflicted upon him when he was mugged on his way from drinking beer at a local tavern during the night:

> PS: It was at night like around 3 o'clock in the morning and I was coming from enjoying myself. They stabbed me (the muggers); they then hit me with a log on my head (*showing the scar at the back of his head*). I was having some money that day on the 25th of June 2016…

To emphasise the point that he was under the influence of alcohol when he was mugged, Piet does not remember how he ended up in hospital. Alcohol abuse clouds an individual's judgment and that is why it is associated with risk behaviours. It is, however,

important to point out that in both cases described above, the participants did not ascribe to a type of masculinity which elevates violence as they reported that they are not people who like to fight but because of alcohol abuse they ended up in risk situations as victims. It is also pertinent to mention that because of the small size of the sample, the findings on alcohol and risk behaviours for the men are not generalisable.

With regards to dagga (cannabis) smoking, there are clear discrepancies as participants reveal that it is good for their health while the WHO (2016:4) states that cannabis-use usually follows a trajectory which leads to cannabis-use disorders. Pitso who is single and stays alone in his RDP house was forceful about the efficacy of the drug arguing that dagga is a health resource that can be used for dealing with stress. It is possible that the nature of the jobs done by the working class men in this study necessitates some men to use dagga as a numbing method from some of the pain and stress associated with work. There is an acknowledgement from among all the participants that the jobs they do come with a lot of physical pain, notwithstanding the fact that some have turned that pain into physical exercise. People often turn to alcohol and drugs to escape adversity and numb the pain of negative social and economic conditions (Madu and Matla, 2002; Williams, 2003). In South Africa, alcohol misuse and in certain instances drug misuse are social determinants behind cases of homicide, domestic abuse, rape and road deaths (Seedat, 2009:1015). In other words, the use and misuse of alcohol and drugs have far reaching consequences to men's health and also to the health of the greater society. When asked about why he smokes dagga, Pitso had the following to tell:

> PM: It keeps me healthy…, people who smoke weed they don't get sick and they don't get bored easily, all of them because at the end their blood is becoming dark… That's why it keeps us healthy. Even the doctors know that… Ganja[8] is healthy, more than the pills we get at the hospital. Put it in the relish like you putting spices, in any case all those spices are herbs...you should put it straight to the pot and eat with your family, or boil some and drink only the water; I give you the guarantee of life.

[8] Slang for dagga

Although the participant perceives dagga smoking as a health resource, his use of the drug can result in addiction, cannabis-use disorders and a predisposition to fatal diseases and accidents (Gullotta, Adams and Montemayor, 1995; WHO 2016). Pitso's use of the drug has clear underlying health problems as he points out that he always has difficulties to sleep at night without smoking marijuana. His addiction to the drug makes him feel invulnerable that he loses sight of seeking any kind of health related help even from family members. Thus, Williams (2003:727) argues that the greater propensity of men to use alcohol and drugs as a coping strategy against stress is costly to them individually as well as the broader society. Reporting on what he calls ruling masculinity in South Africa, Ratele (2008) argues that it is associated with risk-taking behaviours like abusing alcohol and other substances and having multiple sexual partners. Against the backdrop of all the practices mentioned above that men engage in for the sake of their health, their perceptions of the health care system is worth exploring in order to analyse their health seeking behaviours. The next section addresses working class men's view of the health care system.

Men's perceptions of health care services

This theme addresses sub question 2 set in Chapter 1: *How do men perceive and use the health care system?* Access to health care services for working class men in this study is a class issue. From the experiences of respondents, access to health care services cannot be disconnected from institutional bottlenecks which include among many; long distance to the hospital, a shortage of doctors, consulting student doctors and the cheap quality of medicines. According to Marmot (2007:1159), in the context of low-income and middle-income countries, public money for health-care tends to be channelled to services that wealthy people use more than poor people. In South Africa, western and traditional medicines are both ascribed to by the general population (Kahn and Kelly, 2001; Campbell-Hall et al, 2010). In the same vein, working class men pick and choose different paradigms when faced with health-related conditions or for general consultations. Men in the study express mixed views about the health care systems of South Africa. Four participants had a positive perception about the services rendered at

public hospitals and clinics based on their personal experiences. A closer look at these participants shows that their perceptions were good because they experienced positive results after getting treatment for various conditions which include dental care, chlamydia and a flu bout. These are the same participants who reported engaging in preventive medical checkups as part of their health seeking behaviours. Of this group, three live in RDP houses while one is a resident of the informal settlement.

There is a clear sense that sometimes participants choose from various health care systems like the church, traditional healers, traditional medicines as well as Western medicines when it suit them. Three participants were unequivocal about their preference for traditional medicines, comparatively describing them as the best over Western medicines. To this group, two participants are added from the informal settlement who consulted traditional healers for various afflictions and for their life in general. The same participants report that they also visit public hospitals when need be. From among the pool of the participants who are pro-traditional medicines, two reported that they once got infected with *drop* (gonorrhoea) and through self-medicating in traditional herbs they got well. Besides the fact that this group consists of participants in their 30s, it is because of socialisation that they came to appreciate traditional medicines. The last distinct group of participants is the one with strong views against services rendered at public health care facilities preferring to go to private health care systems including pharmacies. The majority of this group feels that medicines from hospitals were not as effective in comparison to those offered at private health care systems. Furthermore, this group neither consults traditional healers nor subscribe to the use of traditional medicines.

