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**HEALTH HELP SEEKING BEHAVIOUR AND HEALTH CARE
SERVICES UTILISATION OF BRUNEIAN MEN: A GROUNDED
THEORY STUDY**

By

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A thesis submitted for the degree of Doctor of Philosophy of
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March 2017

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ABSTRACT

Despite the growth in research on masculinities and health help seeking behaviour we have little idea of how gender and ethnicity intersect to inform health help seeking behaviour among men in multi-ethnic cultures. This paper presents findings from a PhD research project investigating how being a man in Brunei Darussalam, a country with a strong religious and diverse cultural society; influences men's perceptions of and attitudes towards their health and health help seeking behaviour.

Using Grounded Theory, this thesis reports a study that utilised semi structured interviews and focus group discussions with a total of 47 men and women from diverse ethnic backgrounds in Brunei Darussalam. Three key themes emerged from the analysis of interviews with men: 1) The physicality of health and its importance to masculinity; 2) "*Ikhtiar*" as a way of 'doing masculinity' in the context of experiences of ill-health; and 3) masculinity and legitimation of health help seeking. A core concept found in this study relates to the process by which men operate and re-negotiate their masculinity in relation to their engagement with health care services, particularly when their ability to perform masculine responsibilities are potentially jeopardised by ill-health. Themes emerging from interviews with women focused on the relationship between wives and husbands, and daughters and fathers, and the way caring responsibilities reinforced bonds within the family. Women saw men's reluctance to use healthcare as 'normal for men', while men acknowledged that pressure from wives was a factor in their decision to seek help.

This study contributes to the development of knowledge about masculinities and health in a geographical region where to date there has been no empirical research, despite the existence of epidemiological evidence indicating that men's health needs are serious and appear to be unmet.

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GLOSSARY OF KEY TERMS AND CONCEPTS

Ankylosing spondylitis: This is a chronic condition in which the spine and other areas of the body become inflamed

ASEAN: This is an acronym for the Association of Southeast Asia Nations. It comprises of Brunei Darussalam Malaysia, The Philippines, Malaysia, Singapore, Thailand, Vietnam, Cambodia, Laos and Myanmar. This association was motivated by common fear of communism and to strengthen economic development in the region (Asean Secretariat, 2014).

Bahasa Melayu: This is the national language spoken in Brunei Darussalam.

Bertangas: A home based herbal spa. It is done in a traditional way and it uses different types of plants.

Brunei Darussalam: This is the full name of the country where the study was undertaken.

Doctor: In this thesis, the term doctor is generally used to describe qualified medical practitioners working either in the hospital or clinic/ health centres. No differentiation between doctor or GP is attempted in this thesis. This reflects the fact that in Brunei, people generally refer to all medical practitioners as 'doctors', regardless of their speciality.

Ethnicity: Despite the significant debate about the definition of ethnicity and how it differs from 'race' particularly from the point of anthropology (Marcus, 1996), in this context ethnicity refers to a group of people sharing the same characteristics differentiating them from the other groups in the community. These include, for example, language, culture and religion, despite their skin colour. Note there is also no attempt to differentiate between these two terms – race and ethnicity - in this thesis. Thus the concept of 'ethnicity' is broadly defined in this thesis.

Gender: Refers to male or female either defined by their gender or biological sex.

Government servant: This refers to any employers employed by the government, despite their positions in the department. This is common term used in Brunei.

Global South: Less developed countries / also referred as developing countries, located in the tropical region and the Southern hemisphere. This includes Africa, Latin America and developing Asia including the Middle East.

Global North: This includes the United States, Canada, Western Europe, and developed parts of Asia, as well as Australia and New Zealand, which are not located in the Northern hemisphere but share similar economic and cultural characteristics as other northern countries.

Health help seeking behaviour: in this thesis, 'health help seeking behaviour' refers to the process or practices that men do when they are not feeling physically well. This also extends to the use of health services. In this context, use of health services is defined as the process of seeking professional health care, or being a user of the healthcare services, with the purpose to treat any health problems.

Healthcare utilisation: The way men in Brunei use health care services and health care facilities. This includes primary health care, for example, health care centres and hospitals. This is also not limited to public owned facilities but also includes the privately owned ones.

Healthcare centres: This is the term used in Brunei for clinics / health centres. However, please note that in this study, where excerpts from interviews are shared, most participants used the word "hospital" rather than clinic.

Hypertension: This is the term for high blood pressure.

Ikhtiar: This literally means self-reliance whereby men in this study men expressed how they considered being able to initiate self-care and not relying on other people to help as a positive masculine attributes.

Indian shop: This refers to convenience store. As the name implies these shops are owned and operated by Indian

Jabatan Perkhidmatan awam: This refers to the Department of Public Services. This is the government organization that looks after all the government officers and government servants in Brunei Darussalam

Ketua Kampong: Each of the four districts in Brunei namely Kuala Belait, Tutong, Brunei Muara and Temburong, are further divided into counties (or what we called districts). These counties are further subdivided into Kampong or villages. The head of these villages is known as Ketua Kampong.

Ketua Rumah Panjang: This translates as Leader of the Long house. Long house is the traditional house of the Iban community.

Long house: This literally means a long house where one can find a lot of houses, usually around ten to twelve, grouped together in one big house. Some houses are even longer. People living in these long houses are usually all related by blood or marriage.

Manja: literally this means Wimp in English. However in the context of this thesis, women use this term to illustrate how their husband requires and demand more attention from them, particularly in the episodes of being unwell.

MIB: This is the acronym for Melayu Islam Beraja (MIB) / Malay Islamic Monarchy. This is Brunei's national ideology.

Nafkah Batin: Batin refers to the internal and emotional needs. In the context of this study, whenever this term is being used they refers it to 'needs' or responsibility that a man need to attend to, in this case, participants were referring to sexual needs.

Nafkah Zahir: Zahir refers to the outer or external needs. In this context, whenever this term is being used they refers it to 'needs' or responsibility that a man need to attend to., in this case food, paying bills etc .

Panadol: This is the trade name for paracetamol in Brunei.

Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah, Institute of Health Sciences, Universiti Brunei Darussalam: This is the national university in Brunei Darussalam that I work for. For convenience, this will just be shortened and referred to as IHS, UBD in this thesis. Also note that, in the context of UBD, university is spelled as '*universiti*' (ending with "i"). This spelling is used in this thesis in situations where the whole name of the university has to be mentioned.

RIPAS Hospital: RIPAS is the main public hospital in the capital of Brunei. It stands for Raja Isteri Pengiran Anak Saleha Hospital

Tamu Kianggeh: This is the weekend market located in Bandar Seri Begawan.

Undeclared: This refers to those who did not declare their religious beliefs.

STATEMENT OF COPYRIGHT

“The copyright of this thesis rests with the author.

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Acknowledgements

Writing this thesis has been a period of intense learning for me, not only academically, but also on a personal level. It has had a big impact on me. I would like to reflect on the people who have supported and helped me so much throughout this period.

Foremost, I like to thank my two most passionate, caring and wonderful supervisors Professor Simon Forrest and Dr. Sally Brown. Both of you have supported me greatly! Thanks for always believing in me.

In addition, I would like to thank my financial sponsor Jabatan Perkhidmatan Awam, Jabatan Perdana Menteri, Negara Brunei Darussalam. Thanks for this wonderful opportunity. Also to my employer Pengiran Anak Puteri Rashidah Sa'adatul Bolkiah Institute of Health Sciences, Universiti Brunei Darussalam (UBD) and the Ministry of Education Brunei for giving me this opportunity to flourish in my academic field and thank you for having a faith in me.

I would also like to thank my parents, family and friends for their wise counsel and sympathetic ear. You were always there for me. Thank you for believing in me and for the endless encouragement!

Thank you very much, everyone!

CHAPTER 1:

1.1 INTRODUCTION

In this thesis, I investigate the health help seeking behaviour¹ of men in Brunei (Bruneian men) with a particular focus on how they utilise formal healthcare services. Guided by perspectives from sociology and alert to the importance of understanding men's health from a gender perspective, I examine how being a Bruneian man influences perception, attitudes and practices towards health help seeking. The thesis provides insight into Bruneian men's engagement and utilisation of formal health care services. This thesis therefore contributes new empirical research relating to a phenomenon that has not yet been studied. In addition, by orienting the work in relation to the concept of hegemonic masculinities, which has been widely understood and accepted as the major theoretical contribution to understanding the relationship between masculinities and health, I explore its applicability and explicative power taking up the challenge issued by the theory's originator, Raewyn Connell, to test it outside the context of masculinities in the Global North-West. To achieve this

¹ Health help seeking behaviour refers to the process or practices that men engage in when they are not feeling well. This includes the use of health services, which, in this context, is defined as the process of seeking professional health care, or being a user of the healthcare services.

I maintain a dialogue throughout this thesis between this theory, prior research and the findings of this study in trying to account for the experiences and accounts of Bruneian men.

This work concludes with a model of the relationship between masculinities and health relevant to the Bruneian context and also therefore potentially applicable to other regions and states within South East Asia. This model provides an empirically informed nuance to the existing concept of hegemonic masculinities giving space to think about ways that the relationship between masculinities and health in the global north and in Brunei may be similar, different and indeed influence each other.

Furthermore, mindful of the importance of research to policy and practice, I also make some recommendations of how the new knowledge and understanding yielded by this study can be used to inform service delivery in Brunei, the aim being to provide better and more attractive health care services, which are sensitive to both gender and cultural contexts. Additionally, measures that might be taken by my employer, Universiti Brunei Darussalam (UBD), as the main training provider for health care professionals in the country, are also drawn out in this thesis.

In this introductory chapter, the scene is set for the wider thesis. Firstly, I provide a brief background to men's health issues from a global perspective, paying particular attention to their health help seeking behaviour. I draw attention both to the ways that hegemonic masculinities are conceived of and demonstrated to be potentially detrimental to men's health and also the reappraisal of 'hegemonic masculinities' has shown that influence may be less consistently seen as purely detrimental to health or a barrier to health service use. I also bring in evidence from research literature relating to studies conducted with men from South Asia and provide a comparison with research involving men from the global north-west looking for similarities and differences in terms of their health help seeking behaviour and if and how these might be explained with reference to hegemonic masculinities. This enables me both to begin to explore and to critique theory. I then shift my attention to men's health in Brunei Darussalam – the study's immediate context.

Following that, I include a personal account of the factors that motivated me to undertake this study. A description of the context of the study, its significance, the study's aims and objectives, and research questions are outlined thereafter. The chapter concludes with an overview of the thesis content and structure.

1.2 BACKGROUND OF THE STUDY

Over the past thirty years or so, advocates for women's health have argued that women are ill-served by male-dominated health services. In order to provide quality services for women, it has been argued that policies and practices have to change to reflect the specific needs of women (Banks, 2004). There has been a great deal of research, policy and practice development aiming to increase awareness and understanding and achieve improvements in the healthcare provided to girls and women. This is happening at a global level as illustrated by the work by United Nations aiming to reduce HIV infections in ten sub-Saharan African countries. Better known as DREAMS, the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative targets girl and young women as they account for 75 percent of new HIV infections in these sub-Saharan countries ("DREAMS: Working together for an AIDS-free future for girls and women.," n.d.). The significance of women's health can be seen in 2015 United Nations Sustainable Development Goals (World Health Organization, 2017).

An analogous scenario is now developing with respect to men's health. Driven by the need to change policy and practices and establish the reasons behind men's poor health outcomes and their shorter life expectancy (World Health Organization, 2000), we have

seen a remarkable surge of research interest in the field of men's health and health-related behaviour since the mid 1980s. We have moved from a state of neglect on the issue to it now being regarded as a substantive and serious area of research (Baker, 2001; Wilkins & Savoye, 2009). The situation has changed dramatically since the Men's Health Forum (Men's Health Forum, 2004), reported that research involving men's experience of health and illness appeared to have 'lagged behind' considerably in comparison to that on women. A situation in part reflecting the fact that since the 1970's, studies involving women have been a central concern for feminist medical sociologists (Roberts, 1978; Waldron, 1983).

In addition, the scope of interest in men's health has also extended greatly from an initial focus on sexual and urological health to issues concerning men's psychological and social well-being. The terrain in which researchers with an interest in men's health operate has expanded and developed. One imperative question for us to address is therefore, what makes men's health attractive as an area for research?

The epidemiological data is compelling, showing that men have a lower life expectancy and poorer health outcomes in comparison to women (Richardson, 2004). A recent report by the World Health

Organisation (Gollogly, 2009), showed that the life expectancy of men at birth is shorter than women by an average of 4 to 6 years in almost every country in the world (Kraemer, 2000). Brittle & Birs (2007) posited that the genetic fragility of the XY chromosome combination and the male hormone testosterone accounts for this shorter life expectancy for men and their poor health outcomes. However, it is clear that biological explanations are insufficient in themselves to explain the disparity and it has been argued that differences are largely a result of the complex interaction between biology, gender and sociocultural influences (Robertson, 2007). Thus, Robertson (2008) argued that rather than focusing exclusively on genetic fragility, research should be focused on *how* men experience and enact their health. In other words, placing in the foreground a challenge to study health in the context of masculinity and to examine its relationship to their health seeking behaviour and practices.

MASCULINITIES AND HEALTH

Since gendered differences in health help-seeking and health service utilisation cannot be explained by biological difference between women and men, the focus necessarily falls on sociological theories relating to the social construction of gender such as those developed by West and Zimmerman (1987) and masculinity as social practice

developed by Connell (1995). These theories have been strongly influential in the development of my thinking as concepts which enable me to consider the ways gender and specifically masculinities impact the ways that men define health and illness, perceive and enact their health help seeking behaviour.

A central idea in the sociology of gender is that masculine identity emerges through social interaction embodied in the range of gendered practices in which men engage. This has been described as the process of 'doing gender' (West & Zimmerman, 1991) or rather, when we focus on men, 'doing masculinity' (Morgan, 1992). Taking this into account, one of the tasks of the thesis is therefore to see how men talk about their health and health help seeking behaviour in relation to 'doing masculinity' and to explore how constructions of masculinity may relate to and shape the action that they take when they are not well and/or think about their health. It has been forcefully argued that masculinity is socially constructed (Kimmel, 1994) suggesting the fluidity and non-fixity of masculinity. Hence, understanding how men are raised, develop and operate in specific social and cultural contexts becomes imperative to understanding what masculinity is and how it relates to health.

The idea that adherence to, or pressures posed, by particular socio-cultural notions of masculinity may be injurious to men's health is not

new. As long ago as the late 1970s, Harrison (1978) had warned that masculinity is dangerous to men's health, suggesting that men's poorer health may result from their attempts to live up to a 'macho' image which encourages or rewards them for engaging in risky social practices. Subsequently, there has been an increasing body of empirical research on men and masculinities and its negative impact on health.

Several studies have explored how outcomes for specific conditions relate to adherence to or conformity with certain characteristics associated with particular forms of masculinities. For example, Hunt et al (2007), utilised data from a 17 year period to investigate the relation between gender role orientation and risk of mortality from coronary heart disease (CHD), and showed that the less that a man identified himself with characteristics stereotypically defined as 'feminine' or 'expressive', the higher his risk of CHD. Hunt et al's (2007) work supports the earlier finding by McVittie & Willock (2006), who found that the 12 men in their study investigating men's understanding of health and ill-health were able to recognise symptoms of ill-health but delayed seeking help. They concluded that this delay was due to these men's attempts to conform with and enact a particular form of ideal masculine identity in which help-seeking was perceived to be gender inappropriate.

Similar findings and results emerge in research on men's attitudes and behaviour in relation to mental health. Data from a study by Emslie et al (2006) showed that men suffering from mental health issues were far more likely to present to the emergency department than to general practice, and they suggested that this was due to men's denial of their illness, longer self-surveillance and reliance on self management strategies. Emslie et al (2006) concluded that these men tended to feel that, as men, they needed to be relying on themselves and not others.

Banks (2001) offers a possible explanation for this apparent link between adherence to certain beliefs about masculinity and poorer health outcomes and behaviour suggesting that risk-taking with their health is one way men are brought up to assert their maleness to each other and to themselves. Hence, men are more likely to engage in behaviours that have been shown to increase the risk of morbidity, injury, and mortality, for example smoking tobacco. For example, in 2012 a study interviewed men and women in Spain and found that in comparison to women, men tended to overrate how healthy they are and to hide their health problems. The authors suggest that this is their way to portray the image of masculine, tough guy commonly associated with being a man (García-Calvente et al., 2012). Furthermore, Courtney (2000) argued that these behaviours reflect how men construct and reinforce their masculinity.

In the West, the socio-cultural norms surrounding ideal masculinity include the idea that men should be healthy, strong, self-sufficient (Steve. Robertson & Williams, 1998), demonstrate independence, competitiveness, emotional stoicism and self control (Ogrodniczuk & Oliffe, 2011). These characteristics are reflected in is what known as “hegemonic masculinity”.

Connell (2005) defines hegemonic masculinity as the current configuration of practice that legitimises men's dominant position in society and justifies the subordination of women, and other marginalised ways of being a man. Hegemonic masculinity proposes to explain how and why men maintain dominant social roles over women, and other gender identities, which are perceived as "feminine" in a given society. This is regarded as the dominant form of masculinity and because of its dominance all men are required to position themselves in relation to it. In Western society, this dominant form of masculinity includes certain characteristics such as strength, courage, toughness, risk taking, competitiveness, aggression and stoicism (Donaldson, 1993).

It is no surprise that men consider sharing concerns about health and personal issues as a sign of weakness (Courtney, 2000; Galdas, Cheater, & Marshall, 2007; Rosaleen O'Brien, Hunt, & Hart, 2005) and men may worry that doing so can result in them being perceived as less masculine (Robertson & Williams, 1998). In short, there is

good evidence that adherence to this traditional view of masculinity can have serious health consequences (Moore, 2008). Studies have also found that men are more likely to smoke and drink than women and therefore more likely to suffer from health related consequences (Banks, 2001). Men often decline to take part in health-promoting activities (Courtney, 2000; Moore, 2008) and use health services less frequently than women (McEvoy & Richardson, 2004; Moore, 2008; Richardson, 2004; Wang, Hunt, Nazareth, Freemantle, & Petersen, 2013) and even if they do visit their doctor it tends to be later in the course of a condition, potentially leading to poorer health outcomes (Doyal, 2001).

Through these studies a strong sense of the factors, attitudes and beliefs and behaviours that make up normative concept of masculinity emerges as does the relationship between these are health-related actions and outcomes. However, it is important to consider in more detail the way that masculinity is conceptualised.

Masculinity can be considered as a set of attributes, behaviours and roles generally associated with boys and men. Connell (1995) argues that like gender (Schrock & Schwalbe, 2009), masculinity is a performance of multiple acts or displays, so it would be better to talk about [as the field of masculinities and men's studies does] masculinities in the plural sense. Men and women perform/display

different gender identities at different times and in different contexts, with different actors and within different spaces and places. This view is shared by Kimmel (1994) who posited that masculinity is not a declaration of one's true self, but it is rather socially constructed, rather fluid in its nature and varies across different contexts. This focus on context draws the need to understand what constitutes that context and to be aware of the variety and complexity of ways of portraying manliness and the dynamic creation of masculinity through gendered practices (Connell, 2000). It was also posited that there is a need to consider culture, class, race and age when understanding men's lives and the ways in which they relate to each other (Cornwall, 1997) . It has also been noted that practices of masculinity vary across the life course of any one man's life in response to ageing, life events and history (Evans, Frank, Oliffe, & Gregory, 2011).

The prominent sociologist R.W. Connell is well known for her studies of social construction of masculinities and her concept of hegemonic masculinity, a part of her Gender Order Theory, which is one of the most influential theories of masculinities.

As previously discussed, hegemonic masculinity is the form of masculinity that is considered as the ideal or the most socially dominant. The concept of hegemonic masculinity is an attempt to deal with relational issues in masculinity, as Connell suggests that

not all men benefit equally from the institutions of patriarchy and that some forms of masculinity are culturally elevated above others in certain times and place. This brings into focus that there are men who are not able of complying or adhering to this ideal masculinity (Connell & Messerschmidt, 2005). Critically, masculinity is envisioned to take the form of a hierarchy. This includes hegemonic (as previously discussed), complicit, marginalised and subordinated masculinity and this is used to reflect the power dimensions of gender relations (Connell, 1987).

Complicit masculinity

It is argued that this cultural idea of hegemonic masculinity is not normative and only a small number of men may enact it (Connell & Messerschmidt, 2005) with few men actually meeting the standards and expectations set by this idealised hegemonic masculinity. Nonetheless, the majority of men gain from its hegemony, since they benefit from the patriarchal dividend - the advantage men in general gain from the overall subordination of women (Connell, 1995).

Marginalised masculinity

Here, the interplay of gender with other structures such as class, race and disability contributes to the creation of relationships

between masculinities. For example, physical disability can disbar men from display or admittance to an idealised hegemonic masculinity that prizes physical fitness and strength (Connell, 1995).

Subordinated masculinity

According to Connell (1995) these are forms of masculinity that exhibit qualities that are the opposite or conflict of those values expressed and enacted in the hegemonic form. This includes exhibiting physical weakness or men who are very emotionally expressive. This includes gay masculinity and also extends to heterosexual men and boys who exhibit what is perceived to be effeminate behaviour.

THE CRITIQUE OF HEGEMONIC MASCULINITY

As a concept, hegemonic masculinities have provided a useful focus for much recent work on men's health, however there are challenges emergent from the widespread use of the concept as an explanatory resource when applied across a diversity of contexts. It has been argued by Wedgwood (2009) that hegemonic masculinity should not be used as a free-floating concept, because according to Connell's original conception, masculinities occur in a contextualising hierarchy, which includes subordinate, complicit and marginalised

masculinities located in space and time. It has been suggested that studies on masculinities must be specifically devised to study non-hegemonic, as much as hegemonic, masculinity (Wedgwood, 2009). This is important to ‘...ensure a dynamic analysis and to prevent the acknowledgement of multiple masculinities collapsing into a character typology’ (Connell, 1995, p76).

Connell and Messerschmidt (2005) have engaged with these critiques and this thinking about hegemonic masculinities and argued there is a tendency for one specific form of masculinity to be assumed to be ever present and most powerful, regardless of the specific context. There are risks of stereotyping and regarding all men as the same, associated with such globalising assertions about both masculinity and its association with health. Therefore, in this thesis, I will develop an argument which adopts this nuance suggested by Connell that the universal use of this hegemonic masculinities theory to explain men’s health help seeking behaviour for men across different ethnic groups, cultural and social settings may need some nuance to reflect the precise influences and demands of specific temporal and cultural settings. I will argue that the application of this theory to the Bruneian context, with a population largely comprising Malay Muslims and living in a strict Malay, Muslim country enables us to do exactly as Connell proposes and to consider and to develop the concept of hegemonic masculinities in context. I will demonstrate how culture influences

Bruneian men's decision-making and thinking and the process of negotiation of masculine identity that they go through in the event of experiencing symptoms of ill-health. I will also explore the application of the hierarchy of masculinities in relation to men's health help seeking behaviour in Brunei.

To set the scene, as well as considering some of the psychosocial factors which affect men in terms of health help seeking behaviour and practices and how these may differ or be similar across different ethnic groups, I outline my understanding of masculinities. A more detailed consideration and examination of factors relevant to this analysis follows in the literature review where I adopt a systematic approach to appraising our understanding of the health and ways that masculinities and health interact among men in South-East Asia.

CULTURE, ETHNICITY AND HEALTH HELP SEEKING BEHAVIOUR OF MEN

As the main aim of the thesis is to investigate how ethnicity and culture connect, and influence health help seeking behaviours of men in Brunei, I will first share briefly some of the key ideas emerging from research on men's health help seeking behaviour across different cultural and ethnic groups. I will enter into a fuller discussion and consideration of this literature in the next chapter of

this thesis. The primary objective here is to sketch the context of our current understanding and demonstrate the gap in the knowledge base that the review, which follows in chapter 2, addresses.

It is first, however, incumbent on me to explain the relationship between ethnicity and culture having until now referred explicitly to culture but not introduced the idea of ethnicity. In this thesis it is apparent that these concepts are somewhat distinctive but also overlap. For example, men in Brunei share aspects of their cultural life and identity as Bruneian but may also come from different ethnic groups (Malay, Chinese, and Iban, for example). In many studies this distinction or indeed the relationship conceptualised between ethnicity and cultural identities is not explicitly articulated.

That said, whilst little research has been conducted on health help-seeking amongst non-western men, much has been written on non-Western masculinities and particularly relating this to the concept of hegemonic masculinities. This is critical to this thesis in that taking the findings of this research into consideration helps to enable me to make more accurate claims about how my work fits with the existing body of research addressing men's health help seeking behaviour.

Overall, it can be demonstrated that male behaviours and attitudes that affect men's health are strongly influenced by culture. As

mentioned earlier, a traditional masculine ideal common in the West emphasises healthy, strong and self-sufficient men (Steve. Robertson & Williams, 1998). At the same time, however, studies have also shown that what men consider “manly” varies by culture.

For example, a study from 2005 (Hjelm, Bard, Nyberg, & Apelqvist, 2005) explored the health and illness beliefs of Arab men, men from Sweden, and men from the former Yugoslavia, all with diabetes. This study revealed the disparities in belief about health and health practices amongst the various cultural and ethnic groups. This study found that Arab men showed more active information-seeking behaviour than men in other groups and regarded this as more gender-appropriate in comparison to their white counterparts.

The work of Galdas, Cheater & Marshall (2007) further confirmed Hjelm et al’s claim. Galdas et al showed that the Caucasian male conforms to the traditional idea of masculinity in which they perceived health seeking as weak. In this study, conducted in the UK, researchers interviewed white patients who had survived a heart attack and they concluded that their fears of being seen to be weak contributed to delays in seeking medical care and led to reluctance to disclose symptoms to others. Yet the same study found that South Asian men tended to regard seeking help as more appropriate (P. Galdas et al., 2007). These South Asian men emphasised wisdom,

education and responsibility for their family and their own health as highly valued masculine attributes, and this contributed to a greater willingness to seek medical help. Similar findings were also seen in studies conducted in the global south. Following on from the observation about the importance of family responsibilities made by Galdas et al, Cleaver (2002) found that there are strong links between 'masculinity', employment and family issues in Latin America. This study suggests that men's idea of what it is to 'be a man' are strongly oriented by concerns to be the main financial provider to the family. Men from Latin America see the importance of their role as a man in relation to employment and ability to provide for families. What may be discernable in these studies is that similar environmental conditions bear on men's ideas about masculinity and health but that cultural factors may enable them to be mobilized and play out differently. For example, the importance of 'bread-winning' and leadership of the household is important to male identities in the Global North, Latin America and amongst Asian men in the UK but the requirement on men from these groups to rethink this relationship and its implications may differ according to their cultural traditions and the resources that these provide. Meanwhile, for instance, there has been a great deal of change in the social and economic environment in which men (particularly these Western men, living in the developed Global north countries) are growing up today and that experienced by their grandfathers who had a clearly defined role as

the authority in the family (Cleaver, 2002). It may be that these changes may not have taken place yet in the South Asian community and consequently they have attached a different priority to what they consider to be important masculine attributes from their Western counterparts. They may, in short, be part of or living within a north-western culture but able to draw on and mobilise other cultural traditions to make sense of their masculinity within it.

As I will show, in the literature review that follows in chapter 2, whilst the pool of research relating to men outside the global northwest is somewhat limited in terms of the number of studies, findings show clear differences but also continuities in health help seeking behaviour between men of different ethnicities and in different cultural contexts. It is also critical to note that the study by Galdas, Cheater & Marshall (2007) only involved studying the perceptions of men resident in a north-western hemisphere country, similar to other studies as aforementioned (Courtenay, 2003; O'Brien, Hunt and Hart, 2005; García-Calvente *et al.*, 2012; Hennessy and Mannix-Mc Namara, 2014) It can be argued that Asian men who live in their country of origin may have different views in comparison to those who were born and live abroad. This would be plausible given that social environment may influence and shape their lifestyles and attitudes. Indeed, one valid criticism of much of the research literature would be that the studies to which it relates were conducted

in the Western Europe. There are no studies that specifically look into health help seeking behaviour of men in South East Asia, apart from those which are mainly on urological problems (Li, Garcia, & Rosen, 2005; Low, Khoo, Tan, Hew, & Teoh, 2006; Low, Ng, Choo, & Tan, 2006; Low, Tong, & Tan, 2008; Ping, Meng, Yun, & Jenn, 2013; H. M. Tan et al., 2007; W. S. Tan, Ng, Khoo, Low, & Tan, 2011), physician's view on men's' health (Seng Fah Tong, Low, Ismail, Travena, & Willcock, 2011; Yates, Low, & Rosenberg, 2008) and Malaysian men's and women's general perception of men's health (Yun et al., 2008). The latter study (Yun et al., 2008) published in a book entitled "About Men's health: views from Mars and Venus", provides a general overview of men's and women's perceptions of men's health and illness in Malaysia but did not explore this from the lens of masculinity and its relation to health. There has never been a study focusing on men's health in Brunei Darussalam.

HEGEMONIC MASCULINITIES AND HELP-SEEKING

Having considered and demonstrated both that hegemonic masculinities as a concept may be a powerful explicative framework for thinking about men's health and especially their utilisation of health services, that there is a clear opportunity to contribute to the development of the concept in the context of research involving

South-East Asian men living in South-East Asia, and that what research there is already contains indications that culture may mediate men's mobilisation of hegemonic masculinities in complex ways, one other matter warrants comment and some examination – that is to ensure that we have taken into account whether hegemonic masculinities can be universally be regarded as potentially detrimental to health.

Although the potential detriment to health of adherence to traditional or hegemonic male identity has been well established in the research literature, it has also been shown that men in the global north west who adhere to it may not always and everywhere ignore and disregard their health. Rather it has been shown that hegemonic masculinity may have some complex effects and impact on men's health related behaviour. For instance, it has been shown that there are circumstances whereby Western men will reconsider their health behaviour. The **“Don't care, should care”** dichotomy proposed by Robertson (2006) explains how men can be involved in changing and contradictory practices in different times and places.

Some recent studies show how hegemonic masculinity is not necessarily detrimental to health but may even be protective. O'Brien et al (2005) suggest that because of the importance of employment as part of masculine identity, men regarded it as imperative for them

to be healthy in order to retain their job. This was seen as a strong motive for seeking health help, and seeing this as appropriate behaviour. Similarly, a study by Coen et al (2013) shows how participants with depression did not abandon masculine ideals of strength and self-reliance, but redrew flexible boundaries and reintegrated them to improve treatment uptake and efficacy. This was shown whereby men take an active part in and control over the planning and implementation of their care i.e. being an autonomous man; an ideal masculine identity. This is how these men constructed and reconstructed what it means to be a man with depression, and legitimised their health help seeking.

Another argument that challenges the common assumption that all health problems in men are solely or primarily the result of 'masculinity' is brought forward by Macdonald (2006). Social, economic and cultural contexts of people's lives over their lifespan have been shown to have a significant influence on one's physical and mental health. One's personal behaviour can no longer be held solely responsible for one's health and illness (Macdonald, 2006; Marmot, 2005). Hence, Macdonald (2006) postulated that literatures that seek to explain the poor health of men are consistently blaming masculinity and men's adoption of unhealthy male stereotypes, as previously shared in this thesis. He argues this consequently can turn attention away from social and political influences on health,

which he believes is the wrong approach and one which will not help to solve and address men's health issues. He argues that this 'blaming men' perspective is one of the factors impeding the development of an effective health policy for men in Australia. He proposed developing an approach for addressing men's health needs utilising a "social determinants of health" approach, which is a salutogenic approach that should be able to provide such a framework for conceptualising men's health and planning men's health services. According to WHO, there are ten main social determinants of health. This includes social gradient, stress, early life, social exclusion work, unemployment, social support, addiction, food and transport (Wilkinson & Marmot, 2003). Macdonald in his article also commented on how these social determinants are related to one another.

We need to be attentive to the diverse ways that men construct and negotiate their gender identities (Connell, 1995). It is apparent that this is not straightforward but rather complex. The complexities are further amplified by cognisance of social determinants of health, which it can be argued influence one's health behaviour and health outcomes as much if not more than gender.

Here, we can see that we have a 'grand theory' of masculinities in hegemonic masculinities that goes a long way to explaining men's health-related behaviour but we also know that (a) it can play out in complex ways such that not all adherents to idealised masculinities behave in ways that are potentially detrimental to their health (b) that it is less clear how hegemonic masculinities intersect with ethnicity/culture but that there are indications that they do and hence we need to take both into account when considering the experiences and views of men in Brunei.

In summary, a number of things are clear: that it is widely accepted that men's health-related behaviour including health help seeking is influenced by socio-cultural factors including the norms which surround and define masculinity and how men enact these, and also that what constitutes these norms and indeed the dominant masculinities in contexts other than the Global North-West is not particularly understood and creating an invitation to test the relevance and applicability of theory in these cultural contexts. In addition, we also know that it is important to consider how gender, ethnicity and other social determinants intersect and relate with each other and subsequently inform health help seeking in multi-ethnic cultures, many of which are to be found in South East Asia. This in itself raises a very significant question about how far we can apply the masculinities theory, particularly hegemonic masculinity and the

other forms of masculinity in the masculinities hierarchy in the absence of research which tests it in settings and amongst men other than White men or Western/ European men. Further, studies that explore health help seeking and its impact on health outcomes are required to provide a bigger picture and stronger evidence to support our understanding of the impact of masculinities on health.

1.3 THE RATIONALE FOR AND SIGNIFICANCE OF THE STUDY

The absence of research into men's health in Brunei Darussalam highlights the need for this study. As I will describe in greater detail in chapter three, where I deal with the methods and methodological issues and the overall philosophical approach to the empirical research, this absence and an interest in social practice, attitudes and above all meanings given to Bruneian men with regard to health and health help seeking, implies that there is no better way to start this work than speaking to men themselves and thereby trying to understand what they do if they are feeling unwell and their experiences of using healthcare services.

Furthermore, hearing what women have to say about this issue is also significant, as it may help to put men's comments into context. It also allows the exploration of roles that women play in men's life and

how these women see these roles. It also allows me to understand how the dialogic around the men's relationships with women works. I am optimistic that this, first of its kind, study will be able to spark further interest in men's health related research in Brunei Darussalam.

The significance of this research is further enhanced as it mounts its investigation from the perspective of the local culture and its unique ethnic mix and other associated psychosocial, economic and physical factors, which subsequently will bridge the gap in knowledge on men's health help seeking behaviours and practices in Brunei Darussalam. This altogether fulfils the aim of generating new knowledge in the form of theory which has been identified as most deserving of research efforts (Birks & Mills, 2011).

This study has the potential to benefit policy makers and health care professionals, providing them with locally relevant information supporting the design and development of a more comprehensive men's health service and health promotion programmes that are both sensitive to gender and ethnicity and tailored to the needs of Bruneian men. In turn, this means that this study has the capacity to impact on the realisation of the country's 'Vision 2035' which aims to provide proper care for all citizens of Brunei Darussalam in order to achieve a quality of life that is among the top ten nations in the world (Ministry of Health Brunei Darussalam, 2012).

Finally, this research also benefits a wider international audience by generating substantive and new data on Bruneian men's health help seeking behaviours and practices. It also contributes to our understanding of the utility of a masculinities approach to conceiving of and understanding male identities and their relationship to and impact on health help-related behaviour and practices. Furthermore, this study helps to identify areas for future research into men's health in Brunei and potentially stimulate research collaboration with neighbouring countries.

(i) Brunei Darussalam and the status of Bruneian men's health

In Brunei Darussalam, as mentioned above there has been no research into how health help seeking behaviour and practices relate to masculinities, despite worrying epidemiological evidence about health needs among men. The registered number of deaths in 2011 (Jabatan Perdana Menteri, 2011) (Figure 1.1) reveal a significant disparity between male and female mortality. This is reflected in every age range, such that in most cases there are a higher number of male than females dying. A total of 1,235 deaths were recorded with a breakdown of 695 and 540, males and females, respectively.

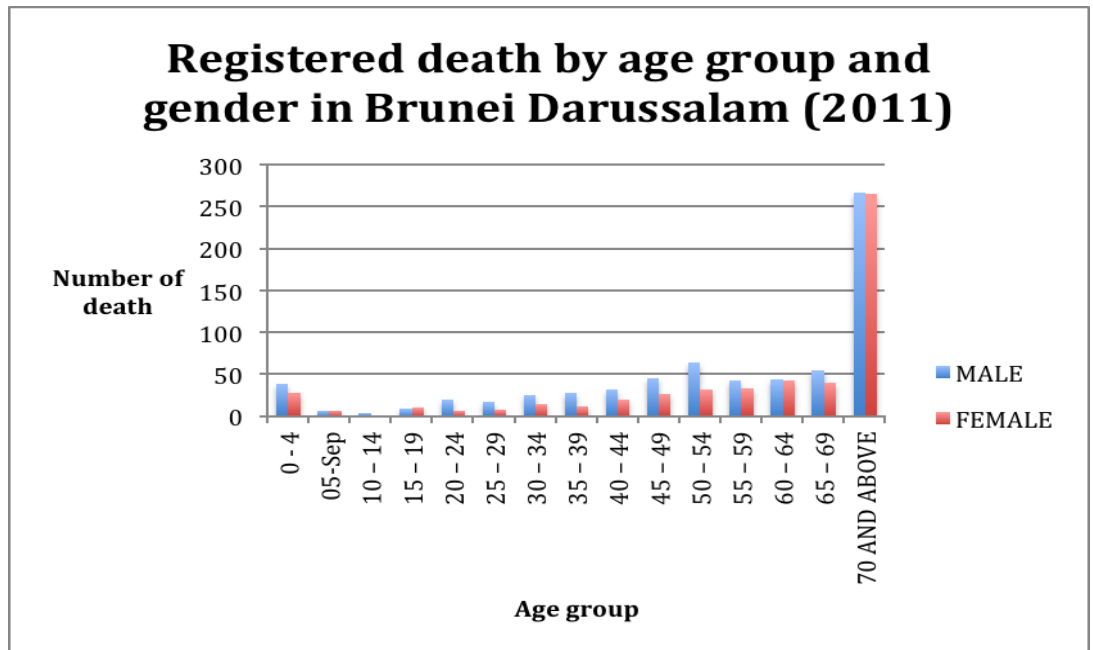


Figure 1.1: Registered deaths by age group and gender in Brunei in 2011.

Looking at the life expectancy by gender from 1981 to 2011 (Hj Md Said, 2012) also revealed a similar pattern (Figure 1.2).

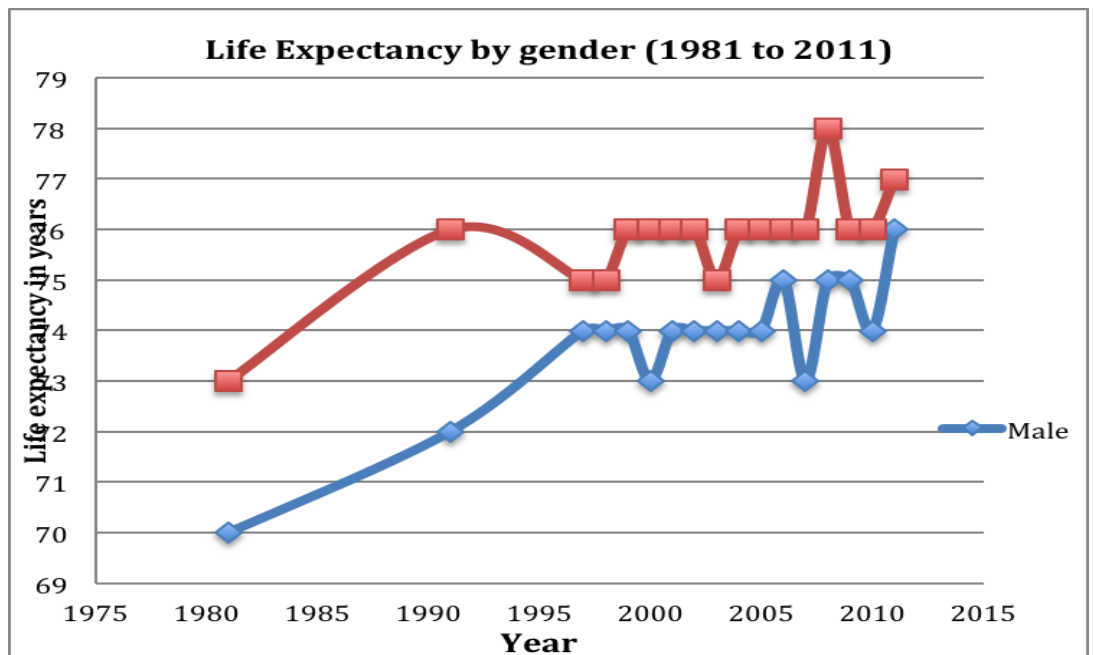


Figure 1.2: Life expectancy in Brunei by gender from 1981 to 2011.

A further investigation of the causes of death in Brunei shows that it is non-communicable diseases and lifestyle factors that contributes to most of these deaths. According to the Ministry of Health in Brunei Darussalam (2012), the four leading causes of deaths in 2012 were cancer, heart disease, diabetes mellitus and cerebrovascular diseases. All were predominant in men as shown below (Figure 1.3).

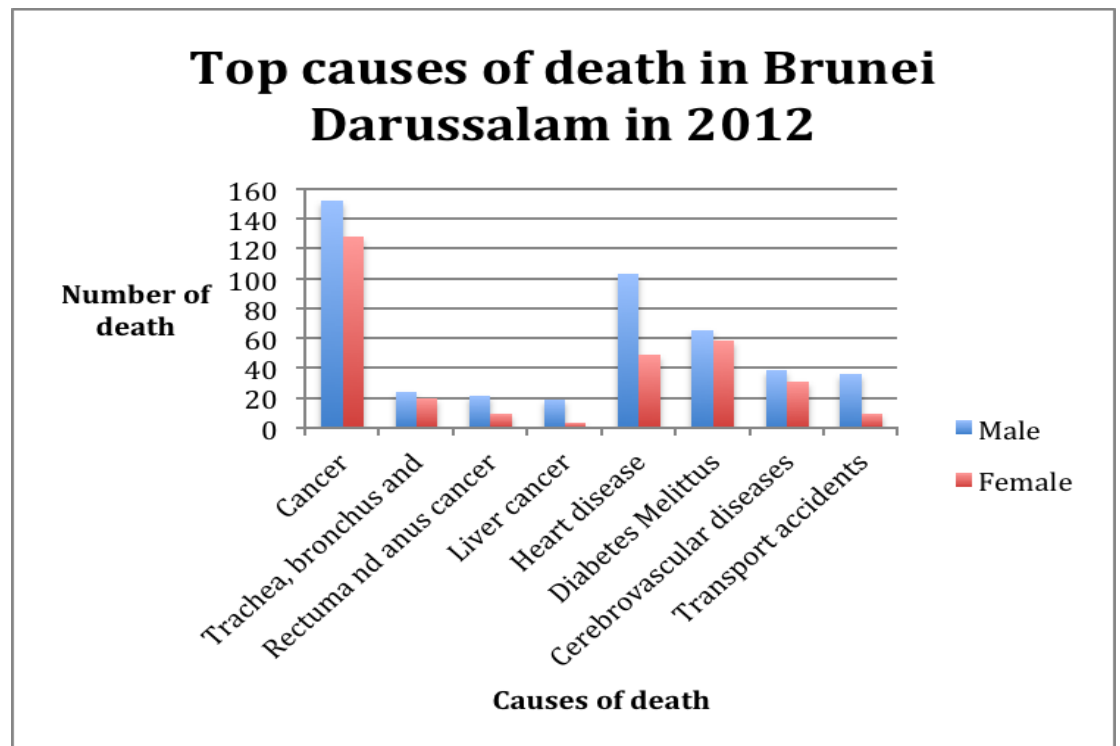


Figure 1.3: Top causes of death in Brunei Darussalam.

Critically Figure 1.3 reports that for the three non-sex specific cancers higher numbers of men than women being affected. Notably, men were also disproportionately represented in deaths attributable to accidents.

A further report by the World Health Organisation from 2014 (World Health Organization, 2014) on risk factors for non-communicable diseases (NCD), the number one killer in Brunei, revealed a further disparity between the men and women in Brunei as shown below (Figure 1.4).

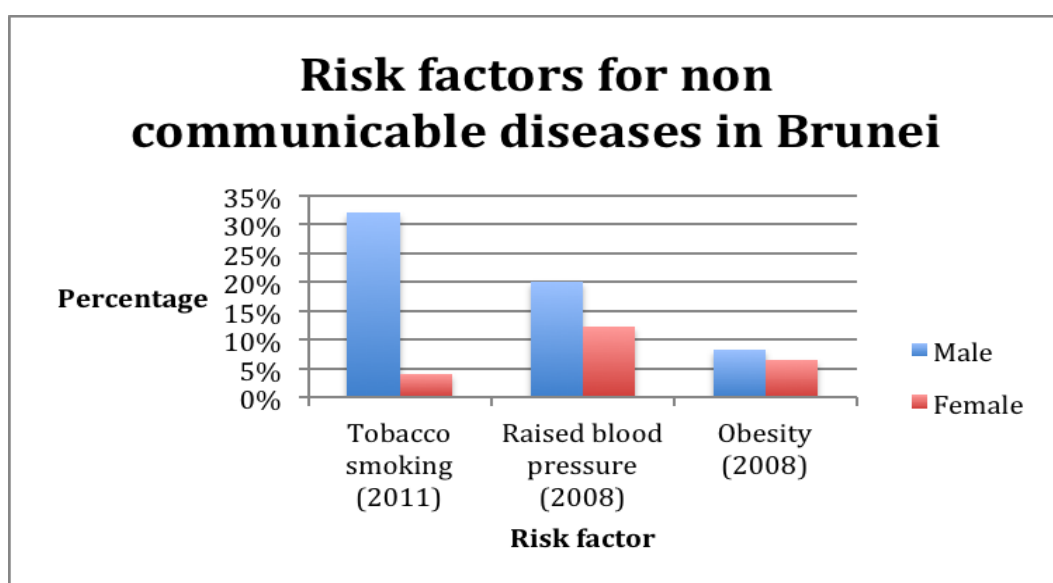


Figure 1.4: Risk factors for NCDs in Brunei Darussalam.

To arrive at a safe inference about these striking gender disparities, it is essential to look at the population of Brunei as a whole and its gender ratio to get a clearer picture on the context. According to the most recent published census held in Brunei in 2010 (Department of Statistics, 2011), out of a total 414,000 people, 219,000 were males and the remaining 195,000 were females. It was further noted that the population has been growing steadily by an average of 2%

annually and that there has always been more males than females recorded in the statistics.

Thus, as this data seems to show, if it is not merely biological factors, which account for the gender differences in health, morbidity and mortality, then the rationale for considering the influence of gender itself becomes still stronger.

Another reason for embarking on this study is due to my personal interest in this area. The area of men's health and particularly their health help seeking behaviour was first introduced to me when I was doing a Masters degree at the University of East Anglia, United Kingdom in 2010. I became aware of the significance of gender when assigned the task of appraising a qualitative research paper entitled "*You ain't going to say...I've got a problem down there': workplace-based prostate health promotion with men*" (Dolan, Staples, Summer, & Hundt, 2005). This paper discussed men's perception of a workplace delivered health promotion programme in raising their awareness of prostate cancer. I remember feeling intrigued by the paper. Once I started reading, issues including "that's how it is with man" and "masculinity" and how these affect men's attitudes and behaviours towards their health and consequently their health outcomes started to emerge from my engagement with the paper. Naturally, being a man myself, I could not help but to reflect on the personal significance of the research. I

saw some immediate similarities and was able to relate to the findings well and also began to understand where other men were coming from. I also somehow began to feel sympathy for men and I became very curious and started to question the situation in my own country. This curiosity led me to conduct some searches of the database, seeking information about any kind of men's health related research undertaken in Brunei. There was none. I started to think about the various things that I could do to help. Ultimately, I realised that as an academic working at the national university in Brunei, I could conduct research in this area supported by the advantages of having access to resources and expertise. I considered this could be my contribution to addressing the health needs of Bruneian men.

My interest was further galvanised when I reflected on my previous experience in clinical practice working as a nurse in hospital in Brunei. I had observed the behaviour of Bruneian men towards health maintenance and health help seeking. My observations showed that in comparison to women, the majority of men came to the hospital to seek treatment rather too late or when their condition had already deteriorated. Interestingly, I reflected that this trend had been most apparent amongst men from the Malay and Iban community and not so common amongst Chinese men. When I enquired about the reason, the Malay and Iban men often said that they did not think their concern was sufficiently serious to warrant

seeking medical help. However, interestingly, discussion with Chinese men about their health conditions suggested that they paid greater attention to their health than any other ethnic group in Brunei. This further triggered me to ask how cultural and ethnic differences may play into masculinities and health.

I also remember my experience growing up as a Malay boy and the level of pressure I felt under to meet the expectations and norms associated with being male. I was brought up in a specific gender orientated environment in which, as a boy, I was expected to be strong and therefore not cry like my younger sister, for whom crying was seen as appropriate. Based on personal experience and observations, this cultural norm of "*boys should be strong and should not cry*" seems to be shared amongst the Malay community. This led me to consider the importance of socialisation and acculturation and the extent to which 'deep' learning might be associated with adult behaviours amongst Malay men in Brunei.

Naturally, curious about these questions coupled with my excitement and enthusiasm, I decided to take this interest further by embarking on this area for my PhD research area and possibly make it my career after the completion of this PhD.

1.4 CONTEXT OF THE STUDY

(i) Study setting

This section provides a brief description of Brunei, the features of Bruneian culture, its population and their health status and health services available for people in Brunei. It is presented to facilitate a better understanding of the context in which the study took place.

Geographical location

Brunei is a kingdom situated on the northwest coast of Borneo island, which it shares with the Indonesian provinces of West, East, South and Central Kalimantan and the Malaysian states of Sabah and Sarawak, and thus Brunei shares a lot of cultural similarities with Malaysia and Indonesia (Figure 1.5). Sitting on the equator, Brunei enjoys an equatorial climate with high temperatures, humidity and rainfall all year round.



Figure 1.5: Map of Brunei.



Figure 1.6: Closer view of Brunei and its districts.

Brunei has an area of 5,765 square kilometres and over 160 kilometres of coastline along the South China Sea. It is divided into four districts namely Brunei Muara, Belait, Tutong and Temburong.

The capital, Bandar Seri Begawan is situated in Brunei Muara district (as shown above in Figure 1.6).

Major economic drivers

This personal income tax-free country has extensive resources of oil and gas and with its relatively small population, it is among the world's richest countries (Commonwealth, 2016). The oil and gas sector dominates the economy and generates the major bulk of export earnings and government revenues (The Prime Minister Office of Brunei, n.d.).

In terms of quality of life, Brunei is ranked highest in the Islamic World and third in Asia, according to the United Nations Development Programme, Human Development Index 2009 (The Prime Minister Office of Brunei, n.d.).

Brunei's population distribution

The population of Brunei in 2014 was 416,000 and is increasing at rate of 2% per annum. Brunei has a young population, whereby 54% are in the 20-54 working age group, another 39% are below the age of 19 while only 7% are 55 and above (*Brunei Darussalam: Country Report, 2011*).

With an area of 5,765 square kilometres, the country's population density is 70 persons per square kilometre (WPRO, 2016).

Nearly 97% of Brunei's population lives in the larger western area including Brunei-Muara, Tutong and Kuala Belait while just 10,000 people live in the mountains of the east in Temburong district ("World Population Review," 2014).

The Bruneian way of life

The 'Malay Islamic Monarchy' (translated as 'Melayu Islam Beraja' in Malay language) is upheld as the national ideology of Brunei since 1991 (Tuah, 2002). It influences the way people live and how the ruling system and government policies operate in the country.

Next, to explain the concept of Melayu Islam Beraja, I break this into three separate parts namely Melayu, Islam and Beraja and explain each of them.

Melayu

Melayu is an ethnic group that can be found in Brunei. Despite, being a multi-ethnic society, three-fifths of the population in Brunei are Melayu or Malay in English.

The Malay, irrespective of its religious denomination comprises the indigenous communities of Brunei, Kedayan, Tutong, Belait, Bisaya, Dusun and Murut as defined in the Brunei Nationality Enactment of 1961 (Jabatan Perdana Menteri, 2011). Others include Chinese (the

second largest group) and this is followed by what is categorized as “Others (*minority groups*)” such as Iban, Indian, Dayak, Kelabit and expatriates which are mostly from European nations, Australia, USA, Indonesia and The Philippines (The Prime Minister Office of Brunei, n.d.). Hence, English is widely spoken by most in the country although Bahasa Melayu is considered the nation’s official language.

Islam

Islam, being the national religion of Brunei, dominates and influences the everyday life of the population. While 67% of the population is Muslim, Brunei also welcomes other religion to be practiced in the country. Other religions that can be seen as practiced in the country include Buddhism (13%), followed by Christianity (10%) and the remaining 10% of the religious population are either Hindus, Sikhs, and undeclared (*Brunei Darussalam Statistical Yearbook 2010, 2010*).

Beraja

The word *Beraja* means ‘monarchy’. This refers to the ruling system practiced in this country.

A king (Sultan), who also acts as the prime minister, rules the country. The present king is Sultan Haji Omar Ali Saifuddien, the 29th

Sultan of Brunei. He was crowned in 1968 following the abdication of his father, Sir Haji Omar Ali Saifuddien.

According to an article cited in the New Zealand Journal of Asian Studies (Talib, 2002), Brunei is the only absolute ruling constitutional monarchy in Southeast Asia.

Next, I share some details on the health care services and provisions available in Brunei. Again, this is done in light of providing a deeper appreciation and understanding of the context of this study.

