A Disease That "Has a Woman's Face": The Social Construction of Gender and Sexuality in HIV/AIDS Discourses

Jing Chong & Lynette Kvasny
Pennsylvania State University, USA

HIV/AIDS represents a growing and significant health threat to women worldwide. Gender inequities in socio-economic status and patriarchal ideology around sexual practices are among the most important, yet often neglected, reasons for the feminization of this disease. A theoretical framework is used to inform the review of literature on how gender and sexuality are socially constructed in HIV/AIDS discourses. This framework is based on the argument that social ideology surrounding gender and power relationships is inevitably reflected and constructed in HIV/AIDS discourses that may influence how women see themselves and their possibilities for social change. The findings suggest ways in which these discourses are limited in truly empowering women in their battle against HIV/AIDS. Constructors and sponsors of those discourses should discard patriarchal ideology and consciously produce empowering discourses to help women survive.

HIV/AIDS represents a growing and significant health threat to women worldwide. According to the United Nations (UNAIDS/WHO, 2004), women made up nearly half of all people living with HIV worldwide. In the U.S., although males still accounted for 73% of all AIDS cases diagnosed in 2003, there was a marked increase in HIV/AIDS diagnoses among females. The estimated number of AIDS cases increased 15% among females and 1% among males from 1999 through 2003 (Centers for Disease Control and Prevention, 2003).

An important reason why women all over the world are at special risk of HIV infection is that HIV/AIDS as a "Disease of Society" (Gatter, 1995, p. 1523) has never been a mere medical issue. It is also a social issue that has provoked reactions of panic and revealed social fissures, inequalities, discriminations, and the stigmatization of marginalized groups in society (Pollak, Paicheler & Pierret, 1992). Biological differences between males and females – the membrane of the vagina is more permeable (Padian, Shiboski, Glass & Vittinhoff, 1997) and HIV is more concentrated in semen (Segal, 1993) – increase women's vulnerability to HIV/AIDS. However, gender inequities in socio-economic status and patriarchal ideology around sexual practices such as abstinence, monogamy, and condom use (Ojikutu & Stone, 2005) are important factors in the feminization of HIV/AIDS that are often overlooked.

The social ideology surrounding gender and power relationships is inevitably reflected and constructed in HIV/AIDS discourses (Cukier & Bauer, 2004). In other words, HIV/AIDS is typically constructed by a set of social, economic, and political discourses (Cullen, 1998). Fairclough (1995) defines discourse as "language use as social practice" (p. 131). He points out that there is a dialectical relationship between discourse and society. On the one hand, discourse is shaped by social identities, social relations, and systems of knowledge that result from the unconscious or conscious manipulation of text and talk in order to secure or maintain power and hegemony. On the other hand, discourse is shaping the society and people's minds. Discourse can be conventional and reproductive, accustoming people to

accept it as common sense or fact; or creative and transformative, awakening people to realize alternative truths and make corresponding responses. The study of discourse can be seen in feminist research in communication which focuses on "how gender is constructed through communication and how gender informs communication" (Foss & Foss, 1988, p. 9), or specifically focuses on rhetoric that "… biological sex and gender don't construct rhetoric any more than rhetoric constructs them; instead, gender and rhetoric reciprocally create and sustain each other" (Downey, 1997, p. 145).

Therefore, the manner in which gender and sexuality are constructed in HIV/AIDS discourses has some bearing on the possibility of social change. Research has shown that the representation of target populations affects self-perceptions about risk and the ability to respond effectively to HIV. Empowering, culturally relevant representations can provide people with a sense of control over prevention behavior while negative associations can decrease that sense of power (Patton, 1993). People's sense of power, community, and self worth greatly affects their ability to change behaviors (Rogers, et al., 1995).

