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Masculinity and the persistence of AIDS stigma

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Abstract

With the expansion of access to HIV testing and antiretroviral therapy in sub-Saharan Africa, questions have emerged if stigma remains a useful concept for understanding the effects of AIDS. There is, however, a paucity of research on how HIV-positive Africans—especially African men—experience living with AIDS. This paper addresses this gap and draws on findings from ethnographic fieldwork in 2004 and 2009 with a support group for HIV-positive men in Kampala, Uganda. The paper demonstrates that stigma is central to how men in this context coped with HIV and AIDS, and it provides a conceptual framework that links men's experiences of AIDS stigma to conceptions of masculinity. In so doing, findings highlight both the possibilities and challenges of involving African men more fully in HIV prevention.

Keywords

stigma; HIV; AIDS; masculinity; Africa; Uganda

In the last five years, HIV testing, counselling, and antiretroviral therapy have become increasingly available in many sub-Saharan African countries. With improved access to services and drugs, questions have emerged if stigma is still a useful concept for understanding how people experience living with AIDS. Research in Malawi and Uganda suggests AIDS stigma is waning (Chimwaza and Watkins 2004; Kipp et al. 2007) and Jewkes (2006, 431) argues the persistent focus on stigma has obscured the 'normalisation of HIV/AIDS' in some South African communities.

There is, however, a surprising paucity of research on how living with HIV is experienced by HIV-positive Africans—especially African men. This paper addresses this gap and is based on fieldwork with the Bwaise Positive Men's Union, a support group for HIV-positive men in Kampala, Uganda. This rare study focused on the lived experiences of HIV-positive African men reveals that stigma remains central to how men in this context coped with HIV, even during a period of expanded access to testing, counselling, and drug therapy.

Given Uganda's widely-recognised success in addressing AIDS, how do we account for the persistence of AIDS stigma among men in urban Uganda? This paper provides a conceptual framework that links men's experiences of AIDS stigma to conceptions of masculinity. It demonstrates that AIDS stigma among men is a reflection of deep-seated concerns they have about their own status in society—concerns that make confronting the dangers posed by HIV and AIDS extremely difficult. This is also one of very few studies to examine HIV-positive African men's attempts to promote HIV prevention and care among their male peers (Colvin, Robins and Leavens 2010) and it provides vital insights into the possibilities and limitations of such interventions.

The paper begins by arguing that insights from gender and masculinity studies need to be integrated into current conceptualisations of stigma. It then focuses on fieldwork with the

Bwaise Positive Men's Union to make clear why we need to attend to the intersection of masculinity and AIDS stigma. Finally, the article examines the lives of two especially open and articulate union members to provide a more intimate description of how men in this context experience AIDS stigma.

Gender, Masculinity, and AIDS stigma

Research on gender and AIDS stigma in Africa has largely focused on the discrimination experienced by women and its effects on HIV testing, access to care, and social support (Campbell, Nair, and Maimane 2006; Mukasa et al. 2001). Such studies are of vital importance but they do not fully illuminate African men's experiences of stigma or adequately conceptualise how stigma is tied to gender relations. Stigma studies including both African women and men living with HIV indicate important gender differences, including men being more likely to internalise blame for becoming infected (Shamos, Hartwig, and Zindela 2009) and expressing greater shame living with HIV (Simbayi et al. 2007). The few studies focused exclusively on heterosexual African men emphasise the internalised psychological distress associated with being an HIV-positive man (Lynch, Brouard, and Visser 2010; Poku et al. 2005). While studies examining links between masculinity and AIDS stigma in Africa are quite limited, both Beck (2004) and Colvin et al. (2010) argue the social exclusion HIV-positive South African men experience is rooted in context-specific notions of masculinity.

There is, therefore, a need to understand more fully how notions of masculinity are tied to AIDS stigma. This requires building on the conception of stigma as a social process tied to power relations and the reproduction of social inequalities (Castro and Farmer 2005; Holzemer et al. 2007; Parker and Aggleton 2003). Gender inequalities are recognised as aspects of stigma as a social process but how gender is intertwined with stigma is rarely explicitly conceptualised (Shamos et al. 2009). This is a critical issue because if stigmatisation reproduces social inequalities one of the primary axes along which it operates is gender difference.

