

Running title: Accountability and sexism in HIV/AIDS talk

‘If they have a girlfriend, they have five girlfriends’: Accountability and sexism in volunteer workers’ talk about HIV/AIDS in a South African health setting

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Abstract

Significant challenges remain in tackling the global HIV/AIDS epidemic. Effective action requires both appropriate policy at a global level and informed practice on the local level. Here we report how workers in a project in Johannesburg, South Africa make sense of HIV transmission. Discourse analysis of data from interviews with 63 participants shows that project workers routinely attribute transmission to men's sexual relationships with multiple female partners. This explanation is so pervasive that it renders invisible other routes to transmission. Absence of consideration of other routes to infection potentially restricts front-line practice, so hindering local attempts to tackle HIV/AIDS.

Keywords: AIDS; critical health psychology; communication; HIV; HIV-infection; discourse analysis

In 2012, an estimated 35.3 million people worldwide lived with HIV (UNAIDS, 2013). Alongside this were reported incident and death rates of 2.3 million and 1.6 million, respectively (UNAIDS, 2013). The disease also has psychological effects in terms of stigmatisation as well as caring for and losing family members. Moreover, there are also developmental and economic effects (Fortson, 2011; Levinsohn, McLaren, Shisana & Zuma, 2013). Children are either forced to remain at home to care for sick family members or they simply cannot attend school as sickness may have resulted in loss of income for the family (Cluver, Operario, Lane & Kganakga, 2012; Taraphdar et al., 2011). At the same time, the loss of income from employment of breadwinners and the costs of living with HIV render many families dependent upon state benefits to alleviate the socio-economic consequences of HIV, resulting in increasing strain on national welfare systems (Woolgar & Mayers, 2014).

In responding to the HIV/AIDS crisis, governmental and non-governmental agencies alike have contributed effort. However, although the UN reports striking global gains in dealing with this epidemic, they note that significant challenges remain. In understanding these challenges and in developing coordinated initiatives to address them, it is important to bear in mind that health-related concerns reflect globally formulated policy, local initiatives, and the understandings and orientations of health workers who are most involved in delivering related policy and practice outcomes (Mulligan, Elliot & Schuster-Wallace, 2012). What this means for the health crisis represented by the HIV/AIDS epidemic is that a full recognition of the issues involved and the responses that will be most effective relies, at least in part, on discovering how those at the 'front line' make sense of such issues and responses. In part, this is because policy and practice must at some stage be aligned with the activities of those most closely involved in delivering intended outcomes. But equally importantly, it is imperative to understand how, and to what extent, the understandings of local actors are

consistent with or at odds with the aims of objectives that drive policy and practice on a more global scale.

One particular remaining challenge relates to the transmission of HIV. As a virus found in body liquids (such as blood or semen), HIV is commonly transmitted in four ways: through (i) unprotected sexual intercourse, (ii) blood transfers, (iii) sharing of contaminated drug equipment, and (iv) mother-to-child in association with birth or breastfeeding (UNAIDS, 2013). Thus, the 2011 UN Political Declaration (United Nations General Assembly, 2011) set out, inter alia, specific targets of reducing by 50% infections in both sexual and drug-related HIV and the elimination of new HIV infections among children by 2015. While some progress has been made, more remains to be done to achieve the targeted reductions. In setting out its targets to follow the 2015 deadline, UNAIDS (2014, p.1) adopts an even more ambitious aim: to achieve ‘nothing less than the end of the AIDS epidemic by 2030’. For this aim to have any reasonable prospect of being met, broad policy agreed at the intergovernmental level of the UN and local policy will have to be translated in practice by agencies who work to reduce rates of transmission in local populations. Thus, to examine how policy is worked out in local practice, we need to examine the understandings that front-line workers have of how HIV is being transmitted and how these inform their health-related advice to those with whom they work.

This paper aims to examine how one group of front-line HIV/AIDS workers make sense of HIV transmission. The study described here was located in South Africa. This is an appropriate context in which to pursue the present goal, because Sub-Saharan Africa as a whole is heavily affected by HIV/AIDS; the area accounts for two-thirds of all people living with HIV as well as the majority of AIDS-related deaths. In South Africa in particular, the HIV adult prevalence rate in 2012 was 17.9% (UNAIDS, 2013). The effects of the diseases can thus be seen on both micro and macro levels across the whole of South African society.