Men's perceptions about western medicines

Considering that the interviews were held between September and December 2016, participants in the study showed that their visits to hospitals and private doctors were fairly recent and were concentrated between August and November 2016 with the most recent being Sipho who last visited a clinic on the 26th of November 2016. For the majority of men in this study, public medical facilities were the first port of call for health-

related help. It is interesting to observe that although men expressed some sense of invulnerability, further probing proved that they too are ordinary human beings with health needs requiring medical attention hence their visits to clinics and hospitals. Only two interviewees stated that they last visited medical facilities for help back in the 1990s. On their actual experiences of being patients in public hospitals or clinics, the majority of the participants expressed satisfaction with the services rendered.

This subtheme will also help to respond to sub question 3 set in chapter 1: *Does the healthcare system in South Africa inhibit or promote men's access to health services? Either way, in what way(s) does it promote or inhibit men's access to health services?* Although Thabiso visited the hospital for dental care, he had praise for the services he received:

> TS: As you arrive there they draw your file, and you queue for the doctor who checks you and after that, the treatment at the dentist was excellent, because when you enter there they ask you what the problem is, they ask you to show them the tooth which is aching and you confirm before they remove it. Even when they finish you don't even feel that they have removed your tooth, you just hear them saying we have finished.

Although Shimani highlighted that the distance to the hospital was too long from where he stays and that sometimes there are no doctors on Sundays, an observation that is well documented (Fassin, 2008; Sekhejane, 2013), his overall experiences with the hospital services showed that he was satisfied, the same way Steve, Jimmy and Mpho reported. To sum their sentiments, Mpho who visited the hospital because he was injured had this to say about his experiences at the local hospital:

> MM: They helped me well and they were patient with me. They treated me as a human being. They saw me when I was coming through the door and they exclaimed and said I was injured and they directed me inside the emergency ward. When I entered I sat down and they greeted me and asked what the problem was and I explained to them. They then asked me to go and wash my blood in the bathroom close by and I did then I returned and they gave me a drying towel to dry my face. They instructed me to lie down on the bed and they injected me for pain and they followed up with the needle to sew me up. They then gave me a prescription to go and collect my medication at the hospital pharmacy…

Being treated with human dignity in a public hospital shows the satisfaction of the participant, something which contradicts the observations by Sekhejane (2013) who argues that the public has lost faith in the health-care system of South Africa and its service providers, particularly in those working for the state. Expressing his satisfaction with the services he received at a local public clinic when he was sick with flue, Piet says:

> PS: It was excellent because they took my urine, phlegm; they tested me for HIV and they found that I am normal…, before they help you they are supposed to test you for everything so that they may know your health condition. You cannot just get there and say I have flue then they give you pills without testing you for other health conditions, it might end up causing some complications on you.

Although the services from the public clinic were favourably rated by Piet, it is, however, the preference of many participants to consult private doctors when financial resources permit. In this case, access to health care services by men becomes closely tied to social class dynamics. In his detailed response to why he preferred consulting private doctors and not public hospitals when not feeling well, Chris mentioned institutional barriers like the fact that queues at hospitals are long resulting in doctors rushing to meet targets without properly checking patients. He further narrated that the hospitals in most cases assigned student doctors to do the work as opposed to experienced practitioners in the private health care system (see Stuckler, et al 2011; Sekhejane, 2013). Japie (JM) voiced his displeasure at being served by a student doctor when he visited the hospital for Herpes Zoster (*lebanta*) treatment. When asked whether he was satisfied with the service, his response was:

> JM: No I was not. The student doctor was receiving instructions from his senior to write like this and that and he prescribed that I get some tablets and some ointment. The service didn't help me at all; he even wrote a letter that I return to work the following day because the pimples were not an issue. He told me that I must change my underwear and that I must bath every day before applying the ointment. That's when I realised that these people are getting paid for nothing because they don't know what they are doing. I was not satisfied at all because their medication only worked for some time and the pimples reappeared again.

From the above extract, participants do not feel comfortable to be attended by trainee doctors. In addition, there is a clear interlink between institutional barriers and societal expectations that a man ought to be strong and invulnerable. The fact that the student doctor wrote a letter for the participant to return to work thereby brushing away his condition as a non-issue is a reinforcement of societal stereotypes about the instrumentality of the male body. When medical help is not satisfactorily rendered to a patient, the result is a germination of distrust towards the whole system. During the time of the interview, the participant claimed that the condition had appeared again and that he was going to try traditional medicines for a change. For Chris, he states that he would rather visit a private doctor when ill:

> CM: …When I go to a private doctor, I know I will get best care unlike at the hospital because the hospital gets full and one or two doctors may be asked to attend 50 or 100 patients … The private doctor on the other hand is one and we are five. It's not all of us who can afford the R350 consultation with a private doctor… There may only be five or seven patients in a day, another day there may be no patients at the private doctor because we do not have the R350 so we run to the hospital but it is always full, the doctor cannot take care of you...he wants to get rid of you very fast so he can attend to another patient and so you cannot get well. That's why they give you some tablets, some panado through and through but if you go to a private doctor he takes his time to check you.