Gender is a social institution that produces durable patterns of social interactions that reflect prevailing power dynamics, evident in gender hierarchies and inequalities (Lorber 1994). These inequalities, like those of class, race and sexuality, provide the social context for stigma and are, in turn, reproduced through processes of stigmatisation. In addition, gender relations are reproduced at a more interpersonal level through everyday interactions between individuals and groups. Thus, while gender hierarchies are formidable they are not wholly resistant to change because gender power relations are not only reproduced in ordinary social interactions but also reconfigured through those everyday gestures and exchanges which subvert established gender identities (Butler 1990).

Mobilising stigmatised individuals, however, can prove challenging because it requires addressing a third level on which gender power relations operate—the intrapersonal level. There are internalised cultural schemas that reinforce gender inequalities and make established gender roles seem natural (C. Epstein 2007).

This three-part schema for understanding gender relations provides a link between the intrapersonal, interpersonal, and structural dimensions of gender power dynamics and the corresponding intrapersonal, interpersonal, and structural forms of AIDS stigma. Distinctions between interpersonal and intrapersonal stigma are well established in the literature. Interpersonal forms are typically referred to as external or enacted stigma while intrapersonal forms are referred to as internalised stigma (self-stigmatisation) or felt stigma (perceived discrimination) (MacQuarrie, Eckhaus, and Nyblade 2009). Structural aspects of AIDS stigma have also received more attention recently both in terms of laws and policies

that institutionalise discrimination and the ways existing structures of social inequality provide the context for stigma as a social process (Parker and Aggleton 2003; Holzemer et al. 2007). What requires further exploration is how these various forms of stigma reinforce the intrapersonal, interpersonal, and structural dimensions of gender power dynamics. These forms of stigma are central to social processes which maintain a given gender order and perpetuate the status quo.

This conceptualisation of gender and stigma, however, raises questions about how masculinity is tied to stigma. If stigma reproduces gender inequalities why would men, who largely benefit from such inequalities, experience stigma? For insight we need to draw on the expanding literature on masculinity and health (Emslie et al. 2006), much of which is rooted in Connell's (1995) conception of masculinity, especially her notion of hegemonic masculinity. This is the dominant form of masculinity in a given social context and it is central to the reproduction of patriarchal power relations. As Connell (1995) and others have stressed, there are multiple forms of masculinity in any setting and this creates a hierarchy of masculine identities that naturalises not only the subordination of women to men but also the dominant position of some men over other men.

Researchers on masculinity and health have argued that behaviours that undermine men's health are often 'signifiers of masculinity' used by men to negotiate social power and status (Courtenay 2000, 1385). These signifiers can include independence, self-reliance, physical strength, toughness, risk taking, and emotional detachment. The enactment of normative masculine gender identities, therefore, often has deleterious consequences for men's health and in the process reproduces gender hierarchies and inequalities that have serious health consequences for women as well.

This literature on masculinity and health provides a connection between masculinity and stigma because the demonstration of hegemonic masculinity requires men to deny weakness and vulnerability. As Courtenay argues (2000, 1397), acknowledging health problems requires men to 'cross over socially constructed gender boundaries, and risk reproach and sometimes physical danger for failing to demonstrate gender correctly.' Living openly with HIV can be seen as a particularly intense form of crossing over for men because it is an incurable disease associated with long-term, physical disability. AIDS stigma, therefore, is an effective means of reinforcing gender boundaries and deterring the types of crossing over that could destabilise hegemonic masculinity.

This conceptual framework helps us understand men's experiences of AIDS stigma and see how stigma is tied to masculinity and gender inequality. At an intrapersonal level, men feel their illness will result in discrimination, and for some this can lead to an internalisation of stigma, or self-stigmatisation, for failing to embody hegemonic notions of being a man. In many contexts, fears of discrimination may in fact be justified and men may experience interpersonal stigma from men and women. Together these micro-level processes work to reinforce the dominant gender order which not only subordinates HIV-positive men but also undergirds gender inequality more broadly at a social structural level. This is because the burdens of hegemonic masculinity also come with significant gender privileges, especially male sexual privilege—benefits that are accorded to men regardless of their ability to embody hegemonic masculine ideals (Connell 1995).

