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

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HIV/AIDS represents a growing and significant health threat to women worldwide. Gender inequalities in socio-economic status and patriarchal ideology around sexual practices are one of the most important, yet often neglected reasons for the feminization of this disease. The social ideology surrounding gender and power relationships is inevitably reflected and constructed in HIV/AIDS discourses which may influence how women see themselves and how much possibility there is for social change. A theoretical framework is used to inform the review of literatures on how gender and sexuality are socially constructed in HIV/AIDS discourses. It is found that those constructions are generally doing little to truly empower women in their battle against HIV/AIDS. Generators 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 now make 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 is 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).

HIV/AIDS as a "Disease of Society" (Gatter, 1995) has never been a mere medical issue. It is also a social issue which has provoked reactions of panic and revealed social fissures, inequalities, discriminations and stigmatism of marginalized groups in society (Pollak, Paicheler & Pierret, 1992). Now "AIDS has a woman's face", as Carol Bellamy of UNICEF put it, after HIV/AIDS has been around for more than twenty years. Biological differences in anatomy between males and females -- the membrane of the vagina is more permeable (Padian, Shiboski, Glass & Vittinh off, 1997), and HIV is more concentrated in semen (Segal, 1993), are only part of the explanations for women's vulnerability to HIV/AIDS, what are often overlooked are gender inequalities in socio-economic status, and patriarchal ideology around sexual practices such as abstinence, monogamy and condom use (Ojikutu & Stone, 2005; Winter, 2005), so that women all over the world "find themselves at special risk of HIV infection because they

lack the power to determine where, when and how sex takes place" (UNAIDS, 2001).

The social ideology surrounding gender and power relationship 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). Discourse is defined by Fairclough (1995) as "language use as social practice" (p.131). He pointed out that there is a dialectical relationship between discourse and the society. On the one hand, discourse is shaped by social identities, social relations, and systems of knowledge either as a result of unconscious discourse generation or of 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. It is either conventional and reproductive, accustoming people to accept it as "common sense" and "fact"; or creative and transformative, awakening people to realize the truth and make corresponding responses. The same idea can also be seen in some 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 focus 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, how gender and sexuality are constructed in HIV/AIDS discourses has some bearing on the possibility of 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, in press). 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) and finally the decision to resist the available content (Foster, 2000; Mitra & Watts, 2002; Morkes & Nielsen, 2003). The result is the initial purpose of

some HIV/AIDS prevention discourse would not be achieved. However, what's worthy of note is that women may also question their original understandings about their own identities and become subservient to what is presented to them either due to the authoritativeness of the discourse providers or to the predominance of certain ideology across different discourse.

In order to change gender inequality and power imbalance in the HIV/AIDS epidemic by making changes to discourses, the first necessary step is to reveal how gender and sexuality are socially constructed and to what degree women are empowered in HIV/AIDS discourses. It is in this way that the vital role discourse can play in the HIV/AIDS crisis that women are faced with can be brought into the attention of the public --- women in particular, and that efforts can be made towards the generation of more, although not completely, neutralized discourse.

A Conceptual Framework

Gupta (2000) has extensively explored the determining role of power in gender and sexuality. The conceptual framework, informed her theory on the role of power in the construction of gender and sexuality in HIV/AIDS discourses, will be used to organize the current relevant literature into a few themes right after this section.

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, 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).

What is fundamental to both sexuality and gender is power. 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 when, where, and how sex takes place (Gavey, McPhillips & Doherty, 2001). 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 & Rao Gupta, 1998).

By using a feminist approach to theorizing gender and sexuality, Gupta categorized HIV/AIDS programs in terms of the degree to which historical power dynamics in gender and sexuality were maintained. The categories summarized in Table 1 are depicted in Figure 1 ranging from the most damaging to the most beneficial ones.

Stereotypical Construction

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 White men 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 as long as they were healthy (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), which was potentially dangerous and was actually proved to be true later when women were increasingly infected. To stigmatize and ostracize a particular group, rather than to focus on personal behavior change, could only make things from bad to worse (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 include 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. The means by which women become infected in the first place was largely ignored, which was primarily through unprotected sexual contact with an infected man or through unsafe drug use. Some brochures even claimed that women can infect men just as easily as the other way around. However, the fact is 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 also depicted as only transmitters to their unborn children. Again, the role of the heterosexual men as fathers was absent, which put them in a privileged position.

Those discourses representing women as transmitters wrongly justify the well-deserved infection of HIV/AIDS by women and run the risk of allowing for a disproportionate blame on them.

Caregivers. After 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 in to others and denying them their own special cultural needs and experiences (Amaro, 1995; Patton, 1990).

Charlesworth (2003) also found this identity being 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 partners and children, especially so when women also act as transmitters. 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.

Those 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 and thus 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 they may risk separation from the important others, decreasing the extent they can assert control over sex behavior and communication (Lear, 1995; Stein, 1995).

"Flower-pots" In the brochures that Charlesworth (2003) investigated, the focus of those targeted at women and the general population is almost exclusively on alerting pregnant women to their risk of infection. In other words, pregnant women are the only group of women consistently warned in the brochures. The reason is obvious: through pregnancy, women with HIV/AIDS can transmit the

virus to their babies. This is the reinforcement of the image of women as caregivers whose lives are of concern only when others are at risk. The ancient 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. If they do transmit HIV/AIDS to their children, they will be facing social criticism, labeled as irresponsible mothers even if they do that only unknowingly (Hassin, 1994).

Although women's sense of altruism, a stereotypical feminine trait, may be reified, which could motivate women to protect themselves for the benefit of others, those discourses will not be effective in alleviating the crisis facing women if they simply stress the priority of the needs of the others women are supposed to care for.