(ii). Overview of the healthcare system

In Brunei, while a large proportion of its 416,000 (as of 2016) population ("Brunei Profile," 2014) lives in the urban area and enjoys a modern lifestyle there are also still quite a number of people who prefer to live a much more traditional lifestyle in the rural, remote areas of the country. Despite these contextual differences, healthcare services are still made available and accessible for everyone to use.

The formal health care services in Brunei exist in two forms - private care and public care. The former are run and owned by private companies or individuals, the latter by the government of Brunei.

Public Health policy in Brunei is handled by the Ministry of Health, Brunei Darussalam. Under Brunei's health policy, health services and treatments are offered virtually for free to every citizen of Brunei, whilst a very minimal fee is charged to non-residents. This is made possible by the strength of the Bruneian economy.

In order to provide an accessible health care service, a large network of health centres are located throughout the country, providing primary health care services including those for mothers and children. In remote areas that are not accessible or are difficult to access by land or water, primary health care is provided by Flying Medical Services at an interval of once a month. At present, there are four government general hospitals, 17 health centres, 15 health and maternal and child health clinics, five travelling health clinics and four flying Medical Services teams serving remote areas (Ministry of Health Brunei Darussalam, 2012), and six dialysis centres and nine medical clinics serving only the personnel of the Ministry of Defence (Hj Md Said, 2012).

There are also two private hospitals in Brunei, namely Jerudong Park Medical Centre and Gleneagles JPMC. These two private hospitals specialise in rehabilitation and cancer, and cardiac care and are located in the capital district of Brunei Muara. The cost of care at both of these private hospitals is covered under the national health system for Brunei citizens if they are referred to a private hospital

through a public healthcare facility. Additionally, apart from small privately owned clinics that can be found through out the country, there is also one large private healthcare centre, Panaga Health Centre in the Belait district, which caters for Brunei Shell Petroleum's employees.

The following map shows the distribution of public health care centres and major hospitals on the country. As seen in the map below, the majority of these public healthcare facilities are located around the coastal region, as this is the most populated area (Figure 1.7).

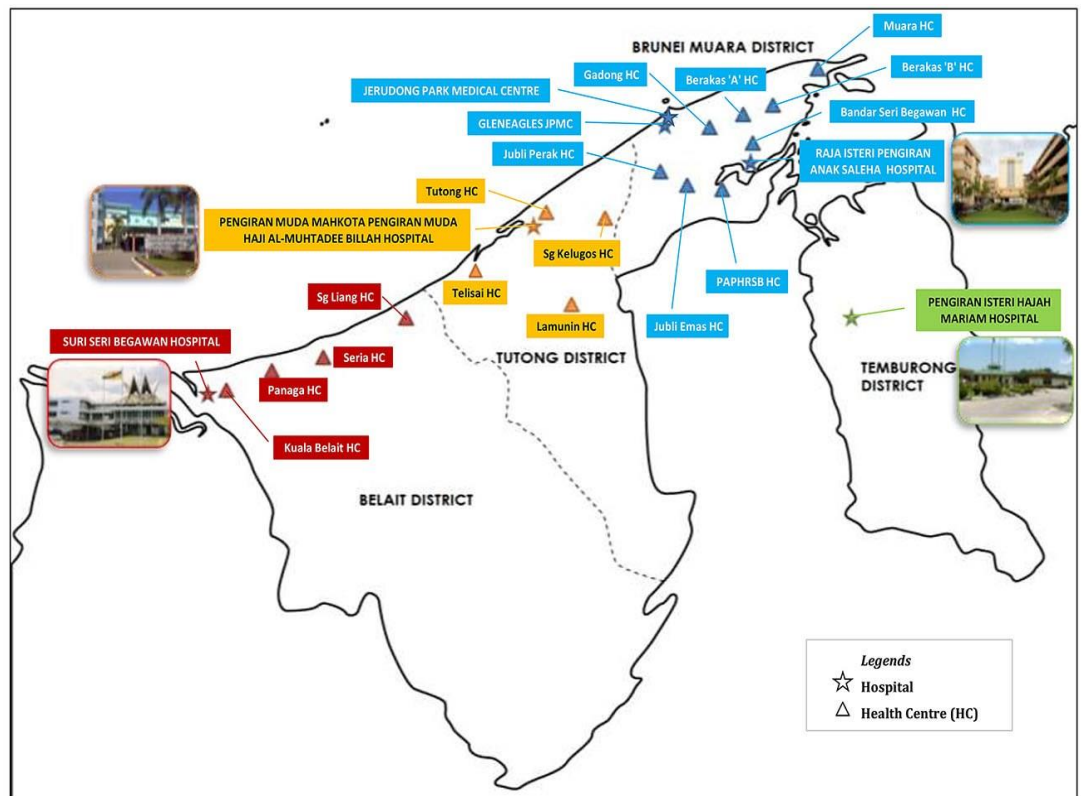


Figure 1.7: Distributions of healthcare facilities in Brunei.

The healthcare system aims to achieve the mission of the ministry of health to improve the health and well-being of the people through a high quality and comprehensive health care system that is effective, efficient, responsive, affordable, equitable and accessible to all (Ministry of Health Brunei Darussalam, 2012). In addition to primary health care services, a great deal of effort has also been put into health promotion activities with the objective of raising health awareness amongst people in Brunei. This is reflected in the annual budget of half a million US dollars allocated to healthcare services in Brunei (Yunos, 2007).

Despite the existence of accessible and free high standard healthcare services and health promotion initiatives, the statistics reported earlier in this chapter suggest considerable health need. Not much is known about the pattern of use among Bruneian men or what they do if they are not well. Statistics that were able to be collected from some of the health centres unfortunately did not have any data on the number of male and female attendances. This made the attempt to see the differences between the two genders, at least from the perspective of attendances, impossible. However, according to the Brunei Health System Survey released in 2014, amongst residents in all the four districts of Brunei Darussalam, those from Temburong were found to be three times less likely to use public healthcare services and also less likely to turn to private health care services (Wong, 2015). According to *The Brunei Times*, a local newspaper that reported this, the survey identified the problem as its geographical location as it is isolated and separated from mainland Brunei (Wong, 2015). Nonetheless, government hospital and healthcare centres and flying medical services are available to the residents in this district suggesting that there must be other reasons why accessing health services were 'less favoured' by the residents.

1.5 THE AIM OF THE STUDY

The aim of this study is to identify and contextualise patterns of health help seeking and utilisation amongst Bruneian men of various ethnicities and to develop a theory that explains this.

1.6 RESEARCH QUESTIONS

According to Creswell (1998), it is fairly common for qualitative researchers adopting a Grounded Theory approach to state the phenomena to be studied in a fairly general way. The advantage of formulating the research questions in a general way is that it provides flexibility to explore the phenomena in an unrestricted manner (Strauss & Corbin, 1990), and the research question can become more focused as the study progresses (Charmaz, 2014).

The initial research questions were set out with reference to concept of the health seeking process based on the work of Chrisman (1977).

The questions were:

1. How do Bruneian men define health and illness?
2. What is the health help seeking process of Bruneian men?

Through the use of these questions, it was possible to meet the

study aims, which are to identify, and contextualised the health help seeking and utilisation amongst Bruneian men of various ethnicities and to develop a theory that explains this.

1.7 ORGANISATION OF THIS THESIS

This thesis is comprised of nine chapters. In this chapter I have presented the background, the rationale for the study, described the basis of personal interest of the study and spelt out the aims and research questions. The broad context of this study has also been discussed. I have also indicated its significance in terms of contribution to empirical knowledge and theoretical understanding of issues located in the field of men's health and masculinities. I am also bringing in some of key emerging ideas about hegemonic masculinities and relatedness to health into dialogue with new evidence from a novel piece of empirical research.

In chapter two I present a review of the relevant academic literature encompassing various health help seeking behaviours and practices of men from Asian ethnic backgrounds. It sheds some light on what we know about how gender and ethnicity intersect and inform Asian men's health help seeking behaviour. I also draw some comparisons with existing European/ Western literature. I identify the gap in

knowledge exposed by the review of the literature and alluded to in this chapter.

In chapter three I describe and discuss the research methods and methodological issues associated with this study. I begin by exploring research philosophies and strategies, describe the process of recruiting participants and data gathering. I also reflect on the experience gained in the data gathering process particularly in terms of what it tells us about Bruneian masculinity. I also consider the ethical issues engendered by this study and describe how I dealt with them.

In chapter four I describe the process of data analysis. This chapter critically discusses the different stages of data coding used in this study. The chapter also presents the rationale for using a manual coding process over the use of computerised programmes such as *Nvivo*.

In chapters five, six and seven I present the findings of the study. Chapter five deals with the importance of the body in performance of healthy Bruneian masculinities. This is followed, in chapter six by discussion of 'Ikhtiar', a particularly Bruneian concept or ideology of self-reliance, and the 'doing of masculinity' in the context of experiences of ill-health symptoms. In chapter seven I report findings

demonstrating how men only use healthcare services for 'legitimate' reasons.

In chapter eight I present a discussion of the core category that arises from a deeper analysis of the three findings discussed in chapters five, six and seven. In this chapter I discuss the relationships between my major findings. The study's rigour, strengths and limitations are also discussed here.

In chapter nine I draw together the conclusions of the thesis with a particular focus on the main findings and implications for the theorisation and conceptualisation of the relationship between masculinities and health. My claim is not that Bruneian masculinity and health cannot be accounted for in general terms by an approach characterised by an understanding of hegemonic masculinities but that there are similarities and differences in the ways that plays out in Brunei and other contexts where the concept has been applied. I also present a series of implications and recommendations for development of policy and practice.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

My dual concerns in this thesis, as I described in chapter 1, are to better understand how masculinity influences men's health as a whole and within that to locate an investigation into how Bruneian men seek health help and utilise health care services. The dearth of research in this area makes it an important topic to which greater attention is warranted. It is salient to the protection and improvement of men's health as has been pointed out as recently as 2000 in the World Health Organization (World Health Organization, 2000) report entitled, "*What about the boys? A literature review on the health and development of adolescent boys*", which recommended more work should be carried out on masculinity and men's health. This drew attention to the lack of understanding of the role of masculinity in shaping men's expectations and behaviours as a primary causative factor for the health disparity between men and women.

As I have pointed out in chapter 1 of this thesis, the academic literature has pointed to the importance of the concept of hegemonic masculinities, which identifies men's need to be tough, stoic and self-reliant as ways of demonstrating conformity to an idealised masculinity and achievement and maintenance of a superior position

in a hierarchy of masculinities, as an orienting concept in the field of men's attitudes and behaviour relating to health services (Buckley & Ó Tuama, 2010; Chaturvedi, Rai, & Ben-Shlomo, 1997; Emslie et al., 2006; P. Galdas et al., 2007; García-Calvente et al., 2012; Hennessy & Mannix-Mc Namara, 2014; Jeffries, 2012). Empirical evidence has shown that men's adherence to the conception of idealised masculinity articulated in hegemonic masculinities may account in significant ways for their health help seeking behaviour and poor health outcomes (Banks, 2004). I have shown that through this literature the way the way that health is regarded within the construct of masculinities affects attitudes, behaviours and hence outcomes appears to be fairly consistent and often detrimental. However, contrasting evidence exists which suggests that we are alert to the fact that the relationship between hegemonic masculinities and men's actions and beliefs in relation to health may be more complex. Indeed some research does indicate the complex ways men operate when negotiating their health help seeking alongside their masculinity (Chris McVittie & Willock, 2006). It has been shown, for example, that there are factors, conditions or circumstances that men perceive legitimise their health help-seeking health help from healthcare professionals. For instance, men may see it is perfectly tenable within a hegemonic masculine identity to seek help for an experience of severe pain (Galdas, cheater & Marshall, 2007) or when to do so is not perceived or experienced as a sign of weakness

or loss of, say, male independence but a means to retain it by making sure one is fit enough to work (O'Brien, Hunt & Hart, 2005). It is clear that how men mobilise masculinities to inform or understand their health-related behaviour is complex and dialogic – that is the influence in not one direction (of masculinities on health) but that masculinities and health-related behaviours are mutually and reciprocally constructed. Consequently, we can see the importance of applying nuance in understanding how men actually mobilise health and masculinities conjointly in terms of their social practice of health help-seeking. This is a point that I pull through in discussion later in this chapter of the thesis.

Furthermore, I will establish, building on my thinking laid out in chapter 1, that a closer investigation of the academic literature reveals that the concept of hegemonic masculinities may be enhanced by some development, especially when employed outside the context within which it was initially developed, that is, the Global Northwest, as a means of understanding the relationship between masculinities and health. Indeed, the originator of the concept, Raewyn Connell, as recently as 2005 suggested that in its original formulation it lacked sensitivity to other cultural contexts. This was all shared in her blog entitled “Raewyn Connell”, available online at http://www.raewynconnell.net/p/masculinities_20.html (Raewyn Connell, 2012).

Critically, despite the appetite for developing the theory, there is no doubt that hegemonic masculinity has provided a useful focus for much recent work on men's health. The risk that we must seek to mitigate is that which may arise from emerge from the widespread use of the concept as an explanatory resource that can be applied across a diversity of contexts without application of nuance. As Connell & Messerschmidt (2005) argued, there is a tendency for this one specific form of masculinity to be assumed to be ever and always present, regardless of the specific context.

As I have discussed in the first chapter of this thesis, masculinity is not fixed, rather it is socially constructed and therefore varies across different contexts as these influence what goes to make it is construction as a concept and set of social practices. Its construction is largely dependent on social, political and historical contexts (Evans et al., 2011). Research literature has also suggested that existing theory relating to masculinity and health may have potential limitations with its origins in and focus on understanding masculinities in late modern, westernised socio-cultural contexts. This is because while the concept of hegemonic masculinity may account for men's poor health seeking behaviour and practices in the UK and other western countries, its utility and relevance has only been tested in a somewhat limited way in other cultural contexts.

Connell's own emerging critique of hegemonic masculinities over the past two decades accepts that most of the existing work on theorising gender and health has been very western-orientated, mainly focusing on the Global North and neither reflecting nor engaging with men from the Global South. This is reflected in the limited number of studies from Global South for instance those, which have taken, place in Latin America and Africa and referred to in chapter one of this thesis.

This results in an inability to test the relevance and universalism of this western derived theory of hegemonic masculinities. In her blog, Connell writes on this issue as follows:

"I have gradually become convinced that there is a profound problem in the way gender theory is usually done. Mainstream gender theory that circulates in the English-speaking world...is mainly written out of the social experience of the global North, and pays very little attention to the intellectual production of the global South. Yet the South is where most of the people live."

(<http://www.raewynconnell.net/2012/02/thinking-gender-from-global-south.html>) (Raewyn Connell, 2012).

The call to embark on a study such as the one carried out in this thesis is clear. In doing so I am undertaking entirely novel research

in territory where no empirical study has been done before and I have developed a theory which partakes of and adds to hegemonic masculinities in the context of gender and health seeking behaviour, relevant and explicative of the health help seeking behaviour of men from Brunei.

Since this study reflects on the concept of hegemonic masculinities as a means of approaching research on Bruneian men's health help seeking behaviour and how they utilise health care services, it primarily focuses on what we can learn about factors that influence health care utilisation, describing these and then beginning to explore their implications for theoretical sensitisation. The iterative approach moving between theory and data is a particular feature of this study, enabling me to establish new theoretical insights in a rigorous and robust way aligned with the principles of grounded theory (Walsh et al., 2015). This approach is made appropriate both by the absence of research on this culturally specific group of men and my intention to develop new theory.

In this chapter, I present a narrative review of the research literature, which leads to identification of this gap in our knowledge around Bruneian men and hence provides the academic context and rationale for the study. In contrast to the previous introductory chapter, in this chapter I focus specifically on enquiring into how men

from Asian backgrounds seek health help and utilise health care services. My engagement with this literature was therefore guided by my exploration of the wider literature that I reviewed and appraised in chapter 1. It was this that makes it apparent that there was a gap in the literature around masculinities and South Asian men, and that this connects to the overwhelmingly Western approach to masculinities research to date.

At the end of this literature review I consider the issues and ideas raised by the review it and bring them into dialogue with concept of hegemonic masculinities and assess the congruence and points of disarticulation with what we know about Asian men's health help seeking behaviour. In short, this chapter presents much more narrow focus on masculinity and health amongst Asian men, unlike the previous chapter.

In conducting this review I followed the steps proposed by Ridley (2008). First, to explore and analyse the academic literature dealing with men's utilisation of healthcare services and health help seeking behaviour with a focus on Asian men; secondly, to critically evaluate the relevance of the research where Asian men are not the sole or main focus and the methods that have been used to conduct these studies. Third and finally, to identify the gaps in the knowledge base

represented by the literature, and thus indicate ways in which my study helps to fill them.

2.2 LOCATING ENGAGEMENT WITH ACADEMIC LITERATURE IN THE GROUNDED THEORY APPROACH.

In reviewing this literature I was keen to acquire an understanding of how, if at all, scholars theorised their findings, and described, defined and mobilised concepts about gender. In doing so, the critical question of how this approach may be accommodated within a Grounded Theory approach with its emphasis on engagement with data unbiased by prior assumptions and knowledge requires some consideration.

There is considerable debate surrounding the issue of undertaking a literature review prior to the completion of the analysis of the data when adopting a grounded theory approach to answering a research question. At one end of the continuum of views sits a 'purist' perspective. This is well articulated in the seminal work, 'The Discovery of Grounded Theory' by Glaser & Strauss. In this they write:

'An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study' (Glaser and Strauss, 1967: 37)

Glaser remained very committed to this view and even three decades later strongly reiterated the need to stick to this rule if one decides to use grounded theory (B. G. Glaser, 1998). The rationale behind this is the researcher may get preconceptions or become “contaminated” by the ideas contained in the literature and therefore become susceptible to the risk of accepting a ‘received’ theory (Charmaz, 2006). However, divergence from this viewpoint has become apparent and more recently Urquhart (2007) has argued that this enforced disengagement appears to discredit a researcher’s ability to be mindful of the extent to which ideas may be informing their research. He also noted that insistence on this approach has contributed to reluctance amongst scholars to use Grounded Theory. Urquhart (2007) posited that a literature review helps to introduce the researcher to the field of study and having exposure to the literature does not stop a researcher from being self-aware and having an appreciation of other theories to which he/she has been introduced by literature does not necessarily prejudice them towards existing theoretical concepts. A similar view has been articulated by researchers such as Cutcliffe (2000) and Eisenhardt (2002). They concluded that it is unrealistic to expect any researcher to undertake a study without having some level of prior knowledge and ideas, as Cutcliffe (2000) suggested that no potential researcher is an empty vessel. Furthermore, it is commonly argued that grounded theory is deemed appropriate for subject areas which are relatively under-

researched and where there is a gap in knowledge (McCann & Clark, 2003). However, it is difficult for a researcher to identify the gap in knowledge and to ascertain that little research has been done in the area under study, without having engaged with the literature first (McGhee, Marland, & Atkinson, 2007).

In addition, reflecting on my own experience, engagement with the literature prior to undertaking the empirical research was critical in helping me to clarify the rationale for this study and the assumptions that stood behind it. By identifying existing knowledge in the field, I was able to provide a concrete rationale for the conduct of the research reported in this thesis (McGhee et al., 2007). This is manifestly useful in all research contexts but there were also somewhat pragmatic demands that led me to make an early engagement with literature. These included the need to develop a research proposal of sufficient detail and persuasive force to secure the support of the sponsorship committee at the Public Service Department, Brunei Darussalam (Jabatan Perkhidmatan Awam or JPA) which enabled me to undertake this study, and in doing so, I demonstrate that I would be making a significant original contribution to knowledge in the substantive area of research where there is a dearth. Similar circumstances were also shared by McGhee et al (2007) and Nathaniel (2006). Finally, it would be a fallacy to enter into the pretence that I have no prior knowledge of the subject given

my professional background in lecturing in nursing and working as a healthcare provider.

Hence, acknowledging the above circumstances, Charmaz's 'grounded theory using constructivist approach' (2014) was employed in this study. Unlike the 'pure' Grounded Theory, this 'modified' (constructivist) grounded theory allows the researcher to access relevant academic literature prior to undertaking fieldwork and to use it in conjunction with the data thereby produced in the process of theory building (Strubing, 2007).

2.3 SEARCHING THE LITERATURE: METHODS

A systematic search strategy was devised to ensure the search process was focused and effective and could be replicated (Parahoo, 2006). The STARLITE framework, was used to assist further in the systematic reporting of the literature search (Booth, 2006). STARLITE is a helpful mnemonic reflecting the key considerations in the search: Sampling strategy, Type of study, Approaches, Range of years, Limits, Inclusion and exclusion, Terms used and Electronic sources.

Sampling strategy

All papers identified by the search were checked for relevance to the research question. Titles and abstracts were examined and those that did not meet the inclusion criteria (outlined below) were rejected.

Some titles and abstracts were clear, indicating the research question, study sample and outcomes, thereby making selection straightforward. Where the title and abstract did not enable a clear decision about in/exclusion a fuller review was undertaken. In addition, a manual search based on the reviewed articles reference lists was also conducted.

Type of study

Qualitative, quantitative and mixed method studies were all included in this review.

Approaches

Apart from the electronic search, manual searching of 'informal' sources such as reference lists from the selected articles was also conducted. This helped to identify additional articles which were not listed in the database (Greenhalgh, 2006).

Range of years

In the attempt to maximise the outcomes, no limit in terms of date of publication was set.

Limits

Initially, it was intended that this review would only include studies, which directly compared health help seeking behaviour and/or health service utilisation between men of different Asian ethnic backgrounds, particularly those from South East Asia. However, this was not very productive as the number of studies on Asian men's health help seeking behaviour is still limited (Tong & Low, 2012). It was therefore necessary to revise this limit. Ultimately, studies that investigate health help seeking behaviour and/or health services utilisation of men from any Asian background were included, ensuring a much broader literature base to refer to.

Inclusion and exclusion

The inclusion criteria were as follows:

1. Studies that illuminated health help seeking behaviours and practices and /or their pattern of health care service utilization or uptake of men from any Asian ethnic background.
2. Type of population under study: Adult men from a clearly stated Asian ethnic background, of 18 years old or above.

3. Type of study: All types of health research namely qualitative, quantitative or mixed methods research.
4. Comparative studies that look at the following:
 - *Comparing Asian men and women's health help seeking behaviour and/or health care services uptake and specifically mentioned their ethnic group in the study.*
 - *Comparing health help seeking behaviour and service uptake of men from various Asian ethnicities.*
 - *Comparing health help seeking behaviour and service uptake of Asian men and Western men.*

Studies were excluded from the review if they were:

1. Summaries. Articles in summary form only were not included in this study.
2. Studies that focused on specific intervention e.g. effectiveness of a specific health education intervention among different ethnic groups.
3. Studies that analyse the prevalence of certain diseases across different ethnicities.
4. Studies that involve Asian men and women but findings did not specifically distinguish between the two.
5. Studies that involve various ethnic groups/ and genders but did not report the findings individually, but rather generalized the findings.

6. Studies that did not clearly indicate the ethnicity of the men involved in their study.
7. Studies that did not clearly indicate the gender of the participants involved in the study
8. Studies that looked into a specific old age health related issue such as dementia.
9. Studies on healthcare professionals' views on men's health help seeking.

Terms used

Using accurate keywords or search terms is one of the important strategies to yield relevant articles from the search process. Boolean operators 'AND', 'OR' and 'NOT' and 'wildcards' such as * were also used and found useful. For example:

*“Asian AND (men OR male) AND (health NEAR/5 (SEEKING OR BEHAVIO*R)”*

The word 'man' in this context refers to either one's biological sex as a male or identification of gender as male. This study focuses more on men rather than attempting to compare sexes since comparative studies are still inadequate (Galdas, Cheater, & Marshall, 2005).

The term 'Asian' was used to further focus the search. This term was not conceived as limiting studies to those which involved men in a

particular geographical location but to include any men who identified themselves as being Asian.

Health help seeking behaviour refers to the process or practices that men engage in when they are not feeling physically well. This also extends to the use of health services. In this context, use of health services is defined as the process of seeking professional health care, or being a user of the healthcare services, with the aim of treating any health problems.

Electronic sources

The literature search was executed in Durham University Library using electronic search engine databases such as EBSCOhost, Medline, CINAHL and PsycINFO. Google Scholar was also utilised.

2.4 SEARCH OUTCOMES

An initial search revealed 96 papers. Subsequent to removal of duplicates and exclusion of papers that did not meet the inclusion criteria, 30 papers were assessed as eligible for analysis. A further round of evaluation excluded 18 more papers that did not state clearly the ethnicity of their participants, or exclusively reflected the views of healthcare professionals and expert opinions. Eventually, only 12 papers reporting 12 different studies were identified and used in this review, reflecting the limitation in the number of studies in this area. This clearly reflects and endorses Connell's (2012) observation that the focus on work on theorising gender/ masculinity and health has tended to be on the men in the global north.

Further information on how this systematic search was performed using the database can be found in Appendix 1. A visual representation of the whole selection process can be found in Appendix 2.

Quality assessment and data abstraction

Included studies were assessed for quality, credibility and congruency with the aim of the review. All results from the primary

studies related to Asian men's health help seeking and healthcare services utilisation were extracted.

These selected studies were systematically organized and recorded in a tabular form with the following headings: authors, title/design, sample, instruments/tools, analysis and results. The details can be found in Appendix 3. Organising the data in such a manner facilitated systematic exploration of these individual studies and allowed comparison between them to be made, and facilitated a critical review and analysis of this literature.

All the studies included in this review were critically analysed using the following criteria so as to assess their rigour. For all the selected qualitative studies, four major aspects were looked at, as suggested by Parahoo (2006), namely:

- 1- Credibility – this refers to the quality or richness of information gathered in the study. A good quality study must be able to establish that the results collected are believable from the perspective of the participant in the research. This, as posited by Lincoln & Guba (1985), increases trustworthiness of the study. This can be achieved via techniques such as data triangulation and member checking.
- 2- Transferability- whether the findings of the study can be used in other settings.

- 3- Auditability – how much and how clear the details provided by the researcher in the report are in allowing one to follow it up particularly in terms of methods, data analysis and conclusions.
- 4- Conformability – measures taken by the researcher to ensure or verify whether the participants and other experts agree with the interpretation made by the researcher.

Whereas for quantitative studies, the following two criteria were used as a guide (Kumar, 2011; Parahoo, 2006):

- 1- Validity – This refers to the level of accuracy in the finding reflecting what is being studied.
- 2- Reliability - This is the measurement of consistency of the tool used in the quantitative study i.e. are the tools measuring what they are supposed to measure?.

2.5 RESULTS AND DISCUSSION

The literature included in this review describes the health help seeking behaviour and healthcare utilisation of men from a variety of Asian ethnic groups. These include men who live in the UK and described themselves as British Asian (mostly from South Asia), American Asian, East Asian (Chinese, Japanese, Korean and

Taiwan) and South East Asian (Malaysia, The Philippines and Vietnam). Only a small number of studies were eligible and included in this review. Studies originating from Asian countries were found to be limited in number, confined to studies conducted in China and large collaborative studies undertaken between a few countries in the East and South Asia. Comparative studies that compared White British men to British/South Asian (n=6) and to American Asian men (n=3) were also included.

The range of health topics and conditions covered by the papers was diverse including urological problems, cardiac and psychiatric disorders. The research methods were also diverse but tended towards the quantitative with only two studies adopting qualitative approaches and ten being quantitative in design.

A critical discussion of patterns of health help seeking behaviour and health services utilisation of these men from various origins and ultimately how this may affect their health outcomes is presented here. I also discuss factors and parameters that influence their health help seeking behaviour and health care services utilisation. Each of these factors are discussed and presented below in the form of themes.

THEME 1: THE IMPORTANCE OF BEING HEALTHY TO DEMONSTRATE CONFORMITY WITH CULTURAL NORMS AND SOCIAL RESPONSIBILITIES ASSOCIATED WITH MASCULINITY

Research conducted in western contexts revealed that reluctance to seek health help resulting in their poor health service utilisation and poor health outcomes tended to be associated with men's adherence to hegemonic masculinity (Buckley & Ó Tuama, 2010; Chaturvedi et al., 1997; Galdas et al., 2007; García-Calvente et al., 2012; Hennessy & Mannix-Mc Namara, 2014; Jeffries, 2012).

For example, in the case of men's experience of chest pain, it was found that Caucasian males in both studies conducted by Chaturvedi et al (1997) and Galdas et al (2007) delayed seeking immediate care from healthcare services. This delay was not due to failure to recognise symptoms, but it was the consequences of their attempt to enact a particular form of masculine identity, whereby responding to symptoms was perceived to equate to a sign of weakness and vulnerability, which was incompatible with ideals of hegemonic masculinity. McVittie & Willock (2006) posited that this masculine concept is associated with power and with stoicism in the face of adversity. Hence, seeking help is regarded as incompatible with hegemonic masculinity and it is viewed as weak and unmasculine (C. McVittie, Cavers, & Hepworth, 2005). This was exactly what

these two studies by Chaturvedi et al (1997) and Galdas et al (2007) confirmed.

Similarly, it has been reported that Irish men view health help seeking as a female trait and not associated with masculinity as it demonstrates a lack of self-reliance (Buckley & Ó Tuama, 2010; Hennessy & Mannix-Mc Namara, 2014). Jeffries (2012) found that white British men also subscribed to this view. This was also the case with Spanish men. In an interview-based study aiming to compare health, vulnerability and ways of coping with illness between Spanish men and women, the researchers found that Spanish men tend to overrate how healthy they are and to hide their problems by projecting the image of being a 'tough guy' (García-Calvente et al., 2012). Taken together the perception of better health and less vulnerability to illness creates a negative influence on these men's health help seeking intentions and utilisation of healthcare services.

It can be argued that this behaviour and perception of masculine ideals are learnt and acquired. According to a recent WHO report boys and young men are often socialised to be self-reliant, independent, devoid of emotion and expected not to concern themselves with their physical health or seek assistance during times of need (Barker, 2000). Somewhat in contrast to these studies,

being able to fulfil masculine norms and discharge the social responsibilities associated with manhood, particularly towards their family was found to be a priority for Asian men and meeting family responsibilities are often considered as attributes to their masculinity. This sentiment was shared by Asian men in two separate studies undertaken by Ng, Tan & Low (2008) and Fazli Khalaf, Low, Ghorbani & Khoei (2013). Asian men in the studies identified that being the breadwinner and head of their family is important for them as a man. They stressed that this ability to perform could potentially be compromised by ill-health. Hence, they would visit their doctor in the event of experiencing ill-health symptoms so as not to risk the compromise to their ability and capacity to discharge roles and actions associated with or enhancing of their masculinity.

In 2007, Galdas, Cheater and Marshall, found that in comparison to the White British men, South Asian men showed a greater willingness to seek medical help (Galdas et al., 2007). They found that the South Asian men considered seeking help as important and acceptable particularly in the case of experience of chest pain so as to avoid unwanted complications. Chiming with studies referred to above, South Asian men in this study drew attention to the importance of male responsibility for the family and regarded health help seeking as a means of avoiding compromising their ability to discharge this responsibility. This study also found that for the South

Asian men, discharging responsibility for the family and maintaining their own health are important masculine attributes. This all contributes to greater willingness to seek medical help. Interestingly, this is the opposite of the white men amongst whom the ability to tolerate pain and discomfort was valued as a masculine attribute. Not adhering to this by, for example, visiting their GP as a first port of call would be regarded as weak and un-masculine.

Findings such as those reported above could offer a possible explanation for the higher rates of attendance to GPs amongst the Asian male community in London when compared to their white peers (Gillam, Jarman, White, & Law, 1989). In a retrospective survey of the various ethnicities that consulted GPs in London between 1971 and 1981, it was found that, in comparison to other ethnic groups, Asian men had a much higher consultation rate (Gillam et al., 1989).

However it can be argued that this does not mean that employment and ability to earn and support the family are not important to White men. It is equally important but they did not prioritise it as much as South Asian men. It can be argued that changes in the social and economic environment drive these men to rework how they consider the ways that masculinity is bound up with men being the sole breadwinner of the family (Cleaver, 2002).

THEME 2: THE INTERSECTION OF AGE AND MASCULINITY AND THEIR INFLUENCE ON PATTERNS OF HEALTH HELP SEEKING

Zhang, Yu, He & Jin (2014) suggest that the influence of the masculine role on health, is mediated in important ways by age and position in life course (their role). This study, which involved a large survey of Chinese men (N= 2,693) recruited from an out-patient clinic treating cases of erectile dysfunction, found that unlike the younger patients, older Chinese men would seek help from their doctor ahead of any other option. This highlights the importance of considering how and why age and their patterns of health help seeking are interlinked.

A further look into the literature revealed a few other studies where the link between age and health help seeking behaviour has been explored. These studies are firstly, a study undertaken by O'Brien, Hunt & Hart (2005) and secondly research in Ireland undertaken by Hennessy and Mannix-Mc Namara (2014). Both of these studies found that as men's age increases, so too does their level of awareness and concern about health and in turn this increases their willingness to access health care services.

O' Brien, Hunt & Hart (2005) concluded that older men tend to re-think and modify certain concepts and/or practices that are traditionally seen as masculine (and potentially in tension with health help seeking) with age. Simply put, this means that the older a man gets, the more likely he is to seek medical help because of the increased impact of ill-health (García-Calvente et al., 2012). Discourses of masculinity and successful ageing are both represented in men's talk about independence and how ageing leads to loss of independence and capacity to engage with physical abilities and increasing morbidity (Smith, Braunack-Mayer, Wittert, & Warin, 2007). Hence, older men negotiate their concept of masculinity so as not potentially to compromise their health further. In the case of erectile dysfunction, it can be argued that Chinese men prioritise their visit to their physician because they might consider erectile dysfunction as compromising their masculinity and manhood. In fact, ability to have sex was identified as an important masculine attribute by these Chinese men (Ng et al., 2008).

Additionally, a study by Zhang et al (2014) found that in comparison to older participants, who would turn to their GP, younger Chinese men identified the Internet as their first point of reference for information and advice regarding any health issues. Perhaps this is rather not surprising as the use of modern digital technologies was found to be appealing to younger men (Woods, 2014).

Greater digital literacy amongst younger men may be a factor accounting for this difference between the two age groups. It was reported that the use of digital technologies could offer some strategies that may help overcome barriers to accessing health care services for males. The use of modern digital technologies was found to be appealing to younger men (Woods, 2014). Another important issue raised by this study is the fact that both groups of Chinese men, irrespective of their preference (either to use the internet or consult with their physician in person), actually seek health help from people outside their family. This is because these Chinese men considered talking to their partners about sexual problems made them feel inadequate. Again here we can see how men link the ability to have sex (in this case, be able to achieve an erection) with aspects of masculine identity.

THEME 3: REASONS FOR ACCESSING HEALTHCARE SERVICES

Literature reviewed in this thesis reveals that men moved between the dominant discourses circulating in western society regarding how 'masculine' men behave – broadly speaking showing that they do not consider or care about their health - to realising that in everyday practice, they should and can actually care about their health. This

is what Robertson refers to when he talks about his “**don’t care, should care**” dichotomy (Robertson, 2006). Positioning ‘masculinity’ as the sole reason for men’s disinterest in their health, and avoidance of health help seeking is clearly not always appropriate. Robinson argues that men’s health seeking behaviour is complex and that with legitimising reasons, men will consider seeking health help.

This highlighted the points raised by Connell (1995) whereby she said that masculinities should be operationalised as ‘configurations as social practice’. According to Robertson, Williams & Oliffe (2016) this means that masculinities should be recognised as diverse processes of arranging and ‘doing’ social practices that operate in individual and collective settings. This explains how men can be involved in changing and even apparently contradictory practices in different times and places. Referring to the empirical evidence reported in these studies, one could not avoid seeing how masculinity seems to be regarded as a negative influencing factor in determining men’s health help seeking behaviour. Adherence to hegemonic masculinities deters them from seeking health help from their GP. As a result, men under utilise health care services and appear to be disinterested in their own health. Whilst those studies focus on and indicate aversion to health help seeking and service

use amongst white men from western countries, there are some indications this may be an over-simplification.

For instance, a recent study by Douglas et al (2013) contests earlier findings that suggest men are not interested in their health. They found that Scottish men are in fact interested in their health and would seek health help. However, this depends on a range of factors. For example, not knowing if the experienced symptoms are serious enough to warrant being seen by the GP was seen as a reason why Scottish men (Douglas et al., 2013) might be reluctant to use health care services. These men also shared concerns that they did not want to waste the doctors' time in attending to their problems because they might be regarded as trivial. Should these men know that their symptom(s) were serious, they would have gone to see their GP.

It was also found that men often perceive illness in terms of the manifestations of symptoms such as intolerable pain and persistence, as serious. This triggered men to look for the causative health problem and consequently to seek help. Breach of their pain threshold and intolerance of discomfort are found to be the strong factors making men engage with healthcare services as asserted by Galdas, Cheater & Marshall (2007). This study found that unlike white men, British Asian men claimed that they would seek

immediate medical help in an episode of experiencing chest discomfort, believing it might be dangerous based on the presentation of the symptom. In such circumstances, they regarded seeking help as gender appropriate and rather important to avoid potentially fatal consequences.

On the other hand, a large-scale study involving men with sexual and erectile dysfunction from China, Taiwan, South Korea, Japan, Thailand, Singapore, Malaysia, Indonesia and the Philippines (Nicolosi, Glasser, Kim, Marumo, & Laumann, 2005) found that the majority of the men from these nine Southeast Asian countries did not think that erectile dysfunction is a medical problem, as it does not manifest itself in symptoms such as pain and not affecting vital organs such as lungs and heart. Therefore they did not see the need to seek help.

Retaining employment was also seen as a major factor for men to be active and positively involved in their health help seeking and health maintenance processes. It is suggested that employment and the ability to earn are regarded as important anchors for masculine identities (Morgan, 1992). This was echoed in study on Scottish men, by O'Brien, Hunt & Hart (2005), whereby men expressed the view that if the need to be physically healthy and seeing their GP for health assessment is a part of their employer's protocol, then it is

acceptable to do so. O'Brien et al (2005) concluded that men's initial reluctance to consult could be understood with reference to a 'hierarchy of threats to masculinity' (p. 514). Configurations of practice linked to the ability to maintain competency and therefore continue employment and earning, meant that help-seeking to stay well in this context did not pose a threat to identity, in fact it was necessary and required. Arguably, this is similar to Asian men whereby they regarded being able to discharge the social responsibilities particularly to their family as a priority for them as a man. However, the major difference is how they see the need for them to work and earn for their family (Fazli Khalaf et al., 2013; Ng et al., 2008).

THEME 4: MENTAL ILLNESS, MASCULINITY AND HEALTH HELP SEEKING BEHAVIOUR.

Evidence on health help seeking particularly in the case of mental illness was fairly consistent in which, not wanting to be seen as weak, nature of therapy, which is regarded as unmasculine and stigma attached to mental illness, are reasons found to deter men from seeking for help.

Evidence also show that stigma attached to mental illness and accessing mental health services was found to be another hindrance factor for men to seek psychological help. According to Pleck (1995) men's conformity to traditional masculine norms such as stoicism, self-reliance and restrictive emotionally, were found to be positive predictors of depression scores and, is tied to the lower rates of detected depression amongst men. This lower rate amongst men is believed to be a result of men restraining from help seeking.

Further, this review found that Asian men have a negative view with respect to seeking help from mental health services. Three studies shared a common conclusion; that Asian men rank below all others when it comes to seeking psychological health help when compared to men of other ethnicities (Huang et al., 2012; Soorkia, Snelgar, & Swami, 2011; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). It may be of course that there are factors influencing this disparity. For example, social and structural reasons relating to service delivery may influence patterns of engagement with mental health service use. However, fear of stigmatisation was commonly highlighted in the literature as a deterrent to Asian men accessing health services for psychological intervention.

This was a particular focus in a quantitative study analysing the factors influencing attitudes towards seeking professional

psychological help among South Asian students (Soorkia et al., 2011). This study, conducted in Britain, utilised four Likert-type scale questionnaires, namely the Attitudes Towards Seeking Professional Psychological Help Scale, Asian Values Scale, Cultural Mistrust Inventory and the Multigroup Ethnic Identity Measure.

It was found that greater adherence to Asian values as portrayed in the 'Asian Value scale' questionnaire (Kim & Hong, 2004) (which aims to explore values, ideas, and concept that are considered salient for the Asian culture) has a negative impact on attitudes towards psychological health help seeking. This is because most Asian men believed that psychological health help seeking was shameful for one's family (Yang, Phelan, & Link, 2008). It is plausible that shame is significant because it may be associated with fear of being stigmatised and discriminated against. Indeed, it has been shown that stigma involves both prejudicial attitudes and discriminating behaviour towards individuals with mental health problems and it leads to exclusion, poor social support, poorer subjective quality of life, low self-esteem and discrimination (Livingstone & Boyd, 2010). It was suggested that stigma and discrimination are major problems for people suffering from mental illness (Bradby et al., 2007). It is also found to be the main obstacle to the provision of care to people with the disorder (Talebi, Matheson, & Anisman, 2016). Time to Change, an organisation in

the UK that looks into mental health issues, conducted a large survey of 4000 people with direct experience with mental health problems and found that 87% of the respondents had been affected by stigma and experienced discrimination (Time to Change, 2008).

Furthermore, fear of stigma due to mental illness is not only limited to the affected men but also experienced by their family and friends. As a result, this reduces the likelihood of them suggesting psychological intervention (Vogel, Wester, Hammer, & Downing-Matibag, 2014). This unwillingness and lack of likelihood that people would make the referrals are both reflected in the questionnaire used in the study.

Respondents in the study by Vogel et al (2014) also expressed a view that existing psychological interventions such as psychotherapy may not be likely to work. This is based on their belief, strongly implied by hegemonic masculinity, that men do not discuss emotional issues with each other. The use of psychological intervention such as psychotherapy, which focuses on emotion, was reported to be the most common to be offered to men who seek a mental health consultation. It has been argued that this approach is not gender appropriate (Morison, Trigeorgis, & John, 2014). This is because compared with women; men tend to be far more concerned with being competitive, powerful and successful. Most men do not like to admit that they feel vulnerable, and so are less likely to talk

about their feelings with anyone, including doctors (Olliffe & Phillips, 2008). Hence, such interventions may not align well with the masculine role, which limits them from sharing their feelings with others, thus leading to poor utilisation of counselling services by men (Good & Wood, 1995).

2.6 SUMMARY AND CONCLUSION

Twelve papers were included in this review. The STARLITE framework was used to assist in the systematic scrutiny and evaluation of the literature search. The search found that the number of studies that look at this issue from the lens of Asian men, particularly from the Global South is very limited. A few studies have sought to compare white men to Asian men, for example those studies from America and the UK. These comparative studies are predominantly quantitative in nature and only one of the comparative studies conducted in-depth interviews with men. There is a clear gap in knowledge and understanding that arises from in depth exploration of the issues from the perspective of these men.

Four themes were identified from the literature: The importance of being healthy to conform with masculine cultural norms and responsibilities; the intersect of age and masculinity and their influence on patterns of health help seeking; reasons for accessing

healthcare services; and finally, mental illness, masculinity and health help seeking behaviour.

It can be concluded that male behaviours and attitudes that affect their health are strongly influenced by culture and within that, change over the life course. Culture influences men's views of what constitute the most important attributes of a masculine identity, and represents the context in which men view masculinity. It impacts directly on the degree of comfort and sensitivity they feel in talking to friends or a GP regarding an existing medical or psychological problem and the appropriateness of help seeking.

Generally, literature from the Global Northwest shows that most western men embrace the ideology of hegemonic masculinity and this influences their pattern of health help seeking. Consequently, they delay or avoid visiting their GP so as to demonstrate and maintain their masculine identity, and not appear weak. However, it was also found that in fact it was not as straightforward as it sounds. Masculinity is rather complex and context dependent. How men view masculinity and their masculine ideals in a particular context influences the way they seek health help and engagement with healthcare services. With legitimising reasons, men would consider their construction and would reconstruct their masculinity in relation to seeking help from healthcare professionals. As previously

discussed, there are social and psychological factors that influence the way men utilise health care services. Factors such as age, intolerable pain, retaining employment, knowledge and perceived level of seriousness of a presenting signs and symptoms, while maintaining masculinity, plays a big part in influencing and shaping Western men's' health help seeking behaviour.

Similarly, studies involving Asian men also found that perceptions and knowledge of presenting signs and symptoms is a major indicator for Asian men to seek or delay health help, as in the case of chest pain and erectile dysfunction, respectively. Perceiving a symptom as serious and dangerous will push Asian men to go and seek immediate help.

However, what is significant in the findings from this review is how Asian men recognised the need to be healthy and treat symptoms promptly, in order to perform their responsibilities to their family: what Asian men regard as the most important masculine attribute. In the case of experiencing ill health symptoms, they tend not to delay seeking for help, particularly if they think it is serious or potentially serious. Delay in seeking health help is seen as potentially able to compromise and jeopardise their ability to contribute to their family. This pattern of belief is culturally shaped. The expectations and responsibilities placed on the shoulders of a man and what it means

to be a man was passed down from one generation to the others. It is perceived that is how it has always been and what is expected from them. A change or shift in social and economic climate might likely challenge this social and relational expectation, like in the case of other developed countries.

Interestingly, on the other hand, where a problem is heavily stigmatised and potentially brought embarrassment, Asian men and their families would avoid seeking health help. Shame seemed to be a concept with particular significance for Asian men and not so much amongst White men. Arguably, this could be all down to levels of awareness of mental health issues. This would depend on the availability and effectiveness of health promotion on mental health in those countries.

Drawing on the studies discussed above, it can be concluded that masculinities are significantly context-dependent. Culture, time and setting are some of the factors identified in this review as mediating both masculinity and health. This highlights the complexity of men's health help seeking behaviour. The mandate for further research that looks into the relevance of the existing masculinity theory in a different context, particularly outside the Global North, where such work is still scarce is clear. That said, the literature is clear about the broad ideas of how gender and health relate and interact. However,

bringing the issues around Asian men's health and help seeking into closer dialogue with the concept of hegemonic masculinities exposes points where theoretical elaboration is required. Critical foci are to be found in relation to the significance of the family, of the cultural norms such as shame and gendered role expectations around relational dependencies and status.

CHAPTER 3: METHODS AND METHODOLOGY

In this chapter I describe the research and methods and methodology used to address the questions identified in chapter one of this thesis. The chapter begins with a description of the methodology used to guide this study. This includes consideration of the research philosophy, approach, strategies, choices, time horizon and techniques and procedures for all aspects of data collection. I go on to report socio-demographic information about the study participants and share some reflections on the recruitment and data collection process. Discussion of methodological issues encountered during the study and the ethical considerations engendered and how they were dealt with are presented towards the end of this chapter.

This organisation of the material reflects the understanding of research methodology as articulated by Saunders et al (2007) in the 'Research Onion', (see figure 3.1 below). It was termed as such because research methodology is seen as comprising layers of thinking, process and activity. These begin with philosophy as the outermost layer and the first to consider since it influences the study methodology and approach and in turn the data collection and analysis, which sits at the innermost layer of the 'research onion'.

I will describe my research methodology starting from the outermost layer and slowly “peeling” this “onion” until I reach its innermost layers. The different layers of the Research Onion are employed as subheadings to ensure the clarity and the smooth flow of discussion in this chapter.

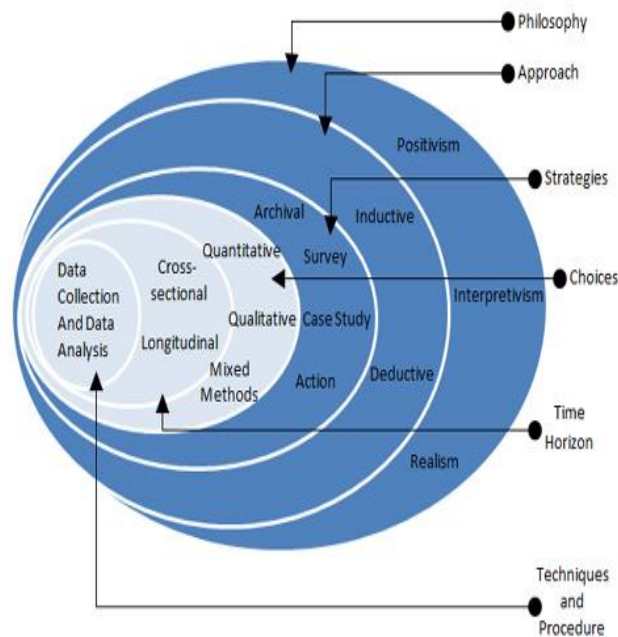


Figure 3.1: Research Onion.

3.1 METHODOLOGY

(A) Research Philosophy

One of the main purposes of conducting research is to generate knowledge. However, in order to generate knowledge one needs to know how it will be surfaced. This point is stressed by Mohd Tobi (2014), who posited that in order for the researcher to know how

knowledge is created, he or she needs a good understanding of research philosophies. Furthermore, a good understanding of research philosophies helps with the process of clarifying and creating research design and making judgements about which research techniques will work (or for that matter not work) based on given circumstances (Easterby-Smith, 2003). According to Mohd Tobi (2014) a research philosophy refers to:

“...an investigation of the nature, causes or principles of reality, knowledge or values based on logical reasoning rather than empirical methods” (Mohd Tobi, 2014:13).

Given the imperative of aligning approach with research philosophy, consideration of the nature of my interest in questions about the contextualised meanings of social phenomena has led me to adopt *interpretivism* as the guiding research philosophy for this study. This in turn strongly implies employing qualitative research methods, which allow the researcher to explore the richness, depth and complexity of the phenomena under study in ways that expose meaning. This approach and these methods accommodate and recognise the importance of dialogue between the researcher and the participants in order to collaboratively construct a meaningful reality. As a consequence I have employed interviews and focus group discussions coupled with some limited in-setting observational work as the most appropriate means of generating and gathering

data. It is also important to note that interpretivism holds that reality is socially constructed and fluid, hence, dependent on the context, situation and time under study. This focus on contingency is highly appropriate to a set of research questions located in a theoretical framing which conceptualises gender and gender-related practices and behaviours as social and culturally contingent constructs.

Thus to sum up, the nature of the research question and the ontological orientation provided by the conceptual resources on which I draw provides the mandate for me to use this approach in investigating the health help seeking behaviour of Bruneian men and their patterns of healthcare services utilisation.

(B) Research approaches

A qualitative research design adopting the inductive-deductive characteristics of constructivist grounded theory has been applied in this study (Charmaz, 2014). The inductive dimension is well suited as it aims to support theory building in relation to a subject and setting which has not been explored in research previously. This is coupled to a deductive dimension reflective of the fact that although Glaser and Strauss (1967) originally suggested that grounded theory required the researcher to be a 'tabula rasa' subsequent development of the theory acknowledged that one does not enter the field or approach a research question with an 'empty head' but

informed by knowledge and ideas gathered through, for example, a reading of relevant research literature.

Indeed my background reading both guided me, in terms of shaping my understanding of the issues prior to undertaking fieldwork and, in an iterative process informed my data collection and the process and approach to analysis, which overlapped. As I will go on to demonstrate, the themes and codes that I used to analyse data were informed by the academic literature but at the same time I also allowed for flexibility and I was open to discovery of new and additional themes in my study as they emerged.

(C) Research strategies

The study adhered to the principle features of constructivist grounded theory namely: (a) theory generation, not theory verification; (b) theoretical sampling, (c) the constant comparative method of data analysis; and, (d) theoretical sensitivity.

In terms of theory generation the principle aim of the research was to generate theory that aids understanding of Bruneian's men health help seeking behaviour and practices. Because so little is known about these phenomena, this makes grounded theory most appropriate in this context (Glaser, 1978). Furthermore, as this study is concerned with understanding men's health help seeking

behaviour and practices in depth and from men themselves, a qualitative study is also deemed as most appropriate (Greenhalgh, 2006).

The aim of developing theory using a grounded approach also influenced my thinking about sampling for participants in the study. This meant that as well adopting a set of inclusion and exclusion criteria to ensure relevance and suitability of the sample to the study aims, I employed a theoretical sampling strategy (Charmaz, 2014; Coyne, 1997). It has been argued that this is essential to the inductive-deductive process characteristic of grounded theory (Becker, 1993). In connection with this Charmaz (2006) asserts that theoretical sampling becomes valuable once categories have been developed as it enables the researcher to confirm, clarify and expand the categories. The use of this sampling approach allows the researcher to look at the data collected and in an iterative analytic process to decide which data to collect next and where to find the participants who can yield this based on the emerging themes (deductive component). This much more robust and systematic approach to sampling is appropriate since this study aims to generate theory, through constant comparative analysis of data (inductive component) in accordance to grounded theory principles (Glaser, 1978).

The inclusion and exclusion criteria are reported below under the section entitled 'Research techniques and procedures'.

(D) Research choice

This refers to the research design used in the study. The research design for this study is 'qualitative multi-method' (Teddlie & Tashakkori, 2009). This is evident in the use two qualitative data collection methods - individual interviews and focus group discussions. I supplemented data collection via these methods with in-setting observational work primarily used to record information about the experience of the interview, its physical context and participant reaction, behaviour and interaction with either me or other research participants. Notes of observations were therefore integrated into field notes made after each research intervention and primarily employed to support and inform analytic thinking and also guide reflection on the conduct and content of the intervention.

My main justification for choosing qualitative methods is congruency with the main objective of this study that is to explore the experiences of men regarding their health help seeking behaviour. Information of this kind cannot be presented easily if at all via numbers and statistics. I was also influenced by pragmatic considerations that such as time and budget constraints, which

rendered the adoption of, for example, mixed qualitative and quantitative methods impractical.