This is not to suggest that men are doomed to reproduce hegemonic notions of masculinity because this would ignore the ways men and women are active agents in the ongoing construction of gender relations (Courtenay 2000, 1388). This leaves open the possibility for emergent forms of masculinity, including those which counter the dominant gender order. Thus, men who experience AIDS stigma, like other stigmatised groups, may in fact be in a

position to critique not only AIDS stigma but also the dominant notions of masculinity that structure how men experience stigma.

Context and Methods

Research was conducted in Bwaise, a densely-populated, low-income community in Kampala, Uganda. The population of Kampala is 1.2 million and Bwaise is a one-square-mile area home to 50,000 people. Bwaise is frequently referred to as a slum by its residents and many Kampalans survive in similar areas in the city's congested valleys and sprawling fringes.

Although formal wage labour was rare in Bwaise, the area did provide opportunities to earn money, even if the work was strenuous, available sporadically, and poorly paid. Despite such economic hardships, masculinity remained strongly tied to the breadwinner identity. In Bwaise, there was one dominant masculine ideal of being a provider, primarily embodied through responsible fatherhood (Wyrod 2007). However, beyond this uncontested male provider ideal other aspects of masculinity were in flux, such as notions of male authority that were challenged by the institutionalisation of women's rights (Wyrod 2008). While the HIV epidemic has generated critiques of male sexual behaviour, male sexual privilege remains an important aspect of men's gender privileges. Men in this context still retain the privilege of having extramarital affairs, assuming they are conducted with the requisite discretion (Parikh 2009). It is in this context of shifting conceptions of masculinity that men in Bwaise coped with HIV and AIDS.

The Bwaise Positive Men's Union was the focus of this study because as a grassroots initiative created by HIV-positive men it was a unique organisation in Uganda in 2004. Seven months of participant observation fieldwork were conducted with the union in 2004, followed by three months of follow-up research in 2009. Research with the union was part of a larger, year-long ethnographic research project in 2004 focused on changing conceptions of masculinity in the Bwaise community.

The union was based at the Bwaise Health Clinic, a government health clinic that was the epicentre of HIV testing and treatment. Two months before joining the union, I spent one afternoon per week observing clinic activities. This allowed me to befriend the nurses and volunteers who were instrumental in helping an outsider like myself gain the necessary trust of union members. The union was only a few weeks old when my research commenced and I participated in all weekly meetings, documented all the union's community activities, and helped prepare outreach materials. After observing each of these activities, I wrote detailed fieldnotes summarising and analysing the day's events.

Participant observation was complemented by nine in-depth interviews with the core union members. Interviews averaged one and a half hours and included questions on: work; notions of 'ideal' men and women; history of sexual relationships; HIV testing; and the effect of AIDS in their lives. Interviews were also conducted with three clinic staff and one volunteer, all of whom were women. I conducted interviews in English or Luganda (with the assistance of a native Luganda-speaking research assistant), and all interviews were recorded, transcribed, and translated into English when necessary.

Follow-up fieldwork in 2009 also combined ethnographic observation and in-depth interviews. I attended union meetings at the health clinic, observed the union's outreach activities, and discussed the union with clinic staff and volunteers. Follow-up interviews were conducted with five union members, three female clinic staff, one female volunteer, plus one new male staff member. Detailed daily fieldnotes were again written for all events and all interviews were recorded and transcribed.

Fieldnotes and interview transcripts were analysed using a thematic analysis approach. All documents were imported into Atlas.ti and first read in chronological order to generate one set of codes. Fieldnotes and transcripts were then re-read and coded to identify the key themes discussed in this analysis. All verbatim quotations included in this paper are from the interview transcripts.

Findings

The Bwaise Positive Men's Union

The Bwaise Health Clinic, where union meetings were held, was predominately a women's space and nearly all the staff, volunteers, and clients were women. Free HIV tests were offered twice a week and during my time at the clinic the vast majority testing were women. Fieldwork in 2004 coincided with the weekly meeting of the Post-Test Club, a support group for HIV-positive community members. The group had 75 to 100 members but only a handful were men. It was at the end of one meeting that Joseph, a lanky, 42-year-old man, invited me to the meeting of the new Bwaise Positive Men's Union.

