PINS, 2008, 36, 45-59

LIVING WITH HIV AS A MAN: IMPLICATIONS FOR MASCULINITY

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Abstract.
This article examines constructions of masculinity by men living with HIV and using antiretroviral drugs (ARVs) in a South African rural village. It explores the impact of HIV on men's lives, and discusses the implications of these impacts for understandings of masculinity. A total of 25 men were interviewed to explore their experience of living with HIV and the challenges posed by HIV sickness to their lives as men. Results show that the men's lives changed dramatically following sickness from HIV and that these changes were perceived to negatively impact on various important markers of masculinity. In particular, the men's provider roles and sexualities were perceived as significantly affected by HIV sickness. Drawing on current debates and theorising in the field of masculinity studies, the article interrogates the perceived threats to these markers and the participants' responses to them.

Key words: *masculinity, HIV, ARVs, sexuality*

INTRODUCTION.

Recent research has focused on the concept of masculinity and its relationship to the spread of HIV (Whitehead, 1997; Foreman, 1999; Campbell, 2001; Kometsi, 2004; Leclerc-Madlala, 2005). In general, these studies have shown that men worldwide construct masculinities in ways that may promote risky behaviour, including unsafe sexual practices. Given this problem, recent interventions have targeted men in order to reduce risky sexual behaviour and halt the spread of the epidemic (UNAIDS, 2001). However, men's experience of living with HIV represents a relatively under-investigated area in this literature. This article explores the implications of living with HIV for understandings of masculinity. Other studies have shown that men who live with chronic illnesses experience challenges to the conventional behavioural and attitudinal codes that underlie masculinity. The illness (or its prescribed treatment interventions) may result in outcomes that constrain men from performing certain gender roles assigned to men, thus undermining their construction of ideal masculinity (Charmaz, 1994; Chapple & Ziebland, 2002). Hence, the article grapples with three key questions:

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What kinds of problems do men living with HIV experience? How do their altered lifestyles challenge their masculinity? How do men living with HIV view their own masculinity in the light of such challenges?

In particular, the article focuses on two key markers of masculinity that have been impacted by HIV sickness, and that also constitute two key components of hegemonic masculinity across different contexts, namely (hetero) sexuality and the provider/breadwinner role. In so doing, it argues that men living with HIV and undergoing ARV treatment experience problems and challenges in relation to the traditional expectations of male sexuality and the male role as an independent provider. Specifically, the article unpacks a set of narratives on how these men negotiate the pressures on them to adhere to their treatment while simultaneously maintaining a positive relationship to their constructions of their masculinity.

UNDERSTANDING MASCULINITY.

Masculinity refers to "social roles, behaviors and meanings prescribed for men in any given society" (Kimmel & Aronson, 2000:503). As members of a society, men internalise these "roles" and "meanings", and then reproduce them in practice. Hence, masculinity is not imposed arbitrarily from the top; it is both constructed and lived (Moore, 1994). Scholars now view masculinity as a socially constructed identity rather than a biological attribute (Courtenay, 2000; Nye, 2005). As such, it is culturally relative (Gutman, 1997). Thus, what it means to be a man in one given context might differ from how manhood is measured in other contexts. Connell (1995) has drawn our attention to the fact that even in one cultural setting there are different versions of what it means to be a man. However, despite this diversity in meanings of manhood, there tends to be one form of masculinity that dominates and subordinates others in particular contexts. Hegemonic masculinity, as Connell refers to it, imposes itself as self-given, hence most men aspire to live according to its ideals. Because of this, other masculinities become less visible, and are marginalised.

