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# Capital, habitus and symbolic violence in the field of reproductive rights: women and HIV

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Critical ethnographic research methods are used in this article to suggest that the concepts of capital, field, habitus and symbolic violence as conceptualised by Bourdieu offer powerful ways to understand the experiences of HIV-positive women dependent on public health-care facilities in Gauteng, South Africa. It is shown that power relations, yielded by biomedical hegemony, androcentric sociocultural practices, material deprivation, fear, discrimination and stigma demarcate the experiences of women living with HIV, and potentially undermine their abilities to become empowered.

## Kapitaal, habitus en simboliese geweld in die veld van reprodktiewe regte: vroue en MIV

Hierdie artikel gebruik kritiese etnografiese navorsingsmetodes om te suggereer dat die begrippe kapitaal, veld, habitus en simboliese geweld soos dit deur Bourdieu gekonseptualiseer is, op kragtige wyse begrip toelaat vir die ervarings van MIV-positiewe vroue wat afhanklik is van die dienste van openbare gesondheidsorgfasiliteite in Gauteng, Suid-Afrika. Dit blyk dat magsverhoudings soos voortgebring deur biomediese hegemonie, androsentriese sosiokulturele praktyke, materiële deprivasie, vrees, diskriminasie en stigma die ervarings van vroue met MIV konteer en dat dit ook hulle vermoëns om bemagtig te raak, ondermyn.

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The notion “reproductive rights” was introduced at the International Conference on Population and Development (ICPD) held in Cairo in 1994. According to paragraph 7.3 of the Programme of Action adopted at the ICPD, reproductive rights “rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence” (UNFPA 1995).

The promotion of this notion of reproductive rights is the legacy of efforts by governments, the World Health Organisation (WHO) and the United Nations Population Fund (UNFPA) to improve reproductive health, curtail population growth, lower maternal and child mortality rates, and lower the burden of sexually transmitted infections (STIs) including the transmission of HIV (Dowsett 2003).<sup>1</sup> The Programme of Action adopted at the ICPD enshrines a vision of reproductive rights and gender equality to replace the old Malthusian population control rhetoric. In 1995, the Fourth World Conference on Women, held in Beijing, reaffirmed this definition of reproductive rights. Moreover, paragraph 97 of the Beijing Declaration extended the definition of reproductive rights to cover sexuality:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (Beijing Declaration and Platform for Action 1995).

1 AIDS refers to acquired immune deficiency syndrome. This is caused by HIV, the human immunodeficiency virus. The HI virus attacks the body's CD4 T-lymphocytes (CD4 counts) and weakens the immune system. The Centres for Disease Control and Prevention (CDC 1986 & 1993) developed a surveillance case definition for HIV infection in 1986 based on clinical disease criteria, and revised it in 1993 to emphasise CD4-cell counts as clinical markers for HIV infection.

Despite the rights-based rhetoric, there has been a steady increase in HIV-infection among women in sub-Saharan Africa since the late 1980s. Women and girls account for 57% of all people infected with HIV (UNAIDS 2004: 4). In addition, 82% of young South Africans between the ages of 15 and 24 living with HIV is young women (Dorrington *et al* 2006: 19). Dorrington *et al* (2006: ii) also report that approximately 38 000 South African babies are infected with HIV at birth and that a further 26 000 infants are infected with HIV through breastfeeding.

This article argues that the concepts of capital, field, habitus and symbolic violence as conceptualised by Pierre Bourdieu offer powerful ways to understand the experiences of HIV-positive women dependent upon public health-care facilities in South Africa. In the current context of health care in South Africa, people are increasingly expected to be involved in their own health care by heeding health-care messages and taking responsibility for their own health.<sup>2,3</sup> Examples are anti-smoking campaigns, arrive alive traffic safety and drinking-and-driving campaigns, and the ABC campaigns (abstinence, be faithful and condomise) for HIV and STI prevention. The “own responsibility” rhetoric can be regarded as a counter hegemonic to biomedical hegemony in the field of health. Furthermore, the idea of self-directed, informed citizens accessing services and acting responsibly suits other mobilising metaphors that delineate a new democracy in South Africa. The “own-responsibility” rhetoric also appears to suit the definitions of reproductive rights as quoted above.

- 2 In a speech on 24 March 2007 at the provincial TB-day event, the premier of the Northern Cape stated: “As responsible citizens of this country, you should also take it upon yourself to have an HIV test, as I myself have done” (Peters 2007).
- 3 President Thabo Mbeki (2002) stated: “[W]e are waging the ABC campaign with regard to AIDS. It can only succeed if the people themselves take responsibility for their lives and do the things raised by this campaign. This also extends to the other diseases of poverty that claim many lives. In this regard, in addition to the things that government must do, questions of hygiene are critically important. The people must be educated to understand that they too have a responsibility for their own health and must therefore do everything they can to take care of their personal hygiene.”