When I attended my first union meeting, I found eight members seated in a tight circle under a mango tree in the back of the clinic. Mukasa, a large, 35-year-old man with broad shoulders, was the union's chairman and clearly in charge of the meeting. During this initial meeting, the men discussed gaining access to antiretroviral drugs, food assistance, loans, and employment opportunities. However, over the course of several meetings, I learned these were not the primary concerns of union members. Most members echoed the goals stated in the union's draft constitution which prioritised confronting men's 'shock, fear, and denial' regarding HIV. The extent to which members had experienced such shock and fear themselves was made clear to me by Edward, a 39-year-old member who disclosed his attempted suicide, saying, 'I was going to die and the children were also going to die. So why should I waste my time and go on, I should just die.' Because union members themselves had grappled with such issues, they were preoccupied with helping their male peers cope with the presence of HIV and AIDS in their lives. As Julius, 57, said, 'I joined this men's union so I can convince other men in the community to come forward to test their blood and know their way forward.'

In 2004, the union slowly expanded membership from nine to 22 regular members. Union members ranged in age from 20 to 60, with all but two members over 30. Few men had completed any secondary school and nearly all were struggling financially. Several members had lost a spouse to AIDS and all had received some HIV counselling, often through The AIDS Support Organisation (TASO), a national NGO headquartered in Kampala.

In meetings and interviews, union members stressed that fear of AIDS paralysed men in unique ways, led them to deny the dangers posed by the disease, and men were unlikely to support each other. Most of the men in the union drew sharp contrasts between the ways men and women dealt with HIV and AIDS. As Richard, 32, explained:

Women, they are very, very, very good. They have managed to share and duplicate their activities. But men, that is our challenge...They don't want to come [to the clinic]. They don't want to share with each other. So women are more intelligent. When they have seen the symptoms, they just rushed to the clinic...Although it is a fatal disease, [men] have some denial. That's why they come when they have already weakened up to the extent of death.

Although women were role models to men in the union, members were also adamant that men needed a male-only support group to address men's denial.

Men's reluctance to test for HIV was a frequent topic for discussion among the members. Over the course of my fieldwork, five reasons emerged for why men were reluctant to test, with most members citing a combination of the following: (1) men were too busy to attend HIV and AIDS seminars; (2) they saw health clinics as women's spaces; (3) they were afraid of being discriminated against by an employer or when searching for work; (4) afraid their sexual partners would leave them; and (5) men were conditioned to be independent and feared having to deal with the consequences of being HIV-positive alone.

When discussing the impact of AIDS in their own lives, a majority of members stressed AIDS-related health issues made it difficult to work and earn money. Several members were experiencing acute financial hardships in 2004 and this remained true for four of the five men I interviewed in 2009, even with access to ARVs. In 2004, Julius, who had been unemployed for some time, told me, 'no one is willing to give you a job because you can see people who are healthy, who are negative...if you are positive no one will employ you, no one will sympathise with you.' In his mind, there was a clear connection between a man's ability to earn money and his reluctance to test for HIV:

Men are always money minded. They have to work up to evening because the man is the breadwinner to get house rent, to get food, school fees, each and everything....other men are worried about taking their blood test because they know it will not be good for them. So they are still afraid. They fear rejection. They fear stigma.

Several other members described losing or leaving jobs as their health deteriorated, including the member who attempted suicide. In 2004, he had left his teaching job and was in a predicament other men feared: he was relying on an AIDS service organisation for food for himself and his children, dependent on his mother for any money, and forced to walk to weekly union meetings because he lacked the bus fare.

While the union was intended to be a refuge from the status concerns members faced as HIV-positive men, several times in 2004 the union nearly disintegrated over conflicts related to the union's structure and leadership. Even though the union was small it had a complex, hierarchical structure. During meetings, the men would often address each other by title and discussions were regimented and formal, usually controlled by the chairman. Leadership conflicts led to several power struggles within the union, sometimes among the older men and at times between older and younger members.

In 2005, Joseph became the chairman after a divisive conflict with the first chairman Mukasa. Under Joseph's leadership the union slowly grew its membership, formed partnerships with local NGOs, received small grants, and conducted new outreach activities. In 2009, however, I was dismayed to find the union had experienced yet another crisis. Several members had become unhappy with Joseph's increasingly authoritarian leadership.

