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Why do men often not use condoms in their relationships with casual sexual partners in Uganda?

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Abstract

With a focus on Uganda, this paper examines men's condom use in sexual relationships with casual partners and what this might tell us about men's vulnerability to HIV-infection. We carried out repeat interviews with 31 men attending a clinic serving women at high risk for HIV infection and their partners in Kampala. We found that the experience of condom-less sex in the men's youth, itself the outcome of a restrictive home-environment, was perceived as influencing later unsafe sexual behaviour. Peer pressure encouraged men to have multiple partners. Alcohol negatively affected condom use. Men often opted not to use a condom with women they thought looked healthy, particularly if they had had sex with the woman before. Some men who were HIV-positive said they saw little point in using condoms since they were already infected. A concerted effort is required to reach men, like those in our study, to halt HIV and the transmission of other sexually transmitted infections.

Keywords: condoms, HIV prevention, sex, relationships, Uganda

Introduction

The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections (UNAIDS 2009). In spite of this, the use of the male condom among men who have sex with casual partners, including female sex workers remains inconsistent in some settings (Foss et al. 2007). In a Ugandan study on condom use among female sex workers it was established that the most common reason for inconsistent condom use was client preference (Bukenya et al. 2013). While this may not be a novel finding considering that similar preferences among clients of female sex workers have been reported elsewhere (Wee et al. 2004; Vanwesenbeeck 2001; Scorgie et al. 2012; Barrington and Kerrigan 2014; Sileo et al. 2015), it is notable that the reasons for such preferences and lack of consistent condom use, have not always been well documented.

Despite the fact that over 70% of HIV transmissions worldwide are between a man and a woman (Higgins, Hoffman, and Dworkin 2010), programmes and interventions have often overlooked structural factors engendering men's vulnerability to infection (Sayagues 2003; Nzewi 2012; Higgins, Hoffman, and Dworkin 2010). While there are notable exceptions that demonstrate that successful safer-sex interventions can work with groups of men living with HIV (Lynch, Brouard, and Visser 2010; Wyrod 2011; Kageha Igonya and Moyer 2013; Colvin, Robins, and Leavens 2010) many interventions have focused on women because of their vulnerability to HIV infection due to biological factors and men's sexual and social control of women (Gray et al. 2005; Krishnan et al. 2008 ; Nzewi 2012; Pulerwitz et al. 2010; UNAIDS 2012). Higgins and colleagues (2010) propose what they term the *vulnerability paradigm* as the model for understanding how and why contemporary literature and policy have tended to ignore men who have sex with women, while men who have sex with men have been the focus of significant research attention over the last decade (Sanders et al. 2007; Lane et al. 2008; Ntata, Muula, and Siziya 2008; Beyrer et al. 2012). Tracing the historical antecedents of current thinking, Higgins and colleagues note that the portrayal of women in HIV-related research and policy has evolved over the last three decades: women, particularly sex workers in East Africa, were initially viewed as vectors of the virus (Serwadda et al. 1985; Kreiss et al. 1986). The perception then was of women as the transmitters in the HIV epidemic, and therefore, that they were to exercise agency, through insistence on condom use, and minimise the spread of HIV. Heterosexual men have in some instances been overlooked by both HIV research and prevention initiatives (Exner et al. 1999; Nzewi 2012; Higgins, Hoffman, and Dworkin 2010). Pertinent to this present paper is the lack of visibility of a key population of heterosexual men who have sex with female sex workers as evidenced by their conspicuous absence from the World Health Organisation's definition of vulnerable populations (WHO 2013).

From the studies that have focused on heterosexual men and risk it is apparent that certain forms of masculinity and structural forces such as class and race can promote men's HIV-related risk (Harrison et al. 2006; Bowleg et al. 2011; Wyrod 2008), especially when these forces interact. Furthermore, dominant forms of masculinity has been associated with men's poor help-seeking behaviour (Addis and Mahalik 2003; Galdas, Cheater, and Marshall 2005), and delayed access to HIV testing and care (Erwin et al. 2002; Bwambale et al. 2008; Mills et al. 2012). Group male peer norms that might appear to encourage condom use have not always resulted in actual use; that is if such discussions happen at all (Fleming et al. 2014;

Barrington and Kerrigan 2014). Additionally, men with mobile livelihoods may engage in risky sexual behaviour while away from home (Deane, Parkhurst, and Johnston 2010).