Within the disease containment rhetoric of public health, people living with HIV are expected to be vigilant about their own health, go for testing, eat healthy food, live positively, prevent further infection, re-infection or superinfection and, when accessing antiretroviral (ARV) treatments, adhere<sup>4</sup> to the treatment regime. HIV-positive women, in particular, are expected to come to terms with their diagnosis, disclose their status to their partners, convince their partners to go for testing and use condoms, access health information and involve their doctors in any future planned pregnancies.

This discourse about self-directedness is backed by a general rhetoric about human and patient rights to information, choice and fair treatment.<sup>5</sup> Taken in conjunction with the sentiments expressed about reproductive rights as discussed earlier, the discourse on patient rights denotes dynamic alertness in the fight for rights in the sphere of health and health care. It also denotes a focus on the informed-of-her-rights-and-options health-care consumer as opposed to a passive, docile patient. The apparent disconnection between the notion of a rights-based responsible health-care consumer and an understanding of prohibitive socio-historical-political constraints to adopt such a role is cause for concern.

HIV/AIDS<sup>6</sup> therefore presents a crisis in the rights-based rhetoric of reproductive health. In this study, being an HIV-positive woman dependent on public clinics and hospitals for information and services to protect one's health was regarded as an important structural location and marginal position to be in.

The aim of this study was to move beyond description to uncover power relations that inhibit empowered decision-making by HIV-positive women in the field of reproductive health. Ten HIV-positive women in their reproductive ages and accessing health care from

4 Adherence (or compliance) means taking medication or undergoing treatment as prescribed. Biomedical wisdom holds that nearly perfect adherence to anti-HIV regimens (that is, 90-95% of prescribed doses taken as directed) is required to avoid the development of drug resistance (Broyles *et al* 2006: 184-5).

5 For a discussion of rights in HIV/AIDS disease curtailment, cf Fidler 2004.

6 Cf footnote 1.

public clinics in Gauteng were recruited as interviewees and interviewed several times. In addition, two ARV and VCT counsellors were interviewed and several pre- and post-tests as well as ARV counselling sessions between counsellors and clients were observed. Fieldwork was central to this research and required immersion in participants' lives over time. This allowed for the uncovering of taken-for-granted assumptions about accessing available public health care by women living with HIV.

It was found that the concepts of capital, field, habitus and symbolic violence as conceptualised by Bourdieu offer powerful ways to understand the experiences of HIV-positive women dependent upon public health-care facilities.

In the following section, these concepts are briefly summarised and linked to the experience of living with HIV.

## 1. Capital, field, habitus and symbolic violence

In Bourdieu's social theory, capital signifies the power of a social actor to be used (or exchanged for other forms of capital) to improve his/her position within a given field. Bourdieu (1986) differentiates between economic, social and cultural capital and when any or all of these capital forms are recognised as legitimate, it transforms into symbolic capital. The different forms of capital are determined by the field in which they are used. Social actors compete to maximise their capital in the field. A person's accrual, control over and use of capital take place in what Bourdieu conceptualises as a "field".

Fields are "semi-autonomous, structured social spaces characterised by discourse and social activity" (Carrington & Luke 1997: 100). Moreover, the field is an arrangement of structures, institutions, authorities and activities relating to people acting within that particular field (Bourdieu & Wacquant 1992). It thus refers to the relational character of social structure. The field is a dynamic entity that modifies as its boundaries are contested by shifts in its practices or power dynamics. This means that every social actor within the field can act on it. Moreover, competition between actors shapes the field. The spread of capital charts the structure of a field, and actual

and potential access to capital delineates power positions relative to the production and reproduction of capital in the field (Bourdieu & Wacquant 1992, Carrington & Luke 1997). Living with HIV and accessing public health care can therefore be regarded as a field in which care providers and recipients/clients/patients differ in their convertibility of the various types of capital available in that field.

In the field of public health, the diagnosis and treatment of people with HIV are influenced by the organisational structures of the facilities, policy frameworks, and personnel in public-health care, and the wider structures of society. Within this field, counsellors, doctors, dieticians, pharmacists, social workers, nurses, other medical personnel, patients, the patients' family members and others interact with one another and with the structural aspects of the field. Such interactions have the potential to alter the nature of the field.

As far as HIV/AIDS care is concerned, there are differences in the assignment of capital between women who are HIV-positive versus those who are seronegative; women living with HIV who are symptomatic with opportunistic infections, including tuberculosis (TB) and have low CD4-blood counts<sup>7</sup> versus those who are asymptomatic; women living with HIV who use ARVs versus those who do not, or are not yet medically indicated to use ARVs; women living with HIV who access a social disability grant versus those who do not have to or resist accessing state support, and women living with HIV who harbour anger about their condition, who drink alcohol, use illegal drugs or smoke versus women living with HIV and conforming to an idealised notion of therapeutic compliancy as constructed within biomedical hegemony.