The participant's lived experience signifies that he is well suited to comment on the institutional bottlenecks he faces when visiting a public hospital. He is among the multitudes who are disillusioned with the poor state of service delivery at public hospitals which impede on access to health care by the poor and uninsured (Harris et al, 2011). With a repetitive panado prescription from the hospital as Chris alludes in the extract, it adds to his disdain of the service as he feels that his condition would not improve. The comparison between the public and the private health care systems by the participant is also revealing and this perpetuates men's negative perceptions of the public health care system. The institutional barriers, in this case, are ultimately implicated in how working class men negotiate their health seeking behaviours.

Although Mpho was satisfied with the service he received at the hospital when he was injured, he reports that he did not proceed to collect the medication from the hospital

pharmacy as prescribed because “I am not used to taking pills; I didn’t grow up taking pills. I don’t dispute the fact that those things work for many people, it's only that I don’t trust them, rather I have my own methods that I trust…” The above participant was forced to go to the hospital because of the injury he sustained at the tavern. He is one of those participants who prefer to use traditional medicines hence the mistrust in tablets from the hospital. In the same manner, Buti was frank about his attitude towards medicines from the public hospitals:

> BN: If I am not well, I take medication from the chemist or pharmacy. I get help through that... I have never gone to hospital for medical help, medications from the hospitals hai[9], I don’t trust them. I only take it for my children and my wife.

From sharing their lived experiences, it is a well-founded explanation that the majority of the men in this research study are not comfortable consulting public health institutions when not feeling well. However, their class position constraints the majority of them from consulting private health care systems and pharmacies. To further shed light on the mistrust of public health care services, Sipho indicated that he often visits these institutions because they are free of charge. His only concern is that his condition does not improve at public hospitals, the same sentiment shared previously by Japie. Describing his condition and his sentiments about public hospitals, Sipho states:

> SN: …I have a problem in my bones like they are painful and sometimes I experience an inflammation and I visit the hospital where they give me some medication, but it doesn’t improve, but when I visit the private doctor or the pharmacies the medication that they recommend is strong than the state medications from the hospitals and the pain will subside but at the hospital you can visit this month and after three weeks the pain resurfaces and you can end up visiting the hospital for a year without recovering but the pharmacies are strong as they possess quality and effective medications.

While the above can be analysed as a limitation of state-funded biomedicine, the fact that the participants argue that they get well after consulting private health care systems means there are some gaps that need further research on the efficacy of western medicine in state-run institutions. Of all the participants in the research that complained about public health care system, the bone of dissatisfaction is on the strength of the

[9] vernacular for no

medicines. In so far as access to health care services can be related to one's class position; individual agency plays a limited but significant role as well. Trust's last visit to a private doctor was in 2015 after having been pierced with a rusted nail. In responding to why he preferred consulting private doctors than state clinics and hospitals, his dissatisfaction was clear:

> TZ: …The truth is that even the service is not good to satisfy you. You see, a person can get a job but is not serious about his work as long as the time is ticking and he gets paid. That's exactly what happens with our nurses at these public clinics and hospitals. They are not so much focused with their work, they are just preoccupied with knocking off and their day is done. You can arrive at a clinic in the morning and you will stay there until in the afternoon while the nurses just ignore you like they don't see you. And if you check closely, the strength of the medication you get from public hospitals/clinics and private doctors, you will conclude that they are not the same. Since we don't pay at clinics, it looks like they give us cheap quality medicines but since we pay at the private doctors, it looks like they buy strong medications, you see. You can buy panado in liquid form at the private doctor and you get the same panado from the clinic, you will find that there is a difference. When a private doctor gives you an injection you will feel that here you are going to be okay, but at the hospitals for example when you arrive there and luck is not on your side, you can die just because of a very small thing...just because of a very small thing; you can die in a public hospital. The same way I had that problem of a rusted nail, had I gone to a public hospital that could have been the end of my life…

In a nutshell, the above sentiments reveal the mistrust men hold against the services provided at public hospitals and clinics. Due to a multiplicity of factors at play in the public health care system ranging from understaffing, staff attitudes and poor quality of medicines, some participants feel that they are hindered in seeking help from there. The private health care system offers a positive leeway to these men but affordability is evidently an impediment. Due to limited financial resources, many of the participants, however, resort to using public hospitals and clinics since they are not on medical insurance. Notwithstanding the above assessment, a number of participants that visited public hospitals and clinics reported being satisfied with the services rendered.

