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**Man is the remedy of man:**  
Constructions of Masculinity and Health-  
Related Behaviours among Young Men in  
Dakar, Senegal

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## **Abstract**

Research suggests that men who endorse hegemonic masculine ideologies are less likely to engage in 'health-positive' behaviours. However, masculinities and approaches to health are diverse and complex, with significant variation across cultural contexts. This study investigated the constructions of masculinity and health-related behaviours of young men in Senegal. It revealed that while participants endorsed hegemonic masculine ideologies and gender inequitable norms, they also engaged in many health-positive behaviours. Constructions of masculinity were influenced by religious and cultural beliefs, through which participants were able to reconcile hegemonic masculinity and health-positive behaviours. These findings contradict the popular conception that hegemonic masculinity and health-positive behaviours are always incompatible.

## 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 incompatible with 'help-seeking behaviours', such as soliciting advice, using health services and speaking openly about health problems. For this reason, it is argued, health policy should take into account the need to challenge and transform hegemonic masculinity. However, other researchers have highlighted the dangers of characterising *all* men as disinclined to protect their health, as reliance on generalisations could ultimately undermine efforts to improve men's health (Gough 2006, 2487). Indeed, men's constructions of masculinity and approaches to health are diverse and complex, with significant variation across generational, cultural, ethnic, religious, socioeconomic and geographical contexts. Research in specific contexts is therefore needed in order to create a richer, more nuanced portrait of men and health across time and space. This study will investigate the constructions of masculinity and health-related attitudes and behaviours of young men in Senegal through a series of semi-structured interviews.

This dissertation will present the study in five chapters. **Chapter 1** will outline the claims that hegemonic constructions of masculinity have negative consequences for men's health. It will then present critiques of these arguments, which often conclude with calls for more research in order to 'trouble the facile equation between hegemonic masculinity and ill-health' (Gough 2006, 2485). **Chapter 2** will briefly explain the conceptual framework of the study. **Chapter 3** will describe the methodological approach to the study, with particular focus on the possible limitations of the study, and endeavours to mitigate these. **Chapter 4** will review and discuss the salient themes that emerged from the interviews, with reference to quotes translated from the participants. These themes include religion, traditional remedies, talking to others, and becoming men. This discussion will reveal that, while the young men strongly adhered to hegemonic constructions of masculinity, they also endorsed and engaged in health-positive and help-seeking behaviours. **Chapter 5** will draw conclusions from this study, elucidating how other influences on the young men's constructions of masculinity and approaches to health allowed them to reconcile their endorsement of hegemonic masculinity with their health-positive behaviours.

## 1 – Literature Review

Much research suggests that ‘men who embrace [...] traditional constructions of masculinity are more likely to engage in risky health practices’ (Mahalik et al. 2007, 2202). For example, masculinity is often associated with aggression, violence and a disregard for personal safety. It is significant that men are ‘more likely than women to be murdered or to die in a car crash or dangerous sporting activities. In most societies, they are also more likely than women to drink to excess and smoke, which in turn increases their biological disposition to early heart disease and related problems’ (Doyal 2001, 1062). Men’s lower life expectancy is commonly linked to their health-related beliefs and behaviours (Courtenay 2000, 1386). For these reasons, the notion that masculinity is ‘bad for health’ is now widely accepted (Gough, 2006).

Men are also portrayed as ‘unwilling to ask for help when they experience problems’ (Addis and Mahalik 2003, 5). It is argued that many men are averse to seeking help with their health due to the value that hegemonic masculinity places on self-reliance, endurance and emotional strength; seeking help may be associated with weakness. Similarly, sharing problems with others contravenes the expectation of male silence and stoicism in times of adversity. Furthermore, the experience of using health services is often characterised as incompatible with hegemonic masculinity, as it compromises individual agency and control: for example, one might be subjected to bodily examinations and tests perceived to be degrading and invasive. According to this view, women’s bodies are scrutinised and penetrated, defined and disciplined, while men remain in control and refuse to be subordinate to doctors’ instructions (Courtenay 2000, 1394). In addition, hegemonic ideologies characterise women as responsible for health, as this is deemed compatible with their ‘traditional’ role of caring for the family (Lichenstein 2004, 371). Health is therefore perceived as a feminine domain.

Indeed, illness itself is often characterised as an affront to hegemonic masculinity, which prizes physical strength, invulnerability and control. Often quoted in the literature on this subject is one Zimbabwean man’s remark that ‘Real men don’t get sick’ (cited in Foreman 1999, 22). As Sontag (1991) wrote, illness is often perceived as an *attack* on the individual; thus, acknowledgement of illness might be interpreted as an admission of *defeat*. Illness can be a confusing, demoralising and undignified experience; secrecy and denial may be considered necessary in order to preserve one’s masculine identity. Indeed, as hegemonic masculinity values the ability to withstand pressure and pain, illness becomes a challenge to be endured.

