

# Constructions of masculinity among a group of South African men living with HIV/AIDS: reflections on resistance and change

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Male sexuality in Africa is often associated with harmful sexual practices, which, in the context of HIV and AIDS, often positions men as central to the spread of the epidemic. Despite this focus on men's practices, there is a lack of research exploring the subject positions of men living with HIV. This study explores how masculinity is constructed by a group of black South African men who self-identify as heterosexual and are living with HIV. Using discourse analysis, a construction of a normative masculinity is identified as being both idealised and perceived as a burden, in that men continually need to engage in actions that affirm their position as 'real' men. By depicting men as invulnerable and unemotional, this construction limits men from acknowledging health risks or accessing support. A second discourse constructs HIV and AIDS as disrupting normative masculinity, in that it restricts men's agency through illness and the need for care. A final discourse relates to a transformed masculinity, where men living with HIV reconstruct their masculinity, as conforming to normative constructions of male identity is perceived as restrictive and harmful.

Keywords: men; masculinity; sexuality; HIV/AIDS; South Africa

## Introduction

In sub-Saharan Africa nearly 60% of people living with HIV are female (UNAIDS 2008), which has resulted in many debates around HIV and gender being focused on women. Women are certainly vulnerable to infection not only because of physiological differences (Goldstein, Pretorius, and Stuart 2003), but also because of power imbalances in their interactions with men and gender inequalities in society. This has contributed to the development of a theme of female oppression in discussions about HIV and AIDS, with very little critical exploration of men's subjectivities. Barker and Ricardo (2005), in a review of young men's constructions of masculinity in the sub-Saharan region, note that most studies focus on examples of prevailing harmful behaviours, with little attention being paid to men who question or contradict dominant norms of masculinity. Research in the context of HIV and AIDS has also perpetuated stereotypes of African male sexuality that posit an exotic, hypersexualised 'other'; a stereotype that still impacts on HIV-related research and policy (Stillwaggon 2003). Overtly negative and simplistic descriptions of masculinity risk positioning men as central to the perpetuation of the epidemic, while simultaneously marginalising men from efforts to curb its spread.

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Theories of masculinity provide a framework to understand the responses and depictions of men in the HIV epidemic. The theoretical approach assumed in this paper is that masculinity is not a fixed, essential identity that all men share, but is instead a fluid and dynamic identity that is socially and historically constructed (Morrell 2001). An idealised normative masculinity mingles with local ideas of masculinity and produces new expressions of what it means to be a man within a certain culture (Cornwall and Lindesfarne 1994). Masculinity is thus constructed in the face of a multitude of influences, such as race and class, and certain life events may also contribute to the complex environment in which gender identity is negotiated (Morrell 2001).

Attempts to provide more sophisticated accounts of men's position in the epidemic can benefit from acknowledging this complexity. It is also useful to explore the possibility that men might respond to the challenges posed by HIV and AIDS in varying and potentially liberating ways. Kometsi (2004, 24), referring to the HIV/AIDS epidemic, states how 'illness seems to interfere with the script of being a "real" man' where men are expected to be invulnerable. It is possible that being HIV-positive is the kind of life experience that prompts transformations in constructions of masculinity or allows for the opportunity to reflect on matters such as sexual practices and gender identity. The present study explores the possibilities of such an intersection between HIV and AIDS and masculinity through a qualitative investigation of the reflections of a group of self-identified heterosexual South African men living with HIV.

### Masculinities in sub-Saharan Africa

African masculinities in particular are heavily contested due to the varying influences of race, economics, class, politics, religion and history (Lindsay and Miescher 2003). While acknowledging the plurality of masculinities, certain common practices that contribute to how men construct and reconstruct their masculinity in the sub-Saharan region, and South Africa in particular, can be identified. Ratele (2006) describes a historically ruling masculinity in South Africa that is constituted of 'assertive heterosexuality, control of economic decisions within (and outside) the home, political authority, cultural ascendancy and support for male promiscuity' (51). Having employment and subsequently being financially independent, considered as conditions necessary for being able to start a family, further serve as important signifiers in 'attaining' masculinity (Barker and Ricardo 2005).

