

To be a man: Exploring masculinity and HIV service needs among African men in London



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ABSTRACT

African migrant men are an underserved risk group in terms of HIV services in London. They tend to present late and face multiple barriers in accessing services. However, little research has been conducted to explore their unique vulnerabilities; rather, much HIV/AIDS research focuses on men as vectors of the disease, responsible for infecting women. This study explored the factors impacting men's use of community-based HIV testing, care and support services with special attention to how constructions of masculine identity affect service use. A diverse group of 23 HIV positive and negative African men living in London participated in individual interviews and focus groups. Results showed that the social, material and institutional contexts in which the men lived were found to affect their engagement with HIV services. Due to challenges presented by immigration status, HIV and other barriers, participants often failed to fulfil the expectations of traditional masculinity. Consequently, some were dissatisfied with HIV support services for their perceived failure in providing practical help in areas such as finding employment. However, some men were able to construct alternative versions of masculinity that promoted health enhancing behaviours. Implications for future service provision are discussed.

Key words: Masculinity, HIV/AIDS, health, migrants, community-based services, African men.

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INTRODUCTION

HIV/AIDS is now a truly transnational epidemic and international migrants embody the globalised nature of the disease. Given the challenges many migrants face throughout the migratory process, it is clear that migrants can face increased vulnerability to HIV due to unstable living conditions and barriers to accessing HIV care and support services for those already infected (UNAIDS, 2009b).

Another characteristic of the current epidemic is the feminisation of HIV/AIDS. Women are disproportionately infected and affected by HIV due to biological, social and economic vulnerabilities. In fact, of young people (ages 15-24) living with HIV in sub-Saharan-Africa, 75% are women (UNAIDS, 2004). In response, research and interventions have increasingly taken a 'gendered' perspective. However, more often than not, gender in fact refers exclusively to women while demonising men (Dowsett, 2003). This marginalization only serves to reinforce negative behaviour on the part of men and even create antagonism towards HIV/AIDS interventions.

This study takes a step towards rectifying this bias by focusing on men as part of the solution. There are two reasons why an alternative approach is crucial. First, heterosexual transmission accounts for the vast majority of infections among sub-Saharan Africans, both in their home countries and in the UK, where 92% of HIV-positive Africans were infected heterosexually (Health Protection Agency, 2008a). If men are largely responsible for infecting women, men must be targeted to decrease the spread of HIV. However, men are also worthy of attention in their own right - they too have a human right to health and face unique vulnerabilities that have yet to be addressed, especially in the context of transnational migration.

Research Question

This project was initiated by and conducted in collaboration with the African HIV Policy Network. They requested an investigation into African men's use of HIV testing, care and support services as this was identified as a priority by their member organisations. As AHPN's members are community-based organisations rather than statutory services, this research focused on the former.

The theoretical approach was based on the social psychological importance of identity. Our 'recipes for living' are largely determined by our social identities; who we are determines what we do (Campbell & MacPhail, 2002). It stands to reason that moving to a new country and dealing with a chronic and fatal disease both have substantial impacts on one's identity. Specifically, both of these major transitions undoubtedly influence men's ideas of what it means to be a man and how they personally fit this concept.

Given AHPN's priority of improving services and a theoretical interest in the role of masculine identity, the following questions guided this research:

What factors impact the use of community-based HIV services by African migrant men living in London?

- A) What role do men's constructions of masculinity play in facilitating or hindering service use?
- B) How successful are community-based HIV services in supporting African migrant men's health?

LITERATURE REVIEW

In order to explore these questions, some demographic and theoretical background is necessary. This section will first outline the existing literature on Africans and HIV in the UK, and then branch out to discuss the literature on masculinity as it relates to health.

Epidemiology - Africans and HIV in the UK

Research on HIV and African migrants in the UK has grown substantially in the last decade. Prevalence rates show a pressing need for attention to this population; amongst Black Africans, diagnosed HIV prevalence is 3.7% compared to 0.09% in the general population (Health Protection Agency, 2008b). Many who are HIV-positive have never been tested, with 36% of African men and 25% of African women unaware of their status (The UK Collaborative Group for HIV and STI Surveillance, 2007).

