MASCULINITY, HEALTH BELIEFS AND IMPLICATIONS FOR HEALTH POLICY AMONG MEN IN TRINIDAD AND TOBAGO

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2

Abstract

Background:
Over the last three decades, men's health has emerged as an area of research interest. The relationship between male socialization, the performance of masculinity and health behaviour has been well established. Within the Caribbean, however, there is a gap in the literature on how masculinity affects health beliefs and behaviour.

Aim:
This study explored men's accounts of "doing" masculinity and the implications for health beliefs and behaviours in order to make recommendations for developing male sensitive health services.

Methodology:
Men between the ages of 19-60 years in Trinidad and Tobago participated in this study during the period August 2011 to January 2012. Fourteen focus group discussions were conducted among men from various socio-demographic groups and twelve semi structured interviews with men involved in clinical and social programs targeting males. Data were coded thematically using inductive and deductive analysis.

Findings:
This study is a contribution to the literature on masculinity, in general, and masculinity and health in the Caribbean, in particular. Men reported three core elements for performing masculinity: being a provider, being a leader and being heterosexually promiscuous. However, these expectations could not be realized fully in their personal experiences. Men were expected to take risks and show disregard for their own health and yet perceived being healthy as essential for 'being a man'. Views about prostate cancer screening were an example of this tension: men wanted to be healthy, were positive about screening in principle but unwilling to access services.

Implications for policy/practice:
Men were willing to talk openly about their health risks, suggesting that they might be willing to access services perceived as sensitive to their needs. Health information and services must be developed and implemented with men in mind to encourage greater participation in health service delivery.

Table of Contents

Acknowledgements

Glossary

DrPH	-	Doctorate in Public Health
DRE	-	Digital Rectal Examination
EBPHP	-	Evidence Based Public Health Policy
ENHRC	-	Essential National Heath Research Council
HIV/AIDS	-	Human Immunodeficiency Virus/
		Acquired Immune Deficiency Syndrome
IEC	-	Information, Education and Communication
LMPD	-	Leadership, Management and Professional Development
LSHTM	-	London School of Hygiene and Tropical Medicine
MSM	-	Men who have Sex with Men
NGO	-	Non Governmental Organization
OPA	-	Organizational and Professional Attachment
PAHO	-	Pan American Health Organization
PhD	-	Doctor of Philosophy
PSA	-	Prostate Specific Antigen
RHA	-	Regional Health Authority
SRH	-	Sexual and Reproductive Health
UNFPA	-	United Nations Population Fund
UTT	-	University of Trinidad and Tobago
WHO	-	World Health Organization

Integrated statement

Having worked in health, in general, for over thirty years and at the management level of public health for the last twelve years, I opted for the DrPH rather than the PhD program of study. The DrPH program is structured to facilitate the development of competencies for individuals who work at the management/leadership and/or policy level in public health. The structure of the program of study was suitable to me since it facilitated the development of core skills and competencies to enhance my function in public health management. Although I have been working at the policy level, it was my view that I had insufficient background knowledge of the process for health policy development. Hence the teaching components of the program were extremely meaningful.

Taught component

The two core courses were Leadership, Management and Professional Development (LMPD) and Evidence Based Public Health Policy (EBPHP). The LMPD component of the programme focused on the theoretical underpinnings of management and how these theories could be applied in one's personal life as well as a manager. The theoretical component was delivered in formal class sessions as well as at a retreat.

This course allowed for personal reflection and evaluation of my management skills and competencies. It allowed me opportunities for introspection of my leadership styles while also facilitating personal behaviour change to enhance my management and leadership functions. The opportunities to interact with management practitioners allowed for sharing of experiences as well as gaining invaluable insights into applying principles for effective management. I particularly enjoyed the self-evaluation using the Myers-Briggs since it allowed me the opportunity to do an evaluation of my leadership style. Since I will be resuming responsibilities at the management level in the organization, the theoretical and practical components of this course have been invaluable in validating some of my actions as well as serving as a catalyst for instituting necessary changes that would redound to the benefit of the organization.

The EBPHP course was indeed an eye opener for me. The practical approach which was punctuated with opportunities to develop specific policy skills including analyzing policies

and developing a policy brief. This particular course was well-timed since I had had little exposure to understanding the rudiments of policy analysis and no experience with developing policy briefs. It also enhanced my appreciation for the importance of evidence to inform policy action. This was particularly challenging coming from an environment where, for the most part, policy development is informed by political demands rather than empirical data. These core courses were done in the first quarter and had to be successfully completed prior to proceeding on the Organizational and Professional Attachment (OPA).

I opted to do three other courses, two that would enhance my capacity as a manager and the other that enhanced my research skills. The two courses taken to enhance my management skills were Health Systems and Health Impact and Decision Analysis. These courses helped to broaden my perspective in using evidence to support health decision making. As an employee working at the policy level of the Ministry of Health, there will be times when I will be required to provide technical guidance that will inform policy decisions. Health Systems is multi-faceted as it relates to the structure and operations of systems and it reinforced the importance of considering the system as a whole rather than its parts. In an environment like Trinidad and Tobago where health management and the delivery of health services are changing this course was of definite benefit to me. Further, the other course Health Impact and Decision Analysis, helped to reinforce the principles that must be considered in decision making. While the theoretical foundation was clear, it was challenging to fully apply the statistical analyses that would inform the parameters that would be used in the equation to determine what decision should be taken for a particular initiative. Although the statistical analyses were challenging it did not take away from the benefit that I received from understanding the importance of considering the various issues prior to decision making. Undoubtedly, these courses will be invaluable in informing how I function at the policy level of the Ministry of Health, and by extension, any other Ministry.

Although I had done courses as well as used qualitative methods in research before my research project was the largest study that I have undertaken to date. As a result, I wanted to enhance my level of preparation for data collection by taking the course Qualitative Methods. The practical approach to the course delivery helped to better prepare me for my data collection and analysis.

Professional attachment

In an attempt to make this course more personal I chose to conduct a policy based study for my Organizational and Professional Attachment (OPA). I was attached to the University of Trinidad and Tobago (UTT) where I conducted a case study on the Essential National Health Research (ENHR) Council. For this project my aim was to understand how knowledge was translated into policy and to ascertain whether the current structure of the organization was suitable to do so. This attachment allowed me insights into the operations of this multi-sectoral committee while, at the same time, explore possible issues that challenged the effective uptake of knowledge into policy. While we were exposed to the theoretical challenges of knowledge translation in the lecture/discussions, the conduct of this study helped to reinforce the importance of taking these challenges into consideration.

Conclusion

I have found that overall the DrPH programme of study is an excellent model that allows access to academic courses of study as well as demanding robust academic research rigor. However, there were some observed limitations that should be reviewed as we move forward if the quality of the programme could be enhanced. In the first place, there appears to be a tacit underestimation of the DrPH as opposed to the PhD programme of study. One gets the distinct impression that since the PhD programme of study has a definite bias towards individuals who are interested in a career in academia it is given greater prominence than the DrPH programme although they both must maintain academic rigor. While they are separated by a word count, the DrPH programme also has the professional attachment component which includes the conduct of a mini study as well. In this regard, it is imperative that more consideration be given to involving a greater number of staff in the supervision of DrPH candidates so that they could develop a greater appreciation for the academic quality of this programme of study.

Secondly, consideration should be given to determining the core competencies that should be developed among DrPH candidates after successfully completing their course of study. While one may be able to clearly articulate the core competences associated with the EBPHP course, the LMPD course does not share such a position. When one considers that the candidates are being prepared to function at the policy and management levels in public

health, it is imperative that core competencies in management be clearly identified as an outcome of the programme of study. This is critical, especially for individuals who may not have gained considerable management experience prior to accessing this programme of study.

Chapter one: Introduction

1:1: Rationale for research project

As Director of the vertical unit of the Ministry of Health with responsibility for the delivery of Sexual and Reproductive Health (SRH) services I developed an interest in men's health with a view to reducing a gap that has been identified in service delivery. SRH services generally targeted women with only a few men accessing these services. A men's health forum held in collaboration with the then Ministry of Community Development and Gender Affairs and the Pan American Health Organization/World Health Organization (PAHO/WHO) in 1999 spawned the idea of developing "male sensitive" health services. Men attending this forum were of the view that although they were willing to access services, these were limited, in that, the only 'male specific' service was offered through Urology Clinics after men were ill, mainly with their prostate. They also highlighted the lack of availability of services outside the traditional working hours since it was inconvenient for men. They perceived the health services, in general, to be female oriented since staff and clients were predominantly female, as a result, they believed that this acted as a deterrent to men's willingness to access health services. It is against this background I chose to focus on masculinity and health for this thesis since it served as an excellent fit in supporting my desire to enhance the availability of "male sensitive" health services as well as generate empirical evidence to inform policy action for the expansion of these services.

Further, this thesis attempts to address an apparent gap in the literature on Caribbean masculinity. While there has been some prior research on masculinity there has been an absence of emphasis on exploring the association between masculinity and men's health beliefs and behaviors. Since I was interested in developing "male sensitive" services, using a sociological study on masculinity was most feasible since it took into account men's perspectives of what those services should look like. As far as I am aware, this is the first initiative that explores men's accounts of socialization and their health behaviour. It explores how men account for their socialization and performance of masculinity in order to shed light on how these might affect their need for or willingness to use health services. Further, it also examines service providers perspectives on "male sensitive" health services since central to this thesis is the development of policy recommendations to facilitate the implementation of such services for men.

1:2: Significance of the study

Since men, in general, perceive health services as female oriented, this may have implications for the way they view their behaviour, especially those that are risk-related, as well as health outcomes. Men in Trinidad and Tobago are similar to men in other countries in that they have a shorter life expectancy than women. The average life expectancy is 66 years for men while 72 years for women (Ministry of Health, 2011). Generally, men are more likely than women to die from serious illnesses that are lifestyle related. In Trinidad and Tobago, epidemiological data showed that men in all age groups had higher rates of diagnosis of heart disease, diabetes mellitus, malignant neoplasm and cerebrovascular accident than women (Central Statistical Office 2010). The data also showed that these diseases are the four leading causes of death among men (Central Statistical Office, 2010). Since men have higher morbidity rates than women for these chronic diseases it has implications for the social and economic cost associated with health service delivery. Some of these social costs may include a reduction in his potential to be employable which could affect his capacity to fulfill his role as economic provider.

Although a number of sociological studies have been conducted on men in the Caribbean, as far as I am aware, only one study focused on the role of socialization on masculine identity (Chevannes, 2001). In the absence of a body of literature to date on masculine socialization and health behaviour, this study will contribute to the empirical literature on masculinity, in general, and masculinity and health in the Caribbean, in particular. In so doing, it will assist in filling the gap in literature on masculinity in the Caribbean. By extension, it also has the potential to be used as a framework for further exploration of the contextual factors that influence masculinity and health from a Caribbean perspective. The qualitative methodology used for data collection focused on soliciting men's views to develop a greater understanding of their perception of masculinity and health. While previous researchers have agreed on the role of socialization on developing masculine identity, this study identified some of the core themes that are central in the process of masculine socialization in the specific context of Trinidad and Tobago and explored the ways in which performance of masculinity influenced health behaviour.

1:3: Background to study on masculinity

Connell's theory of masculinity has been identified as the most significant work that has influenced continued research in the field of men and masculinity (Wedgwood, 2009). Connell (1995), in his initial work, was of the view that masculinity and femininity are relational concepts that are opposed to each other within social boundaries. His theoretical position was that hegemonic masculinity was a way of explaining a male's superior power relations and domination over women. According to Wedgwood (2009), Connell's theory of masculinity was based on the premise that there is a symbiotic relationship between the biological and social processes that shape behavioural practice which can be refined and reproduced over time. For Connell, hegemonic masculinity was predicated on its superiority over a hierarchy of historically defined set of specific masculinities. Although the way hegemonic masculinity is represented may not be consistent across social settings, each social context may have its own definition of hegemonic domination. This may be supported by the way in which society constructs socially agreed masculine and feminine behaviours and set parameters for compliance through established norms.

While there is usually general consensus on how femininity is defined there is an absence of agreement amongst researchers on a consistent and homogenous representation of masculinity. While hegemonic masculinity is considered the "ideal" representation of masculinity, defining masculinity is complex since it could be contested and undermined (Courtenay, 2000b) as well as represented differently in social contexts (Gough, 2006, Addis and Mahalik, 2003, Courtenay 2000c). As a result, the notion of what it means to be a man, and by extension, masculinity may be fluid based on its social construction since its meanings may vary in different contexts. However, Tremblay and Pierre (2005) pointed out that men are more likely to be chained to a socially agreed masculine stereotype than women are to feminine ones. It is the conformation to established masculine stereotypes that, according to Courtenay (2011) has significant implications for men and their health.

Researchers agree that men by the very nature of the way they perform masculinity are predisposed to experience more health problems than women (Galdas et al., 2005, Mansfield et al., 2005). In this regard, Courtenay (2011) concluded that how men perform masculinity influence their health outcomes. Crawshaw (2009) in reviewing lessons from medical sociology notes that in spite of the accepted assumptions that men take greater risks than women, there is an absence of critical analysis on the way masculinity is constructed from the

individual and wider group level and its impact on men's health. Although there is a body of feminist based research undertaken to explore gender related issues including health, with an emphasis on women, it is only within the last four decades that research has been focused on men's health (Sabo, 2000). It is out of these gender-based studies that focused on women that gave birth to studies in masculinity (Doyal, 2001, Sabo, 2000). Crawshaw and Smith (2009) noted that feminist research has been successful at highlighting the problems associated with gender as a defined category which challenged how gender roles are organized. These problems, especially in relation to men and masculinity, may be associated with the social and environmental factors that contribute to men's experience and understanding of health. This is of importance in light of the belief that men are less likely to access health services than women.

At the initial stage of the development of gender based studies, the focus in general, even with the inclusion of men, was on clinical and epidemiological trends in morbidity and mortality (Sabo, 2000, Macdonald, 2006). It has been noted that more recently, researchers have shifted focus from disease pathology and epidemiology to focus on the social and contextual factors that contribute to men's health behaviours and their outcomes (Courtenay, 2011). In spite of the growing body of literature on masculinity and health; addressing issues of men's health is challenging since there is an absence of agreement on what constitutes 'men's health'. In this regard, there is a view that 'men's health' may be *"loosely referring to an array of men's health concerns"* (Sabo, 2000, p133) or an *"emphasis on only a limited number of physiological, psychological and social pathologies of males"* (Macdonald, 2006, p456).

While the socio-cultural context in which men and women function is similar, men may be disposed to greater challenges in matters related to their health. Davidson and Meadows, (2010) note that men, in general, are expected to be behave as though they are invincible while at the same time minimize the importance of individual responsibility for the maintenance of their health. Although men may be referred to as though they were a homogenous group Crawshaw and Smith (2009) postulated that many researchers have oversimplified the understanding of men and masculinity without considering *"the fact that men's lives are characterized as much by diversity as similarity"* (p264). The socio-cultural factors that influence men's experiences in performing masculinity affect men's health negatively. In this regard, Crawshaw and Smith's position could serve a critical role in

justifying the need for more research on exploring the nexus between male socialization and health behaviour to assist in unraveling the socio-cultural nuances that contribute to their health outcomes. It is against this background that this research assumes greater significance since it is an initial attempt to explore the role of socialization on men's health beliefs and behaviour.

There remains contention amongst researchers about what it means to be male since although the term hegemonic masculinity is used most commonly, it is most contested in the absence of consistency in meanings associated with the term (Wedgwood, 2009). In this regard, depending on the perspective of the researcher, the term hegemony is interpreted differently and may be specific to that context. For example, although Connell posits that hegemony is superior to other masculinities, Ragnarsson, et al,. (2010) pointed out that it could be contested, in that, individuals could adopt hyper-masculine behaviours to compensate for their subordinated position. In so doing, hegemony may not be about one representation of masculinity being superior or inferior but the ability of individuals to demonstrate power and control in given contexts. By extension, Crawshaw (2009) pointed out that a deeper analysis of hegemony suggests that hegemony may have little to do with how masculinity is represented and more to do with hegemony of class where individuals from one socio-economic group dominates the other. He argued that it is the hegemony of class that may influence men's response to health with those from the higher social class responding more positively than those who are from the lower class. As a consequence, the notion of masculinity may continue to be a debatable issue since its meaning is developed within social contexts and this may allow for fluidity in meanings depending on the perspective of the individual who is trying to make sense of the concept.

1:4: Research on masculinity in the Caribbean

Although there has been research on men's health over the past four decades (Galdas et al., 2005, Sabo, 2000) there remains a dearth of literature with emphasis on men in the Caribbean, in particular. Reddock (2009) posits that, from the Caribbean perspective, debate on masculinity emerged out of a concern for black male academic underachievement. She cites the earliest examples of this as Miller's initial paper on "The Marginalization of Black males: Insights from the Teaching Profession" (1986) which was closely followed by his book "Men at Risk" (1991). Miller based his argument on the observation that the social, academic and political achievement of women as well as their access to resources would

allow them greater social capital to the exclusion and eventual marginalization of men. In his view, the increasing enrolment of women in education contributed to the academic setting being identified as the environment in which male marginalization has been facilitated. Since then, a number of research studies on Caribbean masculinity have been carried out with some of them opposing Miller's thesis of male marginalization. Some of these Caribbean studies have focused on academic achievement (Reddock, 2009, Mohammed, 1996, Miller, 1986); marginalization (Barriteau, 2000, Beckles, 1996); sexuality and HIV/AIDS (Plummer, 2007); male socialization (Chevannes, 2001) and gender violence (Chevannes, 1999). This research study proposes to add to the growing body of Caribbean literature on masculinity. In so doing, it would address the apparent gaps in literature on masculinity and health through an examination of socio-cultural and contextual factors that contributes to the role of masculine socialization on men's health.

1:5: Structure of the thesis

This thesis is presented using three major sections. In the first section there are three chapters: introduction, literature review and methodology for the study. In chapter one, the introduction sets out the broad background that positions studies in masculinity, in general, and masculinity in the Caribbean, in particular. I also identify the rationale for my research interest as an extension of my occupational role. The introduction is followed by a review of the literature on masculinity in chapter two. The wider international as well as Caribbean literatures are included from a variety of sources encompassing social and health sciences. These covered broad areas of masculine socialization as well as male health beliefs and behaviour. Central to the literature review is a presentation of works by Caribbean authors on masculinity in the Caribbean. Literature from the Caribbean was limited, in that, it was mainly in compiled works or working papers with few authored books or journal articles. I then present the methodology used for the study as chapter three. A justification of the methodological approach used in this study is presented with support from methodological literature. Sample selection, data collection methods, data analysis as well as limitations and ethical considerations for this study are explored in this section. I also present information on participants including their socio-demographics characteristics and justification for their inclusion in the study.

In section two, I present findings from the study in four major thematic areas. In chapter four, I present the findings on *learning to be male*. Issues of male socialization and the multiple

influences contributing to the development of masculine identity are presented here. There is also an analysis of the challenges that men experience in learning to be male. In chapter five, I present findings on how men *'perform masculinity'*. Data relate to the performance of masculinity as central to masculine identity as well as the conflicts identified between what is observed as masculine performance as opposed to expected "ideal" behaviours associated with masculine performance. I argue that "ideal" masculinity is utopian and elusive and inconsistent with masculinity that is performed normally. This is followed by chapter six which focuses on *'masculinity, health beliefs and behaviours'*. An analysis of the data related to the centrality of health to "ideal" masculinity as well as the tensions men experience in living up to this masculine "ideal" is also examined. Men were aware of the importance of taking responsibility for their health but were also unwilling to make necessary changes in behaviours as this was inconsistent with masculine identity. A core example was the way they responded to prostate cancer screening. This section ends with chapter seven that focused on the fourth thematic area *'male sensitive health services'*. I explore the perspectives of men involved in male specific programme and clinical service delivery. Their perceptions of possible barriers as well as facilitators for male access to health services are explored. This chapter formed the basis for the policy and programme implications chapter of this thesis.

The third section of this thesis comprises the final two chapters: discussion and conclusion, policy and programme implications. In chapter eight, I present the major findings in this study and discuss them in light of previous literature. I was careful not to make generalizations arising out of this study but argue that the findings present, in some ways, a unique understanding of issues related to masculinity and health in Trinidad and Tobago. The final chapter, nine, focuses on the policy and programmatic implications arising from this study. Since this is a DrPH thesis, I was careful to recommend plausible options that could be implemented in the short, medium and long term. These recommendations could be implemented and evaluated with a view to formally establishing them as "male sensitive" policy initiatives and programmes that are comprehensive in nature.

Chapter two: Literature review

2:1 Gender

2:1:1: Understanding gender

An individual's sex relates to his or her biological make up while gender is a function of cultural agreement on what behaviours are expected of an individual based on his or her sex. In general, behaviours are socially ordered and dichotomized as being masculine or feminine and associated with one's biology. Ridgeway and Correll (2004) argue that automatic sex categorization is a socio-cognitive process that links gender beliefs to social contexts. Individuals are categorized as male or female as a routine activity in such a natural way that it is often taken for granted. In this regard, physical difference forms the basis for sex categorization while behavioural cues are used to categorize individuals based on gender.

While sex categorization is dichotomous, gender, as a social construct, is complex and not dichotomous. An individual can adopt a gendered identity along a continuum regardless of his or her biology. This position has been supported by Wickman (2003) in Marchbank and Letherby (2007) when she identified that there are multiple gendered identities that have been explored within social interactions, regardless of an individual's biology. Gender is intimately woven into the way in which social relations are organized between men and women, as well as, men and men. It is manifested within social interactions (West and Zimmerman, 2002, Connell, 2005). Gender is a dynamic construct and the meanings of what it is to be male or female is negotiated within social contexts. Marchbank and Letherby (2007) viewed gender as socially determined differences while Connell (2005) viewed gender as organized social relations. The social meanings attributed to male or female behaviours allow for fluidity in the way in which gendered behaviours are interpreted.

2:1:2: Theoretical constructs of gender

The socio-cultural approach to understanding gender contends that masculine and feminine behaviours are learnt within social contexts. Individuals are socialized into normative gendered behaviours. According to Marchbank and Letherby (2007), gendered behaviours are affected by social experiences and influences. Sanctions are used to facilitate conformity to expected norms of gendered behaviours. They argue that gender is not an innate quality but a set of behaviours that are learnt. In their view, gender is socially scripted, dramatic

performances of behaviours that are masculine or feminine. One's gender socialization process is facilitated through mentoring and modeling by significant others. In this regard, there are implicit rules that guide the socialization process of males and females into masculine and feminine roles. For instance, the socialization of males into masculine roles of being daring and insensitive to risks is encouraged through physically strenuous activities. In so doing, a socially reinforcing statement like "big boys don't cry" helps to desensitize males' feelings of physical and emotional pain. As males continue to internalize these messages of masculinity they are used to determine normative masculine behaviour.

An individual's gender is a significant factor in influencing his behavior within social interactions. Ridgeway and Correll (2004) in presenting a theoretical perspective on gender beliefs and social relations, argue that gender is socially institutionalized and organized relations between two dichotomous categories of individuals; male and female. They further argue that these relations are guided by widely held cultural beliefs which define distinguishing characteristics of males and females and how they are to behave. These gender beliefs serve as cultural rules that facilitate the structuring of social relationships in so far as distribution of resources, patterns of behaviour as well as gendered identity. By extension, they argue "social relational contexts" are among the core components that maintain and change the gender system" (p511). They posit further that it is within these relational contexts that cultural beliefs are manifested. This is critical since it is within these contexts that an individual defines himself in relation to others. As a result, gender is used as a significant factor in defining an individual as well as his relationship with others.

Gender also has hierarchical dimensions of unequal status, universally reinforced by institutions including the media, public policy and the family (Ridgeway and Correll, 2004). The hierarchical dimension of gender is posited on hegemonic beliefs that accept the notion that men are generally more competent than women. As a consequence, these beliefs act as the basis for defining behaviours that are socially acceptable within relational contexts. This position is also supported by West and Zimmerman (2002) who asserted that gender difference is institutionalized and normalized as a natural way of organizing life to facilitate social interaction as well as legitimizing difference within society. They also noted that women are socialized to internalize their gendered difference and accept these socially constructed superior/inferior relations as normative. Connell (2005) in supporting this

position argued that gender is structured to facilitate the hierarchical organization of social relations between men and women.

2:2 Masculinity

2:2:1: Social construction of masculinity

Lewis (2006, p2) defines masculinity as "an ideological position by which men become conscious of themselves as gendered subjects". It is not a static social construct since it is associated with acceptable behavioural norms consistent with social expectations from others as well as men themselves (Addis and Mahalik, 2003). Courtenay (2000c, p3) argue that "men and boys are not passive victims of a socially prescribed role, nor do they construct only one role. Rather, they participate actively in sustaining and reproducing a variety of male "roles" and the social structures that foster them". While the meaning of masculinity is developed in social contexts, there is no homogenous representation of how masculinity is to be portrayed (Gough, 2006, Addis and Mahalik, 2003, Courtenay, 2000c).

The culturally idealized representation of hegemonic masculinity projects men as stoic, invulnerable, reluctant to go to the doctor (Noone and Stephens, 2008), unhealthy (Gough, 2006), tough, take health risks, are dismissive of their health needs, independent, self-reliant, strong, robust (Courtenay, 2000b), unable or unwilling to express themselves emotionally, competitive, (Gough, 2006), unproblematic and ontologically stable (Crawshaw, 2007). Men may be more inclined to adhere to this representation of masculinity in an attempt to demonstrate the resilience of masculinity as a socially ordered behaviour. Men who do not adopt the hegemonic form of masculinity are considered subordinated, encompassing men in same gender relationships or marginalized to include men from ethnic minority groups as well as from lower social class (Courtenay, 2002b).

Masculinity is sometimes viewed as a performance to facilitate social acceptance from peers. Buchbinder (2010) note that masculinity, as a construct, is an illusion and, as a result of its dynamic nature, masculinity can be conferred or rescinded by other men. He further notes that within social contexts, normative masculine behaviours "may be understood as masculinity proficiently performed" (p40). As a consequence, some men, in an attempt to "pass" the requirements of socially constructed stereotypes of masculine behaviour, may make deliberate attempts to perform those behaviours overtly while, at the same time, experience internal conflicts. Courtenay (2000b, p1393)) proposed that "(M)asculinity

requires compulsive practice, because it can be contested and undermined at any moment". This has the potential for posing significant challenges in the performance of masculinity among marginalized and subordinated men. While there are different theoretical approaches used to understand masculinity, in this study I shall focus on the social construction of masculinity since meanings associated with masculinity are developed within social contexts. This approach is supported by Crawshaw, (2009) who argued that in order that researchers develop a better understanding of the nuances associated with masculinity and health, there needs to be greater sociological analysis of the social construction of masculinity at both the individual and group level.

2:2:2: Masculinity, health beliefs and perception of risks

Apart from the literature on the social construction of masculinity, a body of works that addressed masculinity and health was also explored. According to Courtenay (2002b), some men believe that they are "supposed" to be healthier and are more resilient than women notwithstanding epidemiological data which show that they suffer more serious chronic conditions than women. Men are also more likely to rate their health as being better than women in spite of taking greater health risks (Courtenay, 2003). They are more likely than women to underestimate the effects of their behaviours or the experiences of illness since they generally believe that they are invulnerable to illnesses. According to Charmaz (1995), in Courtenay (2000b, p1389) this belief serves as a psychological support for men since they perceive that "(I)llness can reduce a man's status in masculine hierarchies, shift his power relations with women, and raise his self-doubts about masculinity". It is possible that men's beliefs about health or illness will play a significant role in influencing their health seeking behaviours in different social contexts (Galdas et al., 2005, Courtenay, 2003, Courtenay et al., 2002).

The literature supports the notion that health beliefs and perception of risks were associated with constructs of masculinity. Banks (2004, p155) notes that men's beliefs about health also support their feelings of invincibility since they view accessing medical attention as "wasting the doctor's time". Davies et al (2000) also state that some men may view the health system as irrelevant to them except in dire situations where their life is threatened or that the staff may not have the requisite capacity to address their holistic needs. Gough (2006) asserts that, for some men, illness is associated with being female and that men are the stronger sex since their bodies are able to withstand negative physiological pressures. A case in point related to

the response of men to the construction of masculinity following impotence resulting from complications of prostate cancer. Oliffe (2004) in conducting a qualitative study among Anglo-Australian men with prostatectomy-induced impotence postulates that loss of sexual potency and sexual prowess challenged some men's ability to maintain their hegemonic masculinity. While some men were happy to be alive and supported by their spouses, their loss of sexual potency made them feel emasculated and powerless. Courtenay (2000b) also argues that some men are willing to ignore the risks associated with certain sexual behaviours to maintain hegemonic masculinity.

2:2:3: Masculinity, socialization and health behaviour

Since men are socialized to perform masculuinity it has implications for their health behaviour. There is a growing body of literature that shows an association between gender, socialization and health behaviour. According to Robertson and Williams (2010, p57) the social nature of "doing gender" facilitates the way men behave since social practices necessitate risk taking behaviours as normative. This exacerbates the conflicts men experience with the "don't care, should care dichotomy" (p55) with respect to their health beliefs and behaviours. While the epidemiological profile shows that men take greater health risks than women, men themselves do not perceive their negative behaviours as problems that require attention or change. In this context, Davidson and Meadows (2010, p109/110) posited that men "face a dilemma between showing that they do not care but knowing that they should care or explaining why they should care" for their health. Such a dilemma serves as a catalyst for challenging their health behaviours associated with their masculine identity.

Some researchers hypothesize that men who adopt dominant hegemonic masculinity beliefs are more likely to adopt negative health behaviours (Gough, 2006, Addis and Mahalik, 2003, Davies et al., 2000, Mahalik et al., 2007, Courtenay, 2000b, Courtenay, 2002b, Robertson and Williams, 2010). On the other hand, men who are considered marginalized are more likely to adopt positive health promoting behaviours (Courtenay, 2000b, Courtenay, 2000c). Hunt et al., (2007) longitudinal population cohort study which examined the relationship between gender role orientation and mortality from coronary heart disease sheds light on this tension. They found that men who had lower scores on "femininity" were at greater risk at being diagnosed with coronary artery disease. They noted further that in circumstances where men had 'high masculinity' and 'low femininity' scores they were more likely to adopt negative health behaviours. Men who adhered to dominant notions of masculinity were more

likely to adopt health risk behaviours. They concluded that the way men construct gender within social contexts has important implications for their health behaviour.

Men's health behaviour is generally associated with their understanding of what is normative masculine behaviour (Courtenay et al., 2002, Addis and Mahalik, 2003). In order to satisfy the social expectations associated with the hegemonic construct of masculinity they are more likely to view maintaining health as secondary to the need for social acceptance from their group. Williams (2010) notes that notions of masculinity can serve as a help or hindrance in the way men behave in relation to their health. By extension, Courtenay (2003) posits that some men are unlikely to consider making changes in their lifestyle behaviours even if such a change may redound to their best health interest. As a result, men are more likely to be dismissive of their health concerns by ignoring their physiological symptoms and experiences (Galdas et al., 2005, Courtenay, 2000b, Courtenay, 2002b, Underwood et al., 2009). While it is believed that marginalized men participate in health promoting behaviours, there remains one area of debate whether they are more likely to adopt positive health promoting behaviours than those who adopt hegemonic masculinity (Courtenay, 2000b, Courtenay, 2000c).

McCarthy and Holliday (2004) in reviewing male sensitive literature on counseling men from the perspective of multicultural competencies further highlights the tensions between masculinity and health seeking. They examined literature that focused on hegemonic masculinity and how it affected men's help seeking behaviour in relation to counseling. They conclude that the literature is dominated by European American men who were from the middle to upper middle class socioeconomic background and heterosexual. The literature failed to consider the multiple cultures within which men function and as a result, is limited to men who "adopt dominant norms and traditional ideologies of masculinity" (p26). They identified five factors that influence men's help seeking behaviour. These include men's mind-set in relation to counseling, adherence to the traditional male gender role, masculine role conflict, undiagnosed rates of psychological problem, for example, depression, and age.

2:2:5: Masculinity, a Caribbean perspective

In general, the concept of masculinity in the Caribbean may be similar to other societies however, there may be some unique characteristics of masculinity in the Caribbean which is facilitated by socialization. Lewis (2003) notes that masculinity, as a subject, has had limited

focus by social scientists in the Caribbean region since gender issues have been synonymous with women's issues. He contends that, in the Caribbean, hegemonic masculinity is predominant and provided with the higher social acceptability which contributes to the high level of homophobia experienced by men viewed as subordinated. It could be argued that the small population sizes of the Caribbean islands places psychological pressure on men to conform to the hegemonic construct of masculinity since they all function in a limited social environment. Lewis (2004, p262) also argues that masculinity

> "is not merely about how men relate to women, but about how men relate to other men, how they seek approval, honor and respect of other men, and how they weigh and ponder the sanctions of other men".

Within the Caribbean, masculinity is viewed as a plural concept since it can be represented differently within socio-cultural contexts (Beckles, 2004). Other Caribbean social scientists agree with this view by arguing that masculinity is a multilayered phenomenon (Lewis, 2003), practiced differently by different men (Lewis, 2006), is rarely static or unchanging (Parker, 2003) and not a homogenous construct (Lewis, 2004). According to Lewis (2003) the heterogeneous construct of Caribbean masculinity is a source of ideological contention since masculinity is viewed as a privileged ideology over femininity. Beckles (2004) argues that not all men espouse hegemonic masculinity hence this ideological position is contested across ethnic, cultural and social classes. Lewis (2003, p122) also notes that the "multilayered phenomenon" of Caribbean masculinity transcends socio-cultural boundaries. While this "multilayered phenomenon" may be explained from a theoretical perspective, in real life experiences it presents challenges for men in the Caribbean since hegemonic masculinity is considered the culturally 'ideal' representation of masculinity.

