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To cite this article: Sarah Rudrum, John L. Oliffe & Cecilia Benoit (2016): Discourses of masculinity, femininity and sexuality in Uganda’s Stand Proud, Get Circumcised campaign, Culture, Health & Sexuality, DOI: 10.1080/13691058.2016.1214748

To link to this article: http://dx.doi.org/10.1080/13691058.2016.1214748

Published online: 11 Aug 2016.
Discourses of masculinity, femininity and sexuality in Uganda’s Stand Proud, Get Circumcised campaign

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ABSTRACT
This paper analyses discourses of masculinity, femininity and sexuality in Stand Proud, Get Circumcised, a public health campaign promoting circumcision as an HIV-prevention strategy in Uganda. The campaign includes posters highlighting the positive reactions of women to circumcised men, and is intended to support the national rollout of voluntary medical male circumcision. We offer a critical discourse analysis of representations of masculinity, femininity and sexuality in relation to HIV prevention. The campaign materials have a playful feel and, in contrast to ABC (Abstain, Be faithful, Use condoms) campaigns, acknowledge the potential for pre-marital and extra-marital sex. However, these posters exploit male anxieties about appearance and performance, drawing on hegemonic masculinity to promote circumcision as an idealised body aesthetic. Positioning women as the campaign’s face reasserts a message that women are the custodians of family health and simultaneously perpetuates a norm of estrangement between men and their health. The wives’ slogan, ‘we have less chance of getting HIV’, is misleading, because circumcision only directly prevents female-to-male HIV transmission. Reaffirming hegemonic notions of appearance- and performance-based heterosexual masculinity reproduces existing unsafe norms about masculinity, femininity and sexuality. In selling male circumcision, the posters fail to promote an overall HIV-prevention message.

Introduction
Public health campaigns attempt to engage their audience and promote change through drawing attention to social and individual dimensions of a public health problem. How the social dimension of public health problems is framed is key because of its impact on social relations within and beyond the scope of individual campaigns. Esacove (2013) identifies a ‘tradition in medical sociology that analyses the effects of [public] health promotion efforts, including how they create and legitimise definitions of gender and sexuality, configure interventions and affect “target” populations and broader social systems’ (33). A useful methodology for examining public health messages is discourse analysis (see, for example, Chong and Kvasny 2007; Esacove 2013), wherein the term discourse refers to ‘language use...
as social practice’ (Fairclough 1995, 131). Critical discourse analysis is an interdisciplinary approach in which the relationship between power and discourse is understood to be dialectical; each contributes to the constitution of the other. Analysing discourse therefore provides a way to understand the ideologies that underpin unequal social relations (Fairclough 2013). Lazar (2005) identifies feminist critical discourse analysis as a methodology that can ‘show up the complex, subtle, and sometimes not so subtle, ways in which frequently taken-for-granted gendered assumptions and hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities’ (142). In this feminist critical discourse analysis of the Stand Proud, Get Circumcised campaign promoting voluntary medical male circumcision as an HIV-prevention strategy in Uganda, we are particularly concerned with how masculinity, femininity, gender relations and acceptable sexuality are configured.

The Stand Proud, Get Circumcised campaign was introduced in 2012 by the Uganda Ministry of Public Health and funded by the United States Agency for International Development (USAID). The campaign’s goal was to support the national rollout of voluntary medical male circumcision (referred to in the campaign materials as safe male circumcision). Targeting adult men for circumcision is an HIV-prevention strategy introduced because of the 50–60% reduced risk of female-to-male HIV acquisition among circumcised men (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007; Padian et al. 2011). There is no direct benefit to women whose HIV-positive partners circumcise, and circumcision may increase the risk to women if couples resume sex following surgery before the wound has fully healed (Wawer et al. 2009). It is speculated that circumcision will indirectly benefit women through reduction in HIV among potential male partners (Marfatia et al. 2015); however the extent of such a benefit has not been identified and is likely to ‘be slow to emerge and have limited impact on female HIV risk in the short term’ (Maughan-Brown et al. 2015, 1171). There have been no clinical trials assessing whether circumcision offers HIV protection to men who have sex with men.

