Working Paper Series

Constructions of M

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Introduction

In recent years, increased attention has been drawn to the relationship between masculinity and health. A substantial body of literature has emerged, proposing that hegemonic constructions of masculinity perpetuate an image of men as strong, resilient and invulnerable, which discourages 'health-positive' behaviours among men. It is argued that hegemonic masculinity promotes risk-taking behaviours that are harmful to individual and social health, such as smoking, drinking and violence. Furthermore, emphasis on male independence, self-reliance and stoicism are

1 – Literature Review

Having identified the main features of hegemonic masculinity deemed detrimental to health, let us now examine some critiques of this characterisation. Many analyses of the implications of hegemonic or ‘traditional’ masculinities seem to be based on the author’s perception of what

‘contextual or cultural specificity’ in literature on masculinity and health, and highlights examples that contradict the popular conception of men as unwilling participants in healthcare, ‘such as the fact that men in countries such as Afghanistan, Nepal, and Pakistan live longer than women (Hunt 1998), or that men are more likely than women to seek prompt treatment for wide-ranging conditions such as the common cold (Hunt 1998) and STIs (Fortenberry 1997; Kramer, Aral and Curren 1980)’.

Generalisations made about men’s avoidance of health-positive behaviours may be reinforced by the negative stereotypes about men from developing countries that frequently appear in ‘gender and development’ literature and HIV/AIDS research. Rivers and Aggleton (1999, 2) argue that ‘[m]en in developing countries have been almost uniformly characterised as inconsiderate, unreliable, predisposed to coercion, rape and violence, as well as being relatively unable to control or change their behaviour’. Many myths about African men have emerged from discourses on the AIDS epidemic, such as ‘Africans won’t use condoms’ (Patton 1990, 78). Men’s own voices are rarely heard in such literature; instead, men appear only as ‘hazy background figures’ (White 1997, 16).

Fortunately, there is increasing recognition that masculinities are ‘multiple, diverse, contested, dynamic and socially located in both time and place’ (O’Brien et al. 2005, 504). Yet in order to ensure that this diversity is taken into account, men’s own views, beliefs and experiences must be documented. As Simpson (2005, 569) argues, ‘[m]ore needs to be known about how boys come to construct, experience and define themselves as men’. Indeed, ‘a first step in analysing men and masculinities may lie in examining men’s ‘private stories’, and how these accounts and experiences support or contradict the ideologies promulgated by hegemonic masculinities (White 1997)’ (Rivers and Aggleton 1999, 4). Researchers also emphasise the diversity and complexity of beliefs and practices relating to health. However, ‘there is still a dearth of health-related research in which gender is explicitly considered. While many studies do include sex as a variable, few explore how culturally dominant notions of masculinity and femininity might influence health practices’ (Gough 2006, 2477). Therefore, more research is needed into constructions of mascuhminl-1.91845ty-4.15818(( )54.2303(a)-1.91845(n)-0.29872(d)-4.15818(( )21.6034(h)-0.3

WHO World Health Survey on Senegal (2003) provides evidence to support this hypothesis: male life expectancy is 54.3 years, while female life expectancy is 57.3 years. However, given the diversity and complexity of masculinities and health-related attitudes and behaviours that exist within societies and even within individuals, the interviews could well produce results that do not correspond to this hypothesis.

2 – Conceptual Framework

Several key perspectives have shaped this research. It is based on a social constructionist view of gender, which proposes that masculinity is not a set of innate characteristics; rather, it is

3 – Methodology

In order to investigate constructions of masculinit

himself as *Toucouleur*. He also described his occupation as ‘student’, though he was not enrolled on a course at the time of the interview.

Three of the interviews took place at the home of a mutual Senegalese friend with whom I was staying, and the other two were conducted at the participants’ homes, according to their preferences. Quiet surroundings, a familiar environment and our previous acquaintance facilitated discussion of personal issues. Participants were shown how to use the voice recorder, to ensure that they could pause it at any time. I also explained that should they not wish to respond to a particular question, there was no obligation to do so. Participants were encouraged to ask questions if they required clarification. It was emphasised that there were no ‘right’ or ‘wrong’ responses; the interviews were simply designed to explore their views on a range of subjects. Anonymity was also assured, although several participants preferred their real names to be used in this dissertation.