Another important reason for analyzing the construction of gender and sexuality is concerned with the efficacy of information consumption, especially for prevention information. HIV/AIDS discourse transmits and exchanges values, beliefs, and norms regarding gender and sexuality, which may be constantly compared by women with their own understandings (Jackson, Warren, Pitts & Wilson, 2007). Cognitive dissonance theory suggests that individuals tend to seek and select information that is congruent with their established attitudes and beliefs, but ignore or avoid information that is incompatible (Festinger, 1957; Oliver, 2002). Relevancy theory (Fiske, 1998) also argues that individuals select meanings relevant to their social allegiances. As a result, if the representation of gender and sexuality in the discourse is in conflict with how women perceive themselves, dissatisfaction and mistrust may arise (Kretchmer & Carveth, 2001; Lazarus & Lipper, 2000), which can lead them to resist the available content (Foster, 2000; Mitra & Watts, 2002; Morkes & Nielsen, 2003). Thus, if HIV/AIDS prevention messages fail to align with women's social allegiances, established attitudes, and beliefs, the messages may not be heeded and women will continue to contract HIV. Empowering HIV/AIDS prevention messages would therefore start from women's daily-lived experiences, lead women to question their original understandings about their own identities, and leverage the authoritativeness of the discourse providers to challenge ideologies that may heighten women's risk for contracting HIV.

The first step toward developing discourses that redress gender inequality and power imbalance in the HIV/AIDS epidemic is to reveal how gender and sexuality are socially constructed and to what degree women are empowered in HIV/AIDS discourses. The challenges that women are faced with can be brought to the attention of the public, and efforts can be made toward the generation of more empowering discourse. It is in this way that discourse can play a vital role in combating the HIV/AIDS crisis.

A Conceptual Framework

Gupta (2000) has extensively explored the determining role of power in gender and sexuality. Gender, according to Gupta, concerns expectations and norms of appropriate male and female behaviors, characteristics, and roles shared within a society. It is a social and cultural construct that differentiates women from men and defines the ways they interact with each other. Distinct from gender, yet intimately linked to it, is sexuality. Sexuality is the social construction of a biological drive, including whom to have sex with, in what ways, why, under what circumstances, and with what outcomes. Sexuality is influenced by rules, both explicit and implicit, imposed by the social definition of gender, age, economic status, ethnicity, etc. (Dixon-Mueller, 1993; Zeidenstein & Moore, 1996).

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men translates into an unequal power balance in heterosexual interactions. Male pleasure supersedes female pleasure, and men have greater control than women over the circumstances of intercourse, including when, how, and with whom intercourse occurs. Therefore, gender and sexuality must be understood as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power. As far as HIV/AIDS, the imbalanced power between women and men in gender relations curtails women's sexual autonomy and expands male sexual freedom, thereby increasing both genders' risk and vulnerability to the epidemic (Heise & Elias, 1995; Weiss & Gupta, 1998).

By using a feminist approach to theorize gender and sexuality, Gupta (2000) categorized HIV/AIDS programs in terms of the degree to which historical power dynamics in gender and sexuality were maintained. In Figure 1, these categories are arranged in a continuum ranging from the most damaging (stereotypical) to the most beneficial (empowering).

The categories are summarized in Table 1. In the next sections, we review and organize literature on women and HIV/AIDS according to the categories found in Gupta's framework.

Stereotypical Construction

In the stereotypical construction of gender in HIV/AIDS discourse, women are portrayed in limited ways that reproduce feminine ideals such as purity and faithfulness, as well as female roles such as wife, mother, and caregiver. In what follows, we discuss each of these stereotypical discourses and why they are potentially damaging for women.

Immune to HIV/AIDS. HIV/AIDS has long been dealt with in divisive terms that assign blame, responsibility for the disease, and threat to the general population, to those who are most affected (Watney, 1987). During the early years of the epidemic, women were largely ignored (Patton, 1993) since at that time HIV/AIDS was mostly affecting white gay men. Women believed that if they didn't engage in high-risk activities with men in this high risk group they would be safe from contracting the disease (Evans, 1988; Peterson & Marin, 1988). They had been sent the message that HIV/AIDS didn't affect them (Charlesworth, 2003). This false sense of security about their chance of being infected made them feel "threatened not by their own risk behaviors but by the people in the 'other' category" (Croteau & Morgan, 1989, p. 87). This false sense of security proved to be dangerous as