Moreover, Africans have the highest rates of late diagnosis of any group in the UK. In 2007, 42% were diagnosed after the point when antiretroviral (ARV) treatment should have begun; African men have higher rates of late diagnosis than women (Health Protection Agency, 2008a; Chadborn, Delpech, Sabin, Sinka, & Evans, 2006). This sex difference in late diagnosis is mirrored in differential rates of seeking medical care for HIV/AIDS (Health Protection Agency, 2008b). Late diagnosis results in poor survival rates, high health care costs and higher risk of transmitting HIV to others (Burns, Imrie, Nazroo, Johnson, & Fenton, 2007).

Barriers to access

Some barriers to service access have been explored for African communities in the UK, although without a gendered dimension. First, stigma is a major deterrent to testing, with Africans twice as likely as white British people to fear discrimination after a positive test (Erwin & Peters, 1999). The stigmatised nature of HIV means that being seen attending HIV services could result in accidental disclosure to community members and family in Africa and the loss of much needed support (Burns et al., 2007; Flowers et al., 2006). A second barrier to access is immigration status; indeed, it is seen by some HIV-positive Africans as a more pressing problem than their HIV status and impacts service access in a variety of ways (Flowers et al., 2006). Undocumented migrants may fear that accessing statutory services or being found to be HIV-positive could result in deportation (Burns et al., 2007). Specialist HIV services can also be prohibitively difficult to access, especially for a person unfamiliar with the NHS and/or the English language (Burns et al., 2007). A third reason for late presentation is a lack of awareness - both of being at risk and of where to test if desired (Prost et al., 2008). Although use of GPs is high among Africans in the UK, attendance at genitourinary medicine (GUM) clinics where HIV tests are available is low (Erwin, Morgan, Britten, Gray, & Peters, 2002).

Depressed socioeconomic conditions experienced disproportionately by Africans increase their vulnerability to HIV infection and compound the challenges of living with HIV. Compared to other HIV-positive ethnic minorities and white British people, those of African origin have the highest rates of insecure residency status and unemployment, and were most likely to have insufficient money to cover their basic needs (Ibrahim, Anderson, Bukutu, & Elford, 2008).

Where are the men?

It is recognised that higher prevalence in African migrant women may also be an indicator of under-diagnosis in men (Health Protection Agency, 2008b; Prost et al., 2008). However, there is little research exploring the causes of this imbalance. At most, heterosexual men merit only a brief mention in studies that discuss barriers to diagnosis and care among African migrants and only a handful of studies have ever been conducted on African migrant men who have sex with men (MSM; Doyal, Paparini, & Anderson, 2008; Kesby, Fenton, Boyle, & Power, 2003; McMunn, Mwanje, & Pozniak, 1997; Prost et al., 2008). No strategies are proposed in this literature to meet men's needs.

An exception to this trend is a set of studies by Doyal and colleagues on the lives of heterosexual and MSM African men with HIV in London - they go further than others by exploring the experiences of men themselves (Doyal, 2009; Doyal, Anderson, & Paparini, 2009; Doyal et al., 2008).

How to be a Man - Masculinity and Health

In the HIV/AIDS field, attention has been focused by a 'crisis of masculinity' in many African countries where traditional markers of manliness have become unattainable due to changes in employment structure, women's rights movements and the HIV epidemic itself (Morrell, 2001).

Several studies have found that the inability to fulfil roles associated with being a 'real' man (i.e. because of unemployment) leads to feelings of failure (Doyal et al., 2009; Fitzgerald, Collumbien, & Hosegood, 2010). Some men respond to this failure by pursuing other paths to masculinity, such as hypersexuality and violence, while others resist the norms by finding alternative ways of being a man.