Subjects for discussion during the interviews had been selected after a comprehensive review of topics raised in the literature on masculinity and health. The interview design was also influenced by ‘pilot’ interviews conducted with other Senegalese friends to ensure that key subjects were

used Wolof or Arabic words for which there is no French translation, for which they then offered comprehensive definitions. As I had studied French and lived in Senegal for several years, during which I worked as a professional translator, I was able to endeavour to make my English

4 – Empirical Discussion

Literature on masculinity and health typically portrays hegemonic masculinity and health-positive behaviours as incompatible. Participants in this study proved strongly attached to hegemonic masculine ideologies and rejected notions of gender equity, as the first sections of this discussion illustrate. Therefore, we might have anticipated that they would avoid health-positive behaviours and refuse to seek help with their health. However, this was not the case: the young men were highly health-conscious, as demonstrated by the res

In discussions on how boys come to be considered men in contemporary Dakar, the importance of work and acknowledgement of one's role as a provider could not be overestimated. Indeed, this finding corresponds to those of a World Bank report, which proposed that 'men's social recognition, and their sense of manhood, suffers when they lack work' (Barker and Ricardo 2005, v). Babacar said that a man who did not work would not receive the same respect:

> 'You won't be as respected. For example, if there are celebrations, ceremonies, you're the last one to be told. If you don't go, people don't ask after you. That's how it happens in Senegal. To be respected, you have to have money. No money – no respect.'

Indeed, it seemed that boys became men when considered men by others. Participants' responses supported the argument that 'a nearly universal feature of manhood is that it must be achieved […] Achieving manhood is in effect evaluated or judged by other men and women; young men in diverse social settings freqently report a sense of being observed and watched to see if they measure up to culturally salient versions of manhoo

Becoming men

The belief that homosexual men were like women, not

> ‘O – …In my religion, in Islam, it is often said: man is superior to woman.
>
> S – In what way?
>
> O – In every way.’

When asked what they thought of these ideas about gender roles, the young men all seemed to accept the rigidity of the divisions, often with reference to religion. This supports the conclusion of Sow (2003, 75) that, in Senegal, ‘obedience to the patriarchal order is looked upon as a sign of commitment to God and religious faith’. Their responses also linked gender inequitable norms to cultural traditions. Saliou said:

> ‘This is Africa, you see! We’ve grown up like this. We come from families where it’s the Dad who works; the Mum stays inside. Her role is to cook, clean and raise the children. We’ve been told that that’s how it should be done. So, if we start saying, ‘the world has changed, she we should change our way of life’, they’ll take it badly. They’ll say, ‘You arrived, you’ve seen us live this way, why do you want to change it?’ They’ll try and bring you down in some way!’

Sidi also explained:

> ‘When you’re very young and you spend time with your father or grandfather, they tell you what characteristics a real man should have. And from a young age, they start teaching you these characteristics; you grow up with them.
>
> Sarah – And do you think they are good values?
>
> Sidi – Yes, yes. Because parents never teach you things that aren’t good.’

Negative perceptions of women

Participants frequently expressed opinions that revealed hostility or disdain towards women. For example, Saliou said that life was more difficult for men than women, suggesting that the shortage of jobs for men was due to the ease with which women could now work. He explained, somewhat angrily:

> ‘Women, you see, if they’re beautiful, they’ve got everything. They can get jobs. A friend told me that in all nightclubs, if you want to be employed, you have to sleep with the boss. [...] And what’s more, girls aren’t like guys. You know, a guy can hold back ! You can be in real need, and you do everything you can so that no one knows you’re in need. But women. If women are in need, they’re ready to sacrifice everything. To get what she desires. Now men can’t find work anymore. Because women are working in their place. That’s why I’m saying things are easier for women than men.’

Saliou clearly felt the injustice lay in women replacing men in the workplace, rather than in the sexual exploitation of women. He was convinced that ‘all women were materialistic’ and easily

seduced by money. He declared that the majority had many boyfriends at once in order to be well looked after financially. He lamented, bitterly:

> ‘You know, girls nowadays don’t know how to say ‘no’. You see the girl for the first time, you talk to her and she accepts [to go out with you]. They do it because they don’t work – it’s their way of extracting money from men.’