Some associations have been made between masculinities and men's practices in relation to their bodies and health which have been shown to impact negatively on their general well-being. In the arena of health, dominant forms of masculinity have been shown to present problems with regards to help-seeking in general, where taboos on men seeking health care are present in many societies (Courtenay, 2000). It is argued that the manner in which masculinity is constructed worldwide promotes behaviour that is unhealthy and risky, such as excessive drinking, drug use or abuse and violence (Addis & Mahalik, 2005). There is also a tendency to associate successful masculinity with such attributes as being strong, competitive, daring and stoical (Moyniham, 1998). These attributes and expectations pose problems for men's health as they not only drive "dangerous" practices for men, but further prevent men from seeking help when they are ill or in order to avoid further illness. Rather than seek help, men would rather portray a strong and healthy "front" or seek help only when a problem is too serious to ignore (Courtenay, 2000). Other men may feel embarrassed to be seen at the health/help facilities if their presence in these sectors is interpreted as a sign of weakness.

MASCULINITIES AND HIV IN SOUTH AFRICA.

In South Africa much has been written about the way in which dominant forms of masculinity are interwoven with men's identities and practices (Morrell, 2001; Kometsi, 2004; Walker, Reid & Cornelll, 2004; Reid & Walker; 2005). Moreover, there is a relatively extensive literature base on performances of masculinity in relation to sexuality and the provider role.

Men as providers.

The role of being an independent provider has been shown to constitute a significant part of what it means to be a man in South African communities (Richter & Morrell, 2006). A man gains entry into manhood status by proving that he is able to live independently and provide for himself and his family. In African communities the role of being a provider is linked to being able to set up an independent household, either away from parents or within a bigger extended family (Niehaus, 2004; Hunter, 2006). One of the strategies that men have historically used to achieve independence was migrant work. Migrant work enabled men to gain financial independence which they would use to set up a household, pay *lobola* (bridewealth) and start a family.

Over the past two decades or so, South Africa has experienced dramatic declines in employment, and men have been severely affected. Several mines have been closed, resulting in men returning from migrant work and being unemployed. South Africa now has men in middle adulthood who have never been employed. These developments have severely affected men's positions as fathers, breadwinners and heads of households. Hunter (2004) shows how, due to being unemployed, some men are shunning their roles as providers or even denying paternity due to being unable to pay *lobola*. Moreover, he suggests that this has led to increasing numbers of men choosing to remain single. Wilson (2006) examines the migrant labour system and how it has impacted on fatherhood and the absence of men in households. Men who live away from home cannot play meaningful roles in the rearing of children; poverty exacerbates this absence further and results in increased familial stress.

Recent work shows that men's roles as providers extend beyond the domestic sphere to intimate relationships outside marriage (Hunter, 2002; Niehaus, 2005; Leclerc-Madlala, 2007). There is an expectation that if a man is involved with a sexual partner, he must provide for her material and financial needs. Thus, Niehaus (2005:68) notes, "Non-marital sexual liaisons have a large transactional component. Men are generally expected to provide their lovers and paramours with gifts and to purchase beer for the women they meet in drinking houses". Hence, men are now beginning to measure their masculinity on the basis of their abilities to provide for multiple sexual partners. In this context, men who are poor or financially less well off than others become marginalised as they are unable to attract or retain sexual partners, thus undermining their sense of masculinity.

Sexuality and masculinity.

Research on masculinity in South Africa shows that sex with women constitutes a significant part of men's masculine identities (Leclerc-Madlala, 2001; Wood & Jewkes, 2001; Hunter, 2004). From a young age, boys engage in sex as a means of achieving masculinity and proving sexual prowess to peers (Makhubele, 1999). When young boys do not engage in sex they are negatively labelled and marginalised by others who are

sexually experienced. This then puts pressure on them to engage in sex as a demonstration of masculinity.

Qualitative studies on (hetero) sexuality and masculinities in South Africa highlight the imperatives for boys and men to take multiple sexual partners as a way of proving their masculinity (Woods & Jewkes, 2001; Walker, Reid & Cornell, 2004; Lerclerc-Madlala, 2005; Mfecane, Struthers, Gray & McIntyre, 2005). A man who is involved with many partners perceives himself as "successful" and also receives positive affirmation from peers. Terms such as *Ingagara* (used as a sign of admiration for achieving something), *isoka* and *udlalani* (both referring to playboy, though *isoka* may be broader than that), are used positively in South African contexts (particularly amongst black Africans) to refer to a man who has many partners.

