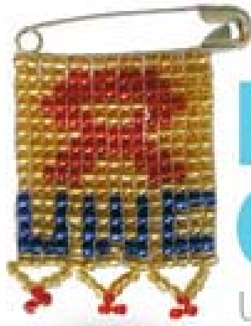

UWC HIV and AIDS Research Centre – "HIV in Context" Working Paper No. 2

Intersections of gender & HIV: Overview and critical reflection on new directions

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The UWC **Centre for Research in HIV and AIDS** was created in 2009 to foster synergies among research efforts across faculties and disciplines, actively engaging communities, schools, the health system, and gender and social equity advocates. Housed in the School of Public Health, Faculty of Community and Health Sciences and with a University-wide mandate, the Research Centre emphasizes **systems and society,** initially concentrating on : **health policies and systems; education and learning; gender and gender –based violence; and capacity strengthening.** The HIV In Context Working Papers seek and contribute to engage scholarship and debate that understands and addresses "HIV In Context". They include a range of genres, from state of the art reviews of the literature to theoretical or methodological think pieces to reflect and experimental contributions from scholars, educators, practitioners, activists and policy makers. The opinions expressed in the Working Papers are those of the authors alone.

Paper commissioned for the School of Public Health, VLIRR/DBBSResearch for Improved HIV Prevention and Care: Addressing Gender Power relations & Gender Based Violence

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August 2009

It is now widely acknowledged that we cannot understand or respond to HIV/AIDS and its impact on South African societies without taking gender roles and gender power inequalities seriously. It is increasingly evident that the way in which HIV/AIDS infection has progressed, as well as the way in which the epidemic has impacted on those infected and affected, is strongly gendered. It is also well recognised that women, especially poor, black, and young women, given other historical inequalities in SA, have been most negatively affected by the epidemic at multiple levels. Both biological and social vulnerabilities of women to HIV and its effects on their lives have been foregrounded in the acknowledgement that women and girls are disproportionately infected and affected by HIV/AIDS (Harrison, 2005; Shisana *et al*., 2005). The 2005 national prevalence survey (Shisana *et al*., 2005) for example, showed that 5 per cent more South African women and girls (13.3%) are living with HIV/AIDS than boys and men (8.2%). The HSRC's latest National HIV Prevalence, Incidence, Behaviour and Communication Survey (Shisana *et al*., 2008) shows that African females ages 20- 34 are the most at risk population, with an HIV prevalence of 32.7%. HIV prevalence for women in this age group has remained very high, at around 33% in all three of the HSRC national surveys (Shisana *et al*., 2002, 2005, 2008).

In many ways HIV/AIDS mirrors existing gender inequalities and normative gender practices, and has also further entrenched and exacerbated existing gender power relations, and women's oppression in particular. This paper presents an overview of key themes emerging from the literature, both popular and academic, and broader social dialogue, that speak to the socio-psychological level of the complex intersection between gender and HIV/AIDS. The paper is divided into two broad areas: a) gendered dynamics relating to the spread of HIV/AIDS; and b) the gendered impact of HIV/AIDS on communities. The paper concludes with some critical reflection on our knowledge production in the area of HIV/AIDS and gender and some suggested directions for new and appropriate research in this area.

Gendered dynamics in the spread of HIV/AIDS in South Africa

The South African HIV/AIDS epidemic, while initially identified amongst homosexual men in this country (Reddy, Sandfort & Rispel, 2009), has been understood as progressing primarily through heterosexual modes of transmission[1]. This section outlines the literature that highlights how gender roles and gender power inequalities intersect with 'normal' heterosexual practices in the context of HIV/AIDS. Since relatively early on in the epidemic there was an acknowledgement that gender roles play a crucial role in the spread of HIV (for example, Abdool Karim, 1998, 2005; Amaro 1995; Du Guerny & Sjoberg 1993; Holland, Ramazanoglu & Scott 1990a; McFadden 1992; Patton 1990; Salt, Bor & Palmer 1995; Seidel 1993a; Strebel, 1993; Walker & Gilbert, 2002a, 2002b; Weiss, Whelan & Gupta 1996). In many ways it could be argued that HIV/AIDS has opened up a 'window of opportunity' for feminist critique of gender roles and relations as well as normative and idealised heterosexual sexuality (heterosex), for it has brought a critique of gender into mainstream research and literature and problematised 'normal' practices of heterosex (see for example, McFadden, 1992; Shefer, 2009a). While feminists have provided a long and sustained critique of heterosexuality as an institution in society, it remains idealised, unquestioned and naturalised, given the 'invisible power of heteronormativity as the enduring ideological formation in post-apartheid South Africa' (Steyn & Van Zyl, 2009, p. 3). On the other hand, I also argue at the end of the paper, that we may have inadvertently reproduced and reinforced some of the traditional gender and sexual roles in society through the way in which we have approached both research and intervention. This section presents four key and inter-locking themes in unpacking the ways in which gender and sexuality are enmeshed in the dynamics of HIV infection: the intersections of other power inequalities with gender in HIV infection; gender power in heterosex; normative gender roles of male and female sexualities; and violence and coercive sexual practices.

Intersectionality of power inequalities in heterosexual relations

At an international level, there is a large body of work, particularly in historically disadvantaged countries and continents, that views the intersection of gender inequality with economic subordination as central to HIV infection and women's reproductive health generally (for example, McFadden, 1992; Schoepf, 1988; Seidel, 1993a; WHO, 1994). With the feminisation of poverty, particularly evident in Africa, women, through the intersection of economic and gender power inequalities, have been shown to be especially vulnerable to HIV infection.