Caribbean masculinity is associated with slavery and colonization (Beckles, 1996, Lewis, 2003, Lewis, 2004). Lewis (2003, p.103) argues that the "European male domination of the social relations within Caribbean society laid the foundation for institutionalization of gender inequality in the region" thus allowing the privileging of masculinity. He further propositioned that the institutionalization of patriarchy not only allows for the domination of women but the domination of men who are considered as representing subordinated masculinities. In this regard, there is little acceptance for any representation of masculinity that is inconsistent with ideal' masculine behaviour. Beckles (1996, p3) contends that Caribbean masculinity developed consistent with "(P)olitical authority, economic power, and

domestic dominance held together the values of white elite masculinity that was culturally familiar to black men". He also argues that Caribbean men "were relegated and negated to otherness"; however they understood that "(T)he possession of power, profits, glory and pleasure was specified as a core element in the articulation of masculine ideologies" (p3).

According to Lewis (2003, p107) there are some unique characteristics of Caribbean males including being "powerful, exceeding promiscuous, derelict in his parental duties, often absent from the household and, if present, unwilling to undertake his share of domestic responsibilities, ... possessing a propensity for female battering and a demonstrated valorization of alcohol consumption". They are also expected to provide physical protection for their families, be fearless, be the breadwinner of the family as well as sexually virile and competent (Lewis, 2006). 'Trinbagonian' calypsonians also encourage men who are not as sexually virile or do not have the economic wherewithal ascribed to the hegemonic form of masculinity to avail themselves of aphrodisiacs to ensure optimal sexual functioning with their female partners (Lewis, 2006). Lewis (2003, p95) also observes that "(F)ew acts are more threatening to men than a public interrogation or ridicule of their masculinity by a woman". Since the capacity to be sexually virile, for the most part defines Caribbean masculinity, this observation finds resonance in this context.

Nevertheless, there are tensions between masculinity as a construct as opposed to experienced. Barriteau (2000, p24) highlights this tension by stating that "(M)anhood is clearly defined but increasingly difficult to achieve and comprised almost exclusively on three elements sexuality/sexual identity, man's primary role as economic provider and scriptural authority for man as family head". The perpetuation of negative stereotypes about Caribbean men as being sexually irresponsible may be more perception than reality. Chevannes (2001), in his study on male socialization in five Caribbean communities found that Caribbean males are assuming greater responsibility in nurturing their children as well as their commitment to their families. This suggests that Caribbean men may be more proactive in redefining masculine identity based on performance than is admitted. However, men may find it difficult to break these commonly held negative characterizations in the absence of a supportive environment that challenges these stereotypes as normative.

Although from a theoretical perspective, masculinity in the Caribbean has been identified as a plural concept, in reality it has been described as almost 'fixed'. The almost 'fixed' notion of

masculinity contributes to the negative response to subordinated forms of masculinity throughout the Caribbean. While some islands including Trinidad and Tobago as well as Barbados have been identified as less homophobic than islands like Jamaica and St. Lucia as well as Guyana (Lewis, 2003, Lewis, 2006) cultural art forms have been used to express homophobic sanctions against individuals who adopt subordinated masculinity. This includes overt calls among Jamaican reggae artists to coalesce and express the wrath of men from the hegemonic masculine community to physically destroy and annihilate homosexuals (Lewis, 2003).

2:2:6: Conclusion

The way in which masculinity is socially constructed may influence men's beliefs about health and illness which act as facilitators for negative health behaviours. While there may be multiple representations of masculinity, within the Caribbean, one particular hegemonic construct of masculinity is widely accepted as 'ideal'. While there have been studies on masculinity among Caribbean men that focused on sexual expressions previously (Plummer, 2007) this study examines how men construct masculinity in all aspects of their daily life and how this construction influences their health beliefs. One of the implications of the literature to date is that health is often not considered as a priority issue among Caribbean men. Since masculinity is based on performance and not biological imperatives, this has implications for the way men perform masculinity and its contribution to their health beliefs and behaviours. This study proposes to build on the existing literature on masculinity in the Caribbean by addressing areas of uncertainty including the influence of male socialization on masculine health beliefs and behaviour.

Chapter three: Methodology

3:1 Study overview

There is a dearth of literature in the Caribbean that addresses the relationship between socialization, health beliefs and behaviour. This study addresses the gap identified in academic work on Caribbean masculinity by focusing on men's accounts of being men and its impact on their health beliefs and behaviours. It explores the extent to which risk taking was viewed as normative behaviour which arises from male socialization. A qualitative design was used to generate men's accounts of their socialization through their personal stories which allowed the researcher to analyze underlying assumptions about normative masculine behaviour. Findings will provide an understanding of the underlying assumptions that arise from the literature on male socialization and health behaviour. Further, they propose to reduce the gap in Caribbean literature on masculinity since little emphasis has been directed previously at understanding how masculinity is constructed and its impact on men's health beliefs and behaviour.

While program managers and policy makers in the Caribbean have been expressing concern for the way in which men relate to their health, a number of initiatives have been implemented to resolve some of those concerns. Examples of such programs are the 'Defining Masculine Excellence' in Trinidad and Tobago and 'Fathers Incorporated' in Jamaica. These programs promote responsible fatherhood and manhood through effective mentoring and support. However, the potential impact of these programmes on how men perform masculinity is still to be tested empirically. This study is not an evaluation of these programs but it focuses on exploring men's accounts of masculine socialization and how it influences their health beliefs and behaviour. Data from this study is not expected to generate a set of prescriptive programmes targeting men but rather serve as a platform that will facilitate a 'male sensitive' approach to health service delivery. While this study is not multi-island in scope, it is envisaged that the findings could serve as a catalyst for its replication in other Caribbean islands. The Caribbean islands, while separated geographically with different languages, share a common history and lifestyle. The interisland travels and shared familial linkages of citizens reinforce the cultural similarities shared among Caribbean citizens.

3:2: Setting

Trinidad and Tobago are the most southerly islands of the Caribbean. It has a population of approximately 1,300,000 persons with diverse ethic representation. The dominant ethnic groups are East Indians and Africans accounting for approximately 34.4 and 32.2 percent respectively (Ministry of Planning and the Economy, Trinidad and Tobago, 2012). The other dominant ethnic groups include Chinese, Caucasians and persons of mixed races. There are two cities, one in north and the other is in the south with the capital city being Port of Spain. Figure 1 show that the country is divided into ten counties; nine in Trinidad and the other is Tobago. The county of St George is the most densely populated and accounts for approximately one third of the island's population.

Figure 1: Map of Trinidad and Tobago
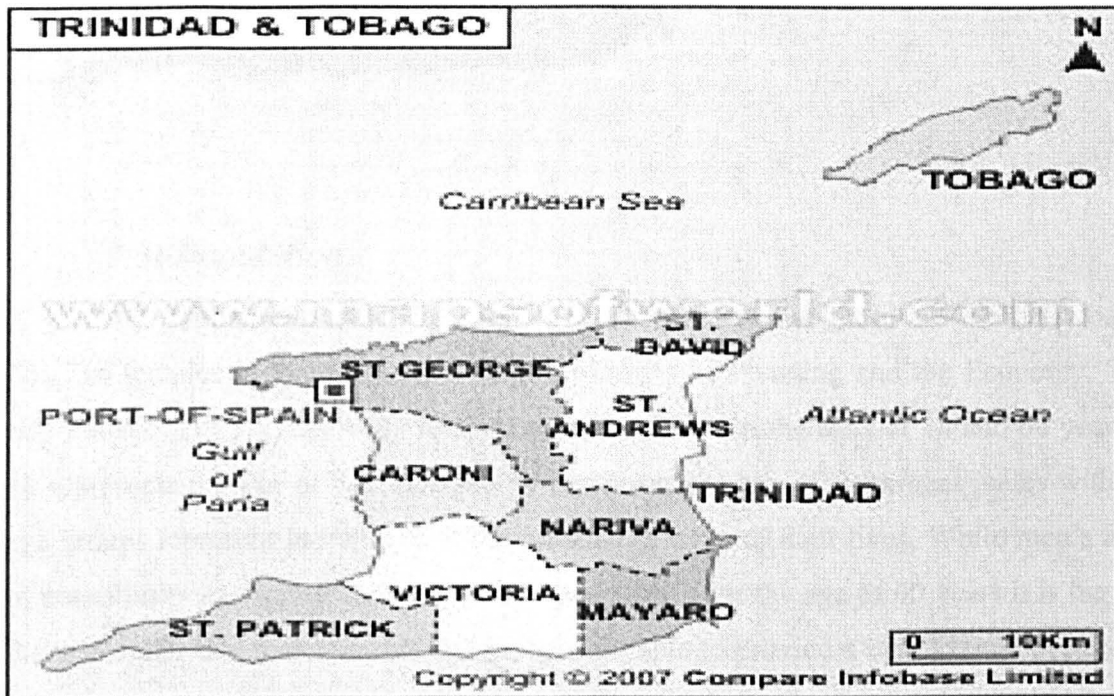
On the other hand, counties Nariva/Mayaro and St. Andrew/St. David are the largest geographical areas but most rural and sparsely populated. The Ministry of Health, through the Regional Health Authority Act 29:05 Act of 1994, delegated authority to the Regional Health Authorities (RHAs) for the delivery of health services (Ministry of Legal Affairs, 2010). However, the Ministry of Health maintained its core functions as policy, financing, monitoring and evaluation. There are five RHAs; four in Trinidad with Tobago accounting for the fifth. Figure 2 shows the five RHAs.

Figure 2: Map showing Regional Health Authorities
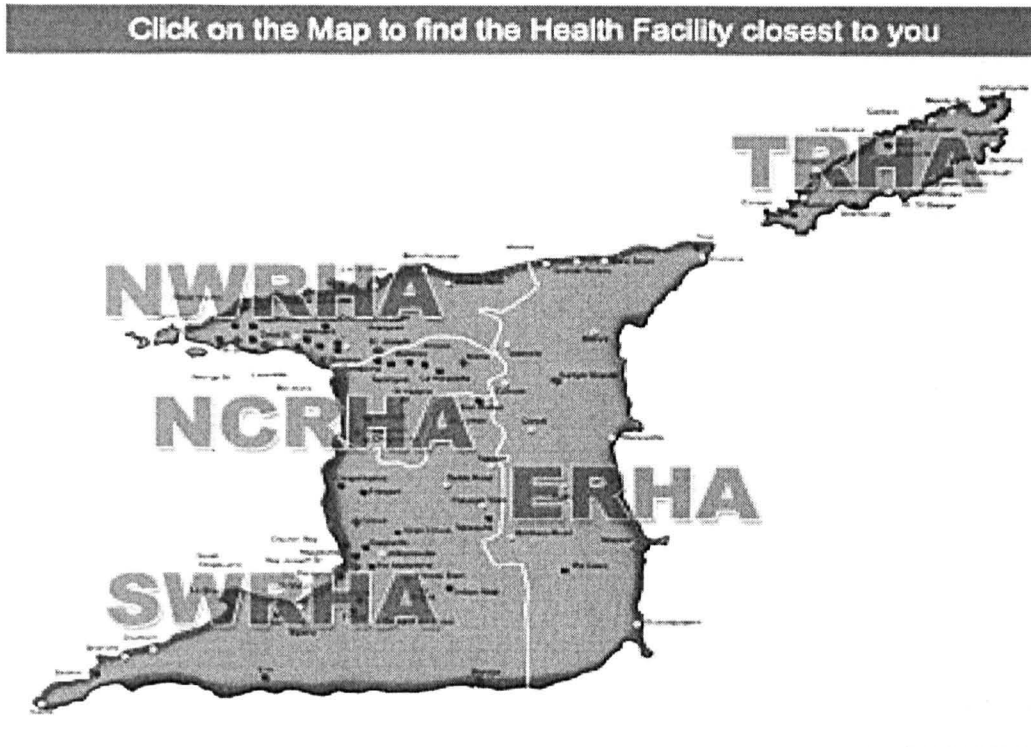
3:3: Population

A recently published population census report revealed that there are 666,305 males and 661,714 females in Trinidad and Tobago (Ministry of Planning and the Economy, Trinidad and Tobago, 2012). This study focused on males between the ages of 18 and 60 years. Since 18 represents the age of majority and 60 represents the age of retirement males within these age groups represent individuals at the productive stage of their lives. While men's accounts of masculinity exist prior to the age of 18 years and after the age of 60 years it is the view of the researcher that males in this age range were able to provide a broad range of accounts of masculinity to adequately answer the research questions. Further, males under the age of eighteen were not considered feasible to include due to ethical challenges including seeking parental consent for their participation.

3:4 Research questions

The following research questions were explored in this study

1. How are males in Trinidad and Tobago socialized to be men?
2. How do men in Trinidad and Tobago "do gender"?
3. How does male socialization affect men's health beliefs?

4. How does men's belief about masculinity contribute to their health behaviour?

5. What are service providers' views of "male sensitive" health services?

3:5 Study aim and objectives

3:5:1: Aim

This study explored the accounts of men between the ages of 18 years to 60 years in Trinidad and Tobago of how they "do" masculinity, its implications for health beliefs and behaviours to contribute to the development of "male sensitive" health policy initiatives.

3:5:2: Specific objectives

The specific objectives of this study were to:

a. Analyze men's accounts of masculine socialization;

b. Examine the socio-cultural factors contributing to the representation of being a man in the Trinidad and Tobago;

c. Analyze how mens' accounts of masculinity affect their health beliefs;

d. Explore the extent to which men's health beliefs influence their health risk behaviours;

e. Explore the potential barriers/challenges that contribute to men's response to current health services;

f. Identify service providers' perspective of the characteristics of a "male sensitive" health service;

g. Recommend policy action for the development of a "male sensitive" health services.

3:6 Study design and rationale

A qualitative design using mixed methods; Focus Group Discussions and Semi Structured Key Informant Interviews with service providers was selected as the most suitable design for exploring the research questions. The use of mixed methods for data collection facilitates the analysis of data on masculinity from the perspective of participants in the study as well as my interpretation of the meanings associated with their perspectives. Since this research focused on soliciting men accounts of masculinity, a qualitative rather than quantitative design was used. Green and Thorogood (2004, p21) in justifying the rationale for qualitative studies noted that it "emphasizes the processes underpinning social activity through detailed descriptions of the participants behaviours, beliefs and the social contexts within which they occur". This design facilitated the collection of data among men within various social settings

using personal accounts as well as shared experiences. It also allowed for an in-depth examination of naturally occurring phenomena within social contexts. Men were drawn from a range of social settings to ensure diversity in ethnicity, socioeconomic status as well as rural and urban representation.

Consideration was given to ensuring that the physical environment allowed for the maintenance of confidentiality and openness with minimal distractions. Further, I ensured that the physical space where the discussions were conducted was familiar to the participants by allowing the 'gate keeper' of the organization to determine the venue for data collection. While the groups were diverse, men were placed into homogenous groups to minimize possible conflicts as well as encourage a greater level of openness in sharing their personal accounts of 'doing' masculinity. Myers (2000, p6) argued for the usefulness of qualitative methods in research similar to this since it provides the researcher with "the ability to seek answers to how persons or groups make sense of their experiences" rather than the ability to make generalizations about observed phenomenon. This is a virgin research project which solicited men's views to generate thick descriptions to unearth their tacit understanding of how masculine socialization influenced health beliefs and behaviour.

According to Green and Thorogood (2004), qualitative research does not place the highest premium on the ability to generalize findings but rather to develop detailed understanding in order to answer questions about the what, why and how of an observed phenomenon. According to the literature, masculinity, as a construct, is diverse and dynamic; hence the intent of the researcher was to elicit men's emic perspectives, as well as, their personal experiences in "doing" masculinity. This study went beyond merely reporting masculine behaviour but explored men's accounts and interpretation of being a Caribbean male, in general, and a Trinidad and Tobago male, in particular, as well as the impact of those accounts on their health beliefs and behaviour to answer the research questions.

Green and Thorogood (2004) indicated further that it is important to clearly articulate concepts and assumptions made based on each concept that is being studied. Concepts are abstract terms used to frame an understanding of the issue, in this case masculinity, while assumptions are implicit beliefs associated with the concepts. The inductive approach used in this study allowed the researcher to analyze the data based on the context in which data are

collected rather than a predetermined theoretical construct. Table 1 summarizes the components of the concepts as well as the assumptions for this study.

Table 1 - Summary of the components and assumptions of the concept masculinity.

Components	Assumptions
Construction of masculinity	Males construct masculinity in social contexts
	Hegemonic masculinity is the dominant and preferred construct among males and females
Masculine socialization	Males are socialized into masculine roles as opposite to females
	Socialization encourages the use of psychological pressure to ensure conformity
	There is a vocabulary to define masculinity
Performance of masculinity	Males perform masculinity to gain social acceptance
	The performance of masculinity may not be consistent with masculine identity
Health beliefs and behaviour	Health beliefs are associated with one's construction of masculinity
	Males do not prioritize health as an issue central to their well-being
	Perception of health risk are associated with normative behaviour
Male services	Males will be willing to access services that are sensitive to their needs
	Staff will be willing to provide 'male sensitive' services

3:7 Data collection

Two sources of data were used in this study: Focus Group Discussions and Semi Structured Interviews. The main source of data using the focus group discussions was collected from men associated with male dominated social groups or professional organizations. Fourteen Focus Group Discussions were conducted with a total of seventy five men between the ages of 19-60 years during the period August 2011 to January 2012. A total of twelve Semi Structured Interviews were conducted among men at the policy and leadership level of programs targeting males between the period November 2011 to January 2012.

3:7:1: Focus Group Discussions

In this study, Focus Group Discussions were used to answer research questions related to male socialization, their health beliefs as well as how masculinity is performed. The first three empirical findings chapters will report on the accounts of men who participated in the Focus Group Discussions. This method was useful since the detailed, thick descriptions generated by their stories were critical to the objectives of this study. I was interested in understanding their normative accounts and the socio-cultural context in which men are socialized to "do" masculinity. This methodology allowed me to bring together diverse groups of men while, at the same time, maintain homogeneity within each group. While these Focus Group Discussions were conducted in various geographical areas in Trinidad and Tobago consideration was given to ensuring that each group was as natural possible. Men within each group were encouraged to be respectful to each other to facilitate the sharing of views and perspectives that were typical as well as divergent. A summary of these groups is presented in Table 2.

Table 2 – Source and demographic characteristics of participants in Focus Group Discussions

Source	No. of participants	Age range (years)	Av. age (years)
Masculinity project	6	28 - 58	47
Police	4	32 – 52	44
Prisons	5	22 – 36	30
Rural area NGO	4	34 – 51	44
Humanitarian NGO	5	24 – 52	29
Community leaders	4	52 – 60	56
Religious leaders (Christian)	6	24 – 52	39
Religious leaders (Hindu)	4	19 – 60	42
Trade Union	4	45 – 58	51
Industrial sector	6	25 – 48	32
Sports leaders	4	20 – 26	23
Footballers	6	19 – 36	24
Sportsmen	9	20 – 42	30
Fishermen	6	30 – 56	42
	75	19 – 60	38

Focus Group Discussions are effective in soliciting a broad range of views among a population on a topic of interest. While it was initially used as an effective strategy in data collection for market research, there is growing interest in utilizing this strategy for data collection in public health research (Green and Thorogood, 2009). This strategy allowed me

to facilitate a small group of 4-9 participants to discuss issues consistent with the research questions using a topic guide. They are advantageous in exploring sensitive issues and examples include Honduran women attitudes and beliefs about their daughter's sexuality (Giordano et al., 2009) and young drivers' decision to drink and drive (Basch et al., 1989). As a result, researchers are more likely to uncover views that are typical of individuals within these groups. However, Robinson (1999) in exploring the use of Focus Group Discussions indicated that depending on the nature of the issue that is being researched some participants may present a normative rather than an individual perspective on the issue. Nevertheless, she concluded that it can "add depth, clarity and a greater understanding of the social context" (p912) of the issue being studied. Since this is an initial research project in Trinidad and Tobago, this data collection method was useful in generating accounts to unpack men's normative views to answer the research questions on masculine socialization, health beliefs and behaviour.

Kitzinger (1994) justified the value of Focus Group Discussions by indicating that they allow the researcher to tap into other dimensions of understanding an issue that conventional interviews will not facilitate. She further noted that they also allow the researcher the ability to listen and observe the richness of interactions between participants as they use language and behaviours in exploring constructs that are prioritized by them. The richness of this exchange between participants could be enhanced, as suggested by Kitzinger (1994, p113), since "diversity within a group ensures that people are forced to explain the reasoning behind their thinking". As a result, I allowed sufficient exchanges between participants since their perspectives on masculinity were central to gaining an understanding of men's typical and atypical accounts in an attempt to answer the research questions.

Each Focus Group Discussion lasted between forty five and ninety minutes using a topic guide. They were digitally recorded after permission was sought from respondents. A sample of the topic guide is presented in Appendix 1. Fourteen was the maximum number of Focus Group Discussions conducted since I was able to reach the point of saturation where no new information was generated. I planned for the possibility that some participants may have been uncomfortable during the Focus Group Discussions; however, there was no observed or expressed discomfort among participants during the discussions. They were also allowed to engage each other in clarifying positions in situations where non-normative positions emerged. This open exchange among participants allowed them to be more reflective and

open in articulating their personal accounts of masculinity even when they were not normative.

3:7:2: Key Informants: Semi Structured Interviews

Semi Structured Interviews were used to solicit a different data set to answer the research question *'what are service providers' views of 'male sensitive' health services?'* The final empirical findings chapter will reflect the perspectives of men who participated in the Semi Structured Interviews. Men who are responsible for the implementation of male specific clinical or social programs or considered influential in the life experiences of men were selected as key informants. Based on their experience at the programmatic and policy levels of male service delivery they were identified as most suitable for providing information that would contribute to the development of practical policy recommendations consistent with the objectives of this study. These men would have had the opportunity to develop considerable experience in interfacing with men from different socio-demographic backgrounds. Based on their experience, it made it easier to discuss the implications for the development of 'male sensitive' health services through policy actions based on their experience at the program and policy levels. Informants also provided information on barriers as well as strategies for the development of 'male sensitive' health services. These males were selected for inclusion in this study since they were able to present service providers' perspectives of the characteristics of 'male sensitive' health services. This data collection method supported me in exploring broader policy implications as well as recommendations for 'male sensitive' health services. A summary of these informants in presented in Table 3.

Table 3 – Sector and occupation of Informants in Semi Structured Interviews

Sector	Occupation
Health	Doctor
Health	Policy Development Specialist
Health	Clinical Nurse
Health	Community Nurse
National NGO (youth)	Youth Officer
Tertiary education	Lecturer
Regional NGO (male)	Secretary
National NGO (male)	Chairman
Community based project	Program Manager
National Program	Program Director
Military	Medic
Industrial	Supervisor

During these Semi Structured Interviews I was not interested in soliciting informants' accounts of how men "do" masculinity but in exploring their perspectives on the characteristics of a 'male sensitive' health service. This was to achieve one of the objectives of this research which was to identify service providers' perspectives of a 'male sensitive' health service. A total of twelve semi-structured interviews were conducted with these program managers and leaders who were chosen using purposive sampling to cover a range of settings where male specific health and social services are provided.

The use of Semi Structured Interviews has been very effective in qualitative studies since it allows the researcher to explore deeply into social and personal experiences of interviewees (DiCicco-Bloom and Crabtree, 2006). In so doing, key informants are recruited to assist the researcher in exploring research to uncover shared meanings related to sensitive issues unlike the Focus Group Discussion which generates a broad range of ideas on an issue. An example of the use of Semi Structured Interviews in qualitative enquiry is Bourne and Robson's (2009) study which explored the lived experience of having 'safe sex' among individuals who are sexually active. They indicated that this methodology was useful in allowing them to explore how participants' make sense of the topic 'safe sex' since, from a conceptual level, discourses were ambiguous. Similarly, there is no consensus on what constitutes "male sensitive" health services. In this regard, males who functioned at the leadership level of male specific services and program delivery were selected since their perspectives were critical in assisting me to explore the notion of "male sensitive" health services to inform policy recommendations arising from this study.

Semi Structured Interviews do not focus on a pre-determined set of answers to questions but provide opportunities for the researcher to listen to the respondent's perspective on particular questions. They allow flexibility in exploring information provided by respondents' through asking for clarification or additional information that may be considered necessary. Since the questions were semi-structured it allowed me the opportunity to gain more information in exploring "male sensitive" health services. During the conduct of these interviews I was able to focus on the responses from respondents to further probe their perspectives on the phenomenon of interest. A sample of the Semi Structured Interview guide is presented in Appendix 2.

3:8 Sampling

3:8:1: Sampling methodology

Given that I was interested in unearthing men's perspectives on masculinity, I chose to include men who were familiar with each other from naturally occurring settings. In my view, having men who knew each other would have enhanced the level of transparency and openness with their accounts. To facilitate this process, discussions were initiated with a number of organizations involved in the execution of social programs targeting males or in agencies that were male dominated for selection of males to participate in the Focus Group Discussions. Agencies were selected purposively including professional organizations, Non-Governmental Organizations (NGO), trade unions, religious organizations and employers in male dominated sectors. These agencies have been in existence for a considerable period of time and are located in various geographical areas including urban, semi-urban and rural. They also included men along the chronological continuum as well as socio-economic status. Since they were naturally occurring groups, I considered it as a pragmatic way to include men from different socio-demographic characteristics.

Agencies were formally written to and 'gatekeepers' were provided with the selection criteria which included being male and between the age 18 and 60 years to recruit four to six respondents for inclusion in the Focus Group Discussion. . A sample of the letter sent to agencies in included in Appendix 3. The date, venue and time for each Focus Group Discussion were selected by the agency after consultation with me. I was particularly interested in the perspectives of respondents who did not adhere to hetero-normative behaviour since this added to the data analysis and interpretation of findings.

To facilitate homogeneity within groups, recruitment was done from among groups as the unit of sampling rather than the individual male. These groups facilitated the inclusion of men representing a broad range of socio-demographic groups with a view to unearthing the broadest range of perspectives critical to answering the research questions. Sportsmen were included since they represented the younger population of men who may still be in the process of developing their masculine identity. Professional organizations, for example, Police, Prisons and the masculinity project included men whose ages were along the chronological continuum as well as different levels of academic achievement and professional status in organizations. Men from the Trade Union and industrial sectors

represented men from male dominated occupational sectors whose performance of masculinity may be different from men in non-male dominated sectors. Fishermen were representative of men who had limited education and a more 'grassroots' interpretation of masculinity. Community leaders included more mature men who would have used their past experience in providing mentoring to younger men in the community. Since some religious groups are closely aligned to specific ethnic communities I included Christian men who were predominantly Africans, as well as, Hindu men who were predominantly East Indians. Attempts to include men from the Muslim community were unsuccessful arising from logistical challenges experienced by the religious leader. Religious leaders represented the dominant ethnic groups in Trinidad and Tobago and individuals who are influential in shaping masculine discourse.

Apart from ethnic representation, these religious groups included men from divergent socioeconomic backgrounds as well. However, smaller ethnic groups may not have been represented in the sample and as a result it may be difficult to make inferences related to men from less dominant ethnic groups in the island.

Selecting men who have accessed previous programs on masculinity could have resulted in respondents showing a high level of interest and support for this research. Nevertheless, there was a potential that since they had been involved in a program targeting men and masculinity that it could have affected their level of personal reflection as participants. To ensure that the researcher solicited more typical accounts of masculinity only one Focus Group Discussion was held with men who had accessed the 'Defining Masculine Excellence' program previously. Some of the participants may have had interactions with me in my substantive role as a public servant. This could have had the potential for providing responses, which, in their view, were appropriate for me to hear. I believed that including a cross section of males as well as having 'gatekeepers' select participants facilitated the generation of more typical views to satisfy the objectives of this research.

Representativeness for the purpose of making generalizations was not the major consideration for this study however, special attention was placed on generating views among men from different sectors of society. Emphasis was given to exploring how men account for the way masculinity is constructed and portrayed that provided an understanding of the socio-cultural and contextual factors that support their health beliefs and behaviours. While each

focus group was diverse, in that, they included participants representing different age groups or levels of hierarchy within organizations, they were homogenous, in that, participants knew each other. This diversity was also evident amongst participants from the NGO sector but the level of interaction observed during data collection may have been enhanced by the level of familiarity that they had with each other. On the other hand, since participants were familiar with each other, it is possible that this could have also affected the level of openness especially with atypical perspectives since they may have been more concerned about presenting typical views to avoid sanctions. It is also possible that this level of openness may have been stymied if, for example, men who were heterosexual as well as MSM were included in the same Focus Group Discussion since they may have been more focused on providing hetero-normative responses.

In general, some of the limitations associated with Focus Group Discussions include its limitation in exploring sensitive issues since it may be difficult for some participants to share sensitive information and this may be of particular concern as it relates to men and this could have implications for the quality of data gathered. By extension, there is the potential that in the case of having dominant individuals as participants, this could influence the level of openness of other participants in presenting their perspectives, especially if they are atypical. As a result, there is a possibility that the perspectives of participants could be a reflection of what the others, including the researcher, wants to hear which may be different if they were situated in their real environment. However, these limitations were not evident among participants in the Focus Group Discussions and this may have been influenced by their familiarity with each other since they were either colleagues who worked together or were involved in organizations together and would have built up a certain level of camaraderie with each other.

3:8:2: Sampling and recruitment

Participants in this study were not statistically representative of the population but represented a range of men from social settings or backgrounds. Men were drawn from a range of social settings to ensure diversity in ethnicity, socioeconomic status, academic achievement and occupational roles as well as rural and urban representation. Men involved in same gender relationships were also included in the study to ensure that their accounts of "doing" masculinity were included in data analysis. While the groups were diverse, I ensured

that men were grouped into homogenous groups to enhance the level of transparency in sharing of accounts of masculinity.

This study did not focus on men with any specific illness, eg. diabetes mellitus or prostate cancer so men were not excluded from the study based on their diagnosis with chronic health problems. Men who were diagnosed with a specific health problem were able to share their personal experiences and how it affected their masculine identity as well as their experiences with the health care system. Bearing in mind the diversity in ethnic groups as well as the urban, semi-urban and rural characteristics of the population I ensured that there was geographical representation amongst respondents. This may have facilitated maximum variation of views amongst respondents who participated in this study.

3:9 Data analysis

3:9:1: Data entry

Each taped transcript was transcribed verbatim by a Research Assistant and the transcripts were then checked by me to ensure content reliability. Consideration was given to using the NVIVO software to manage the data; however, I found it easier to manipulate the data manually.

3:9:2: Coding and analysis of data

While I identified some theoretical frameworks that could be used to guide data collection and analysis, an inductive approach to data analysis was more appropriate for the study *since it is consistent with approaches to qualitative data analysis*. Data were initially open coded to generate conceptual codes and analyzed thematically using these codes. This was facilitated by reviewing each transcript of the Focus Group Discussion and Semi Structured Interviews on paper and making notes related to the key terms that emerged during the interviews. Themes emerged as well as changed during the period of analysis since the process began from the end of the first interview. I identified the common themes that emerged and these are presented in Appendix 4. Themes were developed after reviewing the initial open codes by combining ideas that were common from the data. The thematic analysis was extended beyond simply coding data to allow me to do more extensive analysis of data by exploring relationships between the themes.

3:10: Limitations of study

There were a few limitations associated with this research project.

Respondents for the Focus Group Discussions were selected by 'gatekeepers' in the organization as a result those selected may have been representative of predominant ethic groups available including Africans, East Indians and mixed. Consequently, it may not have been possible to include representation from all ethnic groups present in Trinidad and Tobago. Although I was not concerned with statistical representativeness for generalizability of the findings of the study, the inclusion of minority ethnic groups may have added useful insights in this study.

Although one Focus Group Discussion consisted of MSM, the inclusion of MSM from an NGO was necessary as in a homophobic society few men openly identify as homosexual and it would have been difficult to recruit those MSM who did not identify as such. However, these MSM are unlikely to be representative of the population of MSM in Trinidad and Tobago. In this regard, MSM who were included in this study may not have been typical of MSM which could affect the findings in the absence of a larger sample of men who subscribed to non hetero-normative notions of masculinity.

The inclusion of men between the ages of 19 years and 60 years, while considered appropriate for the study, may have excluded men whose perspectives may have been critical in answering the research questions especially as it related to male socialization. Young men below the age of 18 years are at a critical stage of their development and may have provided information on the current issues contributing to male socialization.

While Focus Group Discussions with men who know each other are effective in exploring various accounts to assist a researcher in exploring a phenomenon they also have limitations, in that, participants may be more concerned about presenting information that is normative. Care was taken to ensure homogeneity among the groups in this study in order to provide access to how men interact in relatively naturalistic settings. However, in the presence of peers it is possible that participants might therefore be reluctant to express more private views. As a result, it is possible that those who held non-normative views may have been unwilling to express same for fear of discrimination in a society where there are, for instance, levels of homophobia.

3:11: Ethical issues

Ethical approvals for the conduct of the study were received from the Ethics Committee, London School of Hygiene and Tropical Medicine and the Ministry of Health, Trinidad and Tobago. I am currently a senior member of staff attached to the Ministry of Health, Trinidad and Tobago. In my substantive role as Director of the Population Programme Unit, Ministry of Health I have responsibility for Sexual and Reproductive Health services. Addressing men's health has been one of my primary areas of interest. I may have interacted at various times with some of the men included as participants in the research process. Further, I have served as an external resource person to a number of the agencies that sourced participants for the study. As a result, this could have posed some challenges for participants especially as it related to levels of disclosure as well as their general accounts shared during data collection. To ensure that levels of transparency were maintained during the process, participants were reminded that all information shared will be treated with strictest anonymity. Each respondent was provided with an information sheet detailing the scope of the research as well as the objectives to be achieved after which they were given an informed consent form that was signed indicating willingness to participate in the study. These are shown in Appendix 5 and 6.

This study did not have the potential to put respondents or informants at any kind of physical risk. Men selected from the various sectors were familiar with each other. This allowed for more fluid exchange of information among peers without having to feel embarrassed or uncomfortable to express themselves. I was also sensitive to the possibility that some men may have become emotional when dealing with sensitive issues related to personal accounts of masculinity. However, at no time did any respondent or informant express or demonstrate emotional discomfort during the process of data collection. There was a level of openness and transparency among men and this may have been dependent on the level of homogeneity among groups. Men felt comfortable to make disclosures that made them vulnerable to negative responses from other men in the group but I ensured that the highest level of respect was afforded such men.