There is also a wide range of contemporary research that explores the way in which dominant practices of male sexuality facilitate the spread of HIV and AIDS (Campbell, 2001; Walker et al, 2004). Research has foregrounded the finding that despite knowing about HIV and AIDS, men continue to engage in multiple partnering as a means of achieving hegemonic masculinity. In fact, the AIDS epidemic seems to have done little to dampen the practice of multiple partnering amongst men (Parker, Makhubela, Ntlabathi & Connolly, 2007). Research further shows that amongst men, some interventions against the spread of AIDS, such as condom use, faithfulness, and monogamy are not viewed favourably, as they contradict the hegemonic conceptions of what it means to be a man (Leclerc-Madlala, 2005).

Given the significance of these two roles in achievement of hegemonic masculinity, what happens when men become ill and possibly unable to perform them? Do they lose their status as men? In the following discussions, these questions are addressed by drawing on the experiences of a group of men who are living with HIV in South Africa. All the men in the study had lost their jobs as a result of HIV and the majority reported being sexually inactive (or having sexual difficulties). The study described below subsequently explored how these men make sense of these losses in relation to hegemonic masculinity.

THE STUDY.

The study was conducted in the rural district hospital in Bushbuckridge, Mpumalanga province, between February 2006 and May 2007. The district is situated approximately 500 km from Johannesburg, South Africa's economic capital. The Bushbuckridge community is amongst the poorest in the country, with over 85% of the population living below the poverty line earnings (less than R19 200 per annum) and only 14% of residents aged between 15-65 are economically active (Business Trust, 2004) Participants, who were all HIV positive, were recruited from a clinic that provides free ARVs from the South African government. The clinic caters for predominantly poor working-class patients; hence the majority of participants in the study were unemployed during the period of research. In total, 25 men aged between 28 and 50 years were interviewed. All but two spoke Shangaan as a home language, and were born in Bushbuckridge. Six of the participants were married; four were cohabitating; three had partners that they did not live with and twelve were single. All participants had at least one child, but only a few were living with their children.

An ethnographic approach was used to recruit and interview the participants (Babbie & Mouton, 2001). In order to recruit participants, the researcher attended support groups for People Living with HIV and AIDS (PLWHA) that take place regularly at the clinic. During the support group meetings, potential participants were identified and then recruited for interviews. If they agreed, an interview was arranged, but it was preceded by informal conversations that took place at their homes and at the clinic, aimed primarily at building rapport and trust. Of all participants that were recruited, none refused to take part as they were already familiar with the researcher through his sustained attendance of the support group meetings.

The formal interviewing followed an interview guide that was administered in all interviews. The interview guide covered some key themes that are related to men's masculine identities and experience of living with HIV. Some examples of questions asked are: What is the meaning of being a man in your community? What challenges do you face as a result of HIV? How do you view yourself as a man living with HIV? The interview process was fluid, allowing participants to depart from the main themes and raise issues of interest to them. This resulted in the emergence of new themes and broadened the scope of the enquiry. All formal interviews were tape recorded and transcribed and translated by the interviewer from isiZulu and Shangaan into English. All standard ethical procedures for research with human subjects were adhered to and ethical approval was gained from the University of the Witwatersrand ethics board.

The analysis of results followed the conventions of ethnographic research enquiry (Babbie & Mouton, 2001). First, analysis began during the fieldwork phase. Interviews were transcribed immediately and read repeatedly to identify dominant responses. These were then grouped into themes and used for follow-up interviews and conversations. Secondly, the analysis was not limited to what was said in formal interviews. As an ethnographer who lived in the study site for 14 months, the researcher kept a record of daily activities and interactions with informants and used these to inform an analysis and verify information given in formal interviews. This has aided in the contextualisation of the research findings. When fieldwork was complete all interviews were read repeatedly to confirm the themes before being coded in *Atlas.ti*, a qualitative analysis package. Codes that belong to each theme were identified and are discussed in the next section.