Figure 1: Continuum of the Social Construction of Gender and Sexuality (Gupta, 2000)

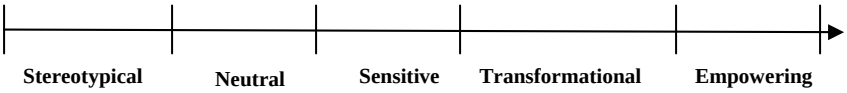

Table 1: Categories of HIV/AIDS Programs Based on Gender and Sexuality (Gupta, 2000)

Category	Description
Stereotypical	The damaging stereotypes of women and men are reinforced.
Neutral	The target is the general population instead of either gender or sex. Despite no harm done and "better than nothing" (p. 5), the different needs of women and men are ignored.
Sensitive	The different needs and constraints of individuals based on their gender and sexuality are recognized and responded to, but little is done to change the old paradigm of imbalanced gender power.
Transformative	The aim is to transform gender relations to make them equitable. The major focus is on the redefinition of gender roles at the personal, relationship, community, and societal levels.
Empowering	The central idea is to "seek to empower women or free women and men from the impact of destructive gender and sexual norms" (p. 6).

women were increasingly infected. To stigmatize and ostracize a particular group, rather than to focus on personal behavior change, contributes to the growing number of HIV infections among women (Croteau, Nero & Prosser, 1993).

Transmitters of HIV/AIDS. Since 1985, the realization of the disempowering consequences of the earlier discourses – HIV extended beyond gay communities and began to affect the general population (Kinsella, 1989) – resulted in the generation of less stigmatizing and broader representations of AIDS, part of which is a new focus on women (Patton, 1993). Women then became more highly visible in public health communication campaigns designed to promote HIV/AIDS prevention and awareness. However, a stigmatizing framework for understanding and communicating about the disease was already deeply rooted and well established, despite increased sensitivity to those affected by HIV/AIDS.

After Raheim (1996) first examined how women were represented in AIDS Public Service Announcements (PSAs), Myrick (1999) extensively analyzed 47 PSAs produced for TV by the CDC – the largest distributors of HIV prevention information in the U.S. He found that in PSAs from 1991 and 1992, women were represented as transmitters of disease to innocent and unsuspecting men, and should be primarily responsible for its prevention. The disempowering strategies used in those discourses included the association of authority and control with male voices; textual/visual representations of women as hypersexual, passive, threatening, responsible for their own victimization; and a decontextualization of women's

cultural, interpersonal, and sexual experiences with men (Amaro, 1995; Patton, 1994; Raheim, 1996).

Charlesworth (2003) examined 45 HIV/AIDS public education brochures produced for women by both public and private organizations and found that the most frequently appearing identity of women was transmitters of HIV/AIDS. Unprotected sexual contact with an infected man and intravenous drug use – the primary means by which women become infected, were largely ignored. Some brochures even claimed that women could infect men just as easily as men could infect women. However, medical research has consistently demonstrated that in heterosexual contact, women are 8-17 times more likely to be infected by men than men are from women (Padigan, Shiboski, Glass & Vittinghoff, 1997). Furthermore, women were depicted as the only transmitters to their unborn children. Again, the role of the heterosexual men as fathers was absent, which put men in a privileged position. These discourses unfairly represent women as transmitters of HIV/AIDS and, consequently, run the risk of allowing blame to be disproportionately attributed to women, while ignoring the complicity of their male partners.

Caregivers. Through gender socialization, women are often placed in positions where they are valued and defined primarily "in relation to others (particularly as caretakers for men and children) rather than in their own right" (Cline & McKenzie, 1996, p. 370). This leads to HIV programs' negligence of women by relating them primarily to others and denying them their own special cultural needs and experiences (Amaro, 1995; Patton, 1990).