In South Africa, this 'ruling masculinity' has developed against the backdrop of the destruction of the material foundation of African masculinity resulting from colonialism and apartheid, which made it difficult for black South African men to attain manhood through traditional signifiers such as paying lobola (dowry) or acquiring land (Hunter 2005). Apartheid also challenged men's role when the displacement of migrant labour caused many fathers to be absent from their families, serving to influence constructions of black South African masculinity (Morrell and Richter 2004). Hunter (2005) traces the historical construction of the *isoka*, the Zulu man with multiple sexual partners, over the last 100 years. This form of masculinity evolved through changing conditions caused by capitalism, migrant labour and Christianity. From the 1970s high unemployment threatened previous expressions of manliness (such as marriage and becoming a household head) – this placed a high value on men seeking multiple partners to compensate for becoming a man through previous means. However, shaken by huge numbers of AIDS-related deaths, men are showing increasing doubts about the *isoka* masculinity. Sideris (2005) also describes how some rural South African men are contesting dominant constructions of masculinity through purposefully negotiating more equal relationships with their partners. These men define themselves as different from the norm in a community where gender-related violence is common.

Although a large body of research focuses on the problematic aspects of men's practice, studies such as those of Hunter (2005) and Sideris (2005) explore opportunities for gender change and transformation of rigid or uncritical masculinities. When considering the implications of exaggerated or ruling masculinities, it becomes clear that men's sexual health is often put at risk through having multiple sexual partners or unprotected sex.

### Masculinities and HIV/AIDS

In considering how dominant constructions of masculinity contribute to HIV and AIDS, Gupta (2000) refers to a 'hydraulic' model of male sexuality that suggests that variety in sexual partners is essential for men to attain sufficient sexual release. Prevailing cultural expectations position men as more experienced and knowledgeable about sex. Such norms put men at an increased risk of contracting HIV by pressuring them into sex to 'prove' their manhood. Expectations of men to be invulnerable can discourage attempts to protect themselves from potential infection, to seek help if they are ill and can lead to denial of their risk (Gupta 2000). Men often neglect to protect themselves through safe-sex behaviours such as condom use as it is seen as inherently unmasculine (Foreman 1999).

Gupta's (2000) ideas provide a framework to view men not only as perpetrators of HIV transmission but also as vulnerable to HIV. In recent years, there has been a growing body of research identifying some of the harmful effects of marginalising depictions of men in the context of HIV/AIDS. Casting men into categories of social deviance or unacceptability can hinder appeals for behavioural change (Wyckoff-Wheeler 2002). Furthermore, the tendency in many HIV-intervention programmes to translate gender into 'women-only' projects, risks creating resentment among men and can fuel negative responses such as domestic violence. This serves to reinforce not only negative behaviour but also negative views of what men are like (Seeley, Grellier, and Barnett 2004).

It has also been noted that by focusing on the position of women in the epidemic, the needs of men who are living with HIV are often overlooked. Men often find support structures such as clinics inaccessible as they are mostly modelled on women's needs (Armstrong et al. 1999), which contributes to men being less likely than women to test for HIV (Barker and Ricardo 2005). Men are also less likely than women to seek help for health-related concerns and access support (Pearson and Makadzange 2008). A lack of support contributes to men living with HIV being at a higher risk for using maladaptive coping strategies such as substance abuse and increased risky sexual behaviour (Olley et al. 2003). Notions of masculinity have clear implications for men's sexual health and a greater understanding of men's realities can benefit the development of programmes aimed at reducing the spread and impact of HIV (Sorrell and Raffaelli 2005).

Despite this growing awareness of the need to explore the complex positions men assume in relation to the epidemic, few studies focus explicitly on the experiences of men who self-identify as heterosexual and are living with HIV. The present study therefore explores how such men construct their masculinity and how their HIV status impacts on their subjectivity as men. It also considers the implications that constructions of masculinity have for men living with HIV, including courses of action available to them, such as accessing support or disclosing their status to others.

## Methods

The study used focus group discussions to collect data and was informed by a social constructionist and discourse analytic framework.

