Social Science & Medicine 296 (2022) 114742

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Marginal men, respectable masculinity and access to HIV services through intimate relationships with female sex workers in Kampala, Uganda

Martin Mbonye [a,b,*], Godfrey Siu [a,b,c], Janet Seeley [b,c]

[a] Makerere University, College of Health Sciences, School of Medicine, Child Health and Development Centre, Uganda
[b] MRC/UVRI and LSHTM Uganda Research Unit, Entebbe, Uganda
[c] Global Health and Development Department, London School of Hygiene and Tropical Medicine, London, UK

ARTICLE INFO

Keywords:
Masculinity
HIV
ART
Intimate partners
Female sex workers
Uganda

ABSTRACT

Masculinity influences men's sexual risk-taking behaviour and affects uptake of HIV services. We draw on data from a year-long (2019) ethnographic study focusing on men in relationships with female sex workers (FSW) in Kampala, Uganda to examine how and why two marginalised groups of people may interact to produce positive health behaviours. Data from in-depth interviews, focus group discussions and participant observation were collected and analysed. We discuss three main themes; the first of which focuses on marginalised masculinities and HIV risk. In this theme we show how accounts of men's life trajectories portrayed a remarkably similar pattern of early deprivation of opportunities and how this shaped construction of risky masculinities. The second theme describes men's relationships with FSW and how this facilitated access to HIV services. We discuss how very marginal women (FSWs) help very marginal men adopt more positive health behaviours. We show how threats to masculinities arising from sex work stigma, men's failure to have exclusive sexual rights over their FSW partner, and men's economic disadvantage are negotiated and dealt with to create an enabling environment for men's uptake of HIV services. The final theme focuses on the positive and negative practices of the men after engaging with HIV services. We conclude that the two marginalised groups can mobilise and combine new aspirations to produce positive health behaviours manifested through FSW assisting their male partners to access HIV services. We suggest that this perspective opens up new opportunities for engaging with marginalised groups and tackling the problem of high HIV infection among key populations.

1. Background

New HIV infections have declined significantly in the general population in most parts of sub-Saharan Africa (SSA) in recent years, but there is limited progress among key populations (Barr et al., 2021). Key populations, which include men who have sex with men (MSM), injecting drug users, and female and male sex workers (M/FSW), are considered the main drivers of new infections in many parts of SSA (Jin et al., 2021). The mechanism by which FSW drive HIV infections and the particular risks and vulnerabilities they face are well documented in SSA generally (Ngugi et al., 2012) and Uganda in particular (Muldoon et al., 2015).

However, little attention is given to their male intimate partners (Schmidt-Sane, 2020). Male intimate partners and clients of FSWs make up an important 'bridge population' in HIV transmission sexual networks (Côté et al., 2004; Do Espirito Santo and Etheredge, 2005; Voeten et al., 2002), and generally tend to have higher sexually transmitted infections (STI) than other men in the general population (Patterson et al., 2009; Subramanian et al., 2008; United Nations, 2021). In Uganda, HIV prevalence among non-commercial male intimate partners of FSW ranges from 18% to 44% (Makerere University School of Public Health, 2010; Namale et al., 2020, Uganda AIDS Commission, 2019). Behavioural indicators are equally poor among non-commercial partners of FSW, with condom use especially low (Choi and Holroyd, 2007; Rutakumwa et al., 2015; Shannon et al., 2015; Wojcicki and Malala, 2001). This is largely attributed to macho sexuality that desires having body to body sexual contact (Campbell, 1997). Yet, despite these risks, male clients of FSW who become intimate partners have rarely been specific targets for HIV prevention interventions (Fleming et al., 2015).

Men and their FSW partners have expectations of each other as a

* Corresponding author. Makerere University, College of Health Sciences, School of Medicine, Child Health and Development Centre, PO Box, 6717, Kampala, Uganda.
E-mail address: mmbonye2019@gmail.com (M. Mbonye).

https://doi.org/10.1016/j.socscimed.2022.114742
Received 4 July 2021; Received in revised form 19 January 2022; Accepted 21 January 2022
Available online 24 January 2022

couple. They may expect faithfulness which is negotiated along some parameters agreed upon between the man and the partner in sex work (Warr and Pyett, 1999). They also share emotional ties of love and affection and like other couples, expect to start families (Syvertsen et al., 2015). When they start families they attain the respect associated with parenting and family building, which is a welcome departure from the shame of sex work (Haram, 2004). However, they must endure the social stigma or 'whore stigma' (Krüsi et al., 2016) that is commonly associated with sex work (Scambler and Paoli, 2008). In these relationships, the men have to contend with the degrading reality of sharing their woman with other men (Huynh et al., 2019). This threatens men's masculinities which may lead to violence (Sileo et al., 2018a, 2018b), or other forms of compensatory practices such as getting other sexual partners to reassert their threatened positions (Ezzell, 2012).

Men who endorse dominant norms of masculinity tend to engage in poorer health-related behaviors (Courtenay, 2000). Hegemonic masculinity is often implicated in men's poor health seeking behaviours. Hegemonic masculinity has been conceptualised as the pattern of practices (often involving the exercise of power) that sustain men's dominance over women and other men (Connell and Messerschmidt, 2005). It is a frame used by individual men to judge their success as a man. Connell (2016) suggests that masculinities are hierarchical and that men, in exercising their masculinity can take up positions that are complicit, subordinate or in opposition to hegemony (Messerschmidt, 2018). The theory of hegemonic masculinity emphasizes that masculinities are multiple, diverse and fluid. Hegemonic masculinity relates with other forms that are non-hegemonic by subordinating or marginalizing them (Connell, 1995). Some practices are considered to be important signifiers of hegemonic masculinity, such as heterosexuality, which plays a part in the sustenance of the female sex work industry (Hammond and van Hooff, 2020).

Describing the social structure of life in the Caribbean, Wilson (1969) introduced the concepts of reputation and respectable masculinities. These two concepts offered a way of framing the behaviours which shaped men's relationships and determined how men conducted themselves in the society. Reputational masculinities referred to the ways in which men show themselves to be tough and defiant of authority, using sexual prowess, including the ability to make women pregnant and have many children, as a way to show one's manhood and strengthen one's reputation in the eyes of peers. Respectability, according to Wilson, was the degree to which men conformed to the widely endorsed value systems of being a good man. This included working hard, getting married, taking care of one's children and generally being economically independent. The two value systems are not mutually exclusive and can be performed at the same time depending on the context (Siu et al., 2013). Both respectable and reputational masculinities are embedded within hegemonic masculinities in showing different facets of male domination in society. Attaining a respectable form of masculinity may not be easy for men who are unable to earn an income, afford to marry or who are otherwise socially disadvantaged. Such men struggle to gain the respect of society and may instead claim their status as a man by using reputational masculine practices, often displaying negative aspects of hegemonic masculinity (Silberschmidt, 2001).