Charlesworth (2003) also found that this caregiver identity is constructed in the brochures. Based on the cultural standard of "true womanhood," women are the only logical choice to fulfill the role of caregiver since they are expected to be pure, pious, domestic, and submissive. Women should learn about HIV/AIDS for the purpose of protecting not only themselves but also those they care for, particularly male partners and children. HIV/AIDS is a woman's health issue not because women are in need of care themselves, but because women have to care for those with HIV/AIDS.

These discourses affect women's self-perception and power in terms of HIV risk and prevention since they subordinate their needs to those of men and children. Consequently, women may not be inclined to see themselves at risk or as subjects of concern (Cline & McKenzie, 1996). They also may be unwilling to request safe sex practices because doing so may place them at risk for separation from important others, and decrease the extent to which they can assert control over sex behavior and communication (Lear, 1995; Stein, 1995).

"Flower-pots." In the brochures that Charlesworth (2003) investigated, pregnant women were the only group of women consistently warned. The reason for doing so is that, through pregnancy, women with HIV/AIDS can transmit the virus to their babies. This practice reinforces the image of women as caregivers whose lives are of concern only when the lives of others are at risk. The longstanding belief still holds that men provide the essential "seed" (sperm) to create a life, while women merely supply the "pot" (womb) where the life can grow (Rothman, 1989). In this way, women are reduced to their wombs and the lives of the children who are valued more. When women transmit HIV/AIDS to their children, they often face social criticism, labeled as irresponsible mothers even if they transmit this infectious disease unknowingly (Hassin, 1994).

Women's sense of altruism, a stereotypical feminine trait, is reified in both the caregiver and "flower pot" discourses that motivate women to protect themselves for the benefit of

others. Such discourses may achieve limited effectiveness in alleviating the crisis facing women if it simply stresses the priority of the needs of those who women are supposed to care for.

Vulnerable Subjects. Women in the U.S. are not the only group of women that researchers have been studying. Women in Africa have become the new face of HIV/AIDS in recent years. From a feminist perspective, Kvasny and Chong (forthcoming) problematize the portrayal of Sub-Saharan women as vulnerable subjects under siege in the discourses dominated by Western ideology and hegemony.

They find that whenever women and HIV/AIDS appear side by side in discourses, women in Africa are almost always mentioned. Nearly every report begins with the HIV/AIDS statistics for women in Africa – "Women comprise about half of all people living with HIV worldwide. In Sub-Saharan Africa, women make up 57% of people living with HIV, and three quarters of young people infected on the continent are young women aged 15-24" (UNAIDS/WHO, 2004). The depictions are, more often than not, presented in imperialist terms, which can be seen vividly in media images and are imprinted on the minds of Western citizens – emaciated black children, bare breasted women, and impoverished communities. These discourses contribute to the historical, economic, and psychological relationship between "us and them."

"Westernized" Subjects. Women in Sub-Saharan Africa are also depicted as subjects who are best served by Western HIV/AIDS prevention approaches. These approaches, however, may not easily transfer across cultures. The ABC health campaign initiated by the US Government, for instance, advocates that in order to prevent the transmission of HIV, Abstinence (A) should take precedence before people are involved in a relationship; those already in a relationship should Be (B) faithful to their partners; if A and B fail, correct and consistent Condom (C) use should be practiced. The ABC approach has been adopted as a public health campaign to combat HIV/AIDS in Africa. However, Kvasny and Chong (forthcoming) argue that the standard ABC campaign may be unrealistic for African women.

In the first component, Abstinence, female sexuality is constructed around traditional cultural images of female purity, chastity, morality, self-restraint, and denial of sexual pleasure (Cheng, 2005). This sexual restraint is imposed through the provisions of Western donor organizations; however, it may be limited in terms of protection for women. Abstinence is not an option for women who are forced into transactional sex for their economic survival, for women with abusive husbands, and for girls and women who are raped. Under these circumstances, men are the only ones who can abstain.

The second component, Be Faithful, does not provide adequate protection to women, either. On the contrary, married monogamous women in Sub-Saharan Africa are among the groups at greatest risk of infection (UNAIDS/WHO, 2003), because the rate of HIV infections among husbands is higher than the infection rate among the boyfriends of sexually active, single, teenage women.

