Psychology in society (PINS), 1998, 24, 4-20

POWER AND RESPONSIBILITY: SHIFTING DISCOURSES OF GENDER AND HIV/AIDS

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" ... a critical study of AIDS discourse with its intertextual awareness is not only a legitimate concern, but needs to be seen as an essential dimension of AIDS research. It contributes towards a more caring and informed society, deepening the democratic project and the struggle to achieve greater sexual "equality" to uphold human rights and human dignity (Seidel, 1990:79).

HIV/AIDS appeared in the early 1980s as a new and serious health problem. Its apparently incurable and untreatable nature posed a major challenge to biomedical technology. Research into modes of transmission indicated that this was not a "neutral" disease, but one which reflected social divisions of gender, class and ethnicity in vulnerability to HIV. With heterosexual spread of the disease in developing countries, women's increased risk of infection was highlighted. As a result, the role of power inequalities in gender relations and the impact of differential access to economic resources were recognised as significant to HIV/AIDS interventions. Thus both social and medical sciences were mobilised and knowledge about the disease rapidly expanded, shifted, accommodated new understandings.

These emerging discourses of HIV/AIDS generate a range of possible discursive positions which mediate responses to the problem. Therefore an analysis of discourses is an important mode of enquiry for theorising about how constructions of social and power relations reflect and constitute HIV/AIDS meanings. In addition it allows for consideration of enabling and constraining actions regarding both HIV/AIDS policy and individual practices. In this way interventions at the level of HIV prevention as well as AIDS care may be addressed. A first aim of this paper therefore was to trace discourses prevailing in the early stages of the AIDS epidemic.

We were also interested in how public discourses resonate in everyday life, the ways in which these are mobilised, challenged and reframed in individual experience and the implications of such positionings for prevention interventions. In South Africa (SA) with its predominantly heterosexual mode of HIV transmission, the role of gender relations is central to understandings of the disease. Hence we report on an empirical study conducted in the early nineties into the experiences of SA women regarding gender and HIV/AIDS; investigating which discourses would be drawn on or silenced, how participants would position themselves in relation to dominant gender discourses of women as vectors or victims, and how this would contribute to identifying spaces for action.

In addition, any analysis of discourses would need to be located within a specific socio-political context. The dramatic and historic changing of power relations in the SA of the mid-nineties, together with the emergence of new political agendas provided a valuable opportunity to explore shifting depictions of the problem, possible entrenchments of hegemonic positions, as well as opportunities for alternative action opening or being closed down. Therefore a third aim of this paper was to review more recent writings on HIV/AIDS for indications of whether and how movements might have occurred in relation to earlier constructions and what these might suggest for prevention interventions.

DISCOURSES OF HIV/AIDS IN THE LITERATURE.

From the earliest work in this field, writings on "the problem of AIDS" typically were prefaced by presentation of the latest figures on the scale of the epidemic, highlighting the alarming rate at which the disease was spreading. This also served to indicate which "high-risk groups" were most vulnerable to infection by HIV.

Thus, in the early literature, originating largely from the United States, HIV/AIDS was depicted predominantly as a disease of male homosexuals, intravenous drug-users and sex workers. This was accompanied by a powerful and dominant stigmatising and "othering" discourse which saw the virus associated with deviant and promiscuous behaviour of minorities, giving rise to moral panic, blaming of others and denial of risk among the general public (Treichler, 1987; Plummer, 1988).

However, it soon became apparent that HIV infection was not restricted to such others and biomedical research into the causes and progression of the virus increased dramatically. Medicalising discourses of HIV/AIDS provided images of an invisible and silent epidemic, invariably leading to a painful and drawn-out death, undectable without sophisticated medical tests, and with no known prevention or cure (Young, 1987; Sontag, 1988; Patton, 1990). The focus of research became the quest for reliable tests, vaccines and effective treatment drugs.

In the face of so few biomedical answers, social scientific research into preventing HIV infection expanded. Drawing on health education models, accurate knowledge about the disease and individual behaviour change were suggested as the only strategies to avoid contracting the virus. However, to a large extent, interventions based on these models did not yield significant reductions in risk behaviour (Becker & Joseph, 1988; Valdiserri, 1989).