Uganda is known for its early success in reducing HIV prevalence (Wyrod 2008), achieved via broad-based information campaigns and behavior-change messages, but rates of infection are currently rising again (Lagone et al. 2014). Heterosexual sex remains the primary mode of HIV transmission in sub-Saharan Africa (UNAIDS 2013). As such, sexual relationships and values, as well as norms of femininity and masculinity, have often been the target of HIV-prevention campaigns in Uganda and throughout the region (Chong and Kvasny 2007; Esacove 2013; Faria 2008). For example, Faria (2008) identified that a major public health campaign in Ghana placed responsibility for HIV prevention with women, despite their social vulnerability, a trend Chong and Kvasny (2007) argued predominates in discourse about HIV and women. Our analysis of the posters disseminated in the Stand Proud, Get Circumcised campaign identifies several implicit messages about gender and sexuality that are relied on and legitimised by the campaign. Examining discourses about gender and sexuality in Uganda’s Stand Proud, Get Circumcised campaign contributes to tracking how gender relations, discourses of sexuality and morality, and sexual agency are shaped through interventions targeting HIV and public health within Uganda and elsewhere in sub-Saharan Africa, where numerous circumcision campaigns are currently being introduced.
The campaign

Background

The Stand Proud, Get Circumcised campaign was rolled out in 2012 as a project of the Uganda Ministry of Health. The campaign was designed by the Uganda Health Communication Partnership and funded by USAID. The posters target two groups constructed as separate: (1) men having sex with new female partners and (2) married men. Each poster features a photograph of one woman, and the target groups are constructed as separate partly through the differences between these women and their reactions. In the poster series labelled by campaign documents as disruptive (Health Communication Partnership n.d.), a young woman wearing makeup and a stylized manicure bears an expression of shock while saying ‘You mean you’re not circumcised!’ Or ‘Forget size, you mean you’re not circumcised!’ (see Figures 1 and 2). In these posters, HIV is not mentioned except in the fine print that explains that even with circumcision, sex without a condom carries an increased risk of transmission. These English language posters were, according to campaign analysis documents, placed in urinals (Health Communication Partnership undated); photos also show them situated in health centres. In contrast, posters targeting married men came in two versions (Figures 3 and 4): (1) urban, featuring a young woman and printed in two languages (English and Luganda) and (2) rural, featuring a middle-aged woman with a head wrap and printed in six languages (including English, Luganda, Luo (Acholi), Rukiga/Runyankole and Swahili). In both the urban and rural versions of the poster targeting husbands, each model had an open smile with the narrative, ‘I am proud my husband is circumcised. We have less chance of getting HIV’. All posters bear the slogan, ‘Stand Proud, Get Circumcised’. Although adult male circumcision is an intervention for men, the posters exclusively feature women,¹ a feature discussed below along with other dominant gender and sexuality discourses.

Figure 1. Example of a disruptive poster, as seen in a health centre ward.
Discourses of masculinity