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 these are, rather than on empirical evidence. For example, studies refer to ‘the traditional masculine identity’ (e.g. Campbell 1995, 208), yet ‘traditional’ cannot be taken to mean ‘universal’, nor can ‘masculine identity’ be referred to in the singular. As Petersen (2003, 5) writes:

‘Definitions of *masculinity* often entail little more than the compilation of lists of what are seen to be characteristic masculine qualities or attributes such as aggressivity, competitiveness, and emotional detachment, which, it is implied, distinguish it from its counterpart, femininity (passivity, cooperativeness, emotionality, etc.). That is, despite scholars’ rejection of essentialism, masculinity is often referred to as though it had a definable, distinctive essence.’

Many researchers have highlighted the ‘dangers of working from a stereotypical description of ‘men’ and their desires, motivations and interests. There is enormous variability between individuals, not only between societies but within them’ (Rivers and Aggleton 1999, 1). Yet discourses on this subject often end up propagating a monolithic – and invariably negative – portrait of men. Gough reports that ‘hegemonic masculinity is often reduced to a singular construct – the stereotypical macho man for example – which is deployed in relation to the ‘crisis’ in masculinity and men’s health’ (Gough 2006, 2477).

Furthermore, while many prolific researchers study masculinity and health only in the U.S. (such as Courtenay and Addis & Mahalik), their observations are accepted as universally applicable. Indeed, traditional medical research has almost exclusively been oriented towards white middle-class men, with findings simply generalised to other groups of men (Gough 2006, 2477). Reports on men’s attitudes to health may also rely on generalisations. For example, in a UNDP report that addressed masculinity and development in the global South, the chapter on health opened with the following quote:

‘A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would face danger fearlessly, take risks frequently, and have little concern for his own safety.’  
(cited in Greig et al. 2000, 14)

This description makes no reference to factors other than gender that might affect an individual’s health-related attitudes and behaviours, such as age, nationality, socio-economic status or personal values. Moreover, the quote was taken from an article entitled ‘College Men’s Health’ (Courtenay 1998), published in the *Journal of American College Health* – a markedly different demographic focus from the UNDP report. Lichenstein (2004, 371) deplores the disregard for

‘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 masculinity and health-related attitudes and behaviours in specific cultural contexts.

For these reasons, the following study aims to investigate constructions of masculinity and approaches to health among young men in Dakar, Senegal. This will be realised through a series of interviews. The existing empirical research on masculinity and health would suggest that, the greater the men’s endorsement of hegemonic masculinity (as characterised above), the less likely it is that they will engage in health-positive and help-seeking behaviours. Statistics from the

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 constructed within a social and cultural context. There is substantial evidence to support this perspective, not least research that reveals the diversity of constructions of masculinities across cultural contexts. Furthermore, the problem with determinist perspectives is ‘the arbitrary nature of the fixing of men’s ‘essential’ masculinity, which can range across a whole spectrum from men’s innate physicality/animality to men’s innate rationality’ (Greig et al. 2000, 7). ‘Masculinity ideology’ is often a focus of research within the social constructionist perspective. This expands on ‘the more neutral construct of attitudes towards male roles’, and ‘conveys the internalization as well as endorsement of cultural beliefs systems about masculinity and male gender’ (Chu et al. 2005, 95). Interviews for this study will therefore explore masculinity ideologies among the young men, as well as their attitudes towards gender roles, as part of the investigation of constructions of masculinity.

This research also took the multi-faceted nature of masculinities into account; individual and social beliefs about masculinity are plural and dynamic. In Senegal, as elsewhere, ‘there are both indigenous definitions and versions of manhood, defined by tribal and ethnic group practices, as well as historically newer versions of manhood shaped by Islam and Christianity, and by Western influences, including the global media. An African young man may perceive gender norms from traditional rites of passage and elders in his cultural group, just as he may receive messages about manhood from rap songs from the U.S.’ (Barker and Ricardo 2005, 4). This perspective informed the design of interviews: questions covered a broad range of potential influences on participants’ constructions of masculinity. In addition, analysis of the interviews will not attempt to define the young men’s approach to masculinity in a singular and static fashion. They will simply evoke the young men’s views, beliefs and experiences with reference to their own words.

NB. ‘Hegemonic masculinity’ may be defined as ‘the form of masculinity that is culturally dominant in a given setting’ (Connell 1996, 209). However, in the literature on masculinity and health, the term ‘hegemonic’ tends to refer to constructions of masculinity characterised by ‘physical and emotional toughness, risk taking, predatory heterosexuality [and] being a breadwinner’ (De Visser and Smith 2006: 686). When the young men’s constructions of masculinity are compared with ‘hegemonic masculinity’, the term refers to the latter characterisation of masculinity.