(E) Time horizons

This research is a cross sectional study. It provides a 'snap-shot' of men's health help seeking behaviour. I only interviewed men and women once and at that point of time only. The study does not include any follow up interviews, unlike a longitudinal study (Saunders, Lewis & Thornhill, 2009). Again this choice was made for pragmatic reasons including the time available for the study and the need to travel to undertake fieldwork.

(F) Research techniques and procedure

Here I discuss both the data collection and data analysis undertaken in this study.

(i) Data collection: Sampling

I employed snowball sampling in this study. This was a pragmatic choice made when I was faced with difficulties with recruitment via other means. These are described later in this chapter. As an attempt to get a representative sample, I developed inclusion and exclusion criteria. Furthermore, the inclusion and exclusion criteria for this study were designed to ensure that I recruited participants to the study with relevant experience as I worked through the

'snowballed' contacts. In this respect, it maximised the chances of obtaining relevant data relating to the research questions (Glaser, 1978).

The inclusion and exclusion criteria can be found on in the following page.

INCLUSION CRITERIA	EXCLUSION CRITERIA
(1) Men of a consenting adult age: 18 years old or older	(1) Below the age of 18
(2) Self identifying as belonging to one of the largest ethnic groups in Brunei namely Malay, Chinese and indigenous groups of Iban, Dayak and Kelabit	(2) Men who do not identify themselves as belonging to any of the largest ethnic groups – Malay, Chinese and indigenous groups of Iban, Dayak and Kelabit
(3) Can speak either Malay or English language.	(3) Men who do not understand Malay or English.
(4) Men who were born in Brunei or have been residing in Brunei for more than 10 years. 10 years is chosen as the criteria because 10 years is considered as the minimum number of years before ones can apply for permanent resident (PR) status.	(4) Men who live in Brunei due to work commitments only.
	(5) Men who have lived in Brunei for less than 10 years
	(6) Men who are admitted to the hospital due to certain medical circumstances / during the interview phase will not be included in this study as this study intends not to involve patients.

This study also sought to elicit women’s perspectives on this issue asking what they think of men’s health help seeking behaviour and the role that they play in men’s lives. Thus, I devised the following inclusion and exclusion criteria for the recruitment of female participants.

INCLUSION CRITERIA	EXCLUSION CRITERIA
(1) Women of a consenting adult age: 18 years old or older	(1) Below the age of 18
(2) Can speak either Malay or English language.	(2) Women who do not understand Malay or English.
(3) Married to a man that belongs to any of the three ethnic groups being studied. This also includes those women who are divorced but whose ex-husband belongs to any one of the ethnic groups.	(3) Women who are admitted to the hospital during the study.

Prior to undertaking fieldwork, ethical clearance was sought and obtained from Durham University’s School of Medicine, Pharmacy and Health Ethics Committee (**Reference number: ESC2/2014/12**). I describe in detail the ethical considerations raised by this research and how I addressed them below in section 3.5 of this chapter.

(ii) Data Collection: Recruitment

I anticipated that recruiting men to the study would be difficult. This perception was shaped by reading accounts of studies in which

researchers had identified the challenge of recruiting men to research and involving them in interviews about their experiences of health and illness. A literature review by Brown (Brown, 2001) illustrates the point well noting that men are often unwilling to participate in studies exploring health. In response I put in place a variety of methods of recruitment to increase the visibility of the study and to attract participants to take part. The recruitment methods utilised ranged from the use of hard copy and electronic posters, to direct recruitment, and snowballing via third parties using social media.

A poster describing the study and providing contact details through email and a phone number dedicated to the research project was placed on notice boards in a variety of public places frequently used by men. These included gyms, shopping malls, libraries and local community centres across the four districts in Brunei. This poster was made available in both English and Bahasa Melayu. A copy of the poster is included in *Appendix 4*. Additionally, in an attempt to reach a wider population, the mobile 'phone application (app) "Whatsapp" was also used to disseminate the poster. This electronic version of the poster was distributed to my contact list and then further shared via these contacts with their network of contacts. The decision to use this app was heavily influenced by a report in a Bruneian local newspaper dated 27th June 2012 which stated that

most people in Brunei were using free messaging services available as smartphone apps such as Whatsapp (Abu Bakar, 2012).

I also used my social contacts to undertake a process of snowball sampling whereby participants were recruited via third parties such as friends, colleagues and partners whom I informed about the study in the first instance either via face-to-face meetings or by using social media. A dedicated Facebook page was set up a month before I went back to Brunei to undertake the fieldwork, with the aim of reaching more people and providing them with ample time to consider whether they would like to become involved in the study. Again, a snowballing process was employed such that this Facebook page was shared with all of my contacts and with their help the intention was that it was further shared with their contacts.

The utility and capacity of Facebook and Whatsapp as means of recruitment to the study was assessed as quite high, partly because Brunei is listed as one of the top users of Facebook in Asia with a total of 234,060 users, i.e. more than half of its population (Hayat, 2012). There is also a strong culture of forwarding and sharing Whatsapp and Facebook posts among Bruneian users on these digital media. In addition, there is some evidence about the value of social media as a recruitment tool in research involving men. For example, Tyler & Williams in their study from 2014 (Tyler & Williams,

2014) managed to recruit twenty-eight young men and conduct two online focus group discussions exploring men's understanding of health, help seeking and health service use using social media such as Twitter and Facebook. The success of this study influenced my decision to explore social media as a recruitment method. The effectiveness of third party involvement in disseminating information about research and recruitment has also been indicated elsewhere in the academic literature (Oliffe & Mros, 2005).

Personal contact with community leaders was also a significant element in recruitment. In particular, in attempts to reach into the Iban community I met one of the "Ketua Rumah Panjang" (see glossary for a fuller description) to inform him about the study and ask for his assistance in disseminating information about it to his people in the long house. This was deemed appropriate and regarded as a courtesy because as the leader of the long house, he would expect to be informed of anything that has to do with his people.

Conscious that evidence suggests that men's responsiveness to advertisements and emails inviting them to participate in studies about health and illness research may be low (Oliffe & Mros, 2005), I also made direct personal contact with men in an effort to recruit them to the study. I undertook this work in venues such as sports

clubs/gyms and at shopping centres. Further attempts to recruit via snowballing were also made after each interview and focus group discussion inviting participants to reach out and inform members of their peer group about the opportunity to participate. The recruitment process is summarised below in Figure 3.2 where I also indicate how it fed into the process of data collection.

FLOWCHART OF RECRUITMENT AND DATA COLLECTION PROCESS

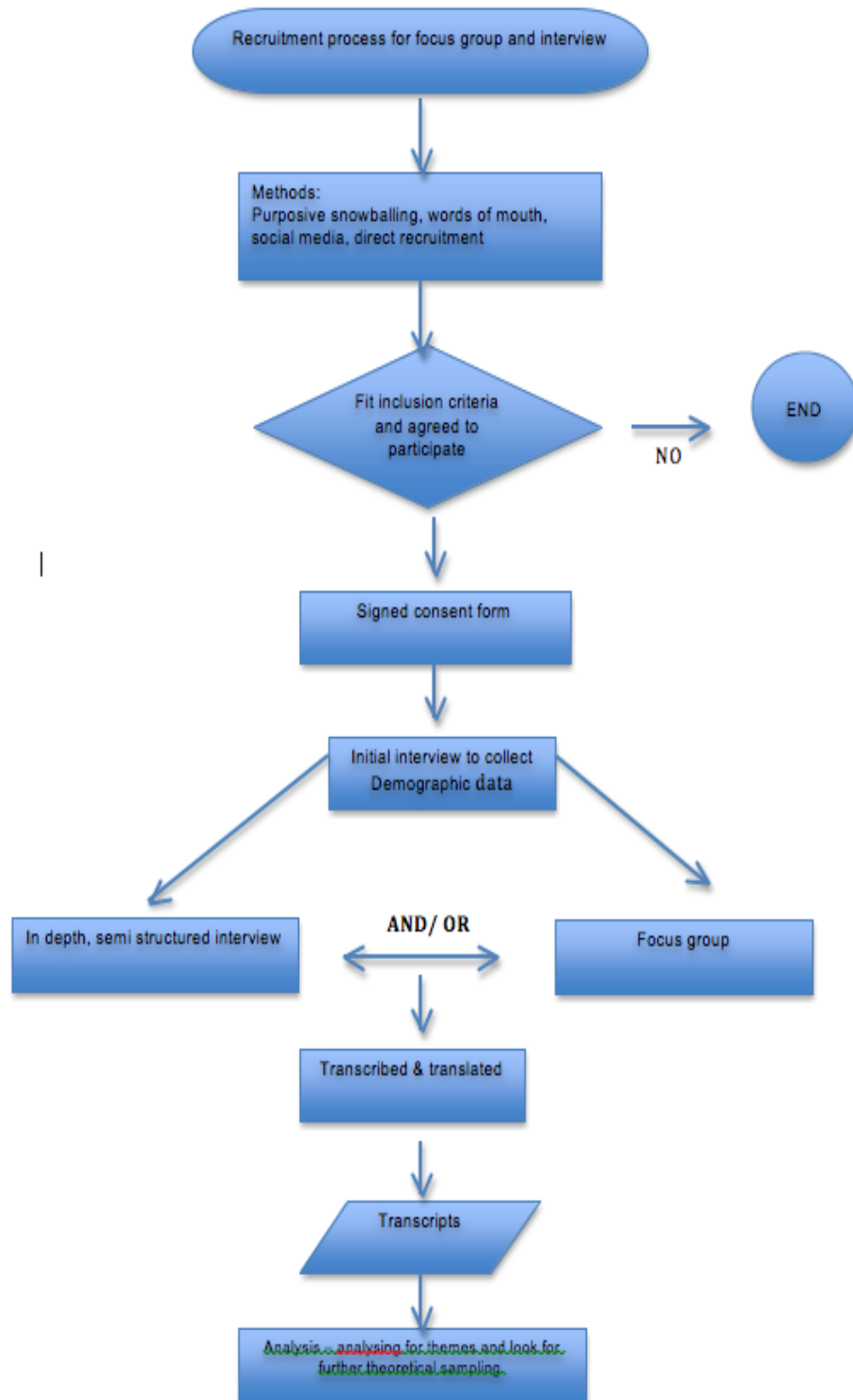


Figure 3.2: Flowchart of recruitment and data collection process.

(iii) Data Collection Process

The process of piloting and conduct of the individual interviews and focus group discussion took about seven months to complete. The piloting took place in November 2014, whilst the interview and focus group took place in two waves between August and November 2015 and then again between February and May 2016. The reason the fieldwork was in two waves was that the financial sponsor of my doctoral studies would only allow me to be in Brunei for a very limited period of up to three months at a time during the scholarship.

The process by which I conducted the interviews and focus group discussions is described below.

The time between first contact with a potential recruit to the study and interview was crucial as a context in which to inform potential participants about the research, address any questions that they raised and to develop rapport. I followed a simple three-step process:

1. Detailed information about the study was relayed to potential participants either in person or over the phone. I provided them with an information sheet outlining the study. The information sheet contains a basic guide to the questions/topics to be covered in interviews and focus group

discussions. I discovered that providing this information not only enabled recruits to make an informed choice about participation in the study but also enabled them to prepare themselves. Additionally, I also found that this method helped to to reduce anxiety that some men may have felt about their capacity to answer the interview questions. Information sheets were made available in both English and Malay. These are attached in Appendix 5, which contains versions of the sheet for individual interviews. Information sheets for focus group discussions with men and the focus group discussion with women that I used can be found in Appendix 6 and 7, respectively.

2. Multiple opportunities were made available for potential participants to ask questions. I reached out to recruits both with the information sheet and subsequently find out if they had any questions about the study.
3. In terms of timing, a follow up call was made to potential participants three days after the first contact, to enquire whether they were still interested in taking part. If so, I agreed practical arrangements to meet for the interview or sent the details about the focus group discussion.

Prior to enrolling them in the study, written consent was sought from every participant. This also applied to the pilot interviews. Appendix 8 contains a copy of the consent form.

In gaining consent I adhered to the following series of procedures:

1. All participants were briefed about the research and I gained confirmation that they understood the study and the processes involved.
2. I confirmed that participation was voluntary and whether the participant wanted to be involved in a Focus Group discussion and/or the interview.
3. I sought and gained permission to audio record the interview for the purpose of transcription and analysis. Issues pertaining to the safe storage and protection of data were explained to all participants.
4. I clarified that all participants understood that their responses would remain anonymous and no real names will be mentioned in study reporting.
5. I ensured all participants understood that they could withdraw from the study at any point
6. I also ensured each participant understood my position as the researcher. They were told that I could not be responsible nor was it appropriate for me to deal with any health issues/

concerns, should they arise during the interview or focus group discussion. I made it clear however, that I could 'sign-post' participants to sources of information or help. I made it clear that a list of health centres and the details of the person-in-charge would be available as part of the study information pack (Appendix 9).

7. Once the participant had confirmed that they had understood the information and agreed to participate, they were asked to sign a consent form. This was followed by obtaining their demographic and personal details.
8. After the session, a food voucher was given to the participants as a token of appreciation for their participation. In common with previous accounts of conducting research with men, for example, Oliffe & Mroz (2005) it has been shown that such incentives are quite useful as a means of showing respect and researcher acknowledgement of participant contribution to research.

Piloting stage

A pilot focus group was conducted on receipt of ethical approval for the study from the Ethics Committee at Durham University, School of Medicine, Pharmacy and Health. This took place in November 2014. Given the congruency of the data from this pilot with that obtained in

the main study and its utility in terms of analysis , it has subsequently been integrated into the main study findings.

The five male participants recruited to the pilot via direct recruitment and snowballing took part in the sixty minutes long focus group discussion. The setting was an office in the Universiti Brunei Darussalam, Brunei. Chairs were put next to each other surrounding a small round table in a fairly informal manner. No fixed sitting plan was imposed on participants. They were free to choose to sit where they wanted. I made these decisions in order to create a relaxed and easy environment during the session. Discussion took place in a mixture of English and Bahasa Melayu as this was the preference of participants. Details of the participants involved in this pilot can be found in Appendix 10.

Conducting this pilot gave me the opportunity to evaluate the meaningfulness of topics to participants and to refine and amend the content and sequencing of the questions that I had formulated into the schedule for the discussion (Morgan, 1988). During this pilot focus group, I managed to 'test' out the schedule, which comprised of questions adapted from Chrisman (1977).

Discussion was facilitated initially by using general questions such as, for example, asking how Bruneian men define health and illness? What is the health help seeking process of Bruneian men? Do

Bruneian men seek health help and for what reasons? Do Bruneian men seek help from family and friends for their health problems? However, the main body of the discussion involved discussion of topics that the participants themselves raised. This allowed the subject of masculinity and specific health practices and beliefs of specific ethnicity and age groups to be explored without too much input from me as the facilitator. Different views on what it means to be a man in Brunei and how men make use of health care services were expressed and shared in the focus groups and these views were also supported, shared and sometimes even challenged by members in the group through their comparison of their experiences and opinions.

The schedule of questions used during pilot Focus Group Discussion is reported in table 3.1 alongside the changes made post-pilot.

PILOT STUDY QUESTIONS	AMENDED VERSION
<ol style="list-style-type: none"> 1. How do you define health and illness? 2. Please reflect back on your past experiences, how would you describe your health help seeking process? 3. Do you seek health help and for what reasons? 4. Do you seek help from family and friends in the case of any health problems? 	<ol style="list-style-type: none"> 1. What does being healthy mean to you? Please explain. 2. How do you know when someone (you) is/are healthy? Please explain. 3. What do you do if you are not feeling well?. Please explain. 4. Do you go to see your GP if you're not well?" 5. Describe a situation when you would see your GP? 6. What do think about men going to the GP if they are not well? . Please explain. 7. When was the last time you saw your GP? 8. How was your experience seeing your GP/using health care services. Please describe this experience.

Table 3.1: Interview schedule – pre-and post-pilot.

The above questions were also translated into the Malay language in order to as enhance participants' understanding of them. However, it became apparent that the issue uncovered in the pilot was not simply the language but rather the way that the questions were formulated. I noticed men did not answer questions straightaway and appeared doubtful and hesitant. They asked for further elaboration

and some sought confirmation that they correctly understood the intended meaning prior to answering.

As a result of the pilot, I reconstructed my questions to be more responsive to men's concerns and needs but at the same time preserving adherence to the main objective. The amended questions are reported in the above table (Table 3.1).

The pilot was also beneficial in the sense that it gave me some first hand insights into Bruneian men's perspectives on the substantive issue of health and healthcare. It introduced me to a number of concepts that came out very strongly in the focus group discussion such as issues around men's cultural norms and responsibilities, the importance of being healthy and the use and misuse of medical certificates. This introduction was important, as it has informed my approach and focus during the subsequent interviews. I began to explore these concepts in more depth in all the interviews that followed.

As well as testing the schedule, the pilot also gave me the opportunity to test out the ground rules and regulations by which I wanted to run the focus group discussions. I also invited the participants to suggest additional ground rules as they thought them necessary and helpful. This was well received by participants, who

seemed to value the acknowledgement of their views. From my perspective I also saw this as an icebreaking opportunity. Overall, the participants did not appear to be having any difficulties in complying with the rules and I personally found that the rules were a good way to manage the group. The ground rules produced as a result of the collaboration between me, as the researcher and pilot study participants were as follows:

Table 3.2: Ground rules for focus group.

Ground rules for focus group:

- There are no right or wrong answers to the focus group questions. Therefore, we want you to be as honest and as open as possible.
 - We want to hear many different viewpoints and would like to hear from everyone.
 - In respect for each other, only one individual should speak at a time in the group.
 - Respect each other's views and opinions.
 - Act appropriately. Being aggressive or abusive towards anyone during the discussion is not acceptable and will not be tolerated.
 - All responses made by all participants must be kept confidential, not just by the researcher but also by each of the participants.
-

Notably the ground rule about wanting to hear everybody's view was only added after the pilot and as a result of an initial analysis of the data. I could hear a sense of frustration from one of the participants

(Taufiq) who seemed to feel that some others were rather passive and not contributing much to the discussion. He said to the group that he did not want them to just agree with him. This is evidenced in the transcript where he clearly implies that he wanted others to talk and express their opinion.

Taufiq said:

You don't just agree to what I said, please say what you think as well. You may have different experiences.

(Taufiq 25 years old, Focus group discussion no. 1- pilot)

The use of individual interviews

As this study requires exploration, interpretation and the obtaining of a deeper understanding of the issues, characterised by a focus on the meanings attributable to the population being researched, I deemed the interview as the most appropriate and principal means of data collection (Greenhalgh, 2006).

In total, twenty-three individual interviews were conducted reflecting theoretical sampling until I had reached theoretical saturation (Charmaz, 2014; Mason, 2002; Parahoo, 2006). How many participants are sufficient for a qualitative study remains contested. Morse (1994) suggested 30 to 50 interviews are required whereas Creswell (1998) suggests that it only requires a minimum of 20

interviews for a grounded theory methodology (refer to Appendix 10 for details of the individual interviews).

Interviews were conducted using a semi-structured schedule of questions allowing me to organise the content in response to interviewees' interests and points of engagement and emergent opportunities for elaboration (Robson, 1993). Furthermore, this approach also allowed me to probe for information and to seek clarification of answers from my participants. This was a frequent experience during interviews (Holloway & Wheeler, 1996). It also provided an opportunity for me to clarify the question if the participant felt it was not easy to understand (Holloway & Wheeler, 1996). In turn, this helped to enhance the validity of the study (Parahoo, 2006).

The use of focus group discussions (FGD)

FGD were employed as a means of enriching the data gathered through individual interviews. Furthermore, I also anticipated that men in a group might give me some insight into the way that men talk to each other and react to issues about health in the male group. This will be shown and discussed later in my findings chapter. One example of this is when men talked about health and ability to have sexual intimacy with their wives.

Three FGDs were conducted with men and two with women. Appendix 11 shows details of the participants for the focus groups undertaken with men. Appendix 12 shows the details of all the female participants in the focus group discussion.

I asked the women to reflect their experience with their significant other male in terms of what men usually do when they are unwell and if and how these men make the decision to seek professional healthcare help. Furthermore, interviewing these women allowed me to explore the role they play in men's lives, to put men's comments into context and finally, to see how the dialogic relationship works between them. Altogether, this enriches the findings of the study.

Apart from focus group discussion, two dyadic interviews were conducted (see Appendix 13 for details for the participants). This sort of interview involves talking to two people at the same time. These dyadic interviews were conducted once for each gender. These interviews took place as a result of the failure of participants to turn up to focus group discussions leaving, in both cases, me working with just two people. These interviews, I do not classify as focus group discussions since they fall short of the criteria of comprising three people (Morgan, Ataie, Carder, & Hoffman, 2013). However, these interviews had some similarities with focus group discussions in that they required me to operate as a moderator facilitating

interaction between participants and the sharing and comparing of their views.

All interviews were recorded and subsequently transcribed to paper for the purpose of analysis. Transcription was undertaken as soon as possible after the interview or focus group discussion in order to enhance recall and capacity to ensure accuracy. This also enabled me to add notes about initial analytic thoughts whilst the events were still fresh in my mind.

The task of transcribing was onerous and in order to expedite it I employed a research assistant for a short period. The research assistant was hired only to help with the transcribing. Subsequent to being briefed and trained, including agreeing to respect and guard the confidentiality of the data, the assistant was paid a fixed rate of £3.40/hour or £25.50/day (7.5 hours per day). The research assistant transcribed five of the interviews and I did the rest.

Transcribing is central to the analysis of qualitative research as it gives access to what exactly has been said (Burgess & Bryman, 1994). In order to ensure high quality transcripts, verbatim transcripts were prepared in the language that was used during the particular interview or focus group. This was in most cases Malay or combination of both Malay and English. This approach was adopted

in order to avoid conceptual meaning being lost during the translation process especially when no equivalent word exist in the target language (Twinn, 1997; Van Nes, Abma, Jonsson, & Deeg, 2010). Van Nes et al (2010) further suggests that translation should be delayed and be undertaken only at the point when the researcher is writing up the findings of the study. This approach was particularly important in relation to this study as I anticipated that there might be ideas and concepts relating to masculinities, gender and health in the Western world that might not apply in the South East Asian context. This precautionary measure helped to ensure study reliability and validity (Burgess & Bryman, 1994).

The voluminous amount of data in this study, ranging from participants' information to recorded interview sessions and transcripts, were managed in accordance with the Data Protection Act ("Data Protection Act 1998," 1998). Unique codes using pseudonyms were assigned to each participant in order to maintain confidentiality. All personal information about the participants and transcripts were kept securely on a password-protected computer and saved on Durham University's server, and was only accessible to me. Hard copies were kept in a locked cabinet.

All recorded interviews and transcripts will be disposed and destroyed after two years of the completion of this PhD in

accordance with the Data Protection Act, UK (“Data Protection Act 1998,” 1998).

(iv) Data analysis

A distinctive feature of this study, aligned with the principles of grounded theory, was that analysis was undertaken simultaneously with data collection. I constantly compared data collected from one interview with another and with the focus group discussions, also referring to my observations about how men and women engaged with the issues and with each other, looking for similarities and differences in what was being said, beginning to develop memos and hence potential themes and codes and also finding becoming sensitised to where there might be gaps in the data. Subsequently, this enabled me to determine what sorts of data were needed next and where to get them from based on the emerging theory (Charmaz, 2014). This is explained in more detail later in this thesis in chapter 4.

By constantly comparing the data collected as soon as they were available, it provided me with information on what kind of data to look out for in the next interview. Theoretical sensitivity enabled me to modify the inclusion criteria for the study making it more specific and focused, to accommodate and fill the gaps identified on the basis of the emerging theory.

3.2 SOCIO-DEMOGRAPHIC INFORMATION ABOUT STUDY PARTICIPANTS

Given the apparent significance of age, socioeconomic background, ethnicity, religion, and differing experiences over the life course in mediating men's experiences and accounts of health and the novel nature of this study in Brunei, I strove for diversity in the study sample.

As different constructions of masculinity may account for health inequalities between men (Payne, 2004) it was thought to be important to include some diversity in men's experiences of masculinity and health in this study. This was achieved partly by including a range of men by age, as shown in the following Table 3.3. This provided an opportunity to consider whether men negotiated their masculinities and health in different ways depending on their life stage (Morgan, 1992).

The following table shows the socio-demographic characteristics of participants in the study. There were a total of 47 participants, comprising 37 men and 10 women. Their ages ranged from 18 to 76 years old. The mean age was 40 years old. In terms of ethnicity, there was a high proportion of Melayu (mainly Melayu Brunei) followed by Iban and Chinese and the majority of the whole sample

are Muslim (74.5%). Albeit, the majority (57.4%) of participants came from Brunei Muara, and there are also representatives from the other three districts in Brunei.

With regard to educational level, the majority of participants (twenty four out of the total forty seven participants) (51%) were in the process of completing a University/College education - either a diploma, bachelor degree or PhD - while amongst the remaining number, 10 (21%) had secondary education and 13 (28%) had primary education as their highest educational level. Overall, twenty-five participants are not working and out of this total figure, thirteen (28%) were students, eight were retired (17%) and five (11%) were full-time housewives.

With regards to occupation, the information here is presented in three categories namely skilled, semi-skilled work and self employed. The first represents work that has specific qualifications, for example, a diploma or bachelor degree or professional training. Meanwhile, those categorised as semi-skilled did not report having these qualifications. Self-employed, as the name suggests, are those who are not employed by anybody, in this case one man who runs his own business. Lecturer, teacher, architect, healthcare professionals, army and government officers are examples of occupations identified

as skilled work. Newsreader and clerk are two examples of semi-skilled work.

With regards to health status, three participants (6%) reported suffering from heart disease; two suffered from asthma (4%) and one has type 1 diabetes. Two participants also reported that they had undergone surgery in the past. This is illustrated in the following table (Table 3. 3). Note that percentages have been rounded and may not total to 100 percent.

SOCIO-DEMOGRAPHIC INFORMATION OF PARTICIPANTS (N= 47)

Characteristics	N	%
AGE (YEARS) (Mean age: 40)		
Range: 18 - 76 years		
18-20	6	12.8
20-30	10	21.3
30-40	9	19.1
40-50	10	21.3
50-60	7	14.9
60-70	3	6.4
70-80	2	4.3
Gender		
Male	37	78.7
Female	10	21.3
Ethnicity		
Melayu	33	70.2
Chinese	5	10.6
Iban	9	19.1
Religion		
Islam	35	74.5
Christianity	9	19.1
Undeclared	3	6.4

SOCIO-DEMOGRAPHIC INFORMATION OF PARTICIPANTS (N= 47)		
Characteristics	N	%
Education Level		
Primary education	13	27.7
Secondary education	10	21.3
Studying at college/university	24	51.1
Occupation		
Skilled	17	36.2
Semi-skilled	3	6.4
Self employed	1	2.1
Detail of those unemployed		
Housewife	5	10.6
Student	13	27.7
Retired	8	17.0
Existing health problem		
Heart disease	3	6.4
Diabetes	1	2.1
Asthma	2	4.3
Past experience of surgery	2	4.3
Self- identified as healthy	39	83
Location- District		
Bandar Seri Begawan	27	57.4
Tutong	3	6.4
Kuala Belait	8	17.0
Temburong	9	19.1

Table 3.3: Socio-demographic details of the participants

In terms of ethnic background and diversity, it should be noted that the majority of the participants were from the Melayu tribe. People from the Chinese and Iban communities are under-represented in terms of proportions of the population. I found that these two ethnic groups were hard

to reach. However, this recruitment was appropriate, reflecting the population make-up but not the precise balance of ethnic populations. This issue is discussed in great detail under '*Strength and limitation*' of the study in Chapter 8.

3.3 CHALLENGES AND 'LESSONS LEARNED' FROM THE RECRUITMENT PHASE

As stated earlier, posters in both hard and electronic versions were put up and circulated a few weeks before I returned from the UK back to Brunei to undertake the data collection phase of this study. This was done in the hope that I would be able to elicit some interest and recruit some potential participants prior to arrival in the research setting. However, on arrival to Brunei it was apparent that there had been no expressions of interest. This continued for a period of three weeks once I was in the setting.

Consequently, I began to question whether I had adopted an appropriate recruitment method. I was confident that people must have seen my posters as they were prominently displayed and intentionally attractive, appealing and designed to stand out from other advertisements posted on the noticeboards where they were located. Over the first few weeks in the field I kept going back to check these noticeboards and one problem was very apparent - often the posters had been removed or been covered by other more recent advertisements. I was somewhat angry and disappointed having

invested a lot of money and time into designing, printing and distributing these posters. I wondered why people covered up my posters when it was perfectly possible to stick theirs next to and not on top of mine. The lack of visibility of the posters would seem to have impacted on engagement via social media since the details of points of virtual contact were not available. I therefore reconsidered the use of noticeboards for physical display of posters and wondered whether I could better exploit digital media to disseminate these and the information that they contain.

Given the ubiquity of digital access and widespread use of social media in Brunei (as detailed above), I was surprised and disappointed that after two weeks in Brunei I had received only a few enquiries via Facebook and Whatapp. I realised that seeing the information about my research might not necessarily convert to responses from potential participants let alone offers to be involved in the study. It was apparent that I needed to be both more proactive and perhaps also more creative in my recruitment strategies. I consulted with a friend and she was very keen to help me out in terms of study recruitment. She offered to disseminate information about the study amongst her large circle of friends, members of whom she believed might be interested in the study. A few days later I received an enquiry over Whatsapp from a man expressing an interest in participating in the study. I explained the aims of the study to him and the study processes offering him the opportunity to participate in either an individual interview or focus group discussion or both. He indicated that he would be interested in participating in a focus group discussion. Of course since I had as yet to recruit to any other research participants I had to explain to him that this would not be

possible at this time unless he knew anyone who might make up a group. Surprisingly, he replied that he had some friends whom he thought might be interested and he agreed to disseminate information about the study to them. He managed to recruit four more men for the pilot focus group. A date and venue for this pilot was set and agreed by all the five men. It was held in an office in UBD.

The next day, after the pilot, my female friend got in touch and said everything had been arranged and she wanted me to come over to her place at an agreed time. Upon arrival at her home, I was surprised to see that the house was busy and looking very festive. There was food and karaoke and at least ten couples in the house. I was invited to introduce myself and to give a detailed description of research, adding to the brief description of the study that my friend had provided when she invited all her friends over. I was also informed that it was their monthly karaoke gathering.

I introduced myself and explained that I was a researcher who was very keen to learn about their experiences of health and illness. I invited them to take part in the study. I was somewhat surprised that they suddenly appeared reluctant and a little anxious. Some seemed to be puzzled about the idea of conducting research. I remember vividly one of the men asked me if I would be taking blood samples as part of the research. I was able to reassure him that I was intending only to talk to participants and therefore no specimens would be taken. I also emphasised to them that the interview would be conducted in a relaxed manner and that I was interested in their views – it was not a question of there being ‘right answers’. Nonetheless, they still

appeared unsure. It was then that the women present, the men's partners, started to play a role persuading them to talk to me whilst they were waiting for their turn to perform on the karaoke.

Although I was initially skeptical about the idea of recruiting to the study this way, to my surprise six men and two women agreed to take part. Given the number of men who expressed an interest I offered them the opportunity to participate in a focus group discussion instead of interview. However, the men did not agree to this proposal preferring to talk to me in the context of an individual interview. For convenience and in order to provide privacy, I undertook the interviews in a room in the house away from the group. The first interview was with two women who wanted to speak to me together. This was followed by three consecutive interviews with men. By the time these were complete it was very late – around midnight – and it was both inconvenient and I was too tired to contemplate undertaking another three interviews with the remaining men in the house. We agreed to arrange another time to meet.

Unfortunately, when I contacted these men to confirm arrangements they changed their minds and declined to participate in the study. Although I had some regrets about not securing their contributions to the study at the point of our initial contact, fearing that they might not be so enthusiastic later, it was clear that the balance of considerations – their and my convenience, tiredness and potentially safety issues (long drive to go home both for me and these participants) – meant that I had done the right thing.

Fortunately, on a good note, a few days after these first interview sessions, I began to receive a lot of enquiries about the study via social media. Some of this interest was a result of snowballing of information through the men and women I had interviewed.

Although the process was slow and challenging, I managed to recruit 37 men and 10 women to this study. Most participants were recruited using third parties such as male acquaintances, their wives, friends and daughters. This method of recruitment was found to be the most effective (J. Oliffe & Mros, 2005). Further snowballing after each session was also found to be effective in recruiting men. Invitation via posters, leaflets and social media failed to elicit any recruits at all.

3.4 METHODOLOGICAL ISSUES

A number of methodological issues arose during fieldwork on which reflection is warranted.

(1) The differences between individual interviews and focus group discussions.

The choice to utilise both individual interviews and focus group discussions as the principal means of data collection enriched the possibilities for understanding of the object of my interest. This is because of the different context and opportunities that they create for disclosure and interaction. I

became acutely aware that focus group discussions are particularly complex environments which can yield particular insight into peer and social norms as participants interact around issues (Smithson, 2000). It has been noted how important it is for the researcher to consider the impact of the group setting and especially the interaction within the group context and its influence on participants' responses (Carey & Smith, 1994).

Individual interviews, in contrast, yielded information that I think probably, would be less likely to be shared in a focus group, especially where the participants know each other. Agar and MacDonald (1995) have noted that if the participants know each other they might be selective in sharing their views in the group discussion. This is probably driven by concerns that private information shared during the discussion might be disclosed (Brannen & Pattman, 2005). The data seems to contain some examples of this. For instance, the following is an excerpt from an individual interview with a man, in which he explains that the reason for telling his wife if he is not feeling well is to get her attention and to elicit care including being touched by her. He very much valued and appreciated this intimacy and it is highly probable that he would have been less likely to share this in a group. It might be suggested that this is particularly the case in contexts where masculinity is strongly defined by self-reliance. Furthermore, in a Muslim community like in Brunei, issues associated with marital relationship are regarded as a personal and it is not common to discuss them openly. In this case the practice of massage, compounds the issue because it is a rather an intimate thing.

Men want to be sympathised by his wife, hoping their wife would then touch them [probably referring to massage, judging by him showing the action of massage using his hands], that makes you feel good.

(Syafie 65 years old, individual interview no. 9)

Not only were there differences in that which was disclosed in interviews and focus group discussions but focus group discussions provided a context where issues, points of view and experiences could be debated, compared and similarities or disagreement discussed.

The following is an excerpt from a pilot focus group discussion involving Adam (18 years old) Salleh (20 years old), Khalid (19 years old) and Taufiq (25 years old). This illustrates rather well how points may be debated, views compared and thoughts worked out:

Adam: We were all thought that men are expected to be leaders and women are not expected (...) men often asked to do heavy stuff and light stuff gives to women

Interviewer (DRI): Can you tell me why do you think that is?

Adam: Um, they are lack of physical strength and men are capable to do heavy extreme stuff

Salleh: I totally disagree with that because most of my female friends nowadays um they love to do extreme sport which I as a man I'm just

too scared to do it and honestly they do have the physical strength way better than me

Khalid: Yeah, [agreeing] but generally men tends to be tougher than the girls

Taufiq: Um, but I think I know what he meant but sorry to say that men and women are equal now but some people in our society are very conservative and we do like what our elders told us. Our elderly put high expectations on us as man and not so on female but now things are changing.

The position and approach I took as a researcher also has a significant influence on the information gathered and the ethos of the session as a whole. All data collection activities, including the pilot focus group discussions, were conducted by the researcher. My position in the interview as a student, doing research about men's experiences was made clear at the beginning of the session. I did not disclose that I was also a lecturer at UBD in most of the sessions but in some this was unavoidable because the method of recruitment utilised my social and professional networks.

Building rapport was an essential part of the interaction with participants in the research. I did this by introducing myself at the beginning of the session, identifying myself as a research student and expressing my enthusiasm for hearing about participant experiences. My decision not to disclose, other

than where unavoidable that I am also a lecturer at the university in Brunei, was taken in order not to broaden or amplify any power imbalance between us, with its contingent potential to have a distorting impact on the discussion. My concerns were that participants might infer that I would be judging them and expecting particular answers to my questions. Further, I also emphasised that they are the experts in the session and there are no right answers to the questions that would be asked during the focus group discussion. I felt that this provided them with a safe space in which to express and share their experiences without feeling concerned about being judged.

Both the interviews and focus groups were conducted in a relatively informal style, employing a conversational approach, enabling free flowing interaction between the participants and between the participants and researcher. This at the same time helped to avoid any risk that participants would become passive and permitted access to a better insights into their understanding and experience because it avoided the use of direct formal questions which may have been interpreted as testing participant knowledge (Olliffe & Mros, 2005).

The focus group discussion sessions with women were conducted in exactly the same format and manner as those conducted with men. During these focus groups, women shared their experiences with regards to their husbands' health help seeking behaviour. Some of these women also talked

about the experiences of their sons as well. The Iban women involved in the discussions were the wives of the male participants.

(2) Challenges with organising focus group discussions (FGDs).

For every focus group I stipulated a minimum of three participants. Prior to the session, the time and place for the focus group were discussed and agreed with all participants. It was not an easy process to negotiate and arrange the time – to manage the participant preferences and competing demands on their time. Bringing all participants together at the same time and the same place in a focus group is understood by Morgan et al (2013) as one of the biggest practical challenges with the method. Unfortunately, there was one session where only two participants turned up. When I called the other participants who were supposed to be there, they told me that they had changed their mind and no longer wanted to take part in the study. Often, when asked, they said transport and time were the problem but even if I suggested alternative means of enabling participants, for instance, rearranging the session or offering them an individual interview instead of focus group discussion or to going to see them at a time and place that suited them the most, they still declined to participate.

(3) 'Breaking the ice' and building rapport.

I regarded creating a safe, positive and structured environment for group discussion as an imperative both for ethical reasons and in order to facilitate engagement with the research. I set about achieving this in two ways. Firstly

by letting the participants discuss and agree what language should be used during the session and secondly, by involving them in setting the ground rules.

Deciding what language to use in the session was the very first task undertaken with the participants. The right to choose one's preferred language was also given to participants from the individual interview. Giving the participants the opportunity to choose their preferred language was found to be important because it helped them to feel at ease and it was also the case that it is central in terms of enabling respondents to represent their sense of self (Wallin & Ahlström, 2006).

As discussed previously the critical element in my approach was to invite participants to not only consider ground rules that I suggested but to add more as they thought necessary. This both initiated interaction between the members in the group and it was easier to achieve adherence to the rules because of a sense of ownership thereby created.

The use and role of humour was important in my attempt to break the ice between me, as the facilitator and my participants and between them, in the case of focus group discussions. For example, in the focus group conducted with the Iban men when the eldest in the group mentioned his age and said he was very old I replied "*not yet...that's not old yet*". This was met with a smile and laughter from him and the rest of the group, acknowledging that the joke was well received by him. Jokes involving age particularly

concerning old age and not wanting to be seen as old are an important part of the Bruneian cultural landscape and common among people in Brunei. Acknowledging cultural norms and respectfully employing them in interactions with research participants was an important contributor to the establishment of rapport.

Another example of how jokes were employed in the focus group was involving the use of English. Most focus groups combined both English and Malay language. Interestingly, I noted that particularly in the dyadic interview involving two elderly men, attempting to speak in English made both of them laugh. They made friendly jokes and gestures about each other's English and pronunciation and this helped to break the ice between the two men. Subsequently, they became more comfortable with each other and this seemed to enable them to contribute to the session. An example of this was when Najib (68 years old) replied to one of my questions by saying:

Najib: *Oh that is very ee-chi*

(Dyadic interview no. 1).

The above was meant to be "easy" but he pronounced it as "ee-chi" instead. Noticing this, Samsul (60 years old) imitated Najib's accent resulting in collective laughter. Critically this seemed to be regarded as acceptable by the participants because the laughter was not mocking – we laughed with him and not at him. However, it should be borne in mind that these two men are quite elderly and it is very rare for them to speak English. As such this

sort of joke involving one's ability to speak English maybe well accepted, but may not be appreciated if it were to be directed to younger men. This is because English is now widely spoken and taught in schools. Therefore there is a cultural expectation that the younger generation have mastered the language. Consequently, there is a risk that jokes about linguistic ability might be seen as an insult. Conscious of this I judiciously avoided making or engaging in joking about language in other focus groups.

(4) Enabling contributions in the focus group discussions.

The most challenging task that I experience in facilitating the focus group was managing the group dynamic. Focus groups involved a mixture of people some were extrovert and opinionated and others seemed more introvert and passive. It was therefore incumbent on me as a facilitator to ensure that no one was dominating the discussion and to make sure that all participants had the opportunity to share their experiences and opinions and have their voices heard. The ground rules were helpful in raising and making explicit this expectation. In addition I actively sought to engage participants who appeared quiet or less participative. I did this by directing questions to them or inviting their view on an issue, for instance, in the second focus group discussion, where one of the participants was dominating the session.

My experience in the second focus group discussion can be contrasted with the pilot focus group discussion. Here, one participant, Ishak appeared frustrated, perhaps feeling it was always him who had to talk first and that

others would tend to agree with what he had to say. This was evidenced in the pilot focus group, in which he said:

You don't just agree to what I said..this is just my opinion..you may think differently.

(Ishak, 26 years old, Focus group discussion No. 1- pilot)

Hearing this, I quickly responded by acknowledging his contribution to the discussion and passed the question to other men in the group. Initially, I opened it to the floor without directing the question to any particular person. However, I then realised they all appeared quiet. I then reminded the participants that their contribution was very important in the session and that I highly valued them. I also re-emphasised that there is no right answer to the questions and the importance of respecting everyone's opinion and contribution. This slowly resulted in them making more active contributions during the session. This was probably due to them starting to feel comfortable and safe in the session and therefore becoming more willing to share.

(5) Making use of appropriate interruptions

In most focus groups, I realised that lots of time was spent with participants conversing with each other on things seemingly not directly related to the questions that I asked. Initially I felt frustrated and trapped between wanting to stop the discussion and redirect it and worrying that I might offend participants if I did so and indeed that I might come across as rude. This was particularly the case for the dyadic interview for the two older men.

The following is an excerpt from the dyadic interview number 1 between two good friends Najib (68 years old) and Samsul (60 years old).

Interviewer (DRI): *So Najib when you hurt your hand last time, did you go straight to the hospital?*

Najib: *Yes because my daughter insisted me to go. All of my children came to visit me at home and they all insisted me to go. In the old days when hospitals were limited, why people can live up to 100 years old? Hospitals were very hard to reach. It was limited. My cousin he said all his life he never wears any shoes even when he goes into the forest*

Samsul: *Yeah even to the shops, no need shoes during the old days*

Najib: *I asked him why you did not wear any shoes, he said why would you need to wear one, there are no thorns or sharps on the road. The shops are in the city. If you want to wear shoe, you can wear them when you go into the forest not to the shops. So the question is why people in the old days can stand it? He only eat rice, salt and no Ajinomoto [MSG – this stands for Monosodium Glutamate. It is a form of seasoning commonly used for cooking]*

Samsul: *Only the rich have them, so sometimes we borrow some from them if we want to cook a nicer meal*

Najib: *During our times we called it Vietcing now Ajinomoto*

Samsul: *Yeah even cooking oil um very rare. Only the rich have them*

Najib: *Yes! only the rich ones*

Samsul: *We would go to their house bring a small cup and borrow their oil and Ajinomoto*

This conversation about the 'old days' continued for another 10 minutes, until I interrupted and diverted it back to his experience going to the hospital, his most recent gardening injury to his hand.

On reflection, my concerns about interrupting and appearing rude are rather a cultural thing because it is not acceptable to interrupt when another person is talking, especially if they are older than you. It is regarded as a sign of disrespect. Therefore, it was very hard for me and I felt trapped in between doing what is culturally acceptable and achieving the aims of the discussion. Listening back to the session, I realised that for the first half of the session I simply allowed the conversation to flow and did not interrupt them. I also remember feeling frustrated about this, acknowledging the fact that this would mean the session would be much longer than what I have expected and also that there would much more to transcribe. This was shown in my field note dated 5th February 2015:

“ Najib shared a lot in the interview, and I felt that at most time, he told me more than I need to know! But still it was interesting to hear his story and nice to know he is willing to share them. However, if this continues, the session will take much longer time and if it is too long participants will lose their interest and concentration. I feel that I should have interrupted him earlier than leaving it to the end! I think it should OK and I don't think participants will be offended, provided I do it nicely. I could apologize to them first and ask them if we could go back to talk about the main issue. I am sure they will understand. I will try this in the subsequent session”.

(Field note, 5th February 2015)

However, when I analysed the data, I realised that albeit rather longwinded in nature, the things that they talked about were related to the questions in which I was interested, although not directly. It became apparent, as the extract from the interview above shows, that the men were talking about health even though they also talked about their youth and particularly how difficult it was to get food compared to today. However, I noticed towards the second half of the session, I began to interrupt their conversation and divert it back to the main issue. This was done respectfully by apologising for the interruption. This was met with the approval of the participants judging from their facial expression and head nodding.

(6) Should participants in the focus group discussions know each other?

Some scholars argue that putting friends in focus group discussions encourages selectivity in response and contribution as participants may feel embarrassed or concerned about confidentiality (Brannen & Pattman, 2005). Furthermore, during a focus group discussion, people will try to manage their own appearance particularly in a situation, which is new to them. It has been observed that they will try to “put on their best face” (Laslett & Rapoport, 1975) whereby participants will be sharing or saying things which are ‘safe’ or conform to a ‘culturally normative pattern’; what Cornwell (1984) has termed as “public accounts” meaning that when a person is being interviewed they may feel pressure to try and ensure that whatever they say will be acceptable to others. It has been suggested that this situation is more likely to arise in focus group discussions especially if participants are unfamiliar with each other. However, I found that men in the focus groups were very opinionated and expressive, perhaps because of their relationships with each other. This was shown well in the focus group that I had with four Iban men. These Iban men were all cousins.

During this discussion, Rezal (50 years old) was talking about what he regarded as bad experiences with the services at the government hospital in Temburong in the presence of Izam (27 years old), who is a nurse in that hospital.

He commented:

If you go to hospital in Temburong, sorry ok [apologizing to Izam] you go because you feel really sick, you feel stressed even more if you go to hospital because you arrived at 7.30 am and you only finish by 12 pm [referring to the long waiting time]. It was such a very long wait

The other two men, Adi (76 years old) and Nazir (59 years old) agreed. They commented:

Adi: *That is true!* [nodding his head and smiling].

Nazir: *That's not as bad as mine! My experience in the past, they asked me to come back in the afternoon because the patients were too many and when it comes to my turn it was lunch time, so they have to close the clinic. They asked me to come back in the afternoon!*

(Focus group discussion no. 3)

It is plausible that Rezal mentioned this experience precisely because he knew Izam and his role as a nurse. It was probably because he knows the nurse and he feels comfortable and safe to voice this view to him, his cousin. Furthermore, it could also be that he could air potentially challenging views because he can do so in ways that bracket off Izam as his cousin rather than a nurse. He could be more honest about these experiences. Interestingly, he apologised in advance to him before he shared that bad experience to the group. This was probably his way of showing respect to Izam and his attempt to understand the shortcomings of the health services.

Izzam seemed to value this apology judging by his calm response and smile.

In his response, he said:

Yeah. I did not deny that. That happens. I understand that everybody wants to be seen as soon as possible and we also want to do that and we tried but sometimes we just could not do it. But we are slowly improving our service.

(Izzam (27 years old, Focus group discussion no. 3)

(7) Gender: recognition and misrecognition

The importance of gender in the dynamics of interviews was very apparent, for instance in the interview that I had with two men, both pensioners aged 60 (Samsul) and 68 years old (Najib).

Interviewer (DRI): *I would like to focus on health for us as men. You mentioned before being healthy is important for both of you. So why do you think that is?*

[Najib's wife walks in to serve tea]

Najib: *Oh, That's very ee-chi [both laugh] if a man is healthy, every man want to get married because as a man you just need "it" and its difficult to control it when you need "it" [Note: "it" here refers to sexual needs]*

Samsul: *That's true*

Najib: *As a man, God [Allah] gives you the ability and desire. If you are healthy then you still can do it, so use it. However sometimes, I'm sorry even being young does not mean you have the ability to do and use "it" no chance! [bending his finger] meaning you are not healthy. God gives you that ability [showing his straighten finger] as a normal reaction to it, so if you cannot then no use being a man.*

Interviewer (DRI): *So it's important for a married man?*

Najib: *Um not necessarily, even if you are not married. Of course for us as a Muslim it's not allowed. Otherwise you just go to the beach, you can find, if you're lucky but that is not good, better you get married.*

[All laugh]

Najib: *Well because for me, I've got 10 kids from my first wife but you happened to like other women so what can you do? What if your children saw you with other women? What will you tell them? Better just get married even if your kids disagree. It's you who will get married to her not them. But for me its OK, all my kids are OK with me getting married again, better than having affairs with somebody else's wife or otherwise just go to Limbang² and pay for it [sex worker]. Many cases now people go out with other's people wife and treated her more than his own wife, not good. That's not healthy. Once in a while that's helping her but if every weekend that is not helping!*

Interviewer (DRI): *Oh, that's you considered as "helping" her?*

² Limbang is a border town and the capital of Limbang District in the Limbang Division of northern Sarawak, East Malaysia, on the island of Borneo. It is located on the banks of the Limbang River between the two halves of Brunei.

[All laugh]

[Najib nodded his head in agreement].

(Dyadic interview No.1)

Analysing the above conversation, I wondered why he was so comfortable in talking about sexual intimacy, given that the culture in Brunei considers sex as a private matter and not something to be talked about openly. There are a number of possible explanations. Firstly, interest in and the ability to have sex is often regarded as a way for men to demonstrate their masculinity (Yun et al., 2008). Therefore, this disclosure may function as a means of acknowledging and 'doing gender' in interactions with other men. This has a particular relevance when men know each other. These two men are good friends and neighbours. They are clearly comfortable with each other. They seem to have few concerns about embarrassment or confidentiality. It is unlikely that such an issue would be broached with a female researcher. A sense of the importance of gender seems to be indicated by my response. This was especially the case when Najib's wife entered the room where we were talking to serve us tea. Secondly, it was probably because of my facial expression showing my surprise and disbelief when he introduced his wife who was almost thirty years younger than him. Of course, I was not aware of my own facial expression at that time and no visual records of the session were made. However, if my facial expression during that time was inappropriate to him, he probably would feel challenged by me and therefore feel the need to show to me that despite his age, he was still able to maintain his 'manhood'. I believed this could be a major factor in influencing his

decision to talk about his ability to have good sex in his old age. He probably felt it was appropriate to respond as such particularly to a young male researcher. I was not able to detect any change in his tone of voice indicating the feeling of anger or intimidation. It was in fact full of laughter, as recorded in the dyadic interview excerpts above.

(8) Researcher role

In this study, I presented and introduced myself as a researcher studying men's health help seeking behaviour. I consistently made this clear to all study participants. Participants were not told about my background in healthcare. However, my prior knowledge and professional experience did present me with some ethical dilemmas. For example, one participant disclosed to me that he was not adhering to his prescription of anti-hypertensive medication and in fact showed me the piles of tablets that he kept in a container. I know from my clinical experience that most anti-hypertensive tablets should have been taken once a day. According to my respondent, when I asked him about this stockpile, he only takes them when he experiences a severe headache. Clearly he did not understand his medication. This is illustrated below:

Samsul: For me being healthy is not consuming too many medications. You know tablets for this, tablets for that, pills for diet, pills for the heart [showing me his anti-hypertensive tablets] also control what you are eating. For me, it's good to do some fasting. It's the food too.

Some people take pills for diet. I don't take those, just these pills
[pointing at his anti hypertensive drugs].

Interviewer (DRI): *How often do you take them?*

Samsul: *Not a lot..rarely!*

Interviewer (DRI): *Like when?*

Samsul: *Well for example if my headache is too much to bear.*

(Samsul, 60 years old, Dyadic Interview No. 1)

Seeing these tablets and identifying his lack of understanding about them, I felt a degree of concern. However, I did not feel it appropriate to step out of role, disclose my background in nursing and advise him accordingly. It is clear that he shared this account because he trusted me and sees me as a researcher who is only interested in what he thinks about health and how he uses healthcare services.

It is also the case that this account may not have been disclosed to if he had known that I was a nurse. Nonetheless, faced with a situation in which there was risk of harm as a consequence of non-adherence I felt it was appropriate to suggest to him that to consider going to see his doctor at his local health centre to get a better understanding of the tablets and drug regimen after the interview. Of course, I left the interview feeling concern and wondering what

would happen to him if his blood pressure got out of control. The fact that he was in his 60's and living alone did not make it any easier for me to dismiss these thoughts and concerns.

Another similar occasion arose in the context of an interview with Ali, an undergraduate student aged 18 years old. This participant was aware that I was a scholarship student studying for a PhD in the UK. Despite the ice breaking activities and reassurances about confidentiality and so on, he still appeared very anxious and quite careful with his words. This was apparent in that he kept asking for approval from me (the interviewer) before he proceeded with his comments. It is possible that his unfamiliarity with research interviews and my status as a PhD student created a boundary between us and made him acutely concerned with ensuring that he managed his part in line with what he presumed to be my expectations. This reaction is what termed as "*managing appearance*" and "*controlling information*" as according to Goffman (1959, :241). Perhaps he saw me as an "expert" so he wanted to say the right thing to me in the interview.

The following extract from his interview illustrates how much saying the "right things and words" meant to him.

For me um you can tell when some one is healthy. You just see his appearance. His body..and his fitness level..appearance-wise nice fit body, not obese and too skinny, that's not healthy. Is that correct?
[directing the question back to me].

(Ali,21 years old, Individual Interview no. 1)

3.5 ETHICAL CONSIDERATIONS

The process of obtaining ethical approval:

This study raised a number of ethical issues since it involved human participants (Polit & Beck, 2006). To ensure that the study was safe and posed no risk of harm to the participants and myself as a researcher, the following ethical principles guided by the Declaration of Helsinki, World Medical Association (World Medical Association, 2013) were adhered to (see Table 3.4).