Health beliefs and behaviours are shaped by masculinity, particularly facets of reputational masculinity, as evidenced by men's tendency to adopt behaviours that increase their risk and delay their uptake of HIV services (Mahalik et al., 2007). Courtenay (2000) offers a relational framework for understanding men's health from the perspective of masculinity. The processes and practices that present men with social power and status also tend to undermine their uptake of health services (Skovdal et al., 2011, Siu et al., 2013), particularly so where health systems are viewed as feminine spaces (Courtenay, 2000). However, although men may be largely described as poor health seekers, there are many that challenge this notion (Jobson, 2010).

In the context of SSA, colonialism, regional conflicts, rapid urbanisation and HIV have combined to shape the type of masculinities that are prevalent in the region (Ouzgane and Morrell, 2005, Seeley, 2015), and how these affect uptake of HIV services. African masculinities have often been presented as uniform, yet they are multiple, fluid and change in the face of adversity (Ratele, 2008). Male dominance has been emphasized in descriptions of African masculinities with this dominance at times maintained through violence (Broqua and Doquet, 2013). In terms of health seeking, the HIV epidemic brought into sharp focus the role that some aspects of masculinities played in sustaining infections and the impact of poor uptake of health services (Sileo et al., 2018a, 2018b; Fleming et al., 2019; Colvin, 2019). Wyrod (2016) describes three aspects of masculinity in an Ugandan urban setting: maculinity and work, masculinity and men's authority over women, and masculinity and sexuality, that shore up hegemonic masculinity (Kippax and Niamh, 2012).

In this paper we expand on the literature on masculinity and men's uptake of HIV services in an African city setting. In particular, our focus on men in relationships with FSW, contributes to the widening of our understanding of FSW and HIV transmission dynamics (Lancaster et al., 2016). Specifically we depart from the focus on marginalised masculinities as sources of negative health outcomes and show how women, who are marginalised by their place in society as FSW, can be agents of positive health change for their male partners. We explore the uptake of HIV services from the perspective of men in relationships with FSW both of whom face social and economic marginalization. We suggest that this perspective opens up new opportunities for engaging with marginalised groups and tackling the problem of high HIV infection among key populations.

2. Study setting

The study took place in two suburbs of Kampala where the participants spent their time. Kampala, the capital city of Uganda is divided into 5 major divisions that share similar characteristics in terms of social economic status and population dynamics. Most of the economic activities are concentrated along the main roads which link one suburb to another. Most people in these communities engage in informal social economic activities some of which are divided along gender lines. For example, hair salons, restaurants, market work are dominated by women while commercial motorcycle riding (boda-boda), taxis, factory work, sports betting, motor vehicle repair workshops and security are male specific. Most residences where the participants stayed were low cost, single rooms locally known as *mizigo* which besides being close to each other, are not properly planned. Drainage and sanitation are a challenge with almost all the residents of these *mizigos* having to rely on shared latrines. Dirty water and rubbish flow through the poorly constructed drainage channels, especially during the rainy season. The population in these popular places is very dense due to the affordable housing. In the evenings, loud music playing from makeshift bars, dance clubs and restaurants, can be heard. This attracts men and women who gather to consume alcohol as the night progresses. Sex workers position themselves in dark alleys and bars to attract revellers. Various scattered guest houses, lodges and brothels offer venues for sex work. Most of the men in this study were from low-income backgrounds just like many of the others in the setting. They had started their relationships with FSW after regularly meeting in the bars or night clubs and paying them for sex. Most of the urban residents also had village homes where their extended families stayed and whom they visited whenever they could.

3. Methods

3.1. Study design, participants, and process

We conducted this ethnographic study between January and December 2019. The main participants of the study were men who were in long term (more than 3 months) relationships with FSW attending a research and intervention project. This project, The Good Health For

Women Project (GHWP) is a longitudinal cohort that was established in 2008 targeting women at high risk of HIV and STIs for research and intervention purposes (Kawuma et al., 2021). In 2011, the GHWP was opened to the non-commercial male partners of FSW.

We briefed the FSW at the GHWP who said they had intimate male partners about this ethnographic study. We then asked them to inform their male partners about the study and obtained contact details of those men who were willing to be contacted. These were invited to the GHWP offices where they were briefed about the year-long study. About 50 men attending the GHWP were eligible to participate. We looked at the different characteristics of these and generated a list of categories that were representative of the group. These included categories such as HIV status, age, duration of the relationship with FSW and period of membership at the GHWP. Using these variables, we purposively selected seven men who agreed to participate in the study. We then proceeded to select another category of male partners not attending the GHWP. The FSW partners of these men were requested to inform us whenever a male partner expressed interest to participate. We would then set up a meeting with the man at a mutually agreed location within their communities. These men were typically recruited whenever an opportunity availed itself and from this category we selected six men. Participant selection was conducted simultaneously with review of the emerging categories in the data to assess data saturation which we concluded happened by the time we had selected 10 men. However, we included 3 additional men who had initially been reluctant to participate but later showed interest, bringing the final sample to 13 men. The age range of the 13 men was 26–51 years and 7 of the men were living with HIV.

The first three months of the study were dedicated to rapport building given the sensitivity of the study population. During this period, the lead author organised with each man to meet and make observations of particular activities of relevance to the men. Such observations focused on the work they did, how they spent their leisure and how they interacted with their partners and peers. On average, the lead author visited each man's home at least 3 times during the rapport creation period. However, during field work, multiple observation visits to homes work places, leisure places, restaurants and the health facility took place. The lead author made appointments through phone calls but when sufficient rapport was attained, unplanned visits to homes of the participants were made. During the observation visits, there were informal conversations held with other members of the household. These conversations augmented the data collected through other approaches.

3.2. Data collection

After three months the lead author conducted the first in-depth interviews because by then rapport was well established. During the field work, acquaintances were made with men from the same community who shared the same interests and spent time with one of the main participants. It was later decided that a group discussion consisting of 8 men from the reference group be held to further generate useful insights related to the study purpose. Topics discussed focused on perceptions about male roles, HIV risk behaviour and uptake of HIV services. To avoid breach of confidentiality, we agreed with the men that we would not interview their FSW partners. However, an exception was made in two different cases where the lead author was granted permission to speak to the partner during home visits.

Conversations and interviews were always conducted in Luganda, the language spoken by most people in the study setting. Typically the lead author made brief notes during field observation visits and later detailed accounts were written and typed up as word documents.

