



Received: 02-02-2024  
Accepted: 11-03-2024

## International Journal of Advanced Multidisciplinary Research and Studies

ISSN: 2583-049X

### Masculinities Inducing Deviant Sick-Role Behaviour: A Qualitative Study of Tuberculosis Patients in the Zambian Compounds

<sup>1</sup> Chidongo Phiri, <sup>2</sup> Jason Mwanza, <sup>3</sup> Harrison Daka, <sup>4</sup> Kalisto Kalimaposo, <sup>5</sup> Adenike Ogah  
<sup>1, 2, 3, 4, 5</sup> University of Zambia, Zambia

DOI: <https://doi.org/10.62225/2583049X.2024.4.2.2516>

Corresponding Author: Chidongo Phiri

#### Abstract

This study aimed at obtaining an in-depth understanding of masculinities which act as barriers to performing the direct observable therapy (DOT) on the expected sick role behaviours among men who were diagnosed with pulmonary tuberculosis in Zambian compounds. The article identifies masculinities that act as gendered barriers to tuberculosis patients. It explores masculine gendered actions situated in an impoverished household. Of concern is considering both the situational aspects of gender and failure to honour the expected sick role behaviours. To do this the article used the Talcott Parson's sick role theory whereby the behaviours, rights and responsibilities of a patient deviates from societal norms because of their disease or disorder" (DeLaune *et al.*, 2019). Methodologically, a maximum variation sampling design

was used to enlist 59 respondents. In-depth interviews were conducted with men anchored on Charmaz's modified constructivist grounded theory informing the article.

The argument in this article is that six categories of masculinities influenced deviant behaviour and accounted for reasons why and how men fail to fulfil the expected tuberculosis sick role behaviour. These categories found were: not being in control of the situation, hyper masculinity, resistance to recommended practices, masculinity stereotype threat, breadwinner and gender identities.

A much closer look at the explored six categories of masculinities that effectuate deviant behaviour, the article asserts that gendered interventions are possible to neutralise sick-role behaviour among tuberculosis male patients.

**Keywords:** Deviant, Tuberculosis, Masculinities, Sick-Role Behaviour, Sex-Roles

#### Introduction

Generally, research has shown that being male is a weak predictor of poor health behaviours (Schofield *et al.*, 2000; The Lancet, 2001; Galdas *et al.*, 2005) <sup>[58, 60, 21]</sup>. Men have been known to be risk takers and tend to exhibit health behaviour risks (Powell-Griner *et al.*, 1997; Verdonk *et al.* 2010) <sup>[57, 64]</sup>. On the contrary, research shows that women are more unlikely than men to behave in a risky manner and tend to engage more in health preventive behaviour than men (Slesinski *et al.*, 1996; Powell-Griner *et al.*, 1997) <sup>[59, 57]</sup>. These differences are social cultural such that gender roles, gender identity and gender relations may be at the centre of risk-taking sick role behaviour which may be termed deviance or sick role deviance. This seems to suggest that gender influences all aspects of our lives (Johnson *et al.*, 2007: 5-7) <sup>[31]</sup>.

Apart from these apparent differences, an attempt to explain men's deviant or negative behaviours using existing social and public health behaviour theories has not been done broadly. In agreement with Phiri (2022) <sup>[54]</sup> who argues that, "other reason for the weaknesses in the strategy to combat deviant behaviour was located in the "bureaucratic locus". Interviews with patients reviewed that "bureaucratic locus" has contributed to the weaknesses in (Phiri, 2022) <sup>[54]</sup> explaining men's behaviour of being sick.

If social or public health theories of health seeking behaviour have not explained men's deviant or negative health behaviours, then perhaps there is something about being a man that influences risk taking behaviour. Therefore, there is merit in writing this article about men and tuberculosis. Brod (1987: 273) <sup>[2]</sup> wrote to support men's studies and stated that "leaving men's lives unexamined, leaves male challenges unexamined." Arising from this, we considered it worth writing about men and argue that consigning masculinities to the periphery means that some of the assumptions that have been made biologically and epidemiologically about men's poorer health status will remain unexplored and unexplained.

There is no empirical evidence among men who are living with tuberculosis suggesting that masculinity traits act as barriers to performing the expected sick role behaviour. In addition, literature has also shown a perverse omission of gender at the level of implementing health promotion as well as disease prevention strategies among men living with tuberculosis. Gender masculinity linked to gendered behaviour especially is one attribute that is given lip service and is often neglected (Östlin, 2002; Keleher, 2004; Östlin, *et al.*, 2007) <sup>[45, 33, 46]</sup> by health care practitioners. This neglect borders on the assumption that any interventions will be just as effective for men as for women (Östlin, *et al.*, 2007:26) <sup>[46]</sup>. For tuberculosis, the interventions tend to particularly ignore the effects masculinity plays in the construction of sick role deviance among men who are suffering from tuberculosis and are receiving or have stopped taking treatment for tuberculosis. These points call attention to identification and understanding of masculinities.

### Background

This article stems from a project that employed a mixed methods design. This study used the method of inductive content analysis as the basis for its data analysis (Phiri, 2017) <sup>[52]</sup>. Patton (1990) <sup>[50]</sup> holds that, “the strategy of inductive designs is to allow the important analysis dimensions to emerge from patterns in the cases under study without presupposing in advance what the important dimensions will be”. Nevertheless, the project was located in one impoverished densely populated compound in the City of Lusaka in Zambia. The project explored men’s and women’s experiences in terms of gendered barriers which are at the centre of inhibiting the fulfilment of the expected DOTS sick role behaviours. In support with Phiri (2017:106) <sup>[52]</sup> “this means that information should be assembled around certain themes and points. In this study, patterns of behaviour were identified from the interviews, participant observations and focus group discussions”. By gathering and interpreting social accounts of a sample of deviant men and women who were living with tuberculosis, this article described why and how men and women living with tuberculosis failed to comply once or many times to honour clinic reviews and get periodic drug refills as well as take medications when scheduled every day.

We selected the theme masculinity from the project data to structure this article. We call as deviance or sick role deviance interchangeably the failure by men to perform the expected sick role behaviour. This is an act of dishonouring clinic reviews of not getting periodic drug refills as well as not taking medications when scheduled every day. Nevertheless, from a sociological standpoint, deviance can be defined as conduct which is generally thought to require the attention of social control agencies, that is, the conduct about which “something should be done” (Gusfield, 1968:55) <sup>[29]</sup>. In support with Erikson (1966) <sup>[19]</sup> who submitted that deviance is not a property inherent in certain forms of behaviour, but a property conferred by the audiences which directly or indirectly witnesses the undesired types of behaviour. In this article, the deviance of concern is the dishonouring of clinic reviews, not getting drug refills, as well as not adhering to the tuberculosis regimen. This deviance should be differentiated from the Parsons’ when he posited medical deviance arising from illness as a kind of sanctioned behaviour. Williams for

instance stated that “Parsons, deviance interfered with normal role capacity but needed channelling in an appropriate fashion through an institutionalized role or niche” (Williams, 2005:124) <sup>[69]</sup>. Though the Parsonian assumptions of sick role behaviour and medical deviance were constructed to explain social action inherent in acute illness, two of his assumptions that deal with the obligations of a sick person and are applicable among people living with tuberculosis are of concern. Parson posited that while a person who is sick is exempted from certain blame and responsibilities of his/her own state without any sanctions, the sick person (Parsons, 1951: 436-437) <sup>[48]</sup> ought to (a) accept that the state of being ill is not desirable, and ought to fulfil an accompanying obligation to want to get well and (b) ought to seek technically competent help, that of a physician and to cooperate in the process of trying to get well. It is here that the role of the sick person living with tuberculosis becomes articulated with that of the health worker who offers a sick role prescription (to comply once or many times to honour clinic reviews and get periodic drug refills as well as taking medications when scheduled every day). This led Parsons to define illness as a kind of deviant behaviour but impregnated with sanctioned behaviours. He argued that a sick person was not able to perform the functions or obligations to society but could only perform the functions of the state of illness (Parsons, 1961) <sup>[47]</sup>. The aim of the prescription in the sick role behaviour is to reintegrate the individual as quickly as possible back into society through a return to normal role capacity (or an approximation thereof).