There has been a growing trend in recent years towards the study of masculinity and men's health. It has partially stemmed from the realisation that men's health-related beliefs and behaviours are a major reason for their lower life-expectancy worldwide (Courtenay, 2000). Identity is largely expressed through behaviour, and health-related behaviours are an important way in which men demonstrate their masculine identities (Robertson, 2007). Traditional masculinity often includes behaviours that can be health damaging; real men are expected to be tough, unemotional, aggressive, deny weakness, and have uncontrollable sexual desires (Lee & Owens, 2002). Thus, in order to achieve a culturally sanctioned masculinity, men must ignore pain and sickness and actively take risks. Conversely, concern for health is seen as feminine and thus subordinate. The resulting gender differences in

health behaviour are often taken for granted; it is common-sense that men are reluctant to go to the doctor and therefore not constructed as problematic (Courtenay, 2000; O'Brien, Hunt, & Hart, 2005). Men's health behaviour thus becomes a self-fulfilling prophecy when men conform to common-sense expectations (Crawford, 1995).

Filling the gaps

This study intended to fill several gaps in the literature. First, as mentioned earlier, there is very little research on the HIV-related needs of African migrant men living in the UK, although parallel research on African migrant women and on men in Africa has been conducted (Barker & Ricardo, 2005; Doyal & Anderson, 2005; Onwumere, Holttum, & Hirst, 2002). Additionally, much HIV research positions men as the cause of the problem rather than as people with unique needs. I intend to establish a better understanding of men's uptake of HIV services and present pathways for action to improve the ability of community-based services to meet men's needs. If men are to be enlisted as partners rather than adversaries in the fight against HIV, a greater understanding of their identities, needs and behaviours is crucial.

METHODOLOGY

In this study, in-depth individual interviews, focus groups and a participatory planning activity were used to elicit the views of African migrant men in London. The study received ethical approval from the Institute of Social Psychology at the London School of Economics.

Sample

The final sample consisted of 23 men, constructed to reflect the range of African men living in London rather than a representative sample. Inclusion criteria required participants to be male, over the age of 18, and identify as African (i.e. born and/or raised in an African country). The men came from eight different countries across the African continent and all had been living in the UK for more than five years. The final sample is described in Table 1.

Feature	Number
HIV Status	Positive n=17 Negative n=5 Never tested n=1
Race	Black n=22 White n=1
Sexual orientation	Heterosexual n= 21 MSM n=2 (Bisexual n=1, Homosexual n=1)
Age	Range: 25-75 Mean = 43
Immigration status	Permanent n=21 Uncertain n=2 (Asylum seeker n=1, Expired visa n=1)

Table 1. Basic sample demographics

Data Collection

The final data consisted of 15 in-depth interviews and two focus groups. One focus group had three men (due to no-shows) and the other had five, all of whom were HIV-positive.

RESULTS

Community-based HIV services are defined as services targeted towards the grassroots of a particular geographic or cultural community whose remit includes raising awareness, fighting stigma, providing support for people living with HIV (PLWH) and information on how to protect oneself and others.

Results showed that the factors affecting African migrant men's use of HIV services fall into three broad contexts: social, material and institutional. Social context can be defined as the culture and ideologies of a social setting, and how these shape the creation of identity. Material context refers to the presence or absence of resources, which in this case include financial, socio-emotional, informational and physical resources; this context includes the services which do or do not provide resources. Institutional context refers to the larger policy environment that influences the way in which services are run. Taken together, the social, material and institutional contexts explain how men's identities are challenged and reconstructed and the part that HIV services play in these dynamics.

SOCIAL CONTEXT

The social context of men in this study was dominated by traditional ideals of what it means to be a man, barriers to achieving these ideals and the alternative constructions of masculinity that some men created to rebuild their identities.

Traditional constructions of masculinity

Many men shared an ideal of what men should do and be, and this was often defined in opposition to women's roles and actions. Certain actions were seen as rites of passage necessary to become a man, and many of these revolved around finding a partner and becoming financially independent. In terms of sexuality, several men professed a view that heterosexuality and being the dominant partner were normal for men. Having multiple sexual partners, although mentioned occasionally, was not a key marker of masculinity among most participants.