### Selection of participants

Participants were initially selected purposively through networks established by the Centre for the Study of AIDS in an urban area in Tshwane, South Africa. After identifying initial participants in this way, snowball sampling was used. The final group of 13 participants were Black, self-identified as heterosexual, ranged between 35 and 45 years of age and resided in the greater area of Tshwane. Most of the participants (11) were Tswana speakers with one participant indicating Zulu as his home language and another indicating Ndebele. By constituting a group of participants familiar to each other it was anticipated that the conversation would be more spontaneous, thereby reducing the artificiality of the research interview (Willig 2001). The motivation for limiting the study to men who identify themselves as heterosexual was based on the present nature of the HIV epidemic in South Africa, where transmission of HIV is described as occurring mainly through heterosexual intercourse (Walker and Gilbert 2002).

### Data collection

Three focus group discussions, of approximately two-and-a-half to three hours each, were guided by a flexible interview schedule and were facilitated by the first author, a White female fluent in English, as well as a co-facilitator, a Black male fluent in both English and Tswana. Where discussions were conducted in Tswana they were translated into English by the co-facilitator and checked by a second researcher to avoid loss of meaning. The presence of the co-facilitator was particularly beneficial when discussing issues that were mediated by racial or gendered subjectivities as well as where an understanding of the role of local cultural meanings was necessary. In addition to this the first author, as an 'outsider', was able to probe these responses in an attempt to elaborate on some of the statements assumed to be understood by the co-facilitator.

The interview schedule included questions related to men's experiences of their masculinity, living with HIV and their sexuality. It should be noted that none of the participants have English as their first language and where quotes are presented no changes were made so as to preserve authenticity. Field notes were kept to facilitate the process of self-reflexivity, where any events occurring during data collection were recorded and continuous reflection on the researchers' subjectivity was documented.

### Data analysis

A discourse analysis was conducted focusing on how particular discourses privilege or limit certain practices by men, as well as how men are positioned by the different discursive constructions (Parker 1992). It also focused on how discourses around HIV and AIDS reflect on and contribute to constructions of masculinity. The majority of the participants were Tswana speakers and although nuances of Tswana culture were not explicitly analysed, the analysis did consider how participants regard their 'Blackness' in relation to their masculinity, particularly as Black male sexuality has often been uncritically portrayed as part of the 'problem' of HIV and AIDS (Stillwaggon 2003).

To this end, the analysis focused on references to cultural and traditional influences linked to participants' understandings of being Black South African men.

The process of discourse analysis rests on the deconstruction of texts in order to reveal the discourses that operate within the text and, in doing so, challenges the taken-for-granted ways of understanding that are put forward by the discourses (Burr 1996). Discourses are not always discrete from one another and clear distinctions cannot always be drawn through contrast. More often there is an interrelationship between different discourses in an analysis. Discourses at times draw support from other discourses and the analysis allowed for identification of these points of overlap where objects might be constructed as similar by different discourses (Parker 1992).

In the present study, the process of conducting the analysis firstly entailed transcribing the recorded focus group discussions. The transcribed text was then carefully read and reread, following Parker's (1992) suggested steps in conducting a discourse analysis and adapting the steps where necessary. At this stage, all potentially relevant references to masculinity were identified, with the authors deliberately including both frequently occurring statements as well as more marginal ones. These statements were sorted into different categories as they began to emerge. In the final stage of analysis the discourses were reduced to those that related most directly to masculinity and HIV/AIDS. As a further criterion only discourses with sufficient support in the form of statements produced by participants were retained.

## Discussion

Three main discourses were identified that relate to participants' experiences of their masculinity in relation to living with HIV.

### 'My son, he's a real man': constructions of a normative masculinity

Participants drew on a discourse of a dominant idealised masculinity, where masculinity is constructed in terms of what defines being a 'real' man. This normative masculinity is described as being attained through certain practices, such as being a financial provider, being in a heterosexual relationship, getting married and having children. These signifiers dovetail with many of the practices that constitute a Western construction of normative masculinity, but also reflect variations where cultural practices impact on expressions of masculinity. For example, participants often spoke of older men who value a traditional construction of a virile heterosexual masculinity being influential in how they themselves regard their manhood. Participants framed the practices they regard as contributing to masculinity in terms of what their community expects of them as men and indicated that they experience pressure to conform to these expectations. The following statements were supported by most of the participants when asked to describe the role of men in their community:

As a man, as a role, mostly if you didn't get married they expect marriage from you, and another thing, after the marriage they expect a baby. (Group 1)

They expect me as a man to be a person who is going to be employed, getting a job and having responsibilities. And to have a family and to get married. (Group 2)

Within this discourse, attaining these signifiers and conforming to a normative construction of masculinity is viewed as positioning men as being under continual pressure. If, as a man, one cannot attain the signifiers that support this type of dominant masculinity, one's identity and worth as a man is brought into question. Participants described HIV and AIDS as interfering with attaining traditional signifiers of masculinity, in that living with HIV makes it difficult to have an intimate or sexual relationship with a partner and to eventually marry. Having children is also seen as problematic as conceiving a child with an HIV-negative partner introduces a level of risk to the child and the partner:

... since people are being diagnosed you start to have a fear to go through to marriage. Other thing is to make a baby if you're living with HIV/AIDS it's expensive now, if you can get that information on how to make a baby with somebody. Secondly, you'll find that I'm positive and I'm with someone who's negative. Again I'm on a risk, if anything comes, if the condom [breaks] or whatever happens you know, I start to have a risk ... (Group 1)

Participants often drew on the notion that it is normative for men to have multiple sexual partners, which supports the dominant discourse of male sexuality in literature (Gupta 2000). Participants stated the following in support of masculinity being linked to men having several concurrent partners:

But there is still this perception ... that you can't get maybe men having one wife. They are having more than one. Why? Then I can [be seen as being able to] afford to look after those two wives. That tradition and what-what and customs they are still there. (Group 1)

I can relate it to my father, you see. My father, when he's with his friends he will praise me, say 'my son, he's a man, he's a real man'. He doesn't have [only] one woman, he's a real man. (Group 2)

I'm afraid when you see men at home getting married with four wives, and you can ask yourself 'hmm, wow, this man is rolling'. [Laughter] So those are the things that you will never even change, it's the culture. (Group 1)

Participants indicated that within this discourse, men who do not conform to the ideals of masculinity set out by culture and tradition suffer harsh consequences. Men who do not show 'sufficient' interest in women through having several sexual partners or who contest the heterosexual norm through homosexuality, are constructed as 'a problem'. They are viewed as different from the accepted norm and intervention from elders or from traditional healers is required to return the person to what is viewed as 'normal':

In our tradition if you said you don't want [more than one] wife it's an insult. That is an insult, they can throw you out, they can chase you .... Or if you say you are gay, you want to marry a man, whoa! They can kill you, they can definitely kill you. They are going to reject you, they don't want you. (Group 1)

One participant explained how traditional healers might encourage a man to have sexual relations with a woman in order to 're-activate' his interest in women and prove his 'normality' as a man:

They [traditional healers] even try, they will try to bring maybe some of your cousins, or other ladies, maybe something will happen [between you and one of the ladies]. They will try to do that. ... The father will become worried. 'Tell me what is wrong, that my son must be like that, he must be a man'. (Group 2)

Participants further drew on a normative construction of men having authority, particularly in the home. This authority and power is exercised over others, with men making decisions on behalf of wives and children. Speaking about his position in the family a participant stated that 'as the man you are the head of the house and whatever you say goes' (Group 1). This authority is not constructed by participants as oppressive, but instead as being to the advantage of their families. Although this discourse seemingly benefits men through affording them a position of power, participants also stated that living with HIV complicates this position as it disrupts normative constructions of men being in control. By disclosing one's status one has to disclose to others that there is something that one cannot control, that might make one very ill and that might limit one's ability to work and provide for one's family:

Because of men, you see if I can come together with maybe a woman or maybe my wife and say I'm HIV-positive, my status as a man will fall down. They will not respect me anymore. Facilitator: Why do you say that? Because as men, as I'm walking down the street I think I must be recognised as a man. As a person who comes first, everywhere. (Group 2)

Participants emphasised this notion of men needing to present as in control and as invulnerable by drawing on perceived differences between men and women. Participants considered women to be more open about their experiences and more willing to ask for support. A number of participants referred to women addressing health concerns more readily, whereas men will delay seeking help to avoid appearing vulnerable. One participant stated the following in reference to men and women seeking help for health concerns:

Men and women are like that. You [as a man] sit down saying 'tomorrow, tomorrow'. Women don't say tomorrow. If she's having a problem, a headache, she goes to the clinic or the doctor. I spent five days having a chest problem; I went to the doctor yesterday. And then my pain was very severe .... If it was a woman, she won't take five days, the first day she'll go to the doctor, but the man he's still waiting ... (Group 3)

Further supporting a construction of men as invulnerable was the notion that men do not openly express emotions that are associated with weakness. Participants made reference to men not being 'allowed' to cry or reveal emotions such as sadness or fear. The notion of men being unemotional was often supported in the groups through the use of a metaphor of men dying like sheep and not like goats. Participants explained that when a sheep is killed, it does not make a sound, whereas a goat screams when it is slaughtered. Participants used this metaphor to explain how men die without ever releasing their painful emotions:

Now I separate with my girlfriend, see. I go to the room and I'm thinking of separating with that girl. Then my mother she sees me, she says 'what is wrong?' But I don't cry, I don't tell her that I separated with that girl. Even my mother asks me 'where is your partner?' I didn't tell her that we have separated. That is why I cry inside, alone. I keep it secret alone, you see. That is why you die like a sheep. (Group 3)

Participants spoke of the role of men's interaction between generations in maintaining this normative construction of masculinity, with the following statement referring to how men are raised to demonstrate emotional restraint. The following participant links this to the difficulties men have in disclosing their HIV status and asking for support:

I can say that's where you go wrong, because my father would say 'you don't have to cry' ... That is where it started to go wrong. That is why if you are HIV-positive, you cannot say to your girlfriend or your wife, 'my situation is like this'. (Group 2)

Although a normative construction of men being invulnerable, unemotional and in control was supported by most of the participants, there were also instances during the groups where participants indicated a desire to reach out to others and seek support. On these occasions, participants described themselves as afraid, as fearing rejection and fearing a loss of status as a man. This fear is constructed as forcing men into silence, as they cannot reveal any perceived weakness or vulnerability:

Somewhere we are afraid to be left alone. If I can say to my wife [that I have HIV/AIDS] she will leave me, my family will leave me. We are afraid of that, so it's better not to talk. We keep quiet. Maybe say someone they are bewitching me, something like that. (Group 2)



This discourse of a normative masculinity is constructed as both something that men should strive to attain, and as something that appears to restrict or burden men. There is a sense that men feel that it is necessary to conform to this idealised notion of what it means to be a man, but the group discussions also denote that men have an experience of being burdened, through reference to 'expectations' of others that men need to live up to. The normative construction of men being invulnerable and showing emotional restraint also has negative implications for men living with HIV, as in attempting to present themselves as self-reliant or unemotional, men might avoid acknowledging health risks or seeking support.

'You become like a baby': constructions of HIV/AIDS as restricting men's agency

Complementing this discourse of a normative construction of what it means to be a man, was a discourse of HIV and AIDS disrupting men's performance of an idealised masculinity. Participants constructed living with HIV as restricting men's agency and positioning them as helpless and dependent on others. The present discourse is positioned in relation to dominant notions of masculinity that require men to be invulnerable, self-reliant, in control and providers in their families. Men living with HIV are potentially faced with periods of illness where they need to be cared for by others and their ability to be autonomous is compromised when friends and family members responsible for their care begin to take control of decisions that impact on them. In the groups, participants felt this positioned them as a child that needs to be cared for by others; one participant described his interpretation of this by stating that one 'becomes like a baby' (Group 1). The experience of being ill and needing care is seen as encouraging other people such as friends and family members to become overprotective:

Like some of the things, they don't allow me to do. Like maybe if I'll be working they say 'no, no, no. Leave that thing, or do something lighter, that thing is not suitable for you'. (Group 2)

Ja, like now, yesterday I was in the hospital for check-up and she [mother] doesn't allow me go on my own, she says 'no I'm not satisfied, I'm not going to let you go on your own'. (Group 2)

One participant related the loss of agency and resultant dependence on others to the reluctance of men to disclose their HIV status:

So since a person becomes positive he starts to have some little bit of red ball pen outside [motions drawing a boundary around him]. You are no longer walking as free as you are. When I was still working I disclosed to my commissioner and he decided to put me on day shift only and not night shift. When I had to pair with somebody he would say 'No, you can help somebody to carry something to court, not to go outside'. You know, what he was doing was giving me a room that I can play [motions small area]. So sometimes that is why people are still afraid to disclose. Because you can look even for men, mostly men who come out, we are so few. (Group 1)

Although on the face of it, the statements by participants indicate that family members and colleagues are protective and considerate of their health, participants interpreted these gestures to mean that they are less capable as men. In participants' accounts, living with HIV risks rendering them defenceless and reliant on others, which is interpreted as a challenge to normative constructions of what it means to be a man. This experience of being positioned as a child is impacted on by the specific meanings participants attach to moving from boyhood to adulthood. In sub-Saharan Africa, the distinction between being a boy and being a man is emphasised through clearly demarcated cultural rites of passage such as initiation or circumcision (Barker and Ricardo 2005; Kometsi 2004). Attaining masculinity or 'becoming a man' is equated with leaving childhood behind, often through the recognition and sanction of older men who have attained culturally-appropriate adulthood (Barker and Ricardo 2005).



Participants indicated that it is the experience of illness in particular that disrupts normative expectations of men to be invulnerable and self-reliant. Severe ill health and the necessity for care can result in the silence around HIV and AIDS being broken and can force participants to disclose their HIV status and seek help. In this sense, wellness colludes with silence, as men can retain the idea of being invulnerable as long as they are healthy or appear to be so:

A man can be open if he is seriously ill. If he is bed ridden, he can be open. But because of we have ARV's now, and then the ARV's make a person better, and then that person, after being better, you don't see him again, he's gone. (Group 2)

This discourse, which suggests that HIV and AIDS disrupt normative masculinity and restrict agency, was more dominant in the talk of men who have experienced severe ill health as a result of living with HIV, lending further support to the notion that illness challenges men's autonomy, control and invulnerability.

### Constructions of transformed masculinity

This final discourse relates to how men living with HIV reconstruct their masculinity in the face of the challenges posed by HIV and AIDS. This discourse sees men as different if they have redefined their masculinity. This relates to the notion of a transformed masculinity discussed by Mfecane (2007), where he recounts how men living with HIV reject certain aspects of normative masculinity that are seen as jeopardising their health. Mfecane (2007) states that through being faced with illness and other constraints introduced by HIV and AIDS, some men reconstruct their masculinity to avoid harmful practices associated with a normative masculinity.

In the present study, some participants framed this change in their masculinity mostly as it relates to their sexual practices, in that they position themselves as now inhabiting more responsible sexual identities. Participants at times described living with HIV as allowing for a reassessment of practices related to masculinity. Through such a reassessment, a deliberate choice can be made to engage in more responsible practices:

Even me since I'm positive, my life is better than before. Because now, I don't live like that time I was drinking, moving too much girls, you see. My life is better now. (Group 3)

For me, on my side it has totally changed, because I used to have several ladies, and as soon as I realised I had actually contracted HIV I decided to stick to one partner. (Group 3)

In this discourse, changes in participants' experience of masculinity are not simply ascribed to the event of being diagnosed as HIV-positive, but instead to the process of accepting one's HIV status. Participants associated such acceptance with increased knowledge about HIV and AIDS, since men who accept their status can inform themselves about HIV and different ways to manage the disease. In this sense, men who draw on this discourse take up positions that actively claim and express agency; they take control over their lives and over HIV and AIDS through accepting it and thereby challenge notions of HIV and AIDS restricting agency.

Referring to how they negotiate sexual practices while living with HIV, most of the participants stated that it is not an option for them to have sex with someone without using a condom. This was motivated by statements relating to unsafe sex resulting in feelings of guilt for putting someone else at risk:

So even sexuality, you have to go and sit down and say 'this is me, I am positive', then 'this is a condom. This condom can add to the days of my life'. Because now if I sleep with that lady without a condom, and suddenly one day when I call that lady and I find that lady has [contracted HIV]. What am I going to think? I'm the one who caused that, you see? (Group 1)

... so if the condom burst you didn't tell your partner, what is going to happen? [Short silence] Guilty. It's better if you tell that lady from the onset. 'Look my sweet heart, I am HIV-positive. It might happen along the way when we're having sex and then the condom bursts. You must know that I'm HIV-positive.' (Group 1)