In the third component, Condom use, the implication is that women are able to act assertively to control the course of their sexual encounters (Gavey, McPhillips & Doherty, 2001). This type of assertive behavior is couched in Western notions of individualism and personal responsibility, and ignores the constraints that women are faced with. For example, women may engage in sex for economic survival (Murray *et al*, 2003). Young women and girls are also at greater risk of rape and sexual coercion because they are perceived to be more

likely to be free from infection. There is also the myth that sex with a virgin can cure a man of infection (UNAIDS, 2001). In addition, condom use has historically been associated with casual high-risk sexual encounters, not intimate sexual relationships. Thus, the social meaning of condom use may go against women's feminine identity and the cultural signification of sexual intercourse as an expression of monogamy, commitment, love, and trust.

It seems arrogant and ineffective to impose Western health campaigns and technologies onto foreign cultures without carefully considering the cultural context. The HIV epidemic in southern Africa is inextricably linked to structural inequities such as poverty, the economic and social dependence of women on men, and a fear of discrimination that prevents people from openly discussing their status (Center for Health and Gender Equity, 2004; UN Office for the Coordination of Humanitarian Affairs, 2004). Although campaigns like ABC provide guidelines for safer sex practices, societal change to facilitate women's agency is also necessary.

Neutral Construction

In neutral construction, the general population instead of either gender or sex, is the target (Gupta, 2000). Materials in public health communication have a tradition of being generic. Generic materials are constructed with an aim to provide as much information as possible with a single round of communication (Kreuter, Farrell, Olevitch, & Brennan, 2000). These materials are effective in that even small changes in behaviors could possibly result in large transformations in the overall health conditions of the general public. In addition, the cost is low since limited resources are invested to reach the maximum number of people (Guttman, 1997; Strecher, Rimer, & Monaco, 1989). However, although neutral construction does not seem to do any harm when compared to stereotypical construction, the different needs and characteristics of diverse demographic groups are ignored in such a uniform and comprehensive set of information (Gupta, 2000).

Sensitive Construction

Some discourses acknowledge the power imbalance that women experience and encourage them to take responsibility for HIV/AIDS prevention. Although these discourses are sensitive to the different situations that women are in, they fail to provide realistic, culturally relevant and specific prevention strategies that women may perceive as possible to implement (Raheim, 1996). The negative effect is that women may have "feelings of powerlessness instead of a sense of self-efficacy and personal responsibility for their own health" (Raheim, 1996, p. 406).

Transformational Construction

In the PSAs released by CDC in 1995 that Myrick (1999) investigated, the representations of women are more progressive. The PSAs emphasize positive behavioral strategies and avoid mere appeals. However, the disempowering elements still remain, although in less explicit and subtler ways. As a result, the message is mixed for women. They

are represented as having more power in terms of HIV prevention, but are still primarily held responsible for its transmission and prevention.

For instance, in one of the brochures that Charlesworth (2003) examined, women were encouraged to subvert cultural ideology by taking control of their own lives and worrying about themselves instead of those they have to care for. Although sounding rather empowering, the message is limited because it is written for women who have already been diagnosed with HIV. It seems that women can be permitted to care for themselves only when it is too late to protect themselves from HIV/AIDS.

Empowering Construction

Rifkin and Pridmore (2001) define empowerment as "creating opportunities and inspiration to enable those without power and/or influence to gain skills, knowledge and confidence to direct their own lives" (p. 519). In this category, the goal is to "empower women or free women and men from the impact of destructive gender and sexual norms" (Gupta, 2000, p. 6). However, it is easier said than done. Gender inequalities did not come into being overnight, and they can not be eliminated overnight either. It requires more action rather than words.