In developing countries, alternative discourses emerged, as the epidemiology of HIV pointed to a predominantly heterosexual disease, with women often the majority of those infected (Ankrah, 1991). On the one hand, the face of AIDS in Africa was synonymous with poverty, overburdened and under-resourced health care systems, decimated communities, AIDS orphans (Panos, 1988; Sabatier, 1988). On the other, women were initially depicted chiefly as vectors of transmission of the virus to babies and via sex work (Campbell, 1990). Attempts to account for women's greater vulnerability to HIV infection drew on biomedical explanations (Panos, 1990), as well as gender and economic arguments, as discussed below.

Sexuality and gender discourses.
It has been widely argued that gender relations, which generally involve differential relations of power between women and men, have significant implications for understanding the problem of HIV/AIDS for women. According to this view, women's position in society plays an important role in their ability to respond effectively to the threat of HIV. In order to avoid infection, women are advised to abstain from sex, practise monogamy or negotiate the use of condoms with their partners. Thus women are portrayed as being responsible for ensuring that safe sex is implemented. Yet these options reflect a focus on a male, heterosexual construction of sexuality which upholds the traditional view of a sex drive for which men are not responsible, but which women are expected to curb and so entrenches dominant gendered power relations. Thus paradoxically, women are required to exert control and make choices in an area in which they have notoriously little power and few options (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990; Juhasz, 1990; Hollis, 1992).

A feminist discourse has argued for alternative responses to the threat of HIV/AIDS. This would require a change in the power dynamics between men and women, toward greater equality and control over their bodies for women, as well as more women-centered notions of sexuality. In addition, the use of the AIDS epidemic to limit women's sexuality needs to be resisted, so that HIV prevention activities do not become a means of controlling women's sexual behaviour (Ardill & O'Sullivan, 1987; Kutzko, 1988; Kippax, Crawford, Walby & Benton, 1990).

Socio-economic discourses.
An additional dominant argument has explored the intersection of other variables like class and "race" with gender, by locating the problem of women and HIV/AIDS within the wider political economy. This view of women's vulnerability to HIV maintains that because of their unequal positioning in society, economic factors impact on men and women differently, so that women often lack power and social status, and thus access to economic resources. As a result they are usually poorer than men, more likely to be unemployed, and are often single household heads. For many women then, sexual relationships with men may offer a valuable source of material support. Therefore, for financial reasons women might come to rely on a number of sexual partners and/or they might be less able to insist on the use of condoms, thereby increasing their risks of HIV infection (Schoepf, 1988; Standing & Kisekka, 1989; Ankrah, 1991).

Thus the central discourses framing much of the writing on HIV/AIDS and gender highlight women's lack of power, both regarding heterosexual relations and economic

position, in reducing their risk of HIV infection. At the same time, a seemingly contradictory account suggests that women take responsibility for implementing safe sex behaviours. Such paradoxical frameworks are likely to translate with difficulty into realistic prevention interventions and were thus a central focus of the study described below.

STUDYING WOMEN'S DISCOURSES OF GENDER AND HIV/AIDS.

While there was a striking increase in research work and writing on the topic of women and HIV/AIDS in many countries in the early nineties, this had not yet happened to any significant extent in South Africa. The study discussed here aimed to undertake an in-depth exploration of the experience and meanings of HIV/AIDS for a sample of women in the Western Cape. In doing this, it drew on a discourse analytic framework to capture both range and interplay of repertoires; to map these accounts in relation to existing depictions of the problem; and to explore how discursive positioning mediated possible HIV prevention action (Treichler, 1987; Juhasz, 1990; Seidel, 1990). The analysis also begins to identify areas where possible spaces and shifts could be expected within the changing socio-political context of SA.

Methods.