In comparison to women, men have been a less prominent focus of HIV public health campaigns in sub-Saharan Africa, for reasons including women’s greater vulnerability to infection, as well as discourses of femininity that position women as responsible for family and community health. Where men do feature, it is often as ‘the problem’ (Shand et al. 2014, 53). That is, men are more often targeted as transmitters of HIV rather than as vulnerable to acquiring the virus. Pointing out the obvious, clearly men ‘cannot infect a woman without being infected themselves’ (Higgins, Hoffman, and Dworkin 2010, 437). Despite this, where men have been targeted, it has routinely been anchored in men’s potential to infect women. Norms of masculinity cohere with the positioning of men as dangerous and irresponsible in relation to HIV: ‘Globally, sociocultural constructions of masculinity are strongly associated with, if not dependent on, men’s risk-taking behaviours, including alcohol and drug use, pleasure seeking, and an alleged lack of interest in their own health’ (Higgins, Hoffman, and Dworkin 2010, 439). HIV stigma interacts with ‘context-specific notions of masculinity’ (Wyrod 2011, 2) in ways that have often impeded Ugandan men from participating in HIV testing, disclosing and seeking care when HIV-positive or otherwise being proactive in relation to HIV. However, ‘one of the main premises upon which men have been ignored, that is, the futility of changing men’s sexual behaviour, has been challenged by studies that confirm that masculine behaviours and attitudes can, in fact, be changed’ (Rutakumwa et al. 2015, 1246). Berer (2007) also problematises the assumption that ‘unprotected, unsafe sex on...
the part of men in sub-Saharan Africa cannot be changed’ as it is relied on within international approaches to HIV reduction in sub-Saharan Africa (46). She notes that while the assumption is false, it ‘could become a self-fulfilling prophecy if male circumcision services – or any other HIV prevention activities directed at men – are not set up in such a way that safer sex and condom use rates are not greatly improved’ (46). It is possible to target men directly, as masculinity is neither static nor monolithic, and can include aspects that are supportive of health for men and their partners; however, discourses characterising masculinity as inherently associated with risky sexuality can prevent such direct targeting.

The nature of circumcision as an HIV prevention tool that requires male participation (and excludes female uptake, though not participation) potentially provides an opportunity to disrupt some gendered discourses. Since only men can prevent HIV through circumcision, the option of voluntary medical male circumcision places men in a position of responsibility with regards to their own, and possibly others’, health. However, the ‘disruptive’ posters (Figures 1 and 2) opt instead to exploit and re-inscribe widespread anxieties about embodying masculine ideals as prescribed and preferred by potential women partners. Embedded here is also a hegemonic femininity whereby an individual woman is positioned as representing the view of all women in her culture through her reaction and through an assertive narrative. This dominant feminine voice is invoked in order to signal how men might more closely align to hegemonic masculinity by being circumcised, not necessarily for the body aesthetic itself but for the masculine capital it purportedly carries in attracting the opposite sex. That is, through this campaign, circumcision is paired with sexual attractiveness and the

Figure 3. Example of poster featuring wives, urban version.
promise of sex itself. The posters appeal to concerns over sexual performance and appearance, as well as perceived cleanliness, potentially exchanging one dominant ideal for another. Admonished to ‘forget size’, a longstanding measure of ‘successful’ masculinity, men are invited to exchange this anxiety for one about appearance and cleanliness that can be best resolved via circumcision. Anxieties about sexual performance have long been exploited by both mainstream advertising and public health campaigns targeting men (Bottorff, Oliffe, and Kelly 2012), while the appearance of cleanliness has also been identified as a concern for men (Greaves et al. 2010). Although Uganda’s goal with adult male circumcision is not to enhance performance, appearance or cleanliness, but rather to reduce the rate of HIV transmission, the campaign trades on anxieties over performance, appearance and perceived cleanliness as effective in mobilising men.

Within the Stand Proud, Get Circumcised campaign, the posters described as disruptive (Figures 1 and 2) signalled women’s displeasure with an uncircumcised penis. With the look of shock one might reasonably conclude that an uncircumcised penis is both unattractive and resident outside the ‘normed’ aesthetics. Rather than focusing primarily on the potential health benefits of the procedure (reduction in risk of HIV acquisition for the person getting circumcised and, possibly, his partner[s]), these advertisements present circumcision as an opportunity for men to conform to a normative appearance. In this case, circumcision is introduced as a new, and newly medicalised, ideal, since the generations of men targeted were not routinely circumcised at birth or as a coming-of-age practice. An appeal to male
pride is explicit in the campaign’s Stand Proud mantra, which fuses an erection (stand) with male pride (proud). Stand Proud also asserts activity over passivity, and connects circumcision with both performing and embodying masculinity.