Such dynamics clearly play a significant role in the South African context. The intersection of economic context with gender power inequalities and other forms of social inequality (such as age, 'race', and so on) in the negotiation of heterosex has

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[1] There has been a recent critique of our lack of attention to alternative sexual practices in our response to HIV in South Africa and an argument that we are missing a 'silent epidemic' since little is known about the current prevalence of HIV among LGBT (lesbian, gay, bisexual and transgender)(see Reddy, Sandfort & Rispel, 2009). Some have argued that this may be linked to homophobia in South Africa and notions of the 'Un-Africanness' of homosexuality (Sember, 2009).

been widely illustrated; in particular the articulation of gender with age and class, positions young, poor women as particularly vulnerable to HIV infection through a lack of negotiation with respect to safe sex, and vulnerability to coercive sexual practices (for example, Harrison, Xaba, Kunene & Ntuli, 2001; NPPHCN, 1995; Shefer, 1999; Simbayi et al., 1999; Strebel, 1993; Varga & Makubalo,1996). The widespread nature of unprotected sexuality linked to economic factors such as poverty, financial dependence and job security has been empirically illustrated (Jewkes & Abrahams, 2000; Vetten & Dladla, 2000).

The post-apartheid heritage of poverty, war and physical dislocation (such as migrant labour systems) have been found to further undermine and impact on women's ability to practise safe sex and therefore protect themselves from HIV infection (for example, Campbell, Mzaidume & Williams 1998; Campbell, 2001; Hunt ,1989).

The articulation of gender, class and age, in particular, positions young, poor women as vulnerable to HIV infection. South African studies illustrate that young women frequently get involved with older men for access to money and/or status (Harrison, 2005; NPPHCN, 1995; Varga & Makubalo, 1996). Similarly, there is some anecdotal evidence that men are seeking younger women to have sex with in order to avoid sexually transmitted illnesses, which may be contributing to coercive sexual practices (Simbayi *et al.*, 1999). Another example of the overlap between age and gender in South Africa and elsewhere in the region, has been the rape of young girls and babies, which has been presented in the media as resulting from the apparently widely accepted belief that sex with virgins is a way of curing or protecting against HIV/AIDS (LoveLife, 2000; Vetten & Bhana, 2001). Of note in this respect is the finding in the latest national prevalence study (Shisana *et al.*, 2008) that the percentage of women with sexual partners who are more than 5 years older than them has increased from 18.5% in 2005 to 27.6% in 2008. This significant increase arguably highlights the unequal status of particularly young, poor women and their vulnerability to unequal, exploitative relationships which puts them at risk for unsafe sexual practices.

With respect to the imperative to sell sex for survival, sexworkers were initially constructed as a 'risk group' for HIV/AIDS and stigmatised internationally (Gilman, 1988; Holland *et al.*, 1990b), as will be discussed later in Section B. Research on sexworkers in South Africa has tended to argue that the context of multiple unequal power relations, in particular related to poverty, power inequalities and gender-related coercion, facilitate a particular vulnerability to HIV infection (see for example, Abdool Karim, Abdool Karim, Soldan. & Zondi , 1995; Leggett, 1999; Richter, 2008; Varga, 1997). A recent study on sexworkers in Cape Town has shown that participants are vulnerable to exploitative sexual practices since the power relation between the client and the sexworker may undermine the latter's ability to negotiate the terms of the sexual engagement (Gould & Fick, 2008); and other studies have highlighted the financial incentives for unprotected sex as one of the primary barriers to safe sex for sexworkers (Varga, 1997). Importantly it seems that the poorest sexworkers, generally black (given the intersection of class and 'race' in South Africa) are more vulnerable to HIV infection,

since sexworkers who are not in the direst of poverty are possibly more able to negotiate safe sex (Leggett, 2008). It could also be argued that through the efforts of organisations like SWEAT (Sex Workers Education and Advocacy Taskforce) sex workers may be more knowledgeable and empowered to protect themselves than women in non-transactional relationships with men, given the amount of training and support work that has been directed at this community in South Africa, and knowledge at least has been shown to be relatively high among some groups of sex workers (Varga, 1997). Moreover, Varga's study shows that it is in their intimate relationships with their own partners that sex workers find it most difficult to practise safe sex, given the complexities linked to the way in which condoms are constructed and the expectations of fidelity and trust in a heterosexual partnership. However, there is still a popular call for educational and support services for sex workers to be made more widely available, especially in rural and less advantaged parts of the country (Palitza, 2008).

Transactional sex that is not sex work in the traditional sense, nor necessarily related to dire poverty, but rather in response to consumerist pressures and desires of girls/women around material goods such as clothes, cell phones, etc,. has also been shown to play an important role in unsafe sexual practices, and is receiving increasing attention in southern Africa (Dunkle *et al*., 2004c; Leclerc-Madlala, 2004; Masvawure, 2009; Shefer, 2009b). The latest National HIV Prevalence, Incidence, Behaviour and Communication Survey conducted by the HSRC (Shisana *et al*., 2008) has also identified intergenerational sex between young women with older men ('sugar daddies') as a significant risk factor for young women with respect to their vulnerability to HIV infection.

Gender power inequalities

In the search for understanding the complex barriers to 'safe' sexual practices, much research has highlighted gender power relations inherent in 'normal' heterosexual relationships. It has been fairly widely reported that even if women have knowledge about HIV/AIDS or wish to protect themselves against pregnancy, they frequently are unable to successfully negotiate this (Shefer, 1999; Strebel, 1992, 1993; Varga & Makubalo, 1996;). Women's lack of negotiation has to be understood within the broader context of unequal gender relations and the way in which these intersect with other forms of power inequalities, such as class, 'race', age, disability, and so on.

The central role that cultural practices of gender and gender power inequality play in creating barriers to the negotiation of safe and equitable heterosex, has been increasingly theorised and researched in an international context. Similarly in South Africa, a growing number of studies have highlighted the way in which gender power relations manifest in the negotiation of heterosex (see for example, Miles, 1992; Shefer, 1999; Strebel, 1993; Varga & Makubalo 1996).