Of the four routes to HIV transmission identified by UNAIDS (2013), two routes, namely transmission by blood transfers and sharing of contaminated drug equipment, are relatively uncommon in South Africa. Transmissions by a third route, that of mother-to-child transmission, have been greatly reduced through the introduction of Prevention of Mother To Child Transmission (PMTCT) guidelines and programmes (Coovadia & Pienaar, 2013). In this context, therefore, sexually-transmitted HIV provides the main focus of concern. However, attempts to tackle HIV infection in South Africa have been greatly hindered by Government policy responses towards the epidemic, which have been at best ineffective, and at worst obstructive to health practitioners' efforts to make treatments widely available by 'denialism' and lack of collaboration with the South African AIDS movement. The outcome has been delay in widespread provision of highly active antiretroviral treatment (HAART) and an ongoing incidence of HIV transmission that far exceeds those found elsewhere (Nunn, Dickman, Nattrass, Cornwall & Gruskin, 2012).

Taking these factors together, the South African context is likely to prove a particularly challenging one in which to achieve the end of the AIDS epidemic by 2030 as set out by UNAIDS (2014). The aim of the present study, therefore, was to examine health workers' constructions of HIV transmission in this context and the extent to which these constructions sustain or challenge policy for reducing sexually transmitted HIV infections.

Methods

Context and data

The data presented here come from a larger study conducted within a non-profit organisation caring for vulnerable children in Johannesburg, South Africa. That study investigated the experiences of AIDS-related bereavement among HIV/AIDS caregivers. The third author worked with this organisation for 12 months, participating in the front-line fight against the effects of HIV/AIDS. During this time, she recruited staff members, international

volunteers, and local volunteers as participants for the study. All international volunteers during the study period were invited to participate, as were staff members and local volunteers who had experienced AIDS-related bereavement. Participants needed to be competent English language speakers. Interviews were conducted with 63 participants (43 female and 1 male staff members, 13 female and 6 male volunteers), aged between 19 and 65 years ($M = 40$ years), with an average service length of 110 months (ranging from 1 to 347 months).

The interviews followed a semi-structured format, covering topics that included participants' experiences of working at the organisation, experiences of working with individuals who are HIV-positive, or have AIDS and/or TB, the training they received, and support available to them in their work. Interviews lasted an average of 36 minutes. All interviews were audio-recorded and transcribed using an abbreviated form of the Jeffersonian notation system (Jefferson, 2004).

The design and conduct of the study incorporated relevant ethical guidelines including the Code of Ethics and Conduct of the British Psychological Society (2009) and the ethical framework of the study was approved by The University of Edinburgh Psychology Research Ethics Committee.

Analysis aimed to identify the forms of explanation that participants produced for transmission of HIV. From initial analysis, we identified forms of talk that recurred across the majority of transcripts within the data set and selected all relevant passages for further analysis. The explanations used did not vary with gender or age of participants. Analysis of selected passages was conducted using micro discourse analysis grounded in the traditions of ethnomethodology (Garfinkel, 1967; Heritage, 1984) and conversation analysis (Sacks, 1992; Sacks, Schegloff & Jefferson, 1974)). In this approach, attention focuses on the situated nature of discourse and on its action orientations, in particular how talk is used to accomplish

particular social outcomes (McKinlay & McVittie, 2008; Wiggins & Potter, 2008). Here, analysis focused on the linguistic design of participants' descriptions, the rhetorical devices employed in their constructions, and how these constructions functioned as explanations. In accordance with recognised principles of discourse analysis, we focused on how the participants themselves oriented to the descriptions that they produced and made these relevant to the immediate discursive context. Finally we examined the action outcomes of these descriptions, in particular how they explained and attributed causality for HIV transmission. Final analysis was discussed and agreed by all authors. The extracts produced below are representative of the data set as a whole (Potter & Wetherell, 1987) and exemplify the forms of discursive constructions used by the majority of the participants.

Results

We turn first to an extract of talk in which one of the health workers describes her role in relation to individuals who have contracted HIV.