### Research Setting

Kanyama Compound is one of the many unplanned settlements in Zambia and development challenges remain enormous. Kanyama Compound lacks essential infrastructure and is impregnated with perennial challenges of inadequate access to clean and safe water as well as unsafe sanitation facilities just like other unplanned urban settlements which are vulnerable to epidemics (UN HABITAT, 2007:6) <sup>[61]</sup>.

Kanyama Compound was chosen for a number of justifiable factors. Firstly, our experiences with the Zambia AIDS Related Tuberculosis (ZAMBART) project indicated that community-based support programs for people living with tuberculosis was functioning relatively well and contact tracing of defaulters was efficient. As such, it was considered methodologically possible to locate potential respondents who were deviant and conduct a community-based study in a natural setting. Secondly, Kanyama’s social demographic and geographic characteristic make it one of the best places to document the behaviours of men living with tuberculosis. Kanyama Compound in addition, is densely populated and has one of the highest rates of tuberculosis in the city. The fourth but not least of the justifications is that our familiarity with the wider socio-cultural context and local languages (*Nyanja*<sup>1</sup> and *Bemba*<sup>2</sup>) which are widely spoken provided essential prerequisites to base the content of this article from.

<sup>1</sup> Bantu-speaking peoples scattered over wide areas of the south-eastern part of Congo (Kinshasa), eastern Angola, and northern and north-western Zambia.

<sup>2</sup> Ibibidi

## Design and Methodology

Within the aim of this study, we demonstrate the meaning of masculinities as gender barriers that men who are living with tuberculosis attach to unsanctioned deviant behaviour. We demonstrate this drawing on the project's original epistemology and methodology inherent in Charmaz's (2003; 2006) <sup>[5, 4]</sup> modified constructivist grounded theory which blends well with double hermeneutic phenomenology. For this article, hermeneutic phenomenology helped to explore men's experiences reported in their own words. For example, understanding perceptions, thoughts, and feelings about their failure to fulfil the expected sick role behaviours. It also paved way to give the men the voice to tell stories about their tuberculosis life world. Husserl's hermeneutic views argue that each person lives in a world, in the natural attitude, as a 'human person living among others in the world' (Husserl, 1989: 411) <sup>[30]</sup>. In this natural attitude, consideration is made for men, for instance, who live with tuberculosis, their social surrounding, values and social life, including kins and friends.

## Sampling

The initial project sample on which the study sample comprised in total 457 men and women who were initially randomly sampled from a cumulative sampling frame of a population of 2,468 over two years. The population was serviced by community tuberculosis supporters. Tuberculosis supporters are voluntary lay care givers in Kanyama Compound who ensure adherence to DOTS at community level. There were 231 (50.5%) women 226 (49.5%) men in the project sample. Of concern to this study are 59 men who were later purposefully sampled using maximum variation from the population of 86 men who were deviant. Maximum variation sampling was employed to obtain 'information-rich' cases that could give in-depth insight into the subject of study (Patton, 2002 <sup>[49]</sup>; Maxwell, 2005; Glesne, 2006 <sup>[26]</sup>; Creswell, 2007 <sup>[13]</sup>). From the 86 men, 35 (15.4%) had missed/stopped taking drugs, 27 (11.9%) missed appointments for clinical reviews and drug refills whereas 24 (10.6%) had missed both (Table 1).

**Table 1:** Demographic Profile of Respondents n = 226

| <i>Marital Status</i>        | <i>Male</i> |          | <i>Female</i> |          | <i>Total</i> |
|------------------------------|-------------|----------|---------------|----------|--------------|
|                              | <i>N</i>    | <i>%</i> | <i>n</i>      | <i>%</i> |              |
| Married                      | 133         | 51.7     | 124           | 48.3     | 257          |
| Single                       | 63          | 54.7     | 52            | 55.3     | 115          |
| Cohabiting                   | 3           | 33.3     | 6             | 66.7     | 9            |
| Widowed                      | 12          | 30.0     | 28            | 70.0     | 40           |
| Divorced                     | 11          | 61.1     | 7             | 38.9     | 18           |
| Separated                    | 4           | 22.2     | 14            | 77.8     | 18           |
| <b>Total</b>                 | <b>226</b>  | <b>-</b> | <b>231</b>    | <b>-</b> | <b>457</b>   |
| <i>Occupation</i>            |             |          |               |          |              |
| I am just a student          | 5           | 71.4     | 2             | 18.6     | <b>7</b>     |
| Other occupations            | 6           | 75.0     | 2             | 25.0     | <b>8</b>     |
| I am a trader                | 31          | 50.8     | 30            | 49.1     | <b>61</b>    |
| I am in sales / clerical job | 8           | 66.6     | 4             | 33.3     | <b>12</b>    |
| I am doing nothing           | 140         | 44.3     | 176           | 55.7     | <b>316</b>   |
| I do casual jobs             | 31          | 70.4     | 13            | 29.6     | <b>44</b>    |
| I am a house boy/maid        | 5           | 55.5     | 4             | 44.4     | <b>9</b>     |
| <b>Total</b>                 | <b>226</b>  | <b>-</b> | <b>231</b>    | <b>-</b> | <b>457</b>   |

In order to determine from the 86 deviant male respondents which ones were to be included in the study, we employed an embedded form of qualitative sampling. This embraced

the sequential application of maximum variation sampling followed by theoretical purposeful sampling. This sequential sampling strategy involved sampling in an iterative process whereby maximum variation sampling provided grounds for theoretical sampling.

We began with maximum variation by first clustering respondents based on a range of attributes that we considered could be used to understand or describe the deviant behaviour in a more elaborate manner. The basic principle behind the use of maximum variation sampling was to gain greater insights into masculinities by making sure that the phenomenon and other attributes were examined from all angles. We used heuristic concepts when conducting maximum variation sampling as a framework for clustering respondents and it was composed of: Sex, Education level (these included; never been to school, primary level, secondary level and college level respondents), Income source (these included; formal employment, informal employment and not employed), Treatment status (those in the intensive and continuation phases) and barriers such as the adverse effects to TB drugs, stigma, pressure from one's family to spend money on travel, medical care and medicine, distance, clinic hours, waiting time, family support).

These heuristic concepts were cornerstones for the in-depth interviews that were conducted. As Glaser (1992:102) <sup>[23]</sup> points out, 'groups (or units my creation) are chosen as they are needed rather than before the research begins. This means that the respondents had to be sampled purposefully based on particular predetermined criteria or attributes in order to cover a range of constituent issues (Miles and Huberman, 1994) <sup>[39]</sup>.