Data for analysis were generated through fourteen focus groups, two of which included men, while the rest were women-only groups. The ninety-five black participants were recruited from a variety of settings: antenatal and sexually transmitted disease clinics, community nutrition centres, community political organisations for women and youth, domestic workers, teachers and tertiary students. Their ages ranged from fifteen to forty-seven, with an average of twenty-six years. For two-thirds an African language was their mother tongue, while the rest were English or Afrikaans speaking. The majority were single, in a stable relationship and without children. Most had at least some secondary-level education, although about half were unemployed. Thus, although they were not a homogenous group, nor representative of SA women more braodly, the sample consisted mainly of young black women, who were likely to be sexually active, facing reproductive choices and financially dependent to some extent.

The discussions, facilitated together with a Xhosa-speaking co-researcher through the use of HIV-related vignettes, were audiotape-recorded, transcribed verbatim and translated from Xhosa or Afrikaans into English where necessary. Discourse analysis, drawing especially on the work of Burman (1991), Parker (1992) and Hollway (1984) was used (See Strebel, 1997).

Results.

Overall women in the study demonstrated good knowledge and strong awareness of AIDS as an issue in their lives. In keeping with dominant discourses discussed above, they drew on medicalising and stigmatising depictions of AIDS as well as a variety of alternative and contradictory positions, which highlighted difficulties they experienced in responding effectively to risk of HIV infection (See Strebel, 1996). Gender relations was the other dominant issue in women's talk about AIDS. These discourses centered chiefly around representations of power and responsibility, as raised in the literature and discussed below.

Discourses of power.
A predominant concern in much of the discussion around HIV/AIDS for these women was the role of power in gender relations. While they generally subscribed to prevailing notions of male power, they also offered challenges and resistances to these dominant depictions, although they made little use of alternative feminist notions of sexuality.

Male power.
A pervasive assumption was that men had the power to determine what happened in relationships. They had multiple sexual partners, while women had very little power to influence such behaviour:

He could be having other affairs / mm / you can stay with him but he could go out and bring back AIDS / mm / he then sleeps with you and you get AIDS / mm. (P)[1]

Okay, we know our men like to have lots of girlfriends ... nor can she ask him to leave other girls, in fact he'll refuse. (L)

Women drew on a number of explanations for this strongly-held construction of male dominance. On one level they saw it as something over which men (and women) had no control, they were just that way; they also saw socialisation as playing a part and thought that men needed to boost their self-esteem by numbers of sexual conquests; then they used a cultural/traditional framework, which saw such behaviour as having been sanctioned in the past; and finally one could understand men's behaviour as a result of political and economic oppression which allowed black South African men few opportunities to assert their manhood other than in the sexual domain:

We are, I mean, we are being brought up to be tolerant of, er, men's behaviour, because you find that in most cases what our men are doing, we don't like them / mm/ but we accept them and we, um, make excuses, you know ... ja, we all know our socialisation. (M)

And you must also bear in mind that in our culture, so-called culture it has been accepted for years that a man has to have many women / mm / I mean, er, just to prove his manhood. I mean, a man sitting, um, with one woman, I mean, he is a laughing stock amongst other men. (M)

You will find a man who is not, er, an unemployed man, the only thing that he can do is to prove his manhood, is just through sex, producing more children, that is all... because he has got nothing to do. (M)

These views of male power to determine the nature of sexual relations are reflected in feminist theory generally, as well as in writings about psychosocial aspects of

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[1]Focus group codes: A, university students; D, domestic workers; E, members of political organisation (women); F, university students; G, antenatal clinic attenders; H, STD clinic attenders; J, members of political organisation (youth); K, nutrition centre attenders; L, STD clinic attenders; M, teachers; N, STD clinic attenders; P, nutrition centre attenders.
Transcription coding: / overlapping talk; ... omitted talk

HIV/AIDS. From this perspective, women define their sexuality in terms of men's needs and drives, which seems to reflect a "*male sex drive*" discourse as identified by Hollway (1984) and other subsequent studies (Gavey, 1989; Kippax et al, 1990; Miles, 1992; Lindegger, 1996). Within the context of this framework, HIV/AIDS education strategies which require mutual responsibility and decision-making are not realistic options for many women.