Extract 1

1 Int And what is your job here
2 (1.1)
3 P20 My job is to::: make sure that the clients that I have (1.0) they >do take< their
4 medication (0.4) the way they should (0.5) and they take full responsibility of
5 their lives

In responding to the question posed, P20 describes her job by outlining her responsibilities and those of others that she describes as her 'clients'. She describes the responsibilities of her clients in normative terms, in that they are required to take medication in 'the way they should' and, moreover, that they 'take full responsibility of their lives'. Her

role is stated to be one of 'mak(ing) sure' that her clients follow these actions. It is interesting to note here her references to those who bear these responsibilities. Her descriptions throughout Extract 1 are gender-neutral, in that as well as describing those involved as her 'clients' she thereafter refers to them using the generic 'they' and 'their' at lines 3 to 5. The requirements to take medication appropriately and to accept 'full responsibility' for one's life are thus presented as the normative expectations of anyone who has contracted HIV.

What we see here, then, is one particular way in which health workers talked about the responsibilities associated with HIV in which locus of responsibility is made out in a gender-neutral fashion. However, as we turn to accounts that were produced by these participants in talking not about those who have already acquired HIV, but those who are in danger of doing so, a quite different pattern of description emerges.

Extract 2

- 1 P57 And the woman (.) woman as well (0.4) like the- there's no problem if you
2 have a boyfriend you can have (0.5) ehm (.) especially the boys if they have a
3 girlfriend they have <five> girlfriends >or even have the< if they have a wife
4 they still have girlfriends (.) and that is one thing I can't understand [...] it's not
5 ((chuckles)) it's not ehm (.) productive (0.4) for the i- m- for (resolving) the
6 issue yah
7 (0.6)
- 8 Int Why do you think it's not productive
9 (0.3)
- 10 P57 Eh because (.) HIV/AIDS (.) I mean (0.4) the most thing that people get
11 infected is is sex (0.6) ehm (0.4) I mean I-I think so ((chuckles)) it is sex
12 (0.5) ehm even if there are other ways to eh get infected I think sex is the most

13 important one (0.4) and if you have like five girlfriends in a country where
14 maybe every third °or fourth woman I don't know the statistic exactly° (0.4)
15 ehm has HIV/AIDS and you have fi(h)ve girlfriends then at least one (.)
16 statistically has HIV/AIDS (0.3) and then if (.) the man does it it's (0.4) kind of
17 (.) that (.) all five woman get get it as well

What is of note in this extract is the particular design of response on offer. Here, P57 begins at lines 1 to 2 by referring to women entering into a personal relationship with 'a boyfriend'. He evaluates this action positively, describing it as 'no problem'. Before however continuing this description at line 2, P57 breaks off without detailing the consequences of such an arrangement for women. Instead he continues by offering a contrasting description of the outcomes for 'boys' of entering into heterosexual relationships. Rather than involving a single partner, personal relationships for 'boys' are formulated in terms of them having multiple partners, whether comprising '<five> girlfriends' or 'a wife' and 'girlfriends'. This formulation is not set out as a factual claim but, rather, as an 'if-then' construction in which for a 'boy' to 'have a girlfriend' is treated as though it naturally leads to the consequence that he will have five girlfriends. This logical connection is heightened at lines 3 to 4, where the case of a 'boy' who has a wife is presented, via 'or even', as a more problematic instance which nevertheless naturally leads to the same outcome. Such arrangements, again in contrast to P57's earlier positive evaluation of women's relationships, are presented as being problematic in being 'one thing I can't understand'. P57 thereafter offers an upshot to this contrast between the relationships of women and those of 'boys', in concluding that the latter which involve multiple partners are not 'productive' for '(resolving) the issue'.

Following this upshot, P57 offers no further detail, suggesting that he is treating this response as a sufficient explanation in itself. The ensuing pause is followed at line 8 by a

question from the interviewer that invites P57 to expand on his description. At lines 10 to 17, P57 does expand on his previous turn by offering an explanation that is formulated in terms of 'sex' and its role as 'the most important' factor involved in the transmission of HIV. This explanation is presented in terms of an 'if-then' format, echoing the 'if-then' constructions presented earlier in lines 2 to 4, that refers to the suggested prevalence of HIV/AIDS within South Africa and the suggested outcome of this prevalence for further transmission.

Specifically, it is suggested that if 'maybe every third or fourth woman' has HIV/AIDS then the probable outcome for a man with multiple sexual partners is that he will contract HIV from contact with one of these partners and then in turn transmit the disease to all his sexual partners. It is particularly noteworthy that P57 here frames his description solely in terms of the actions of the man, arguing that 'the man does it'. His sexual partners are by contrast described only in passive terms in that 'all five woman get get it as well'. Notwithstanding that P57 states that 'at least one (woman) statistically has HIV/AIDS', the effect of this explanation is to attribute to 'the man' responsibility for the onward transmission of HIV to 'all five women'.