Discussion

In this review, Gupta's (2000) theoretical framework is used as a lens for examining how gender and sexuality are socially constructed in HIV/AIDS discourses. It can be seen that the discourses are largely homogenous in terms of empowering extent. A vast majority of the discourses are stereotypical, with fewer that are sensitive to the differences among women and transformational in their intent for change. Even fewer discourses were placed in the neutral and empowering categories. The omission of empowering discourse is alarming because it suggests that there is a dearth of radically new ideas for challenging the power relations that place women at risk for contracting HIV. At best, we find transformative discourses that advocate gender equity within the current system.

What is most saliently reflected in the discourses that we did uncover is the cultural ideology of patriarchy that is realized largely by means of omitting or de-stressing the role that heterosexual men play in the HIV/AIDS epidemic. By identifying with this patriarchal ideology that positions care giving, abstinence, condom use, and faithfulness as primarily women's issues while disseminating significantly less rhetoric to address the sexual practices of their male partners, the constructors and sponsors of the discourses maintain gendered power relations that disadvantage women. Women are given greater responsibility for protecting themselves and their children from HIV infection, but there is little in the way of societal changes that afford women the power necessary to take on these additional responsibilities. If patriarchal ideologies continue to influence rhetorically powerful texts such as those produced by government, international aid organizations, and researchers, these discourses will be limited in accomplishing the supposed goal of reducing the spread of HIV/AIDS among women (Charlesworth, 2003).

HIV/AIDS is fundamentally an issue of human rights. More important than the right to the provision of medical service is the right to the provision of social justice (Renwick, 2002).

Empowering women and encouraging them to take active steps collaboratively to free themselves from the entrenched power inequalities dictated by the ideology of patriarchy should be constructed in the discourses. The government's willingness and resolution to create a democratic environment that is discursively inclusive and repression free should be reflected in the discourses (Renwick, 2002). Promoting condom use and paying more attention to mothers are necessary steps, but these HIV prevention methods are not enough to be truly empowering messages. Gender differences and power relationships have to be radically challenged.

The specific lessons that can be drawn by designers of HIV/AIDS prevention messages are twofold. First, designers should avoid the use of disempowering strategies that assign blame and guilt and place a disproportionate amount of responsibility on women. Second, designers are encouraged to use representations that accurately depict women's cultural experience and provide behavioral strategies that are responsive, relevant, and empowering. Moreover, these HIV/AIDS prevention methods must address the sexual behaviors of heterosexual male partners.

This current study is exploratory in nature and is thus limited in the scope and depth of the literature that has been reviewed. However, this work provides a conceptual framework for understanding gender and HIV/AIDS discourses, and thus has implications for future studies. To further probe feminist concerns in HIV/AIDS discourse communities, studies could expand from the analysis of texts to the exploration of discourses as integrations of texts and other formalities including photos and graphics as well as the overall page layout. Studies could also expand from analysis of printed materials to those online. Comparisons could also be made between discourses generated or sponsored by different stakeholders in the HIV/AIDS epidemic so as to find out how organizational interests might influence the construction and representation of gender and sexuality.

Gupta's (2000) theoretical framework is useful for uncovering the characteristics of current HIV/AIDS discourses. Its usefulness and potential should not be limited to this review. If combined with Critical Discourse Analysis, the examination of language use to reveal power relations (Fairclough, 1995), this framework could be employed in empirical studies, which deconstruct particular materials, in order to demonstrate how HIV/AIDS gains its social meanings at the intersection of discourses about gender and sexuality.

Conclusion

HIV/AIDS is a complex and pressing issue. It is not just an issue of health, but has also been framed in discourses as an issue of personal responsibility, economics, development, and gender equity. It impacts every nation and individual across the globe. In this paper, current research has been examined in order to find out how gender and sexuality have been socially constructed in HIV/AIDS discourses. The contribution of this paper is threefold. First, Gupta's (2000) theoretical framework is introduced for unpacking discursive practices to demonstrate how HIV/AIDS gains its social meanings at the intersection of discourses about gender and sexuality. Second, extant research is organized in the review of relevant literature, and new lines of scholarly inquiry and critique are opened up. Third, and most important, suggestions are made for constructors and sponsors of HIV/AIDS discourses on how to

empower women by manipulating the assumption and structural elements in their discursive practices.

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