One of the potential challenges associated with transparency was over-disclosure. Although men were recruited in homogenous groups to facilitate greater levels of openness and transparency this had the potential for risking over-disclosure during the Focus Group

Discussions. While I was conscious of the tensions that could arise in this regard, the research design would have helped to minimize the potential risks. To control possible risk, respondents were asked to be open but avoid providing sensitive details of past experiences.

While consideration was given to providing men with opportunities for referral to public facilities that offered counseling services consistent with their particular needs there were no expressed or implied requests to access same. All respondents and informants were provided with opportunities to excuse themselves at any time during the process of data collection. To enhance confidentiality of information I was careful to remove any personal information from the data including real names, initials, or specific places that could be used to identify participants. This was critical in light of the importance of this research project in influencing policy action as it minimized potential fall outs that could arise from policy-makers being aware of the identity of participants.

3:12: Conclusion

This study is an initial research project that explored men's perspectives on masculinity and health beliefs. A qualitative, mixed methods approach using Focus Group Discussions and Semi Structured Interviews were used. A total of fourteen Focus Group Discussions and twelve Semi Structured Interviews were used to collect data. I was interested in collecting different data sets using the data collection methods. Men's perspectives on male socialization and how they "do" gender were explored using Focus Group Discussions. In this regard, participants were placed in homogenous groups to solicit typical accounts to develop a tacit understanding of masculinity. To reduce researcher bias, "gatekeepers" were used to select men representing various socio-demographic groups included in this study. Data on men's perception of "male sensitive" health services were collected among men who functioned at the policy and program levels of male service delivery. The methodology was appropriate for this study since it allowed me to explore men's perspectives on masculinity with a view to informing the development of policy initiatives for "male sensitive" health services.

Chapter four: Masculinity as a learnt behaviour

The key research question answered in this chapter is *'how are males in Trinidad and Tobago socialized to be men?'* Four major thematic areas were identified and used to present data related to male socialization. These included ways of behaving consistent with the accepted typologies as well as sanctions associated with non-compliance in the performance of socially acceptable behaviours. Secondly, the role of role models including fathers, artistes and internationally recognized iconic figures as well as mothers and grand-mothers in male socialization. Thirdly I shall explore opportunities for kinesthetic bonding as a way of learning patterns of masculine behaviour. Finally, I shall address social messages on masculinity and their contradictions which contribute to overt rebellion among a specific group of men.

4:1: Elements of learning to be male

4:1:1: Typologies of being a man

"... Not everything that have balls is man, because a ball-bearing have plenty balls..." (EB, Fisherman).

This statement represented the complexity in men's interpretation when they were asked to describe someone whom they considered a "man". There was no mutually agreed description of a man; men identified a number of typologies that described a "man". There were two major oppositional typologies identified by respondents in their descriptions of a "man". To them there was a difference between a social male which was related to his behaviour and a biological male related to his physical make-up. In their view, one's biological make-up was insufficient as a criterion to define a male as a "man". This contradiction was further highlighted when they indicated that there is a difference between a "man" defined by his physical strength and by having multiple partners and a "real man" who was respectful, took responsibility for his actions and a role model to his family.

Based on their typologies, being a "man" was complex since it was fraught with contradictions between what was considered an "ideal" male and the models they saw in their everyday experience. Some of the respondents indicated that there are taken for granted assumptions that every female is a woman; there is no such assumption that every male is a "man". In this regard, being a man was predicated on a male adhering to social "ideals" from

the basics like how he walked, talked or his sexual preferences to the more complex like how he demonstrated responsible behaviour including being an economic provider and protecting his family. As far as they were concerned, there must be congruence between one's biological characteristics and behaviour. An example was:

> *"What I recognize too is that, anybody could be a male but not anybody could be a man" (RM, Police).*

As a result of these contradictions, being a "man" was identified as almost a utopian concept since the typologies used to describe a male was not always consistent with the models of men with whom they associated. A case in point was stated as *"... down by me hardly have real men ... (MW, Footballer).* In fact, for one respondent, the notion of being a 'real man' created a certain level of conflict since he questioned his own capacity to satisfy the unwritten, yet socially accepted criteria for being a "real man". Nevertheless, men in general, felt that they had inherent limitations in satisfying the expectation of what it meant to be a 'man'. This was highlighted as:

> *"... ah doh think it have ah perfect man you know ... I cyah (cannot) be perfect ... if we look at what a real man is about, is a real, real high standard to attain" (LC: Police).*

Further, the contradictions of what constitutes being a male were exacerbated by the belief among some men that an individual who is a male should not have to convince anyone that he is a "man". As a consequence, he will not have to make an overt statement to remind those around him that he is a "man". In general, respondents believed that if a male has to inform others that he is a "man" then he would not be taken seriously nor would he be respected. For some respondents, there were accepted assumptions and expectations of who is a man as well as how that individual should perform masculinity. One of the reasons identified for these contradictions was:

> *"... they (men in general) just don't know what it is to be male" (IM, Masculinity project).*

While these typologies were generally accepted, they were not universal. Men who have sex with men (MSM) saw themselves as men based primarily on their biological make-up. To them, there was no dichotomy between what constituted a "man" or a "real man" since it is determined by biology and not social agreement. They viewed all males as men however, the only difference that they saw between themselves and other men who was on the basis of

their preference of a sexual partner. As far as they were concerned, the only characteristic that defined a male was his penis as this is also a core part of his physical make-up. This was illustrated as:

"... I am actually masculine, ...when I open my sepulcher I see a penis ... I believe I'm a man because I have ...whatever the constructs are, whether is having a penis or donating sperm, biological physiology...whatever the scenario is you are a man ... some men when they open their legs they see a penis, they feel very confident knowing that they're a man because it dangles there..." (NG, Humanitarian NGO).

In this study, MSM believed that being a man was based on biology since all men have the core biological attribute: a penis. However, this was in opposition to heterosexual men who believed that masculinity was not determined by biology but social behaviour. Although respondents identified different typologies of 'being a man', they were fraught with contradictions between biological and social determinants since being biologically male was an insufficient criterion in determining whether a male was a "real man". This contradiction runs throughout this thesis as respondents grappled with the notion of masculinity as "ideal" versus experienced.

4:1:2: Ways of behaving

Men were asked to recall whether while growing up they had noticed differences in behaviour between males and females. They reported major differences in the kinds of games they played, the types of domestic chores that they participated in and their response to stressful experiences. In general, there was a clear separation of sporting activities for males and females with activities like cricket and football considered "male" sports. An example was:

"... yuh have the unisex games as we spoke about ... rounders ... hop-scotch,... it had certain games that were more like for men...Like the football was for men ... cricket was for men, marble pitch was men or boys ...." (GH, Religious Leader Christian).

In looking back, they indicated that involvement in male specific sporting activities required the expenditure of significant energies and males, through their involvement, were able to demonstrate the ability to endure pressure, be tough and rugged as well as show physical strength and endurance. Males were also expected to excel at these sporting activities and if they failed to excel it could result in them being ridiculed or pressured by their

contemporaries. While this demarcation was socially agreed, MSM taking part in this study indicated that they never liked being involved in these sporting activities however, since they were males they were not only expected but had to become involved as children.

All respondents indicated that young boys were socialized to associate certain household chores with being male or female. From their accounts, the more domesticated chores were female oriented while the protective and provider functions were male oriented. In general, males were never encouraged to become involved in 'female oriented' chores since to do so would be interpreted as being inconsistent with how a male should behave. However, many respondents spoke about the importance of men learning how to do 'female oriented' chores in order to maintain their independence at other times in their life. In general, respondents believed that the dichotomy between male and 'female oriented' domestic chores create conflicts for men in their daily life. On the one hand they were to shun all that was perceived as feminized yet they were supposed to be proficient at doing 'female oriented' chores. This represented a real tension that men experienced, in that, being competent in 'female oriented' chores is a necessity for maintaining independence from women since being dependent on them would compromise their masculinity. A case in point was the experience of one respondent who spoke of the usefulness of having learned these skills while growing up since he had to use them in caring for his children after his wife died. Respondents also indicated that men who failed to develop these skills would result in their continued dependence on women since they are to be used, in a general sense, in the absence of a female. A typical response was:

> "... my father ... he used to tell me doh leh no woman break style on yuh. ... you have to do everything... Wash, cook, starch, iron do everything. If today or tomorrow you come and get married and the marriage doh work out and you come back bachelor, you mustn't be depending on anybody ..." (DH, Masculinity project).

Generally, participants reported that as young men they were encouraged to be unemotional by enduring pain and not crying even in the most difficult situation. To them, they were always expected to demonstrate being in control of their environment and the suppression of any physical or emotional pain was an indication that they were conditioned as "men". This however, posed one of the most significant challenges for men in their understanding of masculinity for it influenced their "normal" expression of emotions. While they were expected to demonstrate being tough and able to withstand physical pressure this changed as

they grew older for they were expected to express emotional pain as a normal part of their human experience. This was illustrated as:

"Men are not unemotional, they have been conditioned to live that sort of way, very young you are told men are not supposed to cry ... you grow up with that sort of misconception, ... because I may be perceived as less of a man or effeminate sort of and people are really afraid of being labeled as an effeminate type of individual, ... you strip away that very hard exterior and you understand who they are, they are very soft, very, very soft individuals because of early childhood conditioning they had ... this exterior of hardness and that's why they project as unemotional,...". (NG, Humanitarian NGO).

In general, males learn to be different from women in a number of ways including male specific sports and avoiding 'female oriented' chores. However, they experienced conflicts in how a male should behave. This was highlighted especially as it relates to their response to domestic chores since they were not supposed to do 'female oriented' chores yet were expected to be proficient in the very chores in order to maintain their independence later in life.

4:1:3: Patterns of behaviour to which one would aspire

Respondents also spoke about patterns of behaviour which they wished to emulate as young men which included the way men demonstrated responsible behaviours in the home, how they provided leadership to the family and how men were supposed to relate to females. To take the first of these, my respondents identified that it was necessary to have males in the home for they were seen as being responsible for providing guidance, financial support and security to members of their family. In their view, a man who was unable to provide this level of support to his family could not be respected as a "man". Men across the data reported that they admired these patterns of behaviour however, from their accounts, this was based on what was considered "ideal" rather than the average model that they had seen. In many instances, fathers were either absent or visited at intervals. As a result, regardless of their socio-demographic backgrounds, they reported that, in general, they did not observe the patterns of behaviour in their fathers even when present at home. Nevertheless, they still aspired to this "ideal" notion of masculine behaviour.

While most men referred to their fathers as excellent providers, they indicated generally that did not feel a sense of safety and security in the home especially when their fathers exhibited certain negative behaviours toward their mothers. These accounts, while typical, were

highlighted by fishermen who recounted the many instances when the family had to endure significant financial, physical and emotional conflicts as a result of their fathers' behaviour. A case in point was:

"... but I wouldn't say that my father was no man who wasn't participating in our life financially, ... when he drink and thing he real dread and thing... he want to mash down the place.... not everything I take from him, ..." (AG, Fisherman).

They spoke about the tensions experienced in admiring their fathers while at the same time disliking their negative patterns of behaviour. It was this level of conflict that caused many respondents to decide that such behaviours were inconsistent with what it means to be a man. Although there were contradictions between the "ideal" expectation and real experiences of men, they were consistent in aspiring to the "ideal" A typical account was:

"To be a man, ... you will have to be in charge of your home... And you have to be defensive at the same time ... if you soft, doh have no kinda defensive skill, ... people will come in break you down yuh know, that's why I use the word rough... But not in the true sense ah just bully ... yuh have to be tough..." (DN, Sportsman).

This contradiction was further exacerbated by one of the core behavioural patterns to which young men aspired: how they dealt with women. An example was:

"... I remember being on the block with the guys that are a lil older than you playing football and them kind ah thing and I remember them saying boy ah real man is when yuh fucking real thing. So you growing up now and you are hearing that and you want to be a real man because you want to fuck real thing..." (KA, Masculinity project).

From the accounts of the more mature respondents, women were portrayed culturally as objects of sexual gratification. As a result, in their youth, they longed for opportunities when they could gratify their sexual desires since this was associated with being a "man". Men across the data set believed that the lyrics of Caribbean music further exacerbated this expectation since women were expected to provide sexual gratification while they were not expected to make any emotional investment in the relationship. Young men depended on their more mature male counterparts to either demonstrate or share strategies that ensured success in their pursuit of females. Most respondents believed that, as young men, developing oratory skills was an important strategy in preying on young ladies. For many respondents, if a male failed at being a successful 'female hunter' he could develop self-doubt and by extension have his masculine identity questioned. In an attempt to demonstrate their

50

manliness men were not only expected to be sexually active but they were also required to do so with more than one female sexual partner. This point was illustrated as:

"... the greatest thing for me growing up is liming with people who was much older than me ... So when time come for me to start running the ladies... yuh know how to move. The experience I had talking to older people it coulda carry yuh through ... your experience ..." (EB, Fisherman).

While respondents identified "ideal" patterns of masculine behaviour what they experienced were in contradiction to the "ideal". Fathers are supposed to be leaders/protectors of the family but they got drunk and displayed destructive behaviours in the home. Further, having multiple partners was a 'normal' behaviour for men hence monogamy was not highlighted as an "ideal" behaviour to which they aspired.

4:1:4: Sanctions associated with non-compliance to male behaviour

While respondents spoke about the contradictions between the "ideal" man and their male models, I explored whether sanctions were associated with what they considered non-compliance to agreed male behaviour. Since they were expected to maintain congruence between their biological make-up and behaviour, respondents indicated that there were social sanctions to police compliance. From their accounts, if a male failed to satisfy normative expectations of masculine behaviour, this resulted in males receiving overt emotional, social and/or physical pressure and abuse from family members, other adults as well as their peers. In general, they also recalled that the sexuality or sexual orientation of the male who did not subscribe to the normal masculine behaviours was questioned and so he was subjected to being described using derogatory, female oriented names. These sanctions were often done in an attempt to humiliate the young man and so force him to comply with normal masculine behaviours. A typical example was:

"... we grow up knowing that if a man not involved in certain things yuh call them a tanty man ... if yuh ain't playing football and yuh ain't playing cricket ... we calling yuh ah tanty man" (EB, Fisherman).

Sportsmen, in particular, highlighted that in some instances, inflicting physical blows on the young man was done in an attempt to have him fight back. In their view, the overt expression of displeasure was done to 'toughen up' the individual since a man was expected to be tough and withstand pressure. In general, respondents reported that covert sanctions using non-verbal behaviours occurred mainly among peers. These non-verbal sanctions included denying them opportunities for participation in sporting activities or reducing their

51

entitlements whenever sharing 'spoils' from a social activity. In this regard, males to whom these non-verbal behaviours were directed interpreted such actions as sanctions for their non-compliance to socially acceptable masculine behaviour. This posed emotional conflicts especially for males who were expected to perform female related chores as part of their responsibility in the home. In such situations, they made deliberate attempts to hide this information from their contemporaries or develop hyper-normative masculine behaviour to protect themselves from sanctions. A case in point was:

> *"The boys would want to ostracize me, and tell me I hang up clothes on the line, they see me sweeping, so I is a lil girl. So in order to fit in now, to avoid being ostracized, I would kind of deny that. That is why I used to hide in the back, and I would just try to fit in or look for a fight with somebody just to fit in with them"* (NG, Prisons).

Nevertheless, respondents believed that if a young man was secure with himself he would not have to feel pressured if he carried out non hetero-normative behaviours even with the threat of being ostracized. On the other hand, MSM believed that they were particularly vulnerable to these sanctions. While they indicated that they received support from family members, this did not reduce sanctions from others for their non hetero-normative behaviours as. For some, this created conflicts since they could not understand why those sanctions were meted out to them. This conflict was highlighted as:

> *"... the boys in the neighbourhood kind-a always banished me... I wasn't a part of their clique, you know... So they would never call me out to go and play football or at school fairs they'd never be liming with me or whatever, I was always with girls..." (HL, Humanitarian NGO).*

From their accounts, sanctions whether physical, emotional or social were used as effective strategies for policing masculine behaviour to ensure compliance with hetero-normative behaviours. While MSM were particularly vulnerable to these sanctions, some heterosexuals developed hyper hetero-normative behaviours in order to fit in with their contemporaries.

4:2: Role models

4:2:1: Challenges with finding appropriate male role models

> *"I admire persons like Nelson Mandela, Martin Luther King... I still trying to figure out if I could picture somebody locally who I can say that is a man, that is somebody I could admire...." (FAV, Prisons).*

This response highlighted the challenges experienced by men in identifying males in Trinidad and Tobago who were held as role models since they were unable to identify anyone locally who lived up to the "ideal". I was interested in identifying the characteristics that respondents admired most in role models. Three groups of males were suggested as role models including fathers, recording artistes and internationally recognized iconic figures. Fathers were identified as the most significant since they were expected to be role models in their families. Their presence in the home represented security for members of the family. Further, they were expected to be breadwinners who are able to provide for their family. For men in general, the way their fathers related to their mothers by being respectful and considerate also influenced what they accepted as model male behaviours. To them, a man was one who took responsibility for providing for his family and any male who did not satisfy this expectation was not viewed as a man. A typical example was:

> "... bottom line is taking charge of the household ... being the head, ... if he fall short anywhere there then I don't think he would be called a real man, he shouldn't be called a real man ..." (RS: Religious leader Hindu).

While fathers were identified as "ideal" models for young men by most respondents only about half of the respondents recounted living with their fathers. For the most part, they reported that fathers were either not resident in the home or visited the family occasionally since many of them lived in matriarchal households. Even when their fathers were present in the home they felt a greater sense of connectedness with their mothers. Further, younger respondents spoke about the different representations of fatherhood which caused them to compare their father with other fathers. This posed some challenges for many young men in interpreting how a father was expected to behave. A case in point was:

> "... as a young child, growing up, I used to think, but this man (my father) mad. He always working on something. When he not working outside, he working home ... and the other men just liming just so. So I used to say dad mad. But then as I grow older, I looked at him and say, aye, something wrong with these other men and them. Why they can't be like my father. ... I used to say I striving to be like him. ..." (NG, Prisons).

Yet, in spite of these contradictions, they were consistent in indicating that the "ideal" behaviours expected of fathers were upheld as model male behaviour. This model was highlighted as:

> "Yuh must feel ah sense ah security... ah sense of stability that he providing not just the means but also ah kinda protection... for his family, his children, his wife

and even those around. So you must see 100% male... Not ah half-way man who can't take strain and bawling, yuh standing up to whatever come... Real man could take strain, whatever condition come..." (JS, Fisherman).

Apart from fathers, respondents named entertainers and iconic figures including Nelson Mandela, Fidel Castro, Martin Luther King, Michael Jackson and the Mighty Sparrow as role models. In general, during their youth entertainers were looked up to as role models as a result of having multiple partners. However, they indicated that as they grew older, they no longer looked to entertainers as role models since having multiple partners was 'normal' masculine behaviour. As a result, they now looked to internationally recognized leaders like Mandela or Castro as their role models. In their opinion, these internationally recognized leaders were inspirational and represented individuals who were willing to make difficult decisions, have character and were resilient: characteristics of "real men". From their accounts, these men displayed selflessness in ensuring that the interest of others superseded their own, a representation akin to the male's protective function. While these iconic figures were inspirational they pointed out that it is possible that how they behaved within their families may have been inconsistent with their iconic status. In this regard, these iconic figures may have represented an "ideal" rather than "real" model. A case in point was:

> *"we may be describing real fathers but a real father may not be a real man ... you may mention Mandela as being a real man ... what about his family? ...neglecting other things? ...you may have attributes as being a good father but in other spheres you lacking ..." (RM: Police).*

In the absence of being able to identify a single role model respondents selected attributes from different males to develop their personal "ideal". They also felt that they learned how to be men by trial and error based on the attributes that they selected from those models. For example:

> *"... you are taking little pieces of this one, ... yuh begin to imitate, ... to fashion yourself... add a lil something to that and make it yours now, rather than copy something, but yuh do some lil changes here, there and then you make it your style. ... People don't want to be seen to be a copy-cat,..." (LF, Religious leader Christian).*

A few of the younger respondents reported that they turned to the media through family oriented programmes that projected positive messages from black males to identify role models. While the notion of looking for 'black males' was an important observation this

study did not explore issues of ethnicity since I was more interested in unearthing typical accounts of learning to be men. There were observed contradictions, in that, younger respondents from sub-urban communities reported that males from their communities were more concerned with media images that presented males as 'gang leaders' who were able to plunder communities while living an affluent lifestyle. In these situations, the interpretation of what it meant to be a man was not based on "ideal" behaviours like being responsible or respectful but merely the ability to enjoy a certain quality of life with minimal sacrifices.

4:2.2: Women including mothers and grandmothers

While respondents indicated the important role of fathers in how boys learn to be men there was a view that, in Trinidad and Tobago, women played an increasingly significant role in that process. Generally they stated that when fathers were absent, mothers and grandmothers assumed the role of teaching their sons to be "men". While some respondents indicated that these women demonstrated behaviours associated with maleness, they believed that women would never be able to demonstrate the complexity of "being a man". Although women may be able to demonstrate toughness; a characteristic associated with being male, it is not based on an intrinsic understanding of what it means to be a "man". As a result, mothers' or grandmothers' demonstration of masculinity may more likely be their interpretation of how men should behave. However, they believed that depending on how females demonstrated these characteristics it could create potential conflicts for young men later in life. Men, in general, were of the view that females were unable to act as templates from which young men could effectively pattern male behaviour. Males from the Hindu religious community expressed particular concern when they spoke about the complexity of a female executing the masculine role. This was illustrated as:

> "There are women, single women that has to play both roles... Being a mother-mother and being a mother-father ... they could interpret a good example of a father, ... Better than a father ... a male father ... and the mother is showing you, the female father ... this is how you go about it... The head of the household is now the mother..." (RB, Religious leader Hindu).

In responding to the question how do boys learn to be men respondents indicated that they learned through explicit instructions from mothers and grandmothers. Generally, the reported statements from females focused on how not to be a "female" rather than how to be a "man". For example:

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"...from the time yuh hear yuh hanging too much on the other side yuh mother, especially if yuh do so and yuh like dolly, yuh mother telling yuh see that, that is not for you... Leave the dolly alone right..." (EB, Fisherman).

However, there were exceptions in men's accounts about the explicit instructions received from mothers and grandmothers. MSM indicated that within their families they did not experience such explicit instructions about behaviours that are unacceptable for males. In their view, they did not like playing male oriented games, and as a result, in the absence of overt instructions, their behaviour was "normal". It is possible that MSM accepted their behaviour as normal in their adulthood since they reported experiencing conflicts from the response of others while growing up. This conflict was highlighted as:

"... I thought my reaction to everything was very normal because my sisters, my mother, my father never really punish me or admonish me for doing those things. They were all very normal with me, so in my head I was like if mammy doesn't say anything bad about it, then there's nothing wrong with it you know, cause mothers always say what's bad and what's right and kids go by that... So to me what I was doing, while everyone else thought it was odd, mommy had no problem with it so I could continue doing it..." (HL: Humanitarian NGO).

It could be concluded that females played a significant role in reinforcing hegemonic notions of masculinity but may demonstrate tacit support for males who, early in life, show non hetero-normative behaviour.

4:3: Opportunities for kinesthetic development with father

Respondents, in speaking about their fathers, spoke about his role in creating emotional bonds which served as a template for teaching younger males how to be men. They focused on the importance of being emotionally validated by and having opportunities to work along with their fathers. While they indicated that they knew they were loved by their mothers they recalled that their fathers were financial providers but, in general, emotionally detached. This was highlighted among men from the 'defining masculine excellence' program who recounted that it was only when they were about to leave home to establish their own families that their father indicated that they could always return home. Only one respondent whose father was not gainfully employed recalled that his father demonstrated his love overtly to compensate for his inability to provide economically. In the respondent's view that was an attempt to diffuse the tensions created in the family as a result of his economic status.

On the other hand, some respondents were of the view that fathers' were not generally trained to respond emotionally, and in most cases, their unresponsiveness was done to demonstrate 'toughness' associated with being a "man". A case in point was:

> *"I don't think I could remember my father holding me and saying ... ah love yuh ... We feel men ... doh do dat... that what men is about; showing the masculine side, if we show the softer side we weak.... We not trained to show our softer side..." (LC, Police).*

This was identified as a significant challenge in supporting young men in their emotional development by men from the protective services and those who had participated in the 'defining masculine excellence' program. Although men adopted emotionally distant exteriors, most respondents believed that they still had an unfulfilled desire for validation from fathers. The following example illustrates this point:

> *"... one of the things that men like me, ... have suffered from is that kind of approval from our fathers... I would say my father, they were breadwinners, they making provisions,... but to say to hug, to approve, it was not forthcoming. ... they loved you but they never approved you along the way and say this is good, you have done that, ..." (IM, Masculinity project).*

In general, they recounted that while young, they wanted to learn patterns of male behaviour while being involved in kinaesthetic activities with their fathers since this was an important part of their socialization. As far as they were concerned, these experiences allowed them opportunities not only to learn vital skills, but perhaps more importantly, to learn how men behaved. Although most men did not experience these opportunities, they believed that these opportunities would have played an important role in their development. An example came from one respondent who recalled the experience of being taken to his father's job sites where he had the opportunity to learn technical skills:

> *"... what I am saying in a nutshell is that we as boys yearn for that love and that love comes from the things that you do with your father... Yes, the tactileness you know..." (KA, Masculinity project).*

Men in general, value the importance of developing emotional bonds with their fathers through kinaesthetic activities since it serves an important role in how they learn masculine behaviour.

4:4: Explicit messages about masculinity

4:4:1: Socially scripted and changing

Since mothers and grandmothers were identified as individuals who gave explicit messages about not being female, I was interested in identifying some explicit message that they received about "being a man". A typical message was:

> "... you have to stand up as a man and don't let people walk over yuh, ... you have to be courageous too, ... yuh had to be assertive,..." (JW, Industrial sector).

They reported that the messages were filled with contradictions and changed dependent on the particular social setting. While, to them, there was no clearly articulated social script of what it meant to be a man, there were socially agreed behaviours to which they must conform. Some of the messages they received focused on the "ideal" including maintaining a stoic disposition, being in control of their emotions, as well as being socially, economically and physically stable to fulfill their position of responsibility.

An example was the mixed messages young men received about being a single male without children as opposed to a male who had children or his own family. As soon as he became a father, he was expected to move from being irresponsible and dependent to being a 'real man' by taking care of his new responsibility, in that, he was expected to be automatically productive and no longer 'laid back'. An illustration was:

> "In the context of today's young man, today's young man has two interpretations of a man today. One is the man who is the father and the other is the man who is single and has no male responsibility. ... You would see a young man today who is a father who is single and dressing and going his way as he like and tomorrow you see him and he have a child, especially a daughter, you would want to see a different view of him...." (CAS, Masculinity project).

As a result, these implicit messages projected young, single men as irresponsible, not take life seriously or maintain dependency on their parents or other social support systems. From their accounts, some men, even when they became fathers, were unwilling to act responsibly by providing for their offspring. Even in such situations some men received support from their peers in encouraging their irresponsible behaviour. A case in point was:

> "The other day we had to raise funds for a man, $25,000.00 ... Because after a period of time he not paying his cock tax (child maintenance) and when you see his vehicle, he have 25 inch chrome rim and when you ask how many children he have, ... not one but three ... the fellas start to breaks (protect) for him for they

saying you know the fella does not give trouble on work ..." (ZA: Masculinity project).

However, in spite of the support that he received from his peers, such a male was not viewed as a 'real man'.

Apart from mothers and grandmothers, women, in general, provided messages about being a man. In their view, there were inherent contradictions in the messages received from females as opposed to males about acceptable male behaviour. In this regard, men found themselves in a position of constantly trying to balance these opposing expectations of masculinity. The following quote illustrates this point:

"... the women we live with have an expectation of us that we will behave in a particular way. The men who we lime (relax) with have an expectation that we will contradict that behaviour. But we still have to find a way to maintain the balance on how to still maintain masculinity..." (CAS, Masculinity project).

Men, in general, believed that female partners expected men to be monogamous in relationships while male peers expected them to have multiple partners. In their view, it is messages like these that created contention for men since it affected the very core of what it meant to "be a man": sexually promiscuous. This contradiction was further reinforced this way:

"you have empty males because they don't know they role, ... they think that if I stay with my wife or the women that I got pregnant, society or partners might look at me as a ponk (foolish) because being a man is going around and having ah set ah (plenty) woman"(MC: Police).

These messages also influenced how they responded to roles that were previously viewed as feminine. A case in point was when one respondent referred to a conversation where his mother and sisters indicated that women liked men who are able to assist with domestic chores. Prior to this conversation, he held on to the traditional messages that male and female roles were dichotomized and this highlights the level of contradiction men experience in responding to domestic chores. For example:

"in the early years, the teenage years, it was hard to get a girl who would want a fella who would do dem things (household chores). She didn't care about that. As you get more mature you find that you get more girls who happy to get ah man like you [laughter]" (CAS: Masculinity project).

From their accounts respondents believed that not only were the messages about what it means to be a man contradictory but that they were changing. They recalled that the messages they received as young men about how young men behaved changed as they grew older. A case in point was the view that dichotomous roles for men and women are less desirable and workable based on the current socio-economic environment. As a result, changes in the messages resulted in the demarcation of male and female roles becoming blurred since men were now expected to execute roles that were previously viewed as feminized. This example illustrates the point:

> *"what I have recognized is that the roles, functions or duties as a man is a evolving thing, ... is something continuous and every minute the role of man changing, cause they would continue to ask man to do something different from what they accustomed doing, ... men role actually change and ... the things that women used to do, they doing them no more" (RM: Police).*

One respondent indicated that with the birth of his son he changed his view about men being unemotional and insensitive. His emotional attachment to his son provided him with a new understanding of how men could demonstrate their emotions. In a general sense, while males were socialized to stifle emotions in childhood, this changed as they matured since they believed that they would gain more respect from others; more so if they demonstrated emotional vulnerability. This encouraged them to become comfortable in expressing their manhood in ways that were previously interpreted as not hetero-normative. An example was:

> *"... remember from growing up they telling yuh, yuh supposed to be rough, and rugged and tough so you musn't cry... But after you grow to a certain age and you start to recognizing that we have emotions and feelings too, so as a result of that you start to show some of the emotions that they try to hide from you as a child... As yuh get older yuh start to understand that all of us, whether boy, girl whatever have emotions... people start to recognize that it okay for man to cry when you hurting and you trying to be a man and hide those emotions that you feeling inside, yuh not able to bring them out, that is where mental instability... so now that the openness comes, you recognize that real men shed a tear openly... It soothes the soul. (ND, Sportsman).*

It can be inferred that the constant change in messages about masculinity, especially as men grow older, may exacerbate the conflicts that they experience in performing masculinity.

4:4:2: Opposition to messages contributes to overt rebellion

While there was general consensus related to how men respond and adapt to these changing messages, there was an exception among MSM who reported that they rebelled deliberately.

It was their view that the messages were deliberate attempts to prescribe "ideal" behaviours for males. They felt that many young men were forced to adhere to such prescriptive behaviours in exchange for social acceptance. This, to them, was repressive and an attempt to stifle their capacity to truly express themselves and by extension their interpretation of masculinity. They reported that, if they were to truly express themselves as males then it was necessary to break free from the emotional bondage that was placed on them through socially prescribed stereotypes.

While they admitted that this was not as easily done in reality, it was necessary if they were to truly identify with how they saw themselves as individuals. In their view, the emotional needs of young men are not addressed as easily as their female counterparts and, as a result, justified their overt rebellious actions. They were also of the view that men who subscribed to these socially agreed messages about masculinity often did so out of robotic allegiance and not out of deliberate considerations of the messages that they received. A case in point was:

> "... I will defy the social norms that have prescribed masculinity and sorry I'm not doing that. So that's why I am defiant because I'm not conforming to what has been cast or the type of labels placed upon individuals as males... being stuck in that continuum of repression to a point of understanding who you are as an individual ..." (NG, Humanitarian NGO).

In general, while men who subscribed to hetero-normative notions of masculinity willingly complied with the socially scripted messages about masculinity, this was not similar for MSM. While heterosexuals functioned within the bounds of those messages, as far as MSM were concerned, these messages were restrictive hence their overt rebellion in order that they could express their identity. In hindsight, including men who were within their natural settings from various socio-demographic groups was useful for this study since it may have facilitated greater levels of openness and transparency during data collection. It was evident that participants were very reflexive in their accounts. In general, participants were very transparent in sharing personal experiences and there was observable support from other participants which may have been enhanced by the level of homogeneity within groups. The dynamism that was observed with their interactions, both verbally and non-verbally, contributed to the richness and quality of the data related to learning to be men.

4:5: Summary

One of the major findings thus far is although an individual is born male he has to learn to be one or else reject the notion of what it means to be a "man". Patterns of behaviour associated with "being a man" were similar to those found in other cultures including being tough, resilient, economic provider and sexually promiscuous. However, further analysis of the data concluded that even if a male met these criteria, he also had to demonstrate being responsible and respectful to others to be accepted as a "real man". Fathers as well as iconic figures and artistes were identified as role models through whom males learned to be men. However, the findings from this study showed that these role models represented more of an "ideal" notion of "being a man" since, in general, behaviours observed were in opposition to the "ideals" that they subscribed to. In this context, which may be similar to other Caribbean islands, women, including mothers and grandmothers, played a central role in male socialization. While masculine behaviour was policed to ensure compliance it is possible that women policed masculine behaviour more than males since they focused on "not being female" rather than "being a man".

Although masculinity is multidimensional and culturally determined, in this context, the notion of masculinity was almost 'fixed'. This gave rise to a number of inconsistencies since what was described as an 'ideal' man was often in opposition to what they observed in reality. This tension was exacerbated by the dichotomized male and female roles which expected males to eschew feminized roles and yet be proficient in executing those roles later on as an indication of their independence. The prevalence of socially scripted messages about "being a man" were contradictory as well as in constant flux but nevertheless helped to reinforce hetero-normative ideals of masculine behaviour. Even though MSM subscribed to the notion of masculinity being biologically determined, in a general sense, they conformed to hetero-normative notions of masculinity although they expressed defiance at the messages. In conclusion, based on men's accounts', being a "real man" was utopian and elusive and this has implications for the way men perform masculinity; an issue we shall explore in the next chapter.