It was agreed practice at the GHWP that the first in-depth interviews were not audio recorded in order to build confidence that privacy would be respected (Rutakumwa et al., 2020). The lead author recorded brief notes without disturbing the flow of the interview and then later expanded them. For the focus group discussion (FGD), consent was given for the use of the audio recorder. Later in the study, the lead author interviewed nine of the men a second time to probe for further information and capture any new perspectives. For the second interview, men consented to the use of audio recorders. Audio recorded interviews were transcribed, translated, typed up as word documents and stored in a password protected computer. We developed a flexible topic guide for the in-depth interviews and FGD.

3.3. Thematic analysis

The lead author read in detail all transcribed scripts, then summarized each case and shared the summary with the co-authors for discussions. After reading through the data to get a sense of what it was like, the authorship team then developed and agreed on a coding frame which contained the concept terms and the criteria used to identify them. This was followed by coding. After each stage of coding, the lead author discussed data segments that had been sorted and labelled representing a particular concept with the co-authors. These were later organised into themes capturing common, recurring patterns within the data. These themes were then organized in a thematic matrix generated on an excel sheet. We were guided by the systematic steps as outlined by Braun and Clarke (2006).

The School of Medicine, Research and Ethics Committee, Makerere University College of Health Sciences (#REC REF, 2017-155) and the Uganda National Council for Science and Technology (#SS 4849) approved the study. All participants offered written informed consent for in-depth interviews and FGD. The names used in this paper are pseudonyms to protect privacy. Conversations about sensitive information were held in private spaces and confidentiality was maintained and emphasized throughout the field work. Participants' first interviews were also not audio recorded in line with agreed practice at the GHWP in order to help the respondent feel at ease (Rutakumwa et al., 2020). Participants were reminded that counselling services were available in case the need arose during the field work period.

4. Findings

We report three broad themes that emerged from our analysis: First we explore how marginalised men navigate HIV risk across their life course. Secondly, we describe how relationships with FSW offer male partners a platform to engage in HIV services. Finally, we look at the men's lives after accessing HIV services showing how restored health can be a motivator and a challenge for maintaining the stability of the relationship.

4.1. Marginalised masculinities and HIV risk

Men's accounts of their life trajectories portrayed a remarkably similar pattern of early deprivation of opportunities. Shared interpretation of the consequences of chronological events in their lives shaped men's engagements with valued forms of masculinity in their communities and the nature of relationships they established with FSWs. Participants' accounts suggested a difficult early life characterised by deprivation, poverty and hardship. The families most of the men described were large and usually with little involvement from the fathers who often had multiple partners resulting in multiple 'mothers', each with their own set of children. Mothers bore the biggest parenting burden and received little financial support from fathers which affected the ability to finance education, leading to school drop-out. A combination of these circumstances led a number of young men to question their prospects of becoming successful as men. While they blamed their failure at this stage of their lives on their families, the young men knew that they needed to be resilient and tenacious if they were to turn around their future. The account told by John (aged 40), illustrates the experience of marginalised men and how they struggled to emerge out of the early challenges by drawing on activities that built their peer reputation:

> My life has really been dominated by problems […] I had to drop out (of school) around primary five because of no school fees. After this, I gained some skills in bicycle repairing which I did next. By then I was in the village and had never dreamt of moving […]. It was a very tough time then. [After move to Kampala] I never cared at that time because I was also drinking this crude waragi [a locally made gin] on a daily basis and spending a lot of time in entertainment places.

Both the economically marginalised rural young men and those from relatively resourceful families described their susceptibility to dropping out of school, although the drivers for this varied. While the rural men largely blamed family poverty and quality of education, the urban men described strong peer influences and how the dynamic urban life style characterised by modern entertainment and leisure, alcohol and sex lured them away from schooling. For example, Albert, a 43 year old disc jockey (DJ) living with HIV dropped out of school to become a DJ against the advice of his mother. Similarly, Raymond admitted he still had support from relatives to continue with his education despite the death of his parents. But like Albert, he was influenced by peers to drop out of school:

> I must say I would have continued [with school] but I joined bad groups which introduced me to alcohol and women at that young age.

Dropping out of school was an important turning point in these young men's lives. While some anticipated positive prospects after leaving school, the accounts predominantly and rather regretfully, showed how being at school had, in fact, been a protective factor against some of life's common vulnerabilities and challenges faced by the young men in their communities. Due to family poverty, young men who had dropped out of school found that they were no longer considered dependants; they had to fend for themselves, and/or their families, and many had to start living independently. This required finding 'something' to do to earn a living, usually in a local town or Kampala city. But the lifestyle in town and the money they earned were both a blessing and a curse, as their accounts exemplified. On the one hand, it made them self-reliant, confident of a good-life and heightened their aspirations to fashion out an ideal form of masculinity such as finding a wife, and raising a family. On the other, particularly for those who did not have sufficient social support and guidance, the money earned provided opportunities for engagement in risky masculine practices. These men described facing a higher likelihood of becoming teenage or young fathers, and finding it hard to balance leisure and self-control. The strong peer influence facilitated behaviours associated with reputational masculinities achieved through sexual expression. Many spent their money on alcohol and risky sexual relationships. In many cases these men established multiple relationships with women and inconsistently practiced safe sex, irrespective of whether the partner was a FSW and this resulted in unplanned pregnancies and child birth.

However, unplanned children were not always a stressful experience as taking care of children facilitated the shift in relationships from clients to partners, albeit in reluctant fashion.

4.2. Relationships with FSW and how it influenced accessing HIV services by men

We found that the same complex relationships with sex workers that threatened men's masculinity, simultaneously offered male partners a platform to engage in HIV service uptake. Relationships with FSW were established in a number of ways. Intimate relationships predominantly emerged out of a commercial arrangement before progressing to a level where the parties began to identify as a couple that was in regular contact, shared emotional connections and regularly had sex, and/or moved in to live together as 'husband' and 'wife'. For some men like Donald (aged 45), becoming intimate with a FSW was described as accidental, because she unexpectedly became pregnant and the resultant child changed the perception and nature of the relationship, from client to father of child, as described in the following account:

> My partner was acquired through what I can call these activities of youths [sexual experimentation] who move around taking alcohol and engaging women … she became pregnant unexpectedly and I had to accept responsibility. I had nothing to do but to continue [the relationship] with her since she was the mother of my children.

Some men kept a FSW for extra-marital sexual purposes. In all these cases, the issue of fidelity was sometimes defined fluidly. For those men who had emotional ties to the women, parameters and boundaries were set that enabled such women to fulfil both roles as a 'wife' and as a FSW who offered sex to other men, in any way that was acceptable to both and without feeling a sense of contradiction and much guilt. For example, some couples agreed that the 'wife' would consistently demand that her clients use condoms, while others agreed on the time of day during which the woman would do sex work and return home. Although the men knew that being in such a relationship where they shared their partners with other men denied them exclusive sexual access to their partners, a highly valued attribute of masculinity in the study setting, they also saw some benefits in these relationships in the form of financial support and gaining an identity as a father. As a coping strategy, some men such as Jimmy (aged 38) chose to take an indifferent attitude towards sex work, saying it was not their business to look into every aspect of their partners' life, as he describes below:

> … That is why I don't bother checking her phone and she also leaves mine to me. Those mobile phones can be a point of unnecessary discomfort.