Most participants identified strongly with the traditional breadwinner role and emphasized their financial and decision-making responsibilities within their families. The expectation to support their family in the UK and in their home countries weighed heavily on their shoulders.

Like right now I am here, I am not allowed to work but I am supporting a lot of people back home, I have two children to look after and it's not an easy task because they expect you - being here - they expect you to have so much and you have to try to make ends meet. You can't let them go to poor schools. - Interview 4

Highlighting the differences between men and women's health-related behaviour was one way in which masculinity was expressed. Differences included the ease with which women would seek health services compared to men, which was often explained in terms of women's responsibility for their children's health. Finally, men felt that they were supposed to be seen as, or actually be, stronger than women, and seeking care would belie this supposed strength.

P2: We tend to keep it inward you know because illness in a man is weakness. A man will always be happier if he's known to be very strong and somebody who never gets sick, who never gets a cold, who never got down with flu. - Focus group 2

Some men assumed that this gender difference was the natural order of things. As one participant stated: *"Women are a different species, everybody knows that."* (Interview 6).

Failure to meet expectations

Many participants experienced feelings of failure because they were not able to attain the masculine ideal explained in the previous section. They experienced this failure primarily through unemployment; 14 out of 23 participants were unemployed and several were working at jobs for which they were highly overqualified. Unemployment had two perceived social consequences. First, attracting a partner (seen as central to being a man) was difficult without paid employment. Second, because the breadwinner role was central to some of the men's identities, unemployment brought frustration and shame. As one participant eloquently put it:

P1: There's a group psychological burden on the man in the African context and the man is the provider, he is the supporter and when he suddenly finds himself in a situation where he's unwell he is unable to meet up with what society expects of him, it even begins to eat him even more and then he becomes more isolated, more secluded than -

P2: More frustrated.

P1: Frustration sets in and embarrassment, you can't come out and meet peers and so he suffers in silence. In some cases it can be pretty detrimental and dangerous. - Focus group 2

Disruption of traditional gender roles was seen as another reason for men's failure to meet expectations. Many men felt that gender roles were reversed in the UK - men were sometimes expected to cook and care for the home while women worked. The conflict caused by this reversal was exacerbated by women's perceived advantages in finding employment and the 'preferential' treatment they received in the name of gender equality. Some men felt strongly that being supported by their female partner was threatening to their masculinity. For example, *"Let's say an African woman [is] working for £15 an hour and*

you're working for £5. She is paying most of the field ... She tends not to respect you." (P4, Focus group 2).

Though all participants had been in the UK for over five years, many discussed social problems associated with adjustment to a new culture. Some saw migration as a primary cause of their unemployment (e.g. because of lack of UK work experience, language barriers, etc.), and it was thus connected with their inability to fulfil an important requirement of masculinity. These sentiments were summed up as follows:

P1: The African, you know, probably had a very high position back in his own country and came and cannot do the job that he was used to and just to do some other menial job. It's the wife has a better opportunity and brings more money home. The roles are reversed and the husband feels his position is undermined; this leads to divorce, separation, domestic violence, things like that.

– Focus group 1

In addition to the demise of relationships, men living with HIV frequently mentioned the difficulty of finding a partner and becoming a husband and father and therefore a 'real' man. Meeting a partner was a key motivation for attending HIV support groups.

For those men living with HIV, stigma and isolation blocked traditional masculinity; shame, guilt and physical illness sapped their power.

P1: Especially if you lead a very active life...for somebody to be hit by this it took some time. I've been going through that since 2002 and I was in a cocoon for about three years, I refused to come out, refused to meet -- I lost friends, it was embarrassing to come out you know, your whole confidence goes. – Focus Group 2

In sum, a variety of factors including unemployment, shifts in gender roles, migration, inability to maintain relationships, and HIV related stigma all contributed to African men's sense that they had failed to meet expectations associated with masculinity.