DISCUSSION.

Both the role of being an independent provider and being in a sexual relationship are considered essential markers of masculinity in Bushbuckridge. A man without a sexual partner is negatively labelled as *ngwendza* (no direct English translation), and an unemployed man is called *mahlalela* (this term is taken from isiZulu; it means a man who is employable, but is idle). Many of the male informants lived according to the prevailing social ideals of successful masculinity before contracting HIV, as they were working and had at least one sexual partner. However, as a result of being diagnosed with AIDS, they became unemployed and some lost sexual partners. How they experienced this change in their lifestyles, given the significance of such criteria for successful masculinity in this community is the key focus of this analysis. The following representative extracts taken from the formal interviews with participants illustrate the impact of these changes on participants' constructions of their masculinity.

Provider role.
Prior to getting HIV, Mathe, a 46-year-old man with eight children, was working at a retail store in Bushbuckridge. His wife, who passed away from an undisclosed illness, was a nurse at the nearest hospital. Hence, by local standards he was considered successful. In the interview he was asked to share his views about what a "real man" should be, before being asked to reflect on his own masculinity as a sick man.

Mathe: "In my own opinion I can say a man is someone that has his independent household; he must always think about his family and provide for them. That's a man for me; a breadwinner".

While he was still employed, Mathe fulfilled this role of being a breadwinner. Since becoming sick from HIV he lost his job and then returned to his home to live with his parents. His children are now supported by his parents from their pension money. Mathe explained the impact of being unemployed on his prescribed position as a provider.

Mathe: "I used to work in the past, my brother. And now I have to ask for just about everything I need – soap, food; I don't even have soap to wash my clothes or myself, lotion, food; all these things I must ask for them! And sometimes I'm even ashamed to ask for these things. And sometimes I just wake up and leave, go somewhere where it's quiet; and pray".

The above extract foregrounds the way in which dependence for an adult man is bound up with shame and embarrassment. As a man who was previously employed, Mathe feels ashamed to ask for help from his parents, experiencing this as undermining his status as a man, given the centrality of being a breadwinner to successful masculinity.

Mathe is not the only participant who was in a position of being dependent as a result of HIV sickness. Six other participants reported being in similar positions. Lizo (33 years old) is one of them. Like Mathe, Lizo was working before getting sick, and viewed this as an important marker of his masculinity, highlighting the importance of male peers' acknowledgement and respect for a man's sense of masculinity. Such respect is clearly bound up with material success, so that those who do not have their "own things" are not respected, and therefore not "man enough":

Lizo: "They will not respect you; even if you are a grown-up. Even when calling you they will say "Ekse, Ekse" [I say, I say/ Hey you, Hey you]! But if you have your own things they will call you in a dignified manner; they will call you by your child's name if you have a child".

Lizo became sick with HIV in 2004, while he was working in Sabie, a small town close to Bushbuckridge. His illness forced him to leave his job and return to his home to receive care. Since stabilising in 2006 he has never been employed again. Currently, he is supported by his mother who is a pensioner and who also supports other grandchildren. He said that being supported by a mother is demeaning for him as a man:

Lizo: "It's a concern for me (being dependent), 'cause at the moment I live with my mother. She gets pension, about R800. And she is also building a two-room house.

And we stay with my nieces; our sister left, leaving her children behind. Now our mother is looking up at us, as her male children, hoping that maybe we can do something to support her here-and-there. My elder brother moved out to his own stand and my older brother too. That's what worries me most…sometimes I need to buy a polish; sometimes I need to buy this, and that…I can't ask all of these from my mother" [Long pause and looking down as if about to cry].

The quote from Lizo reveals much about the experience of men who are being supported by parents. He clearly perceives this negatively and less than ideal for an adult man. This is expressed in his feeling of shame in having to ask for basic needs from his mother who also supports others. Lizo's feeling of shame is exacerbated by the fact that he used to work in the past and was therefore independent. In our informal conversations he expressed a longing to be independent again and even asked the researcher to organise either a job or a government grant for him. He said without being independent he cannot attract an intimate partner as women need to be provided for.