Nonetheless, men believed that the ultimate solution was in getting their partners out of sex work. This option was, however, not viable in the absence of suitable employment alternatives and/or income to set up a private enterprise as many repeatedly told. The irony was that sex work had in many cases become the only dependable source of income for the couples and so men had to concede and learn to live with an undesirable situation. John confessed that his poor financial position in the relationship had reduced some of his masculine power and affected his respectability as a man:

> There is nothing to do, I tried to get her out of sex work but she refused because she could not find an alternative income. The other time we had a quarrel and she confessed to me that I should not think that I am the only one and I said oh, so that is how things are? So you have others, I said ok.

In these relationships, HIV risk was from both partners. The men from their risky masculine practices and the women through their sex work. In some cases, the risk from the men was higher than that of their female partners. The FSW took advantage of pregnancies to persuade their partners to test for HIV in order to protect the unborn child. FSW in some cases suspected that their male partners already knew that they were infected with HIV given the way they reacted upon diagnosis. This was, for example, revealed in a conversation with Sula's FSW partner:

> I suspected that he already knew his status and had not told me which made me distrust him [for a while] and so he started falling sick as a result of realizing that I might leave him. I felt pity for him and decided to remain with him to help him deal with the sickness he was suffering at that time. I remained and encouraged him to start on treatment and get better and it is when he was admitted that I came to learn about his history.

Indeed, this suspicion was not unfounded as reflected in the narratives of men who admitted to have frequently engaged in unsafe sex over the years. Peter (aged 35), described how most men in his peer group simply internalised an identity of having the virus and lived their lives as though they were infected. Continuing with high risk activities was

justified by the perception that they already had the virus anyway. The narrative of 'nothing to lose' was common and raised two dilemmas. On the one hand those who were not yet infected risked infection through unsafe practices and on the other hand men reported for treatment late, usually when they were very sick. Peter said:

> Men, I think, tend to judge themselves because they think that being known to have the disease (HIV) is a bad thing. That you did 'bad manners' in the past which many young men don't want to be associated with … but surprisingly many men still get surprised when they find that their behaviours lead to HIV. So when a man has been having many partners they start thinking that they are already HIV positive and so fear to confirm what they suspect.

Once relationships had been established and stabilised men found allies in FSW who helped them access HIV services. Many of the men had spent time privately worrying about their health status but had been unable to confront the fears that held them back from seeking care. Some had even started showing symptoms. Men were glad that FSW did not judge them and instead focused on helping them regain their health which, not only helped preserve the relationship, but also their masculine status within the relationship. However, accessing testing services was a protracted affair and it involved conceding some valuable aspects of their masculinity. Men took a back seat and let their FSW partner take charge of their life, guiding them to the GHWP for testing. By restoring their male partners' health, FSW helped men to commit to relationships thereby distancing themselves from the stigmatized sex work label. Some of the men, such as Stuart (aged 37), described how much the support from their partners was timely:

> When my former partner died, I knew I had become infected with HIV. I later heard from one health worker that it takes one about 5 years to live after the infection [without treatment] and I started my count down from that time. Later my new madam [the FSW] got concerned and decided one day to go with me to GHWP to see the counsellors. My condition was bad. The eyes had problems, the head and the body had wounds all over. They tested me and counselled me and I started taking ART.

Two ways emerged through which women were able to guide their partners to access HIV services. One was through sharing information via direct conversations about the topic since they could see the men suffering with ill health. Such conversations helped soften the men's resistance and helped them face their fears regarding ART which were further allayed when they spoke with counsellors. Raymond (aged 35), was one of the men who had been torn between losing his masculine reputation by admitting infection and accessing HIV services, and watching his health deteriorate. It took him a while but eventually he bowed to the encouragement of his partner and was introduced to the GHWP where he tested and started treatment. He admitted with relief that his health improved, and the relationship was strengthened:

> Yes, I was very relieved when I went to the clinic because I was comforted, and everything went better than I had expected. I was really worried but I was also starting to get sickly so it was good timing even if it was a lot later than I should have done. When I told her [his partner] that I had [eventually] gone to the (GHWP) clinic she was pleasantly surprised and she even came over to see how I was doing that night [she often spent the weekdays at her place of work].

Second, when FSW open up about HIV status, it helped the men to learn about how to deal with the disease from close partners. The FSW sometimes acted as conduit for delivering information from their male partners to the health workers. This back and forth flow of information was something that the men lacked in their peer groups and allowed them to make better informed decisions with support from their non-judging FSW partners.

Accessing services did not always translate into change in behaviour among the men. Men found some masculine practices so attractive that they could not easily abandon them. This pattern of behaviour was described by men, most notably those who worked in what they called the entertainment sector. These men described with pride the ease with which they were able to access women and enjoyed unrestricted sexual opportunities. Albert who was on ART, and his peers who called themselves 'club DJs' described how they were envied by other young men for having easy access to women:

> You know there is something about being a DJ in the sense that you don't have to do much to win a girl. Women were lining up for us to have sex with them at the time [referring to a period when he and his peers moved around the country playing music to admiring audiences].

Members of Albert's reference group, who were interviewed in an FGD, expressed the same sentiments. One of the discussants described how he enjoyed the attention from women: *"that one is not even debatable, women just admire us."* Another described it as a gift from God, *"that is the only advantage God gave us as DJs''*, while another boasted of being spoiled for choice: *''you have sex with those [women] you can manage and leave the rest.''* These accounts demonstrated the rewards men enjoyed from reputational masculinities despite the risks involved.

While these men enjoyed the public lifestyle that gave them easy access to women, they tended to withdraw from their peer groups fearing stigma and abuse from group members. The narrative from these men around HIV suggested that stigma was still a big barrier illustrating how the support from FSW was crucial. For example, one man in focus group discussions highlighted this:

> See, what discourages the young men to go pick the drugs, it depends where he is getting the treatment from and also not wanting to be seen by people picking drugs.

The intervention of FSW therefore broke many barriers for the men. Women in group discussions described how they exploited the emotional connections of love to handle the men and prepare them for testing. These women talked about their experiences of convincing their male partners to take up testing through a negotiated approach. One woman described how she had approached self-testing with her male partner:

> You are the one who actually does the testing yourself in a friendly manner by passing it through his mouth like this [demonstrates with hand gesture the movement across the upper and lower gums in the mouth that the testing follows]. Then you lovingly escort him to the health facility for further advice if necessary.