Chapter five: Performing masculinity

Having described how males learn to be men, this chapter will report on the challenges men experienced in performing masculinity. The findings presented here seek to answer the research question *'how do men in Trinidad and Tobago 'do' masculinity?'* Core behavioural expectations that emerged from the data included being economic providers and heterosexually promiscuous. However, even in the performance of these behaviours men experienced a number of challenges which often arose from a contradiction between socially constructed "ideal" expectations and their 'real life' experiences. Because being a man is learnt; the way a male was expected to perform was almost 'fixed' since men had to behave in ways consistent with "ideal" masculinity. The almost 'fixed' notion of "ideal" masculine behaviour provided men with little room to negotiate how to perform masculinity in this context. In general, males subscribed to the view that they were *"socialized into different roles and functions ..."* (IM: Masculinity project). A case in point was

> *"... when you're a man you're supposed to ... be hands-on ... as opposed to the woman who is supposed to be the care-giver, who supposed to be submissive, that's what we're told, ..."* (LG: Humanitarian NGO).

5:1: The "ideal" man

5:1:1: Man as economic provider: the importance of work

"Ideal" masculine behaviour included men accepting responsibility for being *"breadwinner, head of household"* (MGM: Religious leader Hindu). Across the data, respondents indicated that men were not expected to be *"laid back"* (KQ: Footballer) or *"afraid to pick up the mantle"* (EJ: Footballer) and this was demonstrated by the way he executed his economic functions. Respondents, in general, believed that men who was able to provide economically allowed them to *"have a certain amount of control"* (LC: Police) over their families. In this context, such a man was viewed as *"someone who will stand up to his responsibilities in life"* (JW: Footballer) as well as *"have their (his) priorities in order"* (HH: Footballer). Throughout the discussions, respondents focused on the importance of work as central to their role as economic providers.

Men across the data viewed work as important in supporting men to *"take care ah yuh fires"* (RF: Religious leader Christian) or *"to take care ah yuh family"* (EB: Fisherman). From their accounts, a 'real man' was one who worked and provided for his family. In

circumstances where men were unemployed or unable to secure employment this served as a challenge to their masculine identity. A case in point was:

> "... they (society) have a stereotype of men ... they are breadwinner, ... it will affect how you see yourself and how you will assume your role ... as a male in the house ... if you being the breadwinner and yuh loss yuh job" (MGM: Religious leader Hindu).

It was the nature of work, regardless of the sector in which they were employed, as well as work itself that buffered men from feeling emasculated. In this regard, men placed a higher priority on their jobs and economic well-being than their health. While some of the more mature respondents indicated that they were conscious that the demands of their jobs could affect their health negatively, they prioritized the demands of the job since it facilitated their ability to fulfill their provider role.

While work was important to masculine identity, the implications it had for men's attitude to their health was highlighted specially by respondents from the Trade Union sector. Generally, they were aware that their commitment to work was *"licking up your (their) body" (CG: Trade Union)* but that this was the masculine thing to do; being unconcerned about one's health. Respondents indicated that men were willing to consciously risk their health in the process of working which was consistent with the belief that their inability to provide for their family would encourage feelings of being emasculated. Even when some men were aware that something is *"not normal"* with their bodies and a situation arose on the job *"that needs your intervention" (EAM: Trade Union)* they indicated that men are more willing to remain on their jobs as opposed to leaving work to seek medical assistance. It is possible that men's health status could compromise their ability to maintain employment with implications for their capacity to fulfill their economic function. However, from their accounts, men place greater significance on their work since any perceived loss of economic independence created perceived challenges for men in living up to the masculine "ideal".

5:1:2: Sexual behaviour and masculine performance

Across the data set, sexual potency, exemplified by having multiple partners was identified as one of the defining characteristics of masculine behaviour. A man in demonstrating his sexual power was expected to pursue and prey on his female captors. From their accounts, a man was expected to be the dominant sexual partner and this served as the framework for defining hetero-normative sexual behaviour. Respondents in responding to the question related to

behaviours that men displayed to demonstrate masculinity spoke spontaneously about sexual behaviours. One respondent highlighted this point by indicating men were expected to maintain *"dominance in the bedroom"* and sexual intercourse was a *"very dominant" (OJ: Sportsman Tobago)* male driven activity. It was also viewed as one of the *"important duties" (SS: Community leader)* that men had to perform. Further, most respondents indicated that men are expected to be the *"ram (goat)" (GA: Trade Union),* in that, he was expected to be sexually active in multiple partnered relationships as this was accepted as "normal" since, in general, members of society *"see that as nothing" (SN: Sports leader).* Some of the explicit terms used to describe having more than one sexual partners included *"promiscuous ... butt (have sex with) everybody" (GA: Trade Union);* "bang down enough pussies" (NG: Humanitarian NGO) and *"players" (HL: Humanitarian NGO).*

From their accounts, they believed that this was not a new phenomenon but that it was supported by the historical influence of slavery. This was illustrated as:

> *"... the chief (slave owner) in those days could ah have how much women he want cause he could ah support all ah dem and the same thing applies today ... they never had one woman..." (MK: Sports leader).*

However, among sportsmen in general there was the view that there was an economic dimension to having multiple partners, in that, men who had more economic wealth were more likely to engage in this behaviour. For example:

> *"... ah man who is real wealthy, it is rare that they will have one woman you know ... dey doh have one woman" (MK: Sports leader).*

Regardless of their sexual orientation respondents indicated that multiple partnering was reinforced by the belief that *"men are supposed to be macho and players, he would have the girl of he life but he would also have his concubines..." (HL: Humanitarian NGO).* It was also imperative that he was able to *"hold meh (his) corner" (AB: Community leader)* in providing sexually satisfying experiences whenever he was required to perform sexually. Respondents, in general, believed that having multiple partners could occur without men having any emotional commitment to establish long-term monogamous relationship. A typical response was:

> *"there was no emotional investment, it was just sex because then that is what you've been taught to just have sex with these women" (NG: Humanitarian NGO).*

Sexual intercourse was also associated with a man's ability to maintain power and control over women as well as enhance his profile as being sexually powerful. While these observations were common, responses from Police were generally more explicit in highlighting this phenomenon. In their view a male should be able to *"give ah stink ah road (have sex of endurance) ... because you want people to talk" (RM: Police)*. Although sexual intercourse took place in private it did not detract from men wanting to boast about their sexual encounters since this enhanced their social status among their peers. This point was reinforced by another respondent who indicated that men boasted about their sexual experiences since they wanted *"these stories going around for years" (MC: Police)*.

From their accounts, respondents believed that men valued physical endurance rather than pleasure as a core factor in a satisfying sexual encounter. In general, they reported that the duration of the sexual encounter should be for a prolonged period since it helped to reinforce the male's sexual dominance over females. Any male who was unable to perform sexually consistent with this perception of dominance may develop self-doubt and so contribute to the way he re-evaluated his sexual identity. An example was:

> *"if you cannot have sexual intercourse with a woman continuously for at least two hours yuh is not a real man"* (LC: Police).

This belief underlined the complexity and tensions men experienced in performing masculinity, especially in regards to sexual performance. Men were expected to live up to this utopian, yet impossible standard in sexual performance since it was associated with power and dominance. This tension was highlighted in a conversation among policemen during a Focus Group Discussion as follows:

> *LC: "... society has that if you is a real man and you have sex and you come within that time you cah be, something wrong with you. ...*
> *RM: [LAUGHTER] ... but you doh know is yuh self yuh killing out...*
> *WD: Yeah*
> *RM: Yuh understand meh and this is the problem you know we, we have sex not for pleasure now but for some other thing..*
> *Interviewer Eh-heh*
> *RM: Right, so you find this is why we tend to engage in long sex...*
> *Interviewer Eh-heh*
> *RM: Because we doh know how, some of them doh even know how to get a orgasm*
> *Interviewer: Eh-heh*
> *LC: I am saying if you have sex for two hours because that is, I cyah see the enjoyment in that...*
> *RM: No enjoyment.*

LC: After a while that is work now [LAUGHTER] yuh eh having enjoyment that is work now
MC: You see all this things about how much time you spending in the mirror and thing I keep saying all that is bun-fire stories, a man must be go and he lasts two minutes, he come outside and he say boy was they for a half an hour and this one try to outdo that one and so it keep on going".

It is the desire to live up to this expectation of having prolonged sexual encounters that drove men to use a number of enhancements to further embolden their sexual potency. For example, one respondent opined that men will use *"all kinda tablet and all kinda thing" (MC: Police)* as aphrodisiacs to enhance their sexual performance. Yet, men in general, do not take the time to consider that the use these enhancements results in *"mashing up (harming) yuhself" (MC: Police)*. Although this may be a pragmatic deduction outside of the actual sexual encounter, it did not deter men from using enhancements since they may be more concerned about living up to the society's image of a *"real man" (LC: Police)* when it comes to sexual performance.

MSM held similar views about the importance of sexual power in relationships. They believed that they were no different to heterosexual men except as it relates to their sexual preference for a male rather than a female sexual partner. In their view, their sexual behaviour was similar to other men since they could *"bang down pussies (vaginas)" (LG: Humanitarian NGO)* or *"provide sperms" (CLS: Humanitarian NGO)*. Sexual attraction was associated with having a *"hard, dark body" (HL: Humanitarian NGO)* as this was representative of sexual power and endurance. In general, they believed that since they could do whatever heterosexual men do it made them *"secure in their sexuality as men" (HL: Humanitarian NGO)*. All MSM, except one, highlighted the importance of the size of the penis to sexual potency since they believed that the smaller the size of the penis was consistent with being less sexually potent.

A case in point was shared by one respondent who spoke about always wanting to be a *"big, strong Adonis" (LG: Humanitarian NGO)*. However, as he grew older he redefined his sexual identity since he *"learnt that most Greek men had small penises and I (he) would not want to be Hercules" (LG: Humanitarian NGO)*. It is possible that the perception of a large penis, while highlighted by MSM, may be important for men in general, in a society like Trinidad and Tobago which is highly sexualized. Further, sexual intercourse was considered an important male driven activity and MSM who saw themselves no differently to

heterosexual men may associate the size of the penis with power and domination in the sexual relationship. While one MSM did not highlight the importance of the size of the penis he did indicate *"... I just like a penis inside of me and that's just the moral of the story" (HL: Humanitarian NGO).*

From their accounts, men became anxious about being referred to as homosexuals in situations when they did not respond positively to overt advances from women since they were socialized to believe that women are not expected to pursue men. This anxiety was further heightened in circumstances where women were seen as being more economically powerful and as a result reduced the males' potential to provide commensurate economic means in a relationship. Men, in general, did not want their sexual identity to be questioned and this position was supported by one respondent:

> *"as a man you wouldn't feel good when women questioning your manhood" (MC: Police).*

One of the challenges that affected men in the performance of heterosexual masculinity, as reported by respondents, was related to the way men responded to sexual demands from women. An "ideal" notion of performing masculinity through sexual behaviour necessitated that men prey on multiple women. In circumstances where women assumed the role of pursuers of men, such behaviour was viewed as a threat to men's sexual domination. This view was common among men in general however, it was highlighted and more prevalent among policemen. From their accounts, men experience an initial thrill at being pursued by a women however, they experienced heightened anxieties if they considered resisting her advances since they did not want to be *"seen as soft" (RM: Police)* or a *"macromere (homosexual) man" (MC: Police).* They believed that some women are likely to feel rejected in these situations and *"could go back and tell other women" (MC: Police)* which, in their view, would reduce their perceived sexual power.

Men therefore had to compete with the potential of redefining notions of masculine identity or risk being defined by women based on the women's overt actions as pursuers. Although some men believed that the ability to resist advances from women could be construed as a willingness to *"treat a woman ... with a certain level ... of respect" (RM: Police)* this was in opposition to the "ideal" response expected of men. On the other hand, they rationalized that some women would admire such a man because he would have demonstrated *"respect for*

her" (MC: Police). This tension and anxiety was further exacerbated in cases where men considered maintaining monogamous relationships since such behaviour was not considered 'normal', and, as a result, it created conflicts with commonly held notions of masculine sexual identity.

5:2: Difficulties and challenges in achieving the masculine "ideal"

Although respondents indicated that men were expected to be economic providers; a role central to masculine identity, in practice, this was difficult and almost impossible to achieve. It is possible that they may not have been referring to themselves since all respondents were employed but they were referring to men in general. It is this perceived difficulty in living up to the ideals of these traditional, masculine roles that contributed to the perception that *"masculinity is under threat" (SG: Religious leader Christian)*. In their view, traditional masculine roles are being constantly revised and redefined within their social context. In an attempt to reduce the perceived challenges in achieving the masculine 'ideal' there was a general view that both men and women may have to *"destroy those very rigid distinctions between what it means to be male and female" (ST: Rural NGO)*. This is an issue which is likely to affect men more than women since they believed *"what was masculine long ago is no longer considered masculine" (NG: Humanitarian NGO)*. By extension, most respondents believed that the dichotomized male and female roles are changing. One respondent noted:

> *"I have recognized that the roles, functions and duties as a man is ah evolving thing, as time goes on you find it change" (RM: Police).*

As a consequence, another respondent indicated that with the *"evolution of time you seeing that a lot of these labels being changed" (NG: Humanitarian NGO)*, in that, masculine and feminine roles are being redefined. In spite of their perception that roles are evolving most men in the discussions men believed that being the economic provider for their family remained central to their masculine identity. For example:

> *"men supposed to be going out and look for some sort a bread to bring home for the children and the family" (EJ: Footballer).*

Because their masculine role as economic provider was "ideal", in a general sense, most respondents believed that males will experience challenges in meeting this expectation especially in situations when they were unemployed or underemployed. However, from their accounts, even when a man is unable to fulfill this role, he will still not want to feel emasculated. A case in point was:

"even though ah cannot do that, provide ... I have been called a man" (RF: Religious leader Christian).

A common theme across the data set was that women are no longer dependent on men for their economic survival because the current social environment supported women's ability to provide for themselves economically. It is in this context that men's traditional role as *"the breadwinner" (MGM: Religious Leader Hindu)* or the *"one bringing home the bread money" (EJ: Footballer)* was put under tension especially in situations where the woman *"is bringing in more money" (LF: Religious leader Christian)* than the man. From the accounts of some of the younger respondents, it was their view that although this ideal has not changed men are not standing up to their responsibility. This position was highlighted as:

> *"I find as men we loss that passion for being a man ... If you really check over the world now-a-days is more women trying to gain a little living for the family and most men they go on the side line ... men supposed to be going out and look for some sort a bread to bring home for the children and the family ... I find that it is really ridiculous for a woman to be taking care of a man ... if he have ambition at all ... " (EJ: Footballer).*

However, it did not decrease men's expectation that they wanted to be respected in spite of not being able to satisfy his economic provider role.

In general, the socio-economic environment contributes to tensions that men experience between their "ideal" expectations and "real life" experiences in relation to their economic provider role. A typical example of the difficulty men experienced in achieving this "ideal" was highlighted by men during the discussions among the Religious leaders' Hindu group.

> *"Interviewer: You introduce another important word: emasculate you, what will cause a man to feel emasculated?*
> *MGM: Huh, well the basic one that I could think of,*
> *Interviewer: Eh-heh*
> *MGM: If you being the breadwinner and yuh loss yuh job.*
> *Interviewer: Uh-huh*
> *MGM: Then you wouldn't be in a state to provide for your family...*
> *Interviewer: Mm-hmm*
> *MGM: That is one way that is a major thing.*
> *Interviewer: Yeah.*
> *RB: I have another way too.*
> *Interviewer: You don't think so?*
> *MGM: No, think about it. Well if you can't provide for your family how you going to feel?*

RS: Now you see, like you say before this day and age where women working too right...
MGM: Well the thing is, women working, how many house husbands are there?
RS: Yeah.
MGM: How many men are comfortable being house husbands?
RS: That is, you see, well that is different men, that is their attitude too. With me I don't think that will affect me anyhow.
MGM: Well that is it, different people have different um [cross-talk] attitudes towards it.
RS: I know, I know that okay if I cannot do that and my wife is working, I have no problem with being a house husband...
MGM: Is not a problem...
RS: And she bringing in the...
MGM: The money.
RS: I have no problem with that".

This exchange highlights the challenges and conflicts men experienced in satisfying the masculine "ideal" role as economic providers. Although only one respondent spoke about his willingness to be a 'house-husband', it is possible that this may have been his way of coping with the emerging economic realities. A few of the younger respondents indicated that they had no problems with *"she mining (providing for) me" (SN: Sports leader)* even though they did not refer to themselves as 'house-husbands'. This observation was important within the current social context where women were perceived as becoming more economically independent which made performing their economic function difficult. This was exacerbated by their belief that women are *"educating themselves more than males" (SG: Religious leader Christian)*, *"equipping and positioning themselves" (LF: Religious leader Christian)*, *"trying to set the example more than men" (EJ: Footballer)* and *"stepping away and want to be independent" (RM: Police)*. They also indicated that if men continued to hold on to the traditional roles that they have been socialized to accept while women assumed the provider role it will continue to pose challenges for the maintenance of their masculine identity. A case in point was:

> *"... no longer the male is seen as the dominator, ... to bring home the money ... in fact yuh have a situation where women working for more money than the men" (SG: Footballer).*

Respondents reported that some women who worked for more money than men were comfortable for men to *"stay home and take care ah de children" (SN: Sports leader)*. This was viewed as a reversal in the masculine role from being a provider to becoming dependent on a spouse and that was unacceptable in most discussions. It was still common for a male who accepted the role reversal to be seen as *"lazy" (AE: Sports leader)* or someone who did

not have *"ambition" (EJ: Footballer)*. In fact he was seen as *"not a man at all" (EJ: Footballer)*. Analysis of the data showed that most men viewed such women as ambitious and proactive in changing their economic fortunes while men were becoming domesticated by having to *"take part in things we call women duties" (RM: Police)*. This perceived change in roles facilitated greater involvement of males in household activities and this was frequently viewed as an attempt by women to *"emasculate you (men)" (MGM: Religious leader Hindu)*.

Men experienced various levels of conflicts in trying to constantly redefine their role as provider. Some men had become unsure of their role since their "real" experiences were in direct opposition to their "ideal" expectations. They believed that men were now placed in a position to not only review their role as a provider but also to reconsider how they would perform their leadership role as well. Economic power provided men with a sense of control over themselves as well as their families and if he was unable to do so the average man believed that *"his authority is questioned in a way that would be emasculating" (DM: Religious leader Hindu)*. This may have the potential for exacerbating his perceived loss of *"passion for being a man" (EJ: Footballer)* as well as create self-doubt in his ability to satisfy the criteria for being a man. This was illustrated as:

> *"he doesn't know his role, who he is in regards to the whole definition of a man,*
> *he doesn't really know who he is. He is more like somebody who is just existing*
> *..." (RF: Religious leaders Christian).*

Respondents' believed that women's access to professional development programmes of higher learning allowed them to secure better jobs than men. They perceived that this has the potential for facilitating greater economic and social independence of women from men. They were concerned that as a result of their new economic power, women were becoming more self-sufficient and less dependent on men as economic providers which further exacerbated their anxiety about fulfilling their "ideal" provider role. In coping with this reversal of their perceived masculine "ideal" role younger men were willing to re-evaluate beliefs about their role as economic providers. In this context, they believed that women are choosing to redefine their roles in relation to men and as a result men will be left with no choice but redefine traditional roles central to their masculine identity as well.

5:3: Tensions in masculine performance: Emotions

Respondents not only spoke about the difficulties that they experienced in performing masculinity in relation to sexual behaviour and being economic providers, they experienced tensions in responding appropriately to other aspects of their lives. This was evident by the way they spoke about the tensions that they experienced when dealing with their emotions. As identified earlier, men were socialized to be tough and resilient and, as a result, were expected to maintain a stoic demeanor to demonstrate emotional control over situations. They were expected to be pragmatic and calculated in decision-making, even if they experienced psychological pressure in the process. Demonstration of emotional control was identified as an "ideal" behaviour but they said that this was often done through suppressing their emotions. This created challenges for most men since suppression of emotions, while allowing them to behave in socially acceptable ways created high levels of tensions especially in situations where their usual behaviours was inimical to "ideal" behavioural expectations.

Generally, respondents believed that men *"were not taught to deal with their emotions" (SS: Community leader)* which contributed to them having *"no outlet ... so everything just explode" (GG: Prisons)*. This belief highlighted the tensions men experienced in their day to day lives since there was an underlying assumption that dealing with their emotions in an "ideal" way had to be taught. Yet, they are expected to demonstrate control of their environment and regulate their emotions when doing so. This was more of an ideal expectation than a reflection of their real experiences since they were more disposed to express their emotions in ways that may be deemed socially unacceptable. A typical example of this tension was:

> *"I does get very loud, very aggressive when I angry, ... when ah angry, ah does just get totally blank ... the future in front or the future behind, is just about that moment ... ah does just feel to do what ah had to do, what come to meh head... well after a while yuh does think about the situation (NJ: Industrial sector).*

Respondents indicated that men dealt with their emotions differently in the workplace as opposed to the home environment. A respondent from the protective services sector shared a work related example: *"I will talk in a very empowered manner, in that it helps me to control my anger" (IM: Masculinity project)*. On the other hand, another respondent reported that within the home environment that he *"react terrible ... use explicit cuss ... obscenities" (WD:*

Police). As far as they were concerned, dealing with anger was a physical rather than an emotional response. A case in point was:

> *"When men get vex is a physical thing boy ... is men yuh saying yuh know" (OJ: Sportsman).*

In dealing with their anger, some men described how they managed to express their emotions in socially acceptable ways as a way of diffusing tensions. Some examples were that they will *"take a walk and chill out (relax)" (EB: Fisherman),* try not to use *"ethnic (obscene) language" (ZA: Masculinity project), "cut off and stay quiet" (GH: Religious leader Christian)* or *"compensate by doing the opposite to how I (they) feel" (GG: Prisons).* One respondent also said that he *"write and burn",* in that, he does not *"curse outwardly but write curses" (PF: Prisons).* Most respondents were of the view if men fail to find positive outlets for their emotions it would result in physical aggression. Another respondent, in supporting this response indicated that *"by the time yuh sit down and write ... all the anger done come out from inside you" (NG: Prisons).* To them, these behaviours were deliberate demonstrations of being in control of their environment, although they may be experiencing internal conflicts in the process.

On the other hand, fishermen in general, were more expressive in describing a man who behaved in such a way as a *"peppe man" (EB: Fisherman), "ah real soft man" (JS: Fisherman)* or *"gyal" (SB: Fisherman):* derogatory terms referring to them as female. This was predicated on the belief that men perceived *"quietness as weakness" (RF: Religious leader Christian)* and to remain quiet in an environment where he was expected to be loud and aggressive was unacceptable. However, this opinion was contradicted by one respondent who believed that a man could use the power of quietness effectively although he may not be *"speaking in terms of words ... your (his) whole demeanor is screaming at people" (LF: Religious leader Christian).* Yet this opinion was contradicted by another respondent who reported that it is imperative that men demonstrate their position of power, especially in his home, by stating:

> *"yuh had to show them well I am the man in this house and if yuh stay quiet it come like if you submit and say well you giving in" (GH: Religious leaders Christian).*

Across the data set, men indicated that to be *"macho" (SG: Religious leader Christian)* men *"aren't supposed to cry" (NG: Humanitarian NGO).* This was a direct result of their

socialization in learning to be a man since a core representation of masculinity was being tough and resilient. Although one respondent argued that men were expected to *"show their softer side"* he noted that it *"is difficult for us to show without feeling embarrassed in some way" (LC: Police)*. This had the potential for exacerbating his emotional tension since his real response in dealing with situations may be inconsistent with the "ideal" response that he was socialized to portray. Men were supposed to be *"protective of their masculinity" (KA: Masculinity project)* and crying overtly was interpreted as a contradiction and inconsistent with normal masculine behaviour.

From their accounts, men who had developed crying as a coping strategy found it a cathartic experience since they believed that *"real men does cry" (ND: Sportsman)* or as one respondent identified *"I have found relief in crying" (AB: Community leader)*. While some respondents expressed comfort with crying openly they also spoke about the internal conflicts that they experienced since such behaviour was non hetero-normative. A case in point was highlighted by one respondent where he felt powerless to exact revenge:

> *"I want to do you something ... once I cyah get to do what I want, and cyah get to deal with how I feel I should deal with it I does cry ... if I don't do that I know I going mad" (ND: Sportsman).*

Policing masculine expressions of affection was identified as complex; especially among sportsmen. Men are likely to *"be careful as to how you do certain things" (ND: Sportsman)* as they were expected to express affection in ways that were accepted as *"normal in society" (EJ: Footballer)*, in that, it should be consistent with socially agreed hetero-normative behaviour. This level of tension was highlighted as being most evident in celebrating success since giving a *"hug and kiss" (HH: Footballer)* was a normal expression in sports. If a male behaved in the same way outside of the context of sports, he was seen as a *"sissy" (DN: Sportsman)*. In an attempt to protect his masculine identity a male may be more likely to express appreciation by *"giving a gangster bounce, half hug" (OJ: Sportsman)* or *"go to the bar and drink something" (FAV: Prisons)*. Two typical examples were:

> *"I think like in a football match you know people assume there is a bunch of heterosexual men competing and that display of emotion is only a reaction to winning or joy or whatever. But if you see an effeminate man and another effeminate man hugging you automatically assume that is submissive and that isn't masculine ... " (HL: Humanitarian NGO).*

"... in general, that embrace between two men you know you will feel kind ah ahow (funny). You might do it but after you do it might be wondering; boy ah wonder if anybody was watching, ... there is a lot of conflict ..." (SN: Sports leader).

Concomitantly, they reported that masculine behaviour, apart from being socially determined, was policed through the establishment of normative behaviours to which they were *"cultured" (ND: Sportsman).* Accordingly, one respondent opined *"there is a line" (GG: Prisons),* although imaginary, that is used to set boundaries for masculine behaviour. They believed that there was a level of *"fear" (FAV: Prisons)* that men experienced if they wanted to behave in ways that were inconsistent with the established boundaries. As a result, in expressing affection, they were expected to *"keep it masculine" (OJ: Sportsman)* since to behave otherwise *"becomes taboo" (GP: Prisons).*

Respondents exhibited different emotional responses to situations, especially when there were heightened tensions between what was accepted as "ideal" as opposed to "normal" behaviours. On the one hand, men compensated for these contradictions by attempting to be an "ultra-male" by showing that they could be *"rough and tough" (LC: Police)* or as one respondent indicated being able to *"walk away from horn (infidelity)" (ECB: Fisherman)* without becoming violent. On the other hand, they also believed that some men may defy "ideal" masculine behaviour by being unashamed to express his emotions by crying since this *"showed his softness" (RM: Police)* or show that he is a *"real man" (OJ: Sportsman).* This may suggest that heterosexual men who are comfortable with their masculine identity may be more likely to express themselves in non hetero-normative ways as a way of confronting commonly held notions of masculinity. At the same time, respondents indicated that while men may choose different ways to express their emotions, in the long run, society continued to serve as a policing agency creating unwritten boundaries for determining the extent to which men's emotional responses were considered acceptable or unacceptable. While performing masculinity was fraught with contradictions, participants were generally open in highlighting their own as well as the conflicts of other men in satisfying "ideal" expectations. It is possible that their level of transparency may be an acknowledgement of their challenges and the Focus Group Discussions facilitated ventilation in a non-threatening environment.

5:4: Summary

Masculinity in this context was similar to other societies, in that, it was based on performance. Generally, masculine performance was hetero-normative with some of the core characteristics being economic provider as well as sexually promiscuous. Work was central to masculine performance since it influenced men's ability to execute one of his core functions, that of economic provider. In this regard, men are confronted with the reality of having to redefine previously held notions of 'ideal' masculine performance as economic providers. The complexities and challenges associated with men's 'ideal' role as economic providers were exacerbated by the current socio-economic environment which facilitated the economic empowerment and independence of women. In this regard, men found it increasingly difficult to achieve "ideal" masculine performance since women are now capable of assuming this role. As a result, men were faced with the prospect of having to constantly re-evaluate commonly held beliefs about ideal masculine behaviours including accepting role reversal, for example, being economically dependent as acceptable.

Regardless of sexual orientation, sexual performance, especially in multiple partnered relationships was also identified as a core aspect of masculine identity. While sexual behaviour associated with masculine identity was similar to men in other contexts, there were some unique characteristics which created conflicts in performing masculinity. In this highly sexualized culture which encouraged multiple partnering, men experienced conflicts and negative responses from others in situations where they chose to be monogamous as opposed to having multiple relationships. In addition, prolonging the sexual encounter was central to "ideal" sexual performance which was enhanced by aphrodisiacs. In this regard, the performance of "ideal" masculinity was complex, utopian and inconsistent with men's every day experiences. This has implications for men's response to health, an issue that will be explored in the following chapter.

Chapter six: Health beliefs and masculine behaviour

The findings described in this chapter addresses the two remaining research questions namely; *how does male socialization affect men's health beliefs* and *how do men's beliefs about masculinity contribute to their health behaviours?* Findings from this study showed that men were expected to be healthy but achieve this without taking any responsibility for the maintenance of their health. Risk taking was also identified as "normal" masculine behaviour. A male who was concerned about his health and reduced his health risks was considered as atypical. While men feared being diagnosed with a serious illness it did not have a positive influence on their preventive health behaviours. By extension, seeking health care voluntarily was viewed as unmanly and this further reinforced men's unwillingness to access preventive health services. One of the major concerns of respondents was accessing prostate screening services. Making such a decision created ambivalence for most men which was exacerbated by not only the experience of having to undergo the examination but the meanings associated with the examination itself. The attitude of MSM towards their health was in general no different to other men although their perceived challenges were different, in that, they were more concerned about the attitude of staff and having to expose their sexual orientation.

6:1: Being healthy is core to being male

Across the data set, being healthy was identified as central to the maintenance of masculine identity. A typical example of this was that men were *"not supposed to get sick" (JS: Fisherman).* From their accounts, being healthy was natural for men, so there was no need to consider maintaining their health as a priority. By extension, being a healthy male was associated with being invincible and powerful; characteristics associated with "ideal" masculinity. A male who was perceived as unhealthy was referred to as being weak which affected the perception of others about his ability to demonstrate masculine characteristics like being tough and resilient. Men in this study paid particular attention to projecting an image of being healthy in order to gain respect for their manhood since it was easier for others to respect a male who represented that "ideal" image. This respect was associated more with what men projected rather than what they were experiencing. As a result, it was easier for men to deny that they were experiencing a health problem as a strategy for validating their masculine identity. In so doing, it afforded them a higher level of respect.

A typical description of a healthy male was:

"One whose metabolism is in good working condition ... all his muscles, his organs ... mental faculties ... everything is balanced..." (DN: Sportsman).

Men were expected to have 'model' physical bodies that were consistent with their perception of what constituted 'being healthy'. He was not expected to *"overeat" (VH: Community leader)*, or *"look like he have worms (very thin)" (WD: Police)*, or be *"physically unfit" (ND: Sportsman)* yet he was expected to be *"big and strong looking" (LC: Police)* and have *"muscles" (RM: Police)*. Such an individual was also supposed to have a tough looking exterior, with a *"strong physical structure and physically fit" (ND: Sportsman)*. Since men were expected to execute a protective function for their families, being physically healthy enhanced the perception of others that they were able to fulfill that function. However, from their accounts, few men believed that they met this "ideal". Although they agreed that being healthy was supposed to occur naturally many of them indicated that they *"would not consider mehself (themselves) healthy" (GM: Community leader)*. By extension, they generally saw themselves as being *"unfit" (OJ: Division of Sports)* or *"unhealthy" (AB: Community leader)*.

Even though there was little emphasis on men's personal responsibility for maintaining their health status one respondent spoke about the importance of men taking personal responsibility for their health. In his view, *"you have to eat healthy and eating healthy is an expensive thing" (SS: Community leader)* which suggested that there was a cost attached to being a healthy male. On the other hand, another respondent spoke about his fitness and how he took personal responsibility for the maintenance of his health as a result of his involvement in sports from his youth. However, based on the accounts of respondents, this behaviour was not common among men in this study which further reinforced the notion that "being a man" was being healthy naturally.

While respondents spoke about an ideally healthy man this was based on how he projected himself. A man who was experiencing a health problem would still be viewed as being healthy if he was able to maintain a stoic disposition and not acknowledge that he had a health problem. The ability of men to project a physical image consistent with society's as well as other men's expectation of a healthy male influenced the level of respect that he would expect to receive. In this regard, men may have been inclined to place greater legitimacy on the potential loss of respect from others rather than acknowledge that they were

experiencing a health problem. In such a situation, he worked to maintain the respectability associated with "ideal" notions of being a healthy male. The following example illustrates this point:

> "... I think is ah kind ah weakness to let people know that you are sick..." (MK: Sports leader).

So it seems that many men believe that even though a man may be looking healthy, it may be based on what he was projecting rather than what he was experiencing as one respondent said, a man could be *"looking healthy externally but internally there's a lot of problems"* (SS: Community leader).

The importance of projecting a healthy image was highlighted especially among sportsmen since being healthy was associated with being successful in their sporting pursuits. To sportsmen, even if it meant denying that they were experiencing a particular health problem, they would *"suck it up and go and play"* (CA: Sportsman) to gain the respect of their peers, coaches as well as supporters. Some of them reported that even in the presence of pain *"yuh does have to suppress it for a while and go and play..."* since *"love for the sport and wanting to win"* (OJ: Sportsman) were driving forces that influenced their behaviour. This was reinforced by the expectation that they were to project a healthy image: being tough and resilient even if it meant suffering silently. A typical example was:

> "...sometimes we know we sick and we still go out and play and people look at that and say you see that; he is really ah man, he taking he pain, ..." (AE: Sports leader).