NO	ETHICAL PRINCIPLES	HOW IT WAS ACHIEVED
1	RESPECT FOR PERSON	<ul style="list-style-type: none"> ▪ All measures were taken to ensure that participants have understood the study and its processes involves prior to signing the consent form ▪ Participants were made aware that their involvement was voluntary and they could withdraw from the study at any point without any consequences. ▪ Always listen to what the participant has to say without any judgment made of them. ▪ In the focus group, it was emphasised that all participants should respect what each other has to say and to discuss in a safe, non-judgmental, non-aggressive manner.
2	CONFIDENTIALITY	<ul style="list-style-type: none"> ▪ The research assistant who is solely responsible for assisting in the transcribing process was briefed on confidentiality issues prior to hiring her and was asked to sign an agreement form, which emphasized the need for maintaining confidentiality in its strictest manner.
3	HANDLING OF THE DATA	<ul style="list-style-type: none"> ▪ All the recorded interview and focus groups sessions and transcripts were transferred to computer and securely locked with a password, which was only known to me. Where hard copies are used, these copies will be kept safely in a locked cabinet which only the researcher can gain access to. ▪ All raw data will be disposed after two years in accordance with the Data Protection Act, UK ("Data Protection Act 1998," 1998). ▪ In terms of accessing participant's personal information, it was only me, as the researcher, who had access to full personal information that participants have provided.

	Cont..	
4	BENEFICENCE/NON MALEFICENCE	<ul style="list-style-type: none"> ▪ Beneficence connotes the act of doing good to others (Kinsinger, 2010) and non-maleficence means to do no harm (Beauchamp & Childress, 2009). This also includes providing and ensuring that participants are safe or feel safe during the interview. ▪ The level of risk was low both to the researcher and the participants because all interview and focus groups were done at participants' own homes or in my office in UBD, at time convenient for the participants. In circumstances whereby interviews could not be conducted in UBD, the Lone Working Policy produced by Durham University was strictly adhered to.

Table 3.4: Ethical principles

The study protocol was reviewed by the Ethics Committee within the School of Medicine, Pharmacy and Health at Durham University and a small number changes made prior to approval. The issues raised and action taken are summarised in the following table (Table 3.5).

NO	ISSUES RAISED BY ETHICS COMMITTEE	ACTION (S) TAKEN
1	Safety of the researcher while engaged in the fieldwork abroad.	<p>Abroad in this case refers to outside the UK. However, in my case, although Brunei may be outside the UK, it's my home country and I am very familiar with it and was able to look after my safety. Communication with the university's Insurance Manager was also made and she confirmed that Durham university's public liability and professional indemnity applied to me while I am on my fieldwork.</p> <p>Communication has been made with the scholarship body sponsoring for my study at Durham University – the Brunei High Commission in London. They confirmed that I am being the government officer employed by the government of Brunei was required to report back to work every time I was in Brunei and during my whole stay in Brunei I was to abide by the rules and regulations for every government officers in Brunei.</p> <p>Further, as stated by Brunei High Commission in London, during my whole period in Brunei, I was required to report back to work and act as if I was working for my employer. Thus requiring me to abide to all rules stated by 'Jabatan Perkhidmatan Awam³, Brunei'. This included conducting and behaving in manner that is appropriate and safe in relation to preserving the working ethics and image of the government officer in Brunei. Since, I had access to work in Brunei (UBD), a colleague from UBD was nominated and identified as the central person with regards to the Lone Working Policy. Risk assessment from UBD and Durham's university ESRC Lone Working Policy were used and adapted.</p>

³ Jabatan Perkhidmatan awam refers to the Department of Public Services. This is the government organization that looks after all the government officers and government servants in Brunei Darussalam.

	<i>Cont..</i>	
2	<p>Committee requires further information on the provision of meals that I will give as a token of appreciation and respect for all my participants.</p>	<p>After having a discussion with my supervisors, we agreed that avoiding buffets and hiring a private small catering business, as one not know the hygienic quality of the food preparation. Giving participants a meal voucher from a well-established restaurant was the way to get around this issue. Every restaurant in Brunei is regularly inspected for their food hygiene and safety by the relevant authorities, therefore, we did not have to doubt their cleanliness.</p> <p>Therefore, we decided to give a meal voucher amounting to B\$5.00 (£2.50) from a local restaurant to each of the participants. This voucher could be exchanged for a meal comprising of rice, chicken, vegetables and some hot sauce and a bottle of water at any branch of this restaurant through out Brunei. The researcher being a Bruneian himself confirmed that Bruneians consider this meal appropriate and acceptable.</p>

Table 3.5: Issues raised by the university department's ethics committee.

From the above table, it can be noted that safety was the major concern, not just safety of the participants but also my own safety. Where most of the attention had been given to ensuring participants were safe during the data collection process and all data was handled safely, attention to my own safety was initially lower because the research was to be conducted in my home country. I therefore took things for granted assuming that I should be able to keep myself safe at all times due to my familiarity with the place and its people.

However, after analysing the situation, I realised that it was important to consider one's safety regardless of where one will be conducting fieldwork; it is about assessing the potential risk and taking steps to minimise it. The committee suggested me to look at the Lone Working Policy with regards to ensuring or minimizing harm to myself as a researcher. Chief of these were the steps to be taken when interviewing a female participant. It was necessary to make this sensitive to the issues around a male researcher interviewing women in a strict Muslim country. This amendment was as follows.

Special consideration applying to male researchers interviewing women in Brunei Darussalam.

In the attempt to respect and abide to the religious law and local customs:

✓Always make sure that there are few other females or males, preferably their family members in the house.

✓DO NOT enter the house if the woman is alone.

✓Whenever possible, conduct research (interview) in an open public places where you can be seen, especially if she is alone.

Subject to these amendments ethical permission to progress with the study was granted (Ref: **ESC2/2014/12**).

3.6 SUMMARY AND CONCLUSION

This chapter opened with a discussion about the methodology guiding this study. For this the 'research onion', which comprises of research philosophy, approach, strategies, choices, time horizon and technique and procedure, was used. The use of a multi-method qualitative approach guided by constructivist grounded theory was deemed suitable aligned with the research question that this study addresses. The chapter also contains some reflections on the different processes including ethical clearance, recruiting and data collection procedure.

Despite various challenges, a total of forty-seven participants took part in the study. They were diverse in terms of their socio-demographic backgrounds. Nonetheless, some groups of men were hard to reach notably from the Chinese and Iban communities and these are under-represented in this study. However, this was felt to be appropriate, reflecting the population make-up but not the precise balance of ethnic populations.

Twenty-three individual interviews, five focus group discussions and two dyadic interviews were undertaken in this study.

Chapter 4: DATA ANALYSIS

4.1 INTRODUCTION

In this chapter, I describe and critically consider how the data collected during my fieldwork was analysed.

Data analysis has been described as the process whereby the researcher makes sense of the data prior to presenting it in forms which people can understand (Parahoo, 2006). In accordance with the methodological rootedness in constructivist grounded theory, the main focus for the data analysis process that I employed conformed to the set of flexible process and practices as described by Charmaz (2006).

As mentioned previously in chapter 3, in this study I also conducted in-setting observations whereby I recorded information about the experience of the interview, its physical context and participant reaction, behaviour and interaction with either me or other research participants. Notes on the observations were integrated into field notes made after each research intervention and primarily employed to support and inform analytic thinking and reflection on the conduct and content of the intervention.

During the analysis process, as I starts to code my data, I begin to write memos to help with my thinking and inform my analysis. The observational notes were very useful in formulating these memos. They helped me to recall

specific fieldwork activities clearly and hence be better sensitised to the data. An example of a memo can be found in later section of this chapter.

All data collected was analysed and compared constantly. This process guided me on what data to collect next (and from whom) which is regarded as necessary in order to facilitate the process of generating theory (Becker, 1993). Important topics and issues arising from the findings were incorporated into subsequent interviews and the emerging findings/themes influenced the development of the topic guide used for interview and focus group discussions. The process was repeated with each interview until saturation was reached. This iterative process of data collection and analysis and the constant comparative method of data analysis are regarded as key features of grounded theory (Birks & Mills, 2011).

Due to this iterative process, I began my data analysis at the earliest opportunity after collection, and this was undertaken simultaneously with data collection. Figure 4.1 below shows the iterative process I used in generating theory with the aid of the grounded theory approach.

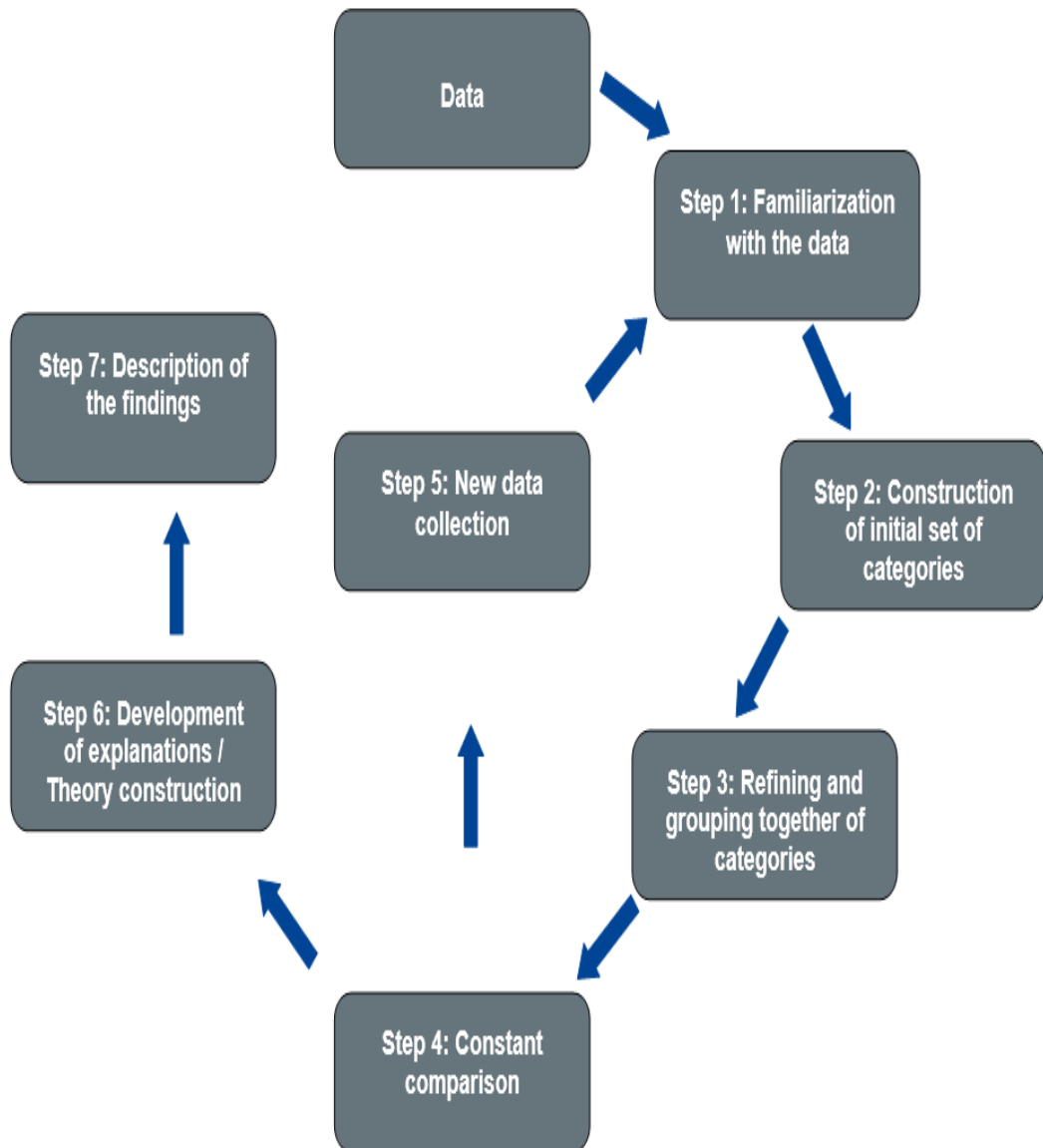


Figure 4.1 Adapted from the KCE Process book available on-line: <http://processbook.kce.fgov.be/book/export/html/348> (Date accessed: 20th September 2015, last updated: 17th Dec 2013)

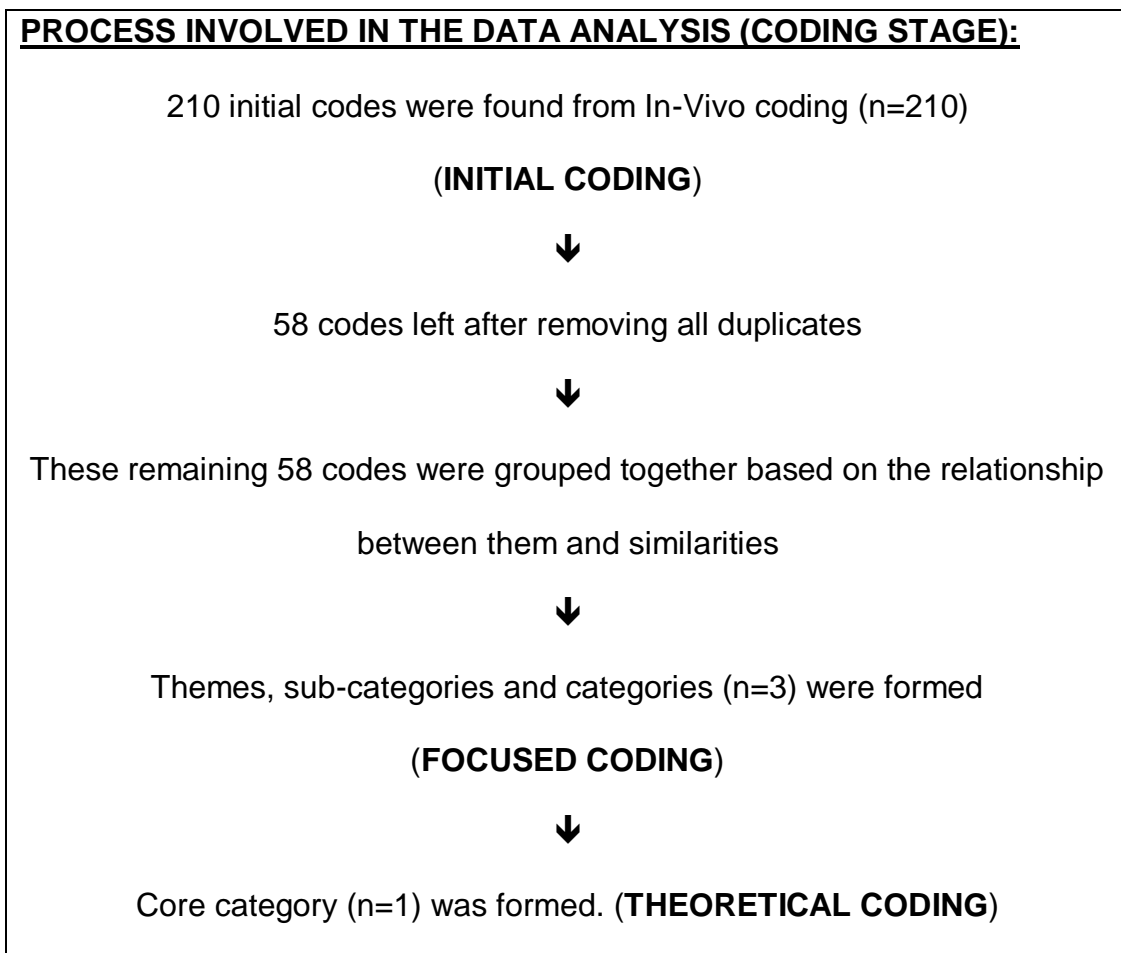
4.2 CODING PROCESS

In accordance with constructivist grounded theory (Charmaz, 2006), I analysed my data in the following steps:

1. Constructing initial codes using line-by-line coding of transcribed data;
2. Constructing themes, sub-categories and categories by focused coding;
3. And, constructing a core category by using theoretical coding.

The following figure (Figure 4.2) describes the process of data analysis involved.

Figure 4.2: Summary of the coding process



I coded all the data manually in order to retain a close sense of the material, a high degree of control over the process and because this was feasible given the number of interviews undertaken in this study.

In the attempt to be systematic and transparent, matrices were used to tabulate and record all the processes that took place in the analysis phase. I placed a great deal of emphasis on this process, including adding a detailed explanation in relation to the development of themes, the purpose being to facilitate the process of auditing the trail in the analysis (Ritchie & Lewis, 2003). This in turn, enhances the credibility of the findings (Smith, Joanna, Firth, & Jill, 2011).

All data analysis was undertaken on verbatim transcripts of interviews and focus group discussions – that is, with the material retained in the original language used by participants. This was mainly a mixture of Malay language and English. This approach was adopted in order to avoid loss in its meaning due to translation (Van Nes et al., 2010). Only once themes were identified, were all findings translated for the purpose of reporting in this thesis.

Data analysis involved the following steps as laid out by Charmaz (2006).

Familiarisation: one step before coding begins

After all interviews and focus groups were transcribed and cross-checked for accuracy, I browsed through all transcripts and started to form an impression of what I thought was happening in the data. I began to read the transcripts

one by one, line by line, not once but several times in order to familiarise myself with the data. I also continued to write analytical memos in this phase, reflecting on what I interpreted as going on in that interview, and as suggested by proponents of studies seeking to develop grounded theory (Bryant & Charmaz, 2010). Re-reading was particularly important although time-consuming, because after reading each transcript for the second time I noted on several occasions that there were several aspects of the data that I only picked up in this round of reading of the transcript.

Having familiarised myself with the data I moved to coding. Coding refers to the process of defining what the data is about. In coding, a word or short phrase is used to summarize and capture the essence of each piece of data (Saldana, 2009). This process is of paramount importance to the development of a grounded theory because it provides a link between collecting data and development of an emergent theory to explain it (Charmaz, 2006). In order to manage coding in a systematic and rigorous way, I used the following approach to generating and identifying codes, as suggested by Harding (2013). I applied a code where the following was the case:

1. The same idea/concept/issue was repeated in several places in the interview;
2. Similar issues/concepts/ideas were found in other transcripts and/or they resonated with a theory or a concept;
3. The issue/comment seemed important even though I couldn't at the point of coding tell precisely why.

Using this approach, coding was undertaken in the following manner:

(1) Initial coding

This was the first level of coding. This is seen as a starting point providing the researcher with analytical leads for further exploration and as, Glaser puts it “to see the direction in which to take the study” (Glaser, 1978: 56)

At this point, I broke down all my data and looked out for distinct codes line by line. I utilised words or short phrases from the actual interview and as used by the participant as codes. This is commonly referred to as ‘in-vivo coding’ and ‘literal coding’ (Charmaz, 2014:134) Coding in this way helps to preserve the meanings of participants’ views (Charmaz, 2006) and thereby enables the researcher to stay true to the data (Ritchie & Lewis, 2003). Saldana (2009) advises that *in vivo* coding can be employed in initial coding and is useful particularly for less-experienced qualitative researchers when learning how to code data, as other methods of coding may appear confusing. This was particularly relevant in my case as it enabled me to immerse myself in the data and also to start to identify potential concepts. In other words, it enabled me to code descriptive ideas, which might begin to explain the meaning of the data. By referring to my observational notes I could take myself back more easily to the event and hence more accurately recall not only what was said, but by whom and how they expressed themselves.

I undertook this process by viewing the transcripts on a laptop computer and using highlighting and font color features available in the word processing

software (Microsoft Word) to identify and label all my codes. These codes were then transferred to the coding matrix and supplemented with a description of the codes and a record of the location of the excerpt from the transcript. This created an easy reference system for further analysis and also provided for transparency in the coding process.

The following (Table 4.1) is an example of this process, showing codes used in the initial analysis of an interview.

As this extract from the matrix shows, the respondent's name is included in the left-hand column, the excerpt from the transcript in the second column and the in-vivo code and finally the analytical description in the third and fourth columns respectively.

Table 4.1: Examples of initial coding using *in-vivo* codes. These respondents are those involved in focus group discussion number 1 (pilot).

RESPONDENTS	EXCERPT FROM THE INTERVIEW	IN-VIVO CODES	WHAT IS THIS ABOUT (Analytical code)
Khalid	After things happened, then you'll know and you change....I injured my knee from playing football..(p4, 135 - 140)	After the things happened...	How past experience teaches him to look after his health
Ishak	They don't understand, they may have thought its nothing serious (p6, 245)	Don't understand	This is how they perceived whether something is serious or not. Knowledge is strongly influenced this.
Khalid	Only if its serious then I go to the hospital...like coughing out blood or something (p16, 702 – 704)	Only if serious..	Perceived seriousness - presence of "serious" signs
Adam	If you can handle it, don't go..(p17, 728)	If you can handle...don't go..	The need for a man to not just give up, the need to fight and handle it first

Adam	Learn from the past experience...do what worked for you in the past..(p17, 728-731)	Learnt from past experience	Doing what works for you in the past, it may work again this time
Adam	If its something to do with the heart then I will have to go (P17, 731)	If it's a heart problem, I'll go	He stated if its heart then he will go straight away, believing it could be serious and may have fatal consequences if not treated.
Salleh	If the symptoms get worse after few days then I will go..(p18, 756-760)	If symptoms get worse...i'll go.	Persistent, worsening symptoms
Ishak	Goes on and on so we might think that there must be something else and so of course we seek for advice (p18, 769-770)	Goes on and on [pain]	Persistent, worsening symptoms
Ishak	Painful (p18, 779)	Painful	Pain legitimizes them to seek health help
Taufiq	MC for school...if I'm on school holiday I wont go to clinic (p22, 945-948)	MC for school [university]	MC is required for not attending classes
Khalid	Just stay at home and take PCM (p22, 968-971)	Stay home... take PC	Talked about how much easier it is just to stay at home and buy PCM than going to see doctor
Salleh	Don't want to bother parents to take me to clinic, they both are working, they must be tired..(p24, 1028-1030)	Do not want to bother others	Not wanting to trouble others to take him to the hospital
Khalid	Serious injury...heavy stuff (p30, 1291)	Serious injury	If they perceived something as serious this would trigger them to seek health help

Table 4.1: Initial coding using *in vivo* codes

In this process of coding, memos were also written to capture my thoughts on the codes and to develop the analysis of the data. The memos also guided me in my next steps in data collection, coding, and analysis. This is regarded as a core activity in the process of generating grounded theory. As Glaser notes, “..if the researcher skips this stage by going directly to sorting or writing up, after coding, she is not doing grounded theory..” (Glaser, 1978:83)

The following is an excerpt taken from my memo, which informed much of my analysis and sampling.

Memo 1:

“After five interviews and one FGD it became clear that many participants were commenting on the problems with service delivery. I noted at the time most of my participants so far talked about how they dislike waiting for two to three hours just to see the doctor at the public clinic. They added that it is not just the long wait, but this was made worse when you got to see the doctor, they (the doctor) did not pay so much attention to them but instead had their eyes glued to the computer in front of them. Does this mean men want attention and want to talk? But doesn’t the literature say that men are not expressive and it is difficult to make them talk?”

They also commented that it is far easier to just buy the medicines from the shop and claims that whatever the problem is, the doctor will likely give you Paracetamol. All these were seen as off putting for most men that I interviewed. However, one man (Abdullah) was suffering from a chronic joint problem affecting his mobility, and waiting does not seem to be bother him too much. He said its okay to wait and he understood that the doctor has a

lot of patients to see. He also said he is used to it as he goes to see his doctor once every three months for treatment, which he said would be very expensive if it were to be obtained from private clinic, whereas he can get it for free from the public hospital.

This has made me think about a few things. In comparison to the other healthy men, a guy that I interviewed today (Abdullah) has a chronic health problem, which requires him to get an expensive regular treatment from the hospital for free. He does not seem to mind waiting. Why is this experience different between these men? Is it because of financial background: they can afford and have the option to go to a private clinic and that's why they complain about the public healthcare services? Probably yes, when I looked at their personal details, most of these men are working for the petroleum company, which often pays a good salary. Abdullah does not have the option to go private as it is an expensive treatment and it is regular so he compromised. I think it would be interesting to explore men's experiences of accessing private clinic. This is because, as it appears to me, that waiting time is a big deterrent for men going to see their doctor at the public clinic. Would it be different if it were a private clinic? Are waiting time and any other inconveniences caused by the healthcare services actually the reason why men do not want to go to see the doctor? It is probably not because they are a man, but rather because of the health care system that actually fails them!

Plan: *To look for man who goes to a private clinic and to explore their experience.*

Look for more men who already have existing health problems for comparison purposes”.

(Date: 10th Jan 2015)