Saliou said girls were reluctant to commit to marriage with one boyfriend as it would prevent them receiving money from the others. When asked his views on polygamy, Saliou said that he would never have more than one wife. His explanatio

and cultural practices with the express purpose of protecting and promoting their health. While the young men did endorse hegemonic constructions of masculinity, it seemed that, with regard to health, the influence of religious and cultural values had a greater impact on their attitudes and behaviours. The following sections present the most salient themes that arose during interviews; the extracts clearly illustrate the health-positive attitudes and practices of the young men.

Staying well

All participants placed a great deal of emphasis on tou[illegible]sct p o

Other participants also endorsed seeking help immediately. Emmanuel stressed the importance of regular check-ups to ensure good health. He also said that at the first signs of malaria, one should go to hospital to receive medication. He also supported the idea of

Babacar said:

> '… the fast is a commandment that the Good Lord has given us. But if we do it, it's not for Him … He says: fast, and you will be in good health. So it's for us.'

When Ousmane was asked how he felt when he fasted, he replied:

> 'I feel very well! Very well. When I fast, I feel relaxed. I find that I'm able to do a lot … But when I haven't fasted, when I've eaten up to here … I feel lazy, I need to sleep a lot. The fast helps me a lot. It's good for my health.'

Circumcision was also perceived as a ritual that is both divinely-ordained and health-promoting. For example, Babacar said that circumcision was recommended by religion, then added that circumcised men are better protected against sexually transmitted diseases. He asserted that circumcision improved male sexual performance; an idea echoed by Sidi. Sidi also stated that circumcised penises were healthier, cleaner and less susceptible to infections. He then said:

> 'And it's something that the Good Lord has recommended. And we say that God always gives us the best things, the best solutions.'

The strong emphasis in Islam on health and hygiene has the result that health-positive behaviours tended not to be associated with femininity, as the literature suggested, but with religion, a domain governed by men. Moreover, Sow (2003) argues that traditionally, many rites to protect health were performed by women in Senegal, but Islam has allowed men to assume leadership in that realm. She explains:

> 'This has had an impact on the traditional rites. By adding a few verses from the Koran to their incantations, male healers have taken over from female healers, giving the rites a new 'holy' dimension. […] Thus, we are now witnessing subtle changes to c

Cleanliness

Closely related to both health-positive behaviours and religious beliefs was the importance participants attached to cleanliness. When asked about their hygiene-related practices, all the participants answered in terms of personal hygiene, often emphasising that this was part of their religion. For example, Ousmane told me that he often had up to four showers a day, then said:

> 'Religion, first of all, is hygiene. First and foremost. Internal and external cleanliness.'

Sidi also asserted:

> ' … to protect my health, I wash myself properly. Every day, two or three times. It is a religious obligation to wash properly, and to smell good.'

When asked what he considered the best way to stay healthy, Saliou's first response was that one should be clean; Emmanuel also emphasised the importance of cleanliness in order to have a strong constitution. Cleanliness was also associated with spiritual purity; several times, Saliou associated religious transgression with being unhealthy and unclean.

The dual nature of illness

Participants made frequent mention of the dual nature of illness: they believed that illness could have both physical and 'mystical' causes and cures. Emmanuel explained:

> 'There are physical illnesses, which doctors can heal. But there are also metaphysical illnesses, which are beyond human knowledge. And humans can't always cure those kinds of illnesses. For example, someone might be possessed by a 'djinn'[5], as we say here, and they can go to hospital every day without getting

(mystical charms that do not contain Qur'anic verses) and the healing ceremonies of the Lebu[6], which involve animal sacrifices, as un-Islamic. However, others did observe various non-religious traditions that were believed to protect against misfortune. For example, Babacar said

Talking to others

Men are commonly portrayed as reluctant to talk openly about their problems, whether health-related or otherwise, which presents a real obstacle to help-seeking. However, the young men I interviewed spoke openly about their health problems. Most also advocated sharing problems with others in order to relieve stress and receive advice. However, the participants all said that they would not discuss problems indiscriminately; rather, they would only talk about problems with close friends, family members or their doctor. Ousmane found talking to his doctor highly beneficial:

> 'He helps me psychologically. He advises me. When I go to see my doctor, I really feel … even before I start taking the medicine, I heal internally. Because he's helping me, counselling me, reassuring me …'

In our discussion on masculinity, Ousmane underlined the importance of a man being able to

He said that he would like to be a good listener an

5 – Conclusion

fasting, and circumcision) are respected as part of one's *obligations* as a believer. Thus, health

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