This level of secrecy about their health problem occurred particularly when the health problem was perceived as central to his performance of masculinity. In general, they expressed concern about confidentiality of their health information, even in a professional encounter since they questioned whether *"everybody go find out"* (SN: Sports leader) especially if others with whom they interfaced, perceived that they were experiencing a health problem. In these circumstances, men were likely to be secretive even with the information that they shared with their doctor. This was often done in an attempt to project the "macho image" of being tough and in control. If a male did otherwise, he risked having peers as well as others in the wider society would look at him differently. This conflict was presented as:

"...men supposed to be the strong ones, they are the ones who are the leaders and you can't be ah leader if some people will think you have ah disease..." (SN: Sports leader).

Although most respondents acknowledged that they knew what they should be doing in order to maintain their health, they also experienced conflicts in making this reality. Although men in this study indicated a willingness to make behavioural changes to enhance their health, it remained *"good intentions" (CG: Trade Union)* that they thought about or was something that they *"give lip service to" (GA: Trade Union)*. This highlights the conflicts men experienced between knowing that they should care for and not showing concern for their health since being healthy was supposed to occur naturally.

6:2: Being a healthy – the responsibility of others

Since men were also expected to be healthy effortlessly, they are not expected to take personal responsibility for the maintenance of their health. Even when men adopted behaviours that had potentially negative effects on their health it was associated with feelings of invincibility. However, they expected others to be responsible for preventing any negative fall outs that arose from their behaviours. Even in circumstances where they were diagnosed with a health problem, men were likely to place the responsibility for the maintenance of their wellness on others. A case in point was:

"... we always tend to pass the responsibility for our health over to somebody else... while we do all the things... detrimental to our health..." (GA: Trade Union).

In their view, if men acknowledged their vulnerability it could be interpreted as an indication of their willingness to take responsibility for their actions; a decision that they are usually unwilling to take. Generally, men reported that it was not their responsibility to take care of or look after their health. For the most part, it was their view that *"men generally do not pay great attention to their health..." (IM: Masculinity project)*. Although, respondents were aware of the negative consequences of their behaviour it did not influence their health behaviour positively hence the tacit delegation of the responsibility for the maintenance of their health to someone else. A case in point presented by a respondent who indicated that he had a chronic health problem was:

"when something happens to me, as a man is always somebody else fault ... I am doing this to myself, but I am not responsible" (GA: Trade Union).

While men deferred responsibility for maintaining their health to others, they did not want to be controlled nor have their behaviour curtailed by those to whom that tacit responsibility was deferred. Even in the presence of health challenges, one respondent stated *"me ain't tell she (my wife)" (EF: Trade Union)* as a strategy for preventing overt coercion for seeking medical help. From their accounts, they were also of the view that persons who were responsible for men's health maintenance may be the very individuals who may be contributing to their health risks. An example was *"although the woman in the kitchen and she is cooking the meals... she hardly eating that set ah meat" (AB: Community leader)*. Although most respondents reported that they deferred responsibility for their health to others, it was unclear as to how it was operationalized. It is possible that from their responses the notion of being healthy may not occur as naturally as they projected. As a result, they may have to concede, in the long run, that they ought to pay special attention to maintaining their own health status. It can be inferred then that men may be more concerned about holding others accountable for their health problems rather than truly delegating the responsibility for their health maintenance to others. This may be predicated on their own observation that they were aware of what they should be doing to maintain their health status but did not feel any compulsion to do so.

6:3: Illness and masculine identity

Given that men are expected to be healthy, although effortlessly, being ill affected how they viewed themselves as men and their performance of masculinity. Men expressed fear of being diagnosed with a *"terminal disease" (JS: Fisherman)* since it could impact on their level of independence causing them to depend on others. In this regard, they believed that their ability to maintain domination in relationships could be severely compromised if they were diagnosed with a chronic and debilitating illness. While respondents in general believed that being ill could result in a perceived reversal of roles from domination to dependence; accounts of fishermen were more graphic. The discomfort they experienced from thinking about being seriously ill served as a catalyst for men to revisit commonly held beliefs about masculinity and power. This was exacerbated by their perception that being seriously ill could result in their inability to maintain their independence. An example was:

> *"... It have certain things I don't want to go through, if I know yuh had to keep cleaning my bottom and thing, gimme ah bad injection let meh go (die), ... hit meh a gunshot and let meh go, ... doh come and wipe my bamcee (buttocks) for me ... meh ain't want that pampers thing..." (AG: Fisherman).*

Being diagnosed with a serious health problem created *"a certain amount of fear"* *(IM: Masculinity project)* and anxiety among men for it was inconsistent with their taken for granted notion that men are naturally healthy. Fear of being diagnosed served as both a catalyst as well as a deterrent in health seeking. Respondents were of the view that *"what yuh don't know won't hurt yuh"* *(DR: Industrial sector)* however, a common observation was that men succumbed to illness faster if the diagnosis was terminal. This caused them to become *"stressed over it and ... can't function after that"* *(JS: Fisherman)*. Being diagnosed caused serious challenges that one respondent reported that it was *"not the actual having it that does kill you but knowing that you have it"* *(ZA: Masculinity project)*. In such cases, it was the general view among respondents that men *"prefer to know you die than to know yuh ill"* *(JS: Fisherman)*. They also believed that in order to cope with their diagnoses men adopted negative behaviours like *"drink ah rum"* *(EB: Fisherman)* as a result of being *"uncomfortable with dealing with issues as it relates to (their) health challenges"* *(NG: Humanitarian NGO)*.

Respondents reported that when a man is diagnosed *"it will all come like everything, like yuh whole life gone..."* *(JS: Fisherman)* which reinforced their use of fear as a strategy for not wanting to know the status of their health. Their perception of the response of others to their illness, especially those closest to them, helped to reinforce their unwillingness to know about their health status. For example:

> *"... when I'm sick, ... I believe I could sweat out everything, ... when I sick, I does work the hardest. ... And then after my girlfriend come home by me and want to play she pampering me and I say, girl, move from her eh ... I just doh feel comfortable with people pampering meh and thing"* *(PF: Prisons).*

A common view among respondents was that being healthy was identified as a *"macho thing"* *(JS: Fisherman)*. In spite of their accounts that they did not accept personal responsibility for the maintenance of their health this was reinforced by the perception that their bodies were invincible. While they were of the view that *"we shouldn't think like that"* *(JS: Fisherman)*, men believed that being diagnosed with a serious illness forced them to re-evaluate commonly held beliefs about men being healthy naturally. A case in point was:

> *"... if I become ill, I begin to worry... I have a greater fear than you could ever think of, especially if your illness is something you cannot see, is something that you could feel..."* *(IM: Masculinity project).*

On the other hand, MSM had a different perspective on the meaning of "illness" on their masculine identity. In their view, the health issues that men were concerned about, in general, were different from their health concerns. As far as they were concerned, being diagnosed with an illness was related to their sexual behaviour since they indicated awareness of the health risks associated with their behaviour. They had an underlying fear that being diagnosed with an illness was more about exposing their sexual orientation as opposed to the diagnosis itself. In such circumstances, they were willing to portray an image consistent with hegemonic masculinity since doing otherwise would expose their sexual orientation. One respondent shared an account of this conflict:

> "... for gay men I know going to an STD clinic you know they may have an infection and most time they will go and they will lie, you know I got it from a girl. They will never go and say well I got it from a guy... and many of them will lie for fear of victimization, ... " (CLS: Humanitarian NGO).

It could be inferred that although men believed that being healthy was natural, being ill served as a catalyst that allowed them to revisit the commonly held illusion of their bodies as invincible, hence being healthy was not a natural phenomenon as they believed. By extension, MSM viewed illness differently to other men, in that, it created greater fear about having to expose their sexual orientation than the nature of the illness itself.

6:4: Taking health risks is core to masculinity

While men were expected to be healthy while, at the same time, not behave as though they were looking after their health, they were expected to engage in health risks. In general, taking health risks was normal masculine behaviour and men engaged in risky behaviours since they did not want to be viewed by others as unmanly.

> "... If you meet somebody and they tell yuh they don't drink, they don't smoke they don't lime... they does only be with dey wife... You not a real man, to be a real man you have to do a certain amount of things... things that detrimental to your health. If you not doing thing that detrimental to your health you is not a man... " (GA: Trade Union).

Generally, men believed that they were invincible and risk taking was an overt demonstration of the ability of their bodies to withstand risky effects of their behaviours. Although they knew that taking health risks was "detrimental to your health" (GA: Trade Union) they perceived their bodies as "invincible" (GA: Trade Union) and that further reinforced their

risk taking behaviours. The common terms used to describe their bodies were *"machine"* *(AB, Community Leader)* and *"Duracell battery" (ND, Sportsman)*. The description of their bodies as machines was representative of the toughness and resilience that it symbolized. It is possible that this mechanistic representation of their bodies reinforced their feeling of invincibility which exacerbated risk taking as normative. In this regard, the higher level of risks that men took may be related to their perceived level of invincibility.

On the other hand, males who made conscious decisions to reduce their health risks were likely to have their masculinity questioned by other men. Men had to prove their manhood, and in so doing, risk-taking was accepted as a "normal" demonstration of masculine behaviour. If a male attempted to reduce his health risks he was viewed as a *"mama-pool (homosexual) man" (GA: Trade Union)*. As a result, men were expected to disregard any potential risks associated with their behaviour. It is possible that the social pressures to conform to normative masculine behaviours may, in itself, be the catalyst for perceiving risk taking as central to masculine identity.

Risk taking was a conscious decision, in that, respondents stated *"you know that you does be doing wrong to your health" (EF: Trade Union)*. Even when they were diagnosed with a chronic non-communicable disease respondents spoke about the challenges they experienced in striking a balance between making lifestyle changes based on their diagnosis and taking risks as "normal" behaviour. Although they had knowledge of necessary changes needed in their lifestyle they found it difficult to institute those changes in their behaviours since they did not want to have their masculine identity challenged. Men were more concerned about being seen as a "man", even if it meant engaging in risks, since this was the manly thing to do; damaging their 'machine'. An example of this level of dissonance was:

> *"You want to be a man so you want to do things that you feel men supposed to be doing ... and it endangers you ... I suffer with high blood pressure, so they give me a diet;... no salt, ... But I like meh pigtail.... How you go tell me no salt? You don't make pig-tail without salt" (GA: Trade Union).*

On the other hand, there was the view that since the body was a machine, due care should be taken at intervals to make checks to ensure that it functioned optimally. A fitting example was:

"... when yuh know how a machine operates you always go back to the manual of that machine ... and the man body operate in that same realm..." (VH: Community Leader).

Men accepted the notion that their body was tough but took time to "check up" on their "machines" only after they perceived their lives were in imminent danger. In the presence of a health threat they were able to step back and ask questions like *"ah wonder if ah maintain meh machine" (AB: Community leader).* However, when the immediate danger subsided, men were more likely to continue their normal behaviour: taking risks. While they used the analogy of the body as a machine and the importance of maintaining same; this was more of an "ideal" rather than reality.

The disconnection between their knowledge about the importance of taking care of their bodies and risk behaviours as normal exacerbated the contradictions they experienced with "being a man". This was highlighted by one respondent who indicated that he knew that he had to take care of his body by being *"balanced"* but noted *"I know I honestly abuse it (my body)" (VH: Community leader).* This further reinforced the notion that risk-taking was "normal", even though they were aware of the need to take personal responsibility for the maintenance of their health.

6:5: Health seeking and masculine behaviour

Since men were expected to be healthy without paying special attention to their health and take risks, accessing preventive health services was not viewed as a priority. They were more reluctant than women to seek health services since to show any concern for their health would have been considered "unmanly". Men were expected to demonstrate a carefree approach, not only to their health but health seeking. This was reinforced by their socialization which contributed to the belief that they were invulnerable and any attempt to be proactive when dealing with their health was inconsistent with "normal" masculine behaviour. As long as men perceived themselves as healthy, they felt no need to seek medical attention. On the other hand, if he demonstrated any concern about his health and took proactive action in seeking help, he was referred to as being "weak".

"... on average I feel it is considered unmanly to be taking care, ... fretting about your health, ... going the doctor..., as a matter of fact even if you are asked about

your health to even suggest that ... you are thinking about it or that you sick and so on, again is also not manly, ..." (ST: Rural NGO).

This was a typical account reflecting men's health seeking behaviour. Men were socialized to believe that being healthy was a taken for granted assumption and as a result they were not expected to even consider health seeking care as a "normal" behaviour. As long as men were not diagnosed with a health problem they were not expected to express concern about their health even though it did not include adopting behaviours that enhanced their well-being. There was a taken for granted assumption that men were well as long as they were *"fit as a fiddle, ain't feeling no pain" (OJ: Sportsman)* and not experiencing any symptoms of illness. As a consequence, men who were willing to access preventive health services were considered as adopting lifestyle behaviours inimical to "being a man".

Generally, men said they only visited a doctor after they experienced symptoms of illness. Although men did not visit a doctor routinely, when this was done, it was to determine whether they were well since *"the person to determine our fitness is not us, is our doctor" (SS: Community leader).* The perception of being ill challenged men's ideal notion of masculinity as tough and resilient and the doctor was viewed as the one whose pronouncement on their state of health counted most. In this regard, they were uninterested in knowing how well they were whenever they visited a doctor since they would not have made a visit if they felt that they were well in the first place. A case in point was:

> *"... I come for a check-up, let me know what's wrong ...I don't need to know what working... tell me what ain't functioning ... what working is no news...I want to hear what ain't working ... So when I leave him now he educate me on what is wrong and how I should go about dealing with what is wrong..." (SS: Community leader).*

Respondents believed that men will not always be healthy which reinforced their unwillingness to seek help. This point was illustrated as: *"ever since I growing up ah always know I come with a manufacturer defect" (EB: Fisherman).* As a result, they believed changes in their health status were normal however, that was until their lives were threatened. However, this belief further highlight the contradictions between the 'ideal' and reality since it was inconsistent with the view that being healthy was natural. This was reinforced by the belief that, if men spent time making routine visits to the doctor in the absence of a health problem, it was considered as *"having too much time to waste on their hand" (ST: Rural*

NGO) since the general view was a visit to the *"doctor is a no no unless something happen to you as a man" (RM: Police)*. The level of reticence to visit a doctor was highlighted particularly among men from the rural community since they indicated that they lived in *"a bush community" (ST: Rural NGO)* where there was *"a number of herbal remedies" (EP: Rural NGO)*. As a result, they saw no need to make routine visits to the doctor because of their access to natural remedies.

This position was supported by the belief that a man who was *"always fit"* but accessed preventive health services was *"a sign of weakness" (LG: Humanitarian NGO)* since healthy men did not need preventive health services. A case in point was:

> *"... somebody who goes to the doctor and does not have a particular problem, not suffering from an ailment ... I think they would be considered weak, ... " (ST: Rural NGO)*.

While men were conscious of the importance of being healthy there was a disconnection between the value that they placed on being healthy and their health behaviour. This was attributed to the belief that *"sometimes we just ignorant to the facts ah life" (DN: Sportsman)* or that men *"does (do) not take care of his (their) body" (RB: Religious leader Hindu)*. Although respondents reported earlier that being healthy was 'normal', regardless of their age or social status, they identified maintaining their health status as their greatest challenge. An example was:

> *"My biggest health challenge at my age right now is to maintain ah clean bill of health ... " (SS: Community leader)*.

This was associated with their *"life structure" (CG: Trade Union)*, *"schedules" (MGM: Religious leader Christian)* or *"getting particular food at a particular time" (RS: Religious leader Hindu)*. Although respondents reported that they knew what was necessary to enhance their health they found it difficult to do so since they believed that they had *"no discipline" (CG: Trade Union)* necessary to adopt those behaviours. Since men generally did not consider their health as vulnerable; deciding to seek health was generally done when it was too late.

While respondents were aware of the benefits of having correct health information, they reported being challenged to incorporate the information as a part of their lifestyle. They indicated that they were *"quick to give advice" (NR: Industrial sector)* to others, but found it difficult to apply that very advice in their personal lives although, if taken for themselves,

would allow them to experience a better quality of life. One respondent reported that, as a man, he knew that he had to change his *"lifestyle"* but to do so *"was really tough" (LC: Police)*. A typical example of this was:

> *"... I quick to give he the advice ... tell him boy go and see about yourself but you ain't studying about you have to go and see about yourself too ... you ain't see your reflection, you ain't looking at that, until something happen to you ..." (NR: Industrial sector).*

Respondents noted that it is common for women to seek medical help: *"... women running by doctor fast" (AG: Fisherman)*, or as one stated that his *"wife does go gynaecologist cool, cool ..." (GH: Religious leader Christian)* and that *"they have no problem with that" (EP: Rural NGO)*. To them, this was supported by the structure of the health system. Men, in spite of their socioeconomic status, believed that the health system was not structured to encourage them to adopt positive health behaviours. This influenced their general unconcern about their health status as they would only consider seeking help if they were experiencing a problem with potential negative consequences. Hence they believed that it would be wasting time:

> *"... to simply walk into a place and sit down for a morning or something and you have nothing wrong with you" (ST: Rural NGO).*

In general, respondents were of the view that men believed as long as *"I feel I am good ..." (RB: Religious leader Christian)* there was no reason for them to be concerned about their health. Even in circumstances where they felt that their health was being threatened, men were more willing to adopt a *"that will go just now" (NR: Industrial sector)* attitude than to be unduly concerned whether any problem existed. If a man displayed any signs of being concerned about his health, it was construed as being unnatural. Not only did men accept the view that it *"is not something natural" (GH: Religious leader Christian)* for them to take care of their health but that it was not accepted that they would regard doing so as a priority. An example was:

> *"I believe men go to doctor when they have to go to doctor... That mean it had to be emergency... Is not something natural..." (GH: Religious leader Christian).*

MSM did not share the traditional belief that there was a disconnection between an individual's knowledge and his health seeking behaviour. Their understanding of health risks associated with their lifestyle as well as their knowledge of their HIV status facilitated a more proactive response to their health. They developed an appreciation for the value of preventive

89

health services as one respondent stated *"being HIV positive I started to pay particular attention to my health" (CLS: Humanitarian NGO)*. As a result they took responsibility for making doctors' visits as another respondent indicated that he looked forward to the *"one on one time with the physician" (NG: Humanitarian NGO)* that provided him with information to enhance his health status. However, they believed that had they not been diagnosed with HIV that they may not have been as proactive in relation to their preventive health. A case in point was:

> *"... I religiously look forward to go to the doctor cause I want to ensure that everything is okay with me... But I don't know if had I not been HIV positive if I would have been paying so much attention to my health..." (CLS: Humanitarian NGO)*.

On the other hand, MSM indicated that apart from HIV, they experienced challenges in deciding to seek medical help for general health problems; especially those related to their sexual health. This was exacerbated by a belief that they would be *"automatically at a disadvantage"* as a result of *"all those labels" (LG: Humanitarian NGO)* about them. This encouraged them to *"create all these elaborate stories"* to minimize *"fear of being stigmatized or discriminated against or labelled" (NG: Humanitarian NGO)* whenever they presented with an illness. Consequently, if a MSM perceived that presenting for health services will result in the health care provider questioning his masculinity, he was less likely to access services.

MSM were willing to behave in ways that were not in sync with hegemonic masculinity: showing concern for their health and this may have been as a result of their diagnosis with HIV. Nevertheless, while their response was inconsistent with the typical behaviour of men with a chronic illness, for example, hypertension, it may be associated with their perception of the outcome of the illness if they were not compliant. On the other hand, like men in general, in the absence of a diagnosis with HIV they were generally unwilling to seek medical help since they were more concerned about having to expose their sexual orientation.

6:6: Responses to prostate cancer screening

(This section of the chapter forms the basis of a paper that has been published in the Journal, Sexuality Research and Social Policy and the paper is attached as Appendix 7).

I had not intended to focus on prostate cancer screening services, and there were no specific questions in the topic guide on this. However, views on prostate cancer screening came up spontaneously in every group and this was an indication as a key factor that put them off from accessing the services. Respondents were asked about physical examinations that they were comfortable to have performed on them but shifted focus to those examinations with which they were uncomfortable. Having to undergo the prostate examination was identified as the one specific procedure that they were uncomfortable to have performed on them. They believed that the examination was important, especially as they grew older; however it did not reduce the high level of reservation that they experienced when they thought about having to take the examination.

They were aware of the different prostate screening services available which included the Prostate Specific Antigen (PSA) blood test as well as the Digital Rectal Examination (DRE). Typical examples of their awareness included *"they could do it without doing that (DRE), they could do it with the blood (PSA) as well" (NR: Industrial sector)* as well as *"the finger (DRE) is the better one" (ECB: Fisherman).* The fact that respondents were able to identify the various procedures for facilitating prostate cancer screening was an indication that they did not lack correct information. However, in spite of their level of awareness of the importance of screening services they were generally unwilling to access the service. They indicated that they were aware that as they grew *"older there are conditions that start affecting men" (CLS: Masculinity project)* or *"when you reach a certain age yuh have to go for this prostate test" (MC: Police).*

Based on their accounts, a high level of homophobia was the major deterrent to accessing prostate screening services. As indicated earlier, hegemonic masculinity was the 'ideal' representation among respondents, and this examination was viewed as being inconsistent with that 'ideal'. This was reinforced by the posture they were required to adopt for the examination as this was viewed as a reversal of the male/female sexual roles which increased their levels of homophobia. While respondents' believed that a visit to the doctor was a professional relationship, many respondents spoke about feeling embarrassed having to undergo the examination. A common description was:

> *"... is a man putting ah finger up yuh butt yuh know? ... that must be shame that embarrassment, that come like yuh loss yuh whole manhood dey ..." (SB: Fisherman).*

The very thought of being penetrated, albeit a diagnostic procedure, created feelings of discomfort for many of the respondents. This feeling of being violated was intense, in that, respondents reported that they had to weigh the benefits of having the prostate examination as opposed to the perception that it was a violation of their manhood. Their belief that the examination would make them feel emasculated exacerbated their unwillingness which caused them to *"keep putting it (the examination) off" (RS: Religious leader Hindu)*. Two typically graphic representations were:

> *"...You have to squat for a doctor to push his long hand up you anus you have to feel that lump... It was kinda ... demeaning ..." (CG: Trade Union).*

> *"... is something nerve-wrecking for you as a man to know that you have to go and skin yuh bottom and a man push in he hand and he pushing, that ah mean it goes against for me everything about being ...ah mean nothing ain't supposed to go inside dey" (MC: Police).*

The feeling of being sexually violated was intense since it was associated with losing one's virginity. One respondent who had undergone the examination shared that he felt empathy with young women who had lost their virginity since the procedure left him feeling that he *"actually know now what a woman goes through, feels like ..." (ZA: Masculinity project).* It left him feeling "dirty" and "unclean" since it was more emotionally than physically draining. Another respondent agreed with this position by stating that the examination made him feel as though he was *"going to find out how a macromere man (homosexual) does feel" (CAS: Masculinity project).* Even if the doctor tried to make them feel comfortable respondents' reported that they did not *"think any man would be comfortable with that (the examination)" (RS: Religious leader Hindu).*

While there was general consensus among respondents related to prostate cancer screening, the fishermen's accounts, while typical, were more graphic than other groups. An example was:

> *"... ah man eh really supposed to touch ah man dey in he bottom in truth yuh know and worse again a finger going up dey too..." (SB: Fisherman).*

As a result, before a man could willingly consent to undergo the examination, he would have to first review his notion of masculinity relative to sexual identity. A case in point was:

"... when yuh going through that finger test, it come like in the back ah yuh mind is ... like anal sex yuh having ... that is why most men will say yuh see that me eh going through that..... because ah that kinda macho-ness in man nah ..." (JS: Fisherman).

Even when respondents spoke about having experienced the prostate examination, it was not the procedure itself that made them uncomfortable but the interpretation of the experience. The examination, although painless, exacerbated their conflicts since, in making a decision, they had to consider the importance of the examination as opposed to their perception of the examination. To illustrate this point one respondent gave his personal account of an examination:

"... ah feel the finger going in eh, ah didn't have no pain and thing, ah really eh feeling no pain but by the time he pull out that finger and he say alright, I feel real uncomfortable. I feel as if we just had an intimate relationship..." (CAS: Masculinity project).

Heterosexuals believed that men who were used to *"receiving it (anal sex) from there freely and willingly"* would be more likely to visit *"the doctor to get that (the examination) done" (ND: Sportsman).* Their homophobic fears were exacerbated by their expressed concerns about the potential implications if men *"happen to fall in love with that feeling" (CP: Prisons);* the insertion of a finger in the anus. In one instance, a respondent shared the experience of a colleague who developed a liking for the feeling of being penetrated anally since he experienced it during a sexual encounter with his wife. They feared that such an experience could move from perception to reality and create further challenges for men in redefining their masculine identity.

Generally, men were concerned about the examination itself however, a few Policemen were more concerned about the sexual orientation of the doctor as this also served as a deterrent. A typical concern was whether the doctor *"could be sexually gratified" (MC: Police)* by the procedure. In this regard, they were willing to protect their manhood and were unwilling to expose themselves in such a situation to the extent that they were even prepared to become violent if the doctor's actions were suspicious. Two examples were:

"... I have to go for a prostate exam ... I might have a firearm and I gone and next thing you see some kinda thing by this doctor right, I forgetting everything else ..." (MC: Police).

"...imagine you watching a man and you experiencing a man doing you that... that's thing to just get up and fight. ..." (PF: Prisons).

However, there was no difference in the level of psychological discomfort experienced by MSM when they considered accessing prostate screening services since they were *"very wary of going to a doctor to be probed, have a finger put up their butt" (CLS: Humanitarian NGO)*. While they were comfortable with their sexual orientation they had difficulty exposing themselves during the examination except in one instance when a respondent reported *"I could tell her anything because she is my doctor from since I small" (KP: Humanitarian NGO)*. In their view, having coitus with another male was as a result of their sexual preference but a prostate examination was viewed as an invasion of their privacy. In this regard, they were more concerned about maintaining their projected masculine identity as *"straight men or machismo men" (CLS: Humanitarian NGO)*. A case in point was:

> *"... as a gay man immediately I'm thinking you know if you have rectal problems or problems with penis... You will be very uncomfortable to go to the doctor and disclose, speak the truth about what is going on ... because of conditioning, ... and we recognize that is one of the reasons why other men develop prostate cancer very late..." (CLS: Humanitarian NGO).*

In spite of respondents' expressed unwillingness to undergo the prostate examination they identified some instances that may serve as facilitators. For those who had witnessed the suffering of their father or a significant male in their life as a result of being diagnosed with prostate cancer they were more likely to access the examination. It was the extent of the suffering that they witnessed that encouraged them to evaluate whether they would continue to hold on to homophobic anxieties or confront their fears by undergoing the examination. The following example illustrates this point:

> *"... After I see what my father went through ... he was diagnosed with advanced prostate cancer and because of the same thing, he didn't want to go and take the test, and after I see that, ... that reduce my fear. So I would do anything that is necessary to keep me in health ..." (NG: Prisons).*

This position was reinforced by another respondent who shared the experience of witnessing his grandfather die as a result of prostate cancer. He opined:

> *"... yuh see the suffering brother, and that cancer ... When I see my grandfather ... he was 63 ... he was a giant. He was a body builder. ... When you see he stand up, he was never hunched, never weak ... and is from fear of going to the doctor, by not going to the doctor that he end up dead. ... I know black men, afro men are numbered among the highest incidence of that and I have a lot to live for. ... I am*

approaching the age where I would have to do that every year. And I going to have a good nice relationship with my doctor" (GG: Prisons).

By extension, a few respondents spoke about the birth of a child, especially a son, that caused them to reassess their personal responsibility for their health including access to prostate cancer screening services. In this regard, men wanted to be alive and healthy to witness the growth and development of their sons and were unwilling to continue taking their health for granted. Such responsibilities were discussed in terms of expressed desires, for instance, to *"at least see him [son] grow to become a man"* and the recognition that being diagnosed with an illness would deprive them of the opportunity to see their children *"carry on the tradition" (CAS: Masculinity project).*

Although men identified factors that served as facilitators for accessing prostate screening services, it did not reduce the levels of anxieties they experienced. In an attempt to minimize their levels of homophobia, men reported that they were more comfortable to have a *"woman doctor" (OJ: Sportsman)* or someone who was not a *"good friend" (SB: Fisherman)* conduct the examination. A female doctor was perceived as having the same level of competence as a male and men's confidence in their practice helped to reduce their psychological discomfort and homophobic anxieties especially with the prostate examination. A case in point was:

> *"I doing anything if it is a female doctor ... I feel very comfortable with a female doctor ... there is nothing that she can't diagnose or prescribe that a male doctor can't ... I am very uncomfortable with men touching me" (FAV: Prisons).*

Men in general, regardless of their sexual orientation, knew of the importance of undergoing prostate screening services however, knowledge was an insufficient criterion to facilitate access. While they identified possible barriers and facilitators which influenced their decision to access the service, it did not reduce their level of homophobic anxieties in making the decision.

6:3: Summary

In summary, respondents believed that being healthy was central to masculine identity, that men were supposed to be healthy naturally and they generally took their health for granted. For the most part, respondents did not feel obligated to take care of their health as this responsibility was deferred to others. Although they tacitly deferred responsibility to others it may have been to hold them accountable for any negative consequences to their health than

actively contribute to their health maintenance. They perceived risk taking as a core aspect of "being a man" and this was consistent with men in general who hold hetero-normative beliefs of masculinity. Although they feared being diagnosed with a severe illness it did not reduce risk taking as "normal" masculine behaviour. Men generally did not visit the doctor and this was reinforced by their belief that they should be unconcerned about their health. However, even if they were experiencing health problems, they were still likely to delay health seeking. Men's overt response to health seeking was not sustained especially when the issue that served as the catalyst for this action in the first place dissipated.

Prostate cancer screening was identified as one of their major concerns about health seeking. While men were conscious of the importance of the examination they generally did not access this examination since it conflicted with their masculine identity. The physiological as well as psychological challenges associated with prostate cancer screening posed formidable challenges for men since it confronted commonly held beliefs about masculinity. Men whose father or other significant male in their lives died as a result of the diagnosis with prostate cancer as well as the birth of a son served as facilitators for accessing screening services. Further, the availability of a female care provider also supported their decision to access the service since it helped to reduce their homophobic anxieties. However, the real and imagined challenges associated with the perceived loss of sexual power that could result from a diagnosis may have also contributed to willingness to access screening services as well.

While MSM are considered as being more inclined to take greater care for their health, this was not supported by the findings. MSM, like other men in this study, did not prioritize their health nor were they less likely to take health risks. However, unlike men in general who were diagnosed with a chronic health problem, they demonstrated greater responsibility for the maintenance of their health; especially those who were diagnosed with HIV. It is possible that their perception of the potentially negative outcome of HIV, unlike other chronic diseases which are viewed as treatable, may have contributed to their willingness to be more responsible for their health. By extension, it may have helped them to develop a greater appreciation for life and, as a result, demonstrate willingness to adopt behaviours that would enhance their quality of life. In conclusion, being a healthy male was fraught with complexity since; on the one hand, men valued being healthy but experienced conflicts in response to whether they should or should not be concerned about their health.

Chapter seven: "Male sensitive" health services - perspectives of service providers

So far I have discussed in the previous chapters findings arising from the Focus Group Discussions. I have explored the social construction of masculinity in Trinidad and Tobago. To be a "man" is to be healthy and that to be a "real man", one has to disregard his health. This belief encouraged men to take risks as a normal demonstration of masculine behaviour. Although respondents expressed unwillingness to access health services in general, they discussed personal challenges associated with health seeking, especially when it came to prostate cancer screening services. This chapter shifts to findings from Semi Structured Interviews among key informants whose views were critical in answering the research question *"what are service providers' views of "male sensitive" health services?"* The findings in this chapter provides the framework for developing policy implications and strategies for implementing "male sensitive" health services.

Men who were clinicians and programme leaders at the management or operational level in the delivery of clinical services as well as male specific social programmes were selected as key informants and included in the semi-structured interviews. These informants worked in the public as well as the Non-Governmental Organizational sectors and were selected because of their considerable experience at the clinical and programmatic levels and were considered as experts in their particular field. Their inclusion also allowed them to share personal experiences in cases where they had either accessed or were currently accessing health services. This was critical in shedding light on the implications for and a way to develop "male sensitive" health policy initiatives. While their perspectives were general in nature, three factors emerged from their accounts including core components of a quality health services, potential barriers to access and contradictions in accessing services.

7:1: Nature and quality of "male sensitive" health services

While developing "male sensitive" health services is an outcome of this study, based on the responses of informants, there remains a complex question "is there such a thing as "male sensitive" health services?" This was a difficult question to answer and possibly a question that may remain unanswered among the research community. While there was no consensus on what constituted "needs" of men, most informants focused on a set of preferences,

depending on their particular experience. It was difficult to dissect perspectives that were "male specific" except in a few instances when they were viewed as facilitators to accessing services. From their accounts, men focused on receiving a high quality of services; the fundamentals of which may be common for both men and women.

Common among all informants was the view that men needed quality health services that were accessible, structured and comprehensive, provided by knowledgeable and competent staff, as well as available in an environment that ensured confidentiality and privacy. In their view, accessibility of services included making services available beyond the normal working hours since working, as identified previously, was prioritized over seeking medical help. Men also wanted service providers who were *"understanding that men work and that men would need to ... come in unconventional hours" (Doctor)*. Informants indicated that health services that were responsive to their needs were provided in an environment that made them feel that their masculine identity was validated. An example was *"men could be entreated and regarded in a way that is best suited to them" (Clinical Nurse)*.

These characteristics were of extreme importance in supporting their own as well as other men's decision to access services voluntarily. Services that were "sensitive" to their needs included timeliness since they believed that having to wait for long periods prior to receiving services was construed as wasting their own, as well as, the doctor's time. From their accounts, a timely service was one that was *"prompt as they could get" (Program Manager)* as men usually *"don't have time to wait" (Secretary NGO)* or *"don't want to spend all day" (Policy Development Specialist)* before receiving services. This was reinforced by the belief that men *"are not accustomed to waiting in line or waiting on a service" (Program Director)* hence timely service was associated with respecting their time.