### 3 – Methodology

In order to investigate constructions of masculinity and health-related attitudes and behaviours among young men in Dakar, I chose to conduct semi-structured interviews with five participants. Although this is a small sample, my purpose was to explore the issues in depth in specific cases; it would have been unfeasible to conduct a study on a scale large enough to be able to make generalisations about young Senegalese men. Therefore, five interviews were sufficient for the purpose of this study. As I wished to collect personal accounts and experiences of masculinity and health, individual interviews were preferable to focus group discussions. Interviews were conducted in French and recorded using a digital voice recorder, then transcribed. Extracts used in the dissertation were translated into English.

As I lived in Senegal for several years, the participants of this study were young men I knew. I had worked as an assistant at an English language school in Dakar, and all the respondents had attended classes there. Prior to my field research, a friend had distributed a brief on my behalf among some students, informing them of my intention to conduct research and inviting them to participate. The purpose of the research was described as an exploration of attitudes and behaviours relating to health, as well as a variety of aspects of Senegalese culture. Views on gender were mentioned as one subject to be discussed, but it was not stated explicitly that the focus of the study was masculinity and health, as it was felt that this would influence participants' approach to the interviews. Indeed, the interviews did cover an extensive range of topics, so the purpose of the study was not immediately evident.

I ensured that participants corresponded to the profile of the group I had chosen to study: they were all unmarried young men from Dakar, aged between 24 and 30. They shared certain characteristics because they had all studied English at the same school. However, courses were part-time and inexpensive, which meant that there was a great deal of variety in the age, socioeconomic status and occupation of students at the school. Indeed, the participants interviewed come from a diverse range of backgrounds and traditions. **Babacar**, 26, is enrolled on a part-time accounting course. He is Muslim, like approximately 95% of the Senegalese population, and belongs to the dominant ethnic group in Senegal, the *Wolof*. **Sidi** is 27, Muslim and *Pulaar*, a sub-group of the *Toucouleur*. He works in the fish exportation industry. **Emmanuel**, 24, is completing his third year of an English degree at the University. He is Catholic. His mother is *Djoola*, and his father is *Seerer*. **Saliou** is 30, and described his occupation as a computer technician. However, he was not formally employed at the time of the interview and spoke at length of his plans to enter the business of exporting gold in the south-eastern region of Senegal. He is also Muslim, and *Seerer*. **Ousmane** is 28, Muslim, and identified

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 included. Interview questions addressed two main subjects: health and gender. The first set of questions focused on the young men’s health-related attitudes and behaviours. For example, the questions explored the type and frequency of their illnesses or health problems, their responses to being ill, ways of promoting and protecting health, and use of health services. The second set of questions related to gender; they aimed to reveal the participants’ masculinity ideologies, and their views on gender roles and relations. Questions addressed a range of topics, including the development of masculine identity, changing meanings of masculinity, role models for young men, and the responsibilities and capacities of men and women. However, while the interview questions provided a basic structure in the discussions, questions were adapted to individual participants, and often their responses would lead to a new line of questioning. Participants would often digress from the subject of the original question, yet this provided a valuable opportunity to hear their thoughts, reflections and stories.

Inevitably, the interviews were influenced by the dynamics between myself as researcher and the young men as participants. Indeed, ‘[the] social characteristics of an interviewer and a respondent, such as age, race and sex are significant during their brief encounter; different pairings have different meanings and evoke different cultural norms and stereotypes that influence the opinions and feelings expressed by respondents (Turner and Martin 1984, 271).

For example, gender issues were being investigated by a female researcher with male participants. I was aware of the ‘threat potential’<sup>1</sup> of this interview situation (Schwalbe and Wolkomir 2001, 90), which allowed me to be sensitive to any problems arising because of this threat and to respond in a way that made the interview successful (ibid, 92). For example, this relationship might have fostered a desire to re-assert their control, causing defensiveness, reticence or antagonism (ibid, 94). Participants might have sought to exaggerate their own enactment of ‘masculine’ characteristics in order to prove themselves before me. Alternatively, they may have presented their views in a way that they expected would correspond to my own. To mitigate effects such as these, interviews were designed according to a number of strategies designed to give participants a sense of control over the format and direction of the interviews, to ensure that the ‘threat potential’ was minimised (see Schwalbe and Wolkomir 2001, 93).

Furthermore, participants may have modified their responses due to my status as a foreigner (Devereux and Hoddinott 1992): for example, they might either have sought to prove the value of their cultural beliefs and practices, or they may have downplayed these to avoid alienating me. Certainly, participants were all aware that cultural and religious practices, as well as gender roles and relations, differ greatly between Britain and Senegal; they occasionally sought to justify their opinions in anticipation of disagreement. Yet while my status as an outsider generated different responses from those that a Senegalese interviewer might have elicited, it also proved useful. For example, participants would explain cultural and religious practices in depth to ensure I fully understood; these explanations conveyed their understanding of the significance and value of these practices. Cultural references that might not have merited discussion between Senegalese people generated discussions that spoke volumes about their opinions on these aspects of their culture. Furthermore, I was already familiar with certain cultural beliefs and practices due to my experience of living in Dakar; this enabled me to design questions appropriately and pursue lines of questioning more fully, affording me an ‘insider’ status in some areas.