4.3. Life after accessing HIV services

Support from FSW was not just crucial before men accessed services but became even more important after they tested for HIV. The women acted in ways that preserved the dignity of the men. The continued support of their FSW partners played a huge role in helping the men retain respect (*ekitiibwa*) and maintain a relatively stable life. The anticipated drastic negative changes within the relationship did not happen, instead the continued support from female partners was a pleasant surprise to many. Men living with HIV continued to enjoy a relatively uninterrupted sex life even when their partners were HIV negative. Sula who was living with HIV described his sexual life with his HIV negative partner:

> Sometimes we never use those condoms but whenever I have any wounds or anything that I feel might place her in danger I ensure that we either abstain or use condoms. I appreciate that my wife accepted me as someone positive and she felt some pity on me otherwise she could have gone.

Although all the men feared the concession of important aspects of their desired masculinity following diagnosis with HIV, the actual experiences were not as bad as earlier anticipated. A combination of the counselling from the facility, support from FSW and positive personal experiences with the treatment helped men cope with life on ART. Fears about side effects even for those who had changed regimens were not as bad as men had feared. This facilitated the reconstruction of new masculinities of men living with HIV and on lifelong ART as Fred (aged 51) described:

> I take one tablet a day and I have had the tablet changed after the earlier one used to make me feel weak. I feel a lot better with ART and I think I am healthy compared to when I had not started and I have no worries about whether I am infected or not which is what worries you if you don't find out the truth. Some people live with worries and it drains them and yet if they went and tested they would be at peace like me.

However, on the other hand, restored health prompted compensatory attitudes that led to resumption of aspects of reputational masculinities which threatened relationships. Although they had made some concessions in the relations with partners, men appeared to have found it difficult to fully let go of some of the entrenched social norms of masculinity against which most men in the study setting were measured. Hence, they variously sought to claw-back their symbolic authority through promiscuous sex or alcohol-fuelled intimate partner violence. Men's proper adherence was affected when relationships were destabilised. For some men it could have reversed the gains of ART. When William (aged 26) had disagreements with his partner, who was the main provider in the house he lived, he was thrown out:

> I stay in the bar at the moment after we disagreed with the woman and I left … Truth be told, my health as you can see me is not good. I am even suffering from sickness now … the truth is that sometimes when I am drunk we fight and I beat her.

Relatedly, men's accounts portrayed a precarious sense of anxiety and powerlessness to protect themselves from the risk of HIV infection even when they knew how to protect themselves. Men found it hard to abandon their sexual behaviours even when they joined the GHWP and got information about the risks and dangers involved. Some of the men who had tested HIV negative always approached the next test with anxiety knowing that they had failed to adhere to prevention advice from counsellors. Donald had joined the GHWP after his partner who had earlier tested HIV positive had encouraged him to also test. He had tested negative but described how he had consistently failed to adhere to HIV prevention counselling messages:

> I am currently expected to go for a check-up at the [GHWP] clinic on the 25th of May [2019] to check on my status. But because of my (sexual) behaviour which involves risk taking, I decided to go to an organization that offers testing services for HIV to test and see. I was negative which was good and I am now waiting with some confidence to go to GHWP.

Donald felt lucky to remain negative.

5. Discussion

We use the value systems of reputational and respectable masculinities as suggested by Wilson (1969), to illustrate how two marginalised groups produce positive health outcomes. Our findings show that men in relationships with FSW find unlikely allies who guide them to access HIV services without damaging their masculinities (Siu et al., 2013). In their youth, the men in their peer groups, were socialised to value reputational masculinities that mirrored hegemonic masculinity (Jewkes et al., 2015). As men transitioned to adulthood and took stock of their lives, they tended to depend more on respectable masculinities as the most suitable to engage in HIV treatment and prevention (Siu et al., 2014). This reflects Wilson's (1969) conceptualisation of Caribbean masculinities and has been echoed in other studies including those conducted in Uganda (Russell, 2019, Siu et al., 2013). The men's life stories depict deprivation, vulnerability and sexual expressions which produced multiple and fluid masculinities among the men. Relationships with FSW brought some stability and hope in ways that were unexpected by the men through restoring health, providing support for the masculine role of providing and thereby facilitating a smoother than expected transition onto treatment for the men living with HIV.

The stability in relationships helped men to focus on treatment but when health was restored, there was a tendency to return to reputational masculinities (Messerschmidt, 2018). This shows the complexity of HIV prevention and treatment efforts for both HIV negative men and those living with HIV (Gottert et al., 2018; Greig et al., 2008). For almost all men however, delayed uptake of HIV services was linked to the fear that confirming HIV status signalled an end of their social lives, something that they could not comprehend (Borgstrom, 2017). This might explain why many men resumed reputational or hegemonic masculine practices when they got better, further illustrating the strength of these masculinities (Levant and Wimer, 2014; Skovdal et al., 2011; Treichler, 2016).

Men living with HIV and on ART benefit from a stable non-judgmental family environment which the FSW created in the relationship through respect (*ekitiibwa*) and love. This is what sustained these relationships despite facing several social and economic challenges that were a threat to the relationships (Haram, 2004). The contribution of the FSW in creating this environment that facilitated uptake of HIV services was highlighted in this study (Thirumurthy et al., 2016). The FSW's knowledge of the health systems was used to preserve and promote practices that strengthened respectable rather than reputational masculinities (Russell, 2019, Siu et al., 2013). However, men delayed to access services assuming they were already HIV infected without testing and so tended to access services late which jeopardised their health (Madiba and Mokgatle, 2017; UNAIDS, 2020). Fortunately, with the help of FSW partners, the damage to masculinities was not as severe as earlier feared and the feared social death did not materialise when men accessed HIV services (Borgstrom, 2017). This finding supports the view that alternative masculinities that are not harmful to men's health are possible and should be promoted (Broqua and Doquet, 2013).

With more than half of the global new infections attributable to key populations and their sexual partners, these findings are an important addition to the literature on handling hard to reach groups (Do Espirito Santo and Etheredge, 2005; Fleming et al., 2015, Schmidt-Sane, 2020). We, however, acknowledge that there is still a long way to go to sustainably engage high risk men. First the criminalization and stigmatization that sex workers face shows no signs of reducing in Uganda (Kawuma et al., 2021) and even in countries with sex work friendly policies (Krüsi et al., 2016). The challenges that sex workers face inevitably extend to their male non-commercial partners which creates more hurdles for reaching these hard to reach men (Harichund and Moshabela, 2018).