Magwa, another unemployed man, shared sentiments similar to those expressed by the above two men. A father of 13 children from three different mothers, Magwa had a successful career in the mines where he was promoted to a supervisory position. He was however retrenched before he became ill, and has since struggled to get work because of his illness. Now he lives alone in a small government (RDP) funded house and sells tobacco for a living. His children stay with his mother who is a pensioner.

Magwa: "So my mother does try here and there, you see. Now she doesn't buy anything for herself – whenever she gets paid she buys, like food for them. And even at school she pays school fees for them, you see. As for me, I can't even contribute a cent; where will I get it? I'm not working! 'Cause really I'm not skilled for any other work, you see; I don't know it … [Interviewer: How does it make you feel personally; the fact that you are unable to support your own children?] "It's painful, man. It doesn't make me feel good about myself. It doesn't make me feel good 'cause now ….eh …eh … I can't explain to you … I really can't explain how it feels, really. I can't tell you … cause I used to have money, but now I can only manage to support myself only, I'm not in a position to support my own children, you see".

As seen above, all three participants endorsed one of the core aspects of hegemonic masculinity, that of achieving the provider or breadwinner role. But they are unable to fulfill this role because of unemployment and illness, which further undermines their employability. Their dependence on others for a living was experienced as painful, shameful and undermining. The majority of participants (like the three above) had lost their jobs at the time of or after being diagnosed as HIV positive, and remained unemployed and dependent. Of all the participants, only one was employed at the time of the research, and four were receiving government grants. Treatment did little to improve their job prospects, as most men complained of being sick and not having sufficient energy to seek or engage in physically demanding work.

Sexuality.

Before getting sick with AIDS, Koko, a 29 year-old participant, was a sexually active man. He had several sexual partners with whom he slept and had sex without using protection. At that time he was married.

Koko: "The thing is I would date a girl, we go to bed; but she is not enough for me. I get another one, we go on well…and these women also talk amongst each other, that 'Eh that guy! Eishhh!'. And you don't even use condoms with some of them. Now you feel that if you use a condom with this one and not with that one, you feel some difference, and you go after this one (not using a condom with), but I'm still not finished with that one. Or maybe I visit Bushbuckridge – I will be there for only two days, but already I will see someone 'Ey this one will be a nice girl for me'. Now you are adding into the total – you have 3 here and you have one there".

Koko attributed his sexual lifestyle to pressure exerted by friends to prove his masculinity. He said that amongst his friends, a man proved himself by having many partners; otherwise he is marginalised and labelled as weak. Koko's experience is shared by the majority of participants and highlights the need to prove sexual prowess as a means of demonstrating successful masculinity in this community. All but two were involved with multiple partners before being diagnosed and/or becoming ill. Participants either reported being single or having lost sexual prowess as a result of their HIV status or the use of ARVs.

Koko said that since he became sick from HIV he refrained from having multiple sexual partners. At the time of the research he was living alone with his six-year-old daughter in a family house. His wife had left him after he disclosed his HIV status to her. When asked to elaborate on his wife's departure Koko cited his poor sexual performance and his general loss of interest in sex as the main reasons why she left him:

Koko: "When you are sick you don't think about sex, but maybe she did. I think that was also a cause; and she is still young, her blood is still hot. Now I'm sure she met up with a stronger person and obviously that rules me out because Im not the same any more – angisafani nakuqala. [Interviewer: What do you mean you are not the same any more?] Well, I'm sick now with TB, flu, HIV. I spend time thinking a lot and you end up not entertaining sex".

Koko's comments indicate a change in his sexual life, which he attributes to his diagnosis and his subsequent illness. HIV is viewed by Koko as undermining his masculinity. Being unable to perform sexually, constructed by participants and apparently their female partners as a key component of their masculinity, Koko feels that he cannot compete with other men who are "stronger".