Across the data set informants believed that the current health services are delivered using a medical model since it *"only focuses on the sickness" (Community Nurse)* of clients. Since men did not readily access services, then the current "illness model" may continue to exacerbate their negative perception and response to their health. This should be of critical concern to policy-makers and service providers, bearing in mind, that they are less likely to access health services than women. Most informants were of the view that little consideration was given to *"what is being offered and what is being benefitted to the man" (Policy Development Specialist)*. One of the strategies recommended to solve this lack of sensitivity

to males was a space that would make them feel respected and treated as though they are receiving individualized care. An example was:

> "the doctors and the senior nurses who would actually be involved in the clinic, their consultation must cater to your needs and be willing to cater to your needs by yourself" (Doctor).

Men may be more inclined to access services that were personalized and responsive to their needs however, this was difficult to ascertain since the "needs" of men may not be homogenous as a group. In this regard, it may be impractical to develop services that were individualized for men.

A "male sensitive" health service was described as an

> "... open clinic where he can access various, a wide range of services at the same facility without being seen or thought of as attending a particular type of clinic ..." (Policy Development Specialist).

It was also described as a health service with *"somebody at the helm who know the needs of men" (Clinical Nurse)* or *"a facility ... that you could go into ... is like you could disappear from the inside" (Chairman NGO)*.

Most informants spoke about the importance of having comprehensive services available. However, a few of them indicated that the service must be provided on a consistent basis. One informant, himself a clinical service provider, in supporting this position noted that "male sensitive" services must be seen as an *"avenue that they wouldn't be missing anything while at the health facility" (Community Nurse)*. The structuring of the delivery of services as a specialist rather than integrated one was seen as less than "ideal" for men. In general, all informants believed that such services *"should not focus on a particular issue" (Policy Development Specialist)* since the comprehensive range of services would encourage greater access among men. While providing services on a consistent basis may not be specific to men, it was a characteristic that was considered "sensitive" to them in light of the observation that it was unusual for men to access health services readily. Inconsistency in service delivery may, in this context, serve as a greater deterrent in considering access to services and may be exacerbated in cases where they are not comprehensive nature.

Apart from the comprehensive services most informants wanted service that was offered by qualified and competent staff. Although men from the focus groups indicated that fear of a

diagnosis with a health problem was a deterrent to accessing services, key informants believed that the availability of knowledgeable staff to answer their questions would assist in allaying their fears. Key informants, especially those who had recently visited a health facility, indicated that the professional characteristics of the health care provider were of greater importance than his or her gender. Professional characteristics included being *"knowledgeable" (Doctor)*, *"show real interest" (Supervisor)* and *"know what he is talking about" (Medic)* and this encouraged them to have confidence in the competence of the care providers. From their accounts, some of the qualities to demonstrate competence included being *"friendly" (Doctor)*, *"polite" (Clinical Nurse)*, *"caring" (Supervisor)*, and *"courteous ... helpful" (Medic)* as well as *"straight forward ... genuine" (Secretary NGO)*. Men wanted health providers who were caring and polite, yet, at the same time, professional by being straight forward in their interactions.

In general, all informants wanted a health facility that was 'gender sensitive', in that, there should be both male and female staff with the male/female ratio of providers dependent on their personal preference. On the one hand, some informants had a preference for more female health care personnel since they were viewed as more empathetic and "sensitive" to their needs. A case in point was shared by one informant who indicated that he preferred a female doctor to care for him since she may be more empathetic and so provide men with opportunities for greater *"interaction ... empathy" (Community Nurse)*. This position was shared by another informant who indicated that he preferred a female care provider since she was viewed as someone who would *"listen"* to his concerns as *"... with men doctors that (listening) doesn't happen as much" (Supervisor)*.

On the other hand, some informants wanted *"more males involved in health care" (Community Nurse)* or *"a male presence as a health care provider" (Doctor)*. They perceived that having more males encouraged men to *"have some sort of confidence" (Policy Development Specialist)* in the delivery of services. Only one interviewee was specific in indicating that it was what he viewed as the "sensitivity" of the health issue that influenced his preference of a male or female care provider. Although he was an experienced health care personnel he used as a case in point *"erectile dysfunction ... not going to feel comfortable relating this problem to a female" (Community Nurse)*. It is possible that this may be a general position among men since, as stated earlier, even in the presence of illness, wanted to

maintain their dignity, and erectile dysfunction was a health problem that challenged their manhood.

By extension, men expected staff *"to be totally professional" (Medic)* in their interactions. However, in several interviews, their views also suggested that men wanted a highly sexualized service. For instance, one talked about wanting to be *"examined by attractive women" (Policy Development Specialist)*, another said (of a female staff member) that he wanted to *"give her some trouble ... flirting" (Youth Officer)*; typical hetero-normative behaviour. This suggests that in this context, men may continue to experience conflicts in the client/provider relationship, in that, they want professional services while sexualizing the encounter with female care providers.

Most informants highlighted the importance of privacy as an essential characteristic when accessing services at health facilities. Two typical responses from informants included *"a lot of men value privacy especially with respect to their health" (Policy Development Specialist)* and that *"you don't want to know yuh friend see you and it start circulating ... he sick with something" (Lecturer)*. There was a general view that men experienced greater levels of comfort in accessing services if they believed that their privacy was protected. From their accounts, men visited the health facility to receive services but they also indicated that men did not want to be recognized by others and liked to maintain their *"anonymity in terms of what you might be there for" (Program Manager)*. Since men, in general, did not visit the health facility normally, most informants believed men wanted to *"go in and out without being seen" (Policy Development Specialist)* by others. This may be more 'ideal' than realistic since services are provided as a public service and offers little potential for the provision of the level of privacy that men wanted.

7:2: Potential barriers identified to accessing services

Since informants identified a number of characteristics of "male sensitive" services, by implication, their absence or limited availability were likely to act as barriers to accessing health services. The major barrier to male access to services was the perception that services were intrinsically structured as "female sensitive". Informants were of the view that, in practice, the sensitivity of the services to females was manifested by staff were predominantly female, health promotion materials were female oriented and the decor of the physical environment was also oriented toward females. The following examples highlight

informants concerns: a male health care provider indicated health services was *"being female dominated" (Doctor)*, in that there were more female care providers. Another informant opined that health facilities were usually *"full of women" (Chairman NGO)* meaning that they are usually filled with female clients. It is this belief that reinforced the perception that, in their view, the current services were not sensitive to the needs of men since care providers as well as clients were predominantly female. Bearing in mind that men, in general, were of the view that "being healthy" occurred naturally and that men were not expected to show concern for their health, their perception of health facilities as "female sensitive" may continue to exacerbate their negative response to health seeking. One informant opined that *"having a male presence as a health provider helps" (Doctor)* could help in changing this perception. It can be inferred that the availability of more males in health facilities may help in reducing the stereotypical perception of the health facility as "female dominated".

Another factor that was highlighted by informants was the limited opportunities available to men to support family members when hospitalized. Men were unable to be present in the delivery suites to support their spouses, for example: *"a father is never allowed in the labour ward ... right in the labour room when the mother is having the child" (Clinical Nurse)*. They are also of the general view that the health system discriminates against men since they were not allowed extended visiting hours like their female partners to be with their hospitalized children. From their accounts, it could be construed that men may develop a more positive attitude toward the health system if they were allowed opportunities to become engaged with family members when ill. This may contribute to the development of a more positive attitude toward their health behaviours. As far as informants were concerned, this problem could be addressed if policy-makers recognize that there is a *"need to redesign services with men in mind" (Policy Development Specialist)*.

Apart from the health system being "female dominated"; most informants spoke about the unavailability of health information targeting males. While they noted that there is a preponderance of available health literature including leaflets and posters, for the most part, they were predominantly female oriented. An example was:

> *"... when you look at those documentaries that come through United Nations; women ... And men have been put to the background ..." (Medic).*

They believed that the limited availability of "male specific" health literature may exacerbate men's health risks since it reinforced the notion that men are not expected to take care of their health.

This suggests that men may be more willing to have information that could support their health decision making than they may care to admit. Although men are expected to show disregard for their health as shown by the data, it may not take away their desire for having access to health information. Informants were not only conscious of the importance of health information but the various media through which this information could be made available. It can be construed that men may be reached differently with information depending on their personal preference. Their general view that if "male sensitive" health information were packaged and available it would *"enhance male responsiveness" (Policy Development Specialist)* to the service since *"they want to feel that the health centre has catered for them" (Doctor)*. By extension, one respondent highlighted the role of the health care provider in the transmission of health information as they *"should be dispensing not only medicine but a higher level of information" (Supervisor)*. This reinforces my interpretation that the availability of competent and knowledgeable health care providers could go a long way in reducing their fears and anxieties in matters related to their health.

Across the data set, informants also spoke about the importance of the physical space where the services were offered. Men wanted to access services in a physical space where the decor and ambience of the environment are representative of "manliness". To most informants, not only were the services sensitive to the needs of women but the physical spaces as well, hence men wanted a space that was not reflective of femininity. A "male sensitive" physical space was described as one that *"must be inviting ... not look female" (Doctor)* which was enhanced by the *"colour scheme" (Youth Officer)*. In general, informants wanted a physical space, not just for its aesthetics, but one that was *"functional ... relaxing for men" (Secretary NGO)*, in that, it must make them feel as though they had entered a male space without feeling as though they had come to a medical facility. The following example highlights this point: men want to feel as though they are *"coming into a space ... where I'm (they) free to be a man ... but vulnerable enough to seek help" (Chairman NGO)*. While this was a suggestion that could be considered as a next step, it could prove challenging in the absence of having clearly designated "male specific" health spaces. From their accounts, it can be deduced that if men

continue to perceive the available services as being "insensitive" to their needs then they may continue to respond poorly to those services.

7:3: Contradictions in accessing "male sensitive" services

Although informants identified barriers to accessing health services, these related to inherent contradictions in their accounts of "male sensitive" services. While they needed "male specific" services that validated their masculinity it was their desire to protect their masculine identity that oftentimes created reluctance in health seeking. Men were generally unwilling to acknowledge that they *"had some (health) problem" (Medic)* since they believed that it was their way of protecting *"your (their) ego" (Community Nurse)*. Being ill was viewed as an affront to their masculine identity as it made them fearful that *"others will laugh at ... look down at him" (Chairman NGO)* and this contributed to men being more protective of their ego. Men wanted professional services yet at the same time some of them wanted to be cared for by a *"female ... good looking nurse" (Youth Officer)* with whom they could 'flirt' or 'give a little trouble'. At the same time, they indicated that *"men does want to be recognized and treated with some courtesy" (Secretary NGO)*. These findings help in understanding the contradictions that men experience since on the one hand they expect to receive a professional services while, at the same time, behave as though they are having a sexualized encounter with female care providers. In such a 'gendered' and sexualized setting, men may continue to experience contradictions and it may be almost impossible to provide professional services to them.

Based on their accounts, homophobic anxieties was an influencing factor that created conflicts for men while health seeking. One of the major contributors to these anxieties related to the level of discomfort that men experienced having to expose the private parts of their anatomy to a care provider. While some informants indicated that were more comfortable to have such an encounter with a female care provider others shared an opposite view, in that, they would be more comfortable doing so with a male care provider. This is a further example of the impossibility of providing 'male sensitive' and professional services to men if everything is 'gendered'.

Another contradiction that men experience related to the configuration of the physical space where the services were being offered. While some informants indicated that men want a health facility that provide *"different waiting areas" (Policy Development Specialist)* since

this enhanced anonymity other informants indicated that men want a facility that allowed for social interaction with other men akin to a social club. Among those who identified the importance of social interactions they indicated that *"male oriented activities" (Youth Officer)* could include *"recreational activities" (Clinical Nurse)* encompassing board games and sports equipment since the facility will serve as a non-threatening space for men to socialize as well as access services.

While this may be a practical consideration, it may be impossible to achieve since such levels of privacy may not be available in public health settings. Further, men want to access health services in health settings but place a high value on maintaining anonymity although his very presence in the facility may be an indication that he was in need of help. However, it had implications for the way in which policy makers expand health services with men in mind as well as approaches that can be taken by health professionals in the delivery of services. From the informants' accounts, men may be more concerned about projecting the false notion that they were well and were utilizing a "male sensitive" space for socialization rather than acknowledging the real intent for their presence at the health facility: to seek help.

7:4: Summary

In summary, informants were of the view that the current structure of the health services was similar to health systems in general, in that, it was more sensitive to the needs of women and girls than of men and boys. Services as well as staff are predominantly female which contribute to the perception that men are generally excluded from the health system. Although men may be less disposed to access health services in general, from their accounts, it can be concluded that men may be willing to access services if they perceived that the services were "sensitive" to their needs and respectful of their masculine identity. Men want services that are provided in an environment that facilitates privacy and confidentiality since it helps in validating their masculine ego. To enhance greater uptake of services, respondents believed that 'male sensitive' services should be provided in a facility that represented more of a social space than a health facility with activities that allowed interaction with other men. However, this may be utopian and unachievable.

It may be easier for men to access health services if they were comprehensive and not disease specific, provided in a timely manner and by staff from both genders with high levels of professional competence. While men wanted a professional service their inherently gendered

view on health suggests that some men perceived the health encounter as sexualized; a factor that influenced their response to health. Their perspectives could provide a number of challenges in providing "male sensitive" services given the contradictions in their accounts. These challenges are also supported by the structural barriers which exclude men from greater involvement in health care settings. By extension, the unavailability of extended visiting hours available to men during the hospitalization of children, although available to women, as well as their exclusion from the labour ward during the birth of a child were construed as insensitive to men. This reinforces the perceived systematic structural and normative approaches in which men continue to be excluded from the health system. These findings are of significance and will be used to address the policy and programme implications arising out of this study.

Chapter eight: Discussion

The evolution of studies in masculinity grew out of studies on women, done mainly by feminist researchers which served as a platform for articulating discontent with the perceived marginalization and social position of women in opposition to men (Sabo, 2000). In general, initial studies on masculinity were context specific, in that, they focused on the performance of masculinity in specific populations. Within the Caribbean, the initiation of studies in masculinity was no different to the international context as an attempt to reposition men and masculinity as central to the debate on gender. While Caribbean researchers had their initial focus on the marginalization of men and boys in education (Miller, 1986), a number of other research studies have now been conducted on masculinity in the Caribbean extending to other aspects of masculine behaviour. However, this research project, as far as I am aware, is the first research study in the Caribbean, including Trinidad and Tobago, that was initiated to explore the role of socialization in the construction and performance of masculinity, with specific reference to how these affect their health beliefs and behaviour.

8:1: "Ideal" representation of masculinity

Data from this study was consistent with other studies in agreeing on a typical representation of hegemonic masculinity as being tough, strong, powerful, self-reliant, competitive and unwilling to express themselves emotionally. In this regard, the notion of what it means to be a man may be consistent in many social contexts although there may be unique characteristic features depending on the context. Connell (2005, p76) argued that while performing masculinity is contestable, it is *"the masculinity that occupies the hegemonic position"* that determines "ideal" masculine behaviour in a given context. While there are socially agreed tenets of behaviour that are consistent with masculinity, in performing masculinity, men *"make situationally specific choices from a cultural repertoire of masculine behaviours"* (Connell, 2005, pxix). In this regard, the way in which a male may choose to demonstrate the "ideal" representation of masculinity may be based on an agreement of behaviours that are appropriate for the given setting. While respondents identified "ideal" characteristics associated with being a "real man" these were in opposition to normal behaviours that they observed in practice and this contributed to the level of tension they experienced in defining masculinity as "ideal" versus observed. Being female was generally taken for granted, unlike being a man since it was not taken for granted that all males were men. As a result, males not only learned to be men but they were also expected to prove that they were men.

From their accounts, "ideal" masculine behaviour was hetero-normative even though men experienced personal challenges in living up to that "ideal". For the most part, men identified "ideal" patterns of behaviour associated with masculinity although the behaviours observed among males were in direct contradiction to those "ideals". There was consensus amongst respondents that there were socially constructed and agreed behaviours associated with being a man. Yet they also spoke about the contradictions that existed between being a 'man' and a 'real man'. Although a male could have all the biological attributes, his biological make-up, in and of itself, did not make him a man. It was only in circumstances where a male's behaviour was consistent with socially agreed normal heterosexual behaviours that such an individual was accepted as a man. Connell & Messerschmidt (2005, p838) postulated that men are comfortable to identify with hegemonic masculinity as the "ideal" representation of masculinity although it may *not correspond closely to the lives of any actual men*. This observation was supported by the findings of this study since generally; the construction of a normative notion of masculinity was more "ideal" than reality.

However, based on participants' accounts in this study, a major finding was that the notion of masculinity, as a construct, was almost 'fixed' and not susceptible to multiple representations. While it is a commonly held belief that the notion of masculinity is dynamic and fluid which facilitates multiple representations, in this study men found it difficult to negotiate multiple representations of masculinity. This was highlighted in situations where respondents spoke about being a 'man' which was the normal masculine behaviour observed on a day to day basis as opposed to a 'real man' which was the "ideal" representation of masculinity. As a result, a male who demonstrated non hetero-normative behaviours was not referred to as a 'man' since such behaviours were outside of the defined behavioural characteristic consistent with being a man. Masculine behaviours were policed to the extent that men who did not demonstrate hetero-normative behaviours were subjected to overt pressure to conform to "ideal" masculine behaviour. By extension, MSM who spoke about rebelling against hetero-normative stereotypes also indicated that, in general, this was not easily done in reality which acted as a strategy that supported their conformity to this almost 'fixed' representation of masculinity.

Although, from their accounts, living up to this masculine "ideal" was utopian and unachievable, men are expected to conform and demonstrate behaviour consistent with this "ideal". It is possible that the small sized population may have contributed to the level of

policing of masculine behaviour which may explain their general accounts which conformed to "ideal" representation of masculine behaviour. In this regard, the findings in this study support Barriteau's (2000) position that masculinity is easily defined but unachievable. However, the almost 'fixed' notion of masculinity is inconsistent with the views of other Caribbean researchers who postulate that masculinity is a plural concept (Beckles, 1996), not a homogenous concept (Lewis, 2004) or rarely static and unchanging (Parker, 2003).

8:2: Role of women in masculine socialization

Although male role models were identified as central in how young males learned to be men, in this study, women played an important role in male socialization. In the absence of fathers, mothers and grandmothers assumed greater significance in the process of male socialization. Within the Caribbean context, including Trinidad and Tobago, where there is a high level of female headed households this could pose particular challenges for young men in developing their masculine identity. The tensions males experienced in learning to be a man may be exacerbated by the contradictory messages that they received about being a man in the socialization process, especially from women. Mothers and other females emphasized messages about "not being female" while the wider society continuously deconstructed and reconstructed "ideal" behaviours associated with what it means to be a male and, by extension, how he performed masculinity. It is possible that females may be more overt in policing masculine behaviour hence they may have been more inclined to focus on "not being a female" rather than "being" a man. This has serious implications for males within the context of a society where men are expected to relate to their experiences in 'gendered' ways.

Clarke (1999) a foremost Caribbean feminist researcher in her classical work on Caribbean families highlighted the importance of women including mothers and grandmothers in the socialization of children; including males. The prominence of the role of women was predicated on the emasculation of men during slavery which denied men the ability to control or exert power within relationships. She contended:

> *"The fathers place in the family was never secure... in general, he was not the source of protection and provision for mother and children... it is against this background of the weakness of the father role in the system of family relationships that those of the mother and grandmother assume particular importance" (p2,3).*

This position was reinforced by Bolles, (1988, p9) who argued that especially in the Afro-Caribbean context, the roles of women *"are as strong today as they were in the days of slavery"*. As a result, the structure of Caribbean families as well as male socialization has, to a great extent, been influenced by the experiences of slavery which reinforces the centrality of women in social development of children in general and males in particular. In this regard, these findings support other Caribbean researchers in highlighting the role of women in male socialization. However, it goes a bit further in identifying the influence of their messages on policing masculine behaviour.

8:3: Sacntions and tensions in living up to "ideal" behaviours

Lewis (2007) argued that learning to be male is facilitated through a multiplicity of influences. Society, in ensuring that men subscribe to an "ideal" notion of masculinity enforces overt and covert social sanctions that are sometimes supported by the legal system. In his view, society does so by validating, rebuffing or interrogating *"some or all aspects of its practice" (p6)*. A male who fails to live up to the expectation of hetero-normative notions of masculinity is often characterized as 'feminine'. He contends further that fear of being characterized as subordinated to other men that facilitates his *"tendency to conform to ideals of normative masculinity" (p6)*. Connell & Messerschmidt, (2005, p831) postulated that it is the *"idea of a hierarchy of masculinities"* that result in the policing of masculinity. In this regard, men in being protective of masculinity may subconsciously challenge any representation that is inconsistent with that "ideal". Although MSM in this study referred to themselves as "real" men, it is possible that they may have done so since they understood the value of adhering to hegemonic notions of masculinity as this was the accepted "ideal".

Research studies indicate that men who may not be comfortable in conforming to hegemonic masculinity are more likely to compensate for their masculine identity by adopting behaviours consistent with an "ideal" notion of masculinity (Soban, 2006, Ragnarsson et al., 2010, Mussap, 2008). In this study, hegemonic masculinity was so overwhelming, in that, all other representations of masculinity were interpreted as *"not a man" (ECB: Fisherman)*. Men, and by extension, the wider society, in an attempt to police masculine behaviour exert overt and covert social pressure in the form of sanctions to encourage conformity. This is supported by the use of popular culture which reinforces compliance to these masculine 'ideals'. Although MSM indicated that they often challenged hegemonic notions of masculinity they complied with socially "ideal" masculine behaviours as a way of preventing overt sanctions from

others. In this regard, sanctions of masculine behaviour helped to maintain the bounds that encouraged compliance and this may have been exacerbated by the small population size. This finding is significant in adding to the body of literature on masculinity since it helps to unpack men's understanding of sanctions as a strategy for ensuring compliance with hetero-normative behaviour.

8:4: Tensions in 'fluid' versus less 'fluid' notions of masculinity

In spite of the biological imperatives that differentiate males from females; masculinity, as a construct, is 'fluid' (Marchbank and Letherby, 2007) and can be constructed, deconstructed and reconstructed as a continuum. Connell (2005) noted that while there is consensus and culturally agreed notions of gender, when it comes to masculinity, there is an absence of consensus. Connell & Messerschmidt (2005), in acknowledging that there are multiple representations of masculinity, argued that the variations in masculinities must not be viewed as simply different but that they are subject to change. Lewis (2006, p6) in supporting this position posits:

> *"masculinity has never been settled in the sense of being fixed and unalterable. Masculinity has always shifted, regrouped, adjusted or reposition itself in relation to the specific configuration of social forces and challenges that it faces".*

Being a man is complex and fraught with contradictions between "being" a man and "doing" masculinity. It is this complexity in defining masculinity that acts as a basis for the general belief that to be male does not automatically result in an individual becoming a 'man'. Researchers have noted that men and boys experience greater pressure than women and girls to align themselves with societal prescriptions of normal hegemonic masculine behaviour (Courtenay, 2000b, Tremblay and Pierre, 2005, Connell, 2005). Connell (2005, p86) noted that men, unlike women, *"are chained to the gender patterns they have inherited"*. In this regard, behaviours associated with being a man are socially prescribed and may be policed more strictly than for females. The notion of being chained to a masculine identity poses further challenges for men as Tremblay & Pierre (2005) argued that even in the absence of masculine models in the lives of young men they are still expected to adhere to masculine gender role stereotypes. Data from this study indicated that males wanted role models in their lives but, for the most part, the men whom they identified as role models were not their fathers although they spoke about their fathers in terms of the masculine "ideal".

The findings from this research further highlight the contradictions between men's notion of what it means to be a "man" as opposed to a "real" man. For the most part, a "real man" was identified as the "ideal" representation of masculinity which, from the experiences shared; was difficult to achieve. Although respondents held precise views of what constituted a "real man", based on their accounts, there were few real examples that they were able to highlight. For example, although they spoke consistently about the "real man", they experienced personal conflict in living up to the very masculine ideals that they identified. In spite of the absence of their fathers as role models, men took what they identified as "ideal" masculine characteristics that they observed from other men whom they considered as role models. In spite of their desire to be "real men" this was elusive and difficult. The findings further support the observed contradictions between masculinity as it defined as opposed to what was experienced by Caribbean men since it is utopian and unachievable (Barriteau, 2000). In spite of the contradictions that men experienced between masculinity as defined as opposed to experienced, they still expressed a desire to be "real" men. Lewis, (2007, p6) opined that it is the desire to adhere to the *"notion of how real men are supposed to behave"* that influences how men perform masculinity since it helps to protect them from being treated as subordinate to other men; a perspective that was shared by Connell & Messerschmidt (2005).

While Connell & Messerschmidt (2005, p836) argued that *"the concept of masculinity is blurred, is uncertain in its meaning"* data from this study suggested a different position since masculinity appeared "less fluid" than in other contexts. While respondents who were heterosexuals did not acknowledge the different representations of masculinity they spoke about dichotomous categories like 'men' or 'real men'. An analysis of their responses revealed that although they indicated that being a "real man" was utopian and an almost impossible reality, they were unwilling to acknowledge the possibility of representing masculinity differently to what was considered "ideal". Across the focus groups, from a range of backgrounds, men universally subscribed to hegemonic notions of masculinity. MSM however, saw themselves as *"real men" (Humanitarian NGO)* in spite of not conforming to hegemonic masculinity. Their responses were in opposition to heterosexuals since they did not subscribe to the socially agreed script of how a man should behave. Their concept of masculinity was also different, in that, it was biologically determined as opposed to heterosexuals who argued that biology was an insufficient criterion to determine one's masculine identity since it was socially determined. However, they experienced conflicts in

performing masculinity since it was hegemonic masculinity that ultimately determined what normal masculine behaviour was.

In this context, the notion of masculinity was perhaps less 'fluid' than has been reported in other contexts. While researchers agree that masculinity is socially constructed and it is the social context that informs how it is represented (Beckles, 2004, Lewis, 2006, Deutsch, 2007, Courtenay, 2000b, Connell and Messerschmidt, 2005), findings from this study showed that any representation, apart from hegemony, was not accepted as "ideal" masculine behaviour. However, although masculinity in this context was 'less fluid', respondents did recognize that the dichotomized meanings associated with masculinity and femininity were also changing. The findings from this study can further contribute to understanding masculinity as performance even in a 'gendered' society where men may be able to assume previously feminized roles in response to the social context without affecting their masculine identity. In this regard, these heightened tensions associated with masculine and feminine behaviors may act as catalysts for redefining how men perform masculinity. Deutsch (2007, p106) supported the notion of masculinity in flux when she postulated that gender *"must be continually socially reconstructed in light of "normative conceptions"* of ideal masculinity and femininity. By extension, Connell & Messerschmidt, (2005, p841) in exploring the challenges men experienced in redefining masculinity contended that men choose to be strategic in how they represented masculinity by the way in which they *"position themselves through discursive practices"*.

8:5: Impact of slavery on masculine identity

The relationship between Caribbean masculine identity and its alignment to slavery must be understood within its historical context. Caribbean researchers have argued that the construction of masculine identity and performance of masculinity spawned out of colonization and slavery (Barriteau, 1997, Lewis, 2006, Reddock, 2004, Beckles, 2004). The domination of black males by their white colonial masters was identified as an "ideal" representation of hegemonic masculinity. Black men were viewed as property and their strong bodies were used as the means of production. It is this enslavement of black males and their productive capacity that, according to Beckles, (2004, p228) *"symbolized the achievement of white male triumphalism"*. In this regard, white domination over black males was viewed as legitimate to facilitate successful economic and social domination. With the abolition of slavery and colonization, the black man in the Caribbean associated power with the ability to

dominate and control others, including men as well as women. It is with the abolition of slavery that new dimensions of labour as a means of production emerged since someone, other than the Colonial masters, had to take responsibility for productivity. It is this change in the new dimensions of labour and means of production that contributed to *"change in the social relations of production"* (Lewis, 2004, p248). As a result, domination and control over women was seen as an "ideal" representation of hegemony; similar to that which men experienced during slavery. By extension, an "ideal" notion of masculinity was associated with the ability to control means of production.

Sexual domination through multiple partnerships was inextricably linked to masculine power and control. During slavery, black women not only provided labor in the field but served as objects of sexual gratification for their white slave masters. Sexual power and domination over women was seen as central to the performance of masculinity. Slave owners exercised their right to sexual gratification from black female slaves, even when they were wives to fellow slaves, whenever they desired. Even when she birthed a child for the slave owner her slave husband was relegated to nothingness and treated as invisible (Beckles, 2004). It is this perception of sexual power that black slaves associated with an "ideal" notion of performing masculinity. Caribbean researchers conclude that being sexually promiscuous was a core feature of African Caribbean males which was patterned from men's enslaved experience (Beckles, 2004, Kempadoo, 2004, Rohlehr, 2004).

8:6: Masculinity as economic power

There is agreement amongst researchers that the notion of masculinity is not about who a man is but more about what he does and how he does what he does (Connell and Messerschmidt, 2005, Lewis, 2007, Deutsch, 2007, Moynihan, 1998). One of the "ideal" masculine behaviours identified in this study included being economic provider. While respondents spoke about the importance of the economic provider role as core to masculine identity they indicated that men's ability to fulfill these roles was challenging to the extent that it was more "ideal" than reality. If men wanted to assume leadership this would have been contingent on their ability to take economic responsibility for their families. In this regard, being productive through work was identified as central to their ability to fulfill their "ideal" masculine role as economic providers.

Although respondents spoke consistently about the importance of being economic provider to masculine identity, they also highlighted the challenges that men experienced in fulfilling this role since men's real experiences were different from the "ideal" expectations. One of the major factors highlighted which contributed to this tension is the changing social and economic fortunes of women. Findings from this study showed that men viewed women as becoming more proactive in assuming their positions in the economic and social landscape which challenged the notion of female subordination. Miller (1991) in confronting this phenomenon theorized that the education system was the vehicle through which the system was structured to marginalize men. His theory has been challenged by fellow Caribbean researchers who argued that it was not the structure of the system that facilitated this perception of the marginalization of men (Mohammed, 1996). Barriteau, (1997) contended that the perception of male marginalization may be facilitated by men who continue to espouse the notion of hegemonic masculinity as "ideal" without an appreciation for the reality that women are redefining their position as partners in development rather than dependent on men.

Barriteau, (1997) challenged the notion of male marginalization by noting that women should not be blamed for this change in the social dynamics in the division of labour. She opined that men will continue to experience this tension if they hold on to the notion of hegemony and domination in an environment that is moving *"toward equality of participation"* (1997, p3) in all spheres of development. This is one of the major challenges affecting men in the Caribbean which is exacerbated by underemployment, unemployment and issues surrounding job insecurity (Lewis, 2007, Lewis, 2006). Chevannes, (1999) in exploring this tension opined that young men are socialized to prioritize making money over having an education or attending school. The effects of such socialization practices may continue to place young men at greater risk for being marginalized in a changing economic environment where qualification and competence are prioritized over gender.

This poses formidable challenges for men in the Caribbean as Lewis, (2006, p13) asserts that his *"breadwinner role appears to be more ideologically affirmed than real"*. Although men may be challenged in satisfying the masculine "ideal" role as economic provider it is possible that women, in general, may have a different position. However, this study did not solicit the views of women since the remit of this research focused on exploring men's perspectives of "doing" masculinity.

8:7: Masculinity and sexual behaviour

Across the data set, heterosexual domination was identified as central to masculine identity. Sexual encounters within monogamous relationships were considered atypical for men. Since sexual intercourse was important in defining masculine performance it was not associated with romance as much as with power and endurance. Men's quest for excellence in performance was predicated on their desire to boast or have their female partners' boast of the experience. As a result, sexual intercourse with multiple partners was viewed as normal since it was an activity that was done without any commensurate emotional attachment. Heterosexual potency is commonly represented in the cultural art forms in the Caribbean in general, and Trinidad and Tobago, in particular. Rohlehr (2004) in reviewing how masculinity is constructed in calypso in Trinidad and Tobago identified that for the male some of the core concepts included hyper sexuality, sexual endurance, multiple partnering as well as having a large penis while for females, focus have been on the vagina, fertility and reproduction.

In this study, heterosexuality was central to masculine performance. However, there were tensions between how heterosexual men and MSM viewed themselves as well as each other. While MSM saw themselves as "real" men, heterosexual men did not accept them as being men since their sexual identity was inconsistent with hegemonic masculinity. This may have contributed to the level of homophobic anxieties experienced by heterosexual men in this study. According to Lewis (2003), Lewis (2006) homophobia has been identified as a real issue that confronts Caribbean societies. Apart from the small island populations, Caribbean researchers postulated that the culture is a critical driving force in exacerbating homophobic anxieties that is facilitated by religious mores and peer pressure (Chevannes, 2001, Bourne, 2010).

It is in this context that the penis has been referred to as *"a symbol ... and the primary image of hegemonic masculinity"* (Tremblay and Pierre, 2005, p134). Since being sexually potent was core to masculine identity, a man's ability to or not have sexual intercourse served as a basis for validating or redefining his masculine identity. Researchers identified that men generally view their penis as more than just an anatomical structure but an indispensable criterion that defined masculine identity (Arrington, 2008, Oliffe, 2004, Tremblay and Pierre, 2005, Rohlehr, 2004). A typical example of the centrality of the penis in masculine identity has been the response of men to the effects of impotence associated with prostate cancer

(Oliffe, 2004, O'Brian et al., 2007, Broom, 2004, Arrington, 2008) or following sexual abuse (Tremblay and Pierre, 2005). Impotence was associated with a loss of power and dominance, factors that are central to hegemonic masculine identity. Arrington, (2008, p301) in a qualitative study on the social construction of masculine sexual identity following prostate cancer found that men were unwilling to contest the common narratives and as a result *"perceived themselves as being less masculine than they were before the diagnosis"*.