In the preceding extract, the presentation of heterosexual dyads as normative is set within an argumentative framework which relates prevalence of partners to health problems: if a man has a partner, then he has multiple partners, and in consequence he is responsible for the transmission of HIV. However, in this instance it is noteworthy that to begin with, P57 does not treat his claims as requiring further warrant and does not offer further detail until called upon to do so by the interviewer's subsequent question. In the extracts that follow, we see a somewhat similar picture. Here, the relationship of one heterosexual man to one heterosexual woman is treated as so 'obvious' that it requires no further warranting and, conversely, relationships that are presented as transgressive of such an arrangement are evaluated negatively without an accompanying justificatory framework. Of particular note

here is the nature of explanation that *is* on offer. As the next pair of extracts demonstrates, the transgressive nature of those who breach this particular normative expectation is itself set within a specific explanatory framework – that such transgressions are the fault of the men who are depicted as the active agents in such arrangements.

In the next extract, prior to this point in the interview, the participant had been describing how she attempted to learn more about HIV/AIDS upon taking up her post. During this account, P36 refers to the personal relevance of such information to herself and her partner, pointing out that she felt it was her responsibility to inform them both, based on her partner's ignorance of such matters.

Extract 3

- 1 Int Why do you say that male can be ignorant
- 2 P36 >Well I mean< most of m-m- (.) males that I've come across are actually very
- 3 ignorant (.) when it comes to HIV (0.2) they don't wanna go for HIV testing
- 4 (0.4) they don't wanna know about HIV they know HIV's there but they (.)
- 5 choose not to know about it (0.3) and they >choose not to talk about< it (0.3)
- 6 and yet they engage in very unsafe (0.2) sexual behaviour (.) >you know what
- 7 I'm saying< (0.4) a:nd (.) you and you ask them (0.4) are you using condoms
- 8 why should I use condom (0.8) how many sexual partners do you have (0.2)
- 9 three (1.1) hello ((chuckles)) you know and eh (.) all of those things and you
- 10 ask them have you been for an HIV test (0.2) no I haven't been but why (0.3)
- 11 no I don't need to (.) you know

In response to being asked as to why she had previously described males as being 'ignorant', P36 describes 'most of m-m- (.) males that I've come across' as lacking

knowledge about HIV/AIDS and as not wishing to engage with such knowledge. Her description of their reluctance is presented at lines 3 to 5 in the form of a listing, with each element referring to absence of appropriate action by the males concerned. This description leads up to a contrasting claim at lines 6 to 8, where P36 states that the 'males' to whom she is referring 'engage in very unsafe (0.2) sexual behaviour'. The remainder of her response takes the form of an imagined conversation with one of the males that she is describing. Here the use of the generalised 'you' suggests that this does not reflect any instance specific to her, but rather is a typical exemplar of a conversation between such a male and someone in her position.

At lines 7 to 8, P36 voices a question that a worker would ask of these males, namely 'are you using condoms'. The response that this would often elicit is presented as being one of questioning the need for taking such precautions. Thereafter, at lines 8 to 11, P36 sets out how she would respond to such a question. Her answer is formulated in terms of asking about the number of 'sexual partners' of the male co-participant and receiving the answer 'three'. At line 9 she treats the introduction of such information as noteworthy, in describing her response as 'hello ((chuckles)) you know', but at the same time as requiring no further detail. This provides the basis for the concluding question to the male concerned 'have you been for an HIV test', a question that is again met with reluctance and denial of the need for such action.

Presented in this way, P36's response describes how she or others would make sense of what she earlier described as the 'ignorance' of males. She sets out the basis for this claim. This however rests not just on lack of knowledge or reluctance, but also on a specific and taken-for-granted notion of how HIV is transmitted, that is that it arises as a result of the number of sexual partners of the male. Engagement with multiple partners is again provided as a self-sufficient explanation for the transmission of the disease.

Indeed, this form of orientation/explanation is treated as so commonplace that it can readily be deployed even where other possible explanations are available. Thus in the next extract we see the speaker weaving this explanation into a response that initially attributes responsibility elsewhere but which subsequently renders men culpable for HIV transmission.