Lizo, another man living with HIV, shared similar experiences. When he tested HIV positive in 2004 his wife also left him. At the time of the research Lizo had no sexual partner. He was asked how he feels about this as a man.

[Interviewer: "Don't you sometimes feel like being with a woman?"]
Lizo: [With a sigh] " ... Yaah, definitely you do get feelings for a woman, but if you can see your condition is not right you better just stay on your own. The minute I bring a woman home I will add to my mother's burdens. And my mother is still struggling to cope with all these children at home. Now I'm unemployed and I bring a wife home – she will demand this and that; she wants soap, I go tell my mother. You see that? It would be adding stress to my mother, so I don't want to do that. [Interviewer: So your main concerns is your mother; you don't want to trouble her?] Yaah, my mother; I would

rather be the one struggling…but if I do get a temporary job or so I will find myself someone to do the washing for me. But it will be someone with a similar problem to mine (HIV positive), we are both on treatment. Because we can have an understanding – if I ask her to do this, she will do it".

Lizo's statements reveal much about the intertwinement of romance with money in constructions of masculinity. According to him, women have material needs and men should provide for them. However, as a sick unemployed man, he believes that he cannot afford a female partner. This resulted in his decision to refrain from sexual relationships, so as to protect his image and his mother who is already under financial strain, given his dependence on her. It is also interesting that Lizo mentions that if he does get a girlfriend he will choose someone who is also living with HIV and using ARVs. For him this would bring "safety" and "understanding", as they would be sharing the same illness. Clearly living with HIV is considered to create a barrier between him and women who are not living with the disease. It is also interesting that when he talked about a prospective partner, he said it would be someone "to do washing for me". This statement shows the way in which a sexual relationship is closely associated with a relationship or partnership in which the woman will conduct normative gendered duties in the household (such as doing the washing) and make material demands. The centrality of (hetero) sex in defining a relationship is also evident in such constructions, implying further challenges for men (who may have a loss of libido due to the illness) in finding a female partner.

The above quotes indicate major shifts in men's sexuality as a result of HIV. The participants cited here had sexual partners before contracting the virus. However, they were both abandoned because of their HIV status and according to them, the impact it had on their sexual relationship. This has put their sexual lives in doubt. Koko is worried about his sexual performance, while Lizo is concerned about his position as a provider. These perceptions reflect the experiences of the majority of participants interviewed.

HIV and sexual performance.

Some participants reported that they were in sexual partnerships despite testing HIV positive. For these men the main change brought about by HIV sickness was a loss in their sexual performance. They said that since becoming sick as a result of HIV they experienced a loss of libido.

Xola, a 44-year-old participant, described his sexual performance as having changed drastically since he became sick in 2003. He lives with his wife who is also HIV positive.

Xola: "Yaah, there are changes. My work rate has gone down drastically; I easily get tired. Things are no longer the same. Like for example in the past neh, I would make sure that a week doesn't end without having sex. But now a month can pass; I don't stress about it; I even sleep with her, just sleeping with her without thinking about it [sex]".

When asked about how his wife feels about his lack of sexual desire, Xola said they have redefined the role of sex in their relationship: *"Yaah, sometimes I would try, but my wife would say 'you know; you don't always need this. Sometimes it's good just to be together ... sex is not important'".*

Thabo, a 46-year-old participant had similar experiences. He attributed changes to his sexuality to the side-effects of ARVs.

Thabo: "Well, of course you don't have the power. You just do one [round] and you go sleep after that [laughing]. Just one…maybe you can do a second one in the early morning, say about 5am, but you are just forcing yourself [Interviewer: And how does that make you feel, I mean not having enough power?] What can I say! I think it's these pills because in the past I would do five rounds, you see. But these days I only do one and then I sleep. The first one is just fine, and then I go to sleep and maybe at around 4 or 5 it gets up again and maybe I can do the second one, but that's rare. And just twice a month is just fine for me; if I get it twice a month I just forget about women. Things have really changed from how they used to be".