Our purpose in this paper is to explore a specific area of risky sexual behaviour: men's condom use in their casual sexual relationships, including with female sex workers, and what this might tell us about men's vulnerability to infections, including HIV, and possible implications for policy.

Theoretical orientation

In the light of the growing body of literature showing that health outcomes are influenced more by the environments within which individuals live and less by individual behaviour (Krieger 2001; Feldacker, Ennett, and Speizer 2011; Busza et al. 2012), we adopted the social ecological model as a theoretical framework for analysis. While there are several variants of this theory, we adopt the version proposed by Busza et al. (2012), which features five interdependent levels. The first level refers to individual influences on behaviour, including risk perception, self-efficacy, and biological and personal history factors that may minimise or heighten the probability of engaging in risky behaviour. The second level comprises of peer and family influences. The nature of an individual's relationship with their closest social peers, partners and family members influences their risk-taking behaviour. At the third/community level, individual behaviour is influenced by cohesion and empowerment, social networks and stigma. The fourth level refers to the sociocultural environment. Here, influences on individual behaviour include gender norms, healthcare delivery practices, religion, and health beliefs. In the fifth and overarching context, health behaviour is influenced by the health system and infrastructure, and the national laws and policies. While individuals operate within these structures, their choices are made based on their motivations and interests which affect the options they see as being available and/or desirable (Barnett et al. 2015). The different levels of structure and the ways in which individual agency is played out are, of course, intimately linked. While, for example, the broader social-cultural environment may shape knowledge and expectations, sexual behaviour is often influenced by more immediate social relations (Kippax et al. 2013), in the case of this paper the relations among groups of men, and between those men and the women they have sex with, with different choices being made by individuals at different times and places.

Methods

Qualitative data were collected from 31 male partners of women participating in a cohort of women at high risk of HIV-infection in Kampala, Uganda. Supplementary quantitative data were available for 80 male partners. The cohort study (also called the Good Health for Women Project or GHWP) started recruitment in 2008 with the aim of studying the prevalence, determinants and dynamics of HIV and STIs among women at high risk of infection in southern Kampala. In 2011, the cohort was expanded to include the regular male partners of the women accessing the clinic, these men attended on the invitation of their female partner. Most women and men accessing the clinic reside and work within the area south of Kampala. To date, there are over 2600 women and about 140 men who are actively accessing the clinic and also participating in research activities.

For this particular study, male participants were purposively selected from among those attending the clinic. Fridays are set aside for the male partners to come for treatment. A

member of the clinic team alerted the social science male interviewer whenever a man came in and the interviewer issued an invitation to each man to participate. Information was provided on the qualitative study which focused on their lives, including their past and present relationships. If the man consented to take part a date was set for the first interview. The definition of male partners was left to the woman who had invited them to the clinic to determine, but typically these were men who they resided with, had a child with or with whom they shared an emotional attachment.

The study was designed to interview these male participants at least three times with each interview building on the previous one. This tested approach (Mbonye et al. 2014) helped to create strong rapport. For the first interview, the participant was given the choice to select the location of the interview, typically these happened in a convenient location within the study area. Subsequent interviews took place at the social science offices within the GHWP premises since the room available was private and secluded. Emphasis on confidentiality was stressed before and during each interview. A topic guide covering themes such as history of sexual relationships, condom use, mobility, health seeking behaviour and livelihood history was used to guide data collection. Interviews typically lasted between one hour and one hour and a half.