A focus on condom use in particular has highlighted the problematic dynamics of heterosexual negotiation, highlighting male power, women's inability to assert their

needs, and the way in which men's sexuality is privileged in decisions regarding condoms (Abdool Karim, Abdool Karim, Preston-Whyte & Sankar, 1992; Bremridge,. 2000; Lesch, 2000; MacPhail & Campbell, 2001; Strebel ,1993; Varga & Makubalo, 1996; Wood & Foster, 1995) .Studies have highlighted how women fear the loss of their partners, are anxious about their men not enjoying sex with a condom, and fear that a request for condoms will be interpreted as a lack of trust in the men or as an admission of their own infidelity (Bremridge, 2000; Campbell *et al*., 1998; Shefer, 1999; Strebel, 1993; Wood & Foster, 1995). While there was a definite increase in calls for women-centred methods of protection against HIV infection (e.g. female condom, spermacides) in the mid- to late-1990s in South Africa (for example, Rees, 1998), there was little research on the efficacy of such methods, and resistance to these methods has been documented (Richards, 1996; Strebel & Lindegger, 1998). What has become increasingly evident through the failure of cognitive models of intervention in HIV/AIDS is the complexity and irrational context of the operation of gendered power in the negotiation of heterosex (Ingham, Woodcok & Stenner, 1992; Kahn, 2008).

Traditional gender roles

There is much literature that highlights how traditional gender roles, not withstanding cultural differences, together with or outside of socio-economic factors, clearly play a significant role as barriers to safe sex practices. Studies show how women's lack of negotiation is strongly associated with socialised sexual practices, where it is expected of women to be passive, submissive partners, while men are expected to initiate, be active and lead women in the realm of sexuality (Shefer, 1999; Varga & Makubalo, 1996). Men are viewed as in control of relationships and sexuality. Much of this is related to the cultural constructions of male and female sexuality. A number of qualitative studies highlight the way in which social constructions of masculinity link with HIV infection, in particular the popular construction of male sexuality as ever-ready, urgent and uncontrollable (Lindegger & Durrheim, 2001; Mankayi, 2006, 2009; Shefer & Foster, 2001; Shefer & Ruiters, 1998; Strebel, 1993). This has elsewhere been named the 'male sexual drive discourse' (Hollway, 1989) that links to hegemonic constructions of masculinity and plays itself out particularly powerfully in the negotiation of heterosex.

Emerging out of the sexualised construction of men is the notion that sex is a male territory. Women on the contrary are viewed as 'asexual', and therefore 'strangers' to matters related to sexuality, with men as their hosts and guides. Women are expected to be focused on relationships and 'love', and sexuality is only legitimised for them if attached to these, what Hollway (1989) has termed the 'have-hold discourse'. As a participant in the NPPHCN study of 1995 (p. 36) pointed out, 'to be a girl is to be a wife and a mother'. A number of authors, internationally and locally, emphasise the lack of a positive discourse on female sexuality – in other words, women do not appear to be able to express or view their sexuality or their sexual desires and pleasures as positive (Holland *et al*., 1991; Hollway, 1995, 1996; Lesch, 2000; Shefer & Foster, 2001; Shefer & Strebel, 2001). There is a growing body of local work that points to this lack of a positive discourse on female sexuality that is believed to play a key role in the challenges to the negotiation of safe and equitable sexual practices (Harrison, 2008; Kahn, 2008; Lesch, 2000; Lesch,& Kruger, 2004; Miles, 1992; Shefer, 1999,

2003).Thus, there is an increasing call for the development of women's voices in the realm of sexuality. It is asserted that if women cannot 'say yes' to sexuality, and 'own' their sexuality and sexual desires, then they certainly cannot assertively 'say no' and negotiate what they desire in their sexual relationships with men. Ironically, as will be addressed later, there is also a growing concern about the way in which responses to HIV/AIDS (in particular moralistic discourses) have negatively impacted on the possibilities of a positive discourse and practices of female sexuality in African contexts (McFadden, 2003).

Linked to the above is the reported pervasiveness of the traditional double standard where men are encouraged to actively pursue sexuality and take multiple partners (Kahn, 2008; Mankayi, 2006; NPPHCN, 1995; Wood & Foster, 1995). On the other hand, women are punished for being sexually active, constructed as 'loose' and promiscuous. Even having knowledge about sexuality, and admitting to having had sexual experience appears to be taboo for women (Shefer, 1999).

Male constructions of female sexuality also show the way in which the double standards operate to sanction male pursuit of sexual pleasure, and constrain women's ability to define their own sexuality. Discourse on condom use, which has served to illustrate male power over women in sexual matters and decision-making, also highlights the traditional prescriptions for female sexuality within the whore-madonna dichotomy. Qualitative research in South Africa, mirroring international literature (for example, Waldby, Kippax & Crawford, 1993), shows how men distinguish between 'clean' and 'unclean' women (Bremridge, 2000; Shefer, 1999;Wood & Foster, 1995), in which 'unclean' women constitute those who step outside prescribed feminine sexuality ('promiscuous' women, prostitutes). Condom use is therefore constructed by both men and women as inappropriate in long-term relationships where faithfulness is assumed. Clearly condoms are not neutral objects, but embody stigmas, which may differ from context to context and from one relationship to another, but nonetheless reflect dominant discourse on gender and gendered power relations and serve to inhibit negotiations around 'safe sex'.