Women also have power.
An alternative view of gender relations was that women were not without power in sexual relationships, as suggested by the fact that they might themselves have multiple partners:

She could have an affair without telling, er, without talking about this thing, do you understand / mm / have an affair. (D)

This contradictory discourse of women having the freedom to select partners, the "*permissive*" discourse as referred to by Hollway (1984), seems to suggest that women are not limited to positions as objects of male sex drive. A further aspect of this perspective on gender relations was that women were able to be assertive in some contexts and so they ought to be able to be more challenging towards their partners regarding AIDS-related behaviour.

The implication was that gender dynamics were not static. Male power was not necessarily unified and coherent, women were not only passive objects: they could both show resistance to male-centered sexual discourses and actively engage in shaping their sexuality through the construction of alternative positions (Holland *et al.*, 1991; Schoepf, 1988). This would suggest the possibility that for HIV/AIDS work there are contradictions and spaces which could be used in negotiating safer sex.

However, in this study these exhortations to confront gender power relations were also problematic. Women pointed out the many obstacles to challenging dominant power inequalities: any fundamental change in gender relations was going to be a long-term process; within the context of political struggle, it was not acceptable for women to challenge male hegemony; and more broadly, women's issues were not yet clearly on the national agenda:

But I think also man, if you talk about education and that, we are basically talking about changing the way people relate to each other / and that is a lo-o-ong term thing / ... because we're talking about ye-a-a-ars of, of, of people's attitudes that has to be changed now all of a sudden. (J)

Even, the, the issue of women's emancipation, it's a burning issue still today / mm / and if we can also introduce this as women you know, it will be some kind of an attack from the women's side on the menfolk you know. (A)

These perceptions reflected reasonably closely more widely-held beliefs about gender relations in South Africa at the time, when issues around the relevance of "*western-style*" feminism for black women were hotly and at times acrimoniously debated locally

(Funani, 1992; Hassim & Walker, 1992). More recent writings suggest that, although women's position has been actively addressed by the new government, such concerns are still pertinent (de la Rey, 1997; Fester, 1997) and have implications for the ways in which notions of gender equality might be approached in HIV/AIDS work.

Discourses of responsibility.

The other dominant gender discourse in the group discussions centered around the issue of taking responsibility for preventing further spread of HIV. Differing depictions of the problem in the literature have given rise to a diversity of responses to the AIDS epidemic, including mandatory testing and isolation of carriers of the virus. However, there is general agreement that behaviour changes can protect people from the virus. Kutkzo (1988:173) has claimed that "women who have the facts can assess their own risk and make decisions regarding their sexual lives". However, this suggests that safe sex is an unproblematic matter of individual/joint responsibility for both men and women, which seems to ignore the broader social context within which infection occurs, as captured in this study.

Discussion around these issues was extensive and wide-ranging. A number of different positions regarding gender, responsibility and preventative action emerged from the groups, which were accompanied by complex and often contradictory implications, highlighting the difficulties involved in attempting to avoid HIV infection.

Taking responsibility for safe sex.

In keeping with the dominant medical discourse on the need for health education to bring about personal behaviour change, participants in the study emphasised the need for individual responsibility in implementing safe sexual practices. Women needed to discuss the issue with their partner; another option was for women to be assertive and insist on the use of condoms and limited partners, otherwise they should refuse sex or leave the man:

Okay, let's say you know that he is going out with 20 girlfriends and yet you still love him. Okay, you tell him: Look (name) whenever you want to have sex with me I will give you a condom, understand? (L)

Or otherwise use a condom / or people should stick to one partner, I mean not sleep around. (E)

It must end / I will terminate the affair / yes because he comes back to make you dirty and leave you with the disease / mos, if that's the way I will also end my affair. (G)

Only one woman raised the possibility of alternative sexual practices:

Men can still do it the old ways. In our tradition men were allowed to have sexual intercourse with their pregnant wives as long as he does not penetrate her ... he would not penetrate you, instead he put his penis between your thighs far from your vagina (laughter) or even if he does he would not ejaculate ... this was done to prevent pregnancy (unclear) our men can do the same / mm. (K)

This relative silence was significant in that non-penetrative sex falls in line with feminist challenges to male definitions of what "real" sex is (Segal, 1987; Kippax et al, 1990). Such alternative depictions of sexuality were notably absent from participants' talk throughout the discussion. Therefore it would be important for HIV/AIDS educators to explore the meanings of these and other practices and potential spaces for their use, especially among youth.