The experiences of Thabo and Xola generally represent those of other participants who were in sexual relationships. It was not clear what the cause of these changes in their sexuality were, physical (side-effects of ARVs or the illness itself) or psychological. According to the health providers that were interviewed informally ARVs should improve one's sexual performance since overall health improves on this regime. However, for ARV users this was not felt to be the case. The health provider attributed participants' lack of libido and/or performance, compared to their past experiences, to psychological responses, "because sex caused their sickness, now when they think about sex they have that fear". The introduction of condoms in their sex life may also have impacted on sexual practice. While this study is not concerned with the reasons for such changes, it was evident that participants did not respond as negatively as might be expected. Rather, they reported reconstructing their relationships with their partners, accepting that sex is neither necessarily central to their connection, nor to proving their masculinity.

RECONSTRUCTIONS OF MASCULINITY.

As a response to the problems highlighted above, some participants have begun to rethink their masculine identities. The majority of men who were unemployed and dependent on others expressed bitterness and a feeling of being emasculated as a result of their present positions. However, despite feeling emasculated, some men were not willing to do hard work, even if they believed it would restore their masculinity. Hard work was seen as a threat to health, and health was a priority. Sipho, a 35-year-old participant was offered a job as a security guard in a nearby shopping complex. The job entailed that he works at night, patrolling the site. Sipho worked for only three days and stopped because he said it was affecting his health: *"I cannot stay there for whole night. That place is cold and they don't offer us a proper shelter ... "*. Sipho's decision to leave his job could be perceived as a sign of weakness by other men. However, for him, as a sick person, it was imperative to take care of his health.

In response to changes in sexuality, the second primary marker of masculinity, the majority of participants took a position that could be described as resisting the centrality of sexual prowess to hegemonic masculinity. Here, despite losing sexual partners and experiencing a decline in sexual performance and desire, most men still viewed their masculinities in a positive light. They said that as men living with HIV, they are in control of their sexuality, unlike other men in the community who still practiced "risky" sexual lifestyles. For these men, health took precedence over sex. Koko, in particular,

said he views his masculinity more positively now than before, because he has control over his sexuality:

Koko: "You see, now that I know my status I feel sorry for other men out there whenever I sit down and think about them. And when I see these women changing men I feel sorry for them too. I ask myself, 'Eh, I saw this girl with this guy before, now she is with another man. Does she know how dangerous our times are"?

Lizo too felt that HIV had given him a chance to reflect on his sexuality and reconstruct it differently.

Lizo: "I can say now ngiphila ngcono [I live a better life], 'cause I know my status. Some just live but they don't know their statuses. Today he is sleeping with this one and tomorrow he is with another one. You might find that he has this disease and he is spreading it all over. But I know my own status. Yhaa …".

Zita, a 32 year old participant added:

Zita: "Someone can look at me and say 'Eh this one can't engage in sex, he's not a man'. I just look at her and say, 'Well, she still has time, she can live her life the way she wants'. But I don't have time; I don't have time to play. Now I'm taking good care of myself, cause this sex is the cause of all these problems, we are where we are today (being HIV positive) because of sex. So what shall I do? I rather live my life the way I want. When the time is right for sex I will do it; when I feel my body allows for it I will do it. But you will never force me; you just leave me alone".

These three comments indicate the new kinds of subjectivities that have emerged from an experience of living with HIV. These are three men who have previously valued sex and sexual prowess as important markers of their identities, and in their lifetime had multiple partners. As a result of HIV they are beginning to question sex and its value in their lives. They now see it as less significant and definitive of their value as men.