(End of memo)

~~~~~

It is also worthy of note that this memo demonstrates some analytical refinement and comparison that took place in terms of my future sampling. This is a particular feature of grounded theory. Through the process of constant comparison, undertaken whilst doing this analysis, special attention was given to the similarities and differences between the following groups and categories of participants:

- I. Single men and married men
- II. Employed men and unemployed men
- III. Those with existing medical conditions
- IV. Younger (ages 18 to 59 years old) and older men (ages 60 and above). This age division is merely based on fact that in Brunei, 60 is the retirement age and the age where one will be eligible for the old pension scheme<sup>4</sup>(Pg Haji Md Noor, 2016).
- V. Types of occupation (between skilled and semi-skilled work)
- VI. Religion (Muslim and non-Muslim)
- VII. The different ethnicities.

In order to structure and capture this comparative analysis I made use of a matrix. Significant findings were highlighted and notes were made, as this provided a reminder and direction for where to focus next. This method of comparison was tabulated in an attempt to make it more transparent and systematic. This is illustrated in table 4.2 below. Again, the iterative process

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<sup>4</sup> Old pension scheme refers to one of the privileges given by Brunei's government to its people after they have retired from their work. The pension takes the form of monthly allowances.

of analysis and data collection was employed and as a result of the comparisons, further questions were developed and then explored in subsequent fieldwork. These included:

- Why do younger men tend to see the role of 'man as breadwinner' as shared? Is this different to what older men (above 60 years old) say?
- Young men talk about looking good in terms of physical appearance. They seem to get stressed if they find something unusual happening to their body that is visible to others especially on their face and hands. Things that affect their appearance seem to be triggers for going to hospital to get them checked out. One participant in a focus group discussion mentioned that, although he is a man he wants to look good too and emphasised that looking good is not just for women. Do older men share this view?
- What are the differences between the socialising behaviours and practices of young and older men? It was noted that young men talk about meeting friends but older ones talk about attending community functions in the village or being at home helping the family. This is not just limited to helping their wife but also their children and grandchildren.
- Why is giving back to community and being part of the community not mentioned by younger men?
- Are there any differences in terms of health practice preferences between age groups and by ethnicity and occupation?

- Does having a history of health problems or an existing medical problem influence men's health help seeking behaviour?

As a result of these questions, a more specific theoretical sampling was deployed and further investigation of these issues was undertaken.



| INITIAL CODING                   | WHO SAID THIS |        |                                        |             |             |             |                |                                               |                  |                    |
|----------------------------------|---------------|--------|----------------------------------------|-------------|-------------|-------------|----------------|-----------------------------------------------|------------------|--------------------|
|                                  | MARRIED       | SINGLE | AGE (18-30)                            | AGE (30-40) | AGE (40-50) | AGE (50-60) | AGE (60 ABOVE) | HAVE ANY HISTORY OF MEDICAL/ SURGICAL PROBLEM | ETHNICITY: MALAY | ETHNICITY: CHINESE |
| Being a husband                  | x             |        |                                        |             | x           | x           | x              |                                               | x                | x                  |
| Being a son                      | x             | x      | x                                      |             |             |             |                |                                               | x                | x                  |
| Being a grandfather              | x             |        |                                        |             |             |             | x              | x                                             | x                |                    |
| Being a breadwinner              | x             | x      | They argued it should be done together |             |             | x           | x              |                                               | x                | x                  |
| Being an employer                | x             | x      |                                        |             |             |             |                |                                               | x                | x                  |
| Being physically able            | x             | x      | x                                      | x           | x           | x           | x              | x                                             | x                | x                  |
| Performing roles like others     |               |        |                                        | x           |             |             |                | x                                             | x                |                    |
| Ability to perform at work       | x             | x      |                                        | x           | x           | x           |                | x                                             | x                | x                  |
| Continue doing things as normal  | x             | x      | x                                      | x           | x           | x           | x              | x                                             | x                | x                  |
| Able to socialise                |               | x      | x                                      | x           |             |             | x              |                                               | x                | x                  |
| Physically fit                   | x             | x      | x                                      | x           | x           | x           | x              |                                               | x                | x                  |
| To perform spiritual obligations | x             | x      | x                                      | x           | x           | x           | x              | x                                             | x                |                    |
| Being able to earn               | x             | x      | x                                      | x           | x           | x           | x              |                                               | x                | x                  |
| Being able to pay loan/mortgage  | x             | x      | x                                      | x           | x           |             |                |                                               | x                | x                  |

Table 4.2

**Key:** (1) X indicates that it was mentioned by this study's participants. (2) Highlighted item indicates it requires further exploration

## ***(2) Focused coding***

This stage is referred to as the intermediate coding level by Charmaz (2014) in her description of constructivist grounded theory. The purpose of this stage is to move from in-vivo coding and being close to the data in a largely descriptive mode to a higher level of analytical thinking. It requires decisions about which initial codes make the most analytic sense to categorise the data as a whole. It also condenses and sharpens what is already done as it highlights what is found to be important in the emerging analysis.

After a few interviews, I had a great deal of data and had generated 110 initial codes. I managed to reduce these initial codes to 58, by removing duplicates. These codes were then grouped together by looking at the relationships between them and their thematic and conceptual similarities. This grouping task led to the formation of thematic sub-categories and categories, a goal in focused coding (Saldana, 2009). For example, I grouped together codes that captured how men define their health in terms of ability to function as a man. Some examples of these codes include being 'able to work', 'able to get up in the morning', 'able to go to classes', 'able to be independent', 'able to have intimate relations with their wife', and 'having stamina'. All these were clearly important to them as evidenced by the high frequency of references in transcripts and the significance attached to it by participants. This whole process helps to direct the analysis (Charmaz, 2014).

Here for reasons of convenience, I labeled all the focused coding in my table as 'category', so as to avoid confusion. This is illustrated in Table 4.3.

Three categories were identified, namely (1) The physicality of health and its importance to masculinity; (2) “*Ikhtiar*” as a way of ‘doing masculinity’ in the context of experiences of ill-health (3) Masculinity and legitimation of health help seeking.

The table (Table 4.3) below shows the process in forming the first category, as part of the focussed coding. I named the category as “***The physicality of health and its importance to masculinity***”.

| INITIAL CODING<br>(IN-VIVO)         | THEMES                                                                    | SUB-CATEGORY                                                                                                     | CATEGORY                                                           |  |  |
|-------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|--|
| Being able to work                  | Health in terms of ability to perform routine activities and to work      | Being able to function:<br>The importance of executing socially constructed masculine norms and responsibilities | <b>THE PHYSICALITY OF HEALTH AND ITS IMPORTANCE TO MASCULINITY</b> |  |  |
| Being able to get up in the morning |                                                                           |                                                                                                                  |                                                                    |  |  |
| Engaging in a normal routine        |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to be independent        |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to go to classes         |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being intimate with wife            |                                                                           |                                                                                                                  |                                                                    |  |  |
| Having stamina                      |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to work                  |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to get up in the morning |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being a husband                     | Defining health in terms of ability to fulfil social and relational roles |                                                                                                                  |                                                                    |  |  |
| Being a son                         |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being a grandfather                 |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being an employer                   |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to socialise             |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to perform               |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being a breadwinner                 |                                                                           |                                                                                                                  |                                                                    |  |  |
| Raising my children                 |                                                                           |                                                                                                                  |                                                                    |  |  |
| Being able to function              |                                                                           |                                                                                                                  |                                                                    |  |  |

CONT..

| INITIAL CODING<br>(IN-VIVO)                                      | THEMES                                                                         | SUB-CATEGORY                                                                                                               | CATEGORY                                                                       |
|------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Can lead prayers                                                 | Being a Bruneian<br>(Cultural orientated)                                      | Being able to function:<br><br>The importance of executing<br>socially constructed masculine<br>norms and responsibilities | <b>THE PHYSICALITY OF<br/>HEALTH AND ITS<br/>IMPORTANCE TO<br/>MASCULINITY</b> |
| Perform Hajj                                                     |                                                                                |                                                                                                                            |                                                                                |
| Able to attend community/ family<br>functions/gatherings         |                                                                                |                                                                                                                            |                                                                                |
| Able to teach children and grandchildren to<br>recite the Quraan |                                                                                |                                                                                                                            |                                                                                |
| Able to look after grandchildren                                 |                                                                                |                                                                                                                            |                                                                                |
| Able to look after parents                                       |                                                                                |                                                                                                                            |                                                                                |
| Being able to pay mortgage and loan                              |                                                                                |                                                                                                                            |                                                                                |
| Unable to work                                                   | Resulting from<br>disturbance to performing<br>roles and functions as a<br>man |                                                                                                                            |                                                                                |
| Affecting income                                                 |                                                                                |                                                                                                                            |                                                                                |
| Affecting study                                                  |                                                                                |                                                                                                                            |                                                                                |
| Unable to function normally                                      |                                                                                |                                                                                                                            |                                                                                |
| Unable to pray                                                   |                                                                                |                                                                                                                            |                                                                                |
| Unable to perform Hajj                                           |                                                                                |                                                                                                                            |                                                                                |

Table 4.3: Focussed coding: formation of first category.

Here, the final four themes shown above are grouped together and termed as *“Being able to function: The importance of executing socially constructed masculine norms and responsibilities”*. This is because men talked about their health as mostly shaped around physical aspects and capacity to undertake certain actions and fulfil certain roles if they are healthy. This is particularly the case in relation to their ability to ‘function’ and perform their roles and responsibilities as men. Furthermore, there is also a sense of cultural context whereby these men talked about roles that are considered as having unique characteristics in a Bruneian context such as spiritual obligations, family responsibilities and obligations as a son – looking after parents - and as a grandfather - to help with child care (grandchildren) whilst the children’s parents are at work. Taking all these into consideration led to development of the final concept / core category – ***“The physicality of health and its importance to masculinity”***, as an appropriate precise summarising category heading.

This second table (Table 4.4) shows the elements, which went into the second category - ***“Ikhtiar” as a way of ‘doing masculinity’ in the context of experiences of ill-health”***.

| INITIAL CODING (IN-VIVO)                                                                                                                                                                                                                                                                                                  | THEMES                                             | SUB-CATEGORY                                            | CATEGORY                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <p>Try to handle itself first, must "<i>Ikhtiar</i>"</p> <p>Don't give up too easily</p> <p>Don't easily ask for help</p> <p>Fight first</p> <p>Do not want to bother others</p> <p>To be strong</p> <p>Lots of work to do</p> <p>Always busy at work</p> <p>Need to continue working</p> <p>Need to continue earning</p> | <p>The need to be independent and self reliant</p> | <p>The inconvenience of public health care services</p> | <p><b>"IKHTIAR" AS A WAY OF 'DOING MASCULINITY' IN THE CONTEXT OF EXPERIENCES OF ILL- HEALTH</b></p> |
| <p>Prefer safer approach</p> <p>Non pharmacological approach</p> <p>Easier option is to go to the shop to buy over the counter medicines</p> <p>Do what worked in the past</p> <p>Normalization of symptoms</p>                                                                                                           | <p>Convenience way to treat symptoms</p>           |                                                         |                                                                                                      |

Table 4.4: Focussed coding - formation of second category.

The final table (Table 4.5) shows the process in determining the third and final category, ***“Masculinity and the legitimation of health help seeking”***

| INITIAL CODING (IN-VIVO)                    | THEMES                           | SUB-CATEGORY                                                     | CATEGORY                                                   |
|---------------------------------------------|----------------------------------|------------------------------------------------------------------|------------------------------------------------------------|
| Learning from bad health experiences        | Finding excuses for seeking help | Needing strong legitimate reasons to access health care services | <b>MASCULINITY AND LEGITIMATION OF HEALTH HELP SEEKING</b> |
| Existing (chronic) health problems          |                                  |                                                                  |                                                            |
| Having no medicines at home                 |                                  |                                                                  |                                                            |
| Experiencing injury                         |                                  |                                                                  |                                                            |
| Expensive over-the-counter treatment        |                                  |                                                                  |                                                            |
| Feeling of uncertainty                      |                                  |                                                                  |                                                            |
| Failing home self treatment                 |                                  |                                                                  |                                                            |
| Persisting symptoms                         |                                  |                                                                  |                                                            |
| Being unable to bear pain                   |                                  |                                                                  |                                                            |
| Nothing works at home                       |                                  |                                                                  |                                                            |
| Wanting to perform responsibility to family |                                  |                                                                  |                                                            |



| INITIAL CODING (IN-VIVO)                                   | THEMES                                  | SUB-CATEGORY                                                     | CATEGORY                                                       |
|------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------|
| Feeling stressed at home due to being nagged               | Influence from family                   | Needing strong legitimate reasons to access health care services | <b>MASCULINITY AND THE LEGITIMATION OF HEALTH HELP SEEKING</b> |
| Being pushed by wife and children                          |                                         |                                                                  |                                                                |
| Continuous support and persuasion                          |                                         |                                                                  |                                                                |
| Losing opportunity at work due to illness                  | Influence from and impact on work/study |                                                                  |                                                                |
| Fulfilling work requirements/needing MC                    |                                         |                                                                  |                                                                |
| Affecting work and earning                                 |                                         |                                                                  |                                                                |
| Affecting my ability to perform responsibilities to family |                                         |                                                                  |                                                                |
| Cannot concentrate in class                                |                                         |                                                                  |                                                                |
| Troubling colleagues, when they need to cover your job     |                                         |                                                                  |                                                                |

| Cont..<br>INITIAL CODING (IN-VIVO)                           | THEMES                                                                                      | SUB-CATEGORY                                                     | CATEGORY                                                               |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------|
| Long waiting time                                            | Factors that put men off visiting government health care services but willing to compromise | Needing strong legitimate reasons to access health care services | <b>MASCULINITY AND THE<br/>LEGITIMATION OF HEALTH<br/>HELP SEEKING</b> |
| Cold waiting room                                            |                                                                                             |                                                                  |                                                                        |
| Short consultation                                           |                                                                                             |                                                                  |                                                                        |
| Do not want to drive                                         |                                                                                             |                                                                  |                                                                        |
| Hard to find parking space                                   |                                                                                             |                                                                  |                                                                        |
| Limited opening hours                                        |                                                                                             |                                                                  |                                                                        |
| Limited government clinics that operate outside normal hours |                                                                                             |                                                                  |                                                                        |

| CONT...<br>INITIAL CODING (IN-VIVO) | THEMES                                                                                  | SUB-CATEGORY                                                     | CATEGORY                                                               |
|-------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------|
| Same treatments all the time        | Factors put men off visiting government health care services but willing to compromise. | Needing strong legitimate reasons to access health care services | <b>MASCULINITY AND THE<br/>LEGITIMATION OF HEALTH<br/>HELP SEEKING</b> |
| Worried about being hospitalised    |                                                                                         |                                                                  |                                                                        |
| Worried about medical diagnosis     |                                                                                         |                                                                  |                                                                        |
| Worried about side effects          |                                                                                         |                                                                  |                                                                        |

Table 4.5: Focused coding - Formation of third category.

### **(3) Theoretical coding**

I then progressed to the third and final stage of analysis by creating a theme sometimes referred to as a *central* or *core category* in grounded theory (Saldana, 2009). This phase of coding is called theoretical coding and is appropriate and necessary in the development of grounded theory (Saldana, 2009). Themes are carefully formulated to represent the selected categories and sub-categories. According to Strauss & Corbin (1998), a theme should be clear and have the capacity to explain an overarching explanatory device or framework for the data.

The next table (Table 4.6) reports how I gathered the different codes together and generated a theoretical coding. These theoretical codes help to conceptualise how the other codes relate to each other as hypotheses to be integrated into the theory (Holton, 2010).

To avoid confusion, I used the term 'core category' to represent my theoretical code.

The following shows the development of the core category formed via theoretical coding.

Table 4.6: The formation of the theoretical code

| CATEGORIES                                                                                   | CORE CATEGORY                                  |
|----------------------------------------------------------------------------------------------|------------------------------------------------|
| The physicality of health and its importance to masculinity                                  | <b>HEALTH HELP SEEKING BEHAVIOUR IS</b>        |
| <i>Ikhtiar</i> ” as a way of ‘doing masculinity’ in the context of experiences of ill-health | <b>GENDERED AND DECIDED VIA THE PROCESS OF</b> |
| Masculinity and legitimation of health help seeking.                                         | <b>BARGAINING AND COMPROMISING.</b>            |

Despite recognising the need to get well and hence return to their normal routines, roles and activities, going to the clinic was seen as the very last option for men because it was inconvenient and represented a potential challenge to expectations of *Ikhtiar*. However, most would weigh the ‘pros and cons’ in making their decision.

### ***Analysis of data from the Focus Group Discussions (FGD) with women***

Data from the FGD with women were analysed separately from the men's groups. Two FGDs were undertaken with women (1 group with Malay women and 1 with Iban women) and one additional interview (dyadic – with two Chinese women)<sup>5</sup>. This data was not theoretically saturated. However, this is not an issue in this study because it is not the core aim of this study to explore women's view of men's health. The focus group discussions were only undertaken to allow me to put men's comments into context and see if there were any similarities or dissimilarities between the views of women and men.

Using a process similar to that adopted with the data gathered from focus group discussions with men, I analysed the data using the verbatim transcripts, written in its original language. I read and re-read the transcripts to try to make sense of the data. This was done in parallel fashion to that with the data from men also as to adhere to the concept of thematic analysis. This data is supplementary and complementary to that gathered from men.

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<sup>5</sup> The *dyadic interview* was done because only two women came during the session, despite making appointment with them few days prior to the interview, which they said they has agreed to come. Data from dyadic interview is treated the same way as the data arise from the FGD with women.

I did it because men referred so often to women as important in influencing their attitudes and behaviour and I structured the intervention with women to explore these issues and their views of their role in men's health. Further, it also allowed me to particularly look into ideas and information about how women see and talk about the issue of men's reluctance to use health services and their role in encouraging them to do so. The discussion on this with the women was structured but not the analysis.

Relevant excerpts from focus group discussions with women are shared in the findings section of this thesis. These are integrated with findings from the men's group in order to show how men's and women's perceptions of the role of women in men's health help-seeking behaviour and the meanings that they attach to them converge and diverge.

Examples of the data from the FGD, both with men and women and how they are used to supplement and complement each other, are provided below.

Ramli (66 years old) said,

*"I just have to go, well eventually, because otherwise she will be angry and she will be talking non-stop..."*

Yusof (60 years old) said,

*“Well, I just go because it will upset her if I don’t go...if I’m not well it would be difficult at home. I am a father, husband, grandfather..lots of responsibilities”.*

In a focus group with the Malay women, the following were said.

Mona, a 43 year-old woman said,

*“I just keep telling him to go, don’t stop. He will go in the end..”.*

Nisa, a 56 year-old woman said,

*“It’s not easy to ask him to go but it’s my responsibility as his wife.. it would be difficult if he is not well...he is the leader of the family..”*

Sara (59 years old) from the Iban FGD shared similar views:

*“He would not go, but I keep persuading him!”.*

From the above excerpt, we can see how men and women are talking about the same thing but from different perspectives. Men sees their action of going to see their doctor as a way of avoiding conflict at home particularly with their wives and ensuring that they perform their responsibility at home for their family.



On the other hand, women see it as their responsibility as a wife. Women also know that it is not easy to ask their husband to go but they will just have to keep trying to persuade them and make them go. Similar findings have been recorded in another study done in Spain by Hennessy & Mannix-McNamara (2014).

Women also said that this is done as a way of ensuring their husband will continue to be well and able to carry out their responsibility as a husband i.e. as the leader of their family. Here, we can also see how these women can successfully influence men by approaching it as an issue of men's responsibility to the family.

Using a process similar to that adopted with the data gathered from focus group discussion with men, I analysed the data using the verbatim transcripts, written in the original language. I read and re-read the transcripts to try to make sense of the data. This data is supplementary and complementary to that gathered from men. I did this because men referred so often to women as important in influencing their attitudes and behaviour and, I structured the intervention with women to explore these issues and their views of their role in men's health.

Relevant excerpts from focus group discussions with women are shared in the findings section of this thesis. These are integrated with findings

from the men's group in order to show how men's and women's perceptions of the role of women in men's health help-seeking behaviour and the meanings that they attach to them converge and diverge.

Up to this point, I have discussed and provided examples of how the coding process was conducted. Tables were used to make the reporting of the codes more transparent. This not only allows reader to see how the analysis was performed but also shows how themes were derived from the data. This also helps to enhance the study's credibility.

Next, I move to briefly discuss how the large amount of data in this study was managed.

#### **4.3 MANAGEMENT OF THE STUDY DATA**

Although there has been a growing trend towards using computerised data management software for qualitative studies, such as NVIVO amongst researchers in masculinity and health seeking behaviour, see for example Chikovore et al (2014) and Räisänen & Hunt (2014). I made an active and considered choice not to utilise this or other similar software to code data. This is because whilst it offers an efficient, systematic way of managing the data it does not assist in any way with

data analysis. This became particularly apparent having attended a training session on NVIVO - this software does not assist the researcher in undertaking the analysis. The “real’ analysis has to be done by the researcher and remains a task of critical thinking and appraisal. Whilst the software contains the data the process of coding and identifying themes must still be done manually by the researcher. The chief benefit is not to thinking but to the reduction in the labour of manually marking up and managing data. NVIVO can assist with making this process easier and faster as it is done on the computer and by utilising the different features of the software.

Instead, I employed programs such as Microsoft Word and Excel. I coded my transcripts in Word by making use of the colour and comment features. Since I was using an ‘in-vivo coding’ approach for the analysis, I highlighted by using different colours, the excerpt from the transcript to support the selected code. Comments were also inserted under these codes either to remind me about the code or to trigger me to consider things that need to be further explored. This was followed by the action of ‘cut and paste’ of all the codes, together with its relevant excerpt from the interview and putting them all together in one separate document. Separate documents were created for each of the codes created. For this purpose, tables using *Excel* were created, whereby each column also contains the details identifying the participant.

Undertaking the analysis manually and making use of computer software in this way enabled me to retain a sense of immersion in the data. As I worked with it I recalled vividly what has been shared during the interviews and focus group discussions. However, this had to be weighed against the time it took to retrieve information from transcripts.

#### **4.4 CONCLUSION**

In this chapter I have discussed the approach that I used to analyse the data gathered from interviews and focus group discussions undertaken during the fieldwork phase of my research.

In accordance to constructivist grounded theory an iterative analysis process was used. The various steps involved in this process have been described in this chapter. I have also provided some exemplary material in relation to the analysis. Similarly, I also ensure that I retain breadth where possible such that the diversity of views and voices is discernible in reporting the findings that are presented in the next three chapters of this thesis.

The findings are presented in terms of themes, which are used as sub-headings to facilitate the flow of the discussion. Excerpts taken from the interviews and focus group discussions are included in each theme to describe and provide evidence. In terms of quoting the excerpts, symbols such as “(…)” are used to indicate that some part that is not particularly relevant to the context of the discussion has been omitted. It is also important to note that excerpts are quoted and in some cases translated directly from the original language (Bahasa Melayu/Malay) into English. In translation I have endeavoured to remain close to the data and preserve the original meaning. I also want to represent the full sense of the words used by participants in their cultural context and native language is an important issue. As a consequence, the grammar is not always precisely accurate as most of these are direct excerpts.

## **CHAPTER 5: FINDINGS & RESULTS**

### **5.1 INTRODUCTION**

In this section of the thesis, which comprises this and the next two chapters, I present the three major findings from this study.

The overarching issue is that health is important for Bruneian men and their conceptualisation and enactment of their masculinities and as the evidence from the literature has shown, they are, like men in other cultural contexts reluctant service users (Galdas et al., 2005; Rosaleen O'Brien et al., 2005). It is argued that, as a man, they portrayed dominant masculine behaviours which reflect the socially constructed "independent, self reliant, robust and tough male" (Courtney, 2000), norms which were mostly learnt from home. Seidler (2006) has argued that behaviours are 'picked up' from home, whereby boys learn how to behave from their fathers. Often, as a child, a boy grows up seeing their father 'function' and performing specific gender role – and it is this that men feel that they need to emulate in order to be like the majority of other men (Frosh, Phoenix, & Pattman, 2002). Undoubtedly, one can see the point that Seidler (2006) was making about 'the acquired behaviour' however, his work was heavily focussed on men in the West and hence it is unclear to what extent it is relevant or meaningful in other cultural contexts. The specific ways in which social practice associated with masculinity might be picked up through processes of acculturation and socialisation, especially in boyhood, stands outside the scope of this study,

but we are alerted to one inference, that masculinity is in important ways generationally patterned and ideas about male role and identity pass through generations via 'big cultural' discourses and expectations that will prove to be useful in understanding how Bruneian masculinities are rooted in very deeply embedded and widely shared ideas about how masculinities should inform men's behaviour as they move through boyhood, to fatherhood and grandfatherhood.

Additionally, the data presented in this chapter begin to show how health is important and how men accommodate ill-health and help seeking into the broad normative conception that men should be self-sufficient and not seek help and advice. While this is recognisable and congruent with the key tenets adhering to hegemonic theories as approach to understanding men and health, it will also be shown that culture, in this case a cultural expectation placed on South East Asian men has a big influence on their health help seeking behaviour that is distinctive from that in the West. It is patterning into and shaping by a particular understanding of the male life course and its associated male roles and how that mediates concerns about health and ill-health that shows that distinctiveness. This highlights and also starts to make manifest the argument that I wish to progress about the opportunities to nuance our understanding of the relationship between hegemonic masculinities and men's health help seeking behaviour.

In this chapter I focus on those findings that emerged under the theme of the physicality of health and its importance to masculinity. The central idea within this theme is how men use and experience their bodies as determinants and

indicator of their health and well-being. They tended to conform with the expectation rehearsed in the theory of hegemonic masculinities that that a fit, strong body equates with good health and is used to demonstrate male power (Connell, 1995) and prowess (Kimmel & Messner, 1998). For many of the men participating in this study, the physical appearance of a man's body was also used to judge his ability to perform the roles and to discharge the responsibilities perceived to be incumbent on a Bruneian man at various points and transitions during his life course.

## **5.2 FIRST CATEGORY: THE PHYSICALITY OF HEALTH AND ITS IMPORTANCE TO MASCULINITY**

### ***The importance of the 'fit' body in the performance of Bruneian masculinities***

Generally, male participants in this study described their body as an external agent that should be seen as 'fit' either by themselves or by others who see them. A physically fit looking body was perceived to equate with the ability to perform the numerous tasks that are culturally assigned to Bruneian men, some of which are religiously rooted. Men described a number of dimensions to the physically fit body:



***i. Health in terms of ability to perform routine activities and to work***

Men were asked, at the beginning of every interview, how they understood health. In common with the experience reported by Robertson (2006) when he interviewed men about health, I noted that some of my participants seemed to have difficulties in knowing how to respond. This required me to keep rephrasing the question and at the same time trying not to pressure the participants and ensure that they were feeling relaxed in the interview. This is important because this was the first research involvement for each of my participants and for them to experience a degree of anxiety was only to be expected. This is illustrated in an excerpt from an interview with a 21 year old male participant called Ali:

Interviewer (DRI): *My first question, if I asked you what is health, how would you describe it?*

Ali: *Err..*[He paused for approximately 20 seconds] *I think health is...*

[Ali appears struggling with the question]

Ali: *Sorry, what was the question again?*

Interviewer (DRI): *Don't worry. No need to apologise. OK let me try to rephrase that. If I asked you to think about what health meant to you, what would you say to that?*

Ali: *Oh OK um for a person to be healthy. I think it depends on the ability of the person like what he can and what he cannot do. Umm I think so. Err...*

[Another pause of approximately 10 seconds]

Here Ali started to look even more anxious and rather unsure, judging from his facial expression and the frequent pauses in the interview

Interviewer (DRI): *OK. Don't worry you can carry on*

Ali: *If you can do anything as usual, that's healthy. If you can't get out of bed, that's not healthy. Is that correct?*

Possible explanations for this is could be that firstly, for Ali as for most of us, the question is difficult to answer because it requires something to be made explicit and conscious that is usually not so. We tend rather to get on with life and everyday social practices without consciously organising it or thinking about them. This also includes health practices (Bourdieu, 1990). Moreover, health is probably one of those things that men do not really talk about unelicited and are rarely asked to discuss. Arguably, as noted above, being involved for the first time in such research activity and this being the first question, a hesitant response from men could simply be the result of nerves.

Nevertheless, and despite the difficulties, generally participants agreed that health is important. Health was defined in terms of what it allows them to do and how it enables them to function and perform - a common theme found in previous research on male perspectives on health (Saltonstall, 1993; Watson, 2000). Specifically, in this context, men referred to health as the ability to carry out everyday tasks and discharge responsibilities as a man without any difficulties. Work was cited as a significant example of why a healthy body is important for these men. Being in good health enabled men to work:

*You know for us um we as men, what's important is able to function.*

*As long you are able to function um that is important and that is healthy (Mohd, 29 years old).*

*Like when there is no problem. No obstacle, you can continue doing your work and everyday tasks (Musa, 49 years old).*

Unlike other men in this study, a number of student participants also highlighted mental as well as physical health issues. In particular, they talked about how stress can be regarded as unhealthy and lead to health problems with the potential to disrupt their ability to function, to study, work and earn. This is reflected in an interview with Muiz, a 19 year old student, who said that, *"I think, health also includes, you know, no stress um you know if stress, you cannot work, cannot study"*.

It is interesting that the issue of mental health and wellbeing only emerged in interviews involving young male students. It is possible that this reflects the fact that these students are in their university years and may be experiencing stress in their studies – and they may also have felt this particularly keenly at the time of the interviews which fell during their term time. It may also be because that young men do not bracket mental health off because in their experience it links to norms about work because the experience of stress can result in an inability to work, re-establishing the link with the ‘functional’ concept of health.

***ii. A ‘Fit’ body as an indicator and sign of good health***

Physical appearance was used by these men to judge their own health and also that of other men. Looking physically fit was seen as a sign of good health. This view was shared by all participants regardless of age, marital status and ethnicity.

*Healthy is fit, good body, you know like me even though I am old, I have no big tummy, see [exposing his abdomen to me] (Najib, 68 years old).*

A body, which is perceived to be neither thin nor obese was thought to indicate good health and was something desired by all men. Having this type of appearance allows one to be perceived as healthy. Khalid aged 19, explained how his toned body served as an advantage for him as the team captain of his football team. With his strong physique, he was able to

motivate his team members to do more exercise and practice and it also enhanced the threat that they posed to the opponent's team.

*For me um you know um I play sport a lot, all the time and sometimes go to the gym. That's how I keep my health mm you know I'm a footballer, if I have good body um like, um you know our team, we all are fit so one time we have football match, we managed to intimidate our opponents just by them looking at our body, we all physically fit, they will think we are hard to defeat (Khalid, 19 years old).*

It is clear how Khalid gave meaning to his active engagement in such health sustaining behaviour by referencing it to his role a leader and associating that with physical power including the capacity to intimidate other men. This need to be powerful and seen to be powerful legitimated and motivated his health promoting behaviours. Here, we can see how the fit body is used as a means of competing and indicating male power. Fit bodies are not only a sign of health but of prowess and power. The idealised male body is muscular, athletic, and disciplined to embody control, presence and the promise of power (Connell, 1995). Again this altogether links to capacity to compete – a critical element in hegemonic masculinities.

It has also been argued that young men in particular used their body as an agent of gendered social practice through demonstration of strength (Kimmel & Messner, 1998). Hence, younger men in this study talk in particular about utilising the gym for toning up and building up their muscles, which represents a 'fit-healthy body'. The practice of going to the gym and working

out so as to 'bulk up' and build up muscles was also identified by young men in this study. For instance, Siddiq, a 30 year old body builder, stated:

*I go to the gym almost everyday. I meet my friends there and trained with them. It's good you exercise and build muscle and make your body nice um muscle you know um not fat makes you looks good.*

His fellow gym goer Fahmi (31 years old) also shared similar sentiments, arguing:

*If I am healthy, I can keep going to the gym and do my training [weight lifting]. That's my routine every afternoon.*

Engagement in body-building has been shown in other studies, to have similar meanings for men. For instance, Groes-Green's work amongst young Mozambique men also indicated that they cultivated their physique and male identity through the practice of bodybuilding (Groes-Green, 2009). They acknowledged how the gym helps them to achieve their desired physicality in this case, a muscular body. In turn, they derive pleasure and excitement from this achievement and the work towards it. Notably, weight lifting is not the same as other exercises like jogging and running. This is because weight lifting is primarily an anaerobic exercise as opposed to aerobic activity. Anaerobic exercise requires little cardiovascular fitness, whereas aerobic exercise e.g. running and cycling, are regarded as healthy and are urged as important for physical health (Glassner, 1990). Thus, indeed the main goal for bodybuilding is to have a 'fit body', which they desired and regarded as

healthy and beautiful (Featherstone, 1991).

The pleasures experienced by these young gym-goers have also been reported by Monaghan (2001) who found that accomplishing the aesthetic aspects - looking good, in other words strong looking, with a fat-free body, which bodybuilders associate with healthiness - is the central aim of their exercise. This is because for them the good-looking fit body signifies health, even though it can be argued that the fit body may not be healthy (Monaghan, 2001).

Older men shared similar views about the importance of physical appearance, especially body size, in judging one's level of fitness. However, unlike younger men, their preferred way to keep fit was using moderately intense aerobic exercises like walking, jogging and gardening. It can also be seen how these older men try to spend time with their family while exercising by doing it together with them. This can be seen below in this account shared by Ramli, a 66 year old retired man:

*I usually go like once a week um you know go jogging with my wife, sometimes I brought my grandchildren along with me. It's good for health (...) also I get to spend time with them.*

The practice of going to the gym was never brought up in any of the interviews with older men. Najib, a 68 year old man, argued that he could still exercise simply by doing the gardening at home and that this enabled him to

'sweat it out and burn some calories'. As he commented;

*No need to do complicated exercise, just go outside, gardening or mow the lawn. There are so many things you can do at the garden. You will also sweat, that is also exercise. I do that almost everyday.*

Here, it can be noted that men in this study mentioned that they are doing some forms of exercise, be it either in the gym or doing gardening in their own garden or backyard. They also appeared to have a sound understanding of the importance of having a regular exercise regime. It can be argued that the recent health promotion campaign on physical exercise mounted by the Ministry of Health, Brunei Darussalam could have contributed to this. In the last few years, strenuous efforts have been made by the Ministry to promote regular exercise to the public in Brunei via the use of media such as television, radio, government newspapers and also social media particularly such as the Ministry's website and Facebook page. Easily and freely accessible sports and recreational facilities were also built for the public.

I have certainly observed that it is now a common sight to see a large number of people taking their afternoon jog or run and going hiking at the recreational and sport centres throughout the country. It is also common now to see mass public participation in charity runs organised by various organisations in the country. This shows that Bruneian people in general appear to be more physically active and take more exercise. A good example of this is at the number of marathon events organised in Brunei and the



extent of public participation. Over the years Brunei has witnessed an increasing number of marathon events such as *The Run*, *Larian Amal Tongkat Ali*, *Colour Run*, *Red Ribbon Run* and many more. A closer look at *The Run*, the biggest charitable marathon event in Brunei, which is held yearly, shows that it has recorded an increasing number of participants. Since its first launch in 2012, where they recorded a total of 3,600 participants. This has risen to 7,000 participants (the limit) in 2013 and 2014 (“The Run: Where every steps matters.,” 2017) (no figures are available for 2015 and 2016). It is plausible that promotion of exercise and creation of facilities is creating a new context and influences both men’s thinking on health and capacity to engage in physical exercise.

### ***Defining health in terms of ability to fulfil social and relational roles***

#### **I. Being healthy and performing an idealised Bruneian masculinity**

The data also show that good health fits into a broader idea of masculinity as a series of relational and especially familial roles and responsibilities, which emerge over the life course. Progressing, over time, from being a good son to a good husband then a good father and finally a good grandfather is the idealised pattern of transitions Bruneian men expect to make over their life course. These different phases of their life course are associated with certain roles and responsibilities, which they as men, perceive that they are required to perform and discharge. These are identified as attributes of their masculinity and socially normative in Brunei. Hence, I have decided to refer

to them as “Bruneian masculinities”. This makes clear the distinction from other masculinities particularly from the West that arise because of specific local factors and cultural context. That is not to say that life course and masculinities are not intertwined in the west but that there are particular local cultural reference points for that which Bruneian men consciously and explicitly report as distinctively Bruneian.

Participants talked about their own or other people’s experiences and the different expectations that were placed on them throughout their life course. It was noticed that the ability to perform these masculine expectations and responsibilities were important for them. They also indicated that this could only be fulfilled with the achievement and maintenance of good health.

*We as men, have lots of responsibilities, so being healthy is very important (Mohd, 29 years old).*

It is possible, working from the data, to present a typology of the role transition that these men are talking about -from being a son to husband to father then to grandfather and to begin to demonstrate how this influences their masculinities and their health help seeking behaviour.

### **Being a good son**

Young and single men talked about how they wanted to financially support their parents after finishing their studies and the importance of securing a good job to enable them to do this. They also described the importance of

being successful in their studies and thereby bringing pride to their family. The idea of being the 'breadwinner', which defines men who can provide economically for families, is also shared in other research conducted in the Global south. The concept of the 'breadwinner' as an ideal seems to be centrally configured, for example, as part of 'hegemonic' masculinity in many sub-Saharan African countries (Groes-Green, 2009). It has importance in the Global North but there are indications that cultural ideas about 'good fatherhood' may be shifting from breadwinning to a focus on other kinds of affective labour and engagement with family and children possibly because of the perceived importance of paternal involvement in terms children's welfare, achievement and attainment (Milkie & Denny, 2012).

Additionally, doing well in their studies, achieving job security and being able to provide for their parents was part of the idealised view of what makes a good Bruneian son and also provided them with a kind of '*road map*' through the early part of their lives. It has been suggested that most young people utilise some form of a plan or have a view of what their future looks like or involves. This is found to be a way for young people to manage and imagine their futures and this helps to prepare them for their transitions (Thomson & Holland, 2004).

The young men also talked about how being single allows them to focus on building and preparing for their future for themselves, their parents and future family. They acknowledged that health is important to them as it allows them to study hard so that they can find a good job, continue supporting their

parents and eventually get married and look after their own family.

*Um, for me..you know if you are healthy you can study better, pass university, get a good job, earn good money then you can help your parents and build your own family, get married (Taufiq, 25 years old).*

*I just want to study hard, get a good job and then make my parents happy, make them proud, look after them, support them, help them...it's my responsibility, they are getting old now and I'm their son (Bakar, 23 years old).*

Married men expressed similar feelings, although they said they are supporting their parents at the same time as providing for their own family. As a consequence, making a significant financial contribution to their parents was more challenging – but some mentioned compensating by contributing in other material ways to support, for example, by helping with everyday household routines. As Abdullah, 38 years old bachelor explained:

*Mum's old now...so I go shopping with her and I carry her groceries and also help a bit with her monthly spending.*

And, Daud (32 years old), who said,

*My family is my responsibility but so are my parents. If I have extra cash I will give them some or buy them foods*

These men also pointed out it is a norm for Bruneian children, both sons and

daughters, to take care of their parents and it is seen as a way of expressing gratitude and showing appreciation for the care that they received from their parents, who had looked after them when they were children. The long-standing nature of this practice can easily be seen when talking to grandparents, which strongly suggested how it has trickled down from one generation to the other. A son would acquire and learn this cultural practice from his father, indeed Ghail (1996) has posited that fathers are the primary role models for their son's masculinities. This is reflected in the following excerpt from my interview with Syafie, a 65 years old, retired man:

*That's how it is and how it has always been. They looked after us when we were younger and now it's our turn to look after them.*

It must also be noted that that even though the responsibility to look after parents is equally placed on the son and daughters, in Brunei, this cultural expectation changes after a daughter marries. This is because a wife's responsibility is primarily towards her husband and their children. While this may not be unique to Brunei in terms of expectations about a daughter's primary affiliation and loyalty after marriage the key point is that it is the cultural norm for a son to take responsibility for the care of his parents. The responsibility for looking after parents continues even after a son has got married and moved out of the family home to live with his wife and children, as Daud (32 years old) said:

*I live in the city now with my family because it is easier for me to go to work, but I go to their house a lot to see them or at least phone them just to make sure they are alright.*

Historically, in Brunei parents used to live with their children, their in-laws and their grandchildren. The main reason for this was so that they can look after each other, especially their parents. Therefore it was common to see large extended families living together in Brunei. However, I have observed that in the past few decades, there has been a change, whereby most children tend to move out and have their own home, especially when they get married. Precisely why this happening is not clear. However, it can be argued that one factor could be the existence of an affordable housing scheme offered to people by the government of Brunei. The government of Brunei via its Housing Development Department, in the Ministry of Development aims to provide affordable, safe and good quality housing for its people (“Jabatan Kemajuan Perumahan, Kementerian Pembangunan Brunei Darussalam,,” 2016). With this being introduced, children could contribute to their parents not only by assisting with monthly spending (if finances permit), but also by frequently paying them a visit and making sure both parents are well, as noted by Daud, above. Moreover, the fact that Brunei is a fairly small country with pockets of high population density and low mobility facilitates close, continuing and regular family contact.

Participants also believe that looking after their parent is not only a good deed in itself but also it is commensurate with and required by Islam. As

illustrated in the excerpt below, Bakar quotes the word '*pahala*'. This refers to good deeds in Islamic teaching. To those who are not practicing Islam, it was seen as a responsibility and a way of saying 'thank you' to their parents for bringing them up. Moreover, taking care of parents is also a responsibility warranted by the government of Brunei and failure to do so can bring about legal complications (Mat Sani, 2016).

Many participants in the study, as shown below shared this sentiment.

*Of course I will look after my parents, you know when they get old. When I finish my study and start to work, I will look after them. Make them happy, they brought me up well, without them I wouldn't be here. For me as a Muslim guy you know its important and its 'pahala' too (Bakar, 23 years old).*

*Oh yes...they look after us when we were younger so now its our turn to look after them (Daud, 32 years old).*

### **Being a good husband and father**

Having good health continues to be significant in this second stage of the male life course - husband and fatherhood. In this stage, men recognised the importance for them to continue working hard and start earning to support their own family. Men identified their priority in this stage as their family, that is to provide them with sufficient shelter and a comfortable life. This is evidenced in this study, whereby married men talked about the need and

expectations for them as a good husband to financially support the family. This was usually discussed in terms of paying the bills, buying food and providing shelter for their wife and children. They acknowledged that this could only be achieved with good health. Here, we can see how paid employment or ability to earn is an important anchor for masculine identities. Some men commented that:

*Health is important for me. If you not feeling well, how do you go to work? Who will support my wife and kids? (Isa, 30 years old).*

*You must look after yourself because you're the leader of the family. If you're sick you can't look after your family (Yusof, 60 years old).*

*Its our responsibility as a man um you know we earn and bring money home for the family (Daud, 32 years old).*

It is noted that men in this study regularly referred to themselves as a leader. Being a leader in this case refers not only to someone who has responsibility to provide for the family but it is also a status acquired as a man and a husband through performance of their provider-role in the family. In this study, these men equated being a husband with being a leader for the family. For them as a husband they need to provide, protect, guide and lead the family - their wife and children. Again these were described as cultural practices and beliefs passed from one generation to another.



Other than financial support, men also talked about the importance for them of good health and fitness so that they could help their wives look after the home, particularly when it comes to doing physically demanding tasks which were regarded as more challenging and less appropriate for them to engage in.

*I help at home, you know all the heavy stuff, all the hard [heavy] tasks, I will do it (Idrus, 43 years old).*

*All the heavy work..um, at home um like carrying heavy stuff, like that. I will do that not my wife; she will do other house work um, like cooking (Khalil, 37 years old).*

Here, it is interesting to note the way that these men foreground physical labour as the form that their contribution to household tasks takes. Again, we can see how body and physical strength is central to masculinities. One outcome of the way that men discuss their responsibilities towards the family is to (re) establish their power and authority at the centre of the family. This is critical because not only does it link the issue of health to role, but to male power.

In an individual interview Daud, a 32 year old married Muslim man with three children, explained that for him as a married man, he is not only responsible for contributing in terms of physical work and financially to his family and parents, but also as a husband he has a responsibility to fulfil the sexual

needs [Batin<sup>6</sup>] of his wife. Again, according to him good health is demanded in order to be able to do this. This is clearly reflected in his interview below.

*You know. Money, home, food, help at home. That's Zahir needs but there is another aspect as well. The Batin needs that is also your obligation as a husband. In Islam we are being taught about that as well, health is important for that.*

Naim also shared similar sentiments. In a focus group discussion with two of his friends (Siddiq and Fahmi) from the gym, this 31 year old newly wed Muslim man shared the following:

*It [Batin need] is important for our wife, um not just for us as the husband. It's a need for us um it's for both husband and wife that's why we got married..thats our [as a man] responsibility.*

It was notable that men see having a mutually fulfilling sexual relationship and physical intimacy with their wives as a responsibility within the married, male role. The following was the discussion that I had with Naim, Siddiq and Fahmi (ages 31, 30 and 31, respectively) regarding 'nafkah batin'.

Interviewer (DRI): *Naim shared the importance of nafkah batin. Do others have any thoughts on that?*

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<sup>6</sup> Zahir and Batin are two Quranic terms. Zahir refers to the outer or external and Batin refers to the opposite. However in this context, whenever these two terms are being used they refers it to 'needs' or responsibility that a man need to attend to. Zahir refers to external needs like food, paying bills etc whereas Batin refers to internal or emotional needs (in this interview, participants were referring to sexual needs)

As soon as this question was directed to them they quickly answered:

Siddiq: *No. I don't know, I'm not married yet.*

Fahmi: *Same with me. I am still single.*

Here, I could also see that they are not comfortable talking about this. Therefore I decided to move on to the next question. Of course, discussing sex in these terms in front of other men can perform other functions. For example, demonstrable ease in discussing and evidence of sexual knowledge and competency carries potential status advantages in some male peer groups.

Reflecting on the above-shared excerpts from interview between the younger gym goers, it can be noted that unlike the single men, these married men used the ability to perform sexually, in this case with their wife, as a way of demonstrating their ability to fulfil their responsibilities as husbands and also men. According to Zhang et al (2014) this is one way used by men to demonstrate their health and masculinity. Because of the censure around pre-marital sex in Brunei this means of establishing and demonstrating masculinity is not available to single men.

Sex and sexuality was not raised as an issue in the interviews with non-Muslim men. This was because the numbers of non-Muslim men were small and so opportunities for the issue to come up were relatively few. Moreover, I am also aware that group discussions are different kinds of contexts to one-

to-one interviews and that raising and discussing potentially complex and sensitive issues such as sex and sexuality might be more difficult for participants. Another likely reason for this is due to the religious connotation attached to attending to 'nafkah batin', as most of the participants are Muslim. This would probably make it a bit easier to talk about this as it is seen as a norm and a responsibility for a Muslim husband. Furthermore, Islam views sexual intercourse of a married couple as an act of worship which fulfils emotional and physical needs as well as being procreative. Marriage places a responsibility on both the husband and the wife to meet each other's sexual needs as emphasized by Islamic law (Al-Sayf, 2007).

### **Being a good grandfather**

Interviews with the older men, who were all retired and aged over 60 ( $n=5$ ) revealed a significant difference in terms of what they valued most as men. At this point in the life course, these men were no longer working and their roles had shifted from being a provider to their family and parents, and leader to their wife and children to being a retired grandfather. Furthermore, they may also have had diminished health and physical capacity. This change in role highlights the significance of creating this sub-theme around grandfatherhood because it is quite distinct from fatherhood in a number of respects. Firstly, it is about work no longer figuring in these men's lives. Secondly, they are men of an age when ill- health and loss of some physical capacity is starting to become a strong possibility. Here we can see how the changes in role through out the life course influence their masculinities, which allows the creation of a model of masculinities and health that is

connected profoundly to the life course and transitions within it: son - father – grandfather.

It has been suggested by Ghail (1996) that unemployment decreases a man's ability to provide for himself and his family and that this potentially provides a challenge to traditional masculine identities. Unemployment can threaten the stability of the traditional masculine identity constructed around the discourses such as bringing home a wage and paying the bills and putting food on the table. Unemployment can bring a feeling of inadequacy or failure to live up to idealised manhood. Although men entering old age and retirement are not becoming unemployed through, for example, redundancy with all that might imply about sense of failing against societal expectations, this work does however point to the importance for them of re-constructing their values and masculine ideals to fit into the situation and circumstances that they face in retirement.

In this study, retired men talked about their routine at home such as looking after grandchildren and sending them off to and picking them up from school. These grandfathers felt that it is for them to help with this since they are no longer working. It was noted that men at this age value the time with their family and helping their wives, children and grandchildren. This is something that they had done less when they were younger and were busy working and earning for the family. This is reflected clearly in the interviews whereby none mentioned work and wanting to have social time with their friends, but they did talk about wanting to be home and helping to look after the family. They

highlighted how much they are required at home and how becoming ill could disrupt their routine and contribution. As men age and illness becomes more frequent, men's self-perceptions of their masculinity are threatened due to inability to sustain hegemonic masculine ideals by keeping the body muscular and strong (Oliffe, 2006).

Changes in role, including unemployment or retirement further eroded older men's capacity to live up to certain masculine ideals associated with 'breadwinning' (Calasanti & King, 2005). Consequently, men are faced with the challenge of redefining themselves within an idealised, masculine culture (Arber, Davidson, & Ginn, 2003). Therefore, it could be that these men are carving out new roles in order to give themselves an identity and create an important place in the family structure and hence bolster their masculinity. When opportunities to be the provider and other means of contribution are reduced or cut off, in this case by their retirement due to age, this is a method used by these older men to make sense of the cultural requirement to play a valuable and clear role in the family. Here, it is interesting to see how these men re-interpret these tasks, which could have been considered as feminising in order to make them appropriately 'masculine'.

I will discuss how the nexus of life course related responsibilities impacts on health-related behaviour in terms motivating service utilisation in the findings presented in chapter seven.

### **5.3 SUMMARY**

In this chapter, I have identified two main themes from the data which take us some way to understanding how health is configured as important within Bruneian masculinities and associated with and experienced as meaning within the seemingly universally shared idea about the life course transitions expected of a Bruneian man. Here, we can see how health and masculinity intersect and are mutually constitutive. Undeniably, there are some similarities to issues in other studies which have been undertaken both in the Global North and South – for instance the attention to the ‘fit’ body, to the body as an expression of male power in relation to other men, and the importance of ability to work as a marker of health - but the data presented here begins to draw attention to ways that these dimensions and relationships are locally patterned and most importantly that Bruneian men reference themselves to local cultural norms and practices.

I have demonstrated how an embodied masculinity is important to performing socially, culturally masculine norms and responsibilities. The body is regarded as an external agent that should be seen as ‘fit’, both by themselves and by others who see them. A physically fit looking body acts on two major things. Firstly, a fit looking body was used to show strength, power and prowess - a critical element of hegemonic masculinities. This is reflected in this study whereby men, especially young men, shared how they exercise and use the gym to get a strong, toned and fit physique and used this to intimidate their opponents, particularly in terms of sports events.

Secondly, the fit body was perceived to equate with the ability to perform the numerous tasks that are culturally assigned to men, some of which are religiously rooted. Men see being 'fit' as healthy and therefore it enables them to be part of the normal life course transition that has been mapped out for them as a Bruneian man. In particular, being healthy also allows them to perform all the different social and relational roles to their family. Of course, responsibilities and priorities change depending on the stage of the life course transition. Performing these culturally expected norms are considered as of paramount importance for these men and are regarded as important attributes to Brunei masculinities.

Ill-health hinders their ability to fulfil these roles and responsibilities and it is this hindering of capacity that comes to be regarded as an indicator of ill-health. There are instances in the data, which I more fully explore in the following chapters, where we can see how this combination of pressure to meet cultural expectations and a limitation posed to doing so by poor health can trigger men to use healthcare services.

However, accessing healthcare services is not necessarily the first option. I will show that this is particularly the case for older men, who often equate seeing the doctor with a risk of being hospitalised. This is viewed as inconvenient as it takes them away from home.

With regard to culturally embedded expectations about the male life course, family role and health the data indicate a clear, shared conception amongst



men about how the idealised life course of a Bruneian man is supposed to unfold, and furthermore, how health, especially retaining good health, is central to that.

Cleaver (2002) has suggested that there is a need for more research into men and gender identities in developing countries, in order to inform gendered roles in different cultural contexts. A life course approach to this analysis enables us to track the changing roles, needs and identities of men. The idealised male life course in Brunei involves developing from a son who is looked after by his parents, to being a workingman who will then help to support his parents, to being a married man who will then be responsible for looking after his own family. This progresses into grandfatherhood in which men perceive that they will stay at home and help their wife to look after the family and grandchildren.

These cultural norms seem to be derived from what these men observed and learnt from the people in their community or from home and especially from their fathers (Mundigo, 1995). As Seidler (2006) argues, it is in the home where boys learn how to behave like boys and what they should do as a boy does. As a child, a man grows up seeing their father function at home, performing specific gender assigned roles and responsibilities. Generally, boys would see their fathers as role models and feel that they need to emulate them. Subsequently, this influences their understanding of how they have to act and what they should do, in order to be accepted as a male, like the majority of others (Frosh et al., 2002).

These findings also show how Bruneian men's priorities change over time. Employment, career, money and building a financially stable family were these men's priorities in the early stages of their lives, particularly in their adulthood and fatherhood phase. This was central to the construct of the form of 'hegemonic' masculinity pertaining in Brunei. This conforms with Seidler's (2006) proposition that during this phase of life, men often construct their masculinity in relation to capacity to work and to earn for the family and this is often a method used by men to affirm their masculinities.

As men move into retirement and grandfatherhood, spending time with and contributing to family life become priorities. Seeing the doctor appears to be worrying to them as they fear being diagnosed with a medical problem and being admitted to the hospital, which would take them away from their family and limit their ability to fulfil the grandfather role.

It is important to note that although priorities changed as men aged, one consistent and overarching feature was the value attached to family and role in the family. This is despite the different ways they show and perform this according to their life trajectory and physical potential. This finding echoes that of an earlier study undertaken in Malaysia that aimed to explore men's perceptions about health and illness and factors affecting their health and illness behaviour (Yun et al., 2008). In this interview-based study, men in Malaysia revealed that family and the need to continuously look after their family both financially and physically, was also a major motivation for them to stay healthy. The findings from this Malaysian study are very significant