Complementary health systems: a man's perspective

In this research study, participants pick and choose from western, traditional and religious systems particularly for health reasons and life in general. There is a strong understanding among the participants that traditional and religious systems are equally strong in helping them negotiate their health concerns the same way western medicines do. Health is therefore perceived as holistic to include spiritual issues hence the tendency to consult traditional and religious systems where the cause of illness is perceived to be supernatural. These systems are consulted, not only when one is not physically feeling well, but even for general life concerns e.g. when one suspects that he is having bad luck. Four of the participants believe in religious systems like churches when in need of some health help. Tony reported that as an alternative to western medicines he goes to church to pray because he believes that God is the guarantor of life. Prayer for Tony is part of a health resource which sees him through his daily activities. An interesting observation is a way some of the respondents easily move back and forth between the church and traditional medicines. In the African initiated churches which include Zionist and Apostolic churches, often times prophets are believed to declare the will of the ancestors (Anderson 1999:298). In other words, the two systems operate in a symbiotic relationship to the believers.

While Chris consults a ZCC pastor for some special tea to use as enemas and for helping with bile (*nyoko*) problems, Shimani's visit to his church pastor who is Pentecostal shows that the nature of his problems are spiritual and he often receives counselling. He states:

> SM: Sometimes I go to church to my pastor, maybe I speak to him for example when I am facing a problem but I don't know how to handle that problem, he is going to speak to me nicely like a professional person who knows, like a social worker who can speak to you and make you to understand. Even if I go to him with any problem, he gives me counselling and he prays for me. After he prays for me, you will feel you are a good person now, you are coming to your senses those things that were troubling you are gone now. You are feeling well…

The above must be understood in the context of Pentecostalism which is defined by Nunez (2015:150) as proposing "the direct and personal experience of God through

receiving baptism in the Holy Spirit or being born again, which occurs subsequently to Christian conversion". Central to this paradigm is the emphasis placed on counselling which enables the client to gain light into the social cause of the health problem he is facing. Counselling in this regard becomes geared towards healing.

In his worldview, Sipho splits pain into physical and spiritual where the former requires medical doctors. The spiritual pain for Sipho requires the intervention of the church pastors:

> SN: What I do when I am not feeling well is to first check the cause of the pain, let's say somebody has hurt me with words or we have a friction with my wife in the house. In that matter, I would first visit the church and consult with the pastors and tell them my pain…

In a separate incident, Sipho reflects on how he joined the pilgrimage to Moria in Limpopo, a holy shrine for Zion Christian Church congregants after having been advised by his pastor when he was not feeling well. His report is that he was healed and that his body became well again. In consulting complementary and alternative medicines, some participants in this study choose traditional healers when faced with health problems. For instance, when Jimmy was bewitched with a *sefola*[10] on his leg during the holidays at his home in Polokwane, with the help of his mother, he consulted a traditional healer. When asked to shed more light on his experience of being bewitched and his course of action to remedy the condition, Jimmy added:

> JN: It was 2014 in January before coming back to Modimolle from the holidays at home that's when it happened. My mother took me to a traditional healer only to find out that there was some *muti*[11] that had been planted at the gate at home and after that I was fired at work.

In his study done in Bushbuckridge, South Africa Mfecane (2011) found out that, besides drinking alcohol, the consumption of traditional medicines was also associated with the construction of masculinity. In this research study, the use of traditional medicines among participants goes beyond narrow conceptions of masculinity as it illuminates on a knowledge reserve of the participants, something akin to indigenous

[10] Sepedi word for a spell cast on him through planting some medicines on his gate
[11] In this context, it is traditional medicine used for witchcraft purposes to bring misfortune

knowledge systems. Semali and Kincheloe (2011:3) argue that "[i]ndigenous knowledge reflects the dynamic way in which the residents of an area have come to understand themselves in relationship to their natural environment and how they organise that folk knowledge of flora and fauna, cultural beliefs, and history to enhance their lives". In this study, a significant number of participants have a strong knowledge reserve about the efficacy and importance of the traditional herbs for their health. This important resource is acquired through socialisation. For Mpho, Pitso and Tony, their knowledge of traditional herbs is indispensable and forms part of a rich cultural repertoire from which they draw upon, not only when they are not feeling well but for sexual strength and general bodily fitness like enema use. These participants are clear on the efficacy of traditional herbs especially for sexually related diseases and sexual performance. In emphasising the efficacy and excellence of traditional herbs, Tony expresses his admiration by stating:

> TN: The medicines from the ground *(traditional herbs*) can get you healthy. If you are drinking that medication your blood cells will be strong always. So if somebody is having HIV, it can't get in easily if you sleep with her because you are drinking that medicine…your blood cells are very strong and your blood also is very strong. Somebody who takes Western medicine will take the traditional medicines for granted, but it is the best. I don't know, but from my side my father told me that the traditional herbs are the best one, I was raised up with that medication; I was always drinking that medicine.

As part of his knowledge base, Tony holds traditional herbs in high esteem such that it has become part of his life since this has always produced desired results. Insinuated in the above quote is the tension between western medicine and traditional medicine in South Africa. In spite of the tension, the use of different medical systems by the research participants should be understood in their subjectivities. All the three participants who use traditional herbs for their health pointed out that they are not traditional healers themselves. Mpho narrates how he came to possess his knowledge of herbs:

> MM: Okay, since the time when I was growing up we would learn from others that if you mix this herb and that one, it can awaken your mojo[12] in bed if you were lacking you see. It's like if someone says he has contracted drop (gonorrhea), I already know what kinds of herbs to mix for him so that he drinks and flushes out the disease. These things are experiential knowledge that we amassed when we were growing up. I am not a doctor, but I can help.