The interviewer discussed each interview with other members of the research team (co-authors on this paper) and an agreement was reached as to how to feed into the next interview to ensure that issues arising were exhaustively investigated. Since tape recorders were not used, because the men were uncomfortable about having their voices recorded, notes were made during the interview and a detailed account written up immediately after the interview. All interviews and other materials related to a given participant were compiled in one file. All personal identifiers were excluded from the scripts. Each man was assigned a number. The interviews were then typed into word documents and translations were made (one interview was in English all the others were in the local language, Luganda). The scripts were then read and re-read to identify patterns that portrayed risk taking behaviours, with specific attention for the purpose of this paper given to condom use and reasons for non-use. The choice of the social ecological model as a useful framework to shape our analysis emerged from this inductive analytical process.

Quantitative data on all clinic participants were collected by the clinic staff at each visit using standardised questionnaires on demographic (age, marital status) and socioeconomic (educational attainment, religion) characteristics, and self-reported sexual behaviour (including condom use). All participants were tested for HIV.

Quantitative data were double entered into an MS Access database. These data were then checked and cleaned before being imported into SPSS 16 for Windows to generate summary statistics, frequency tables and cross tabulations to provide background information on the men attending the clinic for this paper.

Ethical approval was obtained from the Uganda Virus Research Institute science and ethics committee and from the Uganda National Council for Science and Technology. Participants were offered a transport refund of 5000 Uganda shillings (about US \$2) and a bar of laundry

soap for the time spent at each interview. Pseudonyms are used in this paper for the participants quoted or described.

Results

The men were aged between 25 and 57 years. A little over half of them (16) freely disclosed to the interviewer that they were HIV positive (they were not asked for this information). The men's occupations included construction work, local produce vending, motorbike taxi riders (commonly termed as *bodaboda*), casual labouring (truck loader), driving vehicles for businesses and DJ services (hired to play music in night clubs and other related functions). The characteristics of these 31 men were similar to the 80 men for whom quantitative data are currently available, given in Table 1 below:

Table 1: Study sample characteristics (N = 80)

Characteristics	number	% (rounded up)
Religion		
Roman Catholic	32	40
Protestant Anglican	17	21
Protestant Born Again	4	5
Muslim	26	33
Traditional African	1	1
Highest formal school education obtained		
Never went to school	3	4
Started but did not complete primary level	27	34
Completed primary level	12	15
Started but did not complete ordinary secondary level	12	15
Completed ordinary secondary level	13	16
Started but did not complete advanced secondary level	2	3
Completed advanced secondary level	7	9
Completed any tertiary level (university or other)	4	5
Current marital status		
Married (only one wife)	50	63
Married (more than one wife)	18	23
Widowed	1	1
Separated/Divorced	9	10
Single/Never Married	2	3
HIV status		
HIV Positive	26	33
HIV Negative	54	68

Sixty three percent of the male partners interviewed using the quantitative questionnaire reported having one marital partner, 23% said they were in a polygamous marriage. Half of the men said they had two to three 'extra' partners, and 79% of these reported not to have used a condom with these partners the last time they had sex. While the woman who had invited them to the clinic had been recruited into the cohort primarily due to her categorisation as being involved in high risk behaviour for HIV infection, 77% of the 80 men

said that they never used condoms with their regular partner. The main reason given for not using condoms with their regular partner was because they trusted this partner (35%). Others reported not using condoms because they did not think about them (14%) while a similar proportion simply preferred sex without condoms. Of those who had more than one partner, about 35% were HIV positive while among the HIV negative male participants with more than one partner, 56% reported having never used a condom the last time they had sex.

The men participating in the qualitative interviews mentioned higher numbers of casual partners than in the quantitative findings. The difference in reporting might suggest some social desirability bias when men answered questions about sex and relationships for clinic staff. Below we present the reasons given during the qualitative interviews for why men often do not use condoms in their casual relationships.