With respect to the socialisation of gendered sexual roles, there is wide acknowledgement of the significance of early gender development to heterosexual practices. Social and sexual inequalities that are promulgated during childhood and adolescence are powerfully implicated in young people's constructions of sexuality, love and relationships. For girls, some of the salient issues are related to puberty and the beginnings of their menstruation. One central thread is the lack of knowledge and access to reliable and constructive information that young people, in all corners of the globe, have through the process of their development. At an international level, young women in particular appear to lack basic knowledge about their bodies, reproductivity and sexuality (Bassett & Sherman, 1994; Bhende, 1995; Uwakwe *et al*., 1994; Vasconcelos, Neto, Dantas, Simonetti & Garcia, 1995). This lack of knowledge appears to be reinforced by global moralising and gendered discourses on female sexuality, where virginity and sexual naivety are prescribed for girls (Weiss *et al*., 1996). Thus, even if women have sexual knowledge, they face social pressure to maintain an image

of innocence, particularly with men, who may interpret knowledge as past sexual activity. Consequently, it is very difficult for women to protect themselves against sexually transmitted infections (STIs) and AIDS, given that such measures will imply 'the outward appearance of an active sexual life which is not congruent with traditional norms of conduct for adolescent girls' (Weiss *et al.*, 1996, p. 9). In this way, dominant constructions of femininity act to undermine girls' and women's agency in their relationships with men.

In the South African context, both historical and contemporary studies point to the protective construction of girls as sexually vulnerable to 'dangerous' male sexuality at the onset of menstruation (Lesch, 2000; Mager,1996; Shefer, 1998). Practices of forced and immediate placement of girls on contraception, and warnings against boys and men are apparently common in many South African communities. In this way, young girls are taught of their passivity and vulnerability to men/boys, and their menstruation is constructed as a negative, dangerous transition (Shefer, 1998; 1999). As a consequence young women are often unprepared for sexual relationships, lacking not only useful knowledge but also a positive sexual identity (Thomson & Scott, 1991). Similarly, in a recent local study with adolescent girls, Reddy & Dunne (2007, p. 167) point out the way in which:

> The everyday accomplishment of gender and sexual identities was played out through a dominant discourse of heterosexuality that effectively disempowered women. Inequality in sexual decision-making and dyadic negotiation, as well as the different sexual standards regarding sexual practices for young men, posed difficulties for their performances of femininity and encouraged high-risk sexual behaviour.

Boys, on the other hand, appear to be socialised positively (for the most part) into their 'manhood', with puberty signifying a transition to active (hetero)sexuality. As Adomako Ampofo & Boateng (2007, p.41) point out:

> Styles of gender and sexual interaction between males and females are 'rehearsed' during adolescence, and research carried out with and among adolescent boys around the world suggests that viewing women as sexual objects, use of coercion to obtain sex and viewing sex from a performance-oriented perspective often begins in adolescence or even in childhood and may continue into adulthood.

Manhood appears to be rigidly associated with heterosexuality and the ability to be sexual with multiple women, as a range of recent South African work illustrates (for example, Hunter, 2004; Lindegger & Maxwell, 2007; Ratele *et al*, 2007). Thus, those who do not conform or are not successful in this realm may be punished or stigmatised (see for example, Lindegaard & Gibson, 2007). Alternative sexualities, either homosexual or those resistant to traditional macho masculinity, are still not well tolerated in South African communities. For men and boys, the feminist argument of the close ties between heterosexual and masculine identity is borne out by empirical studies. For example, when asked what it means to be a boy, a 12 year old boy replied

'... to have sex with a woman' (NPPHCN, 1995, p. 35). The female answer from a 14 year old girl is similarly stereotyped and makes no mention of sex: 'To be a mother ... to have a husband and to look after children' (p. 36).

While masculinity studies are relatively new internationally and in South Africa, there is a growing emphasis on understanding masculinities, particularly young masculinities, and a growing field of critical men's studies in southern Africa (see for example *Agenda* 1998; *Journal of Southern African Studies* 1998; Morrell 2001; Morrell & Ouzgane 2005; Richter & Morrell 2005; Shefer, Ratele, Strebel, Shabalala & Buikema, 2007), including a focus on the social constructions of masculinites and boy's and men's sexualities (for example, Shefer & Ruiters, 1998; Dunbar Moodie, 2001; Mankayi & Shefer, 2005; Pattman & Chege, 2003).

Understandably much of what we have talked about above with respect to highlighting the way in which traditional gender roles are played out, relates to cultural constructions of gender. In spite of the apparent different cultures in South Africa, very similar forms of culturally constructed gender and sexual roles have been in evidence in the literature. However, there is also some conversation about the extent to which 'culture' may be used as a way of excusing problematic male behaviour and male power in sexual relationships and maintaining the status quo with respect to gender and gendered power inequalities (Ratele, 2005; Shefer, Potgieter & Strebel, 1999). These authors point out how notions of 'tradition' and 'culture' may serve to rationalise and legitimise such practices as the 'double standard' and male promiscuity (based on notions of historical polygamy), as well as male lack of responsibility for contraceptives and safe sex practices.

Coercive and violent practices

At an international level, the complex relationship between gender-based violence and HIV has been widely acknowledged and documented (see, for example, review by Harvard School of Public Health, 2009). Given the high rate and endemic nature of gender-based violence in South Africa, much attention has been paid to understanding the intersection of violence with HIV/AIDS and 'normal' heterosexual practices. There has been a growth of research in South Africa on violence against women, and an increasing focus on the links between violence and heterosexuality and HIV/AIDS infection. Sexual violence against women and girls, whether by known or unknown rapists, is widespread. Coercive sexual practices and abuse been increasingly reported in studies exploring heterosexual negotiation and practices. In this respect, girls and women are clearly more vulnerable to HIV/AIDS and other infection, as well as unwanted pregnancies. It has become apparent that for South African communities, violence and heterosex are inextricably interwoven (Shefer, Strebel & Foster, 2000). The South African Medical Research Council's Gender Unit has been a key role player, together with others, in generating a wide range of research that reveals how widespread and insidious gender-based violence (GBV) and coercive sexual practices are (see for example, Abrahams *et al*., 2004; Abrahams *et al*, 2006; Jewkes, Penn-Kekana & Levin, 2002; Jewkes, Levin & Penn-Kekana, 2003; Jewkes & Abrahams,

2002; Jewkes *et al.*, 2001; Matthews *et al.*, 2004) and how it manifests in intimate relationships between men and women (for example, Jewkes *et al.*, 2003; Kalichman *et al.*, 2005; Vetten & Bhana, 2001). A range of research among adolescents and children in South Africa has also revealed that their sexual experiences are bound up with violence and coercion (Buga, Amoko & Ncayiyana, 1996; Flischer, Myer, Marais, Lombard & Reddy, 2007; NPPHCN, 1995; Richter, 1996; Swart, Seedat, Stevens & Ricardo, 2002; Varga & Makubalo, 1996; Wood *et al.*, 1996; Wood & Jewkes, 1998). One of the significant areas that link GBV with HIV infection hinges around condom usage in safe sex practices. Violence plays a role in negotiations around condoms, with women speaking of the fear and actual experience of angry or violent responses if they insist on condom use (Shefer, Strebel & Foster, 2000; Strebel, 1992, 1993; Varga & Makubalo, 1996).