The edict of maximum variation was that if one deliberately tried to interview deviant men living with tuberculosis, their aggregate answers across and within selected categories ought to be close to the populations' and would render thick descriptions. The method sounds odd, but works well in places where a random sample is not necessary and cannot be drawn (Dennis, 2004) <sup>[15]</sup>. This is an extension of the statistical principle of regression towards the mean - in other words, if a group of people is extreme in several different ways, it will contain people who are average in other ways (Dennis, 2004) <sup>[15]</sup>. Van Manen (1997) <sup>[62]</sup> also submits that a maximum variation sample, if carefully drawn, can be as representative as a random sample.

The second wave of sampling was theoretical sampling. We made sure that maximum variation sampling was employed step by step as we were interviewing the respondents, covering the five broad ranges of dimensions. We ensured that saturation was attained during the interviews. This is in agreement with the founders of theoretical purposive sampling Burney Glaser and Anselm Strauss (1967:45;67) <sup>[25]</sup> who acknowledge that after the initial stages of a study (in case of this study, maximum variation sampling) the researchers should then go to other groups or members, which they believe, will maximise the possibilities of obtaining additional information rich data on their question (Glaser, 1978; Morse, 1991; Curtis *et al.*, 2000) <sup>[22, 43, 14]</sup> enrolling respondents prospectively until data collection no longer yields new information or insights within the emerging categories (Glaser and Strauss, 1967; Ezzy, 2003; Corbin and Strauss, 2008) <sup>[25, 20, 9]</sup>. In other words, we had to stop recruiting respondents when it appeared clear to us that after interviewing five additional or revisiting the

respondents to get additional data, no new properties of patterns of concepts or constructs or categories emerged (Glaser, 2001:191) [24] and to ensure that representativeness was achieved (Chenitz and Swanson (1986) [7]. The embedded application of the two sampling strategies ended up with 59 respondents. The sample size of 59 respondents, who were interviewed in-depth, is even above the guidelines of 30 to 50 respondents recommended by Morse (2002) [42] for achieving saturation in studies involving semi-structured interviews that tend to generate “thin descriptions.” The sample could however be less in studies involving in-depth interviews due to the intensity.

We conducted in-depth interviews in the respondents' homes. Interviews covered the lived life of tuberculosis patients and focussed on the participants' experiences of the illness, treatment and social life. Interviews were audiotaped only when the participant agreed. Interviews lasted between 55 and 65 minutes.

### Ethics

Be that as it may, no code of conduct is effective without agreement as to what is put in the code of ethics (Phiri, 2021) [53]. There seems to be a disconnect between the public code of conduct in the strategies that are put up by health institutions (Phiri, 2021:23) [53]. Therefore, before the interviews, we obtained ethical approval for the study from the local ethics committee. We explained the purpose of the study to the respondents. We asked respondents whether they would be willing or not to participate in this project. We explained the voluntary nature of their participation and we informed that they could withdraw at any time. We assured all the respondents that none of them would face any sanctions from the health Centre if they declined or withdrew from the study as I was not a member of the staff team.

### Analysis

A colleague who had prowess in grounded theory and we analysed the data independently and met to compare the analysis and agreed on the coding and excerpts to be used as exemplars. Analysis was informed by Charmaz's (2000; 2006 [4]) modified grounded theory. This called for the researcher departing from the original Glaser and Straussian classical grounded theory methodology. Charmaz's modified grounded methodology calls for applying a three-step coding process involving open, selective and theoretical coding, at incremental levels of abstraction. This suggests that we had to examine the and code the data looking at the context, conditions, action, interactional strategies, intervening conditions and consequences for the purposes of establishing categories and relationships. The analysis yielded a set of codes at thematic, sub thematic, category and sub category levels.

## Discussion of findings

### Demographic profile

This study took place between October 2010 and July 2012. A diverse sample of 59 men living with tuberculosis was enlisted demonstrating a wide range of social economic backgrounds. The sample was youthful and the youngest was 21 whereas the oldest was 58. The mean age was 36.5 (SD  $\pm$  3.3). A diverse range of marital status, education and income generating backgrounds was observed in the sample. The mean schooling years was 6 (SD  $\pm$  2.6).

The sample was generally impoverished. More than half  $n = 34$  had no income at the time of the study. Within this number,  $n = 18$  had a job of some kind but had lost their income due to the illness. At the time of the study,  $n = 25$  had a means of earning an income and of these,  $n = 15$  had a regular income but not dependable whereas only  $n = 10$  had a regular and dependable income.

### Medical Profile

In the sample,  $n = 36$  were new cases and  $n = 23$  were relapses or retreatments. Thirty of the men in the sample were in the intensive phase of their treatment which stage is designed for rapid killing of actively growing bacilli and of semi-dormant bacilli whereas, 29 men were in their continuation phase of their treatment which is designed to eliminate multiplying bacilli and this phase reduces treatment failure and relapse. More than half of the men (37) were smear positive as compared to 22 men who were not on table 2). This means that at the time of the study, within the sample  $n = 457$ ,  $n = (23.8\%)$  were found to be too ill to leave their home and get to the clinic to be reviewed or obtain drug refills. When the respondents were asked how they looked at the prognosis of their illness, about half of the respondents'  $n = 237$  (51.8%) believed they would recover following treatment,  $n = 37$  (8%) thought recovery was fifty-fifty and  $n = 183$  (40.1%) were uncertain of recovery or thought of reoccurrence. Just over half  $n = 258$  (56.4%) had a smear positive sputum as compared to  $n = 199$  (43.6%) who had a smear negative sputum. There was no significant association between the sex of enrolees and their smear status ( $p > 0.625$ ) (Table 1). More new cases or primary were enrolled in the study  $n = 358$  (78.3%) as compared to  $n = 99$  (21.7%) cases of retreatment or relapse. In spite of this distribution, there was no significant association between the sex of enrolees and case type ( $p > 0.170$ ) (Table 1). Just over half  $n = 243$  (53.2%) were in the intensive phase of their treatment which stage is designed for rapid killing of actively growing bacilli and of semi-dormant bacilli whereas  $n = 214$  (46.8%) were in their continuation phase of their treatment and this phase reduces treatment failure/relapse. However, there was no significant association between the sex of enrolees and treatment phase ( $p > 0.179$ ).

**Table 2:** Medical profile of patients and values of associations

|            | <i>Smear Type</i>               |          |                                 |          | <i>Significance</i> |           |                |
|------------|---------------------------------|----------|---------------------------------|----------|---------------------|-----------|----------------|
|            | <i>Negative N = 199 (43.6%)</i> |          | <i>Positive N = 258 (56.4%)</i> |          | $\chi^2$            | <i>df</i> | <i>P value</i> |
| <i>Sex</i> | <i>f</i>                        | <i>%</i> | <i>f</i>                        | <i>%</i> |                     |           |                |
| Male       | 101                             | 50.7     | 125                             | 48.4     | 0.239               | 1         | 0.625          |
| Female     | 98                              | 49.3     | 133                             | 51.6     |                     |           |                |

|            | <i>Case type</i>                 |          |                                  |          | <i>Significance</i> |           |                |
|------------|----------------------------------|----------|----------------------------------|----------|---------------------|-----------|----------------|
|            | <i>New Cases N = 358 (78.3%)</i> |          | <i>Retreatment N= 99 (21.7%)</i> |          | $\chi^2$            | <i>df</i> | <i>P value</i> |
| <i>Sex</i> | <i>f</i>                         | <i>%</i> | <i>f</i>                         | <i>%</i> |                     |           |                |
| Male       | 171                              | 47.7     | 55                               | 55.9     | 1.883               | 1         | 0.170          |
| Female     | 187                              | 52.3     | 44                               | 44.1     |                     |           |                |