The knowledge about traditional herbs possessed by the participant in this regard supports Mfecane's (2011) study on the use of traditional medicines as a construction of masculinities among men. Similar sentiments of the use of traditional medicines as a knowledge resource are revealed by Pitso:

> PM: … I know some herbs to recommend when somebody is ill like the mountain tea and the other one we call it *matse*[13] for drop (*gonorrhea*). It's better than the pills that you gonna get at the hospital even at the doctor, even at the most expensive doctor. It just grows on the ground, it looks like a mat.

The above quote shows the efficacy of traditional medicines from the participant's worldview. It is interesting to note that the knowledge of traditional herbs by the two participants mentioned above is closely related to sexual reproductive health. When asked how he went about to get help when he was infected with gonorrhea, Mpho was forthcoming to share his experiences:

> MM: I got help from my own self as I had to go to the mountain to get some herbs. When I came back I prepared the concoction and drank it. I had to find the right herbs and I made sure the disease will never come back again into my life. It's different from the medical care that you get from the hospital when you are sick because of drop; they give you some pills, there is a big one and you drink it so that it flushes out that dirty but it's not 100 percent effective because the drop may reappear the following year at the same date as the first appearance. The traditional herbs are effective and they stamp out the whole disease from your body.

Juxtaposing the efficacy of traditional medicines against Western medicines, the participant sums up the sentiments of his other colleagues. Traditional medicines have

[12] libido or sexual strength
[13] Traditional herb used to treat gonorrhoea

a special place among some of the men in this study the same way other participants feel strongly about western medicines.

A synoptic intersectionality analysis

The usefulness of an intersectionality approach to men's health is that it opens up the analytical space for all the factors and assesses these simultaneously. There is no single grand factor that is emphasised over the others. Through an intersectionality lens, working class men's construction of their own identity creates a perspective through which their health seeking behaviours are assessed. Griffith (2012) argues that understanding the link between masculinities and health requires a framework that is privy to the interplay of both individual agency and the social structures that shape health behaviours and health practices. In this study, most men understand their identity through the *motto* of responsible masculinity. Central to the findings of this study is that a responsible masculinity creates positive health seeking behaviours as men attend to their health through visiting the health care system when ill and for general medical check-ups. The context of medical pluralism in South Africa means that some of the men rely heavily on traditional medicines for their health needs. The masculine identity in this study shows that most men rely on the use of enemas for maintenance of their health.

Intertwining individual agency with structural conditions, an intersectionality approach in this study shows that social class which is epitomised in the living conditions like the houses participants live in as well as the working conditions create multiple layers of health disadvantages for working class men. Although race seems salient in this study, Griffith (2012:109) argues that race is an important determinant of health because it influences social class and economic position in society. In Modimolle, residence is a key marker of the interconnectedness of race and social class. Most of the participants agree that they face occupational health risks which translate to negative health outcomes. With marital status comes a responsible masculinity as those married are able to access home cooked food, a resource which is useful for their health seeking

behaviours. Poor education among participants is also implicated in the interplay of factors that shape men's health seeking behaviours as they engage in for example drinking milk as a way of combating the effects of dust particles on their lungs a clear sign of not being well informed.

Conclusion

This chapter has presented the findings and discussed them in line with the literature reviewed in chapter 2. The chapter responded to the sub-questions set in the introduction: *How does masculinity relate to men's health-seeking behaviours? What are the various health related resources men have to maintain health and respond to illness?* In this chapter, working class men enact a responsible masculinity which is captured by the word *maikarabelo* in Sepedi. The participants emphasise a responsible masculinity by establishing their own families independent of their parents. By so doing the participants become household heads thus assuming the provider role. In line with this responsible masculinity, most of the participants take preventive medical check-ups for their health. Although most of the participants shared that they rarely get sick, a closer look at their visits to hospitals or clinics shows that this sense of invulnerability was an expression to conform to societal expectations of what a man must be like. In reality, the participants reveal through their visits to health care institutions and by the use of traditional herbs that they are not invincible as men. Their regular use of enemas is enlightening as it shows their proactive agency towards their health.

Through interrogating men's perceptions of health care services, this chapter responded to the sub-question: *How do men perceive and use the health care system?* As well as to the question: *Does the healthcare system in South Africa inhibit or promote men's access to health services? Either way, in what way(s) does it promote or inhibit men's access to health care services?* Positive sentiments came out in light of the services rendered at the public health care systems like clinics and hospitals. However, there were diverse views with regards to this service as some participants showed that there were clear barriers like understaffing as well as long waiting periods at these health care institutions, something well noted in literature (Coovadia et al, 2009; Ataguba et al,

2011; Govender et al, 2011; Stuckler, 2011). The overarching barrier that came out among the majority of participants was that the medications provided in public health institutions are not as effective in comparison to that offered in private health care system. In light of the high capital investment channeled into the private health care system vis-à-vis what goes into public health, the observation made by participants of weak medications need further exploration so as to allay men's concerns. Some participants are disillusioned by the public health care system and they end up sacrificing the meagre financial resources they have to attend the private health care system. In the backdrop of the plural health care system in South Africa, the participants are able to pick and choose from the Western paradigm and the traditional as well as the religious for health and life in general. The following chapter will raise these important issues in detail as well as offer some recommendations.