Two key conditions have arguably enabled these men to take this resistant stance towards hegemonic masculinity. First is the "near-death" experience resulting from AIDS. This experience forced these men to consider their priorities in life. For the majority, what mattered most (after receiving treatment) was to live rather than be seen by others as conforming to socially sanctioned versions of hegemonic masculinity. Having lived according to ideals of hegemonic masculinity before, these men felt they gained nothing other than their sickness (as seen above by Zita's comments). Second, this resistance was seemingly enabled by belonging to PLWHA support groups. These groups appeared to locate the participants within a new discourse on matters of HIV and sexuality, as well as providing them with a new audience with which to negotiate their performances of reconstructed masculinity. In support groups, multiple partnering was discouraged and stigmatised as being indicative of irresponsible behaviour by someone living with HIV. Any man who had multiple partners was chastised rather than being celebrated as "successful". The support group therefore played a re-socialising role in terms of how masculinities were constructed and lived. It furthermore facilitated a confidence in participants to resist conforming to social expectations of hegemonic masculinity in favour of choosing to be more accountable to fellow support group members. Since support group members discouraged multiple partnering, participants

appeared able to refrain from their old sexual practices while still reconstructing their masculinity and identity in a positive way.

CONCLUSION.

Various studies of masculinities have shown how difficult it is to resist dominant social messages about what it means to be a man, and to adopt alternative positions and practices of masculinity (Aronson, Whitehead & Baber, 2003; Walker, 2005; Lindegger & Maxwell, 2005; Sideris, 2005). Men who resist hegemonic forms of masculinity risk being marginalised and negatively labeled as "weak", "mad", "bewitched", "stupid" (Courtenay, 2000; Frosh, Phoenix & Patman, 2003; Mfecane, 2004; Sideris, 2005). This article focused on men's narratives on the impact of living with HIV on their masculinity, and how they have reconstructed their masculinities to comfortably accommodate the changes brought about by sickness and treatment in their lives. Specifically, the article has shown that HIV caused problems in their lives, which made it difficult to fulfil certain "provider" and sexual roles that are considered masculine. As a response to their situation, some men are beginning to renegotiate these roles: the provider role as definitive of manhood was carefully reconsidered while sex was consistently rejected as being a core component of being a man.

The findings from this study provide a useful way of engaging with masculinity as a shifting rather than static identity (Morrell, 2005). It seems that when men are in crisis, they become willing to rethink their masculinities and accommodate new ideas with respect to what it means to be a man. Clearly, for the narratives of the participants in this study, the crisis of HIV sickness surfaced an incongruity between what they had internalised as definitive features of manhood and their post-diagnosis material and bodily conditions. Prior to illness, all of the participants endorsed having a sexual partner and a job as essential markers of masculinity. However, following illness, these men were unable to fulfil these roles and so began to question the relative importance of these so-called markers of masculinity in their lives.

We should however not solely attribute such changes to the power of agency in resisting the hegemonic discourses of masculinity. Men in this study were perhaps able to change because they were effectively already structurally marginalised by HIV. As physically ill, unemployed and less sexually driven men, their changes may be viewed as being reactive rather than driven by volition. It can therefore be argued that by taking resistant positions towards dominant notions of manhood, these men were engaged in a process of rescuing a lost masculinity. By adopting "responsible" lifestyles (such as controlled, safe sexuality), these men appeared to gain respect from other men to whom they disclosed their status. It was in these support groups that the "problem" of constrained family roles and the de-emphasis of sex as a marker of masculinity were "normalised". In some ways then, the resistances implied in the participants' narratives are endorsed, sanctioned and supported by other marginalised men, rather than men that represent hegemonic masculinity as a lived practice.

Much can be learned from the study about interventions for men towards challenging HIV. So far, intervention programmes in South Africa have targeted men who are not using HIV services and encouraged them to seek help. This has resulted in the needs of men who are already infected being relatively neglected. It should be acknowledged that access to treatment does not represent a solution to the problems of HIV and AIDS. Male ARV users still face pressures from community, family and peers to adhere

to certain standards of manhood. This is particularly true when symptoms disappear and they begin to look healthy again. It is in this context that some would rather stop treatment if it apparently constrains their ability to perform hegemonic masculinity in the form of doing hard work and proving their sexual prowess. Support for men on treatment is therefore needed to foster adherence and overcome the social pressures to “live like a man”.

Acknowledgements.
I would like to thank the two anonymous reviewers of the first draft of this article for critical and constructive comments, as well as the editors for comments and suggestions.

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