Extract 4

1 P62 I get- (0.3) angry at other people's ignorance (1.0) uhm (0.3) and when I say
2 that I mean governments for not educating (0.8) uhm (.) I get (0.4) angry at
3 people for not taking precautions like (0.3) when you just constantly hear
4 stories about (1.2) m- fathers that impregnate (0.7) mothers full well knowing
5 that they're HIV positive and not telling them

At the beginning of this response, P62 refers to 'people's ignorance' and evaluates this negatively in describing as something that provokes anger in her. However, she continues by reformulating the causal locus of this emotional response in stating that 'I mean governments'. It is these latter actors who are at first positioned as ultimately responsible in failing to provide appropriate educational resources. The target for P62's anger is thus depersonalised, moving from individuals to a focus on agencies responsible for educating and protecting them. However, after this initial attribution, P62 reworks her earlier description of the cause of her anger, in stating that it is 'people not taking precautions' that cause her negative emotional response. Here, the notion of unspecified 'people' being in a state of ignorance is replaced with a description of those people acting in such a manner that 'precautions' are available to them and yet they refrain from using these. At this point, P62 again reformulates the target of her anger. In doing so, she introduces, via 'like', an exemplar of the activity she has described: 'fathers that impregnate (0.7) mothers full well knowing

that they're HIV positive'. Thus, the gender-neutral term 'people' is replaced by the gender-specific term 'fathers'. Moreover, the reference to 'people's ignorance' has been replaced by reference to activity that is carried out by someone who is 'full well knowing'. A description that initially positions 'people' as being in a state of ignorance due to governmental inactivity has therefore become one of men acting in a state of knowledge. This transition from ignorance to knowledge is further emphasised by the rest of P62's description of what such men do. They not only carry out the act of transmitting HIV knowingly, they further display their culpability in doing so while, at the same time, refraining from informing their partners what they know about their current state of health.

It is not only the target of P62's anger, and the state of ignorance or knowledge that changes during her description. What also changes is the evidential basis that P62 offers in each case. Whereas she presents the failure of governments to educate people as simply a matter of fact, she describes the actions and consequent culpability of 'fathers' as being evidenced by 'stories' that 'you just constantly hear'. This functions in two ways. First, it suggests that what she describes is grounded in everyday experience rather than being a matter of abstract knowledge. Second, it emphasises the frequency of such practices and suggests that they fail to be recognised as part of the everyday lives of many families. In these ways, the claim that HIV is passed to 'mothers' by 'fathers' who act recklessly and without due concern for their partners is presented as an immediately recognisable and obvious explanation for transmission of the disease.

In the two preceding extracts, we see a particular characterisation of men and their responsibilities for the HIV/AIDS epidemic. One candidate explanation for the existence of the epidemic is that men and women alike are ignorant of its causes. Here, however, two things are worthy of note. First, the locus of causality is attributed to men, not to men and women. Second, the notion that these men are ignorantly causing the epidemic is discounted.

In Extract 3, we see a motivational story in play. It is not that men are contingently ignorant of relevant facts. Instead, men wilfully choose to remain ignorant of these facts. In Extract 4, the stakes are upped. It is not that men are ignorant, or even wilfully ignorant. What one can ‘constantly hear’ is that men are not ignorant about HIV/AIDS but, instead, deliberately ‘impregnate mothers’ knowing that they have HIV or AIDS.

In the previous extract, an initial claim about the culpability of depersonalized governmental agencies was reframed as a claim about men’s culpability. Below we see a similar manoeuvre through which preliminary reference to women’s culpability is used as a local context in which the blameworthiness of men for the transmission of HIV can be introduced. This extract occurs at a point in the interview where P57 has been describing the range of new items of knowledge that he has acquired since taking up his post in the project.

Extract 5

1 P57 and then all the issues like how (.) how ma::n (0.2) treat woman and then they
2 say uhm (1.4) th- the w-wife brought bro(h)ught HIV in the family but
3 everyone knows that the (0.4) bo- the husband has four girlfriends anyway and
4 the (.) wife never cheated on him

In this extract, we see P57 continuing his previous listing (seen in Extract 2) of the items of knowledge that he has gained through working at the project. His description at line 1 is presented in gender-specific terms, where he refers to ‘how ma::n (0.2) treat woman’. This description, similarly to that seen in Extract 2, is presented in terms that attribute very different roles to ‘man’ and to ‘woman’. The man is described as being the active agent in the action being described, whereas the woman is (merely) the passive recipient of what happens.