Thus participants demonstrated that they had knowledge of what was required for safe sex, broadly endorsing notions of responsibility to avoid infection. Yet, while they did not challenge directly such versions of shared responsibility, this did not always fit their experience of relationships and their discussions highlighted just how problematic the options really were.

Gender differences in taking responsibility.
The starting point in gendered notions of responsibility seemed to be that men did not and would not take responsibility for safe sex:

In society, men usually don't take this, um, the sexuality within the relationship as their, their responsibility, man, you know. (J)

You must know that the African man will not be at a loss for words in his own house, he will also tell you that there's no such thing as AIDS, that there is nothing wrong with him, that he hasn't got a sickness, he will not believe. (K)

The other side of this view was that women were responsible generally, so they were the ones who would take the initiative in prevention of HIV infection. For this reason, a device like the female condom, which would give women control over safer sex, was urgently needed:

It is usually men that's stuck on condoms and it's because we are receptive and we women, er, um, we don't usually take things for granted ... and we understand the use of the condoms. (M)

If there was a device that we could use, condoms as used by men, then we could use it freely, so we really know how to protect ourselves. (N)

The role of a female condom in HIV prevention has generated some controversy in feminist literature. On the one hand, it is an option which many women see as helping to give them control over reproduction and disease prevention (Carovano, 1991). However, it is also argued that this device does not provide a real alternative: it does not change fundamental power relations and still requires the permission of the male partner (Patton, 1990). AIDS activists have also maintained that the absence of research into alternative modes of protection specifically for women, like the female condom and spermicides, indicates the sexist bias of research priorities (Hollis, 1992).

Current writings about women and HIV/AIDS continue to call for further research into female-controlled methods like the female condom and vaginal microbicides, which

should lead to increasing women's protection options against HIV infection (Long & Ankrah, 1996; Aalbers, 1997; CDC, 1997).

Arguments like those above for women to take responsibility for HIV/AIDS prevention and care have also strengthened in the past few years. As more people manifest symptoms and die of the disease, there has been increased focus on care of the dying, the problem of AIDS babies and orphans (Holt, 1997). And it is women who are largely cast in this role of strong and resourceful educators and care-givers (Kaleeba, Ray & Willmore, 1991; Long & Ankrah, 1996; Hlatshwayo & Stein, 1997).

However, Seidel (1990) has warned that depictions of women as dynamic, responsible, speaking subjects, while appearing to provide a liberating option may on the contrary impose constraints, for example by framing women as "gaurdians of morality". And it has also been argued that women's strength in the household does not necessarily translate into power in relation to their men (Valdiserri, 1989). Thus the contradictions of responsibility, as captured in this study, remain pertinent.

Dilemmas of responsibility.
The injunction to practise safe sex and the acceptance that this was "*women's work*" generated many difficulties and contradictions for women, which help explain why women cannot easily protect themselves from HIV infection.

i. Responsibility is risky.
Firstly, they recognised that for women, being assertive or even persuasive was not easy, as it was not common to talk about matters sexual. Relationships were also invested with different meanings at different stages. And notions of romantic love meant that it was difficult to raise the issue of safe sex:

The other thing is that we don't even discuss, er, sex that much, even among peers / even among the girlfriend and boyfriend / so then it becomes much more difficult when then there's even condoms involved. (A)

Let me tell you, when we are married, he is no longer the boyfriend, I'm no more the girlfriend, he'll tell you: Why should I use a condom? (A)

Okay, then I dismissed the issue [symptoms of STD] because I love him. (N)

Another important aspect was that of fidelity: if a woman wanted her man to use condoms, it meant she did not trust him or that she had been unfaithful and was thus probably infected or could even imply that promiscuity was being encouraged:

It is not easy because the problem is, he will think you have other men. Also he will think you do not trust him, so it is difficult to raise the subject. (N)

Another woman's marriage came to an end because the husband told her to leave when she advised him to use a condom in order to protect themselves from diseases. He took it as if she is also using it with other men, he told her to pack her things and leave the house. (K)

By allowing him to use a condom, it means you say it's right for him to see other women. (L)

Underlying all these nuances was the fact that the stakes were high for women: their partner could turn to other women, which would increase their chances of infection; or he might physically abuse or desert them, with the serious economic implications which that carried:

Because if you refuse he will beat you, that's what you'll get from him. (K)

But you can't tell your boyfriend that you have AIDS / but you must be honest with your boyfriend, tell him you have AIDS. No, he will run away from you. (G)

But the only women who can afford to stand up for their rights are people who are self-sufficient / ja / 'cause if I don't want to use the condom, I can just refuse because I don't depend on no man to support me. But take a typical township or even some white females, some of them depend / mm / on their men for support, for survival she is dependent on this guy, it is very difficult to be assertive and to stand up. (A)

Thus assuming responsibility for safe sex was fraught with difficulties, and depictions of relationships which these women drew on did not seem to provide real opportunities for negotiating safe sexual behaviour.

The risks as outlined by subjects were also high. Here participants drew on the dominant discourse of economic vulnerability discussed earlier, which suggests that increased levels of poverty have made women more likely to depend on a regular partner, or to resort to multiple partners for financial survival, and thus be less able to insist on safe sex. Recent literature emphasises that this discourse of women's vulnerability to HIV/AIDS as a result of economic disempowerment is still central to understandings of women's risk of infection (Long & Ankrah, 1996; Hlatshwayo & Stein, 1997).

However, the critical role of economic factors in HIV spread remains a complex one and, while improved economic conditions would undoubtedly change dramatically the face of the epidemic in developing countries, to suggest that such measures would remove the kind of gender inequalities outlined above oversimplifies the issues at stake.

The fear of interpersonal violence expressed by participants too is realistic, and underlines the fact that for many women sex has always been associated with danger (Segal, 1987). South Africa has also recently seen sharp increases in criminal and domestic violence (Govender, Budlender & Madlala, 1995; Haysom, 1997), while the coercive and abusive nature of heterosexual relationships for many youth has been documented (Varga & Makubalo, 1996; Wood, Maforah & Jewkes, 1996) so that current AIDS talk could be expected to reflect this. Therefore, suggesting to women that they undertake behaviour which could increase the likelihood of such violence may be irresponsible on the part of HIV/AIDS educators.

ii. Taking/taking away responsibility.
Another problem which women identified about the issue of responsibility was the paradox that by assuming for themselves the responsibility for HIV prevention HIV/AIDS became women's problem. Furthermore, the discourse of women's responsibility also implied that their responsibility extended to the cause of the problem:

I mean, wearing a condom, taking a contraceptive pill, you know, delivering a baby, I mean it's too much ... (laughter) They're doing nothing, you've got to do the cooking (laughter), do the washing (laughter), do everything for them (laughter), I mean / sometimes he doesn't even bring money home / you are an extension of their mothers, I mean, when are they going to grow up and take responsibility. (M)

So it's worse with AIDS, because they want to put the blame to women and I think that's why most of the time when the health people are talking about AIDS they always talk about women. (A)

This perspective again absolved men from the need to take action and was in line with the notion of women as reservoirs of the virus, as evident in much AIDS writing (Gilman, 1988; Ingstad, 1990).

iii. Sharing blame and responsibility.
However, there was also a voice which recognised that the positions were not that unambiguous. On the one hand, women were not only impotent victims of male irresponsibility: they also were reluctant to take responsibility. On the other hand, not all men were the same: some were worried about HIV/AIDS, took the problem seriously and were even prepared to use condoms:

We are also the problem, because I know, I've got a very negative attitude towards condoms. Maybe I also need more education, but I tried a condom for the first time. I told myself: no, I just had a attitude, er, towards this thing, now I'm going to enjoy using a condom, but I never did. (A)