Alternative Masculine Identities

Despite these many challenges, or perhaps because of them, some participants managed to construct alternative versions of masculinity where they saw HIV and care-seeking in general through a more positive lens. Consequently, many men expressed disapproval of others who ignored health problems, denied HIV and failed to access services. Participants distanced themselves from these other men who they often spoke of as 'hiding'. When asked why he thought men were not attending support groups, one participant replied:

Stubbornness, ignorance, arrogance. I've met a lady who comes who attends one of the [support group] things. The husband doesn't want to come; it's a waste of time he says. 'What do you get out of it?' You know, there is that attitude, what do you get out of it? -Interview 11

In contrast to these 'stubborn' men, some men rebelled against traditional expectations by promoting tolerance of gay men, gender equality and expressiveness in

relationships. Pride in their African heritage also stood out as being a pillar of these men's identities.

However, the most interesting aspect of their alternative masculinities was the idea that men *should* care for their health and that traditional masculinity is health-damaging. For some men this attitude was a cause of HIV-testing, while for other men it was a result. One man expressed pride in his new philosophy on medical check-ups, saying *"Once you cross the line and it registers in your brain, you are [the] much, much stronger man than the man who says no, no hospitals not for me, not for me."* (P3, Focus group 2)

In the same focus group, another man lamented men's lack of conversations about health in everyday settings in comparison to women.

P2: [At the pub, men] never talk about health. Health is just a one-liner: when I say to you 'how are you?' The short approach. [All laugh] that's the end of it. You don't say 'I've been feeling...' - it doesn't go further than that. - Focus group 2

Both of the quotes above show men's realizations that traditional notions of masculinity put their health at risk. This realization is also reflected in service users' empowered attitudes towards HIV. In contrast to the men who were 'hiding' from HIV, many participants emphasized how they had overcome challenges and were now striving to live a normal life with HIV. They felt inspired by other PLWH and supported prevention and education initiatives to raise awareness among African communities.

In conclusion, the social context of African men living in London is instrumental in shaping their identities and therefore their use of community-based HIV services. Traditional masculinity places certain expectations on men, which condemn help-seeking as feminine. At the same time, a variety of social factors conspire to block men's fulfilment of traditional masculine roles. In response to conditions that put their health at risk, some men have responded to this failure by creating alternative ways to be a man which question traditional notions of manliness and promote caring for one's health.

MATERIAL CONTEXT

The material context refers to satisfaction and dissatisfaction with the resources provided by HIV services. Here, material refers not just to physical and economic goods but to less tangible social and informational resources that increase men's agency and decrease their vulnerability.

Satisfaction with services

One of the main resources that men gained from HIV services was socio-emotional support, largely through support groups for PLWH. Nearly all HIV-positive participants spoke of *"meeting people at different levels"* to share experiences between the newly diagnosed

and “seasoned people” (Focus group 1). Participants often felt isolated by HIV, and therefore valued the opportunity to socialise with others without fear of stigma. Moreover, attending support groups provided something beneficial to do while unemployed, a crucial resource for sustaining good mental health. However, a minority of men highlighted the lack of counselling they received after testing positive.

Information about medication, side-effects, transmission and how to protect yourself and others was also a valuable resource in living a healthy life. Participants were generally satisfied with the information provided by testing facilities and support services.

Unmet service needs

Despite satisfaction with socio-emotional and informational resources a major gap exists: numerous men highlighted the lack of practical support provided by some HIV services. Their most urgent needs, including poverty, housing, immigration and employment were not being met by community-based services (although it must be said that some were satisfied with the practical support they received). Socio-emotional support was appreciated, but it was insufficient to meet their daily needs.

So whether you counsel someone, that big problem is still lying there...but anyway the solution is what I have said: if people are allowed to work, if people are allowed whatever freedom they can get, all these problems would be solved. - Interview 14

Material barriers also prevented men from accessing services. Some men explained that their peers who were fortunate enough to be employed often worked multiple jobs for long hours to make ends meet - this prohibited them from attending HIV support services. Another material barrier was lack of transport reimbursement.