Chapter 5: Conclusion and recommendations

Central findings

This research study set out to explore the factors that influence working class men's health-seeking behaviours in Modimolle, a town in the Limpopo province of South Africa. In investigating these factors, four sub-questions were set out in the following order:

I. How does masculinity relate to men's health-seeking behaviours?
II. What are the various health related resources men have to maintain health and respond to illness?
III. How do men perceive and use the health care system?
IV. Does the healthcare system in South Africa inhibit or promote men's access to health services? Either way, in what way(s) does it promote or inhibit men's access to health services?

Chapter 4 started off by mapping the structural working and living conditions of the participants. Participants reported doing menial jobs and the majority of them reported negative health consequences resulting from these kinds of jobs. The occupational health conditions participants complained of include kidney and lung problems as well as general physical pain. The jobs done included truck assistants, bricklayers, alarm systems installer, gardeners, cash-in-transit security guard, forklift driver, maintenance worker, and brick makers. There were comparatively clear disparities between participants' living conditions. Residents of RDP houses have access to electricity, piped water and better sanitation, notwithstanding the fact that the research study was carried out during national water crises due to drought. The roads in the area in which the participants lived are not paved. In the informal settlement, participants lived in shacks and had no access to clean and safe drinking water, let alone decent sanitation. The participants as heads of households dug water wells as well as constructing pit toilets on their yards. Although some of the participants made measures to treat their water for drinking, others did not see the need to do so as they felt it was safe because

they covered these wells. However, the majority of the participants in the informal settlement were aware that the water from the wells was not safe for drinking but they did not have any other means to ensure access to clean drinking water. This finding confirms the importance of social context when researching about health inequalities (Gilbert et al, 2009:220). In a study done in a developing informal settlement in Soshanguve Township in Tshwane, Gauteng Province, Ncho and Wright (2013) found out that participants' health was put at risk because of the poor living conditions. A lack of running or piped water coupled with poor access to decent sanitation is on its own a risk factor that predisposes the participants and their families in the informal settlement to unfavourable health conditions.

In light of their working class position, the participants in this study show that good health is a resource which can be traded off for the attainment of individual, familial and societal goals. This is due to the fact that, in spite of the hardships endured by the body at work, the body is disciplined to contain the pressure. In the majority of cases, participants revealed turning the pain associated with work e.g. carrying crates of cool drinks or delivering cash boxes full of coins into bodily exercises. In light of their various jobs, a strong and fit body becomes a useful and significant resource for the participants. On the other hand, ill health is subjectively experienced among the participants. When one is experiencing pain, he is in ill health. Further still, the onset of ill health is preceded by a slackening in bed and this sends a signal to the man that something is not right about his health. For some participants, feeling lazy to do the mundane and usual routines like waking up or thinking is a signal of ill health. Others understand ill health to be associated with pollution which ultimately leads to bad luck. Having established the subjective interpretations of what health mean for the participants; their own understanding of masculinities is insightful.

Most participants report going for a medical health checkup as part of a responsible masculinity. The widely held belief in literature is that men are generally poor at consulting and generally taking care of their health. Further still, in the existing literature, not enough attention is given to what men do to keep themselves healthy. In this research study, the majority of participants reported that they proactively go for general

medical checkups when they are not ill. This contradicts Letsela and Ratele's (2009) study in which men shunned away from taking preventive medical checkups. In line with displaying a responsible masculinity, some of the participants report visiting traditional healers for health reasons and for life issues in general without being motivated by a specific health condition. Interestingly, other participants use their own knowledge of traditional herbs to stay healthy. This is corroborated by Batisai (2016:119) who concludes in her study that African people, despite long contact with western medicine, still believe and have a lot of faith in traditional medicines.

In line with the above practice, the majority of participants reveal using various forms of enemas for their bodies as a way of making themselves healthy. In this context, enemas are understood to have multiple functions (Segal et al., 1979; Anderson, 1999; Gerson and Walker, 2001; Cocks and Moller, 2002). These purposes range from cleaning the blood, relieving nyoko (*bile)*, cleansing the bowels, libido boosters as well as treatment of impotence. Within their lived experiences, these men proactively use different kinds of enemas ranging from those sold in pharmacies, traditional herbs to special kinds of teas prescribed by their churches. In view of enema use, two notions of the body are distinct. The first one associates the body with a car presupposing that the body needs regular service in order to operate optimally. This notion is widely held by the majority of participants in this study. These things that men do are fundamental to how their health seeking behaviours can be understood as it adds to an array of practices they do besides visiting health care systems for their health. The other notion of the body which is held by the minority of participants is that the body does not require the use of enemas to operate but that it possesses natural abilities to regenerate itself when in need. This group does not seek health related help as they believe that the body does everything from preventing to healing naturally.