This concern over appearance arises in relation to the projected response of potential female partners, positioning circumcision within heteronormativity. The woman’s gaze, expression and assertive narrative invoke her preference for a particular type of penis. Ironically, this objectification that separates the man from his penis plays to masculine ideals about objectification of body parts in determining sexual interest. The goal is likely to capture the attention of men through the inclusion of an attractive woman evaluating a potential mate in ways more typically cast as masculine than feminine. The hook here is that women might actually think similarly to men, making the messaging about aesthetics engaging to men. The risk is that the intended public health message – get circumcised – might be lost in the many other messages embedded in the poster. The message to get circumcised is already a watered down message, as it does not include necessary details about whom circumcision protects and what other HIV protection measures are necessary once circumcised. These messages about desire, appearance and sex overshadow the message of circumcision as a prevention measure for HIV and other STIs. The specific source of the woman’s displeasure toward the uncircumcised penis is left ambiguous. It could be about cleanliness – a study by the agency designing the campaign found that ‘The majority of women who were interviewed wanted their men to be circumcised, and their main reasons were that they thought circumcised men were cleaner hygienically, and less likely to spread HIV’ (Health Communication Partnership n.d., 2). Promoting a message that a circumcised penis is ‘clean’ and less likely to spread HIV is problematic when circumcision reduces the spread HIV transmission from women to men, but not vice versa. The reference to size (‘Forget size, you mean you’re not circumcised?’) implicitly links the aesthetics of circumcised versus uncircumcised penises to men’s sexual prowess and women’s sexual pleasure, thereby connecting circumcision to normative masculinity and exchanging existing norms such as size for circumcision. Unlike the posters featuring wives, the women in this series (Figures 1 and 2) do not mention HIV prevention, and instead focus exclusively on aesthetics.

The second set of posters, (Figures 3 and 4) targeting married men in urban and rural communities, is distinct in that the woman’s concern is not aesthetics or related to sexual pleasure. The message of the married woman is more straightforward, identifying decreased risk of HIV exposure for the couple due to her husband’s circumcision. The women are positioned as wives by referring to a husband. In one case, the woman is notably older than the model used in the disruptive campaign and is wearing a kitenge headwrap; her appearance contrasts with that of the women in the disruptive posters whose embellishments are sexy rather than ‘traditional’. In each poster, the married woman states, ‘I am proud my husband is circumcised. We have less chance of getting HIV’. While the ‘disruptive’ posters (Figures 1 and 2) appeal to men’s sexual pride and the self-consciousness that is its mirror side, these posters perhaps are intended to target married women, with the goal that they bring the message to their husbands. Women are often represented as health mobilisers or as the conduit to health care for their family members (Chong and Kvasny 2007). In an article examining couples’ HIV testing and male participation in antenatal care (ANC) and HIV testing, we found that, despite the presence of posters targeting men directly, the primary way men were mobilised to attend ANC and test for HIV was via their pregnant wives (Rudrum, Oliffe, and Brown 2015). Although the text in the posters implies decreased risk to both
partners within a marriage (‘we’), by featuring a woman alone rather than a man or a couple, the posters position women’s views on circumcision as central to lobbying men’s action. By extension, men’s views are positioned as marginal, despite the male-centric nature of circumcision as an intervention. This is consistent with the trend identified by Chong and Kvasny (2007) for HIV public health campaigns to place a ‘disproportionate amount of responsibility on women’ (9).

While centring on married couples, the poster indirectly acknowledges the potential for non-monogamy and/or for sero-discordance (differing HIV status within a couple); if monogamy were assumed, there would be little need to target married HIV-negative people with prevention strategies. Acknowledging the existence of multiple sexual partners is particularly important in Uganda’s context, because polygyny is relatively common among several cultural groups targeted in the campaign, including the Baganda (Wyrod 2013) and Acholi (Muldoon et al. 2011). It is also important as a departure from the environment of secrecy regarding extra-marital sex that the ABC message (Abstain, Be faithful, Use condoms), with its focus on faithfulness, has been criticised for fostering. Failing to acknowledge extra-marital sex or sero-discordance in public health campaigns contributes to HIV risk among married women (Human Rights Watch 2005; Parikh 2007). Parikh (2007) found that:

In the context of highly visible medico-moral HIV prevention messages to ‘be faithful’ and popular culture and religious discourses promoting monogamous marriages, increased secrecy and discretion about extramarital relationships allow husbands (as well as their wives) to manage their public reputations and maintain the appearance of being modern and moral. (1198)

The faithfulness message coupled with secrecy underplays men’s marital HIV risk (Parikh 2007, 1198). It is unclear whether as well as acknowledging infidelity, the campaign also condones or enables extra-marital sex; the likelihood that such risk compensation could negate the effects of male circumcision as prevention is a key element in discussion of the strategy’s potential (Humphries et al. 2015; Kalichman, Eaton, and Pinkerton 2007; Wamai et al. 2015; White et al. 2008).

The message ‘I am proud my husband is circumcised. We have less chance of getting HIV’ concedes, and positions women as acknowledging, that sex is likely to occur outside of marriage. As is typical in public health messaging as well as in HIV research (Muldoon et al. 2011; Rudrum, Oliffe, and Brown 2015), marriage itself is positioned within the campaign as inherently monogamous rather than polygynous in nature, despite the social reality of polygyny among the target audience. While there are benefits in moving beyond a prevention strategy reliant on monogamous faithfulness to an unrealistic degree, infidelity or sexual concurrency is situated within the campaign as a patriarchal bargain, a social arrangement within which ‘women accept overt subordination in exchange for male protection and secure social status’ (Meadow and Stacey 2006, 55–56). The posters position married women as protecting their safety and the safety of her children yet born by avoiding HIV, meanwhile accepting that men will inevitably have sex outside the marriage. As discussed earlier, the assumption that men will not change their behaviour is harmful and has the potential to be self-fulfilling if it means that behavioural interventions, such as condom-use, are not widely promoted in circumcision campaigns (Berer 2007). Within the Stand Proud, Get Circumcised posters, however, circumcision is presented as a stand-alone intervention, with condoms only mentioned in the small print. In contrast, even within other campaigns relying on a message that circumcision is sexy and desirable to women, condom use has been prominently promoted. For example, South Africa’s 2015 ZING campaign depicts a man reaching
for a condom in the lead-up to inaugural post-circumcision sex, and bears the clear slogan ‘Circumcise and Condomize’ (ZING VMMC Campaign 2015).

An additional and serious problem with the Stand Proud, Get Circumcised message that ‘We have less chance of getting HIV’ is its lack of a basis in evidence on circumcision and HIV transmission. Studies to date associate voluntary medical male circumcision with a reduction in female-to-male transmission of HIV, however, male-to-female transmission is not directly reduced; any benefit to women is indirect and has not yet been quantified (Marfatia et al. 2015; Wawer et al. 2009). The poster’s claim that ‘We have less chance of getting HIV’ therefore overstates any protection offered to women through this intervention. A study of whether Malawians who learn that circumcision reduces male-to-female HIV transmission ‘also erroneously infer a reduction in direct male-to-female risk’ (Maughan-Brown et al. 2015, 1170) found that this was the case among 72% of male and 82% of female participants. The study authors therefore conclude that voluntary medical male circumcision campaigns should ‘make explicit that male circumcision does not directly protect women from HIV-infection’ (1170). The Stand Proud, Get Circumcised campaign takes an opposite approach, implying an equal benefit to men and women via the message ‘We have less chance of getting HIV’.