In a sense these participants have assumed an activist identity, where they consider themselves as having travelled a journey of sorts since being diagnosed with HIV. The majority of participants were now leading or attending support groups for people living with HIV, working as voluntary counseling and testing counsellors and hosting events that create awareness around HIV and AIDS. Participants spoke of how living with HIV has instilled in them a desire to facilitate change in others. They spoke of their obligation to educate their partners on safer sex practices, and to encourage responsible behaviours such as testing for HIV before having sex:

I can sleep with her, but my issue is going to be like I have to teach her something. Because sometimes when you take the condom it starts to be an issue. Because mostly women they don't want condom, because of lack of knowledge, lack of understanding why condoms are important. (Group 1)

Because now to stop this, to reduce the spread [of HIV], we have to try to convince people to go for HIV tests, because we already know our status. (Group 3)

When discussing how HIV had changed their masculinity, some participants stated that they are more open to discussing problems they are experiencing or ask for support. In this sense they are resisting normative constructions of men being invulnerable by speaking openly about their problems. This notion of being more likely to seek help and address health concerns was shared by a number of participants who felt that they no longer define themselves as rigidly as before. One participant stated the following, when asked if the manner in which he responds, as a man, to his health has changed in the face of living with HIV:

Ja, it has changed. If I have something, I realise I have a sore, then I won't be afraid to ask someone, 'I have this and it gives me a problem'. Then somebody will say, 'no, use this, it can help'. Then from there I'll use that. If that thing cannot help me, they'll refer me somewhere, 'go to such and such a doctor, and the doctor will help you to deal with the problem'. (Group 2)

This discourse of a transformed masculinity illustrates that despite the notion of normative masculinity being reified and presented as natural in society, it can at times be contested. It sits in opposition to dominant discourses that depict male sexuality as reckless or harmful and provides a subject position that allows for alternative courses of action for men living with HIV.

## Conclusion

The study identified three discourses that contribute to constructions of masculinity among self-identified heterosexual men living with HIV. In the unfolding of the discourses, it becomes apparent that all the discourses identified in the groups in fact play themselves out against an idealised or normative masculinity, either in contesting it or providing support. The first discourse, in particular, contributes to such an idealised masculinity, which is constructed by participants as something that is valued but also as a burden in that they continually need to engage in actions that affirm their position as 'real' men. Participants experienced this as a sense of not being able to 'live up to' normative expectations of masculinity that partners, family members and others in their community value.

The analysis also suggests how HIV and AIDS contribute to constructions of masculinity. The second discourse relates to HIV restricting men's agency and one becomes aware of participants' construction of HIV as something that interferes with attaining a normative masculinity. In the final discourse of a transformed masculinity, it becomes clear that HIV and AIDS require participants to re-evaluate their masculinity, as conforming to normative constructions of masculinity is perceived as restrictive and harmful. Such an idealised masculinity prevents participants from accessing the support they need in managing their health and they, therefore, look towards change.

The findings contribute to debates on whether men can change in response to HIV and AIDS. Participants themselves felt that expectations of them to be invulnerable and exhibit emotional restraint prevented them from seeking support or acknowledging potential health risks. This self-acknowledged tension indicates it is valuable and necessary to challenge these constructions. Debates on these constructions could be held in communities in order create opportunities for men to adequately and openly respond to health risks and for women and other social actors to understand that these constructions oppress men and women and may ultimately be detrimental to the health of all.

By exploring how men are affected by living with HIV and how they experience their masculinity as transformed in relation to their status the findings also contribute to debates around increasing options for men to participate in responsible sexual practice. Interventions that emphasise the increased agency afforded through accepting responsibility for sexual health can assist in fostering responsible sexual identities. It could also be useful for programmes to identify men who adopt such identities and to utilise them as peer educators or role models in communities where uncritical and harmful masculinities are dominant. Such programmes also help to challenge views of men as 'perpetrators' and women as 'victims', an unhelpful binary.