Everyday coercive practices in heterosex are also found to be common, particularly in interactions between older men, who are in more powerful social positions, and young women. Thus it is not only overt sexual violence that is commonplace, rather more subtle forms of coercion and pressure appear to be inherent in many heterosexual relationships. Discourses of love and romance play a significant role in sexual coercion. This appears to be particularly salient for girls/women who speak of 'giving in' to male pressure for sex because of 'love', commitment and fear of loss of the relationship (Reddy & Dunne, 2007; Shefer, 1999; Shefer, *et al.*, 2008; Varga & Makubalo, 1996; Wood, Maforah & Jewkes, 1996;). In these studies, it is evident that girls' sexuality is constructed as responsive to and in the service of male sexuality. Even when young women are aware of power inequalities and double standards within discourses of love and sexuality, there appears to be little space for resistance, given peer pressure and male violence (Wood *et al.*, 1996). A number of South African studies also highlight the widespread nature of coercive sexuality or unprotected sexuality linked to economic factors such as poverty, financial dependence, and job security (for example, Jewkes & Abrahams, 2000; Vetten & Dladla, 2000), and as mentioned, the widespread nature of transactional sex may also facilitate or legitimise coercive sexual practices (Leclerc-Madlala, 2004; Shefer, 2009b). And as mentioned earlier the coercive sexual practices and rape of young women/girls highlights the complex intersection of issues of gender and age in coercive, unsafe sexual practices.

A growing body of local research is beginning to establish a strong link between violence against women and HIV/AIDS (see Vetten & Bhana, 2001 for an earlier review). The link between violence and HIV/AIDS also emerges around the disclosure of HIV status, and attempts to practise safe sex by HIV positive women. Although mostly anecdotal, there is evidence of male violence following women's disclosure of their HIV status in South African communities (Mthembu, 1998; Vetten & Bhana, 2001). A number of more recent studies have also illustrated empirically that South African women who are in male-dominated or abusive relationships are at higher risk of HIV/AIDS (Dunkle *et al.*, 2004a, 2004b, 2006; Garcia-Moreno & Watts, 2000; Jewkes *et al.*, 2006a, 2006b; Kalichman *et al.*, 2005; Van der Straten *et al.*, 1998), which more firmly establishes a relationship between gender-based violence in relationships and HIV/AIDS risk.

Section B: The gendered impact of HIV/AIDS on communities

This section focuses on the way in which the experiences of those who are living with HIV/AIDS and or those affected by the epidemic are also filtered through gender and intersecting forms of difference and injustice. Two key themes are highlighted here: 1) women's and men's different experiences of living with HIV/AIDS; and 2) the gendered stigmatisation and social construction of HIV/AIDS. While much of what pertains here has also been illustrated internationally, both the social construction of HIV and the experiences of living with HIV have been shown to be powerfully gendered in the South African context as well.

Gendered stigmatisation and social construction of HIV/AIDS

> *AIDS has become the symbolic bearer of a host of meanings about our contemporary culture: about its social composition, its racial boundaries, its attitudes to social marginality; and above all, its moral configurations and its sexual mores. A number of different histories intersect in and are condensed by AIDS discourse (Weeks, 1989, p. 2)*

Although the value of the focus on HIV/AIDS for gender equity has been acknowledged above, there is also little doubt that the massive public and professional focus on the virus has served not only to reflect, but also actively in some cases reproduce, many areas of inequality and discrimination in international and local contexts. The proliferation of research and the educational emphasis on heterosexual relationships and women's vulnerability is extremely important. On the other hand, there are also problems and potential concerns with the way in which women have been constructed in these research and educational agendas.

Many authors over the decades have highlighted the way in which certain illnesses have served particular roles as representation of certain social markers, generally tending to reinforce problematic images and stigmatisation of particular groups of people, usually those subordinated or marginalised in a culture. Susan Sontag's (1977) ground-breaking work 'Illness as Metaphor' set the tone for an understanding of the way in which illnesses are socially constructed and play particular roles in social systems. Foucault (1973) had suggested that for every age there is an illness that reflects the conditions of that time, that serves to capture some of the broader social issues and concerns, and plays a political role in constructing dominant meanings of the time. From the start, HIV was clearly a highly stigmatised illness (see Deacon *et al.*, 2005, for a review). A wide range of authors internationally have deconstructed the multiple ways in which HIV has been socially represented and the problematic, stigmatising. 'othering' effects of such representations (see for example, Aggleton, Hart & Davies, 1989; Kopelman, 2002; Patton, 1990; Plummer, 1988; Seidel, 1993a). In particular, it has become clear that AIDS powerfully reflects dominant aspects of norms and constraints with respect to sexuality and is also strongly gendered and raced. Plummer (1988) describes two central discourses operating in the construction of AIDS, one that is overtly medical and scientific, and one that is characterised by social and moral meanings. The medicalising discourse is overlaid by pathologising notions of AIDS as

representing disease, plague and death. Central also are military metaphors, with the virus constructed in terms of invasion and battle (see Brandt, 1988; Sontag, 1988).