On the other hand, Oliffe (2004) in a similar study among Australian men found that men were more likely to redefine their sexuality and notions of masculinity with the inability to experience coitus. This was done by either accepting that they had come to the end of coitus or by rationalizing personal satisfaction and fulfillment with their previous sexual experiences. This study focused on the performance of masculinity in general and not on any specific aspect of sexual performance. However, from their accounts, respondents placed a high premium on the importance of heterosexual performance. It is possible that *"phallocentrality"* (Rohlehr, 2004, p346) may be central to masculine identity in general but reinforced by the cultural art forms within the Caribbean context. In this regard, it has the potential for validating the primacy of sexual performance in masculine identity; a core finding about masculine performance in this study.

8:8: Masculinity and emotional expressions

Although the findings in this study showed that men expressed their emotions similarly to men in other settings, it also showed that there may be some unique ways in which men in Trinidad and Tobago deal with their emotions. Men are expected to be tough and resilient and are not supposed to demonstrate caring; emotions associated with their softer sides, since to do so could result in others questioning their masculinity. Based on their accounts, men experienced heightened anxieties when they chose to express affection or appreciation to another male. Apart from sportsmen who were allowed to express overt affection to a fellow sportsman, even how he chose to demonstrate that affection was policed within the social context. This may have been reinforced by the level of homophobic anxieties that men experienced in demonstrating socially agreed behavioural norms. Even though men are not taught to deal with their emotions, they had to demonstrate both positive and negative emotions in such a way that their masculine identity was not questioned.

Gough (2006) argues that men, in general, are unable or unwilling to express their emotions, however, findings from this study showed that men willingly expressed their emotions even if those behaviours were inconsistent with accepted norms. While men accepted the demonstration of a tough and resilient exterior as normal masculine behaviour, this created tensions especially when they wanted to demonstrate care for other men platonically. Suppression of anger as an emotion by walking away from situations was identified as a positive coping strategy although they indicated their awareness that it fostered aggression in the long run. This represented a real paradox which may have contributed to the complexity that men experienced in dealing with their emotions. Since men from all socio-demographic groups highlighted suppression of anger as a normal response, it may indicate a certain level of sensitivity to the issues associated with the negative consequence of anger as an emotion. However, it may also highlight some peculiarities in men's approach to being proactive in minimizing the negative consequences of anger. However, this finding has to be tested among a wider cross section of men; especially among those from vulnerable communities to ascertain whether other socio-demographic variables like education and socio-economic status may be used as a proxy to explain this phenomenon.

Although depression was not highlighted as an issue associated with masculine identity in this study, the way men dealt with anger was similar to previous studies on depression and masculine identity. Emslie, et al. (2006) in exploring the relationship between depression and hegemonic masculinity argued that depression in males, while often undiagnosed and untreated, is closely associated with gender identity. They studied men from various backgrounds in the United Kingdom who were diagnosed and treated with depression. They found that, in an attempt to mask their depressive symptoms, men found socially acceptable ways to mask their depression like alcohol consumption. In this regard, they took deliberate action to reconstruct their masculine identity by demonstrating socially acceptable coping behaviours. This position was also supported by O'Brian et al. (2007) in a qualitative study that focused on how men renegotiated masculinity in illness. In cases where men spoke about depression, they found that men believed that it was *"appropriate to remain silent and conceal their experience of mental illness" (p190)* since there was a social expectation to do so. The social demands made of men in maintaining a stoic demeanour, in spite of emotional challenges may serve as a critical factor that will continue to exacerbate their negative response to emotional stress. Men in this study viewed silence as an appropriate emotional response since it was perceived as positive in reducing the potentially negative effects of

stressful experiences. This may also contribute to the discourse on finding culturally specific strategies for managing negative emotions.

8:9: Masculinity and risk taking

The tensions that men experience in demonstrating behaviours that are dangerous to their health as an "ideal" expression of masculine behaviour have been well established (Davidson and Meadows, 2010, Robertson and Williams, 2010). Researchers agree that men who adopt hegemonic notions of masculinity are more likely to participate in behaviours that expose them to greater health risks in an attempt to maintain their masculine identity (Robertson and Williams, 2010, Mahalik et al., 2007, Gough, 2006, Davies et al., 2000, Courtenay, 2011). It is this perceived notion of living up to a masculine "ideal" that poses formidable challenges for men to court risk taking as normal masculine behaviour. Men may willingly adopt negative behaviours yet maintain a bravado exterior when demonstrating those risk behaviours. It is the level of social pressure that is meted out to them to behave in hetero-normative ways that increases their health risks since they may not want to have their masculine identity questioned. Crawshaw (2007, p1608) in supporting this position articulated that maintaining hegemonic masculinity *"inevitably mean participating in behaviours deleterious to well-being"*.

Based on respondents' accounts, the findings in this study support other researchers in concluding that risk taking was consistent with hegemonic masculinity. It was taken for granted that being a man was associated with being healthy which encouraged men to develop feelings of invincibility. Although men in general felt invincible, they were also conscious that they should adopt behaviours that would enhance their well-being but were unwilling to do so since showing any concern for their health was inconsistent with hegemonic masculinity. Mahalik et al. (2007) in their study among predominantly, university educated, Caucasian men indicated that hegemonic notions of masculinity reinforced negative health behaviour. They found that men were more likely to adopt risk behaviours if they perceived that the behaviours performed by other men were normative. They concluded that while subscribing to hegemonic notions of masculinity was a significant determinant in risk taking behaviours, other socio-demographic variables, including education and income were not determinants for male health behaviour. It is possible that even when it comes to their health, men may be more concerned about protecting their "machismo image" than showing any overt concern for their health.

Although Crawshaw (2009) agreed that hegemonic masculinity was associated with risk taking behaviour, he suggested that such a belief must be contested. In reviewing lessons learned from medical sociology he contended that men are not a homogenous group as a result to merely conclude that hegemonic masculinity was the defining variable in male risk taking behaviour requires critical sociological analysis. He opined that *"it is not their gendered identities which result in poor health experience" (p283)* since other socio-cultural factors may serve as antecedents to their risk behaviours, including socio-economic status. To him, it was not the notion of hegemonic masculinity that affected men's risk taking behaviour as much as what he referred to as *"the hegemony of class" (p283)* since affluent men may respond more appropriately to health information by adopting behaviour change as opposed to men from the lower socio-economic class. He postulated that there are new constructions of masculinities that are being shaped by the current discourses that present men as vulnerable and in crisis. While these constructions are inconsistent with traditional notions of masculinity, in that, men are supposed to be invincible and in control of their environment, he asserted that in these new discourses socio-economic factors have greater importance in determining male health behaviours. His position was supported by Galdas, Cheater, & Marshall (2005) who in a meta-analysis concluded that gender was not a determinant in health seeking behaviour among men as much as other social factors like socio-economic status.

In this study, regardless of their sexual orientation, men engaged in risk taking behaviours as normative. While the literature suggests that men who are marginalized and subordinated take less risks than those who subscribe to hegemonic masculinity (Mahalik et al., 2007), there was no difference among men in this study. Bourne et al. (2011) in a study among MSM and their perception of potential risk for super infection found that their perception of risk was varied. However, they also found that MSM who had within recent past or were experiencing periods of illness were more likely to be concerned about re-infection which contributed to their willingness to take less risk. In another study which explored the lived experiences of MSM and their perception of risks, biological risks were less important than social and emotional factors that were of concern to them (Bourne and Robson, 2009). In this context, the concept of risk was relative as well as contradictory and dependant on the particular discourse whether biological, emotional or social. They further highlighted the complexity in defining safety in relation to sexual risks since men "rationalized a form of safety that was in keeping with their emotional and relational interests" (p292). It can be

concluded that a male who was unwilling to take risks was viewed as less than a man by his contemporaries. It is possible that men, across the social scale, need validation of their masculine identity and risk taking may be a core part of validating that identity.

8:10: Tension between personal responsibility and masculine identity

From their accounts, men in this study were conscious of the implications of their lifestyle behaviours, were willing to take greater responsibility for their health however, they experienced difficulty in doing so since it was in conflict with normal masculine behaviour. Men, in general, did not want to be ridiculed by their contemporaries for showing concern for their health, and this may have contributed to the disregard that they placed on the maintenance of their health. In an environment where the notion of masculinity is less fluid and hegemony is the "ideal" representation of masculine identity, men may experience greater tensions in attempting to reduce health risks while trying to live up to that masculine "ideal". There is agreement amongst researchers that this tension is exacerbated in situations where men want to take responsibility for their health but also want to maintain social connectivity with their contemporaries (Davidson and Meadows, 2010, Robertson and Williams, 2010).

Generally, men are at increased risk for being diagnosed with major, life threatening health problems than women (Courtenay, 2011, Sabo, 2000, World Health Organization, 2011, Banks, 2004). According to Courtenay (2011) the increase in morbidity and mortality among men is directly related to the behaviour adopted as an extension of their masculine performance. Being healthy was normative to masculinity since men were *"not supposed to get sick" (JS: Fisherman)*. By extension, being ill was not associated with being a man, and as a result, men who were experiencing any illness found it difficult to acknowledge the existence of a problem. The data further showed that men, regardless of their social group, did not accept responsibility for taking care of their health since, to do so, would have been an indication that that they were demonstrating undue concern for their health; a behaviour that was inconsistent with masculine performance.

It is this tension of wanting to be responsible, while at the same time, showing disregard for their health that is referred to as the *"don't care, should care dichotomy"* (Robertson and Williams, 2010, p57). This tension may be exacerbated in situations where men are fully aware of the risks associated with their behaviour as one respondent noted *"you know what yuh does be doing is detrimental to your health" (EF: Trade Union)*. Generally, men were

aware of the behaviours that they could adopt to reduce their health risks however, they felt less empowered to do so as a result of the potential sanctions that could arise from the policing of hegemonic masculine behaviours. This was reinforced by the importance that they placed on hegemonic masculinity which necessitated that they should not be careful about their health as well as not seek health care routinely. A typical example of this contradiction was evident by the way respondents spoke about the prostate screening examination, and more specifically; the Digital Rectal Examination (DRE).

8:11: Masculinity and prostate cancer screening

Men's unwillingness to access health services, including prostate cancer screening, is well established in the literature. Homophobic anxieties contributed negatively to men's health behaviour, with specific reference to prostate cancer screening. Regardless of their socio-demographic characteristics, respondents were aware of the importance of undergoing a prostate examination, especially as they grew older. In spite of their level of awareness men did not readily present themselves for a prostate examination. The meanings associated with prostate cancer screening; especially with the DRE, served as barriers that prevented men from accessing this service. The test was described as an invasion of their privacy and one that was widely associated with homophobic fears. This was exacerbated by the posture that men were required to adopt during the procedure; reported as a reversal of men's 'proper' sexual roles. This contributed to greater levels of unwillingness among respondents to have a DRE.

The views of the men in this study reflect those found for other populations in the region and, to a lesser extent, internationally. Unlike for some populations (for example, Çeber et al., 2008) men were aware of prostate cancer, and the fact that the DRE examination was spontaneously raised in all groups suggests widespread familiarity with screening. However, the levels of embarrassment and anxiety evident in men's discussions in Trinidad and Tobago were reflective of other studies in the region. Bourne (2010), for instance, in a study of male health care workers in Western Jamaica suggested that while men are knowledgeable about prostate cancer, the cultural meaning associated with prostate cancer screening using the DRE is a major deterrent to accessing screening services. More education is unlikely to be sufficient to influence behaviour change in the face of such culturally embedded beliefs. McNaughton et al. (2011) identified similar views among doctors at the University Hospital, Jamaica. While the DRE was raised spontaneously in group discussions men's reported

unwillingness to do so reflected generally articulated views that accessing any preventative services was likely to threaten masculine identity.

These views were real deterrents to prostate cancer screening, as documented in the wider literature (Consedine et al., 2009, Ford et al., 2006, McNaughton et al., 2011). However, such cultural associations of the DRE are not inevitably barriers to accessing services, as suggested by one study from Saudi Arabia which found no relationship between fear, embarrassment, anxiety and prostate screening using the DRE (Alhelih et al., 2010). While respondents in this study identified fear and anxiety, they were in relation to broader health seeking behaviours and concerns about being diagnosed with a debilitating health problem and not specific to prostate cancer screening.

8:12: Masculinity and health seeking

While attitudes to prostate cancer screening may be extreme, this may in a general sense, be a reflection of "ideal" representations of hegemonic masculinity which encourages men to delay health seeking. In this study, delaying health seeking or even ignoring symptoms of illness were common, that is, until the symptoms were unbearable or they perceived that their life was imperiled. Men experienced tensions in behaving in ways that validated their masculine identity while at the same time acknowledging the experience of a health problem since they did not want to be viewed as 'weak'. In this regard, they may be more willing to maintain a stoic disposition and not seek help as a demonstration of hegemony rather than risk being viewed otherwise since it was the masculine thing to do. This finding supported previous research evidence that hegemonic masculinity is not only associated with risk behaviours and but it acts as a barrier to health seeking (Mansfield et al., 2005, Galdas et al., 2005). However, while there is debate among researchers that masculinity is a plural concept and may not be a true representation of all men as a homogenous group (Crawshaw, 2009, Galdas et al., 2005) this may have implications for arriving at conclusions in relation to men and health seeking.

While researchers have concluded that traditional notions of hegemonic masculinity influence men's health seeking behaviour, Galdas, et al. (2005) noted that research findings have stopped short of interrogating how illness impacts on men's assessment of personal risks. While they contended that male socialization may influence negative attitudes to health seeking, there is need for research studies to fill this gap in the literature by considering the

impact of men's perception of risk and health seeking. In this study, respondents, regardless of their sexual identity, did not place a high value on the maintenance of their health since being healthy was perceived as 'natural' and this may have influenced their general unwillingness to seek help.

There is a body of literature that supports the view that men who subscribe to non hetero-normative notions of masculinity may be more proactive and responsible in adopting behaviours that enhance their health and well-being (Hunt et al., 2007, Mahalik et al., 2007). Based on the reports from MSM in this study my findings did not support this conclusion. Among respondents who were diagnosed with HIV/AIDS they indicated that this contributed to his positive approach to health seeking, even though they may not have been as willing to seek help in the absence of that diagnosis. Further, a common concern among MSM was the perceived fear of being discriminated against or having to disclose their sexual orientation and this served as a deterrent to health seeking. In this regard, MSM health seeking behaviour may be similar to other men, in that, they may minimize the perception of a health problem in order to maintain their masculine identity. By extension, since MSM identified themselves as "real men" their response to health seeking may be similar to other men since delaying health seeking was associated with normative masculine behaviour.

8:13: "Male sensitive" versus professional services

While researchers have focused on barriers to health seeking, there remains a dearth of literature that addresses facilitators to health seeking. Although men in this study reported being generally unwilling to seek health care, they may have been more willing to access health services if the services were perceived as being 'sensitive' to their needs. Based on their accounts, a "male sensitive" health service was not specific to the availability of professional staff, but one that provided privacy while, at the same time, allowed social interactions with other men. Men may be more interested in a facility that served as a social rather than medical space for the provision of services. Men's perception of a "male sensitive" health service may be contingent on their personal preferences or needs rather than any attempt to reach consensus on specific group of services for men. Even amongst researchers, there is an absence of data that clearly articulates what a "male sensitive" service should look like. This study, while it focused on men's accounts of a "male sensitive" health service, did not have as a part of its remit, developing a model for such services. I was

interested in considering men's perspectives, in the first instance, since I wanted to uncover their typical accounts of masculinity and health.

One of the challenges related to the paucity of literature on "male sensitive" health services has been identified as the difficulty in adequately defining men as a group and what is meant by "male health" (Macdonald, 2006, Banks, 2004, Men's Health Forum, 2004) or the absence of qualitative methods of enquiry in exploring gendered approaches to health seeking (Galdas et al., 2005). Since being a man and how men performed masculinity is based on social contexts, it provides even greater challenges in attempting to define "male sensitive" health services. While researchers agree that men are not a homogenous group it may not be possible to develop a health service that can be construed as meeting the needs of all men. The findings in this study, that men experience tensions in performing masculinity especially in relation to their health, creates further challenges in determining a "male sensitive" health service.

The role of the media, including health literature, is critical in how men conceptualize being healthy through reinforcement of behaviours observed normally or creating new images that will have positive influences on their behaviour. Crawshaw (2007), in reviewing the representation of men and masculinity in Men's Health magazine concluded that the health magazine helps to reinforce common notions of hegemonic masculinity as destructive while, at the same time, attempts to change the discourse by projecting men as being responsible for their health and well-being. In this regard, there is a deliberate attempt to project newer ways of demonstrating masculinity by being healthy without having men question their hegemonic masculine identity. Accordingly, he opined that men who view being healthy as a core component of their masculine identity could experience reduced tensions by behaving *"in appropriate ways that do not challenge men's fundamental masculine identities" (p1608)*. In a society like Trinidad and Tobago where homophobic anxieties are facilitated by cultural expressions, men may experience greater tensions in demonstrating personal responsibility for their health. However, the fact that they indicated a willingness to have access to 'male specific' health information may suggest positive change towards being personally responsible for their health.

8:14: Potential approaches to developing "male sensitive" services

Except for recommended policy approaches to the development of "male sensitive" health services in England and Wales (Men's Health Forum, 2004) and Australia (Macdonald, 2006)

125

there is an absence of available research literature that focuses on facilitators to male health seeking behaviours. These recommended policy initiatives were developed in an attempt to shift from a medical model to a socio-cultural approach to health service delivery. In one study, Underwood, Berry, & Haley (2009) focused on the promotion of wellness among African American men. They noted that African American men bear greater burdens of disease as opposed to their Caucasian counterparts, hence, the need for giving *"voice"* to their *"thoughts, concerns and opinions" (p53)*. While they explored men's opinions about the available services, they stopped short of exploring their perception of what constituted a male sensitive service, except in instances where they made general recommendations for health education and outreach programs.

Nevertheless, Men's Health Forum, (2004) recommended that the Ottawa Charter for Health Promotion could be effectively used for the structuring and delivery of male sensitive health services. This framework was considered useful since it made recommendations for policy actions from multiple perspectives including the physical environment, human resource capacity, structuring of services as well as, encouraging the development of personal skills. In this regard, services targeting men should be offered in a timely manner with short waiting periods, confidential, allow anonymity, comprehensive rather that focus on a specific health problem (Men's Health Forum, 2004, Banks, 2004); in socially acceptable spaces where they meet normally (Men's Health Forum, 2004, Underwood et al., 2009) and at times beyond the traditional hours (Men's Health Forum, 2004). Men also require health information that moves beyond common health problems like prostate cancer, but information that will support the promotion of their health (Underwood et al., 2009, Doyal, 2001). Doyal, (2001, p1062) noted the importance of crafting messages that are male sensitive since one of the factors that allow men to hold on to the view that health was female oriented was *"that health promotion messages are not addressed to them"*.

8:15: Summary

The findings in this study build on the body of literature on masculinity, in general, and masculinity and health in the Caribbean, in particular. Masculinity was not biologically determined but socially constructed and based on performance. This study found there was more homogeneity on what "masculinity" means than in other settings, in that it was almost "fixed" across all the social groups. Hegemonic masculinity was "ideal" but utopian and difficult to achieve. Core functions associated with hegemonic masculinity across all social groups included economic provider and sexually promiscuous however, men experienced

tensions in living up to these masculine "ideals". The major factor that contributed to these tensions was perceived as women having access to greater social and economic capital. However, performing masculinity was complex since there was inconsistency between "ideal" masculinity as defined as opposed to masculinity performed normally through everyday experiences.

Although there is debate related to the need for greater analysis of data on the social dynamics of risk behaviours men, regardless of sexual orientation, associated "ideal" masculinity with risk taking behaviour. Men experienced tensions in showing disregard for while wanting to take personal responsibility for their health. By extension, the findings from this study also support the difficulty in defining "male sensitive" health services as there was no consensus on its meaning since, in general, they focused more on "quality" services. The tensions men experienced in performing masculinity as well as the inability to define "male health" services have implications for policy; an issue that shall be explored in the next chapter.

Chapter nine: Conclusion and implications for policy and programme development

9:1: Conclusion

This research study represented an initial attempt to broaden the literature on masculinity, in general, and masculinity in the Caribbean, in particular. This was an initial piece of work that moved beyond exploring male socialization to solicit men's perspectives on socialization and its effects on health beliefs and behaviours. The data showed that males believed that unlike females, they had to learn to be "men". There were multiple influences that contributed to the learning process including role models, including fathers, who were mainly absent as well as iconic figures including artistes and international political figures. Women in Trinidad and Tobago also played a significant role in masculine socialization because of the high levels of matriarchal households. However, they served a significant role in policing masculine behaviour since they were more concerned about men "not being female" than "being a man". In this regard, learning to be a man was difficult and almost impossible to achieve since there was incongruence between what was considered "ideal" as opposed to what men observed in their everyday experiences.

Not only was learning to be a man difficult but it also created conflicts for men in how they performed masculinity. From their accounts, masculinity was not biologically determined but based on hetero-normative performance. While researchers agree that masculinity is fluid and subject to change depending on the context in which it is performed, data from the study showed that masculinity in this context appeared to be almost 'fixed'. Performing masculinity was based on discourses on hetero-normative rigidity however, respondents agreed that this was utopian and generally unachievable. While there were core functions associated with "being a man" including economic provider and sexually promiscuous, men, in a general sense, experienced conflicts in satisfying these expectations. They believed that the changing socio-economic environment allowed greater economic and social mobility of women which reduced their dependence on males and this challenged commonly held notions of hegemonic masculinity representing power and domination.

Findings from this study also showed that "being a man" was "being healthy" naturally and their health was taken for granted. Taking risks was a normal expectation for performing masculinity. Men, in general, viewed themselves as invincible and risk taking was a way that

they expressed that invincibility. While men were conscious that they should be more responsive in taking care of their health, they experienced conflicts in translating such beliefs into action. One of the core issues that brought out this challenge was men's response to prostate cancer screening. Men were aware of the importance of accessing prostate cancer screening services, but were unwilling to do so as a result of homophobic anxiety as well as not wanting to appear as though they were showing undue concern for their health. They perceived that the current structure of services was "sensitive" to the needs of women and girls and not of men and boys. While men wanted "male sensitive" services, these were more general in scope and focused on the delivery of quality services. The policy implications for the development of "male sensitive" services are complex since defining the nature of "male sensitive" was difficult.

9:2: Opportunities for progress: Men's willingness to talk about health

Notwithstanding the challenges in defining "male sensitive" health services which could prove to be an uphill struggle, I was taken aback by the high level of openness in interactions among respondents. Men appeared to be so comfortable engaging each other in such a direct way that it felt as though they were having a conversation amongst themselves and were not involved in a research study. A general observation made by respondents after each focus group discussion was *"this thing was better than I thought ... when yuh coming back to continue the discussion"*. Although respondents were informed that they were participating in a research project, their reference to the session as a 'discussion' was instructive. It is possible that while men may have been accustomed to speaking in their groups, these Focus Group Discussions represented a different experience since they were able to explore issues that were personal and relevant to them in an environment that was structured and respectful. Bearing in mind that informants indicated that men want health information, in a setting like Trinidad and Tobago where men usually congregate to talk, this provides a window of opportunity for sharing health information through the oral tradition.

Men were encouraged to be respectful of each other while they were free to disagree with each other in a manner that maintained a high level of respect for each other's opinions. This may be a demonstration of men's willingness to be more engaged in matters related to their health that could serve as a catalyst for informing strategies for the development of "male sensitive" health services. It also suggests that men may be more interested in responding

positively to their health than believed previously if they are availed of opportunities where they could articulate their concerns and receive support from their contemporaries. This may also have implications for the way health providers engage men in matters related to their health, in that, men may be more receptive to health information that is presented in ways that engage them in demystifying issues related to men's health.

9:3: Policy and programme implications

The policy and programme implications arising out of this study may be challenging based on the difficulty men experienced in being a "real man" as well as the lack of consensus on what constituted "male sensitive" services. The data showed inherent contradictions in men's expressed need for "male sensitive" services yet general unwillingness to access services. While they identified deep rooted barriers that affected their access to services, it may be impossible to provide individualized, private and sexualized services that they wanted. From their accounts, the key implications seem to be the almost rigid hetero-normative discourses on gender which meant that even health encounters were sexualized and homophobic anxieties act as a deterrent to health seeking. There can be no "quick fix" solutions arising from this research since, for the most part, the notion of masculinity as well as "male sensitive" services were "ideal" and, by extension, may be unachievable. There are specific programmes targeting men like 'Defining masculine excellence' which creates opportunities for opening-up discourses on masculinity with a view of encouraging change in behaviour in the long run. This programme is sponsored by the Division of Gender Affairs, Ministry of Gender, Youth and Child Development but hosted in different parts of the island at specific intervals where experts are hired to facilitate sessions with males who register for participation. Such a programme serves as an effective strategy in encouraging participation among males in addressing 'male sensitive' issues in an environment that is non-threatening. Findings from this study highlight the importance of creating non-threatening male spaces where men could be supported in exploring issues relevant to masculinity and health.

9:4: Policy and programme initiatives

There are a number of short and medium term policy and programme initiatives that could be implemented to respond to the contradictions identified in this study. Social and health programmes could be developed and evaluated as pilot projects, in the first instance. The lessons learned from an evaluation of these initiatives could be used as the framework for establishing sustainable "male sensitive" services. Further, these initiatives should be

developed to address the more deeply rooted barriers to health seeking including notions of hegemonic masculinity as a dysfunction as well as homophobia.

Although the data showed that men, in general, did not access health services readily there was an expressed willingness to access services that were "sensitive" to their needs. The predominance of females as health providers acted as a deterrent for accessing services. Bearing in mind that men perceived the health services are "sensitive" to women and girls and not men and boys, consideration should be given for hiring and posting males as front-line staff including Clerks and Receptionists. This could go a long way in reducing the negative impressions of "female domination" within the health service while increasing the level of comfort that men experience on entering the facility. The use of men in the non-provider roles may also assist in demystifying these roles as feminine.

The current structure of the health system facilitated the delivery of services during traditional hours, from 8.00am to 4.00pm. Men prioritized work above their health hence they were unwilling to access services during traditional hours except in an emergency. An assessment of "male specific" Sexual and Reproductive Health (SRH) services in Trinidad and Tobago showed that services were available on a limited basis (UNFPA, 2011). This provides an opportunity to leverage current opportunities available for men to access health services within the public sector. Since each Regional Health Authority (RHA) is responsible for the delivery of health services, consideration could be given to developing comprehensive "male specific" model services that could be offered beyond traditional working hours. This may have human resource as well as financial implications for the RHA. However, special arrangements could be made for budgetary allocations to facilitate the piloting of these services in each RHA and the evaluation used to expand and integrate such services as a core part of service delivery.

By extension, the findings from this study can support occupational sectors that are predominantly male in developing "male sensitive" health spaces. Most of the industrial sectors have a fully functional health service available for staff. Since men were conscious of the need to be proactive in addressing their health needs but prioritized their occupations above any health concern, there is a window of opportunity to reduce this challenge by creating "healthy" workplaces. In so doing, apart from providing annual medical checkups as a part of their terms and conditions of service, annual men's health days could be established

with a view to encouraging greater uptake of health services in the work environment. This could be facilitated by building collaboration between the RHA and NGO sector to provide mobile health services targeting men on a consistent basis. In so doing, men may respond more positively to available health services since it could be construed as services that are provided with men in mind without having to visit a traditional health facility.

Prostate cancer is one of the leading health problems affecting men in Trinidad and Tobago (The National Cancer Registry, 2012). While men were aware of the importance of accessing screening services, they were generally unwilling to undergo the screening process using the DRE. Homophobic anxieties resulting from the meanings associated with the examination was a major barrier. Facilitating factors included the birth of a son or observing the suffering of a family member or other significant male as a result of diagnosis. This could provide a window of opportunity to build on these facilitators by creating positive messages through public service announcements highlighting the positive benefits of screening. This could also be enhanced by collaborating with role models including iconic figures since they were identified as influential in male socialization. In this regard, men could be encouraged to take greater responsibility for their health without losing their masculine identity by demonstrating that being responsible is a "manly" thing to do.

At present, health information materials were available but they were generally "female dominated" in content, for example, breast self-examination or cervical cancer. Men desired more access to "male sensitive" health information. This could also serve as an opportunity for greater collaboration with various departments of the Ministry of Health and other stakeholders for the development of Information, Education and Communication (IEC) materials. The fact that men were willing and transparent in their discussions and wanted to have a continuation of these discussions also presented an opportunity for creating alliance with the media in facilitating dialogue to shape discourses on masculinity through talk programmes like 'man talk' which could be a forum to encourage men to speak about health issues that concern them. This programme could be facilitated by men and for men in supporting the opening up of dialogue in a non-threatening space that allow anonymity. While there may be financial implications for this initiative, it provides opportunities to build collaboration with agencies interested in addressing the needs of men. An alliance with the Ministry of Gender, Youth and Child Development could be a facilitator as an extension of the 'Defining Masculine Excellence' project.

While the previous recommendations could be done in the short-term, there are also medium to long term recommendations that could be considered. Men wanted a "male sensitive" health service, although some of the tenets were impractical. Within the current health system, boys accessed services through the Child Health Clinic however, after adolescence, they generally interface with the health system only when ill. The findings in this study provide an opportunity to respond to men's expressed needs by developing a men's health policy for the Ministry of Health/Regional Health Authorities. Such a policy framework should consider a holistic approach to health services for men along the chronological continuum. In so doing, men could be encouraged to view personal responsibility for their health as central to masculine identity and so reduce the current tensions they experienced in the "don't care, should care" approach to health.

Men wanted a gender sensitive staff complement with more males involved in service delivery. In general, the current numbers of nursing staff deployed within the community health setting are female. Further, there is an observed disparity in the ratio of male/female students in general as opposed to psychiatric nursing in Trinidad and Tobago with much less males accessing general versus psychiatric nursing. Data for the period 2006-2009 show that in general nursing 3 to 10 percent of the students were males while in the psychiatric nursing schools 9 to 28 percent of the students were males (Ministry of Health, 2013, College of Science Technology Applied Arts of Trinidad and Tobago, 2013). Consideration should be given to providing increased opportunities for males to access general nurse training. On the completion of their training more males could be deployed as staff at primary care facilities to balance the perceived female domination of staff as well as support the delivery of "male sensitive" health services.

In general, respondents perceived that there were structural and normative barriers which contributed to denying men greater involvement in the care of their families especially when hospitalized. Most significant among the barriers included the unavailability of extended visiting hours when their children are ill as well as their inability to be present in the delivery room during labour. The willingness of men to have greater involvement during a critical time in their family life experience provides an opportunity to revisit current structural and normative barriers which deny them these opportunities. However, it will require reorientation of the approach to the current delivery of health services as well as the training of health care providers to be more sensitive to their needs. Since this will be a radical shift in

policy, a deliberate and iterative approach could be taken which includes the implementation of pilot projects in selected health institutions. These projects could be evaluated with a view to formalizing policy action. In so doing, it could be used as an entry point in demystifying health service delivery and so provide an opportunity to support a "male sensitive" approach to service delivery.

In learning to be a "man", males, in the absence of role models including fathers and men from the wider community developed their own concept of "being a man" by applying positive characteristics from a number of men. Male mentoring programmes that focus on young men, in general, and not just young men from vulnerable communities in collaboration with other Ministries and community based organizations could be established. This would support their emotional development since it was one of the major challenges experienced by men in this study. By extension, it could provide an opportunity for establishing collaboration with the education sector in developing curriculum content that focuses on males and their emotional development. The school environment has a catchment of males who can be exposed to opportunities for the development of life skills, including intrapersonal and interpersonal skills in relating to their emotions.

9:5: Conclusion

While researchers agree that masculine performance is complex, men in this study, while supporting this view, held a more rigid hetero-normative notion of masculinity. This was extended to men's response to health seeking since even their health encounters were sexualized consistent with hetero-normative behaviours. While there are limited programmes available for men, these fall short in confronting deep seated issues related to their response to health. This study did not focus on ascertaining the capacity of health providers to provide "male sensitive" services. However, the findings provide opportunities for building capacity among health providers to respond appropriately to men's unique challenges related to their health since, as far as I am aware, there is no such capacity building programmes available for health providers in Trinidad and Tobago. To facilitate this capacity building program collaboration could be established with international organizations that specialize in training in men's health for training of multi-disciplinary health providers.

This research project provides opportunities for further research on masculinity and health in Trinidad and Tobago as well as the wider Caribbean. While this was an initial piece of

research conducted on masculinity and health, the findings suggested that although "being a man" was complex and fraught with contradictions, we may have merely touched the 'tip of the iceberg'. This requires further study in interrogating factors that influence male socialization and implications for their response to health. It is possible that such studies could act as a framework for developing a model specific to male socialization in the Caribbean. Further, this study included men only and they highlighted the integral role of women in male socialization. It would be of interest if studies on masculinity in the Caribbean were conducted with the inclusion of women to ascertain whether the data would be different from that of men. This could be facilitated by expanding the methodology to include female specific as well as mixed gendered groups as strategies for data collection. It is my view that this research could serve as the catalyst for informing "male sensitive" policy action in the future.

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Welcome. Today we will be talking about topics related to your socialization as men, how your perform masculinity as well as how does your socialization influence your health beliefs and behaviour. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programs and services that are sensitive to your needs. We'll discuss topics such as what it means to be a man, how you developed your own image of being a man, your own portrayal of masculinity and what are some of your health beliefs and how those beliefs influence your access to health services.

Anything you say here will be kept private and confidential. We must ensure that each person is treated with respect and we should not be disrespectful if we do not agree with a person's point of view. We will never mention your name outside of this room. If you prefer not to answer any particular question, that's fine. If you need to leave at any time, that is okay. If you will be more comfortable to share your experiences with me after this discussion, I will be more than happy to have an interview with you.

I will need your permission to tape this interview, as a result, please read the consent sheet provided and ask any questions for clarification prior to signing accordingly.