Finally, the findings also describe signifiers of masculinity that are potentially harmful to men, where certain high-risk practices, such as having multiple sexual partners, are seen as contributing to normative masculinity. Insight gained in the study regarding such an idealised masculinity is useful in the development of programmes aimed at reducing men's vulnerability to infection. The practices that are seen as contributing to this idealised masculinity can be targeted and other social markers that promote responsible masculinities can be reinforced.

Future research can further explore the contribution that ethnicity makes to how men living with HIV construct their masculinity. The present study did not explicitly examine ethnicity but did note the influence of what participants referred to as cultural and traditional influences linked to being Black South African men. Considering that identities are fluid and overlapping, it is possible that participants in this study invoked their Blackness at some points and their ethnicity at others; it is, however, difficult in this study to tease out the contribution made by ethnicity in particular to understandings of what it means to be a man living with HIV.

Future research can also benefit from exploring how self-identified heterosexual men who have never sought treatment or support in relation to living with HIV construct their masculinity. The participants in the present study were either attending a support group for people living with HIV at the time of data collection or had at some previous point attended a support group. Most of the men had disclosed their HIV status to others and many were receiving anti-retroviral treatment. The advantage of having such a group of participants was that it allowed for an exploration of the discourses drawn on by men who are actively contesting dominant constructions of masculinity by seeking support. It was also possible to explore the potential impact of treatment as it could, in cases where men became well again, result in a return to certain normative practices. Men living with HIV who have never sought support or treatment might reflect different constructions of masculinity and future research can explore this.

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## Re'sume'

La sexualite' masculine en Afrique est souvent associe'e aux pratiques sexuelles ne'fastes qui, dans le contexte du VIH et du sida, placent souvent les hommes dans une position centrale a' l'e'tendue de l'e'pide'mie. En de'pit de cette focalisation sur les pratiques sexuelles des hommes, les recherches manquent sur l'exploration du positionnement des hommes vivant avec le VIH en tant que sujets. Cette e'tude explore comment se construit la masculinite' parmi un groupe d'hommes noirs sud-africains s'identifiant comme he'terosexuels et vivant avec le VIH. Gra'ce a' l'analyse du discours, la construction d'une masculinite' normative est identifie'e comme e'tant a' la fois ide'alise'e et perc'ue comme une charge, en ce que les hommes ont constamment besoin de s'engager dans des actions qui assoient leur position de «vrais» hommes. En pre'sentant les hommes comme des e'tres invulne'rables et non e'motionnels, cette construction est un obstacle a' leur reconnaissance des risques pour la sante' ou a' leur acce's aux services de soutien. Un second discours construit le VIH et le sida comme un bouleversement de la masculinite' normative, en ce qu'ils restreignent la capacite' d'agir des hommes face a' la maladie et a' la ne'cessite' de soins. Un dernier discours renvoie a' la transformation de la masculinite', selon laquelle les hommes vivant avec le VIH reconstruisent leur masculinite', afin qu'elle se conforme aux constructions normatives de l'identite' masculine, avec ses caracte'ristiques restrictives et ne'fastes.

## Resumen

La sexualidad masculina en A'frica se suele relacionar con pra'cticas sexuales dan'inas, lo que en el contexto del VIH y el sida muchas veces significa que los hombres se representan como la causa principal del contagio de la epidemia. Pese a prestar atencio'n a las pra'cticas masculinas, existe una falta de estudios en los que se analice el tema del lugar que ocupan los hombres seropositivos. En este estudio analizamos de que' modo se construye la masculinidad por parte de un grupo de hombres surafricanos de raza negra que se identifican como heterosexuales y son seropositivos. Con ayuda de un discurso anali'tico, se identifica la construccion de una masculinidad normativa que es idealista y percibida a la vez como una carga, en la que los hombres necesitan participar continuamente en acciones que afirmen su posicio'n como hombres "de verdad". Al representar a los hombres como seres no vulnerables ni emocionales, esta construccion les impide reconocer los riesgos para la salud o el acceso a ayuda. Un segundo discurso representa el VIH y el sida como algo que altera la masculinidad normativa porque limita las acciones de los hombres debido a la enfermedad y la necesidad de cuidados. Un discurso final se refiere a una masculinidad transformada en la que los hombres seropositivos reconstruyen su masculinidad, ya que aceptar las construcciones normativas de la identidad masculina se percibe como algo restrictivo y dan'ino.