After attending meetings in 2009, it was clear that Joseph had alienated most members in his attempts to consolidate his power. The union was still doing important work, however members and clinic staff made it clear that power struggles over status and control had led to the demise of the union.

Nonetheless, both former members and clinic staff still saw a pressing need to mobilise men and they remained committed to the idea of a men's union. This need was evident, they said, because even with distribution of free ART women remained the vast majority of clinic patients. In 2009, a staff member spearheaded the formation of a new men's union based on a more democratic structure with rotating leadership. As of 2010, the group had

approximately 20 members, met monthly, and conducted outreach activities to men in the surrounding community.

Intimate lives of union members

This section presents brief life histories of two union members who were unusually willing to discuss their experiences and feelings as HIV-positive men. Their histories shed light on why AIDS was so threatening to many of their male peers.

Joseph: youth before AIDS—Joseph, 42 in 2004, first invited me to participate in the union and was an energetic man who spoke quickly and projected intelligence. His eyes also hinted at the difficulties he had been through and at times his natural nervousness failed to mask signs of frustration and depression. At 18, Joseph moved to Kampala from western Uganda after he finished secondary school. City life initially treated him well and he found work with a construction company. The steady income allowed him to have girlfriends in Kampala while supporting a wife and daughter back in the village.

By 1990 however, when Joseph was 28 and already a father, he started seeing his former girlfriends die from AIDS. Concerned about his past, he tested and discovered he was HIV-positive. His daughter was spared this fate but his wife in the village, who Joseph believed had remained monogamous, died from AIDS several years later. Joseph struggled with testing positive and was in denial for several years:

My working colleagues noticed because my life had changed. I was over drinking. I was in the streets all the time. I had no appetite for food. And so they would ask me, ‘Joseph, what’s the problem?’ So others were suspicious that this man, he has a problem. But still it was my secret. I could not tell them, it was my secret.

Eventually, with much counselling from TASO, Joseph came to terms with his status. In 1994, he first spoke publicly about being HIV-positive and in 2000 presented his life story at an international conference in Kampala. However, Joseph never again spent much time in his natal village, saying ‘it was very bad for me in that village that they know my status...people say that is a man that can cause a problem. That is a killer. That’s why I distance myself.’

Joseph wanted a new partner and in 1997 met an HIV-positive woman named Sarah through TASO. They started living together and having sex without contraception which led to an unplanned pregnancy in 1998. This child, a boy, was born HIV-positive and lived for only four years, and after the boy died Joseph left Sarah.

When I met Joseph in 2004, he was living alone but had a new girlfriend who was also HIV-positive. Joseph said he was more careful with this relationship, always using condoms when they had sex. Unfortunately, his employment was precarious at best because he had given up his trade as a carpenter to work as an unpaid health volunteer.

‘I changed the profession because of this AIDS problem,’ he told me. ‘Because my life could not stand such hard labour...I had to switch from carpentry work to medical. Now I’m a counsellor. Counselling people with HIV.’

In 2009, Joseph’s life seemed improved. He was responding well to antiretroviral therapy and he and Sarah had reunited and were living together in her village outside of Kampala. Joseph also proudly told me he remained the chairman of the union and had established a branch office in Sarah’s village.

However, our first meeting at the Bwaise Health Clinic made clear things were not going so well after all. Joseph had organised a meeting of the men’s union but only a handful of

people attended. Joseph also received a rather cool reception from clinic staff and volunteers, with a few commenting that they had not seen him at the clinic for some time. He assured me the union was still strong under his leadership but that many activities had been relocated to Sarah's village. My contacts at the clinic suggested otherwise and felt the union had become moribund under Joseph's leadership.

On my two trips to visit Joseph and Sarah in the village, it was clear Joseph had fallen on hard times. He continued to work as a volunteer with no steady income, his housing in Kampala had become precarious and, according to Sarah, Joseph approached her about reuniting and staying in her home in the village. Joseph also parlayed his influence as the union chairman to establish a barbershop in Sarah's village to disseminate HIV prevention information—a decision which had caused much conflict within the union. While the barbershop was an innovative idea and fairly well executed it operated only sporadically.