  

|            | <i>Treatment phase of case type</i> |          |                                |          | <i>Significance</i> |           |                |
|------------|-------------------------------------|----------|--------------------------------|----------|---------------------|-----------|----------------|
|            | <i>Continuation Phase N = 214</i>   |          | <i>Intensive Phase N = 243</i> |          | $\chi^2$            | <i>df</i> | <i>P value</i> |
| <i>Sex</i> | <i>f</i>                            | <i>%</i> | <i>f</i>                       | <i>%</i> |                     |           |                |
| Male       | 113                                 | 52.8     | 113                            | 46.5     | 1.808               | 1         | 0.179          |
| Female     | 101                                 | 47.2     | 130                            | 54.5     |                     |           |                |

From Table 2 above the  $\mu$  duration of treatment in the intensive phase was 6 weeks ( $\pm 2$  SD) whereas in the continuation phase, the  $\mu$  was 4 weeks ( $\pm 5$  SD). The  $\mu$  total duration (those who had an experience with both phases) was 10 weeks ( $\pm 7$  SD). In spite this distribution, the sex of the enrollee was not a factor in terms of duration or phase of treatment as  $p$  was  $> 0.05$ . In essence, it is very likely men and women take the same duration of treatment in the two phases.

Nevertheless, the current WHO and national TB programme guidelines for TB treatment recommend 8 weeks of intensive and 24 weeks of continuation phase, this study enlisted respondents who had begun their treatment as early as 2 weeks and those who were about to complete treatment up to 24 weeks. The  $\mu$  intensive phase duration was 6 weeks ( $\pm 2$  SD) whereas in the continuation phase, the  $\mu$  duration was 4 weeks ( $\pm 5$  SD). The  $\mu$  total duration (those who had an experience with the intensive and continuation phases) was 10 weeks.

**Identified Masculinities**

The excerpts of interviews below have been selected as exemplars of masculinities. We use pseudonyms to give life to the excerpts in line with arguments by Orb *et al.*, (2000) [44]. This approach is ideal when researchers are maintaining the principle of beneficence, overseeing the potential consequences of revealing participants’ identities is a moral obligation.

Through excerpts of interviews, we concluded that, in Kanyama Compound, men’s social life was radically disturbed by illness which prompted them to reflect on taken-for-granted gendered beliefs and the practices of masculinity they engaged in prior to illness, as well as those affected subsequently. Men faced constraints that bordered on masculine cultural traits. In support with Phiri (2021) [53], who argues that masculinity trait in men is always rendered visible through the long chains of actors linking sites to one another reflected on language. These constraints or barriers indicated motives for failing to fulfill expected sick role behaviours were associated with firmness. Male patients desired to stick to be men even when they were sick. Men had strong desires to demonstrate being in control of the situation while they strived to show what they were made of or their identity. There were situations when men wanted to show those around that they were strong and fast at fixing things. We present illustrations of masculinities that shaped deviant behaviours. Within the masculinities the deviant

gendered barriers that were responsible for the observed deviances included six categories and these were: Identity, breadwinner, masculinity stereotype threat, hyper masculinity, resistance to recommended practices and being in control of the situation. Table 3 shows the relationship between masculinity types and the enacted deviant behaviour below.

**Table 3:** Masculinity types and the enacted deviant behaviour

| Masculinity Type (Inducer of sick role deviant behaviour)  | Enacted Deviant behaviour   |
|--|---|
| <ul style="list-style-type: none"> <li>▪ Being in control of the situation,</li> <li>▪ Hyper masculinity,</li> <li>▪ Resistance to recommended practices,</li> <li>▪ Masculinity stereotype threat,                             <ul style="list-style-type: none"> <li>▪ Breadwinner.</li> <li>▪ Identity</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>▪ Honouring appointments to be reviewed</li> <li>▪ Obtain drug refills</li> <li>▪ Missing/stopping to take drugs</li> <li>▪ Failing to take the correct combination of drugs.</li> </ul> |

The exemplars above attest to the masculinities which were responsible for the enacted deviance. We used pseudonyms or nom de plumes that are an assumed name instead of real names, to give life to excerpts and to crowd the possible recognition of respondents (Orb *et al.*, 2000; Mantzoukas, 2004) [44, 36]. This approach is ideal if researchers are maintaining the principle of beneficence, overseeing the potential consequences of revealing participants’ identities which is a moral obligation. We present the lived experiences underpinned by a phenomenological framework in which there was a desire to focus on the voices of respondents from a holistic perspective. We had to take into account the broader social and cultural context of their lives. Moreover, we made sure that the research process enabled men to speak with their own voices and explain their own experiences. The research findings are presented using six categories which are: Being in control of the situation, hyper masculinity, resistance to recommended practices, masculinity stereotype threat, breadwinner and identity.

**Identity**

Men were occupied in constructing their identity as part of the person’s sense of self which they thought of accomplishing at the expense of the expected sick role behaviour. In agreement with Phiri (2023:71) [51], “this is where the victim has severe consequences concerning her self-image, self-esteem and identity. For example, most of

the men who exhibited masculinities by expressing the need for identity were younger men and a few older men who were not educated. Jackson and Luke render their own testimonies about the need to affirm masculine identity and these act as a gendered barrier to fulfilling the expected sick role behaviour. A young man Jackson aged 24 who was a tyre mender had this to say:

*I do not see myself sitting around at home nursing this illness and taking the pills over and over. What will others say about me? I have to make life you know... drink but not so much and walk around...*

Another young man Luke aged 26 but slightly older and unemployed stated that:

*Often I have to take risks. I love adventure and to say to myself...I am a man. I do take the drugs with some beer...they say do not do so as the two (beer and TB drugs damage the liver). So where is the difference if both have the same bad consequences anyway? So I have experimented two or three days of missing the drugs is not bad and it is four months now and I am getting better. As a man you must not do as women do in life, including not taking beer when on medication. When are you going to say you are a man?*

#### *Breadwinner*

Some men assigned varying priorities to health. While fear of death or complications of tuberculosis appeared to be a central focus for some to comply with the prescriptions of the sick role behaviours, for those who were deviant, family expectations of men and work-related activities appeared to be more important to them. Men who were bread winners competed with the expectations of the sick role. This created in them negative attitudes toward honoring appointments and taking pills when due. The expected sick role was thus dishonored in preference for work responsibilities, finances, and family obligations.

Daniel 33, a self-employed driver who conducts trans-border errands and father of six was influenced by a strong belief of traditional action based on strongly held customary habits of thought that men are breadwinners. Being the breadwinner compelled Daniel to get back to work since it was an only moral thing to do. Daniel had this to say about his deviant behaviour:

*"I was asked to stay away from work I mean given one-month sick leave. But you see I am the breadwinner. The more I continue to nurse this illness by saying I am on bed rest, will actually take me nowhere...My household will not eat bed rest. The more I nurse this illness, the more my household gets deprived...You can now understand as a man in our culture, I have to provide for the family. That is a moral rule... I had no alternative but miss the appointment but to travel to Dar-es-Salaam and collect my client's care as we were badly in need of money".*

Thirty-nine years old Thom and a family man like Daniel faced similar constraints related to being a breadwinner. However, his deviant actions of missing clinic appointments and drug refills were further influenced by traditional beliefs and affectual or emotional reasons.

To be frank, I'm not all that okay when I see my wife making money for the house in the state, I find myself...she is doing everything for me but this is not right on culturally...and health wise for her. I just have to go back into the field. I am the legitimate breadwinner.... That is what a man has to do.... show leadership and love to the family or else you will be under petticoat government (meaning subordinate to a woman).