P57 offers a candidate attribution of blame for the transmission of HIV in the particular context to which he is referring, namely one of 'the family'. The attribution under discussion in this context is one that is clearly gender-specific in laying the blame for HIV transmission with the woman, in that 'the w-wife brought bro(h)ught HIV in the family'. P57's description however distances him from aligning himself with his attribution. First, he attributes this allocation of responsibility to unspecified others in the form of 'they', presenting himself as voicing such a view rather than authoring it. Second, this attribution is presented as something that is merely said, and its factual status is not further commented on. Third, having presented this candidate explanation he immediately marks what is to follow as inconsistent with what he has just said through use of the disjunction marker 'but'.

Having cast doubt on the initial explanation, P57 goes on to provide an alternative and somewhat different explanation for HIV/AIDS in the context of 'the family'. This alternative explanation takes the form of that seen in the preceding extract, referring to the husband and the number of sexual partners that he has, where P57 states that 'the husband has four girlfriends anyway'. It is interesting to note that P57 sets out the relevance of this explanation and the grounds on which it is made, in that 'everyone knows' this to be the case. This establishes the factual status of his claim in that it is an item of knowledge, unlike the earlier claim whose factual status was left undetermined. Moreover, the extent of this knowledge claim is given emphasis in that it is presented as something that 'everyone' knows. However, P57 provides no further detail, treating the information as to the number of sexual partners involved as self-sufficient in this context. Taken together with the contrasting description of the wife's sexual activity, namely that she 'never cheated on him', the attribution of blame to the husband for the introduction of HIV is presented as being the self-evident explanation in this context. More than this, however, we should note that P57's description refers not to any specific family but instead to a generic exemplar. The effect is that men are presented in

general terms as culpable for the introduction of the disease to families as evidenced by the number of sexual partners with whom they interact.

Discussion

As noted above, the leading actors responsible for global policy and practice in the area of HIV/AIDS-related health identify four primary routes to HIV transmission (UNAIDS, 2013). Of these, the route most relevant in a South African context is that of unprotected sexual intercourse, and it is unsurprising therefore that this provides the primary focus for participants' explanations in the present study. There are however three features of these explanations that are challenging for attempts to reduce sexually-related HIV transmission in practice.

First, all responses examined here describe sexual HIV transmission solely in terms of heterosexual sexual relationships. This single focus makes no reference to the high rates of HIV infection found among men who have sex with men (MSM), recently reported as being 48.2% in Durban, 22.3% in Cape Town and 26.8% in Johannesburg, the site of the present study (Icard et al., 2015). Notwithstanding these high prevalence rates of HIV in men who have sex with men, and the even higher risk faced by gay men in South Africa (Lane et al., 2011), such possibilities are absent from our participants' descriptions. Instead, their accounts instantiate what elsewhere has been referred to as 'heteronormative' talk (Kitzinger, 2005): talk in which relevant issues are introduced from a perspective in which heterosexuality is treated as normative. Of course, even within such a context, there is a multiplicity of versions of heterosexual relationships that might have been referred to. However, here we see a single version – what Hollway (1984) has described as the 'male sexual drive' discourse - in which sexual relationships are explained in terms of men's needs and the assumption that women should accommodate to men's 'innate' biological drives. Even this limited form of account provides some narrative space for reference to different

sorts of heterosexual relationships in which men are portrayed as active agents. And yet here we see a single model of such relationships – one heterosexual man in a relationship with one heterosexual woman – being oriented to as a norm and alternative arrangements being treated as problematic.

Second, the explanations here rely upon specific constructions of masculine identities. The masculinities seen above construct men as on the one hand having power over their female partners and on the other hand as routinely engaging in risky sexual behaviours, specifically by not using condoms. These descriptions thus reproduce what traditionally have constituted hegemonic masculinities in a South African context (Shai, Jewkes, Nduna & Dunkle, 2012). Previous writers have argued that successful HIV prevention requires a fundamental change in gender identities (Jewkes & Morrell, 2010) and indeed recent evidence suggests that masculinities can be reworked in ways that are potentially less harmful and less risky than previous versions and that consequently might allow greater possibilities for effective intervention (Gibbs, Jewkes, Sikweyiya & Willan, 2015). Such alternative versions of masculinities are however absent from the descriptions seen here that reproduce masculinities in terms of sexual prowess, power and risk without recognition of different possibilities.