Related to this was the fact that neither I nor my participants were speaking in our first language. The young men were all comfortable speaking in French, although several had trouble remembering certain words, and at times translated terms directly from Wolof, which then necessitated further explanation. However, participants were at ease when speaking to me, possibly because I was not a native French speaker either. At times, in order to express a particular idea for which they had forgotten the French term, they would explain in a way that conveyed a very detailed sense of what they intended to say. Similarly, participants frequently

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<sup>1</sup> ‘It is a threat inasmuch as an interviewer controls the interaction, asks questions that put these elements of manly self-portrayal into doubt, and does not simply affirm a man’s masculinity displays’ (Schwalbe and Wolokomir 2001, 91).

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 translation of participants' responses as faithful as possible. However, it was sometimes impossible to represent the participants' command of French, such as their confusion over the gender of nouns, in translation.

It is also possible that participants were inhibited due to our personal acquaintance and the prospect of further social interaction. However, participants were all loquacious and shared personal information freely. Alternatively, they may have attempted to give the answers they thought I wished to elicit. Yet I believe their responses were honest, partly because they often asserted views that I had heard them express on previous occasions. My work at their school had involved promoting cross-cultural exchange and understanding; to this end we would frequently discuss a diverse range of socio-cultural issues. The interviews were similar to such discussions, rendering the situation very natural and relaxed.

All of the participants seemed comfortable discussing their health-related behaviours and illnesses. However, it is possible that my status as a researcher on health led them to exaggerate the extent of their health-positive and help-seeking behaviours. Indeed, while I endeavoured to make the interview as neutral and non-judgmental as possible, participants may have interpreted the questions as a kind of test on their health-related knowledge and behaviours. Participants' presentation of themselves as health-conscious might also have been facilitated by my being female, if health were perceived as a feminine domain. However, the conviction and confidence participants typically exhibited when explaining their health-positive behaviours suggested that these presented no threat to their masculine identity.

The discussions all lasted approximately two hours, and the transcripts provided a rich set of data. Detailed study of the transcripts allowed me to identify the salient themes that emerged, both within and across interviews. Although there were only five participants, analysis of this in-depth research revealed a great deal about these young men's constructions of masculinity and their health-related attitudes and behaviours. By documenting the opinions, beliefs and experiences of these young men, this study contributes to efforts to create a rich and complex portrait of men, reflecting the diversity of masculinities across cultures.

## 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 responses quoted in the latter sections of this discussion.

### Masculinity Ideology

Questions that pertained to the young men's masculinity ideology consistently returned to the importance of characteristics such as independence, self-sufficiency and the ability to endure suffering. This conforms to the characterisation of hegemonic masculinity depicted in the literature. Yet such traits were not seen to be compromised by seeking help with health. These apparently incongruous ideas were reconciled partly by the notion of male *responsibility*, which frequently features in descriptions of hegemonic masculinity. The young men all emphasised the importance of 'assuming one's responsibilities', and good health is necessary in order to do this. For example, participants considered it imperative that men protect their health in order to work hard to provide for their family. This may correspond to the finding of O'Brien et al. (2005, 503) that 'help seeking was more quickly embraced when it was perceived as a means to *preserve* or *restore* another, more valued, enactment of masculinity', i.e. breadwinning. The following section will demonstrate participants' emphasis on responsibility and the importance of work.

When Ousmane described the cultural conception of 'being a man', he used the term 'responsible':

'First and foremost, being a man is being responsible. It's really a challenge that you have to take on. Being a man is really something very special ...'

Sidi also responded:

'For me, being a man is being dignified, confident, respectful and fearless. It's about knowing how to assume one's responsibilities, and liking to work. *Hard.*'

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 frequently report a sense of being observed and watched to see if they measure up to culturally salient versions of manhood (Barker 2005).' (ibid, 4). For example, Emmanuel said:

'When you're working, people say you're responsible now, you've become a man [...] In your family, when you start working, you get same kind of the respect as the father ... you're like the 'second father'. Then you start to make decisions in the family, you start getting a say in things. You have your say because you work.'

Ousmane reported that men achieve an even higher status when they marry. Yet men have to prove themselves in this role:

'Being married is not easy at all. This woman is your responsibility. People are observing you, how you deal with your wife, how you deal with problems ... that's how you're judged. To see if you're a real man.'

Saliou described becoming a man as:

'The act of assuming your responsibilities. That makes you a man. You're told all the time to 'do everything you can to earn a living by the sweat of your brow'. You shouldn't ask for things. You should do everything you can to get something for yourself. As they say, to be respected you have to be able to provide for your own needs. If you need something and you go asking for it from everyone, they'll say, 'Oh, he's a layabout, he doesn't want to work'. You see. You're looked down on!'