The relative low perception of risk by men in relationships with FSW is attributed to the men's own high risk sexual histories. By the time the men established relationships with FSW, many of them were sure that they were living with HIV but could not summon the courage to access HIV services. Research shows that health care spaces are constructed as feminine and as such counter masculine, accounting for men's reluctance to engage with them (Courtenay, 2000). Although men conceded some gender power when they surrendered to their FSW partners who took charge of their access to HIV care service, they retained masculine privileges in their relationships. This happened because the FSW were keen to consolidate their position within relationships and build a family identity far detached from the shamed one of sex work (Scambler and Paoli, 2008). The men who had feared losing aspects of their masculinity within the relationship context following HIV diagnosis were pleasantly

surprised when the FSW remained loyal partners even in cases of sero-discordant HIV status (Rhodes, 2002, Schmidt-Sane, 2021). This helped strengthen the relationships men had with FSW and facilitated a shift in the manifestation of their masculinity without being judged by their partners. Family stability suited the construction of respectable masculinities which helped men restore fractured masculinities (Sileo et al., 2019).

A limitation of our study was that our sample was obtained from men whose female partners were already linked to an intervention project. We did not find a major difference in responses and experiences between men attending GHWP and those who did not. We could have missed those from the general population who may not even be aware that they are in relationships with FSW. More studies that highlight the experiences of men in these relationships are necessary to shed light onto the broader questions of how to better engage this vulnerable and hidden population and the window of opportunity for targeted interventions. We acknowledge that recruitment of male partners of FSW is very challenging. However, we learned in this study that ethnographic presence, privacy and awareness of the nature of the relationship are reliable approaches in increasing access to such men.

6. Conclusion

Our main finding was that FSW are potential allies in improving uptake of HIV services among their often neglected intimate male partners. We argue that men's masculinities are multiple and fluid, and reputational masculinities remain popular among men in long term relationships with FSW. Despite the concern to adhere to dominant gender norms, these men aspire to and are conscious of the opportunities fashioned out of masculine identities that are meaningful to the relationship as loving 'husbands' of supportive 'wives'. FSW are motivated to invest in the relationship by the need to identify as partners/mothers rather than sex workers. It is through such a process that men at risk of HIV not only saw the opportunity to, but also found acceptance and support from their partners, to access HIV services while retaining masculine respect within the relationship and family.

We conclude that two marginalised groups can effectively harness and combine existing opportunities to produce positive health behaviours. From a position of marginalization, men in relationships with FSW, whilst at risk of a shamed identity, are able to make sense of some opportunities within these relationships to re-establish a masculinity that is sensible to a relationship with a woman who also benefits from the security and longevity of that relationship. We found that rather than creating negative outcomes as tends to be portrayed in the literature, the combination of marginality and aspirations to fashion out a positive masculinity was acceptable to both parties and increased the uptake of HIV services by men in relationships with sex workers.

This opens an important entry point to improve access to services among key populations in Uganda and other similar settings in sub-Saharan Africa. However, multiple approaches that include helping men continue with education, helping those who drop out from school to access safe sex technologies and encouraging positive peer norms could help reduce on risk taking and encourage uptake of HIV services.

Author statement and contribution

Martin Mbonye is the lead author, he designed the study, undertook the data collection and analysis with support from Godfrey Siu and Janet Seeley. Godfrey Siu and Janet Seeley provided substantial support in the drafting of the manuscript.

Acknowledgments

The authors would like to thank staff of Child Health and Development Centre, Makerere University for collaboration, advice and assistance. We thank the MRC/LSHTM/UVRI Uganda Research Unit staff, particularly those under the Good Health For Women Project in Mengo, Kampala for the support in mobilisation and assistance during data collection. We thank the THRiVE 2 secretariat for the support. Finally, we thank participants for their time. This work was supported through the DELTAS Africa Initiative grant #DEL-15-011 to THRiVE-2. The DELTAS Africa Initiative is an independent funding scheme of the African Academy of Sciences (AAS)'s Alliance for Accelerating Excellence in Science in Africa (AESA) and supported by the New Partnership for Africa's Development Planning and Coordinating Agency (NEPAD Agency) with funding from a Wellcome Trust grant (# 107742/Z/15/Z) and the UK government. The views expressed here are those of the author(s) and not necessarily those of AAS, NEPAD Agency, Wellcome Trust or the UK government. The views expressed here are those of the author(s) and not necessarily those of AAS, NEPAD Agency, Wellcome Trust or the UK government

References

Côté, Anne-Marie, Sobela, François, Dzokoto, Agnes, Nzambi, Khonde, Asamoah-Adu, Comfort, Labbé, Annie-Claude, Mâsse, Benoit, Mensah, Joyce, Frost, Eric, Pépin, Jacques, 2004. Transactional sex is the driving force in the dynamics of HIV in Accra, Ghana. AIDS 18 (6), 917–925.

Barr, David, Garnett, Geoff P., Mayer, Kenneth H., Morrison, Michelle, 2021. Key populations are the future of the African HIV/AIDS pandemic. J. Int. AIDS Soc. 24 (Suppl. 3).

Borgstrom, Erica, 2017. Social death. QJM: Int. J. Med. 110 (1), 5–7.

Braun, Virginia, Clarke, Victoria, 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3 (2), 77–101.

Broqua, Christophe, Doquet, Anne, 2013. Considering masculinity in Africa and beyond. Cah. d'Études Afr. (1), 9–41.

Campbell, Catherine, 1997. Migrancy, masculine identities and AIDS: the psychosocial context of HIV transmission on the South African gold mines. Soc. Sci. Med. 45 (2), 273–281.

Choi, Susanne YP., Holroyd, Eleanor, 2007. The influence of power, poverty and agency in the negotiation of condom use for female sex workers in mainland China. Cult. Health Sex. 9 (5), 489–503.

Colvin, Christopher J., 2019. Strategies for engaging men in HIV services. Lancet HIV 6 (3), e191–e200.

Connell, Robert W., 1995. Masculinities. University of California press CA, Berkeley.

Connell, Raewyn, 2016. Masculinities in global perspective: hegemony, contestation, and changing structures of power. Theor. Soc. 45 (4), 303–318.

Connell, Robert W., Messerschmidt, James W., 2005. Hegemonic masculinity: rethinking the concept. Gend. Soc. 19 (6), 829–859.

Courtenay, Will H., 2000. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Soc. Sci. Med. 50 (10), 1385–1401.

Do Espirito Santo, M.E., Etheredge, Gina D., 2005. Male clients of brothel prostitutes as a bridge for HIV infection between high risk and low risk groups of women in Senegal. Sex. Transm. Infect. 81 (4), 342–344.

Ezzell, Matthew B., 2012. "I'm in Control" Compensatory Manhood in a Therapeutic Community. Gend. Soc. 26 (2), 190–215.