The second central means of stigmatising HIV/AIDS relies on other more social discourses, historically familiar within the construction of STIs, which centre around 'moralistic and punitive social constructions of sexuality' (Ratele & Shefer, 2002, p.186). As with syphilis, AIDS has been 'othered' as the preserve of sexually deviant individuals, and powerfully associated with sexual excess and morally deviant behaviours and lifestyles.

In the early years of the global response to HIV, such social representations served to reflect and legitimise the homophobia of the western world, constructed by many in moralistic and religious terms as 'punishment' for deviant sexual and social practices (Aggleton & Homans, 1988; Crewe, 1992; Weeks, 1988). In addition to gay men, HIV stigma was grafted over a range of other stigmatised identities, in particular IV drug users and sex workers (Gilman, 1988; Holland *et al.*, 1990b). The very use of the term 'risk groups' which became widely used in the HIV/AIDS context as a way of highlighting those most vulnerable to infection, merely served to reinforce stereotypes and stigmatisation of existing marginal groups in societies and 'resulted in their further harassment, control and medicalisation' (Seidel, 1993b, p. 176). While there is now widespread criticism of the notion of 'risk group' and a move to talking about 'risk behaviours', arguably this has taken longer to shift in the South, and thereby also shift the existing constructions of those living with HIV/AIDS.

When it became evident that the incredibly high rate of spread of infection in sub-Saharan Africa was predominantly through heterosexual relations, a range of other problematic discourses in this particular context began emerging. Since the early 1990s, a number of authors have identified some of the key discourses emerging in sub-Saharan Africa, opening the way for understandings of how HIV/AIDS serves as vehicle for reproducing power and normative practices with respect to sexuality and gender performance (Seidel, 1992; Strebel, 1993). One of the strongest discourses emerging is probably that of 'African AIDS', the way in which the focus on Africa has allowed the rest of the world to distance themselves from HIV/AIDS by seeing it as an 'African disease' (Patton, 1990; Jungar & Oinas, 2004). It has been argued that linked to this construction are racist representations of 'African sexuality' as uncontrollable and promiscuous (Jungar & Oinas, 2004).

Drawing on a Foucaultian discursive framework, Seidel, following Plummer (1988), has highlighted the salience of the medical discourse in sub-Saharan Africa, which has shaped the responses to HIV/AIDS in a way in which the person living with HIV/AIDS (PLWHA) is notably absent. This de-humanising effect of the construction of HIV/AIDS as primarily a disease has meant that many of the social dimensions of the virus and its progression have been masked. Linked to the medical discourse has been the salient medico-moral discourse which centres around the representation of AIDS as 'punishment' and the calling on Christian chastity as a way to prevent further infection. While some of the churches in sub-Saharan Africa initially challenged the promotion of

condoms for this reason, it seems that there is now more acceptance of the necessity of promoting them, whether or not they adhere to Christian values. At the same time, the continued use of the ABC strategy (abstain, be faithful, condomise) reflects some of these continued conflicts with respect to what messages should be given to young people, and there is still a popular notion that 'talking too much' to young people about sex may encourage them to be more sexually active.

With respect to women and gender, Seidel (1993b, p. 180) called attention to the way in which women have been viewed as both 'polluted and polluting', highlighting how the language for STIs is in some contexts translated into 'women's diseases'. She argues that generally it has been female sex workers and women in general who are blamed for sexually transmitted infections in both the North and South, and this is arguably strongly the case in South Africa; where it may be argued that that this process of gendered stigmatisation has been particularly directed towards black, poor women who have become the repository for all negative constructions of HIV and AIDS. Linked to this process is the way in which the illness has been 'othered' through processes of objectification and distancing tactics. Thus HIV/AIDS has not only been seen as the responsibility of poor, black women but has also been viewed as something which only happens to poor, black women. In this way, whites and men succeed in distancing themselves from the possibility of infection and becoming ill. The dangers of such constructions for educational efforts are more than evident.

A range of local literature has highlighted the way in which popular community beliefs and meaning construction reflect the arguments made about the social representation of HIV/AIDS. For example, in a national study on STIs, involving a range of focus groups with members of diverse communities, the researchers found that ‘stigmatising, pathologising and othering' discourses were omnipresent in the ways in which participants spoke about what it meant to have an STI, with those inflicted almost inevitably constructed as 'other' and/or deviant in some of other respect' (Ratele & Shefer, 2002, p. 188). In particular a strong association of STIs and HIV with sexual promiscuity was evident. With respect to gender, it was more than evident that women were punished far more than men for having an STI, and STIs were constructed as female illnesses with a strong component of blame. This was particularly notable in the view of men who saw women as responsible for starting and spreading STIs, and even constructed women's bodies, particularly their genitalia, as endemically pathological and prone to infect - notions of women being like 'compost' were cited. The pathologisation of women's bodies has been well documented in feminist literature and is powerfully evident in contemporary society through a range of discourses acting on the female body (see for example, Greer, 1992; Northrup, 1995; Wood, 1997) which are played out in particular ways with respect to HIV (Lawless, Kippax & Crawford, 1996; Seidel, 1993b).

Similarly, analysis of local media has highlighted the way in which representations of HIV is gendered, raced and classed. For example, in a study conducted by the Policy Project *et al*. (2003) regarding the print media, HIV/AIDS was most often depicted as affecting people who were poor (31% of articles), black (27%) or living in developing

countries (18%). In terms of sources of information, two out of three sources of information were male, and only one in three were female. Contrary to this, HIV/AIDS was more likely to be represented in terms of women's experience (69% of articles) than men's experience (31%), highlighting the continued construction of the virus as women's responsibility. The study also found that women are more likely to be portrayed as victims of sexual assault or as mothers confronting concerns about infecting their unborn children. In this way, the construction of women as passive, victims and the stereotype of women as mothers is reproduced. Interestingly, male PLWHA who spoke to the media generally spoke as activists (36% of articles) or celebrities (18%) while female PLWHA were given a voice as mothers (44%) or orphans (25%).