#### **Masculinity Stereotype Threat**

There were situations when men living with tuberculosis were coerced to be deviant through masculine stereotype threats by group members in form of gendered masculine stereotype threats. Gendered masculine stereotype threats were used in Kanyama Compound in doing gender and the observed deviance. In Kanyama compound, there were stereotypes that acted as traps into which some men fell because they belonged to the stereotyped groups. Men felt threatened in situations in which they believed that their performance of the expected sick role behaviour would identify them as deviants, which would make them worst examples of their group's negative stereotype. Below are excerpts from Agrippa and Jani which are reflective of masculinity stereotype threats.

Agrippa was 29 years old was an airtime seller. He just did three years of secondary education which could be a factor of coercion. He supported his missing of doses and stated:

*I managed to stick to the doctor's instructions the first four weeks of intensive treatment. I was at home, rested, and ate whatever was considered to be good for a TB patient. Two of my friends came and spoke to me convincingly that I was not enjoying life. I seemed to agree with them. I was encouraged to be man like to go out for a day or an evening. I mean to be strong to walk about to be strong in the face of illness and to consider ill health or "weakness," and disapprove taking my pills with beer as a means of "being tough." So, I decided to take my medications after some booze.... what happened .....I began to skip my doses and appointments.... If it wasn't for these men and women on this community programme, insisting and checking on me, I could be dead by now.*

Jani 23 rationalised his drinking group-based action by keeping the group norms. This adherence to group norms created situations of deviance where men were faced with an offer they cannot refuse and sanctions they could not cope with. Below is Jani's justification of his deviant acts.

*I just like to be the man to admire and safe from blame ...I mean I keep intact and get to what the group (meaning friends he drinks with) says you know...being tough and I also like to look obedient because it has worked many times...them guys support you when in need because you maintain group ethos. I mean they will tell you men do not have to keep on going to the clinic every other day. So, you understand now that I had to show not only myself but my friends that I am the people's real man...together we generally agree what to do and come to each other's help.*

The exemplars presented above show how the existence of negative stereotypes tend to affect those who are part of the

stereotyped groups. Men feel threatened in situations in which they believe that their performance will identify them as examples of their group's negative stereotype. Belonging to a group by avoiding sanctions is taken as compliance and plays a significant role receiving rewards and in establishing oneself among men. Compliance to a group's norms is rewarding and contributes to men's well-being and status in Kanyama. Even if a man did not believe the stereotype or accept that it applies, the threat of being identified with a negative stereotype was an ever-present factor that put men living with tuberculosis in Kanyama in the spotlight and a factor for deviance. In support with Phiri (2021) [53, 55] stereotypes produces emotions that are produced by exchange structures and processes that are critical to an understanding of how and when social exchanges promote or inhibit solidarity in men's behaviour during illness. These stereotypes provide collective, organised meanings of gender especially masculinities and often become widely shared beliefs about who men innately are (Pleck, 1987; Williams and Best, 1990) [56, 68]. Men are encouraged to conform to stereotypic beliefs and behaviours, and commonly do conform to and adopt dominant norms of masculinity (Bohan, 1993; Golombok and Fivush, 1994) [1-27].

#### **Resistance to recommended practices**

Some men placed themselves in the masculine hierarchy of paternalism. This placement revealed a number of ways in which masculinities were constructed in Kanyama through men's everyday health-related practices. These included resistance to recommended health practices which men considered as exhibiting manliness. The men felt that even though they were sick, they were in control of the situation. There were for instance a number of deviant behaviours that were elicited ranging from, failing to fulfil a clinic appointment, failing to get drug refills, omitting a dose or doses, prematurely discontinuing medication, and taking a dose at the wrong time and improperly using medication. James, Muleya and Chibwe and typify how masculinities bring about un-sanctioned deviant behaviours that are contrary to the expected sick role behaviour.

James a factory worker aged 47 and married with a family of 7 was influenced by a masculine traditional action, which is an approved social habit and is largely unquestioned. Phiri (2021) [53, 55] on masculine tradition regards it as an act of African cultural inheritance contained in what is known as "social support". This action is perceived to be correct at the expense of the expected sick role behaviour. Thus, James stated that:

*Just by being a father, you have to balance your recovery and showing your children and wife that you are the man in the house. Everyone expects you to provide...When you have a headache or nausea or some dizziness, you just do not have to see the Clinical officer out rightly...*

James's reason for the elicited deviance is in some way not different from Chibwe's. Chibwe was a young man who was a dependent. He was influenced by masculine stereotypes within the African tradition where orders or advice from seniors ought to be religiously followed. Chibwe's action was perceived to be correct at the expense of the expected sick role behaviour. This is because advice or orders from

seniors act as law and are largely unquestioned. Chibwe defended his initial actions and remarked:

*My big brother had advised to stop taking pills. I abandoned reviews and getting drug refills for four weeks and dropped out of treatment after all I am not a big pill-taker. I did so for four weeks later I saw that it was not helping and I just said no to this nonsense....and went back on them...but very disappointed with myself. I must say that during this period, I resisted advice from Mr. Kaluba (a tuberculosis supporter) and I did not want to listen to my woman (meaning wife).*

These excerpts above are typical of cases of resistance to recommended practices. Thus, they clearly indicate the masculine actions in accomplishing the deviant gendered sick role behaviours.

#### **Hyper masculinity**

Hyper masculinity which is an exaggerated or extreme display of traditionally masculine behaviours (sometimes referred to as machismo), was one of the gender performances that were frequently associated with deviance. Within this category, there were men who, because of socialisation in both the main culture and subcultures, tended to adhere to amplified expressions of traditional gender roles. Because of hyper masculinity, men demonstrated not only deviance to the expected sick role but also demonstrated an antisocial behaviour like excessive alcohol use. Men exhibited hyper masculinity by emphasising their status, toughness and despising feminine behaviour. There were other characteristics that were attributed to hyper masculine men and these included suppressed emotions about the outcome of tuberculosis, fear of being labelled as weak and failure to express of sadness. The experiences presented below of Luke and Gilbert constitute deviance and co existing antisocial behaviour arising from hyper masculinity.

Gilbert 21 married with two children and a  *fendella fenduz* (meaning boys or men who carry merchandise as a way of earning a living) explained that he missed his appointments because he had to balance the demands of social life. His testimony below will indicate deviance and anti-social behaviour:

*After a day's work, you know my job is a fendella fenduz (carrying merchandise). This is a tough job for every man and worse for me who has this illness (TB). So, after a days' work, I have to balance the demands of social life. I have no alternative but to be with them boys (friends). I go clubbing (drinking and do other drinking business....girls and games). At the club, we play pool drink and chase after women. I am the main man to linkup friends to women. I also decide who to pair with when playing pool. In the pubs, I am not called Chairman for nothing... people pour all over me asking for help. So you just do not have to take drugs only. You have to show that you are a man by having one or two girls around you ....If you miss your appointment or doses that is part of life. There is another day for it.*

It is evident that Gilbert was demonstrating a hyper-masculine behaviour which imposes itself as the normal standard when not. From such hyper masculine constructions of deviance and anti-social behaviour, there are huge stakes and Gilbert as a young and married man doesn't care about that. What he cares about is maintaining the expectations of his peer group. His reward for dating violence is group acceptance and status; this outweighs any risk to himself. In the illustration relating to Luke which follow, another young man demonstrates his hyper masculine deviance by being fearless:

*As a man, I do not have to show sickness and not even fear of death otherwise I will be considered weak. Just like Robert and Mule (friends who also had TB and were on treatment), I also to sip (meaning taking liquor) and have fun together. I like taking my Mosi (a Zambian lager). I take it to overcome fears of taking the medication for a long-time death and stigma associated with this illness. My two other friends give similar reasons.*

It is evident that Gilbert and Luke were demonstrating a hyper-masculine and anti-social behaviour as normal standards. The social setting, the form of interaction, and the dimension and appearance of these men performing the deviant tend to embrace the desire to project hyper-masculine identities or status, and behaviours. West and Zimmerman (1987) <sup>[65]</sup> and Courtenay (2000b) <sup>[12]</sup> have shown that hyper-masculinity has been associated with risky behaviours by West and Zimmerman (1987) <sup>[65]</sup>. These excerpts clearly indicate the existence of masculine actions in accomplishing the deviant gendered sick role behaviours.