A majority of the participants reported engaging in the practice of multiple concurrent sexual relations for various reasons like strengthening their intimate relations in the family. It was clear among the majority of participants that practising multiple sexual relations was culturally accepted of men. However, the practice according to the participants created financial strains and neglect for the wife and children at home.

From the participants' accounts, some of them reported contracting sexually transmitted infections as a result of engaging in multiple sexual relations. In one reported case, having unprotected sex with a woman who had aborted nearly cost a participant's life and this is linked to the aura of the dead fetus (Niehaus, 2002; 2007). In light of the view held in this community as argued by the participants that it is societally expected of men to engage in multiple concurrent sexual relations, the risk to men's health seeking behaviours must be viewed in relation to pollution. A man causes pollution upon himself when he engages in unprotected sex with a woman who has aborted, or one in her menstrual period, one pregnant with another man's child or a widow whose husband has recently passed (Niehaus, 2007; Semenya et al, 2013). All these cases serve to illustrate the fluidity of the responsible masculinity to which the majority of participants subscribe to.

Although participants reported engaging in various exercises to keep their bodies healthy, one's occupation and marital status were some of the factors influencing whether a man could undertake the exercises. In this study, single men were not constrained to go for workouts at the gym as compared to married men whose familial obligations inhibited them from regular physical exercises. In view of the fact that some of the jobs are reportedly demanding a lot of energy, some of the participants felt constrained to engage in bodily exercises. Although there is a clear lack of training facilities in Modimolle like gyms, other participants report that they play soccer, walk, and dance or walk to work as part of making themselves healthy.

Bearing in mind the class position of the participants, there was a clear difference in food consumption between married and single men in this study. Important as food is for the health of the participants, the single men were more inclined to consuming fast foods like bread and eggs while the married and cohabiting men reported eating home cooked foods and this is significant as it was understood by the participants to be good for their health. Having a wife at home was an important factor to the health seeking behaviours of men as this facilitated the consumption of healthy food for the participants. The majority of participants reported that they drink alcohol as part of entertainment while for the smokers; it was only a habit to do so. For participants who

admitted to being alcoholics, they engaged in risk behaviours as they reported having been injured because of alcohol. Substance abuse in this research study was related to risk behaviours which had an impact on the health seeking behaviours of men as some of them neglected to seek health help when in need. Turning on to the participants' perceptions of the health care system, different views emerged.

In respect to the public health care system in South Africa, the participants reported institutional barriers as their concern for not seeking health care. It should be borne in mind that these institutional barriers are multilayered as evidenced by the participants' narratives. In contrast to the findings by Leichliter et al (2011) that men in Gauteng felt the staffing of clinics with females was a barrier to their health seeking behaviours, the participants who visited clinics and hospitals in this study did not report such as a problem. However, the problems with government clinics and hospitals according to the research participants were related to long queues, lack of a humane work ethic from the nurses and what Coovadia et al (2009) describe as under-resourcing. This according to the participants resulted in student doctors taking care of the patients, something that did not augur well with them.

There was also a general distrust of public hospitals from the participants and this is corroborated by the study done by Letsela and Ratele (2009). Interestingly, this distrust was not something abstract but was a result of what participants perceived to be the ineffectiveness of medicines offered at public health care institutions. This links in with what Mayosi et al (2012:2036) describe as "the present two-tier system of a well-resourced private sector and a poorly resourced public sector". Because of the perceived negligence at public hospitals, one participant strongly felt that going to the public hospitals when severely ill might actually lead to his death. In that respect, the majority of the participants felt that they would rather visit the private health care system including pharmacies, yet the constraint is that all of the participants did not have medical cover. In spite of their class position, some participants exercised their agency to seek health care from the private doctors because they felt that it produced effective results. For the majority of participants, their options get limited as they become pressed between a poorly resourced public health care system which they strongly distrust and

an expensive private health care system which they are not able to afford. As a parallel medical system, some participants choose to rely on traditional herbs and on religious help from churches for their health.

The nuances brought about in this research study are indicative of the fact that there are numerous factors that determine men's health-seeking behaviours. The concept of health seeking behaviours is a complex one yet enlightening to the understanding of men's health. As evidenced in this research, the concept is useful in that it does not close down but opens up the analysis to a multiplicity of practices that working class men engage in to keep healthy. By limiting one's analysis to a specific illness condition, one loses the finer details of the choices men grapple with for the sake of their health which is a holistic issue. The concept of health seeking behaviours is therefore significant for this research because it ties in with a holistic definition of health which encompasses the physical, social, psychological and spiritual dimensions of the human being. Through the concept, both the structural social factors (living and working conditions) and human agency (personal choices) are brought forth to illuminate on men's health. By presenting two different living settings of the same town, the research study was able to show how health inequities are perpetuated. The participants' view of the instrumentality of the body is worth commenting on as it is situated in the class position. Overall, the construction of a responsible masculinity by participants shows that men proactively take responsibility for their own health.