The televison programme analysis similarly suggested that portrayals in the soap operas may reinforce stereotypes of HIV/AIDS as a 'black' and female disease. In both soap operas analyses, only two individuals were seen with HIV/AIDS, and they were a black woman and a coloured child. In both, they were portrayed as innocent and passive victims (contracted HIV through rape or parent-to-child transmission). The analysis of community radio raised similar concerns, with all of the PLWHA guests appearing on the shows during the research period being black women, inadvertently reproducing the construction of HIV/AIDS as the preserve of black women.

Empirical local literature has further illuminated the way in which HIV stigmatisation is rife in South Africa (see for example, Abrahams, 2006; Shisana *et al.*, 2005, 2008). Studies show how HIV and STIs are 'othered', represented as the preserve of black communities, and especially women, and it is argued that such stigmatisation poses barriers for both prevention and treatment in South Africa (Kalichman & Simbayi, 2005; Simbayi *et al.*, 2007). As a consequence, there has been growing emphasis on the issue of stigma, with a range NGOs and government departments developing policy and practices to challenge discriminatory and prejudicial practices with respect to stigma and HIV/AIDS (for example, UNAIDS/HDN/SIDA, 2001; POLICY Project *et al.*, 2003, 2004).

Gendered experiences of living with HIV/AIDS

A wide range of studies have explored and documented the experiences and challenges of those living with HIV/AIDS, usually intensified by poverty and multiple forms of oppression. Many such studies have specifically focused on women, emphasising the ways in which gender intersects with HIV to exacerbate the experiences of women living with HIV/AIDS (Allen, 2003; Herbst de Villiers, 2006; Sikkema, Kalichman, Hoffman, Koob, Keely & Heckman, 2000; Smyth, 2004; Walker, 2002). HIV-related stigma and the gendered nature of these, as outlined above, of course play a key role in complicating the experiences of those living with HIV/AIDS, in particular women. Such experiences as rejection by family members and communities, and many examples of the experience of both domestic and public violence following disclosure, have also been documented (Baleta, 1999; Bollinger, 2002; Jennings *et al.*, 2002; POLICY Project *et al.*, 2003; Strebel, 1992; and see POLICY Project *et al.*, 2002 for a literature review).

More recent literature has also highlighted how living with HIV has impacted on men. Given traditional constructions of masculinity as centered about sexual prowess and being the breadwinner, the illness experience has impacted negatively on masculine identity, since many men living with AIDS are unable to live up to these social prescriptions of successfully masculinity (see for example, Mfecane, 2008).

Gendered impact of HIV/AIDS on communities

From relatively early on in the development of social responses to HIV and its impact on communities, especially those already disadvantagedas a result of the historical impact of apartheid and colonisation, it was acknowledged that women were bearing the brunt of the impact of HIV/AIDS. Given the construction of gender roles in domestic and community settings, the load of care-giving has fallen primarily on women and girls – both in public settings, where those who take on the role of care-giving (such as home-based care) are primarily women, and in private settings where the task of taking care of ill family members falls primarily on mothers, grandmothers and girl children. With respect to the latter, the number of girl orphan-headed families has also grown hugely, highlighting again the gendered load of HIV/AIDS and its impacts on communities.

The Policy Project *et al*. (2003) analysis of local televison programmes shows how popular media reinforces this image of women as caregivers. In the programmes analysed, all caregivers affected by HIV/AIDS were women, arguably reproducing the stereotype of women as nurturers and rationalising their continued burden of care for the illness.

Conclusion
Critical reflection: The politics of research on gender and HIV/AIDS

> *Research is neither value-neutral nor ideologically pure. Method is political and the manner in which questions are framed and answered transmits ideologies and conditions consciousness… (Sember, 2009, p. 29)*

The proliferation of research and the educational emphasis on heterosexual relationships is extremely important. It may even be argued that, disastrous as the impact of HIV/AIDS has been on our communities, the HIV/AIDS epidemic has opened up a significant space for challenging gender inequality as it manifests in heterosexual relationships, as well as gender roles and inequality more broadly. On the other hand, there are also problems and potential concerns with the way in which heterosexual relationships and gender are currently viewed.

In relation to women, it is arguable that while it is important to highlight women's lack of negotiation in heterosex, the dominant picture of women emerging is that of inevitable victims of male power. Nobody would argue against the significance of acknowledging women's lack of power in heterosex, but it is also important that we do not inadvertently reproduce the dominant stereotype of women's passivity. Contemporary feminist writers

have begun challenging the way in which feminist theories on heterosexuality have historically constructed power as the inherent preserve of (all) men, and women as inevitably disempowered victims of male power (Hollway, 1995; Jackson, 1996; Smart, 1996). Smart (1996), for example, speaks of a conflation of the penis with the phallus, in which she maintains all power is seen as male, and all males are seen as having access to power. She argues that both of these are problematic assumptions, given a post-modern understanding of the multiple, contextual and fluid nature of power. In this way, while most feminists distance themselves from biological determinism, she argues that power and gender are inadvertently essentialised, globalised and decontextualised.

What is probably most problematic about the continued emphasis on women's vulnerability, passivity and powerlessness, is that this emphasis serves to silence the many times that women *do* resist male power and *do* challenge men. Furthermore, the stereotyped image of women as submissive, passive and powerless is ultimately reproduced. Importantly, as mentioned, the predominant picture of woman remains one of asexual victim of male desires, and women's own sexual desires and a positive female sexuality is seldom represented in the literature. While it is important not then to reverse the image to one of women as always ‘survivor’ and agent, as arguably has taken place in much of the literature on HIV/AIDS in Africa (Jungar & Oinas, in press) it is critical that we avoid a binarism where women and girls are either presented as helpless victims or super-women survivors.