But then there are men who do actually want to take responsibility/ mm / and actually take the weight on their side and ... and make sure that you are on contraceptive, otherwise it's like: Let's use the condom and make sure, and those are men who actually are taking responsibility for their lives. (A)

This quite strongly-supported stance seemed to suggest that the situation was not all that bleak. While the notion of male power and dominance was compelling, it was nevertheless not seamless, as discussed earlier. Earlier writings emphasised that an appropriate response to AIDS as a problem for women needed to involve men and their responsibility to practise safe sex (Panos, 1990). Also, if men and women share some common understandings of gender dynamics, there were grounds for mutual problem-solving. Reid (1992:2) expressed this strongly: "Women alone cannot stop this epidemic nor care for its sick and its survivors. Women alone cannot bear the burden of its psychological, social and economic impact. Nor should this be expected of them. To do so would be to build in the certainty of failure, not because of any failing in women

but because the nature of HIV transmission requires a conjoint, shared responsibility." Recent writings continue to draw on this discourse of the need for shared responsibility (Long & Ankhah, 1996).

Responses.
Participants reacted to these seemingly conflicting constructions of HIV/AIDS in a variety of ways. Many women blamed men for the situation, others felt guilty, while some felt fatalistic and helpless:

Then you can blame your boyfriend about it, you tell him it's because of him that you are sick, it's his fault, so he is forced to look after you and care for you, because you got the disease from him. (L)

But if he does not want to use it [condom] then it means that there is no way for you to protect yourself / if you are not prepared to lose him / if he does not want to use a condom, you decide that rather than leave him, I rather sleep with him and die with him. (D)

My younger sister used to ask me: But sisi, what is AIDS, I would like to be a doctor because I don't want to have AIDS. And when it comes to the issue of having boyfriends, she's 12 years old and she says: I wouldn't like to have a boyfriend because I understand people who've got boyfriends they've got AIDS. (A)

An almost inaudible voice was the one which identified women as having some united power, to work together to identify problems and possible solutions, and to make demands as they have in other spheres:

We've got very chauvinistic men, whew! / ja / very / (unclear) women have always stood up for their rights in other issues, work-related issues, the home, domestic issues. I think they should stand up for AIDS exactly / the same way / at the same level they have for other issues / other issues. (A)

This problem requires that we should hold meetings as women and we gradually involve the men and the youth as well. (K)

This more enabling position involved the strengthening of the voice of united action, as has already proved to be an effective strategy for HIV/AIDS work among gay activists (Patton, 1990). Given the political awareness of many of the participants and the strong history in SA of women's struggle (Fester, 1997), the relative silence of this voice in the study was interesting. While at the time, women had played an important role within broader political struggles, they had not yet won many gains on women's issues generally, nor specifically issues of sexuality. Also, HIV/AIDS had not yet featured prominently in national democratic campaigns, which was understandable given the flurry of issues needing immediate attention in the years prior to the first democratic elections in 1994. However, there were hopes that the new SA would bring changes both in gender relations and in approaches to HIV/AIDS.

In summary, the women in this study drew extensively on dominant discourses in their constructions of HIV/AIDS. In keeping with gendered analyses of heterosexual power relations, notions of male power featured strongly in much of their talk. Although they drew on alternative discourses of women's sexual and political power, which posed challenges to the hegemony of these positions, such options did not seem to resonate strongly with their own experience, nor within the broader political context of SA at the time. Economic vulnerability also featured in participants' understandings of the difficulties involved in preventing HIV infection. However, feminist arguments for alternative understandings and practices were largely absent from discussion. Such positioning would seem to reinforce perceptions of dependence and powerlessness.

Prevailing discourses of individual responsibility for HIV/AIDS prevention and care dominated much of participants' talk. Significant here were the multitude of contradictory positions and possible behaviours which notions of responsible action generated. In the light of these dilemmas, blame, guilt and hopelessness were not surprising and the options for effective action seemed rather limited.