Recommendations

This research study should be regarded as exploratory. Having reviewed literature, the health seeking behaviours of men were tied to a particular health condition and this is one of the gaps noted. In this study, the health seeking behaviours of working class men were taken into consideration without any health condition and this can be used as an entry point for any health intervention program that is targeting men. In their reports, the participants reflected a deep distrust of medicines provided at government clinics and hospitals labelling them as weak compared to those offered at private health care institutions. In order to allay the fears of men in general and working class men in

particular, it would be appropriate to have a thorough follow-up research undertaken to ascertain or disprove the claims. In the end, the government must create awareness campaigns targeted at allaying the doubts of men regarding medicines offered at public health care institutions. This could have positive spin-offs as men would feel at ease to access primary health care thereby saving themselves some income that could be used for other important household issues.

In light of the strong views held by the participants against public health care institutions, the researcher recommends the adoption and implementation of the National Health Insurance (NHI) as this would drastically reduce health inequities in South Africa. This research study is invaluable as it maps a way to further studies in the future, as it can be used to explore men's health-seeking behaviours in a comparative study based on class or race.

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APPENDIX A: INTERVIEW GUIDE

Biographical Information

What is your name?

How old are you?

What is your marital status?

Which ethnical grouping do you classify yourself?

What is your highest level of education?

Are you working? What is your work?

Can you describe your work? Eg how many hours do you work? What do you actually do as part of your work?

What kind of accommodation are you staying in? If renting, how much rent do you pay?

Health related questions and issues of masculinities

What is health to you?

Do you consider yourself a healthy person?

How important is your health to you? (Probe further to establish what he does that is health related)

What is it that makes you say you are a healthy or not a healthy person?

When last did you visit a clinic, public hospital or private doctor for medical help?

Do you recall visiting a pharmacy or chemist for non-prescribed medicines? What prompted you to choose the pharmacy and not the hospital or private doctor for your condition?

Besides visiting public hospitals, private doctors, or pharmacies, is there any other source of health service you have visited?

In case of illness, how does your family support you? What kind of things do you do for the sake of your health? How often do you undertake or do those activities?

What are the main foods you eat during the day? How much do you averagely spent on groceries in a month?

What does to be a man mean to you? What are some of the characteristics that define a man in your community?

By virtue of you being a man, what are some of the things you do to keep yourself healthy because you are a man?

Do you drink alcohol? Or smoke?

What do you think about a man having multiple sexual partners? Is this common in your community? In what ways do you think that affects health?

APPENDIX B: PARTICIPANT INFORMATION SHEET



Edmond Madhuha
Private Bag X
WITS, 2050
Email: madhuhae@gmail.com
Phone number: 076 587 0088

Dear Participant,

I am a student at Wits University and for my Masters research I am conducting a study on what the health seeking behaviours of black working class men are. I am interested in understanding your experiences of this as part of my research.

Participation involves making yourself available at a time and place of your preference for an in-depth face to face interview that I expect will last approximately 45 minutes to an hour. If you are interested and available, a further one to two interviews of similar duration would be helpful to me, but only if you are available and would like to.

To make it more private, the only requirement would be that the interviews be conducted when your partner is not present (that is, if you prefer for the interview to be conducted in your home, this should be on a day and time when your partner or family members are not available). I would like, with your consent, to record the interview. This is for no other purpose but ensuring that I would be able to have your responses more accurately.

Participation is entirely voluntary. You are free to decline to participate in the study without any consequences. Participation will not be beneficial to you in any way. There will be no compensation. In the event that you feel in any way traumatised because of the interview, I will be able to refer you to a psychologist or a therapist. You can therefore refuse to answer any questions, and to end the interview and your participation at any time, without any consequences. If you choose to participate, you will be assisting me, and I really appreciate it.

I will ensure that no one will know that you participated in this research, and I will not use your real name in transcribing the interviews, or reporting the results of my research. You will therefore not be identifiable in any way. I will ensure that I send you an electronic link to my research report once it is deposited in the Wits university library and made public. I cannot guarantee that you will agree with my representation of you.

If you are willing to participate, I will be most grateful. You are welcome to contact me at the number listed above, and/or to contact my academic supervisor at the university at any time about this research: Lorena Nunez Carrasco. **Lorena.NunezCarrasco@wits.ac.za: 011 717 4427**

Yours sincerely,

Edmond Madhuha

APPENDIX C: CONSENT FORM INTERVIEW

I, _____ am willing to participate in Edmond Madhuha's research study. I understand that there will be no direct benefit for me in participating in this study and that there are not likely to be any risks involved. I understand that participation is voluntary, there will be no benefits for participation, and I am free to withdraw from the study at any time.

I have been given sufficient information about this research project. The purpose of my participation as an interviewee in this project has been explained to me and is clear.

I have been guaranteed that the researcher will not identify me by name.

I have read and understood the Participant Information Sheet, my questions about participation in this study have been answered satisfactorily, and I am aware of the risks and benefits of participating in the study.

Signed: _____ Date: _____

APPENDIX D: CONSENT FORM RECORDING

I_____hereby give the researcher Edmond Madhuha permission to tape-record the interview.

Signed: _____ Date: _____