### **Being in control of the situation**

Equally, being in control of the situation was observed as an act of localization and contextualization the illness of Tuberculosis. The concept of localization and contextualization falls on the idea that people learn best when experiences in their learning spaces have meanings and have relevance in their lives. Localization is the adaptation of a product or service to meet the needs of a particular language, culture or desired population's "look-and-feel" (Mubita *et al*, 2023). This means that apart from demonstrating resistance to the recommended practices, some men saw it not important to dishonour reviews ad to take drugs as scheduled because they believed they wanted to be in control of the situation while others wanted to show off that they were men. A candid presentation of two masculinity value laden excerpts from Fanwell and Gilbert men serve to illustrate the point.

Fanwell 28 who was self-employed and a grade 10 school leaver who had skipped treatment and later helped by tuberculosis supporters, was initially influenced to be deviant by a strong belief that he did not have tuberculosis because his sample of sputum was negative. This was further buttressed by his inner convictions and day to day lay talk that as a man he needed to be in control of an illness. He strongly believed that it was right or important thing to show not only himself but others as well that even if the drugs affected him, he was in control as a man. Fanwell had this to say to show his inner constructions of motivation for deviance:

*I was getting weaker and weaker the first month of starting treatment. I kept thinking within me that the drugs were not doing any good and especially that there would be many weeks to take them. I was also debating within me and unsure within myself whether the treatment was the correct one and would work in me since my sputum was negative...I also had this urge in me that after all I was a man I will take control of the whole situation. Just after ten days of what is called "intensive treatment", I stopped taking drugs and I also missed my first clinic appointment....I got an inner inspiration by the voice that kept on saying "You see as a man you have to show that you are strong and at the same tough".*

When Fanwell was asked what prompted getting back on the course of treatment, he described how foolish his decision was in the first place. This is evident by his lamentations.

*.... Ok, I had no thought of the consequences of what I had done. I was very sure within me as far as I knew that people who should be on this treatment must be sputum positive. However, what made me realise that I was just fooling myself is that I went down fast without the treatment. What served me was the talk I had with Madam Zulu (the tuberculosis supporter) when she made a follow-up after missing my first appointment. When she visited me.... I broke my silence I was disappointed with myself. I was wrong by the feeling of being a man and in control of the situation.... I was actually going to die.... From then, I have not missed an appointment and I have been taking my pills.....*

Gilbert 21 married with two children and a *fendella fenduz* (meaning boys or men who carry merchandise as a way of earning a living) explained that he missed his appointments just to be in control of his family. His testimony below indicates so:

*There is no way I will just sit. Yeah I will do some work and for go some reviews when I am done..... I will say to myself..... eh I know I will catch up later. That is what a man has to do not only for himself but for his family too or else he will be under petticoat government (meaning subordinate to a woman). I must just show that I am in control of myself and the illnesses..... You now understand why I miss those appointments.*

Men like Fanwell and Gilbert exhibited typical masculinities which tended to be observed in instances and especially among men with humble or low education. The exemplars presented above of masculinity related gendered barriers have highlighted some of the ways in which males being in control and poor sick role behaviours are inter-related by different action types in chronic illnesses. This is not only applicable in tuberculosis but in conditions like cancer and mental illness among others as shown by Elgie (2002) <sup>[18]</sup>, Mason and Strauss (2004) <sup>[37]</sup> and Kilmartin (2005) <sup>[34]</sup>. These masculinities emanate from strongly endorsed health-related beliefs that men should be independent and tough.

### **Discussion of Main Findings**

The aim of this study was to identify masculinities that act as gendered barriers or risky behaviours among tuberculosis



patients in one impoverished densely populated compound in the City of Lusaka in Zambia. Six categories of masculinities were linked to the observed deviances and these are: Being in control of the situation, hyper masculinity, resistance to recommended practices, masculinity stereotype threat, breadwinner syndrome and identity. It is evident that masculinity beliefs among men living with tuberculosis demonstrate risky behaviours and these behaviours are not socially desirable. The six elicited masculine ideals from the men's points of view tend to correspond to the lives of impoverished and less educated men. The experiences of the men in Kanyama Compound demonstrated rationalisations of deviant sick role behaviours. Younger men especially tended to comply with agreed masculinity linked norms in their subcultural groups. Younger men tended to defy the prescriptions of the generalised other. There is disloyalty to the prescriptions of DOTS and the assumed causes of disloyalties in the case of illness are not only a disregard of norms but were also a result of male identity which is linked to abandoning in part or in total the expected sick role behaviours.

The deviant behaviours of these men were constructed using belief systems and practices which were structured around dominant masculinities within Kanyama Compound. Learning from doing gender as posited by West and Zimmerman, (West and Zimmerman, 1987<sup>[65]</sup>; 1991<sup>[66]</sup>; Morgan, 1992<sup>[48]</sup>; Connell and Huggins, 1998<sup>[8]</sup>; Courtenay, 2000), one could be compelled to argue that these masculinities and accompanied deviant behaviours are understood to emerge from social socially guided perceptual, interaction and participation by men through a range of risky gendered practices.

For example, the excerpts from James' and Fanwell's experiences cited above are revealing of the ways masculinities are constructed through social practice as shown in literature (Wills, 1979; McKee and O'Brien, 1983<sup>[38]</sup>). This further affirms previous evidence that men who adopt traditional attitudes about being a true man like the desire of independence, self-reliance, strong, and being tough (Good and Mintz, 1990; Golombok and Fivush, 1994)<sup>[28, 27]</sup> tend to have poor health behaviours and increased health risks to acquiring disease and dying than men with less attachment to traditional attitudes and beliefs about being a true or real man. Additionally, except for elementary reflexes, people are not equipped with inborn repertoires of behaviour (Bundura, 2019:16). They must learn behaviour from the environment they live in (Schreuder 2004:16). These constructions of masculine behaviour and rationalisations raise particular barriers for men to the effective and appropriate use of health services and other forms of help-seeking. The findings point to the fact that men in Kanyama who are living with tuberculosis are not merely passive but are active agents in constructing and reconstructing their dominant norms of masculinity as shown in some literature (Verbrugge, 1988; Charmaz, 1995; Courtenay, 1999)<sup>[63, 6, 10]</sup>. Equally, scholars, Mubita, Milupi, Kalimaposi *et al* (2023)<sup>[32]</sup> on a climate effect argues that changes in water availability, biodiversity loss, reduced landscape aesthetic, altered agricultural production, increased natural hazards, erosion and inundation, damage to infrastructure and the increasing incidence of vector borne diseases, such as tuberculosis. So far this article asserts that the four masculinities act as barriers to the expected sick role behaviour and are relevant points in the

development of interventions to strengthen the DOTS program in Kanyama Compound. But what was also observed as confirmed by Phiri (2022)<sup>[54]</sup> was the issue of how disease is anchored on social justice. For example, sometimes, it can appear as though state institutions and government legislation are biased in favour of the better off in society, and that they often contrive to exacerbate the oppression of those in the lowest social group. Such practices can result in those at the bottom of the social ladder suffering the effects of injustice and inequity (Phiri, 2022)<sup>[54]</sup>.