The close links between masculinity and work are evident in the frequently used Wolof term *goorgoorlou*. As a verb, *goorgoorlou* means to 'get by', or to fend for oneself; as a noun, it refers to the young men in the informal sector who survive by means of occasional jobs or deals. Yet it has a deeper significance: the word *goor* simply means 'man', and *goorgoorlou* may also be defined as 'behaving like a man' (Biaya, 2001).

## Becoming men

Questions relating to how boys become men in Dakar revealed a great deal about the social construction of masculinities. Most participants referred to circumcision as the rite that marks the passage from boyhood to manhood, fostering physical and emotional strength and endurance, traits that conform to the description of hegemonic masculinity given in the literature. Many authors have identified 'initiation practices such as circumcision as 'important factors in the socialization of boys and men throughout the [African] region' (Barker and Ricardo 2005, v). However, in modern day Dakar, circumcision usually takes place shortly after birth, and I asked whether it could still have the same significance. Sidi explained:

'Well, I can't say that a little kid of one is a man, because he doesn't know anything about life yet. But he's entered the first stage of becoming a man. He'll become a man over time. And when he's three or four, he'll start speaking ... At five, when his father's praying, he'll say, 'Come and pray with me', and 'Before eating, you do this, you do that' ...'

Ousmane also said:

'If you are circumcised, you're a real man. That is what it is to be a man.

S – But at such a young age, how can he be a man?

O – We start to *form* him, that man, from that age.'

When asked about the significance of the act, Ousmane replied:

'The real meaning is to show that we ... you have to suffer. You have to suffer. [...] It really hurts. It really, really, really hurts. You have to suffer and then you have to be really strong to be able to overcome all the suffering that you'll face in your life in the future.'

Saliou was the only participant who did not mention circumcision: he explained the process of 'becoming a man' as acquiring male attributes and rejecting female ones. This supports the claim of Royster et al. (2006, 398) that hegemonic masculinity typically consists of 'avoidance of feminine behaviours'. He defined his conception of heterosexual male identity in terms of its distinction from femininity, which he likened to homosexual male identity.

'A boy becomes a man ... well, there are qualities. There are qualities. You know, a boy who behaves like a woman. He's ... frowned on in our society. We beat him. Because we're told that if he behaves like a woman, he might become a homosexual. Often you're told that you shouldn't stay around girls. You should always try to be with boys.'



The belief that homosexual men were like women, not men, was reflected in the Wolof word Saliou used to refer to homosexuals: *goor-jigeeen*, literally, ‘man-woman’.

## Gender Roles

This section will demonstrate the young men’s rejection of gender equity. Participants frequently explained their endorsement of inequitable gender norms with reference to religion, culture and tradition, which illustrates the value attached to these beliefs and norms, and the extent to which they shape the young men’s attitudes and behaviours. Religion, culture and tradition also emerged as salient influences on the young men’s approach to health, as we will examine later, which shows that such beliefs can reconcile both hegemonic masculine ideologies and health-positive behaviours.

Emmanuel described the man’s role in the following terms:

‘We say that men are responsible for the family, which means working to feed the family. It’s up to the man to make the decisions. He is in charge. That means, he has his say; the woman doesn’t get a say. The woman shouldn’t speak. When the man speaks, the woman doesn’t speak. That’s the way it is. In Senegal, that’s what it’s like. In nearly every ethnic group, nearly every culture, that’s the way it is. When the man makes a decision, the woman doesn’t argue.’

Sidi defined male and female roles in a similar way, and explained these with reference to religion:

‘Our religion tells us that women always come after men.’

Ousmane characterised the role of women as follows:

‘It’s really to look after her husband well. To really respect and obey her husband. She should always strive to make her husband happy. That’s it ... In our religion, and in our African culture, that’s the woman’s role.’

He also referred to a complex array of practices that women must perform, such as using *thiouraye*<sup>2</sup> or wearing *bin-bin*<sup>3</sup>, in order to please their husbands and ensure they do not stray; these are believed to have a mystical influence. On men and women’s capabilities, Ousmane was uncompromising:

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<sup>2</sup> Special incense.

<sup>3</sup> Strings of beads worn around the waist.

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 explanation conveyed a degree of contempt for women:

‘Because I say to myself – they’re all the same. They’re all the same – so why look for another? When it’s the same thing! There’s no difference; there’s no difference.’

Babacar expressed a view that demonstrated his construction of the ‘ideal’ African woman, and his disapproval of contemporary Senegalese women, who – in his view – no longer conform to this model:

‘Women, to support themselves, engage in practices that are beneath them. Like prostitution, for money. Or having a husband and having lovers. The African woman, and Senegalese women in particular, they used to have virtues and values. But that behaviour, those attitudes ... they don’t have them anymore. They no longer have them in the least. Sometimes they have inhuman attitudes. Inhuman – they aren’t fitting for human beings.’