Historical factors including those related to community upbringing

Almost all 31 men started sex without proper knowledge about condoms. Indeed the social environment in which some of the men grew up, particularly in rural areas was disapproving of young people engaging in sex and of promiscuity in general. This made access to condoms very hard either due to the unavailability at local shops or through a restrictive environment for young people who were expected to wait until maturity or marriage before engaging in sex. As a result, many young people hid their sexual activity from their elders. However, 21 out of the 31 men engaged in sex as teenagers, with some starting as early as thirteen years old. One man recalled his first sexual encounter in a context where condoms were unavailable:

By that time condoms were scarce and I did not think of anything about HIV/AIDS. I would fear kabotoongo (syphilis). In the villages shop keepers used not to stock condoms because they had an opinion that condoms would encourage more people especially the young generation to indulge in sex. (Michael, 36 year old, businessman, status unknown [to the interviewer]).

Another respondent shared a similar experience from the early years of the HIV epidemic:

I did not go through any kind of screening or testing. Neither did I use condoms then and the reason is that condoms had not yet come to our area and I even did not think about using them. (Henry, 46 year old builder, HIV positive).

For the majority of men, the first sexual encounter was characterised by a lack of condom use and there was a general feeling that they were 'learning on the job' especially in cases where the female partner was sexually inexperienced as well, which was typically the case. This behaviour was carried on into adulthood. The men continued to prefer sex without a condom, as illustrated in the narrative from one of the men below.

I started having sex at the age of 17 years when I was in senior five. I had sex with a fellow student in a certain lodge and we never used a condom. I learned about sex through

watching blue movies [pornographic films] and through peers...after that I became sexually active, and began having sex with other women I got on the streets [sex workers]. I would use condoms with some but not with all. If a woman asked for them I would use them, but if she happened not to talk about condoms, I would have unprotected sex (John, 33 year old, DJ, HIV positive).

One man had not wanted to use a condom with a girl who he thought was a virgin but the girl insisted on the use of a condom. However he said that the condom accidentally broke while they were having sex and both noticed this after the sex act. Subsequently he saw no need to use condoms, since there was nothing to protect himself against anymore.

Once you have unprotected sex with a woman it may not be easy again to wear a condom with her. When I met different women including sex workers, I could use them [condoms] as long as they asked for them and those who never asked for them I did not bother. I feared getting infected but ignored them [condoms] because of the pleasure I wanted (Charles, 25 year old commercial motorcycle rider, HIV status unknown to the interviewer).

In another case, when a man suspected that his wife was involved in sex work, he did not choose to use condoms:

I do not use condoms with her [wife] because I see no reason for condom use now. The first time we had sex, we just ended up having it unprotected and ever since then, I have never used a condom with her again. On the other hand, I do not trust her at all as she goes out to work during the night and returns late in the night. (Ali, 26 year old builder, HIV positive).

Masculinity and peer influence

Of the 31 men participating in this study, 10 men claimed to have only one partner; the rest had more than one, with many having several casual partners alongside their wife. One man in fact argued that managing more than one woman at the same time was evidence of how much stamina he had, and this was prestigious among his male peers. Such prowess was a sign of masculinity demonstrating male power, strength and dominance over females and the impact this had on men's behaviours and attitudes. Another man justified sex with multiple partners as being a right that has been conferred upon men:

`. . . Omusajja wa ddembe okusajjalata,' (translated this means that `a man is free to engage in sex with several women') (James, 36 year old local produce vendor, HIV positive).

Closely related to this was peer influence which promoted sexual encounters without condoms. When they were young there had been pressure on the men to engage in sex as soon as possible in order to fit in. The sexually inactive felt compelled to conform to group expectations lest they were stigmatised as socially and sexually inadequate. A popular topic among men was how and where to socialise and where they could have easy access to alcohol and women, mostly sex workers, as illustrated below:

While in the bar, I made sure that I bought for her alcohol such that in the end I could just take her to the room. I asked her what type of beer she takes and she told me that she

takes Club [a brand of beer]. I ordered three bottles for her and one bottle of Pilsner lager for myself, It was around 7pm when I told her to go in the room and have a rest, she first resisted and she was saying that she wanted to go back home. I paid for the room and seeing that she was hesitant, I held her hand and forced her inside, closed the door and removed the key and put it in my pocket. She soon relaxed but asked whether I had a condom and I said I did not and she asked me to get condoms. I got a packet of life guard condoms. In the act of having sex the condom burst but I did not know what caused it to burst. After ejaculating I realized that it was broken and I told her that the condom got broken. I did not fear HIV because she looked healthy, was smart and had no scars on her body. We continued engaging in sex for the next two months and within that period we had sex like five times and I used to pay her after sex.... These subsequent times I never used condoms after all there was nothing to protect because the condom burst the first time and I saw no reason to continue with them. (Charles, 25 year old commercial motorcycle rider, unknown HIV status).

In addition to alcohol being associated with improper condom use and failure, several men blamed alcohol for inducing a false sense of bravery.

I did not use condoms much because of the alcohol I used to take. The whole problem is brought about by alcohol because once you have taken alcohol, you are not afraid of anything. (Isaac, 28 year old casual worker, HIV positive).

Another man noted:

I did not use condoms consistently with all of them. I used condoms with some of them, and all this was due to the alcohol I used to take. (Samuel, 25 year old employed, HIV positive – said he was in a discordant relationship)

Profiling HIV positive and negative persons

Men's decision whether or not to use a condom was sometimes informed by the socially constructed profile of how an HIV positive and a HIV negative person looked. According to informants, the absence of physical bodily signs signalled good health and absence of the infection. The men claimed to be reasonably confident in their ability to determine who was infected and who was not. This influenced whether or not they chose to use a condom.

One time that woman called and invited me to her home. After lunch I demanded for sex and she allowed. She gave me a condom and I asked her why she was giving me the condom and she told me that she was protecting herself from any STI including HIV. I told her that I was normal [but he had not tested at that time]. My body had no sign of having HIV/AIDS and I felt strong. The woman looked very healthy and her skin was smooth, she seemed not to have HIV.... (Charles, 25 year old commercial motorcycle rider, HIV status unknown to the interviewer).

This perceived skill was brought to bear usually when there was an unexpected opportunity for sex. But the men also drew on this skill in determining an individual's HIV status to manage moments of crisis, for example when a condom broke during sex. In such cases these men consoled themselves by determining that their partners were not HIV positive since they did

not exhibit certain perceived bodily signs of what they thought was a 'typical HIV positive person'. One participant sums up the general perception of men regarding physical appearance as a sign of HIV infection or the absence of it:

When men look at a woman who is smart [term used to describe a healthy looking person without any visible signs of illness on the body] and looks healthy, they may think that she is not infected yet she might be on drugs. (John, 33 year old man, DJ, HIV positive)

Sex as more pleasurable without a condom

Having compared the difference between sex without condoms and sex with condoms, the men all said that the former was clearly much better and for some worth the risk. Many men said that they hoped that the female partner would not request a condom, even when the female partner was a known sex worker. Men who engaged in paid sex said that they did not press for condoms and left it to the woman offering sex to insist on condom use. Usually the male client made the final decision on use. Even when they used condoms for the first sexual encounter, it was likely that the man would abandon the condom in subsequent sexual encounters with the same woman. One man talked of his sexual conquests around the country. His story highlights his decision-making processes:

Ali [not real name] dropped out of school when he reached primary seven because his family could not afford school fees. Having grown up in a rural environment, he never saw himself making it unless he moved to Kampala, the capital city, which he thought would offer better opportunities. Ali's wish of moving to Kampala became a reality when he secured work on a construction site with the help of a relative. He enthusiastically immersed himself in the social activities of the other builders whose main pre-occupation after work was talking about sex and previous experiences with female sex workers. This job required him to move quite often and spend many days and weeks away from his home. He now has a regular partner who stays in Kampala, but having embraced the culture of purchasing sex, Ali is driven by the desire to have as many women as possible. This is because whenever he moves to a new area of Uganda, he spots women who he feels might be different from those he left in another area and the urge to have sex becomes intense just to experience the difference. He justifies his action because he doesn't trust his partner in Kampala. Ali has not been keen on condoms and only uses them the first time he engages with a sex worker, which is his regular pastime activity. Thereafter, if the woman strikes him as satisfactory and beautiful he will have repeated sexual encounters with her, and will not use condoms. At times, he says, it is at the insistence of the woman that he removes the condom but usually he is the one who dictates whether condoms are to be used or not. But above all, it is the pleasure of unprotected sex with a beautiful woman that motivates his insistence on not using condoms. (Ali is a 26 year old builder, HIV positive, this narrative is drawn from the interviewer's notes).