Masculinity, or what it is to be a man according to social norms, is at once hegemonic and subject to change and intervention. The Stand Proud, Get Circumcised campaign consciously exploits the fragility of masculinity, with an awareness that hetero-masculinity can be built or buttressed by female expectations and beliefs, whether perceived or actual. According to background documents, ‘Several messages were developed for specific communities based around: Being a man means undergoing safe medical circumcision [and] Men desire to be attractive to women, and women want their men to be circumcised’ (Health Communication Partnership n.d., 4). This exemplifies a common discursive practice in which, to shift narratives of what it is to ‘be a man’, women are cast as potent change-makers. Shand and colleagues (2014) warn that ‘unhealthy constructions of masculinity’, including ‘sexual prowess and heteronormativity, as a way of asserting manhood’ can in fact act as deterrents to seeking HIV care (53). Similarly, Wyrod (2011) identified that ‘the enactment of normative masculine gender identities’ (3) not only has negative consequences for men’s health, but also reproduces gendered inequalities, thus negatively impacting women’s health. This campaign also reinforces heterosexual norms, as though they can work as a trade-off for lobbying change to a single practice, circumcision. Risked here is the perpetuation, and perhaps even the acceptance and affirmation, of other practices that marginalise and subordinate women, including undisclosed infidelity, disrespect or violence. The patriarchal tax in this circumstance is paid by the women in attempting to reduce their HIV risk. Previous campaigns have positioned women as caring for others in a reified version as femininity as nurturing and self-sacrificing. Here, the women are positioned less so as invested in the health of their man, and instead as deeply aware that their health is connected through intimate relations (again, despite the intervention’s lack of efficacy in directly preventing male-to-female transmission). Such insights should act as cautions against appeals to normative masculinity as a method of public health promotion.

**Discourses of femininity**

Public health discourse on HIV has predominately relied on two norms of feminine sexuality: (1) women’s sexuality is characterised by ‘purity and faithfulness’ (Chong and Kvasny 2007)
and (2) women are ‘sexually powerless and passive’ (Esacove 2013, 39). Both norms are consistent with Chandra Mohanty’s (1988) critiques of the ‘Third World Woman,’ an imagined object of study in Western feminism characterised by powerlessness and victim status (see also Benoit et al. 2013). They are also consistent with an HIV-prevention discourse in which women are positioned as vulnerable to HIV risk and men as embodying risk, sometimes referred to as the ‘vulnerability paradigm’ (Higgins, Hoffman, and Dworkin 2010). Chong and Kvasny’s (2007) review of women and HIV literature found that ‘women are given greater responsibility for protecting themselves and their children from HIV infection, but there is little in the way of societal changes that afford women the power necessary to take on these additional responsibilities’ (7). Overall, they asserted that women were being put forward as the ‘face of AIDS’ while considerably less attention was paid to men’s sexual practices. In a subsequent piece, Kvasny and Chong (2008) critique ABC campaigns as ineffective for women in sub-Saharan Africa due to their failure to take into account gendered and other social inequities or the broader context of reproductive health. Esacove’s (2013) analysis of HIV discourse and gender within USAID during the (G. W.) Bush and Clinton administrations found that ‘While couched in the objective and therapeutic language of science and medicine […] HIV prevention policy is actually organised around narrowly defined moral categories of good and bad sex’ (44). In the Bush era, ‘all sex that is not between married partners is considered risky or bad sex,’ whereas under Clinton the discourse shifted slightly, so that good sex was equated with ‘that which reduces the risk of HIV infection but does not necessarily eliminate it’ (42). That is, ‘bad sex can be made good’ through individual prevention efforts (42). As a strategy, circumcision as prevention fits within the bad sex rehabilitated as good sex approach described by Esacove (2013). The discourses present in global health and development documents analysed by Chong and Kvasny (2007; Kvasny and Chong 2008) and by Esacove (2013) are highly relevant to current public health discourses surrounding HIV prevention in Uganda, which is still funded and shaped by USAID and influenced by globalised constructions of gender, sexuality and morality.