Participants’ responses thus revealed that their masculinity ideologies included a sense of responsibility, the ability to work hard to provide for one’s family, and physical and emotional strength. In terms of gender roles, responses generally ascribed women the role of domestic chores and childcare. Participants often emphasised the inferiority of women on a physical, intellectual and moral level.

### **Health-positive behaviours**

According to literature on masculinity and health, men who endorse such hegemonic constructions of masculinity also embrace risk-taking and reject health-positive behaviours. The literature also portrays men as reluctant to seek help with their health. While the young men I interviewed endorsed hegemonic masculinity, as demonstrated above, they were very health-conscious and would actively engage in many health-positive behaviours. For example, sports, cleanliness and protection against illness were viewed as unequivocally important. Moreover, the benefits of help-seeking behaviours such as visiting the doctor, taking medicines and sharing problems with friends were strongly advocated. The young men also engaged in many religious

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 the importance of sport for preserving health; it was often the first means to staying healthy that they mentioned. Ousmane characterised his attitude towards his health as follows:

‘I respect myself. I don’t want to take risks with my health. I want to conserve my health for as long as possible ... that’s why I train every day, to preserve my health.’

Sport is certainly a health-positive behaviour that is compatible with hegemonic masculinity, as it involves strength and action. However, several young men said that they avoided practising wrestling – the national sport in Senegal – because it was too violent and dangerous. The young men also spoke openly about getting ill, using health services, and engaging in practices to protect and promote their health. For example, all participants explained that they did not smoke or drink with reference to the detrimental effects of these on health.

### **Seeking help**

All participants said that when suffering from any illness, it was extremely important to consult a doctor. Several participants emphasised that taking action was a *responsibility*; a notion that may be reconciled with the masculinity ideologies described in previous sections. The following quote reveals Sidi’s view of the importance of health and seeking help:

‘I really think that, in life, you should respect yourself. And you should assume your responsibilities. You should consult a doctor and not be shy about it. Just say, ‘It hurts here, etc.’ and the solution will be found.’

Ousmane had a close relationship with his doctor, and often called him directly for advice with minor health problems. When asked how long he waited between first becoming ill and seeking help, he replied:

‘When I don’t feel well ... immediately. I don’t wait. I don’t hesitate. I call him. Because I don’t want it to do me any harm.’

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 *seeking help* from others: when asked his opinion on what to do when one has malaria, he replied:

‘Well ... like all illnesses, when you’re ill, you can’t treat yourself. That’s up to the professionals. When you’re ill, you should go straight to the hospital, so they can help you.’

These responses clearly illustrate the young men’s willingness to use health services. They all reported positive experiences of the treatment they had received from their doctors; the only issue raised was having to wait for long periods due to a shortage of doctors.

## **Religion**

Religion was mentioned frequently throughout the interviews. For example, most of the behaviours that the young men practised to promote health were associated with religion, such as wearing charms containing verses of the Qur’an for protection and bathing in *safara*<sup>4</sup> to heal illnesses. Religious laws were also perceived to be good for the believer on both a spiritual and a physical level. Islamic practices such as fasting, abstention from alcohol, circumcision and personal hygiene are believed to be enjoined upon the believer to protect their health as well as their spiritual purity. Emmanuel also advocated all these practices, which perhaps demonstrates the extent to which Islamic teachings shape social norms in Senegal. While these practices are not those typically associated with improving health, the extent to which they were advocated clearly demonstrates a strong commitment to good health among the young men.

Participants always emphasised that obedience to religious laws is necessary simply because God ordained them, but that following the laws is also beneficial for the believer. Ousmane explained:

‘If Islam prohibits something, it’s for your faith, your health, your dignity ... all these things at once. That’s why I’m very attached to my religion.’

All participants said that they did not drink alcohol and mentioned its harmful health effects; the four Muslims also explained that alcohol was prohibited in Islam. All participants also talked about the health benefits of fasting, as well as emphasising that fasting is enjoined upon believers by God.

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<sup>4</sup> Holy water: for example, water might be blessed either by placing pieces of paper with Qur’anic verses written on them in water and mixing the water until the ink has disappeared, as Sidi described, or by praying and then blowing across the water, as Ousmane explained.

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 cultural practices, in line with the gradual Islamisation of the country.’

(Sow 2003, 76)

As health-positive practices are promoted in the Qur’an and taught by male religious leaders, whom young men often cited as their most influential role models, healthcare was considered an obligation for Muslims. Participants did not identify healthcare as a feminine domain; rather, they situated it in a religious context. Indeed, several participants often conveyed the impression that such religious laws were enjoined upon *men* first and foremost; women featured in these discussions not as fellow believers, but as potential deterrents from men’s spiritual development. For example, when I asked Ousmane his opinion on the best way to stay healthy and to avoid health problems, he immediately responded:

‘First, I’d say my religion. You should respect the rules. For example, alcohol. Cigarettes. Women. They’re dangerous. These are really dangerous things. [...] If you’re very careful with these things, you’ll be healthy.’