P3: When it comes to what, to having to pay the transports you have to look at this £5, what it can do. Either you can get on the bus and come to the meeting or you can get a calling card to contact your family members in Africa or you can get a shirt or trousers from the charity shop. So the value of that when you say what can I use my £5, but supposing you're going to the place where you're not going to get that £5 back you know somebody will, that'll be the last time that he comes. -Focus group 2

Thus, the extent to which services do or do not provide necessary resources constitutes a material context where some of the men’s practical needs are not being met.

INSTITUTIONAL CONTEXT

The final section encompasses institutional factors such as the larger policy context and the structure of services, and their impact on service uptake by African men.

Policy problems

Policies set by government appear to undermine the effectiveness of community-based services in meeting African men’s needs. A common theme was lack of funding and restriction of funding to certain boroughs. A pan-London service accessible to men in all boroughs was

seen as preferable. Some participants also felt that policy-makers showed little understanding of life with HIV when they grouped it together with other disabilities.

Although only two participants had insecure immigration status at the time of the study, many participants identified migration status as detrimental to accessing services and employment within their communities. Fear of being caught and deported by the authorities prevented migrants from seeking HIV testing, care and support. An even larger problem was the inability of asylum seekers to work while waiting for the Home Office's decision. As paid work is illegal and official assistance is insufficient, they have few avenues to help themselves.

Immigration here is horrible, that's the way I can...because getting someone and letting him stay there, you can't allow him to work, you can't do anything and you just let him there for 6, 7, 8 years! That tarnishes the image of human rights that they have. I mean, it's another way of torturing people. -Interview 4

Perhaps as a result of Britain's anti-immigration legislative culture, many men had experienced discrimination and continued to feel like outsiders despite having lived in the UK for several years.

Structure of services

The way that community-based HIV services are set up has repercussions for their success in meeting men's needs. Several problems with the way services are run were mentioned. One cited problem was corruption and lack of transparency in management and decision-making. Some service users also felt like they were being used as a statistic to present to funders rather than treated like a person. Others complained of a lack of opportunities to give feedback on services. As one participant stated, *"A group of people at the top, they will just decide this is that we are going to do and not giving any concentration to the people at the bottom."* (Focus group 1)

These frustrations were balanced by satisfaction with the effective cross-service referral systems and outreach programs. In terms of testing, several participants commented that HIV tests were more accessible and routine for women because of antenatal testing. Among men, routine testing and walk-in clinics were considered preferable to appointment-based GUM clinics.

On the topic of which client groups organisations should serve, participants had diverse opinions. They were split between a preference for men only versus mixed gender groups and also between services specific to Africans compared to services open to all groups. Those who preferred men only groups felt more comfortable discussing certain issues, such as sexual dysfunction and alcohol abuse, when women were not present. However, some men cited the advantages of being able to exchange experiences and meet prospective partners in mixed gender groups. Benefiting from others' diverse experiences was also seen as an advantage of mixed cultural group services. In contrast, some participants felt more comfortable in services run by and for Africans, viewing them as free of discrimination and more culturally appropriate. Equally divisive was whether services should separate MSM and heterosexual men. Some participants strongly objected to mixing with men they saw as

'immoral', whereas others promoted tolerance of gay men, appreciating the part they had played in the early campaign for accessible ARV medications. This variety of opinions supports the diversity of HIV services currently available to serve all combinations of client groups.

In sum, the institutional context captures men's views on the consequences of policy and service delivery decisions for their health. Despite their best efforts, services and users are frustrated by health and immigration policy. In addition, greater opportunities for users to influence community-based services from the bottom up would result in greater success in meeting men's needs.

DISCUSSION

This study aimed to examine the factors that influence migrant African men's uptake and satisfaction with HIV services. The social, material and institutional contexts within which these men live impact their interaction with and reaction to community-based HIV services.