Third, the positions made available in these explanations for female sexual partners are in themselves problematic. In attributing problematic health outcomes to men's behaviour these findings resemble those found in previous research that has examined how health professionals deploy gendered constructions of men's and women's behaviour in health contexts. For example, in their study of how health workers discuss men's health issues, Seymour-Smith, Wetherell and Phoenix (2002) noted that men were described as 'child-like' and consequently irresponsible in terms of maintaining their own health. In consequence, women were positioned as being responsible for supervising men's health.

What we see in the present study is again men being described as irresponsible in health terms, this time in relation to the impact of their behaviour on women. Thus, women become victims of men's irresponsibility. What is common across these studies is the common construction of men's irresponsibility, whether impacting on their own health or that of other people. Women, by contrast, are presented as the recipients of men's unhealthy actions, in either having to deal with the ensuing problems or in having little or no control over them. Yet, previous work has pointed to the possibilities for women to initiate HIV protection, albeit that the use of such forms of protection in practice is at best limited (Mantell, Dworkin, Exner, Hoffman, Smit & Susser, 2006). Potentially, then, the explanations found here can be heard as criticisms of female sexual partners for leaving responsibility in these matters to men and failing to take responsibility themselves to protect against transmission. This discourse, although critical, appears perhaps in some respects less blaming of women than previous versions. For example, here blame becomes attributed through omission, that is due to failure to take responsibility, rather than through commission such as women's promiscuous sexual activities as found in previous work (Strebel et al., 2006). In many respects, however, the disempowerment of women in the fight against HIV continues; the need to empower women in the fight against HIV/AIDS in Africa (Baylies & Bujira, 1995) remains a challenge.

What the data indicate here, then, is that health workers' talk orients to one highly specific form of sexual HIV transmission, that found in normative heterosexist relationships, involving men with one version of masculine identity, and in which women are effectively disempowered. The central problematic revealed by the current findings is that the very people who might be viewed as central in tackling the problems of HIV/AIDS within this particular setting are those who engage in discursive practices that are complicit in perpetuating those problems in rendering invisible many forms of sexual transmission. The more that the transmission of HIV is treated and sustained as a self-evident outcome of men's

sexual practices, that is ‘what men are like’, the less susceptible the transmission of HIV becomes to other forms of intervention.

These constructions point to some of the challenges that have to be overcome if the UNAIDS (2014) aim of achieving ‘nothing less than the end of the AIDS epidemic by 2030’ is to be realised. Of course, the realisation of policy aims in practice is commonly problematic. For example, in a study of how global health policy was taken up in steps to address dengue fever, Mulligan and her colleagues (Mulligan et al., 2012) found that global policy designed to control dengue fever presented the disease as one that predominantly affected the poor. Health workers in Malaysia who took up these understandings of the disease were in practice unable to control the incidence of the disease in non-poor neighbourhoods. Here, by contrast, we see health workers in South Africa reworking broad policy relating to sexual transmission of HIV to a single route to transmission that excludes other possibilities. The question in the present case, therefore, is that of how practice on the ground might otherwise orient to broad policy aims relating to the reduction of HIV transmission. Recent initiatives have pointed to some ways in which young women can seek to negotiate different forms of femininities, even against a backdrop of culturally prevalent and powerful masculinities. For example, Jewkes and Morrell (2012) note that some young women make claims for ‘modern’ femininities that potentially allow for some control over their lives and sexual practices, while others argue for mutual respect for and from their sexual partners. One possibility, therefore, is for health promotion initiatives to support women to construct such identities for themselves and thereby to explore the potential for them to exercise some control within their relationships. Realising this potential will be difficult but surely is necessary at least as one part of broader attempts to address and reduce continuing high rates of HIV prevalence in South Africa. And more generally, if the ambitious aim of ending the global AIDS epidemic by 2030 is to be met, it is unproductive

and obstructive for health workers in South Africa or elsewhere to rely on single limiting explanations for HIV transmission. No matter how obvious and self-evident such explanations might appear, ending the global AIDS epidemic by 2030 surely will require recognition of all routes to transmission and all possibilities for change.

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