It is worth considering whether the Stand Proud, Get Circumcised posters labelled by the campaign as disruptive (Figures 1 and 2) do in fact disrupt existing discursive norms of femininity. This could be the case in two ways: (1) the posters introduce female sexual agency and desire by featuring female displeasure at an uncircumcised penis, and thereby presumed preference for and pleasure with a circumcised penis and (2) the implied sexual encounter is ‘casual’ in that the woman pictured has not seen her partner naked before and is not positioned as a wife or exclusive partner. The implied encounter is not characterised by ‘purity and faithfulness’ such as in the married posters (Figures 3 and 4) within the Stand Proud, Get Circumcised campaign, or by ‘powerlessness and passivity,’ such as in another contemporaneous Ugandan public health campaign, the Let Girls be Girls campaign to ‘reduce teen pregnancy, maternal mortality among young women and girls, and the cost of post-abortion medical care’ (IRIN 2014). By introducing female pleasure and casual sex, the posters present a departure from existing discourses of femininity in relation to HIV. However, any transformative potential of such a departure is limited because the woman’s experience of pleasure and casual sex is framed to appeal to male imaginaries, and not to female sexual agency.

Acknowledging the existence of female desire and the need for HIV prevention in the sexual encounters that occur outside of the contexts of marriage or violence interrupts
previous global public health discourses about feminine sexuality as either chaste or vulnerable. However, women are still pictured in these posters as the ‘face of AIDS’ (Chong and Kvasny 2007) and positioned as having responsibility for leveraging men’s actions with regard to HIV prevention and sexual health. Although there is some implied female sexual agency in the campaign, the change being promoted is male circumcision, a decision in relation to which women have only limited, or proxy, agency, and via which women stand to benefit only indirectly. Similarly, female sexual pleasure is not positioned as the women’s domain, but as something that men can aspire to igniting through adhering to a new form of masculine embodiment, the circumcised, clean penis. Despite being potentially transformative in comparison to the Bush era ABC messaging that continues to shape sexuality and HIV in Uganda, the disruptive posters (Figures 1 and 2) are primarily used to promote specific masculine ideals of sex based on erection, penetration and climax, rather than interrupting such discourses. Since men are the target of the intervention, the women are represented in such a way as to engage the men in the fantasy that women might be objectifying men in search of casual sex. While the campaign has been described as having a ‘provocative approach that spoke to men through women’ (Kibira et al. 2016, 2), a focus on women and relying on women to reach men has, in fact, been the problematic norm for HIV public health discourses (Chong and Kvasny 2007; Rudrum, Oliffe, and Brown 2015). Within such a norm, estrangements between men and their health are also perpetuated.

**Discourses of heteronormativity**

As described above, women have been the face of much HIV prevention in sub-Saharan Africa. The targeting of women is important within the context of heterosexual sex as the primary mode of transmission in the region. However, other populations also remain vulnerable to HIV. Men who have sex with men have long been acknowledged to be conspicuous through their absence when it comes to HIV prevention in Africa (Parker, Khan, and Aggleton 1998). Making the case for a diverse approach to prevention that avoids faith in magic bullet solutions, Piot et al. (2008) argue that “Combination prevention” is as necessary as “combination treatment” when it comes to stopping the pandemic (846), since focusing on one group, women, even if they are highly vulnerable, cannot be effective on its own. ‘Men who have sex with men account for a large proportion of the epidemic even where heterosexual transmission predominates, such as in sub-Saharan Africa’ (Piot et al. 2008, 8490). This sub-group of men is often highly stigmatised and therefore already marginalised when it comes to health services. Despite this, HIV-prevention strategies rarely, if ever, explicitly explore the impact of the pervasive and overarching heteronormativity of African societies that reaffirms these harmful social and cultural norms (Seale 2009, 86). While the focus on heterosexuality within the Stand Proud, Get Circumcised campaign is in keeping with current evidence on circumcision and HIV prevention, it is nevertheless a public site reifying heteronormative relationships.