## 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’<sup>5</sup>, as we say here, and they can go to hospital every day without getting better. Yet there are Islamic leaders, traditional healers, priests ... these kinds of people can pray for them [...] I think it’s a gift from God. I think these kinds of people can heal people.’

When asked whether they observed religious or cultural traditions believed to protect health, several participants talked about practices they observed for protection from *evil spirits* or malicious and envious people that could harm one’s well-being. For example, Ousmane wore a variety of ‘gris-gris’ – traditional charms believed to have either religious or mystical significance – for protection. Participants also described a number of cultural practices for protection or to promote health that did not have a religious basis. Attitudes towards these were mixed: some said it was important to respect African traditions, others said that these were incompatible with religion. For example, several participants condemned ‘fetish’ gris-gris

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<sup>5</sup> Mentioned in the Qur’an, djinns are fiery spirits believed to inhabit the same world as humans, yet they exist in an invisible realm.

(mystical charms that do not contain Qur'anic verses) and the healing ceremonies of the Lebu<sup>6</sup>, 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 that he sometimes used ashes 'to protect himself from evil spirits', referring to the practice of inhaling the smoke from a special kind of incense, believed to cleanse the person of illnesses with mystical causes.

Often religious and mystical beliefs merged, as illustrated by Emmanuel's account of the religious healings practised at his church: these included 'charismatic' prayers to restore health and exorcisms. He said:

'With regard to these 'mystical' illnesses. Not everyone is allowed to attend the prayer sessions. Often, people tell you that things went on there – 'He said things like this, the devil came out through there, went back in there' ... [I've seen] strange things. People jumping, saying things you can't understand, speaking in tongues. And those who are ill, they make these gestures, things you can't understand ... For example, they can light a fire and put it on their bodies without burning themselves. We often say they're possessed ...'

All the participants engaged in *mystical* practices as ways of protecting and promoting their *physical* health. Importantly, none of the participants mentioned whether men or women were more likely to engage in these practices; they are simply commonly practised.

### **Traditional remedies**

Participants also talked about traditional remedies with a medicinal, rather than a mystical, basis. Indeed, 'at least eighty percent of Senegal's total population use traditional medicine', either solely or in conjunction with modern western treatment (Keita 1996, 156). Babacar chose to use both 'modern' and traditional medicines when ill; for example, anti-malarial drugs to treat malaria and powders to treat the anaemia that often accompanies it. Saliou regularly took a root called *sendjène*, known to kill worms. For malaria, he said that one could boil the leaves of the *nîme* tree and wash with the water; one could also place the leaves on one's head in a towel to soothe headaches. Saliou also referred to other medicinal powders that could be taken with water for stomachaches. He frequently used these remedies if medicines from the pharmacy were ineffective. Sidi also mentioned taking *bissaap* leaves as a cure for stomachaches that might occur as a result of working too hard. When asked about healthy eating, several participants expressed dissatisfaction with the low-quality rice and oily sauces of Senegalese dishes. However, they explained that they had little choice with regard to what they ate, emphasising that it is impossible to avoid such foods in Senegal.

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<sup>6</sup> An ethnic group.



## 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 withstand pressure and difficulties. However, he also said that it was acceptable for men to talk about their feelings and problems:

‘... It’s often recommended in our religion and culture, that if you have problems, don’t hide them. You should go and talk about it with friends, with relatives. Because often, if you’re hiding all your problems inside, they say that one day, it’ll all come out. Explosively. It makes you do stupid things ...’

Sidi also endorsed the idea that it was beneficial to talk openly to others. He said he was very comfortable with his doctor:

‘... We talk about everything. We talk, there are no secrets. Because I think that if you want to progress in life, you mustn’t be shy, you should say what you feel, and then you can be corrected, you can be told what you should do. There’s always a solution to every problem.’

He said he was most comfortable discussing health problems with his doctor, emphasising that he was never ill at ease with his doctor:

‘If he told me to strip naked, I could do it. Because it’s his job, and above all, he’s a man, and I’m a man ... It’s between men!’

Like Ousmane, Sidi said that it would be a pleasure to advise others and help them overcome problems. When Emmanuel was asked how he felt about discussing problems with friends, he said:

‘... First of all, it’s a relief ... When you talk to someone, it allows you to ... the thing that you had deep inside, that was worrying you ... When you talk, it allows the person to listen, then give you advice and try to calm you down.’

He said that he would like to be a good listener and to help others, quoting the Wolof expression '*Nit nitay garabam*': 'Man is the remedy of man'. Several participants quoted this expression during their interviews. Emmanuel explained the significance of this expression in terms of cultural values, emphasising that in Senegal, help from others is believed to be more valuable and effective than any medicine. This finding stands in clear contrast to empirical research on men's approach to help-seeking in other contexts. However, like all the participants, Emmanuel laughed at the idea of men crying:

'Crying? No, men shouldn't cry ... They say that crying makes you weak. Well, men can cry, but not because of *feelings*, not because of women or anything like that.'