because of the similarities in cultural and religious context to those found in Brunei. Similarly, a study using a standardised questionnaire undertaken with 5,134 men from five Asian countries (China, Japan, Korea, Malaysia and Taiwan) yielded similar findings (Ng et al., 2008). This study showed that almost all participants considered having a career, their ability to earn money and the capacity to provide for their families as the most important attributes of their masculinity.

I have also drawn attention to the influence and impact of government policy on men's understanding of masculine role and responsibilities. In this study, men talked a lot about the importance to them of providing and caring for their family and parents. Some explicitly mentioned the word 'nafkah' in the interviews, while others referred to it in speaking about providing food, shelter and other necessities for their family and parents. For Bruneian men, this is a tradition and a norm. In addition, married men also talked about the ability and the importance of providing sexual needs or 'nafkah batin' for the wife and their relationship.

Closer investigation revealed that this tradition was actually further reinforced by the various interventions taken by the government of Brunei. Principal amongst these would seem to be the imposition of Syariah law and also education at school. Brunei Darussalam as an Islamic sultanate adopted Islam in the 15<sup>th</sup> Century and since then has had upheld Islam as a way of

life. Syariah law<sup>7</sup> has long been embedded in the country's system of governance with the Malay Islamic Monarchy (MIB) ideology. However, it was only in May 2014 that phase 1 of the new Syariah Penal Code Order, 2013 came into force. According to Haji Hassan Haji Metali, the chief registrar of the Syariah Appeal Court, quoted in Brunei's newspaper by Mat Sani on June 12<sup>th</sup>, 2016 (Mat Sani, 2016), there are two common types of *nafkah* in the Islamic Family Order: *nafkah* for the wife and *nafkah* for the parents. These apply to the husband and children, respectively. This *nafkah* is given by the husband to his wife. This is written in Section 217 under the Islamic Family Order of the Syariah Law. This does not refer only to monetary assistance; it includes all the basic necessities in everyday life, like food, clothes and shelter. Men in this study described this as '*nafkah zahir*'.

According to Islamic Family Order, section 184 of the Syariah law, children are required to provide *nafkah* for their parents and older relatives such as uncles, aunties as well as grandparents. Like *nafkah* for wives and children, this is not limited only to provision of monetary assistance. This law says that it is compulsory for children to give *nafkah* to their parents and ensure their parents have food to eat, a house to live in and clothes to wear.

If children do not demonstrate responsibility towards their parents despite them having a job and means to afford provision, legal action can be taken against them. In cases where older uncles and aunties are not married, their nephews or nieces are responsible for their care.

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<sup>7</sup> *Syariah Law- offences and punishment for crimes prescribed by Al-Quran and Sunnah (tradition of the Prophet Muhammad)*

As an incentive to instil the value of respecting and looking after parents and family, the government, via the Ministry of Education (MOE), has taken various measures. These include the introduction of various subjects into the school curriculum, both primary and secondary and also in religious schools. One example of this curriculum development involves a subject called Social Studies. These were first introduced in 2009 for students, aged from nine to eleven years old (primary four to primary six). Later in 2012, Social Studies was extended to secondary school students (Year 7 and Year 8). Social studies is an integrated study of subjects drawn from the social sciences and humanities to enable understanding of human interaction with the natural and social environments, as well as the inculcation of Bruneian attitudes and values. According to the Director of Curriculum Development Department, MOE (*Social Studies for Brunei Darussalam, Year 7.*, 2012), it is hoped that through this subject students will develop an understanding of Bruneian society and culture and therefore become responsible and civic-minded citizens.

Here we can see how work and ability to earn and providing *nafkah* are regarded as hegemonic idealised forms of male life course. This also has a major influence on their health behaviour and has some specific cultural dimensions.

Notably, familial responsibilities and work are important in hegemonic masculinities in the global north (P. Galdas et al., 2007; Hjelm et al., 2005), in Global South such as in Latin America (Cleaver, 2002), Malaysia (Yun et

al., 2008) China, Japan, Korea and Taiwan (Ng et al., 2008) and similarly in Brunei. However, what is unique is that in the existence of cultural-political context and especially the drive to enforce and maintain a particular set of gender role relationships and form of family life seen in Brunei

## **5.4 CONCLUSION**

In this chapter, I have described how the appearance of body, and specifically the 'fit body' is used as an indicator of men's good health. Health is also perceived by men as part of being a man and that is associated with important cultural expectations around life course and roles through the life course, which progresses from son to fatherhood and finally to grandfatherhood. It can also be seen how the changes in role through out the life course influences their masculinities, which allows the creation of a model of masculinities and health that is connected profoundly to the life course and transitions within it.

There is also a sense of great deal of stability of idealisation, which men see as handed down through families and 'deep' culture, but it is interesting to note that the government is taking conscious steps to reaffirm, encourage and indeed enforce adherence to the value of respecting and looking after parents and family through combination of legislation and education intervention.

In this chapter, I also have considered and show how my findings relate to research from the global north and also global south in this case, from

Malaysia and other neighbouring countries in Asia and also a study from Latin America. I have also shown how the findings can be related to the theory of hegemonic masculinities but most importantly, I also provide space to think about areas that should be considered as an extension to the theory of western hegemonic masculinity, in particular the need to employ the concept in ways that partake of the culturally and context specific.

Here Bruneian men talk about the fit body, its function in their everyday life and how it enables them to be part of the expected life course transition and perform it's associated masculine roles and responsibilities. This is what they considered as positive masculine attribute as a Bruneian man. This practice and belief has been mapped out for them and is passed from the older to younger generation.

## **CHAPTER 6:**

### **SECOND CATEGORY: “IKHTIAR” AS A WAY OF ‘DOING’ MASCULINITY IN THE CONTEXT OF EXPERIENCES OF ILL- HEALTH**

In the previous chapter, I have shown the centrality of the body in conceptions of health to the Bruneian men in this study. They use their body as a medium and health as a factor in performing their roles and tasks as a man, and for that reason I also discussed the way that health is configured within the life course and Bruneian men’s idealised view of the male gender role through boyhood, adulthood and into old age.

In this chapter, I discuss how study participants define and understand ill-health and how that is linked to their attitudes and behaviour in terms of health help seeking. I also engage in some considerations about how the findings relate to the emerging idea that the relationship between Bruneian masculinities and health show some similarities to what is understood about that relationship in the Global North but also some important differences largely associated with the nuance provided by the impact of more or less specific cultural factors.

When health and well-being are defined in the way that the Bruneian men who participated in this study do – as bodily function and capacity to perform socially and culturally prescribed gender roles - it is threatened by illness or loss of physical function and capacity, and men have to find ways of giving



meaning to their experiences and managing the impact in the context of this conceptualisation. One touch point that enables us to consider these processes is the concept of 'the care of the self' developed by Michel Foucault (Foucault, 1988). The concept of care of the self as a means of understanding and managing ill-health in socially acceptable ways has potential utility in this analysis because its approach aligns particularly well with the conception attached to health and body by men in this study.

At its most straightforward, according to the concept of 'care of the self', people are expected to take care of themselves and lead a healthy way of life (Armstrong, 1995). This concept proposes that medicine, science and technology should not be regarded as holding the sole responsibility to cure people, but in order to be a good citizen, the individual is required to follow, for example, the recommendations and guidelines that are proposed to them by the healthcare team. However, Foucault posited that the care of the self is more complex and he creates the notion of '*biopower*'. He argues this as the overarching authority of medicine and science and policy, which effectively sets the parameters or requirements of the people and that the power is exercised not only straightforwardly on people but by their taking on its imperatives and demands as largely internalised, unconscious practices (Pylypa, 1998).

Consequently, we can see that the term "biopower" refers to the ways in which power manifests itself in the form of daily practices and routines through which individuals engage in self-surveillance and self-discipline, and

thereby engage and locate themselves within and in relation to discourses of power.

Pylypa (1998) posited that this concept focuses on the body as the site of subjugation, and it highlights how individuals are implicated in their own oppression as they participate in habitual daily practices such as the self-regulation of health.

In this chapter, I will utilise this framework to support and inform an exploration of how men account for and deal with episodes or experiences of ill-health.

It was noted that in situations and circumstances where men who participated in this study described themselves as being ill, they talked about wanting to get better in order to perform and to function as a man. They considered being healthy as critical to their fulfillment of those expected roles. In the example below we can see how men talk about their responsibilities as a son and as a father particularly in terms of the importance of earning to look after their parents and family. Executing these responsibilities are important to them not just because it is culturally expected but also because within the Syariah Law imposed by the government, it has become even more crucial and indeed a legal requirement for these men to be able to perform the responsibilities. Therefore, here we can see how the concept of biopower articulated through

the care of the self applies in a Bruneian context. Health and the self-regulatory requirement to protect and maintain it become systemically and structurally enshrined through legal and cultural expectations about male role in family and social life. In short, men want to be healthy both for themselves but also because of obligations which reach through those experienced as associated with the immediate relational context of the family to those now captured explicitly in law.

*If you are not well, it's difficult. For example like me, it is hard for me to go to work so I need to get better soon. I'm a teacher and I'm always busy with my classes and my students. Work is important, got loans from the bank to pay, pay bills, support myself and help my parents (Khairul, 31 years old).*

*If I'm unwell, I want to get better fast and go back to work, you know I run my own business, time is precious. I don't earn fixed income, so I need to work hard (...) need money for my family too, my wife and children (Idrus, 43 years old).*

In analysing the above interview excerpts, we can argue that in Khairul and Idrus's responses, we can see them enacting 'care of the self' because what they do is internalise a socio-cultural expectation around the male gender role in relation to work and family as a demand for them to get better when they are ill. Similar findings were found in a study from 2014 conducted in the United Kingdom (Tyler & Williams, 2014) whereby the study describes how

men can be understood to be enacting the concept of 'care of the self' to describe their reactions to ill-health. Further, here we can see how the Foucauldian idea of discourse as a means by which that power is exercised and interpolated into the individual.

### **What do men do when they experience ill-health symptoms?**

The data in the study show men assuming responsibility to get better. They do this so that they can return to their normal routines and discharge their variety of responsibilities that they perceive that they shoulder. This can be seen in the excerpts from the interviews with a bachelor, Khairul, aged 31 years old and Idrus, a 43 year old, self-employed, married man. Both of these men stressed the importance of getting better quickly if they were ill so that they could go back to work and start earning again.

The data show that there is a pattern of repeating behaviour amongst these men; that is they tend to do whatever they have done in the past to reduce or eliminate the symptoms. To discuss this further, I will use the following sub-heading, '*the use of easy and readily available treatment that are perceived as 'effective'.*'.

#### **I. The use of easy and readily available treatment that are perceived as 'effective':**

Many men talked about taking a rest or a nap when they experienced ill-health symptoms:

*Usually when I have chest pain, I just sit down and stop whatever I was doing and rest, take it slow, calm down, breathe properly. You know sometimes that's all it needs and it been working OK so far (Ramli, 66 years old).*

*For me, usually if I have a migraine, I usually just sleep it off. Usually when I wake up it will be gone! (Musa, 49 years old).*

These excerpts show, Ramli used rest to calm himself down and also to distract himself from thinking about the pain. In the case of Musa, he uses sleeping as a way of coping with the pain or perhaps more accurately as a way of not facing the pain. From the above narratives we can see how for both men's successful attempts to manage their pain in the past via this method motivate them to continue practicing this method of dealing with the pain.

However, if the pain is too great and the measures to distract themselves or to sleep it off fail, they would turn to using treatment that is easily accessible to them. This includes the use of both modern medication and traditional medicines and practices.

*I usually do like those things you know like things you can do at home without using medicines. I search on Google. You know like breathing technique, calming my self down something like that. If that did not*

*work then I will take Panadol (Muiz, 19 years old).*

*That time the migraine was too much. I tried to take a nap and called my boss at work to tell him I will come a bit late to work but it didn't work so I took Panadol, I took two tablets and after few hours I take them again (Khalil, 37 years old).*

It was found age and knowledge influence men's preferences for modes of treatment. This will be further explained in the next section of the chapter.

Taking *Paracetamol*, which can readily be bought from a wide range of shops also appears to be the most common first-line treatment sought by these men. This is because the medication is easily available and it is perceived as having been effective in reducing or eliminating their symptoms in the past. Purchasing Paracetamol from the convenience store is also identified as being far more convenient than seeing the doctor. There is also evidence showing how men rely entirely on this over-the-counter analgesic.

*For me as usual Panadol<sup>8</sup>! It's easy, just go to the Indian shop<sup>9</sup>! It's very easy and quick. Take the Panadol then rest or take a nap, then when you wake up you will be OK (Isa, 30 years old).*

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<sup>8</sup> *Panadol is the trade name for paracetamol in Brunei.*

<sup>9</sup> *Indian shop refers to convenience store. As the name implies these shops are owned and operated by Indian.*

*For me..Panadol, always, all the time! Just buy. Easy everywhere can buy. I just Panadol all the time if 'I'm not well, Panadol is my best friend (Fahmi, 31 years old).*

Women confirmed these views noting that their husbands and sons would usually prefer to self medicate by buying medicines from the shop. For example, Sara and Rina said, speaking of their husbands, that:

*Um, he don't want to go clinic. He just all the time take Panadol, Panadol, Panadol [sigh]. He bought them from the Indian shop. (Sara, 59 years old).*

*He just take a rest, a nap and if he is still in pain he will take Panadol (Rina, 49 years old).*

This study also revealed that most male participants appear to be reliant on Paracetamol, as exemplified by the comment of Fahmi, a 31 year old bachelor:

*For me, Panadol, always Panadol. Panadol is my best friend.*

Fahmi had successful episodes of managing his symptoms just by taking Paracetamol, hence enhancing his confidence and trust in this medication.

Furthermore, it was found that men and their families retain medications and stockpile them. Men reported using these stockpiled medications, as Musa (49 years old) said:

*We have lots of medication at home; you know from last visits um either my visit or my wife or children. We keep and save them for future use too we don't throw them. If you need them its there, no need hospital or buy if you already have it!*

Notably, as can be seen from the above excerpt, the presence of medication at home from previous visits made it much easier for men to self-medicate and hence perhaps it supports and enables them to avoid engagement with formal health advice/services.

The findings of this study are also consistent in terms of the views that older men express about herbal and traditional treatments locally known as 'Ubat kampong'. Older men in this study prefer traditional medicine and/or traditional practices for various reasons. These includes firstly, they perceive this kind of treatment as safer. Secondly, they have been practicing it since they were younger and it has been effective and therefore they do not see any reason to change and try something else. Malay men in this study talked about how they used plants and roots not just for maintenance of health but also to treat ill symptoms.

*I have been practicing drinking and eating all these herbs its good for*



*health like you know prevents diabetes, high blood pressure. I also used them if I have pain or headache. Its safer too its from plants you know leaves, roots not those chemicals!* (Ramli, 66 years old).

*Better use it [traditional medicines] because you know you made it yourself. I sometimes made it myself; go to my backyard and collect certain herbs and make it. If you don't know how to make it you can go to Tamu Kianggeh<sup>10</sup> in the weekend. There you can see this man selling all these herbs! This is safer, its natural so no effects, no kidney problems! like my friend he has to go for dialysis now!* (Samsul, 60 years old).

The above accounts show how older men consider traditional medicines as safe because they are made from natural sources such as plants. They also claimed that they have no negative side effects, but still have pharmacological and curative effects. This is the opposite from how they perceived modern medicine, as being dangerous and with the potential to cause health complication(s) in the future. This perception of modern medicines is derived from what they see or hear happening in their social circles.

On the other hand, the older Iban men in this study shared how they used 'bertangas' when feeling unwell, particularly to relieve body ache and fatigue. According to Yi (2014) 'bertangas' is a procedure that uses steam to 'cure'.

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<sup>10</sup> Tamu Kianggeh: this is the weekend market located in Bandar Seri Begawan.

Many Iban elders would prepare 'bertangas' for a sick person in their longhouse. They believed this steam helps to alleviate the pain or illness.

An Iban man named Nazir shared with me how he and his father used plants for "Bertangas<sup>11</sup>" when they felt unwell. He said,

*Um usually we [referring to himself and his father] will collect plants like daun biabas [leaves from guava tree] lemon grass, lots more different types. I boiled it and use the steam form the boiling water to heat my body (Nazir, 59 years old).*

Meanwhile, a Chinese man called Lee talked about how some of his Chinese friends are still using Chinese traditional medicines and practices, not just for treatment of symptoms but also for health maintenance.

*Some Chinese families are still practicing that um like Chinese herbal medicines and treatment, now easy you can buy them from the shops you know like roots, bird's nest all that. The shop assistant can tell you what to take and how you can also get Chinese acupuncture. I have not tried them because I usually just buy medicine [referring to modern medicine] or supplements from the shop. My friends they know what to take, some even started using them when they were younger (Lee, 50 years old).*

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<sup>11</sup> Bertangas is a home based herbal spa. It is done in a traditional way and it uses different types of plants.

In the above excerpt, it can be noted that despite knowing that Chinese medicines and treatments are now easily available, Lee still continues with his normal practice, which is taking modern supplements and medicines, which have been working for him for some time and therefore did not see the need to change. Here, we can see age of the men is significant in influencing which measures they will take in the episodes of experiencing ill-health symptom and not their ethnicity.

Evidently, these men's preferences were shaped by their childhood experiences and the way they have been brought up. Older men recalled memories and experiences of being ill in the past, particularly before the development of hospital and health centres in Brunei, which largely took place from the 1950's onwards. These older men shared stories about how the journey to visit a clinic or hospital was difficult, and how it would take them one or two days to travel there and back. Finding alternative measures to manage their symptoms was therefore regarded as preferable to making these arduous trips. As previously mentioned, they described using traditional medicines and practices, mostly using natural plants as supplements and remedies to manage the symptoms, as these were readily available. They also added that, based on their experience, these treatments never fail and they rely and trust them even with the better availability of health care services and medications. This motivates them to keep continue using such practices.

However, despite evidence showing the need to get well and recover from ill-health symptom(s), it was also noted that asking for help and accessing health care appears to be the last resort for most men. The concept of self-reliance or what the participants called as *Ikhtiar* is critically important to men in this study and this has influenced their action in terms of what they do to manage their illness symptoms in this case delaying access to health care services. This is no doubt similar to those of hegemonic masculinity found in previous studies in the Global North such as Boman & Walker, 2010; Galdas et al., 2007; Johnson, Oliffe, Kelly, Galdas, & Ogradniczuk, 2012 )whereby, men expressed the need to adhere to hegemonic masculinity, in this case being self reliance as a way of conforming to the masculine identity and consequently, delay seeking health care.

We might also consider that self-reliance or *Ikhtiar* also fits rather well into the concept of 'care of the self'. Here a cultural and religious practice which is locally very significant and regarded by men as 'Bruneian' can be well understood as a form of discourse which men mobilise to 'do' their experiences of management of instances of ill-health. However, this does not include accessing healthcare services, at least not at the very first instance. This stems from a variety of factors, which I will discuss later in this chapter.

Interestingly, here it also has a unique context and meaning in Brunei as it has some very distinctive religious and cultural dimensions for Bruneian men. *Ikhtiar* is a term that these participants used and it is originated from

Arabic language used in the Quraan<sup>12</sup>. However, what interesting here are firstly, the meanings of *Ikhtiar*. *Ikhtiar* literally means 'to initiate', 'to attempt' or 'making an effort' and it is not exclusive to health seeking behaviour only. The term can be used in other context as well. Secondly, albeit it is an Arabic or Quraan word, the term was used not only by Muslim men but generally used across men of different religion. It could reasonably be assumed that the people have socially used this word and that it no longer necessarily has a religious connotation to it.

Interestingly, in this study, the importance of *Ikhtiar* can be seen as factor or set of beliefs and behaviours that militate against straightforward progression of Bruneian men through the being ill to accessing help and intervention. This does represent adherence to the literal definition of *Ikhtiar* in the Quraan, which emphasises the importance of making an effort. Men in this study define *Ikhtiar* by initiating care by themselves or being self-reliant. They do whatever they can for themselves and only to ask for assistance from healthcare professionals if these actions or practices are not successful.

Many participants spoke about *Ikhtiar* in the context of describing episodes of ill-health. For example, Noh told me about how he would just take a nap and some Paracetamol whenever he had a migraine or gastric pain, which has frequently been the case since his teenage years. He recalled this as follows:

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<sup>12</sup> Quraan is the holy book of the Muslim people.

*I always have this really strong headache um I think its migraine like really painful. I also have muscle cramps on my tummy and gastric pain. I have been having it since I'm like 16 years old. I just rest and take Panadol. It's always like that. I don't go clinic straight away, I only go if like really cannot do anything then I would go! (Noh, 22 years old).*

In the following section, I discuss how men use the concept of self-reliance or *Ikhtiar* as a way of understanding their responsibilities as a man experiencing ill-health and how *Ikhtiar* influences the action that they take when they experience ill-health. Self-reliance seems most importantly to provide a way of acknowledging ill-health and responding to it and negotiating the tensions between potential perceptions of weakness attached to help seeking and undermining of independence and social roles which are so important to Bruneian men. This study contains some evidence suggesting *Ikhtiar* is a way men can in fact negotiate ill-health use and show adherence and conformity to the demands of masculine identity. They equated being able to initiate self-care and not turning to others for help as a positive masculine attribute. They also saw it as evidence that they are 'tough' enough to face the real world and fulfil the demands they shoulder as men.

The interviews also demonstrated the usage of terms like "*manja*" [literally 'wimp'] to describe men who 'give up' by seeking help too soon, without trying to solve the problem themselves first. It should be noted that lacking

*Ikhtiar* and being *manja* is not ideal for these men and it is seen as weak. They justified this by arguing that men cannot be weak because they are [or will be] the leader of their family, which they considered a major defining responsibility of masculinity. Here we can see how these men identified being independent and strong as a character of a leader, who will be able to perform the masculine obligations expected from them. This includes working hard, earning money and looking after the family. Men both from the individual interview and in the focus group shared this, as shown below.

The following is from the individual interview:

*That's difficult! Imagine even with little things you need to go to the doctor, how on earth you will be able to live, you know as a man you need to look after your family, we have lots of responsibility (Mohd, 29 years old).*

Meanwhile, the following exchange between Najib (68 years old) and Samsul (60 years old) arose in the context of a focus group discussion with men:

Najib: *We as a man, you know, cannot be too manja, it will be difficult if you as a man are too manja, cannot!*

Samsul: *Yes..that is right! That will be difficult.*

Interviewer (Me): *Can you elaborate more on that point?*

Najib: *Yes I mean even with little things you just go straight to see doctor...not good*

Samsul: *Yes..that's not right! It would be hard if like that [giggle]. Not everything needs to be taken to the doctor.*

Najib: *Must try handle it yourself first.*

Samsul: *Whatever it is, as a man we must try first to deal it by our selves first!*

Najib: *Yes! Ikhtiar first.*

Samsul: *Yes! Ikhtiar! That's right! Men must Ikhtiar first!*

From the above excerpts, it can be noted how these men define their masculinity in part through the ability to be or appear to be strong, in this case, being self reliant and not asking for help from others and at the same time avoiding from being labelled as wimp. Being called or labelled as wimp would mark them as having a 'subordinated masculinity' (Connell, 1995:79), demonstrated by an inability to withstand or tolerate physical pain and discomfort. So, it is not surprising that these men identified that asking for help from others and going to see their doctor is the last resort. However, it is important to explore whether this is actually just the ideal expectation these men have of each other or whether this actually happens in their lives.



From the above discussion between Samsul and Najib, it can be seen how Najib strongly believed in the importance of men being self-reliant or practicing *Ikhtiar*. Najib's strong, extrovert personality meant that he dominated the discussion. Samsul appeared, in contrast, to be passive during the session. Despite taking various measures to ensure both had chances to talk, I did wonder whether Samsul's introvert and quiet personality may have made him feel that he had to agree with Najib's statements. In fact I noted this group dynamic in a field note made at the time. This was useful to refer to during the analysis. It is plausible that even if Samsul may have had a different view of *Ikhtiar*, and he could possibly have felt that he just needed to demonstrate his agreement with Najid.

This is likely to have been, firstly, to avoid a further and possibly heated discussion. Secondly, to avoid being perceived as not agreeing with the masculine norm around *Ikhtiar* and being 'unmanly' by Najib. Hence, he was behaving this way. Moreover, acknowledging the fact that the interviewer (researcher) is also a Bruneian man may affect the way men wish to present themselves. It is argued that when somebody is put in a social situation such as an interview and focus group discussion surrounded by other men and in this case also being interviewed by a man, they would tend not to disclose everything or give you answers that others would expect to hear. This is what the interview data showed.

In contrast to what was said by men, discussions with women revealed

something rather different about their experiences with their husband(s) and son(s). It must be brought to attention that all these women are married but only three out of ten involved in the focus group were actually wives of the participants. These three were from the Iban ethnic group. In contrast to the claims made by their husband in the interviews, Rina (49 years old) and Wina (43 years old) revealed that they were very needy in times of sickness. Far from displaying *Ikhtiar* they explained how their husbands and sons demanded extra attention from their wife and family.

*When he is sick he [giggle] demanded a lot um this and that. Not like usual (Wina).*

*Yes, mine demanded a lot from me too when he is unwell (Rina).*

Yana (45 years old) also explained that her husband becomes very needy and requires more attention from her when he is feeling unwell. She said:

*He [husband] asked for lot of things from me [sigh]. More than usual!  
He want me to cook him porridge, soup, to do massage for him so many things, he becomes manja.*

Women also added that men's behaviour could become difficult when they were experiencing ill-health and that they needed to be persuaded to seek health care. They believed that men use this to get the attention and care from their wife and children and once they receive it, it somehow reassures them they are still loved by their family.

During the focus group Mona (43 years old) said,

*I think he [her husband] just wants to manja with me. It's ok, we are husband and wife.*

Another women in the group, Farah added,

*Yes, they want to be manja to their wife.*

This was followed by a giggle in the room from the other women. Here, it can be seen how these women interpreted the extra attention demanded by their husbands when they were unwell as a way of enhancing the relationship between husband and wife - it made them closer. It was also a way of showing that they cared for their husband.

Men are also seen to acknowledge and regard their wife's willingness to look after them when they were ill as a way of knowing that their wives care about them. This was shared in an individual interview with Yusof (60 years old), whereby he said,

*It feels nice to see that you know when she massaged me and cook porridge for me when I was unwell, I know she cares about me.*

Women commented that it is difficult to ask their husbands and sons to go to seek health care. They said their husband or son would usually delay seeking health care. This was confirmed by the four Malay women who participated in the member-checking phase of this research. The following is

part of the conversation that took place during the member checking.

Interviewer (DRI): *From the interviews that I had conducted with women, it was shared with me that it was difficult to ask their husbands and sons to go to seek health care. Men often delay seeking health care. Does anyone want to say anything to that?*

Nisa (56 years old): *Yes! Like my husband, he is very stubborn [sigh] but if you keep persuading him to go he will go eventually!*

Farah (56 years old): *Yeah, they want to be persuaded [sigh but smile after that and laugh about it with the group].*

Wina (43 years old): *You know um my son is also like that! Remember I shared about him during our last meeting [referring to the focus group]? Yeah he was too stubborn until his appendix ruptured!*

Mona (43 years old): *I agree! That's how they are!*

What can also be gathered from this is how these women appeared unhappy about their husbands' and sons' reluctance to seek health care. However, they acknowledged the need for their husband to go so as to avoid further health complications and therefore, they do whatever they can to make sure their husbands and sons go to their doctor.

Women also shared that when men are ill, they want their wives to prompt, persuade and encourage them to go to clinic, suggesting that this is a way men get attention and care from their wife. All the four women in the focus groups agreed with this point, as shown below.

Nisa (56 years old): *That's correct! They [men] want the encouragement, they need to be persuaded*

Wina (43 years old): *Yes! That's true! I agree! Not just my ex-husband, but now my son is like that too!*

Farah (56 years old): *My husband is always like that!*

Mona (43 years old): *Um, yeah, we just need to keep trying, encourage, persuade, they will listen. It's our responsibility.*

These views were expressed across all three focus groups representing the Malay, Chinese and Iban ethnic groups. All the women claimed the need for them to be the person to prompt encourage and push their husbands and sons to seek health care. It was also noted that this was seen as physically and emotionally demanding. Indeed judging from when the issue was discussed with women the accompanying facial expressions and lots of sighing suggested exasperation. However, undeniably, it is evident that women have a critical role in positively influencing men's health seeking behaviour, by acting as a supporter, providing reminders and advising men.

This is congruent with the findings of a recent study conducted in Ireland (Hennessy & Mannix-Mc Namara, 2014) which found that the process of prompting men to seek help is not thought to be easy by women. They also believe that it has limited effectiveness but nonetheless through a continuous process of nagging, men would eventually be encouraged to go to the GP. Further, the Irish men in this study positively acknowledged the role of women in prompting them to seek help.

Up to this point, we can see mounting evidence suggesting that significant others such as parents, wives and children play an important role in influencing men's decision to engage with healthcare services when they are unwell. The opportunity to elaborate our understanding of the ways that familial and especially uxorial pressure and support functions to 'push' men into health service use was provided by the data emerging from the focus group discussions with women.

Women reported that their husbands and sons often require them to keep reminding, encouraging and even forcing them to go to see their doctor, otherwise they would not do so. They said that this approach does not work straight away but after few 'pushes', men will eventually go. These women appear to be frustrated and tired by their efforts but accepted that it is part of their responsibility as a wife and mother.

Men going to see their healthcare professional after being pushed and nudged by members of their family can also be located within the application

of the Foucault's concept of 'care of the self'. It is through its insertion into a discourse about gender relations, role and power and responsibility in and for the family that men can also mobilise a legitimate concern for their health.

From the above excerpts, some differences in the statements given by both men and women regarding men's behaviour in the episode of experiencing ill-health can be noted. This raises two critical questions that warrant further consideration. Firstly, why does the image of being strong and self-reliant appear to be significantly important for these men and how does this relate to their health seeking behaviour? Secondly, how is this idealised appearance of being strong and self-reliant experienced and enacted in practice? I address these questions, with reference to the concept of 'hegemonic masculinity' which I described earlier in this thesis. In summary, and with reference to these accounts of men's management of ill-health, Connell's working of hegemonic masculinities posits that this is the culturally shaped dominant or ideal form of masculinity (Connell, 2005). According to Donaldson (1993), these ideals include the stereotypical masculine identity and norms of being assertive, risk taking, aggressive, dominant, controlling, exerting physical strength, self reliance, resilience and emotional restraint. Empirical studies support this claim demonstrating that adherence to this idealised version of masculinity enables men to retain their strong image and appearance by withstanding pain, being independent and showing ability to recover quickly. Critically, adherence to ideals of hegemonic masculinity seem to inform the belief that seeking health care is a sign of weakness and, therefore, militates against or results in delay in seeking health care (White

and Johnson, 2000; Galdas, Cheater and Marshall, 2005; Evans *et al.*, 2011).

This is consistent with the findings of this study, whereby men idealised having a strong appearance and being independent. This is what they shared in the interviews and said that they portrayed in public, although evidence in this study also suggested that it is not always the case, in their private life, for example, in the context of the relationship with their wife. This is a clear example of the existence of the split between public and private accounts of the participants. According to Goffman (1959) the former is what people do or say in front of others. This is largely in alignment with social norms or expectations. Meanwhile, in private it is possible for men to shift away from the norm, just as we see the data is suggesting is happening with the men in this study.

It was found that men in this study tend to delay seeking health care but demanded care and attention from their wife/mother. It can be argued that this public projection of ideal masculinity was done to avoid being labelled as weak or in their words *manja*. Furthermore, being seen as *manja* would also have implications in terms of how others might judge or even doubt their ability to perform their masculine roles and obligations.

From the data shared previously, we can see how men see self-reliance as an indicator of strength. Being strong, based on judgements made on the basis of one's 'fit body', symbolises good health; similar findings found in an



Irish study, (Hennessy & Mannix-Mc Namara, 2014) . This in turn, enables them to carry out their role as leader of the family, which they regard as hard work and physically demanding. This again highlights how these men view and associate health with physical strength and how physical strength is needed in order to perform those culturally prescribed masculine roles. In addition, by publicly being self reliant and *Ikhtiar* in the episode of experiencing and managing ill health symptoms they continue to feel as belong and are just like other men. These men claimed to avoid or delay seeking health help from health services and blamed this on *Ikhtiar*, but the findings show that in private, men turned to their wife for attention and care during those illness episode(s). This altogether highlights the importance of portraying the image of ideal masculine men in public to these Bruneian men.

Notably, in contrast to majority of men in this study, some young ones, particularly students, appear to be contesting the labelling of men as *Manja*, because of their pattern of engagement with health care services. These young men are able to describe circumstances in which help seeking can be identified as acceptable and rather important. Taking advantage of early detection and treatment, wanting to live healthily for their own peace of mind and wanting to get well soon are the common sentiments shared by these young men in justifying their visit to their doctor.

*I know some people say that [referring to manja] for me it's not fair to be called as such. I mean what if it's serious but maybe to others it*

*doesn't look serious, but only you know. If it's serious at least you got treated early!* (Ahmad, 24 years old).

*At least the doctor has checked me. I feel relieved (...) if you well you can study, work, earn and that's important for you as a man, you know as a son, father, husband* (Ishak, 26 years old).

The above excerpts reflected another good example of how these young men are exercising 'care of the self'. It can be argued that these young men are mobilising discourses about gender and health in rather interesting ways that in at least the case of Ahmad, may show some resistance to an apparent dominant norm of disinterest in one's health. Ahmad sees himself not as wimpish (*manja*) through health help-seeking but appropriately taking responsibility for his well-being. In Ishak's account we see this same idea explicitly linked to the greater discourse about being healthy (and hence help-seeking) as legitimate in order to be able to meet expected demands of being a man. Here, Ishak is suggesting that he seeks health help not for his own sake but because of the more important demand in his life to earn and look after the family.

An important finding from the interviews with these students is how they appear to frame health help-seeking as an action of expression of rights as well as responsibilities; believing it is everybody's right to access healthcare services and get treated and therefore that one should not be judged for doing so. However men in other age groups did not share this view. It may

be that a combination of education and awareness of the developing human rights agenda as informing health is influencing the views of younger educated generations in Brunei. Unfortunately, there is no wider pool of evidence available to test or support this claim.

## **6.2 SUMMARY**

### ***Being ill, care of the self, Ikhtiar and preference in managing ill-health symptoms.***

Using Michal Foucault's concept of 'the care of the self' as a touch point, in this chapter I have explored how men account for and deal with episodes or experiences of ill health. Previously, I have shown that men in this study define health from what can be regarded as a functional point of view. The ability to perform masculine norms and expectations is of paramount importance to them. Thus, men do not ignore the onset of illness. These men are doing what they could to get better, as what is regarded as individual responsibility in order to be a good citizen in accordance to the concept of care of the self.

However in this case they do not necessarily engage straight away with the health services. Men in this study have different preferences in treating and managing their ill-health symptoms. Practices that they perceived as easy, convenient, effective and safe are often their preferred choices, and this

tends not to not include visiting formal health care services to get help or advice from health care professionals.

Treatment that is convenient such as taking over-the-counter medication and traditional medicines/practices are done but only if a non-pharmacological approach has not been successful in aiding recovery. Age, experiences with usage and knowledge or perception of the type of treatment are influential in their preferences.

Unlike younger men, who prefer over-the-counter modern drugs, the older generation in this study believe that consuming traditional medicines is safer than seeing the doctor. This is because they believe that if they see a doctor, they will be prescribed modern medicines, which are made from chemicals, which they believe to have side effects for their health. This is consistent with the findings of a local study in Brunei, which aimed to assess the prevalence of traditional medicines (TM) (Nurulaini et al., 2014). This study found that out of the 2,400 respondents in this quantitative study, 91% of the traditional medicines users used local herbs and 94% claimed that there were no adverse effects. Additionally, 62% of these participants perceived TM as safe because it is from natural sources. Similar findings were reported in the local newspaper 'Brunei Times' dated 6<sup>th</sup> June 2015, whereby an interview with a traditional medicines practitioner claimed that his medicines are in great demand as they do not just help to cure the patients but it do not do any harm to the body, unlike modern medicines (Nambiar, 2015).

Here, we can see the connection between *Ikhtiar* or 'the doing masculinity' and not wanting to go to see the doctor due to worry about being prescribed 'chemical' medicines, which they perceived as dangerous.

It can be argued that modern medicine might be perceived as disabling in terms of *Ikhtiar* because the power of diagnosis and decision-making passes very much to the physician and that could be understood as undermining self-reliance. Further, as aforementioned, men are worried about being hospitalised. In the previous chapter, we saw that being hospitalised was men's biggest concern as it would upset and disrupt their daily routine, and here we can now argue that being hospitalised could also mean loss of independence, as they will be taken care of by the health care professionals. This could also be seen as undermining self-reliance.

These considerations, supplemented by data extracted from the interviews, require us to think hard about how they might be accommodated in an approach inflected by the concept of 'care of the self'. This concept emphasises the responsibility of sick people to self-manage and to seek medical care and professional advice and to follow this advice. However, it is not as straightforward as men being situated in and mobilising a discourse of 'care of self' in terms of health-help seeking. There is at least the potential for tension to arise between men's interest and desire to be self-reliant and the need to take care of their health. In some ways this is surmounted by referencing health help-seeking not to the self but to a responsibility externalised and manifest in cultural demands and responsibilities put on

them as men. The introduction of legislation in Brunei made it even more important for men to be looking after themselves in order to perform their responsibilities to their family.

Furthermore, these Bruneian men have their own acquired practices and beliefs about treatment and medicines, which warrant acknowledgement and to be discussed properly in the interaction between the health care providers and the patient. Patients should be part of their care planning and not merely at the receiving end of the care. Otherwise, they could be seen as an attempt to take away their sense of independence and self-reliance.

Secondary to how men's self reliance can be undermined by being sick and by engaging with formal health care services, this also creates a tension between wanting to get well and not wanting their independence and self-reliance to be taken away and undermined. Consequently, men tend to fall back on self-treatment at home and often turn to their wives for extra attention. There is no threat to masculinity in doing this since this a private space. The doing of this 'not so masculine behaviour' was only disclosed in individual interviews and in most cases disclosed by their wives, indicating how men are consciously choosing what to disclose in the interview, bearing in mind that they are still portraying that they are 'doing their masculine norms'. Significant others, in this case mothers and wives, play an important role in prompting, persuading and encouraging men to access health care services.

### **6.3 CONCLUSION**

In this chapter, I have described how illness causes difficulties and disruption in men's life, particularly in the discharge of their daily routine as a man. This disruption impacts on them and also their partners, parents and family. As performing culturally expected masculine norms are crucial for men, the existence of ill-health symptoms, which may threaten this capacity, cannot be ignored.

*Ikhtiar* is used by men to show adherence and conformity to the demands of masculine identity. They equated being able to initiate self-care and not turning to others for help as a positive masculine attribute. Subsequently, this influences action taken by men in the context of episodes of ill-health. Using methods to distract themselves when in pain, and the use of easily accessible treatment over the counter or at home is favoured most by men as a way of managing any symptoms of ill-health. In sum, it can be learnt that what men do in the event of ill-health or onset of symptoms is mostly shaped by prior experience, knowledge, existing practices and beliefs. This can be developed at home particularly from observing their parents and grandparents. It is also influenced by the working environment, past experiences and also other people's testimony.

Accessing the formal health services is the least favoured option for these men. However, it was also found that significant others, especially wives and family members play a crucial role in influencing men to engage with the

formal health services so as to get proper treatment. Being looked after in a men's 'private space' and getting continuous prompted and support from their wives was seen as way of expressing care and love for the husband.



## **CHAPTER 7:**

### **7.1 THIRD CATEGORY: BRUNEIAN MASCULINITIES AND THE LEGITIMATION OF HEALTH HELP SEEKING**

In chapter six, I demonstrated the importance of endorsement and encouragement, whether from family or friends, in enabling and promoting Bruneian men's engagement with formal health care services. In this chapter, I develop and add to this analysis by providing a deeper account of the specific factors that men cite as militating against their engagement with formal healthcare services. In summary, these include fear of hospitalisation and the possible side effects of modern drugs, practical barriers such as concerns about long waiting times and limited clinic opening hours and provision of treatment perceived as repetitive and ineffective. There was also evidence of men believing that the medicines commonly prescribed by GPs can more easily be obtained simply by purchasing them over the counter.

I then examine the factors that positively influence men's use of formal health services. These include experience of chronic health problems, perceptions that a physical injury is a sufficiently serious reason to seek health-help, the requirements of the workplace and contracts of employment, the expense of over the counter medications, experience of severe pain and ways of avoiding arguments and upsetting circumstances in relationships with significant others in the family, especially wives and mothers. I consider how

these Bruneian men's attitudes and behaviour can be understood in the context of the concept of hegemonic masculinities demonstrating some of the similarities of findings from this study to those emerging from research with men the global north. I also point to some of the important ways that Bruneian men's behaviour possess very clear local, culturally specific dimensions that need also to be considered.

By way of background and context, I first briefly recap the structure of healthcare services in Brunei and their operation.

### ***The organisation and structure of the formal healthcare system in Brunei Darussalam***

As described in Chapter 1, the management and operation of Brunei Darussalam's healthcare system is the responsibility of the Ministry of Health (*MoH*). The broad aim of health policy is to improve the health and well-being of the people through provision of a high quality and comprehensive health care system that is effective, efficient, responsive, affordable, equitable and accessible to all (Ministry of Health Brunei Darussalam, 2012).

With regards to distribution of health care centres, the majority is located where the population density is highest. This was clearly described in Chapter 1 of this thesis. In an attempt to improve service delivery and patients' experience of accessing and using health services various measures have been implemented by MoH. These include opening more health centres to cater for the growing population, extending and making

opening hours more flexible, implementing a fast registration system, introducing self-certification for sick leave and a queue-cutting system for older patients. However, the development of such services within the formal health service is relatively recent and many participants in this study were unaware of them. The experiences they shared here in interviews largely related to prior experience, which for some had been one to two years prior to participation in this study. This will be discussed in detail in this section of the thesis.

Next, factors that militate against men's engagement with health care services are discussed below.

**i. Potential negative psychosocial impact resulting from engaging with formal health care services**

Men in this study regarded being hospitalised as problematic because they perceived that it causes disruption to their everyday routine. Men commonly associate hospitalisation with worrying about their work and family and have a fear of being medicalised. These were common and recurrent themes in the interviews and some of the reasons that men identified for avoiding engagement with formal health care services.

For example, Khairul, a 31 years old bachelor, explained to me how his father refused to go to hospital because he was worried that he would be admitted. His father often expressed concerns about picking up his daughter

from work and helping his wife to look after their grandchildren. Khairul reported that his father was worried that he would not be able to help at home and support his daughter if he was hospitalised.

*Khairul: My dad always like you know worried if he sees the doctor and they will admit him.*

Interviewer (DRI): *Why do you think that is?*

*Khairul: He always said you know things like who will help at home, who will be at home with my mum during the day time you know because we all are working so in the morning its only mum and dad at home. Not just that he is also often worried about who will send and pick up my sister from work and my nephews and nieces to and from school.*

The belief that it is likely one will be hospitalised was common amongst older men, particularly those over 40 years old. They also described how they believed that once they had seen a doctor, they would be diagnosed with all sorts of medical problems, of which they were neither aware nor, in some cases, even knew existed. In turn, this would make them worried and affected their mood and everyday life. To avoid being hospitalised and or being diagnosed with medical problem(s), many men said that they avoid the doctor.

This is illustrated in the following excerpt from my interview with Ramli (66 years old):

*If you see the doctor, they will likely admit you!*

The following is an extract from the conversation between Samsul (60 years old) and Najib (68 years old) showing how they believed that medicalisation was a modern phenomenon.

*Samsul: Once you see the doctor, the doctor will start telling you that you have this and that. You know high blood pressure, diabetes all that. Sometimes it's just surprising really you don't even know that you have this problem and you don't feel like you actually have that problem. When you go, they tell you then it make you worried! That's what the doctor does; tell you that you have this and that! [Sigh].*

*Najib: Yes, true! That's common, high blood pressure and diabetes, heart problems, these three are always together, and they are best friends! There are a lot these days!*

*Samsul: We don't have that in the old days, right?*

*Najib: Yes! That's what the doctor does, tell you this and that, um, you have this, you have that!*

Here, we can see how hospitalisation is a major concern for men and how concern about medical diagnosis creates anxiety amongst them, which consequently affects their daily life. Hence, men would try to avoid engaging with health care services. Coupled to men's concerns about over-diagnosis and hospitalisation, the interviews also uncovered evidence that men face considerable practical problems that discourage them from accessing formal health care services. These are seen by many of them as off-putting and therefore they avoid the services.

## **ii. Structural barriers to men's access to public health centres**

Past experience of engaging with public health services, particularly primary healthcare services, was highly influential on and seemed to predict men's intentions to use them in the future. Despite various measures taken by the MoH to improve service delivery, as listed above, men in this study were either unaware or did not believe that services would have altered and that therefore any future use would follow the pattern established when they last used them. Prior experiences were perceived largely to be negative. Some of the issues highlighted by participants as deterrents to service use were the opening hours of the government clinics – regarded as inconvenient, long waiting times coupled to short consultations, and provision of treatments regarded as ineffective.

**(A) Long waits and short consultations**

All government health centres in Brunei operate a numbering system that means that patients are seen on a first-come, first-served basis. Each patient is required to take a number from a machine and wait for the nurse to call them for baseline measurement of their vital signs (blood pressure, temperature, Body Mass Index). This information is recorded in the newly introduced computerised patient record system “Bru-HIMS”, which aims not only to quicken the speed of patient registration but also to integrate the management of patient information (“Bru-HIMS,” 2016). Patient details including personal information and medical history and treatment can be found in this computerised database, which can be accessed across all in country medical and health services.

After all this information is uploaded into Bru-Hims, the patient will then wait for the physician to call them in to a consultation. This numbering and triage system was implemented with the intention of speeding up the process of access to the physician and making patient management more systematic and efficient. However, men in this study expressed frustration about being made to wait for a long time at public health centres. Participants also stressed that the waiting rooms were unwelcoming and cold places, amplifying the poor quality of the experience. Adi, a 76 year old man from Bangar, Temburong recalled his most recent experience at the health centre:

*I go to our hospital here in Bangar out-patient department um sometimes I come early in the morning you know, you would think in the morning there will be less people, um, but still, I waited too long! Then after all that you then still need to wait for your medicine.*

In another interview, Ramli (66 years old) confirmed that his experience had been the same:

*That's true! Waiting, it's too long! Wait to see the doctor then wait to pick up your medicines. Not just that it's also too cold in there [waiting room] it makes you feel worse!*

Accounts of this kind were not only heard during the initial phase of data collection but reiterated during the process of member checking. Five men who attended the member checking session shared the same sentiments, implying that the waiting time at the health centre was a serious deterrent to service use and cause of dissatisfaction.

Syawal (43 years old): *For me that's the issue really, we have to wait for a long time and its very cold.*

Khalil (37 years old): *Yeah very uncomfortable.*

Daud (32 years old): *True!*

Interviewer (DRI): *What about the rest, anything you want to say to that?*

Taufiq (25 years old): *I agreed and that's exactly what I said last time in the interview.*



Ishak (26 years old): *Yes! That's the one. The waiting room is too cold and the waiting is too long, its off putting.*

Interestingly, none of the six older men in this study (aged 60 years old and above) and who come from all of the four districts in Brunei, seem to have benefited from the recent introduction of a *Fast track/ cut queue service* focusing on enabling people over 60 to get quicker services for blood tests and the collection of medication. This may be accounted for by lack of awareness of the service, its lack of availability at the time when they used the service and information that suggests that service provider engagement with the initiative is patchy and implemented at the local level.

The significance for men's engagement with and attitudes toward health services in terms of convenience, accessibility and opening hours combined with the frustrations produced by queuing and waiting times resonate with findings reported elsewhere. For example, a study conducted in Australia that set out explore the pattern of men's engagement with healthcare services revealed that waiting time is one of chief factors that puts men off visiting their GP (Malcher, 2009). Additionally, and especially having waited a long time to see a physician/GP the brevity of the consultation with the doctor was also seen as unsatisfactory by these men.

*You know you waited very long, then you see the doctor very short maybe 10 minutes or less, maybe? Basically, its short... [sigh]*  
(Khairul, 31 years old).

*The doctors nowadays, you come in, they asked you what's wrong with you, then they quickly check you...very quick then prescribed you your medicine (Ramli, 66 years old).*

The sentiments, shared by Khairul and Ramli, clearly indicate that they wanted to have a bit more time with their GP. The comments of Ramli in particular may also suggest dissatisfaction with the level of the doctor's attention leading to a perception that it is perfunctory. Of course, such a short consultation may militate against men telling their GP about their health issues or concerns because they are not provided with the time to do so. Indeed, men emphasised that the short consultation time could potentially lead them to think that they do not have time to tell the doctor about their concerns. They also interpreted this as an indication that the doctor may not be interested in hearing about these concerns.

Of course, GPs may think they have spent adequate and sufficient time with patients in their clinic. The reluctance of men to express their concerns and needs may lead GPs to have low awareness that they may be required to invest time and attention to draw or ease men's concerns out of them. GPs are also bound by the pressures of patient management to time-limit consultations. They are constrained between this and an understanding that effective consultation is achieved by good relationship building between patient and doctor (Singh, 2015). This is because a good patient relationship enables the GP to gain cooperation from the patient and in turn maximise

information flow to achieve better treatment and care decisions and outcomes.

It is not yet the case that in Brunei there is centralised guidance on the length of consultations, but recent changes developed by the British Medical Association (BMA) in the UK suggest that consultations should last 15 minutes (Blackburn, 2016). It was also noted how important it is to inform patients about consultation times because greater understanding of the system and rationale for consultation duration can produce greater patient understanding, acceptance, cooperation and reduce complaints.

**(B) Limited opening hours for public health care centres:**

Most government health centres in Brunei operate only during office hours (between 7.45 am and 4.30 pm with a lunch break from 12.15 pm to 1.30 pm). Like other government offices, most are closed on Friday, Sunday and on public holidays. People who need urgent medical attention outside these hours are advised to go to the Accident and Emergency department at the nearest main hospital. This was seen as problematic, especially in areas where clinics are difficult to reach and for those men who are employed in jobs where they work during office hours. They described this organisation of provision as inconvenient and frustrating, as shown below.

*Ours [referring to his local health centre] is only open office hours!  
Some major clinics are open at night too. Ours not. Um maybe they  
think we don't get sick after office hours? [in a sarcastic tone] (Najib,  
68 years old)*

*Its difficult, we are always busy at work and if you want to go after work, they are already closed!* (Rezal), 50 years old.

This point was also made by all five men who participated in the member-checking exercise. They confirmed the observation made by men in the initial data collection period. For example, Taufiq (25 years old) and Ishak (26 years old) reported the following:

Interviewer (DRI): *Another thing that the study found is the limited opening hours of the public health centres which is regarded as inconvenient and as a result harder to access. What would you say to that?*

Taufiq: *That's true, it's hard! The opening hours are limited and make it harder for those working people to go.*

Ishak: *That's true, it's hard!*

Similar challenges, and associated dissatisfaction and demotivation amongst men to use formal health services have also been noted in other research. Notably, Malcher (2009) in a report published in the Australian Family Physician Journal, reported that difficulties in accessing services in normal business hours is one of the barriers to engagement with health care facilities. Furthermore, several studies (Dalziel & Leishman, 2003; Malcher, 2009; Monaem, 2007) have similar findings stating that there the lack of

extended hours of operation in evenings and on weekends, decreased accessibility.

### **(C) Overly prescribed treatment**

There was general agreement amongst study participants that paracetamol were prescribed on each and every one of their visits to health centres regardless of the symptoms with which they presented:

*Even if you go to see a doctor, Panadol still I'm sure...always Panadol*  
(Syafie, 65 years old).

*Panadol, Panadol, Panadol. Do we not have any other medications?*  
(Musa, 49 years old).

*No use to go, he will still give you Panadol, it does not work* (Khalil, 37 years old).

Evidently, this frustrated these respondents for two main reasons. Firstly, because Paracetamol may be easily and cheaply obtained from convenience stores; and secondly, it is not perceived to be either an effective or rapid treatment for their symptoms. As it is easier and more convenient to buy their own Paracetamol, most men said they would simply avoid visiting their doctor. They also noted that this avoided the need for them to queue at the health centre. This behaviour was particularly commonly practiced by younger men.

*Just buy...can buy it [Panadol] anywhere..no need to waste time. The shop is near, parking easy, no need to wait (Mohd, 29 years old).*

*Sometimes I have this bad headache so what I usually do is just buy Panadol and take it..then just rest for a while in the office then back to do my work. You don't need to be out of the office (Musa, 49 years old).*

As these young, working men's comments illustrate, work was sufficiently important and service access regarded as so inconvenient that they were reluctant to take time away from work to drive to the clinic and go to the trouble to find a parking space, only to get Paracetamol from the GP. It was seen as rather unnecessary and a waste of time. Furthermore, not only did they observe that taking time off was inconvenient due to their commitments at work but it might also result in a loss of income. As I demonstrated earlier, income loss has special importance given its significance as a maker of men's capacity to meet responsibilities to provide support for their family. It is in this context that men prefer buying their medicine from shops and avoid visiting health centres.

All the aforementioned issues are mostly related to structural issues of accessing health care services. It must be noted that in Brunei men can have access to both private and public care. The former requires one to pay for the consultation and treatment. Meanwhile, the latter are provided for free by MoH. The issues discussed above refer to care in the public health sector.

As an alternative, and in an attempt to have better experiences, some men turn to private healthcare. Men claimed that private clinics have longer opening hours, shorter waiting times, and provide better treatment. However, this comes at a high cost, unlike the care from public services, which are provided for free by MoH. Hence, only men with the financial means would turn to the private healthcare sector as an alternative.

One striking finding in this study is the role that men play as a father in pursuit of the best care for their children. It was evident in this research that men would prioritise their children over themselves in getting the best treatment for an experience of ill-health.

*If my children are not well, I take them to the private clinic right away. If me if I need to go I can just go to government [paused few seconds] well, you know I don't want my children to go there and wait long! They are kids. I don't feel good doing that to them so let them go to private. It's faster and better (Idrus).*

The above excerpt shows how Idrus (43 years old) prioritised the needs of his children whilst he continued to use the public health care. It could be argued that by doing this, he was not only discharging his paternal responsibility but also 'doing his masculinity', whereby he was able to demonstrate that he could cope with his own ill-health symptoms and need not rush to get the prompt treatment to be found from private health care. In terms of adopting an approach informed by the concept of hegemonic

masculinities we might also consider that it is also a rational way of conforming to normative expectations meaning men somewhat disregard their own health needs by explaining that as a consequence of trading off putting their responsibilities as a good father first.

Some men turned to private clinics to obtain medication, which they perceived as more effective than those prescribed from public health care settings. However, despite this, other men that I spoke to were sceptical about whether they really did get different or better medication from private providers. This can be seen in the excerpt below from an interview with a graduate teacher, Khairul, 31 years old. Here, Khairul also added that he recognised that the perception of the service might matter. Khairul commented:

*I think it's the same medication either government clinic or private. I think the medication would work if you believe it! It's psychological! What do you call it, um, is it placebo effect or something you call it? Um, I think it's all down to that.*



## **7.2 FACTORS WHICH LEGITIMATE MEN'S ENGAGEMENT WITH PUBLIC HEALTH SERVICES**

Having identified some of the structural and also perceived impediments to men's health service use, I want now to explore what factors men describe as legitimising and/or prompting their engagement with services. These factors include: experience of chronic health problems; problems with disruption of men's capacity to perform their daily male-role associated responsibilities; experiencing severe pain; the perceived level of seriousness of symptoms; ability to work; and, occupational requirements and financial considerations.

### **i. Existing (Chronic) Health Problems**

Unlike those men who declared themselves healthy, who tended not to hold positive views about health services, service providers or to regard health as a major concern, interviews with two men suffering from long-term chronic illnesses revealed a different set of attitudes towards healthcare. These were dependent on and requiring a different understanding and mobilisation of *Ikhtiar*.

These men stated that they were particularly concerned if they experienced signs and symptoms that they believed related to their existing identified health problems. This represented sufficient motivation to engage with a health service. In addition, they noted that they could ill-afford any

deterioration in their health because it posed a threat to their capacity and ability to discharge their roles and responsibilities in relation to their family. It was the recognition that ill-health might have these consequences that led them to re-evaluate their attitudes and beliefs and find new ways of accounting for their use of health services in ways that they still allowed them to subscribe to the ideal Bruneian masculinity. This was important given that in any given society, the idealised version of masculinity is dominant or hegemonic (Connell, 2005). Thus, those who do not live up to these ideal forms are liable to experience subordination or marginalisation as a consequence. By renegotiating the reasons for their attention and concern about their health they could create accounts of the behaviour that they did not perceive as rendering them subordinate.

This triggers a further analysis in exploring this issue from the point of the view of men who did meet these ideal traits, for example those with a physical disability or living with a chronic health problem.

A closer analysis of the interviews undertaken with men who had ill-health conditions such as asthma, arthritis and diabetes found that similar to those men who identified as healthy these men did not believe that their physical restrictions exempted them from performing the obligations and roles associated with Bruneian masculinity. Abdullah, a thirty eight year old single male, who suffered from *Hypertension*<sup>13</sup> and *Ankylosing spondylitis*<sup>14</sup>, explained how he worked hard so that he could be a good son, bring pride to

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<sup>13</sup> *Hypertension is the term for high blood pressure.*

<sup>14</sup> *Ankylosing spondylitis is a chronic condition in which the spine and other areas of the body become inflamed.*

the family, help his parents and be a good husband in the future. As he put it:

*For me even though I have difficulty in my movement and to stand up straight, I still help my mother to do her groceries shopping and I carry her shopping. At work, you know in the office, I work as hard as others and want people to see and treat me like the others and evaluate and see me fairly based on my capabilities and potential. I work hard, I want to get promoted, earn good money, help my mom and save for my future, you know maybe get married one day or something like that.*

We can see here Abdullah is reworking the central elements of an idealised, physically healthy masculinity into his personal health context. Although he is potentially cut off from an idealised masculinity due to his disability he still subscribes to its norms including having physical strength. We can see how he seeks to compare himself to other 'healthy' men by working 'as hard as others' and being 'seen as others'. Being responsible and able to support his mother is important for him. He does not allow his illness to stop him from performing his role as a son. This is the way that these men used to maintain and re-negotiate aspects of their male identities in light of illness. Perhaps we can also assume that he did not want to be 'dysfunctional' and still wanted to be functioning efficiently with regard to societal expectations of sons in Brunei.

## ii. Acute Health Problems/Needs

Whilst experiences of chronic conditions were rare amongst the participants and hence not frequently commented on, acute conditions were perceived quite differently.

Acute conditions that manifest in observable signs and symptoms and which men perceive to be dangerous were regarded as sufficient and legitimate reason to access health care services. This was particularly the case with physical injuries that involved blood loss. This was illustrated in the accounts of two participants, both of whom had experienced injury in the past. In the first case, an eighteen year old man, Khalid, a team captain for his football team, said that when his ankle had swollen and he injured his knee ligament after one football match, he immediately went to the hospital and did not attempt to manage it by himself or to 'tough it out' as might be predicted by adherence to an idealised hegemonic masculinity. He explained his actions by pointing out that he could see the major swelling on his ankle and that it was very painful. He also believed first aid treatment given to him on that day would not be of much help. Similarly, Najib, a sixty-eight year old retired man, in the interview in which he participated with Samsul, told a story about when he accidentally cut his right hand with a machete while he was gardening, resulting in profuse bleeding. Despite his firm belief that men should be independent and *Ikhtiar*, in this circumstance, he said that without exception this kind of injury should be taken straight to the doctor, as there are no effective measures that can be taken at home. He further noted that this was an exceptional case and stressed that failure to do so will likely be

harmful. He commented:

*That was big injury you know lots of blood non-stop and you can see the inside of my hand! The cut was big...so must go, it stupid if you don't that is looking for trouble! Maybe I can try to cure it using traditional medicines but it won't recover fast enough and wont stop the bleeding straightaway (Najib).*

Samsul agreed with this point of view and he added:

*Yeah! That's a must to go! If you see like that case blood! a lot of blood and it doesn't stop, that's a must to go!*

It was also noted that when something is not perceived as a problem due to the absence of obvious physical signs or symptoms, it is often not recognised by men nor understood as an injury. Hence, in these cases and situations, they do not think it requires prompt professional help.

For example, Samsul, a 60 year old man recently diagnosed with hypertension shared with me how he found it difficult to comprehend his diagnosis. He reported having his usual attack of headaches and feeling unwell, but only decided to go to see to see his doctor a few months ago when his headaches were coming frequently and becoming too much for him to handle. Upon referral to the doctor, who undertook an assessment, he was diagnosed with hypertension. He said he did not go earlier because he

did not think it needed to be taken to the doctor. He assumed that it was just a normal problem and not serious enough to warrant medical attention. It could be argued that because his hypertension did not manifest itself in physical signs, like the spectacular injuries described by other men, he did not perceive it as necessary to rush to the hospital. It is striking that Samsul regarded his symptoms as insufficiently serious to be brought to the attention of the doctor. This is rather similar to findings from a study undertaken in 2008, which found that unless symptoms are perceived as serious by men, they will not go to see their doctor (Noone & Stephens, 2008).

These apparent distinctions between types of condition or injury, especially the bracketing of headaches as minor raises interesting questions about other experiences where the link between the psychic and somatic dimensions may be understood in particular ways by men.

What, for example, would Bruneian men do if they experienced an occurrence of sexual dysfunction? Presumably, sexual dysfunction would not be considered as an injury by men and therefore could be ignored. However, as previously reported in chapter five, men regarded being able to perform sexually and meet the sexual needs of their wife, what they termed as '*nafkah batin*' as part of their masculine role and a responsibility as a husband. How this would impact Bruneian men's health help seeking behaviour, in the case of erectile dysfunction, warrants further investigation. Unfortunately this was not the main focus of this study, and there were good cultural reasons for not actively asking men about sexual health and

sexuality, so it is difficult to arrive at any conclusions on this issue. However there is literature that shows that Chinese men do not consider erectile dysfunction as a serious problem and therefore do not regard it as warranting intervention from health care services (Zhang et al., 2014).