Thus, Joseph's identity as a 'proper' man remained fragile and he continued to use his position as union chairman, however tenuous, to shore up his male status. Not surprisingly, these issues also affected his renewed relationship with Sarah. From interviews, it was evident they were not very close. Sarah described their relationship as involving little love or communication, saying 'he is a silent man I also spend most of my time silent...I have nothing else to do because I don't have any other partner apart from him.'

Joseph was preoccupied with having another child—ideally a son to compensate for the boy that he and Sarah had lost to AIDS. Because Sarah could no longer conceive, Joseph said he was also seeing another HIV-positive woman in Kampala. He was quite open about this arrangement and while Sarah resented Joseph for having another partner she said there was little she could do to change his behaviour. It was not surprising, therefore, to learn that a month after the fieldwork Joseph had left Sarah to live with another woman in the city.

For Joseph, AIDS had a profound impact on his relationships but in many ways the effects moved in slow motion across nearly 15 years. He came to terms with his status in the early 1990s but still had a child in 1998 who was born HIV-positive. It was also not clear exactly how much responsibility he was still willing to take for his first wife's death. Nonetheless, Joseph would be the first to admit that men have problems coping with AIDS stigma and denial. It was this issue more than any other that made him such a strong advocate for the men's union.

Richard: youth during AIDS—Richard, 32 in 2004, was a large, muscular man who could have easily hidden his HIV status. However, Richard was open about being HIV positive, mostly due to his involvement with TASO which encouraged members to share their life stories. Both denial and victimisation were central to Richard's story and he cast himself as a victim of peer pressure when discussing key events in his sexual history.

When interviewed, Richard had a well-rehearsed testimony ready and said his problems could be traced to an outing with friends after he finished secondary school. It was 1992, when he was 20, and his friends took a trip where he was 'pressured' to pair up with a woman and have sex. In his official narrative, he suggested he had had very few sexual encounters before this one. Three months later he found out his partner was pregnant and although he initially wanted to deny responsibility he began living with this woman. Aware of AIDS, Richard and his partner took an HIV test together and their results were negative. Yet, according to Richard, over the course of the next two years both the mother and child became ill and eventually died of AIDS.

When pressed, Richard reluctantly discussed earlier sexual encounters that he had omitted from his official testimony. Between the ages of 18 and 20, he had ‘many’ sexual partners, and again he framed this as a result of peer pressure. Richard also eventually revealed he had a child with another woman in 1991, and he was reluctant to discuss how this period of his life could have placed him at risk of HIV infection.

In 1994, after the death of his partner from 1992 and their HIV-positive child, Richard moved in with his parents in the village and relied on his mother for financial support. Having lost his child and partner, and unable to support himself, he fell into a deep depression. He said it took him some time before he acknowledged he too might be HIV-positive, and even after testing positive in 1995 he remained in denial, saying he was ‘shocked’ by the positive test and even contemplated suicide. ‘I had a big stigma,’ he told me. ‘A stigma so I didn’t want to disclose it...I thought that I am going to die. So I spent the whole year in the village because I thought that I had no hope.’ After a year of living in a ‘cage of fear and denial’ in the village, Richard eventually sought counselling from TASO.

When asked what was the root of his denial, he sidestepped the question. Instead he focused on other men, saying men feared AIDS and do not want to admit being HIV-positive. He said men like thinking that, ‘I’m still alive. I still have something to look forward to...I [can] still love another.’ Richard said he too was burdened by the thought that as an HIV-positive man he might never be able to start another relationship that would allow him to provide for a family of his own.

Counselling changed Richard’s life and it was through TASO that he met a new partner who was also HIV positive. They began cohabiting in 1998 and Richard spoke tenderly of the intimacy they had shared coping with living with AIDS together. Sadly, this partner also died from AIDS in 2004 which once again left Richard in the grips of depression. Continued counselling was helpful and he hoped eventually to find another partner who would help him move past the loss.

In 2009, Richard was in a much happier place. A year earlier he met an HIV-positive woman at a TASO workshop and they became very close. They had been cohabiting for two months and trying to raise money for a wedding ceremony. In addition, Richard was receiving free ART and responding well to the drugs. He and his partner were planning to have children, and they had sought out counselling on preventing mother-to-child transmission of HIV, making Richard optimistic for what the future might hold.