Though maleness can be an advantage to health because men have more often privileged access to resources than women (Doyal, 2001)<sup>[17]</sup> this study has shown the contrary. Unlike writers like Doyal (2001)<sup>[17]</sup> who claim that being male is a 'mixed blessing' because in many cultures, men are required to take health risks, there are other masculinities (like the ones elicited in the study that fall within risky behaviours that men take). This study has also shown a perverse notion that men who are sick should be pre occupied with tending for the family as bread winners. This creates opportunities for them to be vulnerable to deterioration in health and even death (Verbrugge, 1988<sup>[63]</sup>; Doyal, 1995<sup>[16]</sup>; Courtenay, 2000).

#### **Limitations and Strengths of the Study**

Like all studies have limitations, this study too has its peculiar limitations and as such, the findings should be interpreted contextually.

The first limitation of the study has to do with the use of a case study method to bring out the studied phenomena. The focus on only one site in spite of a large qualitative sample, is not generalisable beyond Kanyama Compound. Though generalisation is certainly not a possible, an alternative possibility of generalisation called transferability in qualitative research (Lincoln and Guba, 1985; Misco, 2007)<sup>[35, 40]</sup> is possible. This can be done as follows. The first one relates to using the codes that were generated. One might use the four themes that have been generated using one option. This calls for extrapolating this research using Donald Campbell (1986)<sup>[3]</sup> arguments by applying the proximal similarity model. Within the proximal similarity model, researchers and consumers envision which contexts are more or less like the one in the study. Detailed pictures of deviant behaviour, men, and contexts of the setting have been described; that is it is possible to proximally match individuals and places similar to those in the focal study. Lincoln and Guba (1985)<sup>[35]</sup>, who used the term fittingness to refer to the degree of congruence or similarity between two contexts, suggested a similar idea.

In spite of these limitations, from a methodological point of view, the current study is significant in terms of contributing to future research. The study has scored a first by generating masculinities which are linked to sick role deviance around tuberculosis and associated justifications to non-performance of the expected sick role behaviour by grounding lived life in empirical observations.

#### **Policy Implications**

These findings provide strong evidence of need for risk reduction among men who are living with tuberculosis through preventive practice. There is need to design a set of actions with a coherent objective to bring about change or produce identifiable outcomes for men who are living with tuberculosis in Kanyama. The sets of actions are structured

to meet micro level benefits (personal or household based) and meso level based (community centred).

To this effect therefore, there is absolute need of fostering the DOTS strategy at community level through tuberculosis supporters by providing training which embraces doing gender.

There is need for enhanced patient pre-treatment counselling and education on tuberculosis at the Tuberculosis Corner. This should emphasize the importance of adherence and eventual completion of treatment without interruption. There is need to take masculinities as an aspect of gender differences into consideration in terms of initial vulnerability capacity assessment of every person living with tuberculosis when planning and implementing community DOTS measures. The tuberculosis supporter should do the assessment during the initial home visit in order to evaluate each person's situations, based on his or her own experiences. These individualised assessments could then be collated to even prepare community-based action plans. Since Kanyama is geographically small and easily accessible, a wide range of participatory assessment tools and techniques including Focus Group Discussion, Participatory Rural Appraisal and transect walks could be used to map out existing and potential hazards, vulnerabilities, and capacities.

### Conclusions

From a masculinist standpoint, the constructions of sick role deviant behaviours demonstrate an unexplored life of men living with tuberculosis. Eliciting the lived lives of men and confronting masculinities which perpetuate risk taking may well improve adherence to sick role behaviour because men who are living with tuberculosis are *at risk* of developing drug resistance and dying from tuberculosis. Through the empirical accounts of men's beliefs, attitudes and practices, DOTS interventions could be effective if they could embrace mitigating deviance linked masculinities.

### References

1. Bohan JS. Regarding gender: Essentialism, constructionism, and feminist psychology. *Psychology of Women Quarterly*. 1993; 17:5-21.
2. Brod H. The case for men's studies. In: Brod. H. *The making of masculinities: The new men's studies*. London. Allen and Unwin, 1987.
3. Campbell DT. Relabeling internal and external validity for the applied social sciences. In: Trochim, W. (Ed.), *Advances in quasi- experimental design and analysis*. Jossey-Bass, San Francisco, 1986, 67-77.
4. Charmaz K. *Constructing grounded theory*. London; Thousand Oaks, Calif. Sage Publications, 2006.
5. Charmaz K. Grounded theory - objectivist and constructivist methods. In N. K. Denzin and Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry*. London: Sage, 2003.
6. Charmaz K. Identity dilemmas of chronically ill men. In: Sabo, D., Gordon, D.F. (Eds.), *Men's health and illness: gender, power and the body*. Sage Publications, Thousand Oaks, 1995.
7. Chenitz WC, Swanson JM (Eds). *From practice to grounded theory: Qualitative research in nursing*. Wesley, Menlo Park, California, 1986.
8. Connell R, Huggins A. Men's health: Healthcare policy is beginning to recognise, issues of masculinity. *Medical Journal Australia*. 1998; 169(6):295-96.
9. Corbin J, Strauss AL. *Basics of qualitative research*. 3<sup>rd</sup> Edition. Thousand Oaks, CA: Sage, 2008.
10. Courtenay WH. Situating men's health in the negotiation of masculinities. *The society for the psychological study of men and masculinity bulletin* (The American Psychological Association). 1999; 4(2):10-12.
11. Courtenay WH. Engendering health: A social constructionist examination of men's health beliefs and behaviours. *Psychology of men and masculinity*. 2000a; 1:4-15.
12. Courtenay WH. Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*. 2000b; 50:1385-1401.
13. Creswell JW. *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage Publications, 2007.
14. Curtis S, Gesler W, Smith G, Washburn S. Approaches to sampling and case selection in qualitative research: Examples in the geography of health. *Social Science and Medicine*. 2000; 50(7):1001-1014.
15. Dennis L. Maximum variation sampling for surveys and consensus groups. Adelaide, 2004. Retrieved October 15, 2012 from: [www.audience dialogue.org/maxvar.html](http://www.audience dialogue.org/maxvar.html).
16. Doyal L. What makes women sick: Gender and the political economy of health. *Medical Journal*. 1995; 324:1076-1911.
17. Doyal L. Sex, gender and health: The need for a new approach. *British Medical Journal*. 2001; 323:1061-1063.
18. Elgie R. Mental illness: The need to raise awareness of depression in men. *Men's Health Journal*. 2002; 1(3):77-79.
19. Erikson K. *Wayward puritans: A study in the sociology of deviance*. New York: Wiley, 1966.
20. Ezzy D. *Qualitative analysis: Practice and innovation*. New York, NY: Routledge, 2003.
21. Galdas PM, Cheater F, Marshall P. Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*. 2005; 49(6):616-623.
22. Glaser BG. *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, Ca. Sociology Press, 1978.
23. Glaser BG. *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press, 1992.
24. Glaser BG. *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press, 2001.
25. Glaser BG, Strauss AL. *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine De Gruyter, 1967.
26. Glesne C. *Becoming qualitative researchers: An introduction* (3rd Ed.). New York, NY: Pearson Education, Inc, 2006.
27. Golombok S, Fivush R. *Gender development*. New York: Cambridge, 1994.
28. Good GE, Mintz LB. Gender role conflict and depression in college men: Evidence for compounded risk. *Journal of Counselling and Development*. 1990; 69(1):17-21.
29. Gusfield JR. On legislating morals: The symbolic