Component	Guide
Socialization	What was it like for you as a child growing up as a male? What kinds of activities were boys involved in? How did other males react to boys who were not involved in these activities?
	Think about someone you considered a male role model, what are the characteristics that you admired most? Why? Which characteristic are you most likely to identify with? How do you feel about men who do not portray this characteristic?
	Think about a male that you do not consider being a typical male, what are some of the characteristics of that person?
	What does it mean to be a man? How do boys learn to act like men? How do you think "real" men act? Can you describe someone you think is a "real" man? Would you like to be like him? Or someone who isn't? What happens if other men act differently than they are "supposed" to?
"Doing" masculinity	Are there any special behaviours that men are expected display to show that they are men? How important is it for you to be recognized as a real man?
	Think about the last time that you were angry or sad, how did you show it? Why? What is your view of this behaviour as a male?
	When last did you have your blood pressure checked? Was there any special reason why you have it done?
	When was the last time you were ill, did you visit the doctor? Tell me about that experience.

141

	Can you share an experience when you needed health care but did not seek help? Why?
Health beliefs	Think of someone who is healthy, what do you think of?
	Think of someone who is unhealthy, what do you think of?
	Think about some physical examinations that doctors may want to do on you, what are some examinations that you are comfortable having? Why?
	What are some of the physical examinations that you are uncomfortable to have done on you? Why?
	If you need psychological help to deal with an emotional situation, what will you most naturally do? Why?
	Would you consider such a response as normal for a man? Why?

Welcome. Today we will be talking about topics related to your socialization as men, how your perform masculinity as well as how does your socialization influence your health beliefs and behaviour. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programs and services that are sensitive to your needs. We'll discuss topics such as what it means to be a man, how you developed your own image of being a man, your own portrayal of masculinity and what are some of your health beliefs and how those beliefs influence your access to health services.

Anything you say here will be kept private and confidential. We must ensure that each person is treated with respect and we should not be disrespectful if we do not agree with a person's point of view. We will never mention your name outside of this room. If you prefer not to answer any particular question, that's fine. If you need to leave at any time, that is okay. If you will be more comfortable to share your experiences with me after this discussion, I will be more than happy to have an interview with you.

I will need your permission to tape this interview, as a result, please read the consent sheet provided and ask any questions for clarification prior to signing accordingly.

1. If you were to access health services, what would encourage you to do so? Why?
2. When in your view are men most likely to access health services? Why?
3. The last time you accessed health services, what is your opinion of the services you received?
4. If a man visits a health facility what may be his likely experience?
5. When you think of a health facility for men, what will this facility look like?
6. When you look at the current health facilities, how suitable are they in meeting the needs of men? Why?
7. If you should visit a health facility, with whom will you be most comfortable to provide services to you? Will it be dependent on the type of service you are going to receive? Could you give an example?
8. If you need some health advice, where will you be most comfortable to access this help?
9. What are some of the recommendations that you would like to make to help improve health services targeting males?

3A Batchyia Branch Trace
San Francique Road
Penal.

June 14, 2011.

President

Dear President

I am in the process of preparing for data collection for the completion of my requirement for the award of the Doctorate in Public Health at the London School of Hygiene and Tropical Medicine. My research topic is entitled **"masculinity and health beliefs among men in Trinidad and Tobago".**

This study aims at exploring accounts of "doing" masculinity among men between the ages of 18 years to 60 years in Trinidad and Tobago, their health beliefs and implications for the development of male sensitive health policy initiatives. This research study will also support the work done through your Division in areas targeting men both from the youth and adult perspective.

The findings from this study will be used to:
1. Recommend policy action for the Ministry of Health to develop male sensitive health services;
2. Recommend development of a national male policy addressing issues germane to the study including socialization, male sensitive health policy and support services;

In this regard, I would be very grateful if positive consideration could be given to sourcing a group of 6-8 men from your organizations to participate in a focus group discussion on the research topic sometime in July 2011. Attached is a copy of the information sheet.

Yours truly

OSCAR NOEL OCHO.
Contact: 716-7191 (mobile) 647-5584 (home)
Email: Oscar.ocho@lshtm.ac.uk

Appendix 4: Common themes on masculinity, health beliefs and behaviour

1. **Elements of learning to be male**

Role models
Include fathers/ icons/ artistes
Opportunities for bonding through kinaesthetic development

Females including mother/ grandmother
Learning to do craft skills to facilitate independence, especially in later life

How not to be female through explicit instructions

Messages
Socially scripted and changes constantly

Opposition to messages contributes to overt rebellion

Idealized masculine behaviour
Leader/provider

Sexual behaviour

Being a male
Ways of behaving

Patterns of behaviour to which one would aspire

Typologies of being a man

Sanctions associated with non-compliance

2. **Performance of masculinity**

Health beliefs
Being healthy is core to masculinity

Masculinity, work and identity

Being healthy is effortless

Illness and masculine identity

Risk taking is core to masculinity

3. **Health beliefs and masculine behaviour**

Responses to prostate cancer screening

Health seeking and masculine behaviour

Tensions in masculine performance

Real experiences different from ideal expectations

London School of Hygiene & Tropical Medicine
Keppel Street, London, WC1E 7HT, United Kingdom

INFORMATION SHEET

Study title: **Masculinity and health beliefs among men in Trinidad and Tobago.**

Investigator Name and Contact No: Oscar Noel Ocho
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Background
This research project forms a core component of a Doctorate in Public Health. This research topic is "Masculinity and health beliefs among men in Trinidad and Tobago". Issues affecting Caribbean men have not been well through research. Further, the health system is structured in such a way that the needs of women are addressed at all levels of the continuum while the needs of men are not adequately served by the same health system. This research project will be conducted among men as individuals and in groups to explore their accounts of "doing" masculinity and its impact on their health beliefs and behaviour. While the epidemiological profile shows that the leading causes of death among men is lifestyle related, it is the view of some researchers that that health is not viewed as a priority among men. This is often related to their socialization as well as their perception of vulnerability to illness.

Study aim and research questions:
This study proposes to explore accounts of "doing" masculinity among men between the ages of 18 years to 60 years in Trinidad and Tobago, their health beliefs and implications for the development of male sensitive health policy initiatives.

The study will involve answering the following research questions:
6. How does socialization affect male health beliefs?
7. How do their accounts of masculinity contribute to their health beliefs?
8. How do men in Trinidad and Tobago "do gender"?
9. What are men's views of a "male sensitive" health system?
10. How can a male sensitive health care system be developed?

A qualitative methodology using mixed methods, semi structured interviews and focus group discussions will be utilized for data collection.
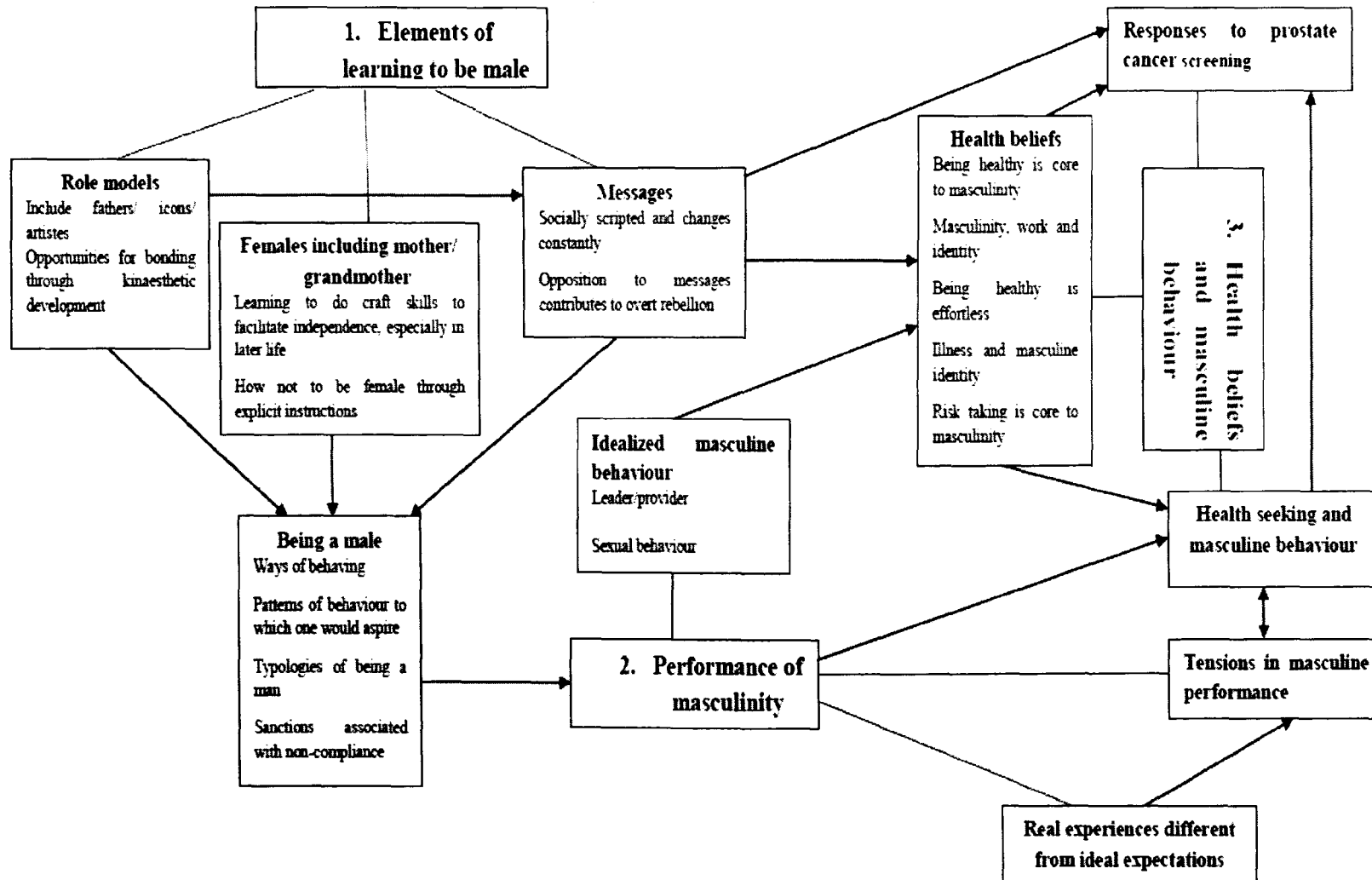
The findings from this study will be used to
3. Recommend policy action for the Ministry of Health to develop male sensitive health services;
4. Recommend development of a national male policy addressing issues germane to the study including socialization, male sensitive health policy and support services;

146

5. Build collaboration with other researchers to conduct a Caribbean region research project on masculinity and health.

Your participation in this study is important to provide input on your accounts of masculinity and how did these accounts influence your health beliefs and behaviour. Your participation will provide information that will be used to make necessary recommendations to policy makers to address gaps in the current services available to men.

Participation
Participation in this research is confidential (participants will only be identified by a study number, not by name) and entirely voluntary. Withdrawal with no adverse consequences is possible at any time without having to give a reason. If you agree to take part, you will be invited to participate in an interview or focus group discussion to explore your views in more detail. If consent is given, the interview may be tape-recorded.

How confidentiality will be ensured
The transcripts of meetings and interviews will be available to the investigator only. Information obtained through interviews and observation will be used in aggregate form. Where transcripts are quoted no reference will be made to the name, age, gender or job title of participants except prior approval is received. All transcripts will be kept by the investigator in a secured file and for the duration of the doctorate candidature after which they will be destroyed. There will be no financial reimbursement for taking part in the study.

Ethical approval
This study was approved by the London School of Hygiene and Tropical Medicine's Research Ethics Committee.

If you have any further questions or queries about the study please do not hesitate to contact me at oscar.ocho@lshtm.ac.uk.
or
(868)716-7191

With thanks

OSCAR NOEL OCHO
DrPH Student

London School of Hygiene & Tropical Medicine
Keppel Street, London, WC1E 7HT, United Kingdom

CONSENT FORM

Study title: **Masculinity and health beliefs among men in Trinidad and Tobago**

Investigator Name and Contact No:
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Health Services Research Unit
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Email: oscar.ocho@lshtm.ac.uk

<u>To be completed by participants</u>

Please tick as appropriate

1.	I have read the information sheet concerning the study and I understand what will be required of me if I participate in the study.	
2.	My questions concerning the study have been answered adequately by the researcher.	
3.	I understand that at any time I can withdraw from the study without having to give a reason.	
4	I agree to participate in the study.	
5.	Please tick one of the following	
	a. I give my permission for the interview to be recorded.	
	b. I do not give my permission for the interview to be recorded.	
6.	Please read the following carefully and tick one	
	a. I agree that the material from my interview may be quoted and these quotations may be attributed to me	
	b. I agree that the material from my interview may be quoted, but I would like my name to be annonymized	
	c. I agree that the material from my interview may be quoted, but not my name as well as the organization in which I work as well as my position.	
	d. I do not agree that the material from my interview may be quoted.	

NAME: ....

SIGNATURE: ....   DATE: ....

148

COVER SHEET FOR EACH 'RESEARCH PAPER' INCLUDED IN A RESEARCH THESIS

Please be aware that one cover sheet must be completed <u>for each</u> 'Research Paper' included in a thesis.

1. **For a 'research paper' already published**

    1.1. Where was the work published? *JOURNAL SEXUALITY RESEARCH AND SOCIAL POLICY*

    1.2. When was the work published? *MARCH 2013*

       1.2.1. If the work was published prior to registration for your research degree, give a brief rationale for its inclusion

       ....

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       ....

    1.3. Was the work subject to academic peer review? *YES*

    1.4. Have you retained the copyright for the work? Yes /**No**
    If yes, please attach evidence of retention.
    If no, or if the work is being included in its published format, please attach evidence of permission from copyright holder (publisher or other author) to include work

2. **For a 'research paper' prepared for publication but not yet published**

    2.1. Where is the work intended to be published? ....

    2.2. Please list the paper's authors in the intended authorship order

    ....

    2.3. Stage of publication – Not yet submitted / Submitted / Undergoing revision from peer reviewers' comments / In press

3. **For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)** *Oscar Ocho (lead)
.... on writing this paper, conducted the data collection and lead on analysis*

NAME IN FULL (Block Capitals) ....

STUDENT ID NO: *197664*

CANDIDATE'S SIGNATURE .... Date *16/04/13*

SUPERVISOR/SENIOR AUTHOR'S SIGNATURE (3 above) ....

Perception of prostate screening services among men in Trinidad and Tobago

Abstract

Background:

There have been calls for greater involvement of men in Sexual and Reproductive Health (SRH). One of the major SRH issues affecting men is prostate cancer. Prostate cancer represents the leading cause of cancer related deaths among men in Trinidad and Tobago. A key contributor to this burden of mortality may be low uptake of screening services.

Aim of study:

This study explored men's perceptions of prostate screening services to identify implications for policy and practice.

Methods:

Data were drawn from fourteen focus groups, including seventy five men between the ages of 19 and 60 years representing a cross section of socio-demographic groups in Trinidad and Tobago. Data were qualitatively analysed.

Findings:

Across all groups, men were aware of prostrate screening services, and aware of the need for examinations, particularly at older age. Men reported feeling responsible for maintaining their health, but were unwilling to access prostate screening services. Concerns about digital rectal examination (DRE) were universal, and spontaneously raised in discussions. Expressed levels of anxiety were related to fear of the negative implications of being diagnosed with prostate cancer. More significantly, unwillingness to seek screening was related to sensitivity to the associations of the DRE with homosexual activity and an 'assault on manhood'. In a cultural context of extreme homophobia, such cultural meanings were a barrier for most men.

Conclusion:

The major barriers to accessing services in Trinidad and Tobago are cultural beliefs, not lack of knowledge. Whilst addressing homophobia may be a long term goal, in the short term, health promotion which focuses on reducing the associations of digital rectal examinations with a threat to masculinity, and stresses the responsibilities of men to take care of their own health, may be productive in improving outcomes in this important area of men's sexual and reproductive health.

Key words: masculinity, prostate cancer screening.

Introduction

Within the last two decades there has been a growing interest in men's health as a priority health issue, with the International Conference on Population and Development (ICPD) 1994 calling for greater involvement of men in Sexual and Reproductive Health (SRH) (United Nations Population Fund, 1995). Prostate cancer is a major SRH issue for men. It is the second leading cause of cancer related morbidity among men globally (Jemal, et al., 2010) and the second leading cause of mortality among men over 60 years in the United States of America (Bloom, et al., 2006). Men in the Americas have the highest incidence of prostate cancer globally (World Health Organization, 2011), with African American and Caribbean men at an increased risk compared to Caucasian men (Consedine, et. al., 2006; Ford, et al., 2006; McNaughton, Aiken, & McGrowder, 2011). Indeed, African American men from the Caribbean have the highest incidence of prostate cancer globally (Lee, et al. 2011). Within the Caribbean, prostate cancer is the most common cancer among men in Jamaica (McNaughton et al., 2011) as well as Trinidad and Tobago (The National Cancer Registry, 2012).

There is debate around the effectiveness and cost-effectiveness of preventive screening for prostate cancer in the general population (The University of York, 1997). However, for Afro-Caribbean men the benefits of screening may be greater, with studies from both the United States (Shelton, et al., 2005) and Tobago (Bunker et al., 2002) identifying high prevalence of screening-detected prostate cancer, and recommending programmes to increase community screening uptake for high risk populations. Trinidad and Tobago is one such population. However, even if effective in principle, screening relies on willingness to use services and, in the Caribbean in particular, considerable reluctance has been documented (Bourne, 2010). Some factors contributing to this reluctance are likely to be common to men in all populations, such as fear and anxiety associated with diagnosis and embarrassment (Bourne, 2010; Consedine et al., 2009; Ford et al., 2006; McNaughton et al., 2011).

Bloom et al. (2006), for instance, in a study of African American men, found relationships between both levels of anxiety and perceived discomfort associated with the procedure with unwillingness to access screening services. Fear and anxiety were also exacerbated by cultural interpretations of the Digital Rectal Examination (DRE) (Bourne, 2010; Lee et al., 2011). It is also likely that there are specific cultural factors that influence screening uptake across the Caribbean generally and Trinidad and Tobago in particular. Lee, et al. (2011), for instance, in a comparison of US-born white, African-American and Afro-Caribbean men in the United States identified men from Trinidad and Tobago as having low rates of DRE, and relatively high rates of 'worry' about prostate cancer, which they hypothesised may deter initial screening attendance.

While there is no clearly articulated policy on prostate screening in Trinidad and Tobago, both Prostate Specific Antigen (PSA) and DRE are available to men in health facilities based on their expressed needs rather than as a routine service. In a recently conducted mapping exercise on male specific SRH services in Trinidad and Tobago, prostate cancer screening is available on a limited basis (UNFPA, 2011). In most instances the PSA test was offered

initially and based on the results, other diagnostic examinations were offered including the DRE. Nevertheless, there remains hesitance among men to voluntarily access prostate cancer screening services. Based on the epidemiological data, prostate cancer is the leading cause of cancer related morbidity (Ministry of Health, 2012) with an increase in mortality among men in the 65 years and over age group annually (Central Statistical Office, 2009, 2010).

Given the disproportionate burden of prostate cancer in the Caribbean in general, and the evidence that higher screening uptake might be of benefit in Afro-Caribbean populations, there is an urgent need to understand in more detail the potential cultural barriers to accessing screening services in settings such as Trinidad and Tobago. Despite a number of qualitative studies of the view of African American and Afro-Caribbean men in the USA and the UK (Consedine et al., 2006; Odedina et al., 2004; Thomas, Saleem, & Abraham, 2005), there has been, to our knowledge, little research exploring the views of men in Trinidad and Tobago. This study aimed to explore men's views of prostrate screening in order to identify potential implications for policy and practice to improve screening uptake.

Methodology
To better understand men's perspectives, a qualitative methodology was utilized. The data here are drawn from a larger study of 'Masculinity and health beliefs among men in Trinidad and Tobago'.

Data collection strategy:
Fourteen focus group discussions were conducted, including seventy five men between the ages of 19-60 years during the period August 2011 to January 2012 (see Table 1). To maximise interaction, groups were homogenous, in that they included participants from similar workplaces or communities. Data were collected using a semi-structured interview guide which included prompts on using health services. Each respondent was provided with an information sheet and an informed consent form to be signed indicating consent to participate in the study. The focus group discussions lasted between forty five and ninety minutes. They were digitally recorded after permission was sought from respondents. Each focus group discussion was facilitated by the lead author (OO), transcribed verbatim by a Research Assistant and the transcripts were checked by the researcher.

Recruitment and selection:
To ensure a cross section of the population was included (in terms of income, ethnicity, religion and sexual orientation), men were recruited with the help of 'gatekeepers' from a number of agencies representing various socio-economic demographic constituencies including professional organizations, church leaders, non-governmental organizations (including one for men who have sex with men (MSM)) and employers in male-dominated sectors. To reduce researcher bias, 'gatekeepers' were sourced and provided with the criteria for selection of participants. These gatekeepers were requested to invite four to six men between 18 and 60 years old to a focus group discussion. Some groups included larger numbers; all recruited men were 19 or over. The aim was not to include a statistically

representative sample, but rather to include a range of participants whose perspectives were central to understanding men's perceptions of prostate cancer screening.

Table 1 – Source and demographic characteristics of participants in Focus Group Discussions

Organization	No. of participants	Age range (years)	Av. age
Division of Gender Affairs	6	28 - 58	47
Police	4	32 – 52	44
Prisons Officers	5	22 – 36	30
Rural area NGO	4	34 – 51	44
Humanitarian NGO	5	24 – 52	29
Community leaders (Tobago)	4	52 – 60	56
Religious leaders (Christian)	6	24 – 52	39
Religious leaders (Hindu)	4	19 – 60	42
Trade Union	4	45 – 58	51
Industrial sector (Central)	6	25 – 48	32
Sports leaders	4	20 – 26	23
Footballers	6	19 – 36	24
Sportsmen (Tobago)	9	20 – 42	30
Fishermen	6	30 – 56	42
	75	19 – 60	38

Data analysis:
Data were coded thematically, using both inductive (i.e. analysing the data for emerging themes) and deductive (e.g. coding data with topics identified in the literature) methods, with both authors discussing coding and analysis.

Ethical considerations:
Ethical approval for the study was received from the Ethics Committee, London School of Hygiene and Tropical Medicine and the Ministry of Health, Trinidad and Tobago. No monetary incentive was provided to participants but a snack plate or lunch and a drink, depending on the time of day when the discussion was conducted. In this paper, all identifying details have been removed to protect confidentiality, and data extracts are tagged with the source group (not the participant).

This paper reports on one particular set of themes that were identified in the data. Prostate cancer screening services was a topic that was raised spontaneously during the focus group discussions. Men were asked *'what are some of the examinations that you would be comfortable to have performed by a doctor'?* In all focus group discussions their responses focused on an unwillingness to undergo the prostate examination, more specifically the Digital Rectal Examination (DRE).

Findings

From the data, three major themes relating to prostate screening emerged which included level of awareness of the prostate examination, barriers that serve as deterrents and facilitators to accessing services.

Level of awareness

Regardless of their socio-demographic characteristics, respondents were aware of the importance of undergoing a prostate examination, especially as they grew older. This was evidenced by their spontaneous responses when speaking about physical examinations that they were uncomfortable to undergo when visiting the health facility. Typical responses were *"I recognize that as I grow older there are conditions that start affecting men" (Division of Gender Affairs)* or *"when you reach a certain age yuh have to go for this prostate test" (Police)*. In spite of their level of awareness, men do not readily present themselves for a prostate examination. An example was stated as *"I too thought that I should go and take an (prostate) examination but I keep putting it off" (Religious Leader Hindu)*.

This was supported by their view that men who are asymptomatic *"tend to put it (screening) in the back burner" (Industrial sector)* in spite of acknowledging its importance. In instances where they become symptomatic they reported being disposed to delaying health seeking until they could bear the discomfort associated with the symptoms no longer. They were also aware of the variety of tests that are available for the prostate examination, including the Prostate Specific Antigen (PSA). Typical examples of their awareness included one respondent indicating that *"the finger (DRE) is the better one" (Fisherman)* while another stated *"they could do it without doing that (DRE), they could do it with the blood (PSA) as well" (Industrial sector, Central)*.

Barriers

Across the focus groups, irrespective of sexual orientation, religion, or ethnicity, the meanings associated with prostate cancer screening, especially with the DRE, served as barriers that prevented men from accessing this service. The test was described as an invasion of their privacy and one that was widely associated with homophobic fears. The actual DRE procedure was identified as 'unnatural' since some respondents believed that it was similar to engaging in *"a kinda homosexual act" (Fisherman)*. This was exacerbated by the posture that men are required to adopt during the procedure, reported as a reversal of men's 'proper' sexual roles. As a result, this contributed to greater levels of unwillingness among respondents to have a DRE. A typical comment was: *"... ah man eh really supposed to touch ah man dey in he bottom in truth yuh know and worse again a finger going up dey too..." (Fisherman)*.

When respondents spoke about having experienced the prostate examination, it was not the physical discomfort of the procedure itself that was of concern, but the interpretation of the experience. This was explicitly related to associations between the act of the DRE and its associations with (culturally) devalued identities of homosexuals or women: the DRE examination was described, for instance, as something that would make you feel like a

"macomere [homosexual] *man"* or to *"know what a woman goes through"* *(Division of Gender Affairs)*. In this regard, men discussed the test as making them feel *"embarrassment ... shameful" (Fisherman)*. The meaning associated with the procedure was a greater deterrent than the procedure itself.

Both the act of the examination and the gender of the health personnel conducting the examination were highlighted as barriers to screening. Respondents expressed homophobic anxiety about the possible sexual orientation of the male health care provider which exacerbated their unwillingness to access services. A typical example was
"yuh wondering if this doctor straight, is he in the closet cause it have plenty men ... I say they gay but it have plenty of them bi-sexual ... so you have to ... gauge this person and see well if yuh think this person is a straight person or not because ... you had to go and skin your bottom and this man he seeing a male they and he could be sexually gratified by a male" (Police).

For men who have sex with men (MSM), homophobia was also a barrier, with this group agreeing that they were generally *"very wary of going to the doctor to be probed" (Humanitarian NGO)*. Their greater concern when considering the DRE was disclosure of their sexual orientation since they feared that they would be discriminated against by staff members. Reported unwillingness to attend for prostate screening reflected a general cultural belief that preventative health behaviour was threatening to masculine identity.

Across the groups, men reported that it would be seen as *"unmanly... to be fretting about your health, to be going to the doctor"* *(Rural area NGO)*, and that seeking services for prevention rather than emergency care was not conducive to a strong, respected masculine identity.

Facilitators
While respondents in all groups identified cultural disincentives to accessing preventative services in general and the prostate examination in particular, within the data were also some more implicit facilitators to health seeking. Although men rarely reported actually seeking screening following the birth of a child, losing a father or a significant male in their life to prostate cancer, these life events were discussed as points when men would reassess their orientation to responsibilities to their own health. Such responsibilities were discussed in terms of expressed desires, for instance, to *"at least see him [son] grow to become a man" (Division of Gender Affairs),* and the recognition that being diagnosed with an illness would deprive them of the opportunity to see their children *"carry on the tradition" (Division of Gender Affairs)*. For a small number of respondents who had seen their father or another significant male die from prostate cancer, this was reported as a spur to seeking screening: *"after I see what my father went through ... I will do anything that is necessary to keep me in health" (Prison Officer)*.

In general, men were willing to have the PSA test done as the preferred screening method. This was viewed as being non-invasive as well as not challenging their masculine identity although they were generally uninterested in knowing their health status in relation to their

prostate. They were also willing to take the screening examination using mechanical instruments rather than the DRE since they believed that it would cause less anxiety while undergoing the examination. A case in point was shared by one respondent: *"when I heard about how the prostate test is administered ... I say I hoping by the time I reach the age they develop some other method ... "* (Police).

Given the homophobic anxieties related to DRE, it was not perhaps surprising that men reported that physicians who were least similar (in terms of gender or community) were least likely to be a barrier and as a result, encourage care seeking. Thus, some men indicated that having to expose themselves, especially the private parts of their anatomy, to a male care provider, was most likely to be *"demeaning"* (Trade Union). Some explicitly expressed a preference for having a *"woman doctor"* (Sportsman, Tobago) or someone with whom they were unfamiliar since it would make them feel less *"uncomfortable"* (Prison Officer) in terms of threatening their masculine identity. The position that men are expected to assume to undergo the examination represented a reversal in their sexual roles hence having a female to conduct the examination provided less emotional trauma in confronting their masculine identity.

Discussion
Despite the large literature on the high prevalence of prostate cancer in the Caribbean, and the particular problems with use of screening services in Trinidad and Tobago, this is (to our knowledge) the first study that has reported on men's perception of the prostate screening examination in this population.

The views of the men in this study reflect those found for other populations in the region and, to a lesser extent, internationally. Unlike for some populations (Çeber et al., 2008) lack of knowledge was not a barrier: men were aware of prostate cancer, and the fact that the DRE examination was spontaneously raised in all groups suggests widespread familiarity with screening. However, the levels of embarrassment and anxiety evident in men's discussions in Trinidad and Tobago are reflective of other studies in the region. Bourne, (2010), for instance, in a study of male health care workers in Western Jamaica suggested that while men are knowledgeable about prostate cancer, the cultural meaning associated with prostate cancer screening using the DRE is a major deterrent to accessing screening services.

More education is unlikely to be sufficient to influence behaviour change in the face of such culturally embedded beliefs. McNaughton et al., (2011) identified similar views among doctors at the University Hospital, Jamaica. We have identified similarly well entrenched cultural views, associated with homophobic anxieties, among a wide range of men in Trinidad and Tobago. That the DRE specifically was raised spontaneously in group discussions may suggest men's consciousness of the importance of screening although they were unwilling to undergo this particular examination. However, reported unwillingness did also reflect generally articulated views that accessing any preventative services was likely to threaten masculine identities.

These views are real deterrents to prostate cancer screening, as documented in the wider literature (Consedine et al., 2009; Ford et al., 2006; McNaughton et al., 2011). However, such cultural associations of the DRE are not inevitably barriers to accessing services, as suggested by one study from Saudi Arabia which found no relationship between fear, embarrassment, anxiety and prostate screening using the DRE (Alhelih, Rabah, & Arafa, 2010). While respondents in this study identified fear and anxiety, they were in relation to broader health seeking behaviours and concerns about being diagnosed with a debilitating health problem and not specific to prostate cancer screening.

There is controversy about the value of PSA as an ideal marker in mass screening of men who are asymptomatic (Duffy, 2011). While it has been shown to accrue modest benefits in reducing mortality this may not be sufficient to outweigh potential harm related to over detection and overtreatment. In the USA, Lee et al., (2012) identified that perceived health system barriers were more closely associated with PSA screening behaviours among African American and African Caribbean men. However, this was never raised as an issue among respondents in this study, in a setting where health services are publically funded. The fact that they were able to identify availability of services and their anxieties associated with their perception of the examination suggests that access to services was not as a deterrent.

Implications for policy
Homophobia is a real issue that confronts Caribbean men and influences their health behaviours, especially in relation to the DRE. Whilst its root causes are likely to be located in historical and political processes, homophobia is, as noted by Bourne, (2010) reproduced through socialization and deeply religious cultures in which men are highly protective of 'masculine' identities and highly concerned about threats to that identity.

Such concerns were evident across the groups included in this study, affecting men in all groups, including those of MSM. Addressing these deeply rooted cultural views is perhaps a longer term aim, and understanding them outside the remit of a small scale qualitative study. However, in the short term, there is an urgent need to identify ways to increase uptake of cancer screening services in order to improve the sexual and reproductive health of men in Trinidad and Tobago, and the Caribbean more generally. Two potential strategies are suggested by our findings in light of the larger literature.

First, despite unwillingness to undergo a DRE, men may consider accessing alternative prostate cancer screening services (Çeber et al., 2008; McNaughton et al., 2011). Lee et al., (2011) found that although high levels of worry were a deterrent to initial attendance for screening, they were not associated with the rate of annual attendance after that: i.e. once men had overcome initial high levels of fear associated with the DRE screening and undergone the procedure, they were more likely to continue with an annual examination. Combining the DRE with others tests like the PSA served as a catalyst for encouraging greater access to screening services, given that the PSA test did not have the same level of complex association between fear and anxiety. In our study, given reported willingness to access a PSA test, a

similar 'gateway' process utilising PSA tests may be one route to increasing screening uptake.

Second, there is the potential to build on the reported willingness of men to take greater responsibility for their health in the context of their roles within the family. Discourses of 'responsible fatherhood' were prevalent in the focus group discussions, and one possible route for health promotion materials that acknowledge the discomfort of screening, but stress the 'responsibility' of 'real' men to overcome this discomfort. If framed carefully, to avoid simply reinforcing dominant homophobic and misogynist models of masculinity, such messages might resonate with those more positive associations of masculinity (bravery, responsibility) as overcoming the potential threats to masculine identity through the short term discomfort of an examination which suggested devalued or stigmatised roles.

Limitations

Although this study could serve as a baseline for initiating other studies on masculinity and prostate cancer screening in the Caribbean, there are some limitations. Our sample included a wide cross section of men, but the majority were from public sector workplaces, and there were few private sector, businessmen or higher paid professionals whose experiences and perspectives may or may not have been different to other men as a result of their socioeconomic status. In this regard, there were limited opportunities to compare similarities or differences in perspectives related to socio-economic status.

The study focused on men between the ages 19 to 60 years; however, epidemiological data showed that men in the over sixty years age group have the highest incidence of prostate cancer, and are more likely to undergo screening services. Their inclusion as participants may have provided more robust data on corroborating findings in this study based on their previous experiences in relation to barriers or facilitators in health seeking.

Conclusions

This study provides insights into men's perceptions of prostate cancer screening. Men are aware of the value and recognized the importance of personal responsibility for seeking these services. However, fear of the DRE was identified as a significant factor that prevents their willingness to accept prostate screening examinations. Accepting personal responsibility for their health in the light of past diagnosis with prostate cancer by their fathers or a significant male, or in the face of feeling responsible for their children, served as facilitators to intending to undergo screening services. This has implications for the packaging and delivery of health care services targeting men, in relation to prostate cancer screening. There is an urgent need for the development of a culturally sensitive approach to health promotion messages and to providing prostate cancer screening services. This study is a contribution to informing such services, and sensitising health care providers to the cultural associations of the DRE.

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