The above discourses and discursive practices were located within a particular social context, with SA on the brink of substantial political changes. Five years later, with the country facing a return to the ballot-box, it seemed timely to revisit the issues, to explore how changing socio-political circumstances would be reflected in AIDS-talk, whether shifts have occurred which create new spaces for action or constrain previously heard voices.

THE CHANGING FACE OF HIV/AIDS DISCOURSES?

[I]f the cure for AIDS were a single glass of clean water, most of the HIV-positive people in Africa would still be doomed. (Newsweek, 1997:47)

Firstly, images of AIDS as universal epidemic have shifted to HIV/AIDS as disease of the disempowered. While figures on current rates of infection indicate that these have stabilised in the West, those for sub-Saharan Africa are considerably higher than originally forecast (Campbell, 1997; Newsweek, 1997). Moreover, in both contexts, women continue to carry a particularly heavy burden of infection and increasingly too of care for those infected (Cohen & Trussel, 1996; Long & Ankrah, 1996; CDC, 1997).

Secondly, the efficacy of biomedical research has been re-established. Despite early pessemism about the likelihood of producing vaccines or effective treatments, much progress has been made in the development of drug therapies (Newsweek, 1997; Economist, 1998). However, the exorbitant costs of these treatments make them completely inaccessible for the vast majority of HIV/AIDS patients in developing countries, and thus especially so for poor women. Added to this is the fact that drugs like AZT have been shown to lower risk of HIV transmission from mother to infant (Newsweek, 1997).

Thirdly, behaviour change as viable prevention option has been consolidated. Reports on responses to HIV/AIDS education prevention messages have been mixed, but success stories are beginning to emerge (Newsweek, 1997; Economist, 1998). Moreover, there have been staggering increases in the number of condoms distributed

worldwide and locally, although it is not always clear what actually happens to these condoms (Medical Research Council, 1997). For women, the female condom appears to offer an encouraging additional prevention option, although research into effective vaginal spermicides has not yet been successful (Long & Ankrah, 1996; Aalbers, 1997; CDC, 1997).

However, HIV/AIDS awareness and prevention strategies do not always benefit women. It appears that a widespread practice among men in SA is to have sex with younger girls, whom they believe are less likely to be HIV-infected (Hlatshwayo & Stein, 1997; Pauw & Brener, 1997). There are also many reports of HIV-infected women being deserted by their partners and carrying the stigma of AIDS alone. Even more alarming are media reports that men are also engaging in sex with baby girls in the belief that this will cure the disease. Such responses are only possible if girls and women continue to have limited power in gender relations.

Turning to discourses of gender relations, one of the major recommendations from HIV/AIDS research such as that described above, is that profound changes in gendered power relations are needed in order to reduce risk of HIV infection in both women and men. Recent literature in the area of women and HIV/AIDS continues to endorse this theme (Long & Ankrah, 1996; Hlatshwayo & Stein, 1997; Pauw & Brener, 1997) However, while the new government in SA has implemented significant changes regarding women's status (representation of women in Parliament, Commission on Gender Equity, Termination of Pregnancy Act, etc), as yet little appears to have changed on the ground for women regarding socio-economic status, gender relations and violence toward women (Haysom, 1997; Friedman & Gool, 1998). With time it is hoped that changing public representations of women will impact on practices at this level too.

A significant emerging trend in gender writings has been debates concerning masculinities and heterosexuality (Morrell, 1998; Shefer & Ruiters, 1998). While it is not yet clear how this will affect AIDS work, the opening of such spaces is encouraging and begins to address earlier concerns about approaching the heterosexual spread of HIV through a focus only on women.

Overall then, while there have clearly been some significant changes in the way HIV/AIDS is understood, depicted and responded to, the impact of this depends substantially on social, economic, political position. In this regard, it appears that technological advances occur more easily and rapidly than social changes. For South Africans generally and women particularly, it seems that some constraining factors have become more entrenched, some possible opportunities for new understandings and practices have emerged, while in some areas little has altered. The task remains to find creative ways to work with discourses of HIV/AIDS in increasing realistic and effective interventions.

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