In recent years, virulent homophobia in Uganda has been fomented by international Evangelical Christian groups (Cheney 2012), politicians and the press. The public narrative on same-sex sexuality has been characterised by repression, control and stigma. The public outing of gays in the media and the subsequent murder of gay activist David Kato are prominent examples (Akinyemi 2016). State-sanctioned homophobia is exemplified by The Anti-Homosexuality Act, first introduced in 2009 and signed, but subsequently annulled, in 2014;
its author and the president have both stated that it will be reintroduced (Biryabarema 2014). Existing laws criminalise homosexuality; the Anti-Homosexuality Act goes further, seeking to criminalise the failure to report known ‘homosexual behaviour’ and to penalise ‘aggravated homosexuality,’ a category that targets HIV-positive men who have gay sex with the threat of life sentences (Nyanzi 2013; Strand 2011). The act demonstrates and reproduces a context of extreme heteronormativity – the normalisation of heterosexuality and concomitant marginalisation of other sexualities (Cacchioni 2007). Anti-Homosexuality Acts, apart from attempting to legislate hate, are likely to reduce access to healthcare and negatively impact HIV programmes (Beyrer 2014). Such effects of the proposed act are likely to be exacerbated by the HIV Transmission and Control Act (2014), which criminalises transmission, requires health workers to divulge patients’ HIV status and makes testing compulsory under certain circumstances (Devi 2014).

Within the contemporary context of homophobia, sustaining hegemonic masculinity in order to position circumcision as a norm to which heterosexual men should conform is harmful in reproducing a narrowly defined sexual norm for men. Pigg and Adams (2005) make the case that where ‘science, medicine, and public health are the idioms through which sexual matters are articulated, the relational dynamics of power and difference are often forged around contested meanings of “the sexual”’ (10). Part of the problem is that stigma around sexuality leads to fear over disclosing relevant sexual information to care providers (Stuber, Meyer, and Link 2008), who under the proposed act would be required to report known instances gay sex, or seeking care at all. While heterosexual sex remains the primary mode of transmission in Uganda, moves to stigmatise same-sex sexuality contribute to vulnerabilities within this sub-community, as social and healthcare services are unable to target a group outlawed and ostracised from public view and therefore public health discourses. While circumcision is targeting the prevention of female-to-male HIV transmission, its rollout is intended to be extended to all men. Just as the role of circumcision in protecting women needs to be clarified in circumcision campaigns, gay men and men who have sex with men will be looking to these new campaigns for health information. The inclusion of such information is of relevance to gay men’s decision-making but also, importantly, to their representation and acknowledgement in public discourses about sexuality and health.

**Conclusion**

A public health campaign targeting men for voluntary medical male circumcision provides a unique opportunity to identify how men, so often neglected in messaging on HIV, are targeted. Even within this prevention strategy that is male-only, however, men were absent, with women presenting the campaign’s public face. We found that this was in keeping with widespread messages about gender and HIV in the region that position women as the central actors. Despite the absence of men in the Stand Proud, Get Circumcised poster campaign, messages about normative masculinity were evident. These departed from the message of men as dangerous, instead trading on anxieties about the penis as a site for the physical assessment of masculine sexual prowess or failure. The reproduction of normative heterosexual masculinity and the concomitant lack of reference to gay men affirm hegemonic masculinity as embodied by straight, circumcised, sexually active men. Similarly, discourses of femininity departed from a women-as-victims discourse by introducing sexual pleasure; however, this sexual agency was relevant only for its ability to impose conditions for sex,
thereby influencing men to circumcise. The discourses around gender in this campaign, therefore, are not socially transformative; instead, they are positioned to reproduce norms of gendered sexual interactions that privilege male power and affirm norms of masculinity that have proved to hinder both men’s and women’s health. Dominant discourses about masculinity, femininity and sexuality reaffirmed in this campaign offer little hope for creating structural changes to gender relations that might hinder HIV transmission. The posters sell circumcision, but by neglecting to highlight the evidence that women are not directly protected or that other tools of prevention including condoms remain important despite circumcision, they fail to promote an overall HIV-prevention message. Due to such omissions, the posters position circumcision as a magic-bullet approach, a claim in relation to which the intervention can only fall short.

Note

1. Other campaign materials, including videos, do feature men’s accounts.

Disclosure statement

No potential conflict of interest was reported by the authors.

References


ZING VMMC Campaign. 2015. Online resource. Accessed May 13, 2016 https://www.youtube.com/watch?v=8k0WwqTHyA