Discussion

For the men in the Bwaise Positive Men’s Union, both denial and stigma were central to how they themselves had experienced with living with HIV. In their view, they were not alone because many men equated being HIV-positive with no longer having intimate relationships, being unable to produce children, and not being able to earn money to provide for their families—all key components of the hegemonic masculine ideal of being a provider in urban Uganda.

AIDS remains so stigmatising for men in this context, I argue, because the disease symbolically encapsulates the challenges men in urban Uganda face living up to local ideals of masculinity. Stigma turns on fulfilling norms of social status in culturally appropriate ways and a man gains *ekitiibwa* (respect) and status in a place like Bwaise first and foremost by providing for his family (Wyrod 2007). While poverty and unemployment make this difficult, it is not impossible for many men. Yet AIDS is a challenge of a different order and union members suggested that coming to terms with a protracted, fatal illness was too troubling to acknowledge for many men. Male peers would be of little support because they

too had been socialised to be independent, with relationships between men defined more by hierarchy and deference than mutual support and cooperation.

While union members voiced an implicit critique of masculinity, they were also grappling with these issues themselves. The bureaucratic conflicts over titles and positions were emblematic of the desire these men had for status in their lives more generally. As HIV-positive men, members had a heightened sense of insecurity about their identity as productive and valuable men in the community. The men emphasised hierarchy within the union because of the prestige a hierarchical union promised. While men's concerns over status did eventually lead to the downfall of the union, members had nonetheless taken the difficult step of publically disclosing their HIV-positive status and reaching out to their male peers.

The life histories of Joseph and Richard provide a more intimate view of how some Ugandan men experience living with AIDS. Joseph's life history illustrates the tight coupling between his HIV status and his status as a man in this context. Living with AIDS created significant additional obstacles for Joseph as he struggled to embody notions of being a 'proper' family provider. His ability to disclose his positive status is commendable, as is his decision to have intimate relationships only with HIV-positive women. However, his story underscores why other men would deny the dangers of AIDS and remain reluctant to disclose their status to their sexual partners.

Richard's life story also indicates how HIV status and male status are intertwined. Coming to terms with being HIV positive created much psychological distress for Richard—stress tied to living up to local ideals of being a man. However, Richard eventually became open about his serostatus and had found happiness in a new relationship. He also remained committed to encouraging other men to confront the stigma, denial, and depression he had experienced so intensely. Importantly, while both Richard and Joseph were burdened by certain aspects of hegemonic masculinity they nonetheless benefited from the gender privileges accorded to men, especially with regard to having multiple sexual relationships at different points in their lives.

What emerges from this discussion is the centrality of intrapersonal forms of stigma to men in this setting. It is notable that men in the union rarely recounted any actual experiences of being discriminated against for being HIV positive. Such interpersonal forms of stigma were much less salient in their narratives than were the repeated articulations of their feelings of diminished self worth and fears of being stigmatised as men living with HIV. For such men, AIDS was perceived as a formidable obstacle in their attempts to be 'productive' men, which included being self-sufficient, earning money, having children, and supporting a family. Given the entrenched poverty in this community, the need for men to embody these characteristics is intense, which fuels AIDS stigma, especially self-stigmatisation.

These findings are at odds with the literature that suggests stigma is no longer as useful a concept in understanding how Africans are living with AIDS. Kipp et al. (2007) report that discrimination against AIDS patients and their family members in rural Uganda has eased. Chimwaza and Watkins (2004) found similar trends in rural Malawi and report that caregivers for AIDS patients received a range of support from relatives and community members. However, neither study included HIV-positive individuals and nearly all the caregivers were women. Neither study, therefore, adequately captures how HIV-positive African men experience living with their condition.

The dominant narrative presented by both union members and clinic staff was that men feared addressing the dangers of HIV and AIDS, denied they were at risk of infection, and were unwilling to disclose their serostatus—all issues that underscore that stigma remains a

valuable concept for understanding how men in urban Uganda experience HIV. The persistence of AIDS stigma has been noted in other recent studies which suggest that access to treatment and care alone will not eliminate AIDS stigma (Maughan-Brown, 2010). This makes clear the importance of recognising that there are multiple forms of stigma and these forms affect groups of individuals in different ways.