For Ali and several other men whose work involved travel to other areas of the country and beyond, travelling presented an opportunity for sex with 'new' women. As Ali suggests, travelling from a home area to new unfamiliar areas offered a man an opportunity to experience difference, not just spatially but more importantly, in terms of the women he expected to meet. Our study findings show that the desire to experience the difference was a key motivation in men's efforts to establish new sexual partnerships in areas away from

home. With regard to the risk of HIV-infection this behaviour was exacerbated by the men's disinclination to use condoms.

Complacency and denial

Participants were keenly aware that multiple sexual partnerships put you at high risk for HIV infection. This was exhibited in the doubts they expressed over their own HIV status, given their history of such partnerships, especially for those who were experiencing on-going illnesses but had tested HIV negative in the recent past. Yet despite this awareness 21 of the 31 men said they were involved in multiple relationships, and several regularly paid for sex while on their travels.

I have used condoms with only two women [female sex workers] whom I found in the western part of Uganda but the rest I go without condoms. For these two women, I was prompted by their insistence to use them and I would have had unprotected sex with them if they had not talked about condom use. (Michael, 36 year old business man, HIV status unknown to the interviewer).

Even when men were already living with HIV, or told the interviewer that they suspected that they were HIV-positive, they often preferred sex without a condom. To these men, it was pointless to protect yourself from a disease you already had and they displayed a general disinterest in HIV testing or in asking about the HIV status of their partner (with many believing that female sex workers were already living with the infection). Many men had preferred to wait until the signs and symptoms showed rather than take a test when their body was still strong (indeed it was often when a man became sick that their regular partner referred them to the clinic).

Discussion

Men's inclination towards sex without a condom, or more broadly, men's risk perception and behaviour, were heavily influenced by the behaviour of others and their knowledge and beliefs they hold about risk. The family and peer environment play an important role in shaping boys' attitudes and behaviours, which are carried over and reinforced in the broader social environment as a boy transitions into adulthood. These findings feed into the broader literature on the influence of the social environment on individual behaviour (Krieger 2001; Feldacker, Ennett, and Speizer 2011; Busza et al. 2012).

As they grow up, the men in our study reported internalising masculine norms and expectations, and an attendant sense of entitlement to multiple sexual partners. In fact, many men seemed disinclined to use condoms because they perceived the practice to be incompatible with the masculine values of male power and strength. This is consistent with observations from earlier studies where similar masculine attitudes of independence and resilience (Siu, Wight, and Seeley 2014), and the associated ideology of *reputational masculinity* (Siu, Seeley, and Wight 2013) were found to affect men's health seeking practices. These masculine attitudes and norms are further reinforced at the broader societal level. Our study builds further on research on the social environment (Krieger 2001; Feldacker, Ennett, and Speizer 2011; Busza et al. 2012) in shaping men's HIV risk behaviour by normalising such sexually risky practices including a preference for sex without a condom (Stutterheim et al. 2013; Flood 2003; Sileo et al. 2015).

While some commentators have shown that male support groups can reinforce safer-sexual behaviour (Colvin, Robins, and Leavens 2010; Kageha Igonya and Moyer 2013; Wyrod 2011, 2008) we found that peer influence may engender men's HIV vulnerability by encouraging the men in our study into high HIV risk behaviour, such as involvement with female sex workers among whom HIV prevalence has been found to be as high as 37% (Bukonya et al. 2013). This is especially so where alcohol consumption is involved, as other studies have found (Winskell, Obyerodhyambo, and Stephenson 2011; Scorgie et al. 2012; Mbonye et al. 2014; Sileo et al. 2015).