Fleming, Paul J., Barrington, Clare, Perez, Martha, Donastorg, Yeycy, Kerrigan, Deanna, 2015. Strategies for recruiting steady male partners of female sex workers for HIV research. AIDS Behav. 19 (2), 362–368.

Fleming, Paul J., Rosen, Joseph G., Wong, Vincent J., Carrasco, Maria Augusta, 2019. Shedding light on a HIV blind spot: factors associated with men's HIV testing in five African countries. Global Publ. Health 14 (9), 1241–1251.

Gottert, Ann, Pulerwitz, Julie, Siu, Godfrey, Katahoire, Anne, Okal, Jerry, Ayebare, Florence, Jani, Nrupa, Keilig, Pamela, Mathur, Sanyukta, 2018. Male partners of young women in Uganda: understanding their relationships and use of HIV testing. PLoS One 13 (8), e0200920.

Greig, Alan, Peacock, Dean, Jewkes, Rachel, Msimang, Sisonke, 2008. Gender and AIDS: time to act. AIDS (London, England) 22 (Suppl. 2), S35.

Hammond, Natalie, van Hooff, Jenny, 2020. "This is me, this is what I am, I am a man": the masculinities of men who pay for sex with women. J. Sex. Res. 57 (5), 650–663.

Haram, Liv, 2004. 'Prostitutes' or Modern Women? Negotiating Respectability in Northern Tanzania. Re-thinking Sexual. Afr. 211–232.

Harichund, Charlene, Moshabela, Mosa, 2018. Acceptability of HIV self-testing in sub-Saharan Africa: scoping study. AIDS Behav. 22 (2), 560–568.

Huynh, Anthony, Shamshad, Khan, Nair, Sapna, Chevrier, Claudyne, Kerstin, Roger, Shajy, Isac, Bhattacharjee, Parinita, Lorway, Robert, 2019. Intervening in masculinity: work, relationships and violence among the intimate partners of female sex workers in South India. Crit. Publ. Health 29 (2), 156–167.

Jewkes, Rachel, Morrell, Robert, Hearn, Jeff, Lundqvist, Emma, Blackbeard, David, Graham, Lindegger, Quayle, Michael, Sikweyiya, Yandisa, Gottzén, Lucas, 2015. Hegemonic masculinity: combining theory and practice in gender interventions. Cult. Health Sex. 17 (Suppl. 2), 112–127.

Jin, Harry, Restar, Arjee, Beyrer, Chris, 2021. Overview of the epidemiological conditions of HIV among key populations in Africa. J. Int. AIDS Soc. 24, e25716.

Jobson, Geoffrey, 2010. Changing masculinities: land-use, family communication and prospects for working with older men towards gender equality in a livelihoods intervention. Cult. Health Sex. 12 (3), 233–246.