Service use and masculinity: A process of change

In some cases, testing was a wake-up call to change behaviour among both men who tested positive and negative. For those who tested positive, initial denial and fatalism were often followed by a change in health behaviour as time went on. Gaining information and learning how to better manage one's health was a way of expressing agency when other means had been blocked by their illness. Support groups may have played a role in identity change as well. Many men spoke of learning from the experience of others in support groups and being inspired to change their health-related behaviours. Perhaps the norms of this new male peer group made resistant masculinity socially acceptable.

Future directions for service provision

Men's level of satisfaction with community-based HIV services is partially dependant on satisfying the life roles they feel they should play. In this study, men faulted HIV support services for failing to provide practical help that would assist them in finding employment or subsist in the meantime. Housing and immigration support (including legal aid) was also deemed to be inadequate. There are two interesting elements to this unmet service need. First, participants had internalised the relationship between employment, the ability to provide for one's family and masculinity, a relationship strongly supported by previous research (Dixon, 1998; Lee & Owens, 2002). Thus, men wanted services to help them fulfil the expectations necessary to achieve total manhood.

The demand for more practical help could also indicate that it is more appropriate to traditional masculine forms of coping. Men prefer practical actions they can take to concretely improve their situation rather than the emotional support that tends to be preferred by women (Sullivan, 2003).

Although greater instrumental support would be helpful, the importance of counselling should not be discounted. Changing men's attitudes through counselling would be beneficial in allowing men to see how a traditionally gendered lifestyle restricts health behaviours and causes family problems. In this study, some men seem to have gained this awareness regardless of whether that was the aim of the counselling services they accessed. If these men were used as peer educators, perhaps more men could be exposed to their health-enhancing alternative views.

Recommendations for action

One of the aims of this study was to provide hitherto non-existent strategies for meeting African migrant men's HIV service needs. Here, a number of recommendations are outlined. First, as the men highlighted, women are more likely to talk about health in everyday settings and share health information amongst themselves. For men, the only acceptable spaces in which to talk about health were support groups or clinics - facilities dedicated to health. This highlights the need for more spaces in which men can share their experiences with each other and work towards more health enabling behavioural norms. To tackle two problems at once, perhaps income generation could be combined with a behaviour change intervention similar to the IMAGE study in South Africa (Pronyk, Harpman, Busza, Phetla et al., 2008). This study used microcredit and participatory gender and HIV education with women to successfully catalyse social change.

A second set of recommendations is for community-based HIV services. Considering the interconnectedness of employment and masculinity, a greater focus on practical help is necessary to assist men in meeting their identity maintenance needs.

Thirdly, changing the structure of services could go far in increasing men's uptake of HIV testing. As some men recommended, testing should become as routine for men as it is for women, who are tested through antenatal care. This implies that men currently see sexual health as a women's sphere, related to pregnancy and childbirth.

Finally, the participants in this study had insightful recommendations into how policy and the structure of services could be improved to better meet their needs. This report is one channel through which their views will be transmitted. However, more avenues are undoubtedly needed for men's feedback to reach the appropriate authorities.

CONCLUSION

Future Research Directions

Future could use a longitudinal design that follows African migrant men from testing and diagnosis through service access or non-access. This would illuminate the process whereby men choose various health-related behaviours.

Final thoughts

The contexts in which men live must be holistically examined in order to understand their actions. No amount of renegotiation of masculinities will change the material and institutional contexts that limit African men's abilities to live fulfilling lives in the UK. Equally, even ideal services and policies combined with full employment would not create a health-enabling context alone. The sum total of the social, material and institutional contexts in which men live must be considered to comprehend the factors impacting their use of community-based HIV services.

African migrant men face multiple vulnerabilities. However, the men in this study were also remarkably resilient. Their inspiring take on life with HIV and their ability to overcome myriad challenges are admirable. As such, it is due time to examine the other side of gender and HIV/AIDS and the possibilities of healthier constructions of masculinity that open doors to men as well as women. For this to happen, both men themselves and professionals in the HIV field must change their view of men from part of the problem to part of the solution.

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