- process of designating deviance. *California law review*. 1968; 56(54):54-73.
30. Husserl E. Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Second book: Studies in the phenomenology of constitution. Dordrecht. Kluwer, 1989.
  31. Johnson JL, Greaves L, Repta R. Better science with sex and gender: A primer for health research. Women's health research network. Vancouver, BC, 2007.
  32. Kaiko M, Inonge MilupiI Inonge Kalisto Kalimaposo K. Responding to Challenges in Tourism in the Era of Climate Change in Zambia. *International Journal of Education and Social Science Research*. 2023; 6(2):129-139. ISSN 2581-5148
  33. Keleher H. Why build a health promotion evidence base about gender? *Health promotion international*. 2004; 19:277-279.
  34. Kilmartin C. Depression in men: Communication, diagnosis and therapy. *The Journal of Men's Health and Gender*. 2005; 2(1):95-99.
  35. Lincoln YS, Guba EG. *Naturalistic inquiry*. Beverly Hills, CA: Sage, 1985.
  36. Mantzoukas S. Issues of representation within qualitative inquiry. *Qualitative Health Research*. 2004; 14(7):994-1007.
  37. Mason O, Strauss K. Testicular cancer: Passage through the help seeking process for a cohort of UK men (Part 1). *International Journal of Men's health*. 2004; 3(2):93.
  38. Mckee L, O'Brien M. Interviewing men: Taking gender seriously. In E. Gamarnikow, D. Morgan, J. Purvis and D. Taylorson (Eds.). *The public and the private*. London: Heinemann, 1983.
  39. Miles M, Huberman M. *Qualitative data analysis: An expanded sourcebook*. Beverly Hills, CA. Sage Publications, 1994.
  40. Misco T. The frustrations of reader generalizability and grounded theory: Alternative considerations for transferability. *Journal of Research Practice*. 2007; 3:1-11.
  41. Morgan D. *Discovering men*. London: Routledge, 1992.
  42. Morse JM. *Qualitative health research*. Thousand Oaks, CA: SAGE, 2002.
  43. Morse JM. Strategies for sampling. In: Morse JM, Editor. *Qualitative nursing research: A contemporary dialogue*. Rev. Ed. Newbury Park, Calif.; London: Sage Publications, 1991, 127-145.
  44. Orb A, Eisenhauer L, Wynaden D. Ethics in qualitative research. *Journal of Nursing Scholarship*. 2000; 33(1):93-96.
  45. Östlin P. Gender perspective on socioeconomic inequalities in health. In: Mackenbach J., Bakker M., Editors. *Reducing Inequalities in Health: A European Perspective*. London and New York: Routledge, 2002.
  46. Östlin P, Eckermann E, Mishra US, Nkowane M, Wallstam E. Gender and health promotion: A multisectoral policy approach. *Health Promotion International*. 2007; 21(Suppl 1):25-35.
  47. Parsons T. An outline of the social system. In Parsons, T., Shils, E.A., Naegle and Pitts, J.R. *Theory of society*. New York. Free Press, 1961.
  48. Parsons T. *The social system*. Glencoe IL: The Free Press: Ch. 10, 1951.
  49. Patton MQ. *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage, 2002.
  50. Patton M. *Qualitative evaluation and research methods* 2nd ed. Newbury Park: Longma Publications, 1990.
  51. Phiri C, *et al*. Corruption-Violence against Women in Zambia and Lesotho Correctional Facilities of Abettors and Heroines. *International Journal of Research and Innovation in Applied Science*. 2023; 3(6):70-76.
  52. Phiri C. The Social Act of Exchange in Power Relations: The study of the Phenomenon of Nichekeleko at the Weighbridges in Zambia. *Sociological Review / Revue Africaine de Sociologie*. 2017; 21(2):100-114. Published by: CODESRIASable URL: <https://www.jstor.org/stable/10.2307/90018699>JSTOR
  53. Phiri C. Internal strategies and mechanisms for combating corruption during the Covid-19 pandemic in Zambia: A linguistic turn. *Journal of Anti-Corruption Law*. 2021; 5(1):23-40.
  54. Phiri C. Internal strategies and mechanisms of combating corruption: The Nolle Prosequi phenomenon in Zambia. *International Journal of Advanced Multidisciplinary Research and Studies*. 2022; 2(4):188-193.
  55. Phiri C, Kandondo CS. Exploring and Deconstructing the Chimbuya Phenomenon at the University of Zambia in the School of Education: Lecturer's and Learner's Perspectives. 2021; 8(11):40-53. Doi: 10.20431/2349-0381.0811006
  56. Pleck JH. *The myth of masculinity*, 3rd Ed. M.I.T. Press, Cambridge, MA, 1987.
  57. Powell-Griner E, Anderson JE, Murphy W. State and sex specific prevalence of selected characteristics - behavioural risk factor surveillance system, 1994 and 1995. *Morbidity and Mortality Weekly Report, Centres for Disease Control, Surveillance Summaries*. 1997; 46(3)1-31.
  58. Schofield T, Connell RW, Walker L, Wood J, Butland DL. Understanding men's health and illness: A gender relations approach to policy, research, and practice. *Journal of American College Health*. 2000; 48:247-256.
  59. Slesinski MJ, Subar AF, Kahle LL. Dietary intake of fat, fibre and other nutrients is related to the use of vitamin and mineral supplements in the United States: The 1992 national health interview survey. *Journal of Nutrition*. 1996; 126(12):3001-3008.
  60. The Lancet. Time for creative thinking about men's health. *The Lancet*, 2001, 357:1813.
  61. UN-HABITAT. *Enhancing urban safety and security global report on human settlements 2007 United Nations human settlements programme*. University Press, 2007.
  62. Van Manen M. *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Ontario, Canada: Althouse Press, 1997.
  63. Verbrugge LM. Unveiling higher morbidity for men: The story. In: Riley, M.W. (Ed.), *social structures and human lives*. Sage Publications, Thousand Oaks, CA, 1988.
  64. Verdonk P, Seesing H, De Rijk A. Doing Masculinity, not doing health? A qualitative study among Dutch male employees about health beliefs and workplace physical activity. *BMC Public Health*. 2010; 10:712.
  65. West C, Zimmerman DH. Doing gender. *Gender and society*. 1987; 1(2):125-151.
  66. West C, Zimmerman DH. Doing Gender. In Judith

- Lorber and Susan A. Farrell (Eds.). *The Social Construction of Gender*. Newbury Park, CA: Sage, 1991.
67. Wills TA. The helping process in the context of personal relationships. In S. Spacapan and S. Oskamp (eds.), *helping and being helped: Naturalistic studies*. Newbury Park, CA: Sage, 1992.
68. Williams JE, Best DL. *Measuring sex stereotypes: A multination study*. Sage Publications, Thousand Oaks, CA, 1990.
69. Williams SJ. Parsons revisited: From the sick role to...? *Health*. 2005; 9:123-144.