Some of the men, having had a history of multiple sexual encounters without a condom, and with no noticeable problems in the past, saw little point in using condoms in their adult lives. Yet even for those men who were in poor health some were not motivated to use condoms with casual partners since they considered that they were already infected, particularly female sex workers. A study in South Africa showed that changing such established gender roles and perceptions might not be straightforward. HIV positive men attending a support group failed to initiate condom use with female partners with whom they had never used condoms previously. And with the reluctance to disclose HIV sero-status, this increased the chances of infecting their female partners (Mfecane 2013).

Our study findings suggest that information from the long history in Uganda of mass awareness campaigns has not affected these men's behaviour. Men made different choices on condom use depending on their potential partner and the place of their encounter, often using socially constructed profiles of HIV positive and negative persons in determining the HIV status of potential sexual partners. This assessment influenced the decision not to use a condom where they considered that the potential partner was HIV negative. Thus, while the socio-cultural environment and local norms influenced men's behaviour, what happened in any single sexual act was influenced by the assessment of the potential partner. For example, the pursuit of sexual pleasure in an uninhibited manner, that is, without a condom, with women in areas away from home because of the expectation that these women were different, exacerbated men's vulnerability. Our findings echo those from other studies, which also associate such masculinity-driven attitudes with poor health seeking behaviour and poor condom use (Shai et al. 2012; Stutterheim et al. 2013; Wyrod 2008; Sileo et al. 2015).

We acknowledge a number of important limitations to this research, not least the relatively small sample of men from whom we collected detailed information, and that this study was conducted in one area of Kampala. While some commentators may see our lack of recorded data as a limitation, this is not our view. In our study setting, many participants are suspicious of recordings and this in our experience affects the information they are willing to share. Skilled interviewers, who construct detailed accounts of their conversations from their notes, are able to put interviewees at ease and collect very detailed information.

We propose that future HIV policy interventions need to target heterosexual men as one of the key population groups, principally for three reasons: 1) that these men have received less attention, and that when they are targeted for interventions they have been viewed as a proxy for improving the health of their female partners (Hawkes and Hart 2000), 2) that the

drivers of ill-health – particularly masculinity – impact not only men but women as well, and therefore that interventions aimed at undercutting the impact of these structural drivers would benefit both men and women – this echoes Hawkes' (1998) observation that failure to include men as a target group for service provision may generally render unattainable the objectives of STI control programmes, and 3) that one of the main premises upon which men have been ignored, that is, the futility of changing men's sexual behaviour, has been challenged by studies which confirm that masculine behaviours and attitudes can in fact be changed (Barker, Ricardo, and Nascimiento 2007; Watts and Seeley 2014; Colvin, Robins, and Leavens 2010).

At policy and programme level, we therefore advocate programmes and interventions that aim to transform gender roles and nurture gender-equitable relationships between men and women (Barker, Ricardo, and Nascimiento 2007). Similar interventions for men that focus on HIV and reproductive health have been found to be more effective than gender-neutral ones, which generally do not pay attention to the unique needs of men in comparison to those of women (Higgins, Hoffman, and Dworkin 2010). Moreover, an earlier systematic review of behavioural interventions targeting men (Elwy et al. 2002) showed that such interventions had a positive impact on men's behaviour.

Additionally awareness campaigns could be designed to boost HIV-related literacy particularly among men, and be delivered by trusted information gatekeepers from within the community. Such interventions might significantly reduce men's reliance on socially constructed profiles of HIV positive and negative persons in determining the HIV status of prospective partners. After 30 years of the HIV epidemic in Uganda a concerted effort to reach men, like those in our study, is needed to halt rising HIV incidence in some sectors of the population (Kiwanuka et al. 2014; Lindan et al. 2014).

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