This research with the union also demonstrates that intrapersonal forms of AIDS stigma are especially salient for men in urban Uganda, and other research also finds intrapersonal stigma, especially internalised stigma, among men. Nyanzi-Wakholi et al. (2009) report that positive Ugandan women were more likely to report overt experiences of discrimination while positive men recounted feelings of self-inflicted stigma tied to their fears of how the community perceived HIV-positive men. In Kenya and Swaziland, men were more likely to blame themselves for becoming infected (Shamos et al. 2009; Yebei, Fortenberry, and Ayuku 2008), and in South Africa men more frequently said they were ashamed of being positive (Simbayi et al. 2007). Beyond the African continent, the few AIDS stigma studies that include heterosexual HIV-positive men also indicate the significance of intrapersonal forms of stigma (Doyal et al. 2009; Poku et al. 2005). In addition, Beck (2004) and Colvin et al. (2010) also stress the links between context-specific conceptions of masculinity and the ways African men experience AIDS stigma.

There are important limitations to this research that should be acknowledged. While this ethnographic fieldwork provides a rich account of this support group for HIV-positive men, the number of participants was small and the study was conducted in only one area of Kampala. This study, therefore, cannot address how Ugandan men in other settings experience AIDS stigma. TASO now runs similar support groups for positive men's at several of their branches across Uganda and research with these groups or similar groups would be valuable for comparison.

Masculinity, Stigma, and HIV Prevention in Africa

This research with the Bwaise Positive Men's Union underscores the importance of understanding links between gender, masculinity, and AIDS stigma. A conceptual framework has been proposed that links the structural, interpersonal, and intrapersonal dimensions of gender relations to related forms of AIDS stigma. This research extends our conceptualisation of AIDS stigma by examining in detail how one axis of social inequality—gender inequality—is intertwined with stigma as a social process.

An essential insight is the need to remain attentive to differences in how men and women experience AIDS stigma. There is ample evidence that HIV-positive African women experience overt forms of stigma and discrimination that are rooted in structures of gender inequality (Campbell et al. 2006; Mukasa et al. 2001; Simbayi et al. 2007). While men as a group benefit from such gender hierarchies, this research shows that stigma experienced by HIV-positive men is also tied to these normative gender relations. Hegemonic notions of masculinity that frame men as self-reliant family providers subordinate HIV-positive men as unmanly and inadequate. For many positive men, this leads to experiences of intrapersonal stigma, especially internalised stigma, for failing to embody hegemonic masculinity. Thus, normative gender relations are intertwined with AIDS stigma and stigmatisation in turn reproduces entrenched gender inequalities that have deleterious consequences for both women and men.

Although structures of gender inequality are formidable, they are not resistant to change. Union members did not question the hegemonic masculine ideal of men as family providers but they were critical of how many of their male peers coped with HIV and AIDS. They

stressed a different formulation of masculinity centred on a more active role for men in their own, and their female partners', sexual health.

This union provides a valuable model for how HIV-positive men can confront stigma and critique the normative gender relations that drive such stigma. However, I am not suggesting that stigma could be addressed if individual Ugandan men simply took more responsibility for their own sexual health. To the contrary, this paper emphasises that social structural factors tied to gender relations shape and constrain the behaviour of men in this context—factors which pose limits to HIV and AIDS health campaigns stressing personal responsibility and individual behaviour change.

In addition, this research also presents a cautionary tale. The limited number of men willing to join the union and its ultimate demise demonstrate the obstacles men face organising themselves. Colvin et al. (2010) note similar issues among men in Cape Town and Lyttleton's research (2004) with positive Thai men demonstrates such challenges are not unique to men in Africa. The life histories of Richard and Joseph also underscore that even socially-underprivileged men are able to capitalise on male sexual privileges that accord men much greater freedom to pursue sexual relationships, including concurrent sexual relationships.

Nonetheless, spaces that allow HIV-positive men to safely discuss the stigma they experience could be transformative. While alternative models of masculinity are not easily cultivated, there are examples of such notions emerging as men confront health challenges, including AIDS (Beck 2004; Colvin et al. 2010; Emslie et al. 2006; Lynch et al. 2010). This research with the Bwaise Positive Men's Union illustrates that some HIV-positive African men are willing to take steps to address the stigma associated with HIV and AIDS. Harnessing such enthusiasm is crucial for transforming those aspects of masculinity that place both men and women at risk of HIV infection across the African continent.

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