The flipside of women being constructed as inevitable victims (or super-women survivors) is the reproduction of the stereotype of men as inevitably powerful and controlling in relation to women in heterosexual relationships. While some authors have pointed out the salience of the 'male sexual drive' discourse in talk on heterosex, the literature itself appears to reproduce this stereotype. Clearly there is a silence around alternative ways of being men. Although multiplicity in the performance of masculinity is widely acknowledged in the literature, the demonisation of men, boys and masculinity continues, even in the public and academic terrain (Pattman, 2007). As Ratele (2008, p. 521) points out:

> Yet another problem is that along the way the term masculinity has accreted negative overtones. Interestingly, this occurs among critical citizens as well. Even though analyses have shown that there are multiple, fluid forms of masculinity (Connell, 2005), there is a tendency to deploy the term as if it is a synonym for trunk-sized biceps, deep voice, gun in hand, laddish habits, unflagging sexual stamina or a more or less similar set of traits or unchanging behaviours.

There is very little literature that highlights men's resistance to traditional masculinity, or speaks of men's vulnerability to women and their difficulties with hegemonic masculinity. In some research, fragments of male vulnerability and the pressure on men to conform to hegemonic masculinity, are beginning to emerge (see for example, Pattman, 2007; Simpson, 2007; Mfecane, 2008). Nonetheless, there is still little work that gives a voice to the different ways of being men, and offers alternative and more nuanced versions of masculinity, especially as it is performed in heterosexual relationships.

Finally, it is significant to note that while heterosexuality continues to be the normative sexual practice, idealised and romanticised in the public eye, the literature on heterosexuality in the light of HIV in South Africa overwhelmingly presents a picture of an oppressive, inequitable and often violent institution. While the 'troubling' of the institution and practices of heterosexuality has been an important step in the struggle towards gender equality and justice, it is problematic that heterosexuality is presented as an homogenous, unitary and singular experience in the literature. Furthermore, most work seems to accept a construction of heterosex as centred around penetrative sexuality, again reproducing, rather than challenging, the social stereotypes of what heterosex is and should be. As with masculinities, alternative pictures and experiences of heterosexuality and heterosex, some of which may offer useful strategies for intervention (e.g. the focusing on foreplay as a shift from penetrative sex), are silenced and/or marginalised. It could be argued that if we are not presented with alternative images and discourses on heterosex, there is no way in which we can challenge the current oppressive context of heterosexual relationships.

Conclusions and recommendations

By all accounts there are major barriers related to the power inequalities of gender, class and age that stand in the way of open and equitable heterosexual negotiation for safe sexual practices in South Africa, which has been our primary focus for educational intervention in South Africa. Moreover, the the way in HIV/AIDS has been gendered, such as the powerful gendered stigmatisation of HIV/AIDS, has been shown to further undermine our efforts to challenge infection and mitigate the impact of those affected and infected with HIV.

We also however need to be cautious about the way in which the current focus on heterosexuality and gender in HIV/AIDS, in both research and public health practice, may itself perpetuate these problematic practices. I would like to suggest that we need to move beyond criticising and highlighting the inequities of heterosex and/or women's vulnerability and 'victim; position, to also exploring the alternatives and resistances to this dominant mode of relationship. Thus, while we need to be cautious of denying the problematic reality of heterosexuality and gender inequity for many women (and men), and the way in which it currently facilitates women's (and men's) vulnerability to HIV/AIDS, STIs and unwanted pregnancies, and impacts on women's and men's experiences of being infected and affected by HIV, we also need to allow for the development of an alternative picture of men, women and heterosex. It is important to begin representing and narrating different experiences of gender, and developing new ways of thinking and talking about the sexual relationships between men and women as well as women's and men's experiences of living with HIV/AIDS. One way of doing this involves highlighting the marginalised experiences and voices on sexuality and of living with HIV/AIDS, such as those of men who resist taking power and control in heterosex, voices of men's vulnerabilities with respect to pressures of hegemonic masculinity; and of women who resist passivity and have positive experiences of their sexuality with

men, as well as women’s multiple responses to living with HIV/AIDS, not only those that position them as vulnerable and disempowered in the face of such challenges.

Moreover, we need to begin documenting some of the experiences which contradict our 'normal' image of men and women – such as men who enjoy affection without sex, and examples of women's strength and agency in resisting male power in heterosex. Men need to be encouraged to admit to their vulnerability in sexual relationships, just as women need to begin to assert their sexual desires and own their sexuality. We also need to begin documenting alternative stories of the impact of HIV/AIDS on those infected and affected. Alternative representations of both women and men living with HIV as well as community responses to the dominant images of women as vulnerable victims and men as uncaring partners in denial of their HIV status, also need to find a space. Finally, we need to be able to facilitate the hearing of different stories of heterosexual relationships and different responses to living with HIV/AIDS. It is strongly recommended that our research is more directed towards opening up more silenced and marginal experiences and narratives in this respect.

At the broader level though, we need constantly to acknowledge that in order to challenge the current gendered nature of the dynamics of transmission, as well as the gendered representation of HIV/AIDS, and the differential impact of HIV on men and women, we need to acknowledge the complex intersections of HIV with broader gender power relations and injustices, and acknowledge how as researchers and practitioners in this area we may inadvertently reproduce or legitimise these if we are not actively foregrounding a rigorous understanding of gender in our work. Importantly, we cannot afford to view HIV/AIDS in isolation from other national goals and imperatives in transforming South Africa. It is more than evident that poverty and other forms of inequality like age and race, are powerfully implicated in the gendered nature of HIV and its impact on South African societies. Research efforts need to attempt to harness a more holistic framework in this respect.

The current picture emerging of the complex intersection of HIV/AIDS with gender shows that we do know quite a lot about the gendered dynamics of both infection and the impact on those living with HIV/AIDS. It seems then important to begin focusing our efforts on challenges – in particular more work reflecting on what we have done – both through programmes and broader popular campaigns. While a start in this direction has definitely been made, we need to broaden our research efforts with respect to generating and evaluating interventions.

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