What is clear throughout the data, and in relation to men across different age groups, is that they are aware of healthcare services but *Ikhtiar* regulates their engagement. With *Ikhtiar*, men tend towards managing their symptoms or effects or ill-health/injury via self-care. However, at the point where illness/injury impinges on their functioning, *Ikhtiar* also comes into play not as an impediment to health help seeking but as a motive for taking responsibility to seek help in order to be able to discharge roles and responsibilities associated with masculinity. Furthermore, it is important to note that although *Ikhtiar* may create conditions or circumstances that pose risks to men's health, it is as a result of self-reliance rather than conscious risk-taking.

### **iii. Health help seeking behaviour and occupational/institutional policy**

It was found that if visiting the doctor was a routine requirement imposed by a man's employer or occupation, for example if they were required to submit to an annual medical check-up, this was regarded as acceptable. It may be that a combination of the fact that this is a stipulation of employment and the fact that men see this as enabling them to work and thus fulfil the 'bread-winning' role accounts for this view. Indeed, a number of studies suggest this may be the case (Jeffries, 2012; O'Brien, Hunt, & Hart, 2007). For example,

in O'Brien et al's (2005) study involving Scottish men, the participants regarded health seeking as a means by which to preserve or restore an important aspect of a man's life - the need to be fit and physically healthy for work is acceptable and rather essential. Bruneian men in this study shared a similar view.

*If work demands it, I guess its OK! Like us you know we have to be fit and healthy because we have this yearly fitness test and we must pass that. So seeing the doctor for a medical check up is normal for us (Isa, 30 years old).*

Men serving in the army also reported that the annualised requirement for a medical check up normalised medical fitness testing. For this reason, they would usually work hard to improve their fitness level, particularly before the test so as to ensure that they passed the examination. Failure to pass this annual fitness test would affect their job performance appraisal.

*For us, you know, a few months before the medical check up, we will monitor what we eat, we exercise you know jogging, hiking, running all that (Isa, 30 years old).*

*That is normal for us before the fitness test, we go exercise so we will be fit for the test. We go jogging and hiking (Khalil, 37 years old).*



Interestingly, other participants who were not required to demonstrate their medical fitness to their employer said that they would welcome such an examination. It is plausible that establishment of a universal requirement of this kind was understood as discharging men from assuming the responsibility and active personal agency in making a decision to engage with health services.

Furthermore, a requirement to undertake a medical or check up would force their employer to accommodate time off from work in order for an employee to go to the hospital for this procedure. This was seen as an important measure because time to make visits was not available to these men, particularly those working within the government or the private sector. A few participants also suggested that the employer should invite the healthcare professionals to come to their work place and to provide a health programme and medical check-up. This would help to save the employee from leaving their workplace to go to the hospital and ensure everyone had their health check.

*I like to suggest if the nurses and doctor you know can come to our departments, office it will be easier, because it's difficult for us to leave work. I've seen this done in other countries. You know like myself I'm always busy but if they come to us and we make it compulsory to be checked surely everybody will do it and maybe start looking after their health (Lee, 50 years old).*

In the event of being unwell and not fit to go to work, men reported that they have no choice but to go to see a doctor in order to obtain a medical certificate (MC). The MC enables them to take time off work in order to rest and recuperate at home. In Brunei, any government servants<sup>15</sup> who are unwell and unable to come to work are required to present their medical certificate (MC) to their line manager or Head of Department (HoD). This MC can only be obtained from a doctor working in a government health centre, hospitals, out-patient department or from a certified private clinic. With the MC they are excused from going to work.

While the position and process is relatively clear for men working in the public sector the procedure appears to vary from one company to another in the private sector. In the case of Brunei Shell Petroleum (BSP) (*the largest private company in the country*) employees are given six days of paid self-certified sick leave annually. This means that BSP employees are not obliged to go to a clinic to get their MC for short periods of sick leave. This saves them from spending a long time in the clinic to get an MC. The option to take self-certified sick leave was not available for any government servant at the time this study was conducted.

The majority of the male participants in this study (n=14) were government servants; therefore it is not surprising that their concern and experiences of

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<sup>15</sup> *Government servant refers to any employers employed by the government, despite their positions in the department. This is common term used in Brunei.*

the MC were particularly evident in the interviews as reflected in the following excerpts.

*That time I had a bad fever and migraine maybe...you know like a headache but it was so strong. I could not work, I need to rest so I go to doctor and ask for MC (Syawal, 43 years old).*

*For me you know I'm working. If I'm too unwell to go to work and need rest at home, I must to go to clinic to see doctor so he can give me MC (Daud, 32 years old).*

Students, another large constituency in the study sample (n=13) also expressed similar sentiments. Due to the strict policy at their university and college, they are not allowed to miss any university day without presenting an MC as this will affect their overall attendance and consequently, may make them ineligible to undertake examinations. Similarly, in the event of feeling unwell, they have to go to a clinic to see the doctor and get their MC which must then be presented to their college and university.

*I was too sick to go to class, so I went to clinic just to get MC so I can give it to my college. You know, they check our attendance (Ahmad, 24 years old).*

Whilst acknowledging the power that a medical certificate from the GP holds in giving a protected right to sick leave for both to employees and students alike, it was not however, without problems. Men's concerns clustered

around issues of misuse of the MC. Participants talked about how their friends and in some cases they themselves had misused the MC to get a day off work or away from their studies.

*I've done that before! I mean we all must have done it surely. I remember when I was still working. You know like after long weekend, you feel tired and don't want to work on Monday so I went to clinic to get MC just tell doctor I'm not well [giggle] (Najib, 68 years old).*

*I know people who do that [giggle]. One time I saw my friend he just keeps being absent from class and keep obtaining MC but even if he was on mc there were times, I saw him playing football and another time out shopping! I mean if he was not well, he was supposed to rest. (Bakar).*

However, those who already had a medical problem and have had experiences of being ill in the past were not concerned about perceptions of the legitimacy of their MC. They argued that if others knew about their medical problem, they would likely understand and not question them. They also regarded their MC as justified due to their existing chronic medical problem. The following excerpt below shared by Abdullah, who was aged 35 years old and suffering from Ankylosing spondylitis, illustrates this.

*Others who do not know me, my condition um maybe they will think so many things about me, maybe not so nice things but I think if they*

*know that I am not well like them, I think they will understand. I'm lucky my colleagues at work understand my situation...I mean when I'm unwell, I am really unwell (Abdullah, 38 years old).*

Here we can see how Abdullah, a man with physical disability regards his physical illness as a legitimate reason for visiting the doctor, and having an MC. In addition, we can see how despite potentially departing from ideal masculinity by virtue of his disability, he negotiated and rationalised his experiences and behaviour in the context of an idealised norm about maleness and self-reliance. We can see how he does not want to be branded as a malingerer by stating that he has an illness and truly deserves the MC. This could also be a way for him not to be seen as either weak or manipulative.

#### **iv. The costs of over-the-counter medication**

The price of the medication was seen as a major factor in influencing men's decisions of whether to self-medicate by buying medicines over the counter, to see a private GP or seek treatment from public healthcare services. However, it was also noticed that this sort of practice will change as soon as they know that they may need something else and not Paracetamol. If the purchase price of the medicines over the counter is high, they will then consider going to their GP and asking for it in order to obtain it for free. This was shown in the following excerpts from interviews with Khairul and Ishak.

*One time I went to the clinic because I do not want to buy the eye drops from the shop, it was expensive! It was like \$20. I can get it for free from the government clinic! (Khairul, 31 years old).*

*That time I do not have much money, you know I'm a student and at that time my monthly allowance was not out yet. I do not want to buy Panadol and cough syrup from the shop and I do not have any left in my fridge, so I just go to clinic and get them for free (Ishak, 26 years old).*

Interestingly, these sentiments were not shared only amongst students. As was the case for Khairul and Ishak, it was also noted that men who were earning in work also reported that they would opt for the same approach when the price of the medication was perceived to be too high. This was apparent in an interview with Hassan, in which he recalled how his uncle would first establish the purchase price of a medicine prior to making the decision of whether to buy it or go to a health centre to obtain a free prescription.

A similar argument was also made by men with regard to using private GPs in order to get a faster service and to obtain better and stronger medication. Choosing this option largely depended on one's financial position; hence, this option was not open to everybody. Those who are not able to use a private GP appeared more likely to be accepting and to express gratitude that they are given access to free healthcare by the government. They began

to normalise the situation and rationalised the differences between these two sectors - private and public clinics - making reference to perceived drawbacks in private provision in terms of efficacy of the treatment on offer.

This can be seen in extracts of accounts from Najib and Musa:

*Its OK, I'm feeling grateful and blessed that you know its there for us, its free. They did not charge us for anything, free consultation, free medicines, its good maybe not excellent but it's free so you cannot really complain but still you get your medication and the doctor still sees you. Also I think if you go private it is not good in long term because they will give you stronger medications hence more side effects! (Najib, 68 years old).*

*I just go to public clinics because private ones are expensive! It's the same..you will still get your medicines (Musa, 49 years old).*

#### **v. Unbearable pain**

As previously noted, men participating in this study acknowledged the importance of self-reliance and Ikhtiar when they experienced episodes and symptoms of ill-health. However, if their attempts at self-management were not successful and, as was often the case, their condition worsened by for example, an increasing level of pain, this was regarded as legitimate reason to seek help from health care services. As Isa commented:

*After you tried everything you could it still not getting better or pain is getting too much that you cannot hold anymore, I think its then time to go to see doctor! Don't wait! (Isa, 30 years old).*

Like men, women in this study were also of the view that men often delay health help seeking and only seek help either when the pain gets too much for them or as a way of avoiding conflict at home with their wife and children. The following excerpts show how these women think their husbands and sons are reluctant to go to see their GP, unless the pain exceeds a bearable threshold. Inability to bear the pain any longer and failure in terms of their *Ikhtiar*, legitimise men's action to visit a health centre to see a GP.

*He [son] don't want to go but one time he went, he asked me..mum can you drive me to clinic? I was surprised..but you know, um, because, um, that time his pain was too much for him, that's why! (Wina, 43 years old).*

*That time he [husband] just rest, take Panadol, he refused to go. He said he just need to sleep it off and he will be better after a nap! But of course it did not get any better, the next thing I know he agreed to go (Farah, 56 years old).*

Women also put the blame on men's egotism saying that this resulted in men delaying seeing their doctor. They regarded this as normal for men. They recognised men are egotistical because they want to appear strong and able



to handle things on their own. Therefore, they refuse help from healthcare professionals until it is too much for them to handle.

*That's normal! Men have this ego. They think they can handle it [sigh]*  
(Wina, 43 years old).

*My husband, uh never want to listen to me! Difficult! ego you know.*  
*They are men!* (Sara, 59 years old).

Reflecting back on findings gathered from men, there was no mention of this egotism. However, when this was shared with them during the member checking exercise, they did not appear surprised. They felt that this how most women would see them: as being egotistical and wanting to appear strong. However, men did not reject this claim as a mere perception on the part of women. They added personality could be part of it for some men. However, they emphasised that their engagement with healthcare services was mainly influenced by the service provision and how it would impact on their daily life. Men re-emphasised how they were let down by the public healthcare services and how being admitted to hospital could disrupt their daily life routines. They regarded prior experiences as the greatest influence on their decision-making with regard to future occurrences of ill-health.

#### **vi. Not wanting to upset significant others**

Being continuously pressured by their family members was seen as another 'push factor' for men to go see the doctor. Despite men reporting feeling

stress at home due to being encouraged to visit a health service, it was accepted that it was this continuous pressure that eventually made them go to see the doctor. It also appeared that men's agreement to go see the doctor was a way to manage their relationship with their wife and family. All the men involved in the member checking confirmed this to be the case.

Men recognised that not going to see a doctor would just worsen the situation. Firstly, because they will be put under even more pressure by their families and secondly, because their wife and family will become even more upset and finally, when both sides are equally upset it would more likely end up in misunderstanding and arguments.

*You know that time when I had the chest pain, initially I just rest it as usual because it comes and goes, but that time my wife found out and she asked me to go to hospital to see a doctor, but I don't want to. But then she keeps telling me off and keep pressuring me. I can't stand it. She's making too much noise at home! So that's why I go to see the doctor (Ramli, 66 years old).*

*I don't want to go at first, so she [wife] called all of my children and the next thing I know they [his children] came! They insist on taking me to see doctor so what to do. I have to go (Najib, 68 years old).*

However, despite men reporting the stress of being under pressure and feeling "forced" to go, they acknowledged that the pressure was applied for

good reasons and with good intentions. They saw this as a sign of support and love. They also felt relieved that they were forced to go. This is because for them it was reassuring knowing that their family cared about them. This is evidenced in the following excerpt taken from the interview with Sulaiman and Syafie:

*Its all about them being concerned, they care about us. So um, eventually we do listen (Sulaiman, 26 years old).*

*It feels nice you know it shows she [wife] cares about me (Syafie, 65 years old).*

In addition to regarding concern expressed by their significant others as an expression of care, here, we can also see how persuasion from wives or children provides an external locus of control and creates a sense of responsibility for decision making around health issues which sits around but outside the individual. Men reported feeling a responsibility to act as their significant others desired in order to make their wife/ children feel less worried.

*My wife wants me to go, well I told her its OK I can just rest at home but she was worried, so I just go! I do not want her to be worried, um, who doesn't love their wife? [smile] (Naim, 31 years old).*

*I don't want to go but she (wife) called all my children. I have to go. They are worried about me. (Najib, 68 years old).*

### **7.3 SUMMARY**

#### **Governmental efforts to address the structural issues with provision of public health centres and services.**

Major common factors verbalised by men during the interviews that militate against them engaging with formal health care services are related to structural aspects of the health care system, whether they be public or private care. Public health care facilities are seen as inconvenient to use due to the lack of flexibility in opening hours, perceptions that patients risk over-prescription of treatment and the long waiting times preceding short consultations. However, men offer different views on private health care. In contrast to public care, private care is considered much faster and better in terms of its treatment. However, some men again argued against this, pointing out that the cost is high and expressing scepticism about the effectiveness of the medication prescribed by private care.

This study revealed that private care may be considered far more convenient than public care but may not be an alternative for some. Unless, they have enough money, going to a private clinic was not seen as a feasible alternative. This option remained closed to those with limited budgets. Even

for those having access to financial means, making the choice required considerable deliberation and weighing up the advantages and disadvantages.

For men who have limited financial means, the choice is sometimes to divert their money into enabling their children to access private healthcare whilst they continue to use public services. This is one way men use to emphasise the role that they play as a good father, which they defined as one who is able to provide the best care that they can for their family, in this case their children. Critically, in this circumstance, men are positioning their own healthcare service use within a wider understanding of paternal and masculine roles such that whilst their own wellbeing may assume a lower priority than that of their children in doing so they can simultaneously demonstrate the socially and culturally desirable masculine attributes associated with being a good father.

Men also talked about how Paracetamol was commonly prescribed in the public health care sector. Paracetamol was regarded as neither sufficiently strong nor effective in controlling their illness symptoms, but men recognised that it is cheap and it can be obtained for free from public healthcare. However, for those who wanted to access more effective medication - that is perceived to work faster in managing symptoms - and where they have the financial means they would go to private clinics. Turning to a private clinic for 'better medication' is rather unsurprising because according to Paulson et al (1999) when men seek health care, they want to be cured. However, men's

motivations for seeking healthcare are not only intrinsic but also coloured by contextual possibilities. Critically, in Brunei, it is important to consider how men's interests are managed and experienced within a health system, which offers both private and public care.

For commercial reasons, private clinics pay attention to patient satisfaction as a first order priority in order to attract and retain customers. However, in public health services budgetary and operational constraints may distort this focus. In the attempt to provide the public with better experience while assessing the public health care in the country, the MoH has launched a number of initiatives, which aim to ease engagement with services and cut down waiting time.

It should be brought to attention that during the period in which this research was conducted, MoH in Brunei launched its first service offering extended opening hours at the Berakas Health Centre (Yap, 2016) . This health centre offers services from 7 am to 9 pm on Mondays to Thursdays and Saturdays and from 2 pm to 9 pm on Fridays, Sundays and public holidays. This was done in the hope that the public could have a more flexible time to visit the health centres. This could help to address men's difficulty in going to health centres during their regular office hours. With this new initiative, men can access this public health centres after work or even during their day off, in most cases Friday and Sunday for government servants.

Furthermore, this could also help to reduce the number of attendees during office hours. Having longer opening hours could help to spread out the number of attendees and therefore may help to reduce waiting time. Other initiatives like a 'fast track' for those above 60 years old have also been recently implemented. The impacts of this development on men's engagement with health services are yet to be evaluated. However, the literature suggests that the lack of extended hours of operation in evenings and on weekends is regarded as causing decreased accessibility to healthcare facilities (Dalziel & Leishman, 2003; Malcher, 2009; Monaem, 2007).

Additionally, in light of trying to cut down waiting time at public health centres, self-certification for sickness has also been introduced for government officers. This has always been a practice amongst private companies but only introduced recently in government offices. Like the extended opening time initiative, the impact of this is yet to be evaluated. However, it can be argued that this initiative could potentially produce two different outcomes. First, a reduced number of attendees at health centres and therefore shorter wait and second, it could lead to men drifting even further away from health centres. Under the self-certification system, people are no longer required to go to health centres to get their MC but they can simply call in sick to their employers. Exceptions are, however, given in two areas; firstly, if they require more than three days, they need to see their doctor. Secondly, this policy also published a list of health problems or

symptoms that fall under this policy and qualified for the self-certified sick leave (Appendix 14).

Apart from addressing issues relating to structural dimensions of the public health care system, the MoH has also taken a proactive measure in achieving its mission to provide good health for all citizens of Brunei. This is by implementing an initiative to encourage people to go for check ups. This takes the form of a free-of-charge comprehensive health-screening programme. This is especially targeted at men above forty years of age. This programme, known as "*Lakas tah bercek*", which literally mean "*lets go for a check*", was launched in 2015. With this programme, men and women above 40 years of age who do not have a pre-existing health condition are invited to come to their local health centres to get their health assessed. This screening involves checking blood sugar level, blood pressure, Body Mass Index (BMI) and blood testing for cholesterol and sugar levels. Those with abnormal results or needing further investigation are then referred to outpatient departments or other healthcare services, as necessary. In the attempt to reach more people, this programme was also implemented in some workplaces.

The programme is mainly targeting those above 40 years old mainly because chronic, non-communicable diseases such as heart problems, diabetes mellitus and cerebrovascular diseases are high in Brunei and the top causes of mortality in the Sultanate (Ministry of Health Brunei Darussalam, 2012). The quality of life of people suffering from NCDs could be better enhanced through early detection and treatment. Unfortunately, it was found NCDs are



often detected late because men do not go for, or delay going for, health check ups and/or screening. The programme aims to enhance early detection and enable earlier implementation of appropriate treatment.

Since it has only been recently launched, the effectiveness of this initiative in attracting men to go for check ups is as yet not known. However, it may be this initiative will make healthcare more accessible and appealing to men. By offering them the referral it may legitimise making visits to health centres.

## **7.4 CONCLUSION**

In this chapter, I have identified factors that militate against men's engagement with formal health services. These factors include firstly, concerns and worries about the psychosocial impact of seeing the doctor such as perceived risks of hospitalisation and being diagnosed with a serious illness. I have also explored how men's attitudes and behaviours can be situated and understood within the conceptual framework offered by hegemonic masculinities.

In this chapter I have shown how men's accounts cluster around perceptions and experiences of structural factors as practical impediments to use of formal healthcare services. These include the medical certificates and prescriptions, service accessibility, and men's concern about medicalisation, which is quite new in Brunei and so there was quite a lot of concern about over-diagnosis. These were regarded as deterrent factors influencing men's

engagement with healthcare services

Various measures have been implemented to improve patient/public satisfaction, however most men in this study seemed to be unaware of these. Their decision to avoid using health care services were mostly shaped by their past experiences and particularly those which they felt has been poor.

The existence of chronic health problems, acute needs such as experience of an injury, workplace/employer requirements to undergo medical check ups, severe pain, the expense of treatment and avoidance of disheartening significant others were all factors that men cited as legitimising their use of formal health care services. This finding is congruent with other studies conducted with men in the Global North.

The existence of these factors allows men to seek help from health care services whilst still adhering to the concept of *Ikhtiar*, and therefore not injuring their masculinity. This again altogether highlighted the need for masculinities to be operationalised as 'configurations as social practice', which help to provide explanation on how men can be involved in changing and contradictory practices in different times and places. Importantly, whilst the general conceptual approach offered by hegemonic masculinities helps to explain men's attitudes and behaviour and also how they account for their experiences in terms of norms around masculinity, I have also identified some particular dimensions salient in the Bruneian context. The mobilisation

of Ikhtiar is clearly a local, culturally specific dimension that needs to be considered.

The findings in this chapter therefore provide some important examples of the way that masculinities are patterned into men's understanding of service use in complex ways that can be understood as congruent and coherent with both hegemonic masculinities and the findings of research around men's use of healthcare services in the global north but patinated by local factors ranging from the structure of health services, employment regulation and cultural norms about masculinity.

## **CHAPTER EIGHT: DISCUSSION**

### **8.1 INTRODUCTION**

In this chapter I summarise the main findings arising from the analysis of data generated by this study into Bruneian men's health help seeking behaviour, and bring them into dialogue with the dominant theory which has been used to explicate and conceptualise the relationship between masculinities and health, that of hegemonic masculinities. Further, I illustrate the ways in which this study extends and elaborates our thinking about the applicability of this conceptualisation to non-western socio-cultural contexts.

In doing so I demonstrate that whilst the concept of hegemonic masculinity has good applicability, and the ideals about masculinity proposed by the concept and especially the ways that they impact on health have to be mapped on a Bruneian context with care and attention to local health policies, services and wider cultural norms and practices around masculinity. Ultimately I propose a development of this theory which is highly congruent with Connell's own thinking that hegemonic masculinities requires testing and refinement through adoption of the approach in contexts outside the global north-west where it originated. I do not oppose Bruneian masculinities with western/hegemonic ideals but present ways to think about how we can consider Bruneian masculinities and health that are broadly similar but different in nuanced ways to the model.

In doing so, I can lay claim to a significant development of the field first through the generation of rich descriptive data about phenomena previously not subject to research, and secondly through enhancement and refinement of theory.

This chapter concludes with an evaluation of methodological issues and strengths and limitations of the present study, and some suggestions about areas, which warrant further research.

## **8.2 SUMMARY OF FINDINGS**

In the previous three chapters, five, six and seven, I presented three themes that arise from the analysis of the data elicited by interviews and focus group discussions with men and women in Brunei.

In chapter five I discussed how men described being healthy as a significant part of their life and contribution to their sense of masculinity. Good health enables them to perform the social and relational roles, which they perceive to be expected from them throughout their life course as a Bruneian man. Changes in perceptions of what being healthy entails and involves, how it is assessed and episodes and experiences of ill-health responded to are linked to critical markers of transition through the life course. The reconceptualisations of how health and masculinity relate that Bruneian men undertake are not simply dependent on life course but also in turn influence

their passage through these transitions. For example, becoming a father was clearly perceived as bringing new meanings to being healthy which were strongly connected to the male exercise of responsibilities towards children, partner and parents. Men not only reacted to circumstantial changes in making these renegotiated meanings but anticipated, and indeed expected them, and therefore they had a dialogic quality with the transition moments and health conceptualisation and behaviours being mutually constitutive.

In short, men pointed to the importance of concepts of health and healthiness, their enactment and health-related social practices not just as part of this life-course transition but also as necessary to perform the life course. As the male role changes, so too does health perception and possible course of action, and negotiation of these allows me to create a model of masculinities and health throughout the Bruneian life course. Important transitions relate to moving from being a dependent son to an independent father (who shoulders responsibilities towards others) and then to grandfatherhood. With old age and retirement, men talked about role changes from being the '*provider*' to '*being the supporter/ being there*' for the family. This is the new role that older men create to adapt to the changes in their life. This enabled them to portray themselves as continuing to play a major part in contributing towards their family's welfare - a critical part of men's life and masculine identity.

In chapter six I demonstrated how the execution of a masculine role was affected by the onset or experience of ill-health. Since the performance of the

social and relational roles and responsibility are crucial for men, the onset of illness and its symptom(s) cannot be ignored because it impinged on men's ability to discharge and perform these roles and responsibilities. I employed the concept of the 'care of the self' developed by Michel Foucault (1988) to explore Bruneian men's engagement with health services as a response to ill-health symptoms. Bruneian men conform to the concept in that they assume responsibilities for their health and do what they can to recover but they do not necessarily turn to a doctor straightaway. This is because engagement with formal health care was perceived to be at best in tension with and at worst to conflict with their expectations that they should be self-reliant. Therefore, in situations where they experienced ill-health symptoms, *Ikhtiar* was preferred by men. Men would do whatever they could to avoid formal health care, in the first instance. Whilst still adhering to masculine identity, their action is also tailored around factors such as perceived ease, convenience and effectiveness of health service access.

In chapter seven I discussed how issues related to the structure and provision of formal health care - long waiting times, limited opening hours and perceptions of overly prescribed treatment - deters men from engaging with the service. Furthermore, concerns and worries about psychosocial impacts that might result from seeing the doctor were also highlighted as deterrent factors.

While these factors militated against engagement with formal health services I have shown that when motives are strong men will consider accessing

services. Experience of chronic health problems, acute needs such as a physical injury, workplace/employer requirements to undertake a medical check up, severe pain, the expense of treatment and avoidance of disheartening or disappointing significant others are all factors that men report legitimise their engagement with and access to formal health care services. The existence of these factors allows men to seek help from health care services, whilst still subscribing to the concepts of *Ikhtiar* and self-reliance, which are positive masculine attributes for these men.

Bringing together the these three main themes – around masculinity and health, *Ikhtiar* and motivations and factors that militate against or promote health help seeking enables me to develop a core category or theory emerging from the final stage of the analysis, in accordance with Constructivist grounded theory (Charmaz, 2006). As previously mentioned, men define their health primarily in terms of their physical capacity to discharge every day roles. These roles and responsibilities are central to their sense of Bruneian manhood. Good health enables the discharge and performance of these roles and responsibilities; ill-health poses a potential threat to them. When the threat was sufficiently great and unmanageable via other means, men would be triggered to respond.

It is in the context of a conceptualisation of masculinity as constituted by a series of role-related responsibilities towards the self and others that men make decisions about what action to take to protect their health and when faced with an episode of illness. As seeking health help particularly from



formal health care is in tension with concepts of this idealised masculine norm of being strong, independent and self-reliant, men often resort to trying to self-medicate or fix themselves first at home. This typically means that they delay accessing formal healthcare. This response was viewed as a masculine way of reacting to illness episode – fix it themselves first. There is a high level of congruence with the concept of agency and masculinity proposed by hegemonic masculinities apparent in this view of male attributes and behaviours.

Interestingly, the study also shows that they felt 'trapped' between either the decision to go or not to go to see their doctor. This was felt particularly acutely when they realised that their own *Ikhtiar* to fix themselves was not proving successful. Critically, whilst wanting to adhere to masculine norms, they also felt that they were still responsible for the performance of their roles as a man with respect to their family- be it as a son, father, husband or grandfather. They felt these roles were harder to fulfil if they are ill.

What the data shows is the complexity of men's actions in response to any illness episode. The way they use health care services (or not), reflects not only their perceptions of idealised Bruneian masculinity but also how this can be accommodated and negotiated into their own experience and specific features of the cultural landscape such as the idealised Bruneian male life course.

Academic literature on masculinity generally finds that there is a dominant

form of masculinity, or 'hegemonic masculinity' as Connell (1995) refers to it that influences men's understanding of what practices of masculinity men need to engage in order to be perceived as 'acceptably' masculine. The meanings participants in this study attached to help seeking echo findings reported elsewhere that suggests that men associate help seeking with: loss of control and autonomy, the appearance of being unable to cope and ultimately damaged to masculine identity (evidence by the use of word like 'manja'). This is clearly seen when participants started to use the ability to handle ill health symptom and self managed as a sign of independence and control and they used this as an indicator of a man's ability to be leader of family.

In this study, I found that it is not always the case that adherence to an idealised masculinity militates against health help seeking including engagement with formal health services. This is largely similar to findings of studies in other contexts where hegemonic masculinity is not straightforwardly a barrier to health action and service use. Indeed, as discussed in previous chapters, a number of studies suggested this, such as O'Brien, Hunt and Hart (2007) and Jeffries (2012).

O'Brien et al's (2005) study involving Scottish men found that the participants regarded health seeking as a means by which to preserve or restore an important aspect of a man's life - the need to be fit and physically healthy for work is acceptable and rather essential. Bruneian men in this study shared a similar view.

In the case of Bruneian men, I have shown that being a man means being able to act out positively regarded masculine attributes. One of these is contributing to their family; a responsibility that men have had attached to them across many generations, and men acquire this role and learn it from their elders. Whilst familial responsibility and generational tradition have both been found to be important in male health and masculinities in other contexts, this has specific Bruneian dimensions and these are consciously articulated as such by men in this study. In a sense this is not surprising because such masculine specific responsibility is shaped and determined by culture. As Mundigo (1995) asserts it is culture that determines gender roles via a process of learned and socially transmitted values acquired as a person interacting within their culture.

I observed that whilst the strength and importance of sense of responsibility toward the family was still very great in Brunei this may be waning in some contexts within the global north where social changes in gender and work may be influencing the way that men think about power, gender relations and gender responsibilities. Such social change and perceptions appear not to have taken place in Brunei as yet.

Needing to provide for the family was found to be a major driving factor motivating men to seek out and to engage with formal health care. The high value these Bruneian men placed on family and discharging responsibilities towards their well-being is also echoed in some Asian studies. For example, a study undertaken in Malaysia aiming to explore men's perception about health and illness and factors influencing their health and illness behaviour

found that the need to continuously look after their family is a major motivation for them to stay healthy (Yun et al., 2008). However, this study did not explore what these men did when they got ill or experienced symptoms of ill-health. Despite this limitation, the findings from this study are still significant because of the similarities of the socio-cultural contexts, particularly in terms of culture and religion, between Malaysia and Brunei.

Another study, larger in scale and that involved a telephone interview using a standardised questionnaire, of 5,134 men from five Asian countries (China, Japan, Korea, Malaysia and Taiwan) and aiming to identify attributes to masculinity for Asian men yielded similar results (Ng et al., 2008). This study demonstrated that men generally considered having a career, their ability to earn money and family, as the most important attributes of their masculinity. This confirmed a previous UK study (Galdas et al., 2007) in which the researchers found that responsibility to family and being able to look after them is the most important attribute of masculinity for the Asian men involved in their study. As a consequence they tended to be positive about health help seeking behaviour when they experienced cardiac chest pain.

It is clear from this study that Bruneian men are equally reluctant users of health services just like men in other studies undertaken in a range of cultural contexts, however, what I want to argue is that the process of decision-making about service engagement is complex and involves the renegotiation of the norms and expectations associated with idealised masculinities in a specific cultural context. This study also shows that locating an understanding of the relationship between health help seeking

and masculinities within a specific cultural context is central to theorising behaviour and gendered identity.

In this study, it was found that men often consider both factors that militate against utilising formal health care and those that encourage them to do so. Men in this study were reluctant to utilise formal health care services because they feared hospitalisation with its perceived deleterious impact on their gender, social and relational roles and how being under the care of a health care team would undermine their self-reliance. Maintaining and performing the masculine norm is crucial for them and this apparently influences what they do in episodes of ill-health and experiences of ill-health symptoms. This locking together of health and gender is a critical insight, which concurs with that of Courtney (2000) who, in exploring the relational theory of men's health from a social constructionist and feminist perspective concluded, that "*doing health is doing gender*" because health related behaviours are a means of demonstrating masculinities and femininities.

Connell (1995) argues that masculinity is a social construction hence it is dependent on a specific historical time, culture and locale. This is also what was confirmed in this study. The relationship between Bruneian men and masculinities and health are co-constructed and that process is not free of but dependent on a great variety of factors such as culture, educational background, occupational policy, income/ financial situation, knowledge, family support, the existence of a medical problem, the nature of symptoms, past experiences and structural issues relating to accessing health care

services. It is these factors that constellate around and orient and influence individual Bruneian men's attitudes and behaviours in the context of a clear and common idealized Bruneian masculinity. It is possible to conceive of this as the background against which experience and personal positions are mobilised.

Regardless of socio-demographic background, all the men involved in this study shared a strong belief and common understanding of the importance of being able to perform and live up to Bruneian masculine norms – characteristically articulated in terms of male roles and responsibilities. There is a culturally embedded expectation about male life course, family role and health, and all these are further reinforced by governmental intervention and policy such as the law, and education at school. This includes validating and being a good son, who is able to help support their parents and bring pride to family, being the breadwinner during their youth to middle age then moving to being the supporter for their family once they reach retirement. This greatly influences their health help seeking behavior.

The embodiment of masculinity was apparent in this study, whereby men see 'the fit body' as important as a sign of good health which in turn, enables their execution of various masculine roles and responsibilities. According to Watson's Male Body Schema (Watson, 2000), this is what known as 'Pragmatic embodiment'. This is whereby men recognise the importance of maintaining a functioning body in everyday life to fulfil gender roles and expectations.

Going through and also performing the life-hood trajectory is a perceived and expected norm for these men. This was passed down from the older generations. Despite seeing some impact of modernisation and globalisation, particularly on the younger generation, there are no discernable challenges to the traditional idea of masculine roles and expectations. Young men accepted 'that is just how it is' and are preparing themselves for those various roles.

In contrast to health, illness is widely regarded as the inability to fulfill these expectations. It is this threat to role that leads men to act upon experience of ill-health and ill symptoms. However, what they decide to do is depend on the kinds of local and individual factors mentioned above. Therefore, it is not a straightforward "Yes" or "No" to seeking health help or engaging with formal health care. There are circumstances whereby men would re-negotiate their masculinity, and reconsider the need for engagement with formal health care. Men go through a process of weighing all the pros and cons, and consider the bargain that they would get and compromise that they have to make in terms of masculine identity in seeking help from healthcare professionals. In short, this suggests that it is possible for men to make healthier choices or a more positive health seeking behaviour, but only by negotiating the other, often hegemonic ideals.

Structural issues relating to the use of formal health are often disincentives men from their engagement with the services. However, men also realised despite the long waits, inflexible opening hours, and overly prescribed

treatment, they got to see their doctor in the end, got checked and received treatment for free. This was seen as worth the bother. Where the advantages weigh more heavily than the disadvantages of not going to health services men will tend towards access and engagement. This pattern and behaviour of health seeking and engagement with health services portrays men as the legitimate users of the services. Similar findings are to be found in a study by Robertson (2006), in which he illustrated this using the concept of what he termed as the '*Don't care/Should care dichotomy*'. He posited that there is general agreement in the research literature that men are reluctant users of health services but he argued with good and strong reasons, a man would move towards the 'should care' offside of this dichotomy.

The chief feature of the cultural context that needs to be taken into account is how these Malay, Iban or Chinese men are realising the practice and ideology of Islam and the strong national philosophy in which family values are strongly upheld and practiced by its people. As aforementioned, this was further reinforced by its educational system and its law. In turn, it was apparent that family was seen as of uttermost importance for these Bruneian men. Ensuring that their family is well looked after is often men's top priority, the chief expectation that they perceive to be levered on them, both from the point of view of cultural and religious tenets and beliefs. Evidence from this study also shows that ability to execute masculine roles and responsibilities was not only quoted by participants as a cultural and social expectation but also came from religion.



Providing '*nafkah zahir*' (to their family and parents) and '*nafkah batin*' to their wife was commonly shared across all the men, regardless of ethnicity and any other socio-demographic background. This is further reinforced by religion and law. This can be clearly seen in the case of Muslim men, whereby they see this as a responsibility that is demanded in Islamic teaching, i.e. to be a responsible man to their family throughout their life course transition. The importance of executing this role was seen as a major factor for all these Bruneian men, not just those who practice Islam. Hence, for them being 'fit' and healthy is of paramount importance, as the otherwise would affect their ability to perform.

However, these men's adherence to masculine norms (of wanting to be self-reliant) plus their previous unpleasant experiences whilst engaging with formal health care services has largely impacted their behaviour and attitudes towards the need to seek for help from health services. Engagement with formal health services is often their last choice, and would resort to self-care or *Ikhtiar*. They equated being able to initiate self-care and not turning to others for help as a positive masculine attribute. Subsequently, this further influences action taken by men in the episode of ill health.

In deciding whether to engage with formal health care services, men go through a process of thinking about the pros and cons and consequences of their action. If the consequences of not engaging with health care services are serious and would affect their ability to perform their role and

responsibility towards their family, men would renegotiate their action. I called this a process of 'bargaining and compromising'.

The figure below (Figure 8.1) illustrates the process of weighing the 'pros and cons' of utilising formal health care (either private or public care) and how that leads to them re-considering their masculinity and consequently, settling for health help from health care services. The figure has two columns labelled as "*what if I go...*" and "*what if I don't...*" These titles for the two columns are chosen due to their self-explanatory nature. Both columns illustrates the pros and cons that men take into consideration in making their decision in seeking health help from formal health care services.

The weighting scale is carefully chosen to represent this data because it illustrates the process men go through when making the decision prior to engaging with formal health care services. Men go through the process of negotiating their masculinity, priorities and beliefs and often consider the positive and negative consequence of their action.

Figure 8.2 summarises the processes involved in shaping health help seeking behaviour of men in Brunei. It exhibits all the three themes and a core category as a process. It starts with "The physicality of health and its importance to masculinity" then followed by *Ikhtiar* as a way of 'doing masculinity' in the context of experiences of ill-health. Next, it presents "Masculinity and legitimation of health help seeking". Finally, "Negotiation: bargaining and compromising action in seeking health help" is shown. The

arrows connecting each of the boxes present the sequencing and potential movement of men from one phase to another. However, it must also be brought to attention that this processes it not a linear sequence as such. A man could fall straight into the process of negotiation of his masculinity by considering all the pros and cons of engaging (or not) with health services. For example, in this study, it was found that for a man who has a chronic health issue, this health issue may in and of itself be a sufficient factor to influence his health help seeking behaviour. The experience of the chronic health condition may legitimise their health help seeking and engagement with formal health care services. This action may also be justified by the need for them to be 'fit' in order to be able to execute their social and relational roles, particularly with their family. Nonetheless, whilst a man in these circumstances may enter the model at the third legitimising stage, he could then move to the first stage where he has to consider how he can accommodate his body (which may well be constitutionally unfit) in the context of the idealised view of the fit male body.

The various elements of this model are shown in the following diagram.



Figure 8.1: Shows the process whereby men weigh all the pros and cons in making their decision whether to engage or not with formal health care

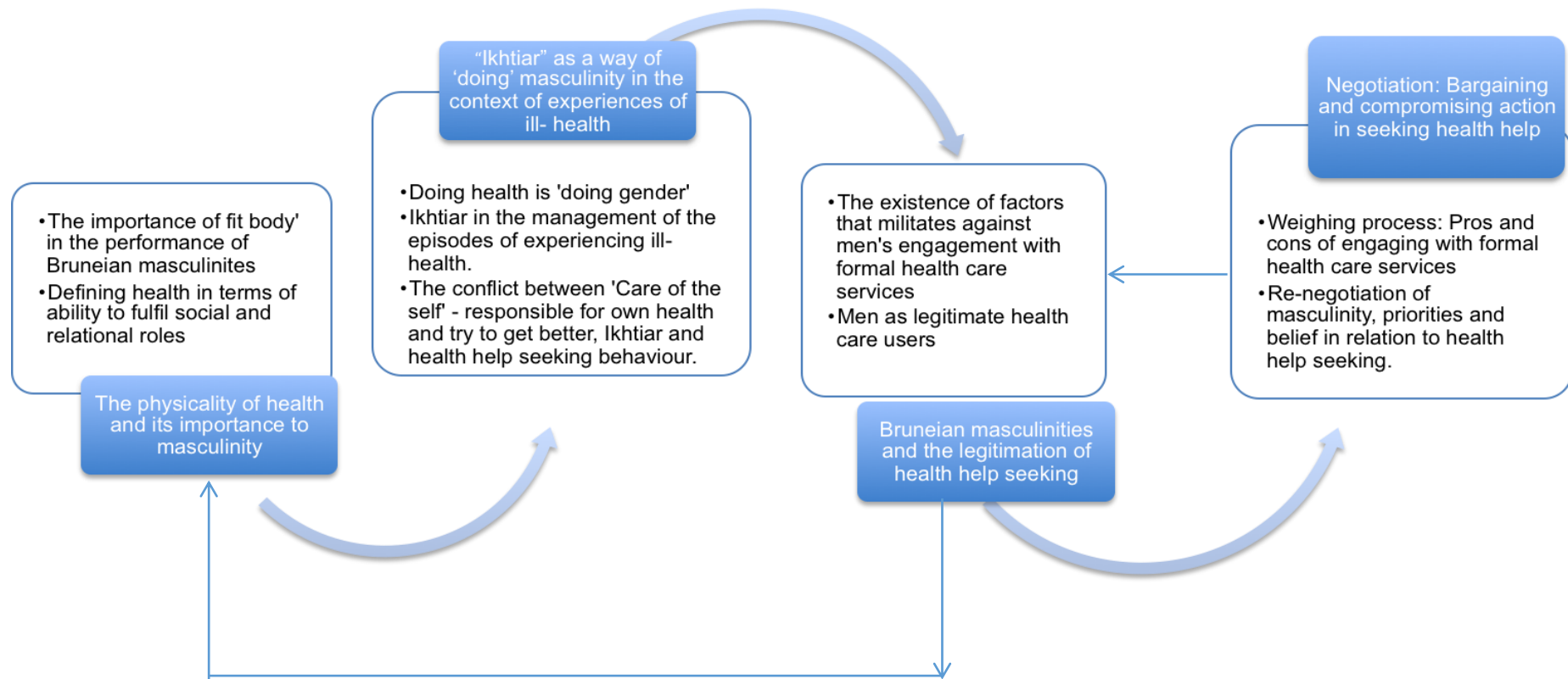


Figure 8.2: Visual representation of the processes involved in shaping the health help seeking behaviour of Bruneian men.

### 8.3 STRENGTHS AND LIMITATIONS OF THIS STUDY

This study has a number of strengths relating primarily to its validity and reliability, issues surrounding the recruitment processes employed and participants recruited, the means and methods utilised for data management and analysis.

#### **Validity and reliability of the study**

Validity and reliability are important considerations in all research because the accuracy, dependability and credibility of the information the researcher gains and reports are dependent upon them Hammersley defines validity as follows:

*'...an account is valid or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorize.'*  
(Hammersley, 1992: 69)

In qualitative research, terms such as quality, rigour and trustworthiness are commonly used instead of validity. To avoid confusion, I have employed the term 'rigour' throughout this thesis.

With reference to qualitative research, Hammersley suggests that reliability

*'...refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions.'* (Hammersley, 1992: 67)

In this thesis, I have chosen to talk about dependability as this is common practice in qualitative research, whenever the discussion on reliability takes place and is regarded as more suited to the nature of qualitative research (Davies & Dodd, 2002). I sought to ensure rigour and dependability throughout the study described in this thesis in a number of ways. These are described below. However, the foundational basis for this claim rests principally on the understanding, derived from Hammersley's work, that reliability is construed as largely being concerned with the process of data analysis. A key mechanism for achieving reliability in this work has been the high degree of transparency I have brought to my reporting of the analytic processes and procedures employed in this study. Careful attention to making it clear how decisions were made about data coding and categorisation, and the development and articulation of themes, provides a strong basis for staking a claim to a high degree of reliability.

### **Study rigour**

#### ***(1) Self description and the reflective journal***

This relates to how reflexivity was maintained in this study. Porter (1993) sees reflexivity as a process whereby the researcher reflects on his/her own beliefs in the same manner as they examine those of their respondents. In this study, every attempt was made to ensure that my beliefs and values were made explicit and taken into account. Although this process is ongoing through the thesis, this was initially evidenced in the account I gave in chapter one where I

described the origins of my interest in this study and provided a detailed explanation of how this may have influenced my analysis of the data

In chapter three (Methods and methodology), I also discussed how my professional status as Bruneian scholar studying for a PhD in the UK has influenced the way my respondents (in this case Ali - Interview no. 1) reacted to my questions. This was evidenced by my reflexivity with regard to his repeated request for reassurance that he was answering my questions correctly and he appeared to manage his contribution to the interview in line with his presumptions about my expectations.

## ***(2) "Member checking"***

I employed member checking as a means of affirming the meaningfulness of the findings generated by this study and especially the emerging theory. I achieved this by meeting with a small group of study participants who volunteered to participate in this phase of the study. During this session participants were given the opportunity to amend, add to or disagree with my analysis of the findings. This process was undertaken in order to ensure that my interpretation and analysis was true to their experiences. It was also posited that the member checking process was important in an interpretive qualitative study such as this in order to enhance the trustworthiness and credibility of the analysis (Creswell & Miller, 2000).

Nine out of forty-seven participants (19.1%) of the participants agreed to meet for the member checking. This group comprised five men and four women. Two of the male participants agreed to meet together as a group, whereas the other



three were met individually. All the four women were met as a group. During the member checking process men re-emphasised the importance of cultural expectations placed on them as men, the importance of family and the pivotal role played by their wives in persuading them to engage in health help seeking behaviour, particularly encouraging them to visit their doctor when they experienced symptoms of ill-health. Importantly, this process also reaffirmed that women regarded the continuous persuasion of their husbands as flowing not only from care about and for them but also they were worried about potential consequences that their husbands might suffer as a result of neglecting to seek timely engagement with health professionals and healthcare provision. They highlighted that further health consequences would not only affect their husband but also the family as a whole.

### ***(3) The use of data in its source language***

Participants' comfort and confidence in the data collection as well a capacity to represent their sense of self (Wallin & Ahlström, 2006) was enhanced by allowing them to undertake interviews and focus group discussions in the language of their choice. Furthermore, transcription and analysis were also conducted in the source language as suggested by Twinn (1997) as particularly appropriate in cross cultural research in order to reduce risks of loss of meaning which may be associated with translation. According to Lincoln & Guba (1985) this is one way of maintaining internal validity or rigour in qualitative research especially those involving different languages.

#### ***(4) Rigour in relation to a quality grounded theory***

According to Birks & Mills (2011), research expertise, methodological congruence and procedural precision, are the three important determinants in ensuring the rigour of grounded theory research.

##### ***I. Researcher expertise***

As a PhD scholar, I have received training, support and supervision from my two supervisors, who have extensive experience in conducting research and particularly in grounded theory. Additionally, as a PhD scholar, I have also extensively referred to the academic literature related to grounded theory. These are important processes of knowledge acquisition and skill development, preparing me both for this study and also for the research activities beyond.

##### ***II. Methodological congruence***

As I demonstrated in chapter three, where I described the research onion approach to aligning ontological, epistemological and methodical elements in a study design, I have achieved congruence or '*fit*' across these dimensions of the study including, for example, aligning the research problem and the question, the research question and the method and between the methods, data handling and analysis.

For easy reference here I reiterate the research question, method, data sources and analysis technique.

The research questions for this study were “How do Bruneian men define health and illness?” and “what is the health help seeking process of Bruneian men?”.

Method and methodology were guided by the principles of constructivist grounded theory. Data was obtained from semi structured individual interview and focus groups/ dyadic interviews.

In conducting the analysis, the study aims for theoretical sensitivity in developing its concepts via the different stages of coding towards theory generation. Data collection and analysis were done simultaneously to allow constant comparison and inclusion criteria were adjusted and became focussed (theoretical sampling) once analysis was done.

In summary, the nature of the research question with its focus on generating understanding of social phenomena and human views, attitudes and behaviours implied that my methodological orientation should be towards grounded theory with its focus on building conceptual means for understanding of social practice within a grounded theory approach. The methods selected align well with the research question and the analytic approach is congruent with working from data to theory.

### *III. Procedural precision*

In ensuring procedural precision the three following areas warrant attention: maintaining an audit trail, managing data and resources and demonstrating procedural logic.

In order to avoid confusion at later stages of analysis and writing up, Corbin & Strauss (2008) advise that all decisions made in relation to the research should be recorded as the research activities are carried out. This also helps to prevent the researcher from making a second guessing decision. To make apparent the decision-making processes in the analysis I utilised memos. These memos were used to record all the research activities, changes in the research direction and the reasons for every choice that I made in relation to this research. I also used memos to record all my thoughts, feelings and ideas in relation to the project from the start of data collection to theory construction, as suggested by Bryant & Charmaz (2010). In turn, this also increases the quality particularly in terms of transparency and the reflexivity of the study. This is particularly important for research with an interpretive component (Birks & Mills, 2011) such as this. Furthermore, I found that as a less experienced researcher the use of memos was very useful in allowing me to refer back accurately to issues and thoughts at a particular point in the analysis phase of the work.

Additionally, a detailed audit trail was developed to ensure dependability in this study. This involved recording of all sources of data, collection techniques and experiences, assumptions made, decisions taken, meanings interpreted, and influences on the researcher. The purpose of this is to allow others to evaluate the study by following the steps involved in it and comparing it with their own conclusions made from the same information (Parahoo, 2006). This is a way to show that I, as the researcher, have remained true to the data and to the limitations of the sample (Mason, 2002).

In this thesis, the decision audit trail is contained primarily in the detailed discussion of the methods used, data analysis, and also in the discussion of

findings, whereby a mixture of description and detailed data excerpts from the interviews and focus group discussions have been included in order to allow the reader to see the broader context in which comments were made and how the analytical themes have been derived. This has enabled me to be transparent in terms of process and to exercise the reflexivity of the study (Karnieli-Miller, Strier, & Pessach, 2009) at the same time enhancing its auditability (Parahoo, 2006).

In terms of managing the data, word processing and spreadsheet applications were used to store interview transcripts and memos. These were all coded and saved on a secured server located at Durham University. The Data Protection Act, UK (1998) was strictly adhered to in relation to handling and managing data.

Finally, in terms of the procedural logic of this study, all the essential steps and stages in a grounded theory approach to study design and implementation were applied. This was so as to ensure its procedural logic and in turns increase the credibility of this study.

### ***5) Reflexivity of the study***

In presenting the findings of qualitative research, it is unavoidable that they reflect the assumptions that the researcher brings to the analysis (Hammersley, 1992). Therefore, a researcher must recognise how their own values, assumptions and preconceptions may influence the data and findings. Reflexivity is essential to ensuring this. Thus in this thesis, I explicitly reported

my personal and theoretical biases, which I perceived I could bring to the research (Lincoln & Guba, 1985).

I was acutely aware of my gender, my position as a male, my professional status as a nursing lecturer and PhD researcher at a university in the UK and the need to consider these reflexively in the analysis presented in this thesis. This is because all these factors have the potential to influence the research process (Silverman, 1993). McKeganey & Bloor (1991) argue that age; social class and gender are some of the variables that may impact on the data collection in the fieldwork setting. As discussed earlier in this thesis, I have demonstrated how my introduction to my participants potentially influenced the interview outcome and what they revealed during the session. By positioning myself as a researcher, I tried to ensure that participants were comfortable revealing their dissatisfaction with the healthcare services. This may also have influenced their confidence about disclosing some health-related behaviours, including, for example, the participant who disclosed that he was not taking his tablets. It could be that he would not have revealed this had I positioned myself as a healthcare professional or at least being someone who is related to Brunei's MoH.

#### **6) *Recruitment methods used in the study***

The recruitment methods employed in this study were designed to achieve high visibility to potential participants. By using social media, posters, direct recruitment and recruitment using third parties, assurance was provided about the extent to which no individuals or groups were excluded by design. This issue was discussed in detail in chapter three of this thesis.

### **7) *Breadth of recruitment***

The diverse background of the participants involved in this study enhances both the credibility and also the richness of the findings. The diversity ranges across dimensions including ethnic background, age, marital status, area of residence, educational background, occupation, religion, previous history of surgery and existence or history of a medical condition. The sample size of forty-seven participants is adequate for allowing both the capacity for me to understand the perceptions of the members of the sample and achieve theoretical saturation, which is a point whereby gathering more data about a theoretical category reveals no new properties nor yields any further theoretical insights (Charmaz, 2014).

### **8) *Methods of data collection***

I collected my data in this study via the use of in-depth interviews structured with a fairly loose topic guide. This enabled me to obtain rich findings about participants' concerns. This would not have been possible within the constraints imposed by, for example, utilising a semi-structured interview schedule.

The guide helped me to steer the interviews in a way that was valuable and since I was able to control the direction of the interview through the use of probe questions and also follow up on topics of interest that arose naturally during the interaction. This was especially the case whereby the participant mentioned something interesting that I wanted to explore more.

Despite a number of methodological strengths this study is not, as is always the case, without limitations. The limitations of this study are as follows.

**1. *Limited representation from the Chinese community***

The majority of the study participants were Malay Muslims and Iban. There were only a small number of Chinese representatives recruited in this study despite active attempts to target them. Only two Chinese men and two women volunteered to be involved. Therefore, the study may not fully reflect the views and experiences of members of the Chinese community. There is more work to be done to establish why this group is apparently hard to reach.

**2. *Inability to look through the lens of sexual orientation in the analysis***

The study did not actively seek to elicit information from participants about their sexuality or sexual orientation. Whilst there is no doubt that sexuality is imbricated in considerations of gender in significant ways the legal context in Brunei, particularly if one is found to be homosexual in the country, meant that it would not be in the best interests of participants, to raise considerations of sexual orientation in this study.

However, it must also be noted that in one of the interviews (Dyadic interview no. 1 - with two men) the issue of sexuality did come up. This confirmed that sexuality is connected to gender and health in the Bruneian context but the exact connection between them remains unclear. This provides a tantalising insight into what might be possible in future research.



### **3. *Inability to recruit from geographically remote areas***

Despite having communicated with gatekeepers and having had assistance from third parties, I did not manage to recruit any participants living in very remote areas in Brunei such as Mukim Ulu Sukang and Mukim Melilas in the Belait district. These remote areas are less well served in terms of healthcare services in comparison to other areas in Brunei, hence the perspective of those with less access might have been under-represented in the study.

## **8.4 ISSUES FOR FURTHER RESEARCH**

The significance of this study is I hope self-evident: it is the first research ever undertaken into issues around men's health in Brunei. It provides insight into the factors that influence Bruneian men's health help seeking and helps to ground that insight in an emerging theory of masculinities and health relevant to South Asian men. However, it also raises a number of questions that warrant further consideration and should be the basis for further research.

This study has shown that Bruneian men do not have a clear understanding of the rationale for being prescribed medication. Improving patient understanding of prescriptions is of paramount importance as it can improve their adherence to their prescribed treatment. However, little is known about how patient education is delivered to patients, particularly by health care professionals in Bruneian health settings.

It has also shown that there is a preference, particularly amongst older men, to

use traditional medicines. These practices, their basis and the potential benefits warrant further research.

Further work could also usefully elaborate the issues uncovered in this study with additional sub-groups. For example, the issue of how boys perceive their health and health needs could extend our knowledge into a population which is not represented in this study. This study has demonstrated that age is a factor influencing men's perception of their health and their patterns of health help seeking behaviour. Generally, it was noted that good health is closely linked to the ability to perform socially constructed masculine norms and roles and is conceptualised in terms of the life-hood trajectory that these men regard as well mapped out. Undertaking research with a younger generation would supplement our understanding of how the life course and anticipated transitions impacted on their understanding and enactment of health.

The specific needs and experiences of men from minority ethnic groups which proved hard to reach in this study could also be usefully further investigated. Men from Chinese and Iban ethnic groups would be potential targets. Similarly, work with men in hard to reach areas such as the interior parts of Brunei would be warranted to better understand how lack of access to healthcare provision mediates views and experiences.

Men who have chronic or long-term illnesses also represent a group worthy of further study, The implications of chronic and long-term conditions for individual wellbeing, for masculine identity and wider social issues such as healthcare provision are sufficiently serious to suggest that a study dedicated to

understanding these is warranted.

More work with women on their role and experience of men's health particularly on their understanding of the cultural norms about gender roles also need to be investigated.

Healthcare professionals' perceptions of men's health needs and their response also felt an important area of exploration. This is because healthcare professionals are the gateway to the healthcare system. Unless these professions understand the needs and issues of the male public, attractive gender sensitive care can never be developed nor delivered.

Finally, despite the difficulties posed by the cultural-legal context, further investigation of the way that sexuality is associated with gender and health for men is needed. Targeting MSM and gay men may be difficult but would be valuable.

## **CHAPTER 9: CONCLUSION**

### **9.1 INTRODUCTION**

This chapter concludes my thesis. In it I summarise the main findings of the research and link these to my original research questions, I also highlight the ways in which the work adds to our knowledge and understanding in two important ways: in terms of providing entirely new insights into issues around men's health help seeking in Brunei; and, elaborating and developing the dominant theoretical understanding of the interlocking of masculinities and health proposed by the concept of 'hegemonic masculinities'. My claim is not that Bruneian masculinity and health cannot be accounted for in general terms by an approach characterised by an understanding of hegemonic masculinities but that there are similarities and differences in the ways this plays out in Brunei and other contexts where the concept has been applied. I also present a series of implications and recommendations for development of policy and practice.

### **9.2 THE RESEARCH QUESTION AND STUDY**

The research evidence suggests men are reluctant users of health care services. Men use health care services far less frequently than women and often delay or fail to seek health help from formal health services. It has been argued that this is because of men's adherence to idealised forms of masculinity in which seeking health help is perceived to be weak. Help seeking is therefore at best in tension with, if not opposed to, the concept of hegemonic

masculinity, which identifies an idealised form of maleness as self-reliant, self-sufficient, strong, aggressive and independent. Consequently, many men would avoid or delay their engagement with health care services. For this reason, masculinity itself has been seen as detrimental to men's health. However, under various circumstances masculinities are re-negotiated. One of the key constituting dimensions is health and attitudes to it, and hence it can be said that when men 'do health' they are 'doing their gender' too.

The academic literature appears to show that masculinity influences men's health help seeking behaviour in a fairly consistent way. However, this evidence is derived primarily from studies conducted with men in the Northern hemisphere and to date, there has been no study investigating Bruneian men's health help seeking behaviour and health care utilisation. Consequently, there is a lack of empirical research with which to test relevant theory in this cultural context.

A look into epidemiological evidence, such as the statistics produced by the Ministry of Health in Brunei, shows the disparity in terms of life expectancy between men and women in the country, whereby the former has a shorter life expectancy. This further fuelled the need to embark on this study. It is the first of its kind investigating health help seeking behaviour and patterns of utilisation of health care services amongst South East Asian men, particularly those living in Brunei. It aimed to identify and contextualise patterns of health help seeking amongst Bruneian men and to develop a theory which was informed by but also extends hegemonic masculinities to explain this. I discussed this background in detail in chapter one. In order to contribute to filling these gaps in knowledge

and understanding I have described in this thesis how I designed, implemented and worked with the data produced from a research project which employed a grounded theory approach and involving interviews and focus group discussions with men, supplemented with a focus group discussion with women.

Furthermore, this pioneering study is important in supporting development of practice and policy. Based on the findings of this study, some tentative recommendations were also made, which can be found in later chapters of this thesis.

### **9.3 PRINCIPAL FINDINGS**

I presented the principal findings of this study in three chapters at the heart of the thesis: chapters five, six and seven.

In chapter five I discussed how important to men the appearance of their body is, specifically the 'fit body' as an indicator of their good health. Health is perceived by men as constitutive of masculinity and that is located/associated within important cultural expectations around role, which are plotted throughout life – from son to fatherhood and to grandfather hood. This has informed the development of a model of Bruneian masculinities in which health is central and connected to the life course and transitions within it.

There is also a sense of great deal of stability in the idealisation of the male role

over the life course. Men see this as handed down through families and a feature of 'deep' culture, but it is interesting to note that the Bruneian government is taking conscious steps to reaffirm, encourage and indeed enforce adherence through a combination of legislative and educational intervention. The power of the idealised masculine life course and roles and its association with good health is so strong that men conform to it, albeit in different ways, irrespective of physical disability or health state.

In chapter six I described how men define illness and its link to men's attitudes and behaviour in terms of health help seeking. Since the performance of culturally-expected masculine norms are crucial for men the existence of ill-health symptoms cannot be ignored because of the threat they pose to this.

*Ikhtiar* or being self-reliant was seen as a priority for men in coping with and responding to episodes or experiences of ill-health. *Ikhtiar* is a concept realised in social practice to maintain masculine attributes. Men in this study used *Ikhtiar* both in ways that push them away from service use and also in some circumstances, pull them towards it. Treatment and management of ill-health symptom(s) that men perceived as easy, convenient, effective and safe are often their choices, and unfortunately this does not include visiting formal health care services. Further, engaging with formal health care services was also seen as undermining their self-reliance as they are generally expected to be passive in their care. Consequently, they revert to self-treatment.

However, if ability to perform their masculine norm is affected, men would

consider assessing health services and they see this as a way of retaining their social masculine role particularly responsibility to their family. In addition, I showed that access to formal health services is also mediated by practical concerns about the potential outcomes of a visit to the doctor. Men were particularly concerned about being admitted to hospital and worried about being given a diagnosis. This undermines their sense of self-reliance.

In chapter seven, I described how men required strong reason(s) to legitimise their engagement with formal health care services. The existence of chronic health problems, acute needs like injury, work-place requirements to receive medical check-ups, experience of severe pain, the expenses of treatment and avoidance of disheartening significant others were all factors that legitimise men's access to formal health care services. In such circumstances, *Ikhtiar* is no longer a block to seeking help. Men seem to convert the requirement of *Ikhtiar* to a different form of self-reliance which requires them to access help in order to avoid further complications that can further compromise masculinity by threatening capacity to discharge their gendered roles and responsibilities.

It was also found that wives and family members play an important role in influencing men's engagement with formal health services. Women reported that encouraging men to do this is exhausting but accepted that it is their role as a wife/ mother. Wives ensure men are keeping well and seeking proper health help so as to avoid further complications to their husband's or son's health. Men tended to comply, albeit not straightaway, as they know they need to be healthy to 'be a man'. The act of persuading by women and complying by men was viewed conjointly as an expression of love and care for each other.



Through constant comparison of the three categories in chapter five, six and seven, theoretical coding was conducted to identify a core category. This endeavour resulted in constructing the 'theory of negotiation: bargaining and compromising', as a core category. This was presented in chapter 8.

## **9.4 IMPLICATIONS FOR THE DEVELOPMENT OF THEORY**

While the concept of hegemonic masculinity may account for men's poor health seeking behaviour and practices in the UK and other western countries, its utility and relevance has only been tested in a limited way in other cultural contexts. Indeed any simplistic application is now starting to be critically challenged in more recent men's health research (Connell & Messerschmidt, 2005). It is less well understood how gender, ethnicity and other wider social and cultural determinants of health intersect and relate to each other and how this subsequently informs men's health seeking behaviour and health care utilisation.

In chapter two of this thesis I presented a critical review of the academic literature aiming to investigate how gender and ethnicity intersects with other psychosocial parameters in informing Asian men's health seeking behaviour. From the review, it was found that being able to fulfil masculine norms and discharge the social responsibilities associated with manhood was a priority for Asian men. Asian men see being the breadwinner and leader who provides food and shelter for their family as important and potentially compromised by ill-

health. Therefore, they would seek help in the case of experiencing ill-health, which somewhat contrasts with the majority of findings from Western literature relating to white men. It may be that the pace and nature of social and cultural change in gender roles and relationships accounts for some of this difference.