This illustrates that, although the young men endorsed the hegemonic construction of men as strong and resilient, sharing problems and helping others did not compromise this construction. It was evident that the young men's constructions of cultural values had a greater impact on their health-related attitudes and behaviours than their adherence to hegemonic masculinity.

## 5 – Conclusion

‘The term ‘Men’s Health’ is now very much in vogue across academic, policy and media texts. It is typically associated with the following set of claims:

- there is now a men’s health ‘crisis’ since men are particularly vulnerable to a range of health problems;
- men do little or nothing to protect their health;
- ‘masculinity’ is to blame for men’s poor health; and
- dedicated research, policy and service provision is required to address the problem of men’s health.’

(Gough 2006, 2477)

The findings of this study evidently do not conform to the claims outlined above, which problematizes the popular conception that health-positive behaviours are incompatible with hegemonic masculinity. While the young men interviewed in this study endorsed hegemonic masculinity and gender inequitable norms, they were also highly health-conscious, as evidenced by their avoidance of behaviours detrimental to health, such as smoking and drinking, as well as their health-positive behaviours, such as sport, cleanliness and religious and cultural practices believed to protect and promote health. The young men also engaged in many help-seeking behaviours: they visited both traditional healers and doctors, used both traditional and modern medicines, and recommended speaking openly about health problems. Several participants referred to the Wolof expression *Nit nitay garabam*, which translates as ‘Man is the remedy of man’, meaning that the help of others provides the best medicine for any ailment. This challenges characterisations of men as reluctant to admit to illness and seek help.

The young men did not perceive any contradiction between the hegemonic masculinity they endorsed and their health-positive behaviours. Indeed, their beliefs on masculinity facilitated their health-positive behaviours: protecting health was seen to allow men to fulfil their other obligations, such as being strong and working hard to provide for one’s family. Participants often emphasised the importance of ‘assuming one’s responsibilities’ in relation to both masculinity and health. Furthermore, the young men were highly attached to their religion and culture, which meant that religious and cultural beliefs and norms often took precedence over those of hegemonic masculinity. For example, the importance of interdependence in Senegal cannot be overestimated: sharing problems and helping one another is perceived as integral to the culture, as demonstrated by the expression ‘Man is the remedy of man’. Therefore, help-seeking behaviours are strongly endorsed. Cultural traditions (such as using traditional remedies and wearing gris-gris to protect health) also demonstrate that one is close to one’s *thiossane*<sup>7</sup>, which is highly valued. Moreover, religious practices perceived to promote health (such as prayers,

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<sup>7</sup> Roots, or cultural heritage.

fasting, and circumcision) are respected as part of one's *obligations* as a believer. Thus, health has strong associations with religion, which is principally a masculine domain in Senegal (Sow 2003).

This study demonstrates that 'individual men can engage in various behaviors typically associated with different ideologies' (Addis and Mahalik 2003, 8). One's attitudes, behaviours and values are unlikely to be determined by one's affiliation to a singular identity, such as hegemonic masculinity. Instead, a complex interplay of influences shape one's beliefs and practices. 'Thus, men who endorse traditional masculine ideologies may cry, men who endorse nontraditional ideologies may make homophobic remarks, and men who subscribe to masculinity norms of self-reliance may ask for help under certain conditions. It is precisely this sort of within-person and across-situation variability that needs to be understood if [we] are to adequately understand and facilitate help seeking' (ibid). In this case, religious and cultural values had shaped constructions of masculinity that reconciled strength and dominance over women with responsibility for health and well-being. Yet as masculinities are 'fluid over time' and 'socially constructed', rather than permanent and unalterable (Barker and Ricardo 2005: v), further research on constructions of masculinities might prove useful in endeavours to challenge and transform gender inequitable norms in this context.

This study clearly supports arguments that highlight the dangers of stereotyping men as uniformly disinclined to engage in health-positive and help-seeking behaviours. Health interventions targeting men on the basis of this assumption could be meaningless, stigmatizing or alienating for those men who readily engage in health-positive behaviours. Certainly, the young men interviewed would not identify with the approach to health so commonly attributed to men in literature on the subject. Furthermore, if academic discourses propagate the notion that all men are disinterested in health, they might inadvertently discourage health-positive behaviours among men, for masculinities are often constructed with reference to such received ideas. As Gough (2006, 2486) argues, such discourses must avoid perpetuating stereotypes; rather, they must investigate forms of masculinity that prove conducive to health-positive behaviours, 'so that strategies can be devised which appeal to more men'. In this study, religious and cultural identities, as well as values of responsibility and interdependence, emerged as factors that facilitate health-positive and help-seeking behaviours among young men. Further research could investigate how these elements might be utilized in campaigns to promote health.

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