Vulnerable Subjects Women in 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 found that whenever women and HIV/AIDS appear side by side in discourses, women in Africa would almost always be 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, in pessimistic terms, which can be seen vividly in media images featuring "Black children with emaciated bodies, impoverished communities facing environmental and epidemic catastrophes, and bare breasted women standing besides grass huts are imprinted on the collective consciousness of citizens in the West." These discourses contribute to the historical, economic and psychological relationship between "us and them".

"Westernized" Subjects In the ABC health campaign initiated by the US Government, it is advocated 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. ABC approach has been adopted as a public health campaign to combat HIV/AIDS in Africa. However, Kvasny and Chong (forthcoming) argues 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 is limited in terms of

protection for women in Africa at least. Abstinence is not an option for women who marry young, for women with abusive husbands, and for girls and women who are raped. Under these circumstances, men are the only ones who can abstain.

In the second component, Be Faithful, again does not apply to women in African quite well. On the contrary, married monogamous women are among the groups at greatest risk of infection (UNAIDS/WHO, 2003), while the rate of HIV infections in husbands was higher than in 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, et al., 2001), which is couched in Western notions of individualism and personal responsibility and ignores the constraints that women are faced with. For example, women in Africa 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 and because of the myth that sex with a virgin can cure a man of infection (UNAIDS, 2001). They can't go against their feminine identity to require protected sex due to the cultural significations 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. HIV epidemic in southern Africa are 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, 2004). Although campaigns like ABC is not useless, societal change to facilitate women's agency is most necessary.

Sensitive Construction. Some discourses acknowledge the power imbalance women experience with men and encourage women to take responsibility for prevention. Although they 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 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" (p. 406)

Transformational Construction. In the PSAs released by CDC in 1995 that Myrick (1999) investigated, the representations of women are more progressive. The emphasis is more on positive behavioral strategies and less on mere appeals. However, the disempowering elements established in the initial PSAs still remain, although in less explicit and more subtle 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.

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 cheering, this kind of discourse is still not empowering since it is written for women who have already been diagnosed with HIV. It seems like women can be permitted to care for themselves only when it is too late to protect themselves.

Discussion

In this review, Gupta (2000)'s theoretical framework is used as a lens to dissect 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 them are stereotypical with only a few being sensitive to the differences among women and being transformational in their intent for change. Although strengthening the already deeply ingrained stereotypes would do harm to the prevention efforts oriented towards women, the sensitive and transformational discourses are no better when it comes to the potential negative effect they might have in the long run.

What is most saliently reflected in those discourses is the cultural ideology of patriarchy which is realized largely by means of omitting or de-stressing the role heterosexual men play in the HIV/AIDS epidemic. By identifying with this cultural ideology, the generators and sponsors of the discourses could maintain the status quo of the power relations. Those negative identities of women would be even more harmful if they are rhetorically replicated by other institutions in our society, most notably the government. If placed under the influence of such rhetorically powerful texts without enough awareness, women tend to have false self-consciousness of their own identities. As a result, those discourses would in no way accomplish the supposed goal, i.e. to reduce the spread of HIV/AIDS among women (Charlesworth, 2003).

In all, 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). What should be constructed in the discourses are empowering women and encouraging them to take active steps collaboratively to free themselves from the entrenched power inequalities dictated by the ideology of patriarchy which has lasted for thousands of years. What should be reflected in the discourses is the government's willingness and resolution to create a democratic environment that is discursively inclusive and depression free (Renwick, 2002). Promoting condom use and paying more attention to mothers are not unnecessary, but they are not enough to be really effective messages. Gender differences and power relationships have to be taken into account.

The specific lessons that can be drawn by designers of HIV/AIDS prevention messages include but not limited to:

- Awareness of the tendency to use disempowering strategies that assign blame, guilt and disproportionate responsibility in the representations of populations;
- Recognition of how basic textual elements like the use of narrators and the representations of character can be useful to empower populations by shifting the focus of such strategies to the position and perspective of those populations.
- Use of representations that accurately depict their cultural experience and provide behavioral strategies that are responsive, relevant and empowering;

This current study is exploratory in nature and thus is limited in the scope and depth of the literatures that have been reviewed. However, this work provides a rough clue of what have been investigated in this area and thus has implications for future studies. In order 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, graphs as well as the overall 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 turns out to be effective to uncover the characteristics of current HIV/AIDS discourses. Its usefulness and potentials should not be limited to this review. If combined with Critical Discourse Analysis (CDA) --- the examination of language use to reveal power relations (Fairclough, 1995), it could be employed in empirical studies which deconstruct particular materials 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, the current research has been examined in order to find out how gender and sexuality has been socially constructed in HIV/AIDS discourses. The contribution of this paper is three fold. Firstly, Gupta (2000)'s 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. Secondly, the status quo and trend of

research in this field becomes clear in the review of relevant literature, and new lines of scholarly inquiry and critique are opened up. Thirdly, and most importantly, suggestions are made for generators and sponsors of HIV/AIDS discourses on how to truly empower women by manipulating the assumption and structural elements in discursive practices.

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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", 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".

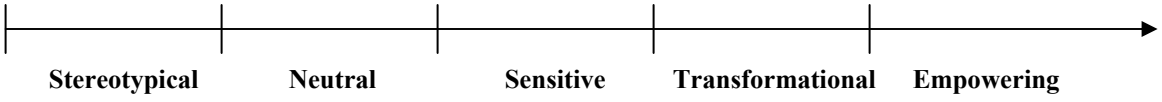

Figure 1: Continuum of the Social Construction of Gender and Sexuality