It was also found that culture influences men's views about their role and important attributes as a man, the context of how men view masculinity, their degree of comfort and sensitivity in talking to friends or a GP regarding an existing medical or psychological problem and the appropriateness of health help seeking.

Additionally, the review revealed that the influence of masculinity is mediated by other social and psychological factors. Age, level of knowledge, cultural ideals and adherence to masculinity are factors that men take into account in making their decisions to access health care. Further, it has been shown that the idea of how men seek health help and use healthcare services is highly context dependent. Results vary across different times, contexts and settings. Again this highlights the heterogeneity of masculinity and how it influences health help seeking behaviour and ultimately challenges any assumption about the straightforward universal application of the hegemonic masculinity theory without reference to culture.

What is now clear with regard to theorising Bruneian men's health and help seeking is the following:

- The meaning of masculinity and men's beliefs, values and life experiences influence their perceptions of health, illness and the decisions that they make about healthcare access and engagement. When men can no longer fulfil their obligations, they are motivated to seek health care. The conceptual model presented in chapter eight (Figure 8.2) illustrates the interrelatedness of identity, manhood and its influences on health and illness. This strong connection may or may not be true universally, however it is integral to a man's identity in Bruneian culture. A man's beliefs and behaviour are a reflection of how he perceives himself in society. This is true for health belief and behaviours when he determines that health care is needed. Illness to a Bruneian man results in an impairment or a threat to his manhood. To regain his sense of identity he will seek help in restoring his health and thereby his ability to be a man. However, their adherence to the masculine trait of being self-reliant and strong often makes engaging with formal health services a last resort. It is therefore the case that in broad terms the findings from research conducted in the western world that identify men as reluctant users of health care services applies just as much to Bruneian men. However, what is significant is how men operate in those times of illness and mobilise/renege their masculinity. On this point a basic premise of hegemonic masculinities is in tension with the findings of my research. Adherence to ideal masculine traits, executing uniquely culturally and socially embedded masculine roles and finding strong reasons are major components that men take into consideration when they experience an episode of ill-health. As much as men least favoured engaging with formal health care services, it is often not a definite

straightforward 'no'. Men renegotiate their masculinity and its enactment in this context in subtly Bruneian ways. This I have described as weighing the 'pros and cons' of their action (Figure 8.1). When more advantages are likely to be gained, men would consider going to see their doctor and at the same time mobilise this as a way of fulfilling their masculine responsibilities.

- The key mediating factors are culturally specific and although they do not fall outside the hegemonic masculinities model at a grand theoretical level to understand Bruneian men's health related attitudes and behaviours requires us to understand and to take into account the concept of *Ikhtiar* is and its roots go somewhat beyond gender identity into religious and cultural concepts of personhood and cultural identity.
- The above findings highlight the need to think about the importance of continuing to utilise and elaborate the hegemonic masculinities model outside the context of the Global North. It can be concluded that some aspects of the findings of this study, as previously discussed, can be understood through application of the concept of hegemonic masculinity, but others are highly inflected by culture and setting. In this case, the Bruneian life course transition and associated masculine roles and their influences on health-help seeking and the concept of '*Ikhtiar*'. This, altogether, gives an additional dimension or extension to the hegemonic masculinity model. Furthermore this research demonstrates how other such elaborations can be achieved in other contexts.

## 9.5 IMPLICATIONS FOR POLICY AND PRACTICE

The findings of this study are timely in terms of potential to support and inform development of healthcare policy and practice in Brunei, as the MoH is in the process of upgrading and improving its services, in an attempt to achieve the 2035 vision “*Towards A Healthy Nation*”.

This study found that Bruneian men’s health help seeking behaviours are context-dependent. This context has a number of aspects, which can be broadly regarded as falling under two principal dimensions. This includes firstly, those relating to the structure and provision of health. Secondly, those relating to cultural aspects. Cultural expectations placed on men; in this case, to be a good responsible son, husband, father and grandfather influence their perception of the importance of being healthy. Consequently, this influences their actions in the event of experiencing ill-health symptoms.

To most men, accessing health care services is seen as inconvenient, and worst if it resulted in hospitalisation. Inconveniences caused by admission and being sick include disruption in their income/wages and performing duties like sending and picking up children from school. Furthermore, for the elderly men, engaging with health care services was perceived to make them more likely to subject to medicalisation.

The first group of implications reflect those areas of the findings of this study that relate most closely to the development and enhancement of health promotion policy and practice. These areas are as follows:

(1) The results of this study clearly mandate a gender-sensitive focus and approach to health promotion activities.

- A key component would be to make men an explicit focus for health promotion such that the perceived imbalance, which primarily targets women, is redressed. Male participants in this study suggested that the majority of health promotion activities currently in place target women. This would seem to be borne out by the active promotion of awareness of breast cancer and cervical cancers in Brunei (Jalil, 2016; Mahmud, 2014).
- Activity relating to raising awareness about prostate cancer and testicular cancer is far lower in quantity and frequency. The focus seemingly largely falls in November to align with the international Movember<sup>16</sup> campaign. It could be that campaigns need to be year round, to target specific men's health issues and also acknowledge that generic conditions and concerns affect men as well as women.

2) To use the information about Bruneian masculinities gained from this study to shape the messaging, services and engagement activity targeting men, health promotion needs to be cognisant that:

- Men regard physical fitness as central to the way that define and understand their health-status and this in turn is associated with culturally

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<sup>16</sup> Movember is a worldwide campaign to raise awareness about men's health, prostate, testicular and mental health issues. This takes place in the whole month of November. Men grow a 'mo' (Australian slang for moustache) for charity in a bid to raise awareness of this men's health issue.

embedded assumptions about the male role in social, relational and family life. To talk about bodily fitness may be a 'hook' for working with men but it is only a surface concern connected to profound issues of gender and identity.

- Men may seem to consider their health in terms of their own bodily function and health status but its significance in terms of the transactions within relationships, especially with female partners mean that health promotion for men may consider the role that women play in influencing men's health action.

3) Health promotion practice and policy needs to take into account men's reluctance and the practical obstacles that they may face in accessing formal health services situated in clinics and hospitals. There may be merit in considering outreach activities such as offering health checks in occupational settings. These sessions could become legitimizing gateways and referral points to other services.

4) Making regular health check ups a workplace requirement should be explored. Men reported attending hospitals for check ups when their employer requires it. Bruneian men perceive engagement with occupational health check-ups as non-threatening to their masculinity because in this context maintenance of health is linked to the gendered expectations of job retention.

- Initiatives such as the '3PK' screening programme launched by the MoH in 2015 may provide the model for further workplace-based health screening and promotion. 3PK aims to detect non-communicable chronic

diseases in their early stages amongst those over the age of 40 years old. Under this programme, healthcare professionals go to different Government ministries to provide health check ups for all civil servants, particularly to those who are not known to suffer from chronic illnesses and not on the database of clients receiving treatment (Kamit, 2015). In Australia, it was reported that using informal locations such as at the workplace was successful for male outreach services. In Australia the outreach health check-up program, which targeted male blue - collar workers called the '*Tradies tune up*', reported near 100% take up for the screening at their various sites (Baird, 2012).

- The use of media and digital technologies should also be fully explored. This should not only be limited to television and radio but also modern technologies such as the Internet. Modern technologies offer some strategies that may help to overcome barriers to access health care services and health information for men. The data in the study albeit not exclusively shared in the interview, shows how young men use the Internet to achieve easy and quick access to advice and information about health. Furthermore, reflecting on my experience during the recruitment phase of this study, the Internet was found to be most effective in reaching a wider population.
  
- Men's preference for using modern technology should be exploited and of the potential of digital media for the dissemination of information about health promotion and service provision explored. Brunei, rates as one of the highest users of *Facebook* in Asia (Hayat, 2012). This could be used



as an opportunity to reach men in the country. Digital social media platforms can be used disseminate information on service provision and for health promotion purposes. Social media such as Facebook, Twitter and Youtube has been used in Australia where reports emerged suggesting that it was particularly appealing for younger men (Woods, 2014).

5- Health promotion and information provision needs to be linked to service development. This study implies the following:

- Waiting time. Healthcare settings practice a triage system whereby they prioritise which patient to see first. This triaging procedure may not be understood by patients. Therefore, an explanation of this system maybe helpful in increasing male patient understanding of the factors which affect waiting times.
- For non-emergency cases in the health care centre, a numbering system is used, which operates on a first come first served basis. The inconvenience of waiting could be reduced by sending notifications to men via their phone telling them when it is their turn to see the healthcare professional. This system is widely used in business premises and the potential for transference to the healthcare setting should be explored.
- Extension of the fast tracking for the older men (above 60 years old) initiative could help to cut down waiting time at the health centres and

out-patient departments. Where this exists, it was noted that this is poorly understood by men and warrants better promotion.

- The number of health centres that offer extended opening hours and are open on Friday and Sunday should also be increased to meet demands. This would appear to be more attractive to men, especially those who work office hours from Monday to Thursday and Saturday.

### **Social and welfare provision:**

Improving health promotion and enhancing service provision also needs to be coupled to areas of development of social and welfare support.

- Establishing easily accessible health support. This is especially important since participants raised concerns that as awareness of ill-health increases so too does anxiety if they do not have any access to further information and support. This was particularly evident with respect to cancer.
- There is a need to establish better financial support for those patients in need. Participants commonly experienced disruption of their everyday routine and a negative impact on income (particularly for men who were self employed) resulting in admission to hospital. The availability of financial support to assist them would lessen their concerns reduce the obstacle to service use and anxieties about seeking professional help.

- Social support could also be extended to patients and family because when men were admitted to hospital the disruption extended to their families where the impact was felt on issues such as providing transport for children to and from school as well as loss of household income.

### **Healthcare workforce development:**

This would be particularly relevant to UBD as the provider for training of healthcare professionals in Brunei. From the study we can see that there is clearly scope to consider how healthcare professionals in Brunei are trained to better engage and support men in the clinical encounter and setting. A key component might be to utilise the findings of this study to develop a training package, which raises awareness and understanding of men's concerns about service access. This could also aim to increase their understanding of masculinities and capacity and confidence to provide a gender sensitive approach.

I would like to recommend that attention is given to the following areas:

- Improve doctor-patient communication. Most participants felt the communication between the healthcare professionals and men is now rather limited and not to their satisfaction. Enhancing the doctor-patient relationship is likely to improve both satisfaction and outcomes. It may also impact on men's future attitudes towards healthcare providers and services. Evidence indicates that patient-centred communication whereby healthcare professionals

communicate effectively with the patient and involve patients in the consultation process is significant towards building a therapeutic relationship (Pinto et al., 2012).

- Men did not always fully understand the rationale for being prescribed medication by their doctor. There is therefore scope for misunderstanding surrounding the usefulness of the medications. Improving patient understanding of prescriptions is of the paramount importance.

6- Consideration should be given to expanding the role of the pharmacist in the community setting. Many participants preferred to buy their medication 'over the counter' as this was regarded by them as far more convenient than visiting the doctor. This creates scope to enhance the service provided by pharmacists, as a means of ensuring accurate and accessible advice is available to men. Additional contingent benefits may include the opportunity to refer or signpost men to other health services and reduction of the pressure on hospitals/clinics. There is scope to enhance professional confidence and competence in working with men through training. It is recommended that all courses for health professionals should include a module or section on gender and health including masculinities.

To conclude, this study provides entirely new insights into issues around men's health help seeking in Brunei, and, elaborating and developing the dominant theoretical understanding of the interlocking of masculinities and

health proposed by the concept of 'hegemonic masculinities'. The study shows that Bruneian masculinity and health cannot be accounted for in general terms by an approach characterised by an understanding of hegemonic masculinities but there are similarities and differences in the ways that plays out in Brunei and other contexts where the concept has been applied.

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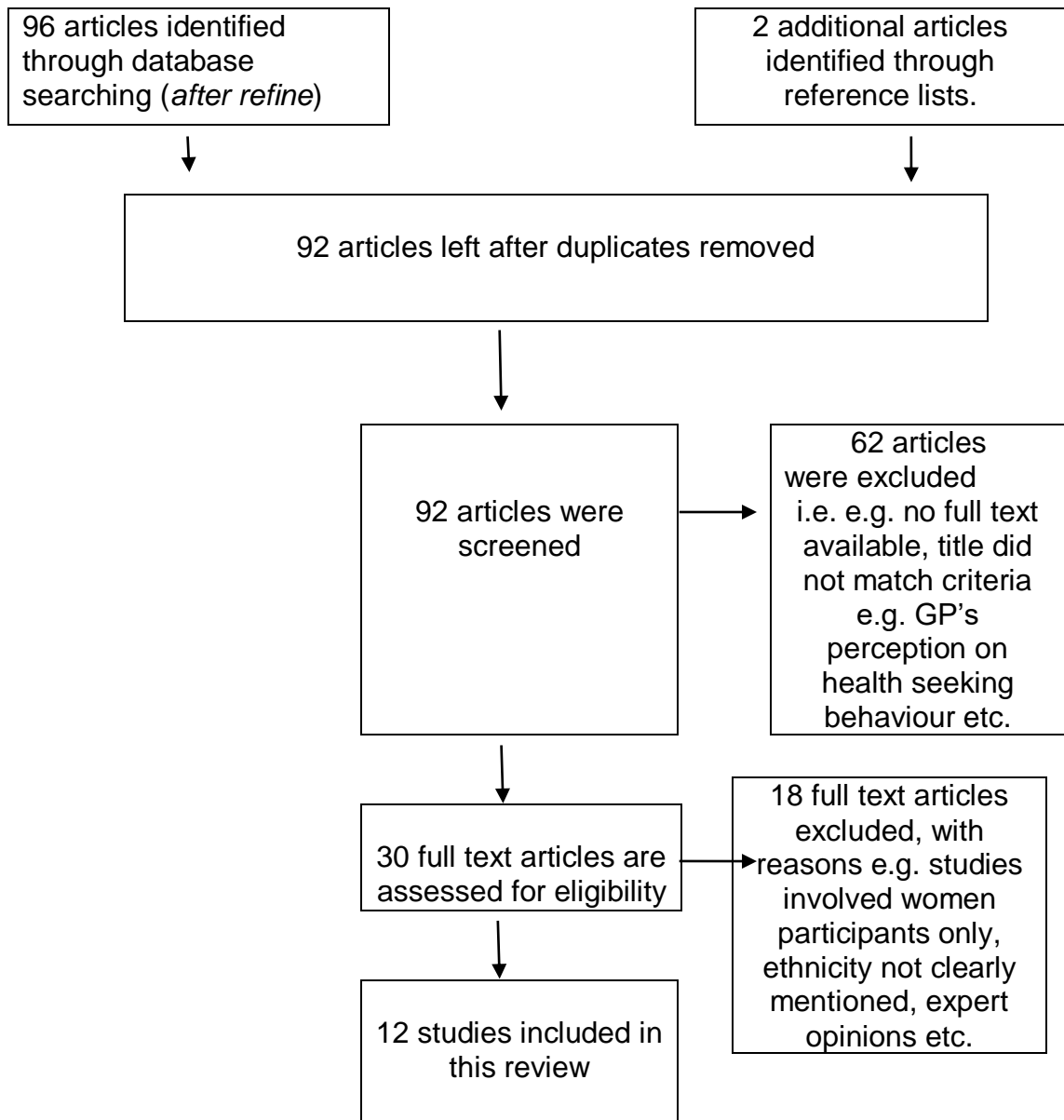
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**Appendix 1: Systematic search using database such as Medline, CINAHL and PsycINFO using EBSCOhost**

|    | Query                                                | Limiters/Expanders                                                                                                                                                                                                                                                                                                           | Last Run Via                                                                                                                                                               | Results |
|----|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| S6 | (health seeking behaviour)<br>AND (S1 AND S2 AND S5) | Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Boolean/Phrase                                                                                                                                                                                                           | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 96      |
| S5 | health seeking behaviour                             | Limiters - Linked Full Text<br>Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Find all my search terms                                                                                                                                                                  | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 22,637  |
| S4 | (TX asian men)<br>AND (S1 AND S2)                    | Limiters - Linked Full Text<br>Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Boolean/Phrase                                                                                                                                                                            | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 206     |
| S3 | (TX asian men)<br>AND (S1 AND S2)                    | Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Boolean/Phrase                                                                                                                                                                                                           | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 206     |
| S2 | TX asian men                                         | Limiters - Linked Full Text;<br>Language: English;<br>Language: english; Human;<br>Sex: Male; Human; Sex: Male; Age Related: All Adult: 19+ years; Language: English; Population Group: Male<br>Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Find all my search terms | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 10,512  |
| S1 | SU health help<br>OR health seeking                  | Limiters - Linked Full Text;<br>Language: English;<br>Language: english; Human;<br>Sex: Male; Human; Sex: Male; Age Related: All Adult: 19+ years; Language: English; Population Group: Male<br>Expanders - Apply related words; Also search within the full text of the articles<br>Search modes - Find all my search terms | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search Database - eBook Collection (EBSCOhost);Anthropology Plus;CINAHL;MEDLINE;PsycARTICLES;PsycINFO | 25,411  |



**Appendix 2: VISUAL REPRESENTATION OF THE SELECTION PROCESS  
FOR PAPERS INCLUDED IN REVIEW**



### APPENDIX 3: Summary of studies included in the review

| AUTHORS                    | TITLE/DESIGN                                                                                              | SAMPLE                                                                                                                                                                                                                                                                                                                                | INSTRUMENTS/TOOLS                                                                                                                                                                                                                                                                                                                                                                                               | ANALYSIS                                                                                                                                                                                    | RESULTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (1). Vogel & Wester (2014) | Referring men to seek help: The influence of gender role conflict and stigma.<br><br>Design: Quantitative | N= 216 male college students in Psychology or communication classes at a large Midwestern university.<br><br>Breakdown:<br>n= 85% European American<br>n= 3% Asian American<br>n= 3% Latino American<br>n= 3% multiracial American<br>n= 2% African American or Black<br>n= 1% native American<br>n= 3% other international students. | Questionnaires, which includes:<br>(1) 16 items Gender Role Conflict Scale (measures negative cognitive, emotional and behavioral consequences associated with male gender role socialization).<br>(2) 12 items Stigma using the Perceived Devaluation-Discriminations scale<br>(3) 7-item measure assessing willingness to encourage others to talk about mental health issues or seek mental health services. | Statistical analysis was performed.<br><br>The Full Maximum Likelihood method in the LISREL 8.8 program was used to examine the measurement of the structural models used for the analysis. | Men are unlikely to refer friends and family members to mental health service because it go against the traditional male gender role stereotypes regarding men talking to other men about emotional issues.<br><br>Men who show greater restricted emotionality were less willing to refer friends and family members experiencing mental health concern to seek treatment. Likewise men who endorsed greater stigma in relation to mental health issue would also very unlikely to refer friends and family members to seek for help. |

| <b>AUTHORS</b>                  | <b>TITLE/DESIGN</b>                                                                                                      | <b>SAMPLE</b>                                        | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>ANALYSIS</b>                                                                                                                                                                                                                                                   | <b>RESULTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (2) Zhang, Yu, He, & Jin (2014) | <p>Help seeking behavior for erectile dysfunction (ED): a clinical based survey in China</p> <p>Design: Quantitative</p> | 2693 Chinese men recruited from a Outpatient clinic. | <p>Questionnaire survey of ED patients was used. Questionnaire needs to be done while they were at the clinic.</p> <ul style="list-style-type: none"> <li>• Patients were asked how long they were aware of their erectile problem and whether they had sought help or advice from a variety of sources.</li> <li>• Patients were also asked about the first method they used to treat ED and their reason for using it. If patients did not take any action to treat ED, they were asked why.</li> <li>• Patients were asked whether they consulted a physician about their sexual problems in the last 3 months, or in the next 6 months.</li> </ul> | The prevalence of a specific characteristic was calculated by dividing the number of cases by the corresponding population. All analyses were conducted using the Statistical Package for the Social Sciences (SPSS), version 16.0 (SPSS Inc., Chicago, IL, USA). | <p>Age: Older patients claimed that they would first seek help from physician unlike young ED patients, whom would first go to internet.</p> <p>Perceived severity also plays factor – most perceived ED is not serious hence, not seeing their physician.</p> <p>Culture: unlike Western men, Chinese men would first refer to their physician /internet before talking to their partners as they regarded men talking to their partners about sexual problem as in adequate – “having no self confidence as a man”.</p> |

| <b>AUTHORS</b>                                   | <b>TITLE/DESIGN</b>                                                                                                                                                | <b>SAMPLE</b>                                                                                                                                                                                 | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                         | <b>ANALYSIS</b>                                                                                                                                                                          | <b>RESULTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (3) Huang, Appel, Nicdao, Daniel Lee & Ai (2012) | Chronic conditions, behavioral health and use of health services among Asian American men: The first nationally representative sample.<br><br>Design: Quantitative | Nationally representative sample of =998 from National Latino and Asian American Study (2002 – 2003).<br>Breakdown:<br>n= 284 Chinese<br>n= 235 Filipino<br>n= 243 Vietnamese<br>n= 236 other | Self reported questionnaire on the following:<br>Chronic conditions<br>Behavioural and drug and substance use.<br>Mental health issue based on DSM-IV.<br>Service seeking frequency including mental health service use and visits to physician and mental health professionals. | Statistical descriptive analysis was performed for selected variables. Chi-square tests were performed to check the variables.<br><br>All analyses were performed using SPSS version 18. | No ethnic subgroups differences in most of the physical and chronic conditions except for hay fever, arthritis, asthma and blood pressure.<br><br>Health seeking behaviours varied among the various ethnic groups but overall Asian Americans man reported low levels of health care seeking patterns. This could be due to distrust or stigma attached to seeking services, lack of English proficiency and culturally insensitive providers. |

| <b>AUTHORS</b>                       | <b>TITLE/DESIGN</b>                                                                                                                              | <b>SAMPLE</b>                                                                                                                                                                                                                                                                                                                           | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>ANALYSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>RESULTS</b>                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (4) Soorkia, Snelgar & Swami (2011). | Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain.<br><br>Design: Quantitative | N= 148 (81 women, 67 men). All participants were born and raised in Britain.<br>Breakdown:<br>41.9% Indian,<br>20.8% Pakistani<br>6.8% Bangladeshi<br>30.4% other South Asian descent.<br><br>Breakdown in terms of religion are as follows:<br>45.9% Hindus,<br>36.5% Muslims<br>6.1% Christians<br>11.5% other religious affiliation. | Questionnaire which comprises:<br>(1) Attitudes towards seeking professional psychological help scale (ATSPPH) – 29 items rated on a 4 point Likert type scale<br>(2) Asian values scale – 36 items rated on 7 point Likert type scale<br>(3) Cultural Mistrust Inventory- 46 items rated on a 10 points Likert type scale.<br>(4) Multi group Ethnic identity measure – 12 items rated on a 4 point Likert type scale<br>(5) Demographics | Priori power analysis (G* Power V.3.0), which indicate their sample size.<br><br>All remaining analyses were conducted using SPSS v. 16.0. This includes:<br>- Analyses of variance (ANOVAs) to examine between-group Differences (sex: women versus men; ethnicity: Indian versus Pakistani versus Other)<br>All correlations between<br>- All variables were computed. Hierarchical multiple regression to examine<br>- predictors of ATSPPH were performed. | South Asian men and women in this study reported negative attitudes towards seeking psychological help. Women are more positive towards seeking psychological help than men. Greater adherence to Asian values was negatively associated with attitudes towards psychological help seeking. This is likely due to shame and stigma associated with mental illness and psychological help seeking amongst South Asian . |

| <b>AUTHORS</b>                                           | <b>TITLE/DESIGN</b>                                                                                                                                                                           | <b>SAMPLE</b>                                                                                                                                                                                                                                                                    | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                                                                                                                 | <b>ANALYSIS</b>                                                                                                                                                                            | <b>RESULTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (5) Vogel, Heimerdinger-Edwards, Hammer & Hubbard (2011) | <p>“Boys don’t cry’: Examination of the links between endorsement of masculine norms, self stigma and help seeking attitudes for men from diverse background.</p> <p>Design: Quantitative</p> | <p>Men recruited via internet websites. N= 4,773 ranged in age from 18 to 79. Breakdown: n= 3,471 European American n= 479 Asian American n= 348 Latino American n= 226 African American n= 192, Multi racial n= 27 native Americans n= 30 did not indicate their ethnicity.</p> | <p>Questionnaires, which were completed online. These comprises:</p> <ul style="list-style-type: none"> <li>- Conformity to dominant masculine gender role norms.</li> <li>- Self-stigma of seeking helps scale.</li> <li>- Attitudes towards seeking professional psychological help scale.</li> <li>-Centre of epidemiological studies of depression scale.</li> </ul> | <p>Procedure to check for outliers was performed. If outliers were found, those cases were removed from subsequent analysis.</p> <p>Analysis of variance (ANOVA) was also carried out.</p> | <p>Differences were found among ethnic groups of men.</p> <p>Conformity to dominant masculine norms-stigma relationship was weaker for African American then for European American men. Men of colour often marginalized from hegemonic European American culture, and create tension between dominant and culture of origin gender role. Thus, they identified less with certain dominant cultural views of masculinity and instead define their masculinity by their own cultural values. Asian American also shares the similar findings with African American men, as they adopt their own set of unique masculine ideas.</p> |

| <b>AUTHORS</b>           | <b>TITLE/DESIGN</b>                                                                                                                                                                                     | <b>SAMPLE</b>                                                                                                         | <b>INSTRUMENTS/TOOLS</b>                                                                                                             | <b>ANALYSIS</b>                                                                                                                                                                                                                                                                             | <b>RESULTS</b>                                                                                                                                                                        |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (6) Ng, Tan & Low (2008) | <p>What do Asian men consider as important masculinity attributes? Findings from the Asian Men's Attitudes to Life Events and Sexuality (MALES) Study.</p> <p>Design: Quantitative, cross sectional</p> | 5 Asian countries participated (China, Japan, Korea, Malaysia and Taiwan), involving 10,934 men aged 21 -75 years old | Computer assisted telephone interviews and street interceptions were used. Standardized questionnaire based on MALES study was used. | <p>Analysis was done using statistical analysis method.</p> <p>Masculinity traits were presented as percentages in descending order. Descriptive comparisons of the frequency of masculinity traits across the five countries and in different age groups are presented as percentages.</p> | Findings vary across the 5 countries, which reflected the 'heterogeneity' of the Asian population but overall, Career, honour, Control, Family and all cited Money as most important. |

| <b>AUTHORS</b>                          | <b>TITLE/DESIGN</b>                                                                                                                           | <b>SAMPLE</b>                                                                                                                                                                                                                                                               | <b>INSTRUMENTS/TOOLS</b>                                                                                              | <b>ANALYSIS</b>                                                                                                                                                                      | <b>RESULTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (7) Galdas, Cheater and Marshall (2007) | <p>What is the role of masculinity in South Asian men's decisions to seek medical help for cardiac chest pain?</p> <p>Design: Qualitative</p> | <p>Participants were theoretically sampled by age, socioeconomic status, ethnicity, experience of chest pain and route taken to access to health care services.</p> <p>N= 56 men comprises White (n=36), Indian (Sikh n= 5 and Hindu n= 3) and Pakistani (Muslim n= 12)</p> | <p>Interviews were conducted in English using semi structured interview guide at participant's hospital bedsides.</p> | <p>Interviews were audio recorded, transcribed verbatim and imported into QSR Nvivo V.4.0. Data were analysed using three stage coding process in accordance to Grounded Theory.</p> | <p>Men's ethnicity and culture influence their representation of masculinity and further shaped men's medical help seeking response to chest pain. Ability to tolerate pain and discomfort was valued as masculine attribute to white men but not by the Indian and Pakistani men. South Asian men find it is gender appropriate to seek health help unlike the white men as they seen it as weak.</p> <p>For the South Asian, wisdom, education and responsibility for the family and their own health are important masculine attributes. This all together contributes to greater willingness to seek medical help.</p> |



| AUTHORS                                                                                           | TITLE/DESIGN                                                                                                                         | SAMPLE                                                                   | INSTRUMENTS/TOOLS                                                                                   | ANALYSIS                                                                                                                                                                                                                                                       | RESULTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (8) Taylor, Mcgrother, Harrison, Assassa & The Leicestershire MRC Incontinence Study Team (2006). | Lower urinary tract symptoms and related help seeking behaviour in South Asian men living in the UK.<br><br>Design:<br>Quantitative. | 7810 men were included. Out of this, 409 were Asian, 7401 are White men. | Participants were sent a postal questionnaire addressing urinary symptoms, bother and help seeking. | Prevalence rates of self reported lower urinary tract symptoms were compared on the basis of the Office of Population Censuses and Surveys ethnic classifications.<br>- Logistic regression was used to estimate the relative risk of symptoms between groups. | Symptoms were significantly higher in Asian men.<br>- Reported levels of bother were the same in both population groups, but actual help seeking was significantly less in Asian groups which could probably be due to social influence. It could either be because of the extended family that most Asian people have in the UK, they tend to receive more support from their family, although there is evidence that this is not the case.<br><br>Also cultural differences play a role in the case of urinary symptoms in determining men's willingness to discuss symptoms with family members or others.<br>25% of the South Asian said they actually had sought help in comparison to the 53% of the white men who had sought for help (p=0.001). |

| <b>AUTHORS</b>                                         | <b>TITLE/DESIGN</b>                                                                                                                                       | <b>SAMPLE</b>                                     | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                            | <b>ANALYSIS</b>                                                                                                                                                                  | <b>RESULT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (9) O'Brien, Hunt & Hart (2005)<br>Design: Qualitative | "It's a caveman's tuff, but that is to a certain extent how guys still operate: men's accounts of masculinity and help seeking<br><br>Design: Qualitative | N=55 men.<br>Asian men n=4.<br>Scottish men n=51. | 14 focus groups (FG) were conducted. Out of this 1 FG were a group of Asian men. Diversity sought in samples by age, occupation, socioeconomic background and current health status | Focus groups were audio recorded and transcribed verbatim. These transcripts were read and analysed to look for themes. Discussions were done among the team to agree on themes. | It endorses 'hegemonic ideology of masculinity especially among younger men in the study. Some instances its view as acceptable to seek for help especially when it is perceived as a means to preserve or restore another e.g. For work – fire fathers (need to be fit to retain work), or maintaining sexual performances, common to those with prostate cancer Men with sexual health problem rather consult their GP than put it in a greater jeopardy by not able to have sex. |

| <b>AUTHORS</b>                                        | <b>TITLE/DESIGN</b>                                                                                                                                            | <b>SAMPLE</b>                                                         | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>ANALYSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>RESULT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (10) Nicolosi, Glasser, Kim, Marumo & Laumann (2004). | Sexual behavior and dysfunction and help seeking patterns in adults aged 40 – 80 years in the urban population of Asian countries.<br><br>Design: Quantitative | N= 6700, comprises n=3350 men n= 3350 women with response rate of 27% | Random population survey was carried out among urban residents aged 40 – 80 years in China, Taiwan, South Korea, Japan, Thailand, Singapore, Malaysia, Indonesia and the Philippines.<br>The questionnaire elicited demographic details, health, relationships, sexual behaviour, attitudes and beliefs.<br>Subjects were asked if they had engaged in sexual intercourse during the past year. Those who reported having a sexual dysfunction were asked whether they sought help or advice from a series of sources. Subjects with sexual dysfunction who did not consult a physician were asked the reason for not doing so. | Qualitative analysis was presented in forms of percentages and graphs.<br>The prevalence of a specific characteristic was calculated by dividing the number of cases by the corresponding population. The denominator for the calculation of the prevalence of sexual dysfunctions was the number of sexually active people (i.e. at least one episode of intercourse during the previous year). The prevalence estimates were age-standardized using the age distribution of the entire study population (by gender when appropriate) and are presented with 95% CI | Several sociocultural factors appear to be preventing individual from seeking medical help for sexual dysfunction problem. This applies for both men and women.<br><br>-Most of sexually active men and women sought no help or advice for their problem.<br>- Southeast Asian countries reported making use of family/social support.<br><br>- Lack of perception of their problem or belief that it is not a medical problem causing men and women for not consulting doctor in all countries. |

| <b>AUTHORS</b>                           | <b>TITLE/DESIGN</b>                                                                                                    | <b>SAMPLE</b>                                                                                                                                                                                                                                                                           | <b>INSTRUMENTS/TOOLS</b>                                                                                                                                                                                                                                                                                                     | <b>ANALYSIS</b>                                                                                                                                                                                                                                             | <b>RESULT</b>                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (11) Chaturvedi, Rai & Ben-Shlomo (1997) | Lay diagnosis and health care seeking behavior for chest pain in South Asian and Europeans<br><br>Design: Quantitative | 2000 people were randomly selected from GP's list in London to receive 2 sets of questionnaires, 1 questionnaire each time. Eventually only 903 responded. n=553 were European origin (237 men, 316 were women), n=124 Hindu (52 men, 72 women), n= 235 were Sikh (110 men, 125 women). | Two sets of questionnaire. 1st questionnaire – scenario of a man with angina pain was given and respondents were asked how they would react if they were experiencing the same. 2nd questionnaire- medical history, attitudes to health and demography. This questionnaire was adapted from British Social Attitudes Survey. | Quantitative data analysis was carried out and result was presented in forms of statistical information. Variables were tested and calculation for sample size was done. Multivariate analysis and calculated odd ratios and 95% CI by logistic regression. | It was found that South Asian was more anxious about the pain than would the European. - 55/553 (23%) European men, 20/124 (38%) Hindus, and 52/235 (47%) Sikh men said they would seek immediate care. Of women, 24%, 35%, 46%, respectively (both men and women). This basically means that Hindus and Sikh were reported to have a greater likelihood of seeking immediate care for angina symptoms than European. |

| AUTHORS                          | TITLE/DESIGN                                                                                                   | SAMPLE                                                                                                                                                          | INSTRUMENTS/TOOLS                                                                 | ANALYSIS                                                                                                                                                                                                                                                    | RESULT                                                                                                                                                                  |
|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (12) Gillam, Jarman & Law (1989) | Ethnic differences in consultation rates in urban general practice.<br><br>Design: Quantitative, retrospective | Patients registered with the practice in London Borough of Brent during the 23 months to April 1981 who accounted for 67 197 consultations. N= 10 877 patients. | Retrospective data from one practice were collected from the period of 1979-1981. | Quantitative analysis was conducted.<br><br>Ethnic state, sex and social class distribution, and diagnosis of patients consulting and frequency of consultations analysed as standardised consultation ratios and standardised patient consultation ratios. | Compared with other ethnic groups male Asian showed a much higher consultation rates. Consultation rates for mental disorders were reduced in all of immigrant descent. |



## **Appendix 5:**

### **PARTICIPANT INFORMATION SHEET – INDIVIDUAL INTERVIEW**

#### **STUDY TITLE: “HEALTH SEEKING BEHAVIOUR HEALTH HELP SEEKING BEHAVIOUR AND HEALTH CARE UTILISATION OF BRUNEIAN MEN”.**

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

The following are some of the basic questions that you may have regarding this study.

#### **Who am I?**

I am Mr Deeni Rudita Idris, a government officer currently undergoing my ‘In service Training’ and doing my PhD in Health Science at Durham University, United Kingdom. This study is part of my PhD program at this university.

#### **Why is this study important and what is its purpose?**

Some people say unlike women, men are likely to involve in behaviors that have been shown to damage their health e.g. cigarette smoking. Men also often decline to take part in activities that are good to their health and men use health services less frequent than woman and even if they do visit their doctor, it tends to be much later leading to poorer health outcomes. Many studies have been carried out to find out the reasons behind this but they are all derived from the West. Therefore, this study will give access to Bruneian men’s experiences and perception on this matter and subsequently, provide an opportunity to address the health needs of Bruneian men. Additionally, also bringing in Bruneian’s women’s perspective on this issue further enhances this study.

#### **Why have you been invited to take part in this study?**

You are suitable because you are....

- You are a man or a women of 18 years of age or above
- Can speak either Malay or English language
- You are either Malay or Chinese or from any indigenous groups of Iban, Dayak or Kelabit
- You were born in Brunei or have been residing in Brunei for more than 10 years (Permanent resident)

### **Will this study benefit you?**

This is the very first study of its sort ever conducted in Brunei! You will be the voice for men in Brunei and your participation will provide us with access to studying the health needs and concern of Bruneian men.

### **Do I have to take part?**

It is up to you to decide to join the study. I will describe the study and go through this information sheet. You do not have to make your decision now. After this session, I will give you a copy of this information sheet to take home. You will have time to think and decide if you want to get involved. Should you wish to get involved, please do contact me (email: [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or sms/Whatsapp me +6737105109). I will arrange time for us to meet and you will ask you to sign a consent form to indicate you have agreed and volunteered to participate in the study prior to the interview. A copy of the signed consent form will be given to you and one copy will be kept for the researcher's study file. Some socio-demographic data will also be obtained from you before the interview.

### **What if you changed your mind or don't want to be involved?**

Volunteers are free to withdraw from the study at any time. However data/ information collected from you will still be used for the study up the point of your withdrawal. No new data will be collected from you after your withdrawal. If you are a participant, please talk to me if you wish to withdraw. I may ask you why you are leaving the study. Explaining why will help me when designing future studies. However, you do not have to give any reasons for your withdrawal if you do not want to.

### **How will this study be done?**

It will involve the use of individual interview and group discussion, both of which will be audio-recorded. I will meet you in an agreed place and time as per your convenience, preferably public open places e.g library. During this session, I will ask you few questions and make some notes. It is estimated it will takes about 40 – 50 minutes.

The following is some of the potential questions that I may be asking you during the session. It is my intention to provide you with these questions prior to the session so that you have time to think about them. There is no right answer to these questions. So you DO NOT have to worry.



**Potential questions:**

1. *“What does being healthy mean to you?”. Please explain.*
2. *“How do you know when someone (you) is healthy?”. Please explain.*
3. *“Being a Malay/Chinese/Iban/Kelabit/ Dayak, what do you or men normally do if you are not feeling well?”. Please explain.*
4. *“ Do you go to see your GP if you’re not well?”*
5. *“ Describe the situation when you would see your GP?”.*
6. *“What do think about men going to the GP when they are not well?”. Please explain.*
7. *“When was the last time you saw your GP?”*
8. *“How was your experience seeing your GP/using the health care services?”. Please describe this experience.*

**What will happen to the information that you have given in the interview?**

All recorded interviews and information obtained from this study will be handled safely and in strict manner as accordance to guideline by Data protection Act, UK (1998).

The data from the recorded interview can be used and shared for publications and/or meetings/ conferences/ seminars/ workshops. Additionally, apart from this study, the information collected from this study may also be used for any other future publication or relevant research purposes.

**Are there any risks or hazards involved?**

NO risk is involved. The interviews will be conducted at place of your choosing preferably, public places e.g. library or community centre, it can also be done at your home, should you wish to do so.

**Will people be able to find out your details because of this study?**

Apart from the researcher and his team, no one will find out about your details. Your details will be kept confidential and code will be used to protect your identity.

**Are there any payment involved in this study for the participants? Will you be paid by taking part in this study?**

No expenses is involved in the study and no money can be offered to your participation. However it is my intention to provide each participant with a meal voucher as a token of appreciation and my ‘thank you’ for your participation.

**What will happen to the result of the research study?**

The results will be used in writing the full thesis of this PhD at Durham University and hopefully for publication in journal as well. I will also send you the summary of the study by the end of this PhD project in 2017.

**Who is organizing and funding the study?**

The sponsor of this study is Durham University. The Brunei High Commission in London covers the financial aspect of the study.

**Who has reviewed this study?**

This study has been reviewed and approved by the School of Medicine, Pharmacy and Health ethics sub-committee, Durham University.

**Further information and contact details.**

Should you wish to have further information regarding this study or wish to talk to someone on anything about the study, please do not hesitate to contact me at +6737105109 (call/ SMS/Whatapps) or **email:** [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or **Facebook:** [www.facebook.com/dean.pgr](http://www.facebook.com/dean.pgr)

## **Appendix 6:**

### **PARTICIPANT INFORMATION SHEET – FOCUS GROUP WITH MEN**

#### **STUDY TITLE: “HEALTH SEEKING BEHAVIOUR HEALTH HELP SEEKING BEHAVIOUR AND HEALTH CARE UTILISATION OF BRUNEIAN MEN”.**

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

The following are some of the basic questions that you may have regarding this study.

#### **Who am I?**

I am Mr Deeni Rudita Idris, a government officer currently undergoing my ‘In service Training’ and doing my PhD in Health Science at Durham University, United Kingdom. This study is part of my PhD program at this university.

#### **Why is this study important and what is its purpose?**

Some people say unlike women, men are likely to involve in behaviors that have been shown to damage their health e.g. cigarette smoking. Men also often decline to take part in activities that are good to their health and men use health services less frequent than woman and even if they do visit their doctor, it tends to be much later leading to poorer health outcomes. Many studies have been carried out to find out the reasons behind this but they are all derived from the West. Therefore, this study will give access to Bruneian men’s experiences and perception on this matter and subsequently, provide an opportunity to address the health needs of Bruneian men. Additionally, also bringing in Bruneian’s women’s perspective on this issue further enhances this study.

#### **Why have you been invited to take part in this study?**

You are suitable because you are....

- You are a man of 18 years of age or above
- Can speak either Malay or English language
- You are either Malay or Chinese or from any indigenous groups of Iban, Dayak or Kelabit
- You were born in Brunei or have been residing in Brunei for more than 10 years (Permanent resident)

### **Will this study benefit you?**

This is the very first study of its sort ever conducted in Brunei! You will be the voice for men in Brunei and your participation will provide us with access to studying the health needs and concern of Bruneian men.

### **Do I have to take part?**

It is up to you to decide to join the study. I will describe the study and go through this information sheet. You do not have to make your decision now. After this session, I will give you a copy of this information sheet to take home. You will have time to think and decide if you want to get involved. Should you wish to get involved, please do contact me (email: [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or sms/Whatsapp me +6737105109). I will arrange time for us to meet and you will ask you to sign a consent form to indicate you have agreed and volunteered to participate in the study prior to the group discussion/focus group. A copy of the signed consent form will be given to you and one copy will be kept for the researcher's study file. Some socio-demographic data will also be obtained from you before the interview.

### **What if you changed your mind or don't want to be involved?**

Volunteers are free to withdraw from the study at any time. However data/ information collected from you will still be used for the study up the point of your withdrawal. No new data will be collected from you after your withdrawal. If you are a participant, please talk to me if you wish to withdraw. I may ask you why you are leaving the study. Explaining why will help me when designing future studies. However, you do not have to give any reasons for your withdrawal if you do not want to.

### **How will this study be done?**

It will involve the use of individual interview and group discussion, both of which will be audio-recorded. I will meet you in an agreed place and time as per your convenience, preferably public open places e.g library. During this session, I will assigned you randomly in a group comprises of 4 to 6 men having the same ethnic background as you. I will ask you and the group few questions to discuss and I will make some notes. It is estimated it will takes about 40 – 50 minutes. The following is some of the potential questions that I may be asking you during the session. It is my intention to provide you with these questions prior to the session so that you have time to think about them. There is no right answer to these questions. So you DO NOT have to worry.

**Potential questions:**

1. *“What does being healthy mean to you?”. Please explain.*
2. *“How do you know when someone (you) is healthy?”. Please explain.*
3. *“Being a Malay/Chinese/Iban/Kelabit/ Dayak, what do you or men normally do if you are not feeling well?”. Please explain.*
4. *“ Do you go to see your GP if you’re not well?”*
5. *“ Describe the situation when you would see your GP?”.*
6. *“What do think about men going to the GP when they are not well?”. Please explain.*
7. *“When was the last time you saw your GP?”*
8. *“How was your experience seeing your GP/using the health care services?”. Please describe this experience.*

Some ground rules will also be set prior to conducting the focus group. As I do not want to overwhelm you with all the information, I will brief you on this on the day itself. It is pretty straightforward, so do not worry.

**What will happen to the information that you have given in the group discussion/ ‘focus group’?**

All recorded interviews and information obtained from this study will be handled safely and in strict manner as accordance to guideline by Data protection Act, UK (1998).

The data from the recorded interview can be used and shared for publications and/or meetings/ conferences/ seminars/ workshops. Additionally, apart from this study, the information collected from this study may also be used for any other future publication or relevant research purposes.

**Are there any risks or hazards involved?**

**NO** risk is involved. The interviews will be conducted at place of your choosing preferably, public places e.g. library or community center, it can also be done at your home, should you wish to do so.

**Will people be able to find out your details because of this study?**

Apart from the researcher and his team, no one will find out about your details. Your details will be kept confidential and code will be used to protect your identity.

**Are there any payment involved in this study for the participants? Will you be paid by taking part in this study?**

No expenses is involved in the study and no money can be offered to your participation. However it is my intention to provide each participant with a meal voucher as a token of appreciation and my 'thank you' for your participation.

**What will happen to the result of the research study?**

The results will be used in writing the full thesis of this PhD at Durham University and hopefully for publication in journal as well. I will also send you the summary of the study by the end of this PhD project in 2017.

**Who is organizing and funding the study?**

The sponsor of this study is Durham University. The Brunei High Commission in London covers the financial aspect of the study.

**Who has reviewed this study?**

This study has been reviewed and approved by the School of Medicine, Pharmacy and Health ethics sub-committee, Durham University.

**Further information and contact details.**

Should you wish to have further information regarding this study or wish to talk to someone on anything about the study, please do not hesitate to contact me at +6737105109 (call/ SMS/Whatapps) or

**Email:** [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or

**Facebook:** [www.facebook.com/dean.pgr](http://www.facebook.com/dean.pgr)

## **Appendix 7:**

### **PARTICIPANT INFORMATION SHEET – FOCUS GROUP FOR WOMEN**

#### **STUDY TITLE: “HEALTH SEEKING BEHAVIOUR HEALTH HELP SEEKING BEHAVIOUR AND HEALTH CARE UTILISATION OF BRUNEIAN MEN”.**

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

The following are some of the basic questions that you may have regarding this study.

#### **Who am I?**

I am Mr Deeni Rudita Idris, a government officer currently undergoing my ‘In service Training’ and doing my PhD in Health Science at Durham University, United Kingdom. This study is part of my PhD program at this university.

#### **Why is this study important and what is its purpose?**

Some people say unlike women, men are likely to involve in behaviors that have been shown to damage their health e.g. cigarette smoking. Men also often decline to take part in activities that are good to their health and men use health services less frequent than woman and even if they do visit their doctor, it tends to be much later leading to poorer health outcomes. Many studies have been carried out to find out the reasons behind this but they are all derived from the West. Therefore, this study will give access to Bruneian men’s experiences and perception on this matter and subsequently, provide an opportunity to address the health needs of Bruneian men. Additionally, also bringing in Bruneian’s women’s perspective on this issue further enhances this study.

#### **Why have you been invited to take part in this study?**

You are suitable because you are....

- You are a woman of 18 years of age or above
- Can speak either Malay or English language
- You are either Malay or Chinese or from any indigenous groups of Iban, Dayak or Kelabit
- You were born in Brunei or have been residing in Brunei for more than 10 years (Permanent resident)

### **Will this study benefit you?**

This is the very first study of its sort ever conducted in Brunei! You will be the voice for men in Brunei and your participation will provide us with access to studying the health needs and concern of Bruneian men.

### **Do I have to take part?**

It is up to you to decide to join the study. I will describe the study and go through this information sheet. You do not have to make your decision now. After this session, I will give you a copy of this information sheet to take home. You will have time to think and decide if you want to get involved. Should you wish to get involved, please do contact me (email: [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or sms/Whatsapp me +6737105109). I will arrange time for us to meet and you will ask you to sign a consent form to indicate you have agreed and volunteered to participate in the study prior to the group discussion/focus group. A copy of the signed consent form will be given to you and one copy will be kept for the researcher's study file. Some socio-demographic data will also be obtained from you before the interview.

### **What if you changed your mind or don't want to be involved?**

Volunteers are free to withdraw from the study at any time. However data/ information collected from you will still be used for the study up the point of your withdrawal. No new data will be collected from you after your withdrawal. If you are a participant, please talk to me if you wish to withdraw. I may ask you why you are leaving the study. Explaining why will help me when designing future studies. However, you do not have to give any reasons for your withdrawal if you do not want to.

### **How will this study be done?**

It will involve the use of individual interview and group discussion, both of which will be audio-recorded. I will meet you in an agreed place and time as per your convenience, preferably public open places e.g. library. During this session, I will assigned you randomly in a group comprises of 4 to 6 women having the same ethnic background as you. I will ask you and the group few questions to discuss and I will make some notes. It is estimated it will takes about 40 – 50 minutes. The following is some of the potential questions that I may be asking you during the session. It is my intention to provide you with these questions prior to the session so that you have time to think about them. There is no right answer to these questions. So you DO NOT have to worry.



**Potential questions:**

1. “What do you generally think about men and their health seeking behaviour?”  
Please explain.
2. “What do you think a Malay/ Chinese/Iban/ Dayak/Kelabit men would usually do if they are not well?”. Discuss (this can be based on your own experiences with your husband/ son/ male siblings/male acquaintances)
3. “What is your opinion or experiences on men and the way they seek help from healthcare services?”. Please discuss.

Some ground rules will also be set prior to conducting the focus group. As I do not want to overwhelm you with all the information, I will brief you on this on the day itself. It is pretty straightforward, so do not worry.

**What will happen to the information that you have given in the group discussion/ ‘focus group’?**

All recorded interviews and information obtained from this study will be handled safely and in strict manner as accordance to guideline by Data protection Act, UK (1998). The data from the recorded interview can be used and shared for publications and/or meetings/ conferences/ seminars/ workshops. Additionally, apart from this study, the information collected from this study may also be used for any other future publication or relevant research purposes.

**Are there any risks or hazards involved?**

**NO** risk is involved. The interviews will be conducted at place of your choosing preferably, public places e.g. library or community center, it can also be done at your home, should you wish to do so.

**Will people be able to find out your details because of this study?**

Apart from the researcher and his team, no one will find out about your details. Your details will be kept confidential and code will be used to protect your identity.

**Are there any payment involved in this study for the participants? Will you be paid by taking part in this study?**

No expenses is involved in the study and no money can be offered to your participation. However it is my intention to provide each participant with a meal voucher as a token of appreciation and my 'thank you' for your participation.

**What will happen to the result of the research study?**

The results will be used in writing the full thesis of this PhD at Durham University and hopefully for publication in journal as well. I will also send you the summary of the study by the end of this PhD project in 2017.

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**Who has reviewed this study?**

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**Further information and contact details.**

Should you wish to have further information regarding this study or wish to talk to someone on anything about the study, please do not hesitate to contact me at +6737105109 (call/ SMS/Whatapps) or

**Email:** [d.r.idris@durham.ac.uk](mailto:d.r.idris@durham.ac.uk) or

**Facebook:** [www.facebook.com/dean.pgr](http://www.facebook.com/dean.pgr)

## Appendix 8:

### CONSENT FORM

**Full Title of Project:** "Health help seeking behaviour and health care utilisation of Bruneian men".

**Name of Researcher:** Deeni Rudita Idris

Please initial the boxes to confirm you agree with each statement.

|                                                                                                                                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. I confirm that I have read and understand the information sheet dated 13 <sup>th</sup> October 2014 (Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory.                                        |  |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. I understand and information collected up until the point of my withdrawal will be kept and used as part of the research. |  |
| 3. I understand that by taking part in this research, I will be interviewed and I agree that the interview can be audio recorded                                                                                                                                                               |  |
| 4. I agree to the use of my anonymised quotes when this research is published.                                                                                                                                                                                                                 |  |
| 5. I agree to take part in the above study.                                                                                                                                                                                                                                                    |  |

**Name of participant:**

**Date:**

**Signature:**

**Name of person taking consent (Researcher):**

**Date:**

**Signature:**

**Participant identification number (*for researchers to fill in only*):**

*When completed 1 copy for participant, 1 for researcher study file.*

## Appendix 9:

List of health centres in Brunei Darussalam and contact person.

### Location: Brunei Muara district:

| NO | NAME OF HEALTH CENTRES                  | PERSON IN-CHARGED                             |
|----|-----------------------------------------|-----------------------------------------------|
| 1  | Pusat kesihatan Bandar Seri Begawan     | SSN Hajah Kamsiah Bte Amat                    |
| 2  | Pusat kesihatan Gadong                  | No Dyg Cathrina Bte Hj Sigie Al-Islam         |
| 3  | Klinik Perubatan Polis                  | SN Adlina Bte Dayem                           |
| 4  | Pusat kesihatan Berakas A               | NO Hjh Jamilah Bte Sulaiman                   |
| 5  | Pusat kesihatan Berakas B               | SN Hj Marsallehan Bin Omar                    |
| 6  | Pusat Kesihatan Muara                   | SCHN Dyg Siti Noor Dzuhardah Bte Hj Awg Damit |
| 7  | Pusat kesihatan Pengkalan Batu          | SCHN Norhaslina Bte Jamil                     |
| 9  | Pusat kesihatan Jubli Perak, Sengkurong | No Hjh Ramlah Bte Kisut                       |
| 10 | Pusat kesihatan PAPRSB, Sg Asam.        | SSN Noriah Bte amat                           |

### Location: Tutong district:

| NO | NAME OF HEALTH CENTRES       | PERSON IN-CHARGED                                                  |
|----|------------------------------|--------------------------------------------------------------------|
| 1  | Pusat kesihatan Pekan Tutong | No Hjh Dang Rani Bte Hj Suhaili                                    |
| 2  | Pusat kesihatan Telisai      | SCHN Dyg Kolinmo Yumni Bte Abdul Aliy Yuin @ Kolinmo Bte Yuin/Owin |
| 3  | Klinik Perubatan Lamunin     | SCHN Hjh Asmah Bte Hj Ali                                          |
| 4  | Pusat kesihatan Sg Kelugos   | SCHN Hajah Norhani Bte Hj Sidi                                     |

### Location: Kuala Belait district:

| NO | NAME OF HEALTH CENTRES                                     | PERSON IN-CHARGED                          |
|----|------------------------------------------------------------|--------------------------------------------|
| 1  | Pusat Penjagaan kesihatan Asasi (OPD), Kuala Belait Tutong | No Hjh Saritah Bte Hj Suhaili              |
| 2  | Pusat kesihatan Seria                                      | SCHN Noraini Bte Majid                     |
| 3  | Klinik Perubatan Sg Liang                                  | Dayang Hjh Norazarenawati Bte Hj Abd Malik |
| 4  | Pusat kesihatan Labi                                       | SN (CH) Hjh Napisah Bte Hj Damit           |

### Location: Temburong district:

| NO | NAME OF HEALTH CENTRES            | PERSON IN-CHARGED      |
|----|-----------------------------------|------------------------|
| 1  | Pusat kesihatan Bangar, Temburong | SSN Norsiah Bte Ismail |

**Appendix 10:** Details of men involved in individual interview.

| NO | CODE     | MARITAL STATUS | AGE | ETHNICITY      | PREVIOUS MEDICAL/ SURGICAL HISTORY   | OCCUPATION            |
|----|----------|----------------|-----|----------------|--------------------------------------|-----------------------|
| 1  | Ali      | Single         | 21  | Kedayan        |                                      | Undergraduate student |
| 2  | Khairul  | Single         | 21  | Melayu Brunei  |                                      | Undergraduate student |
| 3  | Syawal   | Single         | 43  | Melayu Brunei  | Back injury                          | Teacher               |
| 4  | Bakar    | Single         | 23  | Melayu Brunei  |                                      | Undergraduate student |
| 5  | Abdullah | Single         | 38  | Melayu Kedayan | Ankylosing spondylitis, Hypertension | Lecturer              |
| 6  | Mohd     | Single         | 29  | Melayu Brunei  |                                      | Healthcare prof.      |
| 7  | Muiz     | Single         | 19  | Melayu Tutong  |                                      | HND business student  |
| 8  | Yusof    | Married        | 60  | Melayu Brunei  |                                      | Retired - BSP         |
| 9  | Syafie   | Married        | 65  | Melayu brunei  |                                      | Retired               |
| 10 | Hassan   | Single         | 18  | Melayu brunei  |                                      | Undergraduate student |
| 11 | Khairul  | Single         | 31  | Melayu Brunei  |                                      | Teacher               |
| 12 | Musa     | Married        | 49  | Melayu Belait  |                                      | Government servant    |

Cont..

| NO | CODE     | MARITAL STATUS | AGE | ETHNICITY      | PREVIOUS MEDICAL/ SURGICAL HISTORY                          | OCCUPATION                                               |
|----|----------|----------------|-----|----------------|-------------------------------------------------------------|----------------------------------------------------------|
| 13 | Isa      | Married        | 30  | Melayu Brunei  |                                                             | Army                                                     |
| 14 | Sulaiman | Single         | 26  | Melayu Murut   |                                                             | Healthcare Professional                                  |
| 15 | Daud     | Married        | 32  | Melayu Belait  |                                                             | In media/ news reader                                    |
| 16 | Ahmad    | Single         | 24  | Melayu Dusun   | Asthma                                                      | Undergraduate student                                    |
| 17 | Ramli    | Married        | 66  | Melayu Kedayan | Osteoporosis, Hypertension, DVT. He had angioplasty in 2013 | Retired                                                  |
| 18 | Idrus    | Married        | 43  | Melayu Brunei  |                                                             | Self employed                                            |
| 19 | Khalil   | Married        | 37  | Melayu Belait  |                                                             | Army                                                     |
| 20 | Lee      | Married        | 50  | Chinese        |                                                             | Government officer                                       |
| 21 | Jonathan | Single         | 33  | Chinese        |                                                             | Lecturer                                                 |
| 22 | Yap      | Single         | 18  | Chinese        | Diabetes                                                    | Undergraduate student                                    |
| 23 | Noh      | Single         | 22  | Iban           |                                                             | Undergraduate student/ work part time at private company |

## Appendix 11:

Details of the participants for the focus groups, including pilot (men's' group).

| <b>NO</b> | <b>CODE</b> | <b>RESEARCH ACTIVITY REFERENCE</b> | <b>MARITAL STATUS</b> | <b>AGE</b> | <b>ETHNICITY</b> | <b>EDUCATION LEVEL</b> |
|-----------|-------------|------------------------------------|-----------------------|------------|------------------|------------------------|
| 1         | Adam        | Pilot (Focus group 1)              | Single                | 18         | Melayu Brunei    | Diploma                |
| 2         | Taufiq      | Pilot (Focus group 1)              | Single                | 25         | Melayu Brunei    | Degree                 |
| 3         | Ishak       | Pilot (Focus group 1)              | Single                | 26         | Melayu Brunei    | Degree                 |
| 4         | Salleh      | Pilot (Focus group 1)              | Single                | 20         | Melayu Tutong    | Diploma                |
| 5         | Khalid      | Pilot (Focus group 1)              | Single                | 19         | Melayu Murut     | Diploma                |
| 6         | Naim        | Focus group 2                      | Married               | 31         | Melayu Brunei    | Degree                 |
| 7         | Siddiq      | Focus group 2                      | Single                | 30         | Melayu Brunei    | Diploma                |
| 8         | Fahmi       | Focus group 2                      | Single                | 31         | Melayu Brunei    | Diploma                |
| 9         | Izam        | Focus group 3                      | Single                | 27         | Iban             | Diploma                |
| 10        | Adi         | Focus group 3                      | Married               | 76         | Iban             | Primary                |
| 11        | Nazir       | Focus group 3                      | Married               | 59         | Iban             | Primary                |
| 12        | Rezal       | Focus group 3                      | Married               | 50         | Iban             | Secondary              |

## Appendix 12:

Details of women participated in the focus group.

| <b>NO</b> | <b>CODE</b> | <b>RESEARCH ACTIVITY<br/>REFERENCE</b> | <b>MARITAL<br/>STATUS</b> | <b>AGE</b> | <b>ETHNICITY</b> | <b>EDUCATION<br/>LEVEL</b> |
|-----------|-------------|----------------------------------------|---------------------------|------------|------------------|----------------------------|
| 1         | Wina        | Focus group discussion no. 1           | Divorced                  | 43         | Melayu Belait    | Secondary                  |
| 2         | Nisa        | Focus group discussion no. 1           | Married                   | 56         | Melayu Belait    | Secondary                  |
| 3         | Mona        | Focus group discussion no. 1           | Married                   | 43         | Melayu Belait    | Secondary                  |
| 4         | Farah       | Focus group discussion no. 1           | Married                   | 56         | Melayu Belait    | Secondary                  |
| 5         | Lina        | Focus group discussion no. 2           | Married                   | 73         | Iban             | Low Primary                |
| 6         | Nora        | Focus group discussion no. 2           | Married                   | 44         | Iban             | Secondary                  |
| 7         | Yana        | Focus group discussion no. 2           | Married                   | 45         | Iban             | Secondary                  |
| 8         | Rina        | Focus group discussion no. 2           | Married                   | 49         | Iban             | Secondary                  |



### Appendix 13:

Details of participants involved in dyadic interview.

| <b>NO</b> | <b>CODE</b> | <b>GENDER</b> | <b>RESEARCH ACTIVITY<br/>REFERENCE</b> | <b>MARITAL<br/>STATUS</b> | <b>AGE</b> | <b>ETHNICITY</b> | <b>EDUCATION<br/>LEVEL</b> |
|-----------|-------------|---------------|----------------------------------------|---------------------------|------------|------------------|----------------------------|
| 1         | Samsul      | Male          | Dyadic interview                       | Married                   | 60         | Melayu Tutong    | Primary                    |
| 2         | Najib       | Male          | Dyadic Interview                       | Married                   | 68         | Melayu Tutong    | Primary                    |
| 3         | Sara        | Female        | Dyadic interview                       | Married                   | 59         | Chinese          | Secondary                  |
| 4         | Lisa        | Female        | Dyadic Interview                       | Divorced                  | 51         | Chinese          | Secondary                  |

## APPENDIX 14:

### **“Self certified sick leave for government servants**

When this thesis was written (towards its completion), the MoH Brunei Darussalam has started to introduce “*Self certified sick leave*” or known as “*Cuti Sakit disahkan sendiri (CSDS)*” for all government servants.

This policy says that, government servants are no longer required to present a sick certificate to their department for any sick leave not longer than two consecutive days. CSDS allows them to just call-in sick and informed their Head of Department about their absence. Only those requiring sick leave of more than two consecutive days are required to see their doctor and obtain an MC.

This was made effective from 1<sup>st</sup> September 2016 (Jabatan Perdana Menteri Brunei Darussalam, 2016). This was done as an incentive to help to reduce/ stop the abuse of MC and reduce unnecessary trip to the health centres.

Based on the official announcement made by the Prime Minister office, Brunei (Jabatan Perdana Menteri Brunei Darussalam, 2016), the following is what this new policy entitles.

- *CSDS is limited to six days in a year.*
- *The number of CSDS leave taken will be deducted from the annual leave allowed of the individual government servant. This is to prevent misuse of CSDS leave and unnecessary non-urgent consultation with GP at health centres.*
- *If more than 2 consecutive days of leave are required, a qualified doctor need to verified this. For this reason, a medical certificate is necessary. If medical certificate is present then this will not be deducted from the annual leave.*
- *This only applies to ‘minor illnesses’ (refer to Table below for list of these minor illnesses) that can be self treated and controlled using over-the-counter drugs.*
- *To take a CSDS leave, employee only required to called in sick and informed their head of department, on the same day (not more than 24 hours)*

List of minor illnesses that fit for CSDS

| <b>Types of minor illnesses</b>                       |
|-------------------------------------------------------|
| Cough and cold                                        |
| Piles                                                 |
| Gastroenteritis                                       |
| Hay fever                                             |
| Indigestion                                           |
| Vaginal thrush                                        |
| Back pain                                             |
| Tooth ache: * That does not requires tooth extraction |
| Period pain                                           |
| Headache/migraine                                     |
| Sore throat                                           |
| Constipation                                          |
| Neck strain                                           |

**Note:** This list is not exhaustive. These are some of the common health complaints presented at health centre.