Kawuma, Rachel, Sentoogo Ssemata, Andrew, Bernays, Sarah, Seeley, Janet, 2021. Women at high risk of HIV-infection in Kampala, Uganda, and their candidacy for PrEP. SSM Popul. Health 13, 100746.
Kippax, Susan, Niamh, Stephenson, 2012. Beyond the distinction between biomedical and social dimensions of HIV prevention through the lens of a social public health. Am. J. Publ. Health 102 (5), 789–799.
Krüsi, Andrea, Kerr, Thomas, Taylor, Christina, Rhodes, Tim, Shannon, Kate, 2016. 'They won't change it back in their heads that we're trash': the intersection of sex work-related stigma and evolving policing strategies. Sociol. Health Illness 38 (7), 1137–1150.
Lancaster, Kathryn E., Cernigliaro, Dana, Zulliger, Rose, Fleming, Paul F., 2016. HIV care and treatment experiences among female sex workers living with HIV in sub-Saharan Africa: a systematic review. Afr. J. AIDS Res. 15 (4), 377–386.
Levant, Ronald F., Wimer, David J., 2014. Masculinity constructs as protective buffers and risk factors for men's health. Am. J. Men's Health 8 (2), 110–120.
Madiba, Sphiwe, Mokgatle, Mathildah, 2017. Fear of stigma, beliefs, and knowledge about HIV are barriers to early access to HIV testing and disclosure for perinatally infected children and adolescents in rural communities in South Africa. S. Afr. Fam. Pract. 59 (5), 175–181.
Mahalik, James R., Burns, Shaun M., Syzdek, Matthew, 2007. Masculinity and perceived normative health behaviors as predictors of men's health behaviors. Soc. Sci. Med. 64 (11), 2201–2209.
Makerere University School of Public Health, 2010. The Crane survey report: high risk group surveys conducted in 2008/9, Kampala, Uganda. Makerere University.
Messerschmidt, James W., 2018. Hegemonic Masculinity: Formulation, Reformulation, and Amplification. Rowman & Littlefield.
Muldoon, Katherine A., Deering, Kathleen N., Feng, Cindy X., Shoveller, Jean A., Shannon, Kate, 2015. Sexual relationship power and intimate partner violence among sex workers with non-commercial intimate partners in a Canadian setting. AIDS Care 27 (4), 512–519.
Namale, Gertrude, Kamacooko, Onesmus, Kawuma, Rachel, Bagiire, Daniel, Mayanja, Yunia, Ssali, Agnes, Kiwanuka, Thadeus, Mbonye, Martin, Seeley, Janet, 2020. HIV prevalence and sexual behaviour risk among male regular partners of female sex workers. A mixed-methods study at a Peri-urban clinic in Kampala, Uganda. Research Square.
Ngugi, Elizabeth N., Roth, E., Mastin, Theresa, Nderitu, M.G., Yasmin, Seema, 2012. Female sex workers in Africa: epidemiology overview, data gaps, ways forward. SAHARA-J (J. Soc. Aspects HIV/AIDS Res. Alliance): J. Soc. Aspect. HIV/AIDS 9 (3), 148–153.
Ouzgane, Lahoucine, Morrell, Robert, 2005. African Masculinities: Men in Africa from the Late Nineteenth Century to the Present. Springer.
Patterson, Thomas L., Goldenberg, Shira, Gallardo, Manuel, Lozada, Remedios, Semple, Shirley J., Orozovich, Prisci, Abramovitz, Daniela, Strathdee, Steffanie A., 2009. Correlates of HIV, STIs and associated high risk behaviors among male clients of female sex workers in Tijuana, Mexico. AIDS (London, England) 23 (13), 1765.
Ratele, Kopano, 2008. Analysing males in Africa: certain useful elements in considering ruling masculinities. Afr. Asian Stud. 7 (4), 515–536.
Rhodes, Tim, 2002. The 'risk environment': a framework for understanding and reducing drug-related harm. Int. J. Drug Pol. 13 (2), 85–94.
Russell, Steve, 2019. Men's refashioning of masculine identities in Uganda and their self-management of HIV treatment. Qual. Health Res. 29 (8), 1199–1212.
Rutakumwa, Rwamahe, Mbonye, Martin, Kiwanuka, Thadeus, Bagiire, Daniel, Seeley, Janet, 2015. Why do men often not use condoms in their relationships with casual sexual partners in Uganda? Cult. Health Sex. 17 (10), 1237–1250.
Rutakumwa, Rwamahe, Bernays, Sarah, Kabunga, Elizabeth, Tumwekwase, Grace, Mbonye, Martin, Seeley, Janet, Joseph Okello Mugisha, 2020. Conducting in-depth interviews with and without voice recorders: a comparative analysis. Qual. Res. 20 (5), 565–581.
Scambler, Graham, Paoli, Frederique, 2008. Health work, female sex workers and HIV/AIDS: global and local dimensions of stigma and deviance as barriers to effective interventions. Soc. Sci. Med. 66 (8), 1848–1862.
Schmidt-Sane, Megan M., 2020. Qualitative Research on HIV with Hard-To-Reach Men in the African City. SAGE Publications Ltd.
Schmidt-Sane, Megan M., 2021. Provider love in an informal settlement: men's relationships with providing women and implications for HIV in Kampala, Uganda. Soc. Sci. Med. 276, 113847.
Seeley, Janet, 2015. HIV and East Africa: Thirty years in the shadow of an epidemic. Routledge.
Shannon, Kate, Strathdee, Steffanie A., Goldenberg, Shira M., Putu, Duff, Mwangi, Peninah, Rusakova, Maia, Sushena, Reza-Paul, Lau, Joseph, Deering, Kathleen, Pickles, Michael R., 2015. Global epidemiology of HIV among female sex workers: influence of structural determinants. Lancet 385 (9962), 55–71.
Silberschmidt, Margrethe, 2001. Disempowerment of men in rural and urban East Africa: implications for male identity and sexual behavior. World Dev. 29 (4), 657–671.
Sileo, Katelyn M., Fielding-Miller, Rebecca, Dworkin, Shari L., Fleming, Paul J., 2018a. What role do masculine norms play in men's HIV testing in sub-Saharan Africa?: a scoping review. AIDS Behav. 22 (8), 2468–2479.
Sileo, Katelyn M., Kintu, Michael, Kiene, Susan M., 2018b. The intersection of intimate partner violence and HIV risk among women engaging in transactional sex in Ugandan fishing villages. AIDS Care 30 (4), 444–452.
Sileo, Katelyn M., Reed, Elizabeth, Kizito, Williams, Jennifer, A Wagman, Jamila, K Stockman, Wanyenze, Rhoda K, Chemusto, Harriet, Musoke, William, Mukasa, Barbara, Kiene, Susan M., 2019. Masculinity and engagement in HIV care among male fisherfolk on HIV treatment in Uganda. Cult. Health Sex. 21 (7), 774–788.
Siu, Godfrey, Seeley, Janet, Wight, Daniel, 2013. Dividuality, masculine respectability and reputation: how masculinity affects men's uptake of HIV treatment in rural eastern Uganda. Soc. Sci. Med. 89, 45–52.
Siu, Godfrey, Seeley, Janet, Wight, Daniel, 2014. Masculinity, social context and HIV testing: an ethnographic study of men in Busia district, rural eastern Uganda. BMC Publ. Health 14 (1), 1–11.
Skovdal, Morten, Campbell, Catherine, Madanhire, Claudius, Mupambireyi, Zivai, Nyamukapa, Constance, Gregson, Simon, 2011. Masculinity as a barrier to men's use of HIV services in Zimbabwe. Glob. Health 7 (1), 1–14.
Subramanian, Thilakavathi, Gupte, Mohan D., Ramesh, S Paranjape, Brahmam, Ginnela NV., Ramakrishnan, Lakshmi, Adhikary, Rajatashuvra, Kangusamy, Boopathi, Beena, E Thomas, Srinivasan, Kallam, Girish, C.P.K., 2008. HIV, sexually transmitted infections and sexual behaviour of male clients of female sex workers in Andhra Pradesh, Tamil Nadu and Maharashtra, India: results of a cross-sectional survey. AIDS 22, S69–S79.
Syvertsen, Jennifer L., Bazzi, Angela Robertson, Gustavo, Martinez, Rangel, M Gudelia, Ulibarri, Monica D., Fergus, Kirkpatrick B., Hortensia, Amaro, Strathdee, Steffanie A., 2015. Love, trust, and HIV risk among female sex workers and their intimate male partners. Am. J. Publ. Health 105 (8), 1667–1674.
Thirumurthy, Harsha, Masters, Samuel H., Mavedzenge, Sue Napierala, Maman, Suzanne, Omanga, Eunice, Agot, Kawango, 2016. Promoting male partner HIV testing and safer sexual decision making through secondary distribution of self-tests by HIV-negative female sex workers and women receiving antenatal and post-partum care in Kenya: a cohort study. Lancet HIV 3 (6), e266–e274.
Treichler, Paula A., 2016. Men at risk: masculinity, heterosexuality, and HIV prevention by Shari L. Dworkin. Bull. Hist. Med. 90 (4), 756–758.
Uganda AIDS Commission, 2019. Presidential Fast-Track Initiative on Ending HIV and AIDS in Uganda: Fact Sheet 2019. Uganda AIDS Commission, Kampala, Uganda.
UNAIDS, 2020. Global AIDS Updates/2020. Seizing the Moments: Tackling Entrenched Inequalities to End Epidemics. UNAIDS, Geneva.
United Nations, 2021. Addressing inequalities and getting back on track to end AIDS by 2030. In Report of the Secretary-General Geneva.
Voeten, Helene ACM., Egesah, Omar B., Ondiege, Mark Y., Varkevisser, Corlien M., Habbema, J.Dik F., 2002. Clients of female sex workers in Nyanza province, Kenya: a core group in STD/HIV transmission. Sex. Transm. Dis. 29 (8), 444–452.
Warr, Deborah J., Pyett, Priscilla M., 1999. Difficult relations: sex work, love and intimacy. Sociol. Health Illness 21 (3), 290–309.
Wilson, Peter J., 1969. Reputation and respectability: a suggestion for Caribbean ethnology. Man 4 (1), 70–84.
Wojcicki, Janet Maia, Malala, Josephine, 2001. Condom use, power and HIV/AIDS risk: sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. Soc. Sci. Med. 53 (1), 99–121.
Wyrod, Robert, 2016. AIDS and Masculinity in the African City: Privilege, Inequality, and Modern Manhood. Univ of California Press.