In terms of the field and power, it can be argued that an HIV-positive woman, who belongs to the first category of the above list of dichotomies, will be less likely to make independent decisions relating to childbearing, treatment and care, due to her dependence on the prescriptions, care and treatment of the public health system. Such a woman therefore possesses less capital within the field (public health care setting) in comparison with other social actors

7 Cf footnote 1.

in that field. Using a notion of power as constraining and enabling, however, implies that some women may use the HIV-positive label to gain power in the field by, for example, gaining access to a social disability grant, withdrawing from social responsibilities or gaining employment as a lay HIV/AIDS counsellor.

Bourdieu's notion of symbolic violence as "violence which is exercised upon a social agent with his or her complicity" (Bourdieu & Wacquant 1992: 167) is pertinent to an understanding of stigma and women living with HIV. Symbolic violence is the device whereby the socially subjugated naturalises the status quo and blames herself for her structural subordination in society's hierarchies and injustices. Symbolic violence and hegemonic discourses combine in HIV/AIDS to establish social order and control in a struggle for power. In addition, symbolic violence and hegemonic discourses convince the dominant to accept existing hierarchies and to limit the ability of the oppressed to resist the forces that discriminate against them. Leclerc-Madlala (2001: 533) illustrates this convergence of symbolic violence and hegemony poignantly in terms of women and HIV, stating that the growing popularity of virginity testing in, for example KwaZulu-Natal, should be regarded as "a gendered meaning-making process consistent with commonly held beliefs that the epidemic is the result of women being sexually out of control" and as "an attempt to manage the epidemic by exerting greater control over women and their sexuality".

Lovell (2004: 51) suggests that symbolic violence is inflicted on women because of their sexed identities. Combined with an HIV status the force of symbolic violence is amplified. This raises the notion of reflected appraisals whereby individuals form self-perceptions on the basis of how they perceive others to perceive them. This also extends to situational identity negotiation whereby people strive for congruence between their self-perception (own identity standard) and reflected appraisals (Kaufman & Johnson 2004: 808-11). This "working" on the self — or in Goffman's (1963: 63) words "the moral career of the stigmatised" merges with the notion of own responsibility in health. For the woman living with HIV, this presents a predicament to perform the prescribed (as specified in counselling

at public health-care facilities) role of women's responsibilities in curtailing new infections and caring for the sick and vulnerable. Whereas disease curtailment and care are certainly points to consider, the empowerment of women does not imply that women living with HIV should be considered as therapy-activated soldiers in the fight against the epidemic.<sup>8</sup>

Bourdieu (1990: 53-6) uses the habitus notion to account for aspects of social life that go beyond aggregated social actions and are shaped by implicit aspects of tradition, history and customs. The habitus therefore has an inherent, undisputed nature as an embodied reality that social actors unconsciously incorporate into their lives (Leach 2002). In the habitus, Bourdieu offers a system of prereflexive dispositions that depart from the model of agency that is wilful and rationally utilitarian. In addition, the habitus has a past, present and future: "this system of dispositions — a present past that tends to perpetuate itself into the future by reactivation in similarly structured practices, an internal law through which the law of external necessities, irreducible to immediate constraints, is constantly exerted" (Jenkins 1992: 6).

Although Bourdieu (2001) envisages women as holders of a feminine habitus denoting subjection, feminists such as McNay (2000 & 2004) and Fowler (2004) argue that gender is neither a field nor a habitus, but rather a form of symbolic violence in a cultural field so that different forms of femininity emerge. This study argues that the notion of therapeutic compliance for a woman living with HIV as envisaged by public health care implies a restructuring of the patient's habitus to fit the principles and customs of a responsible person fighting off new infections and adhering to prescribed treatment regimes.

8 To carry this war metaphor further, to regard women as being sufficiently equipped in the public treatment therapy sessions (which is containment-driven) to become the change agents from the ground up can be likened to sending troops to the front armed with little more but some knowledge about danger and a will to protect themselves and their loved ones against it.



## 2. Details of the study

The study encompassed a qualitative approach informed by critical social theory. In particular, critical ethnography as described by Car-specken (1996) was used in order to, besides examining people's meanings, experiences and subjective understandings, include elements of structure which, according to Layder (1998: 95):

represent the standing conditions confronting people in their everyday lives — and representing what Marx and Engels describe as circumstances transmitted and inherited from the past.

The study relied on in-depth interviews with research participants over a period of two years.<sup>9</sup>

Immersion in the worlds of women living with HIV led to the discovery of structures of power and privilege that extended beyond the immediate social and institutional arrangements of health information and service delivery for women living with HIV. This exposed decision-making about reproductive health not as unproblematic, harmonious, consensus-driven and empowered, but rather as fractured processes characterised by disjuncture, rupture and contestation.

By working through a community-based organisation, research participants were recruited from referrals in a snowball sampling technique. Volunteer participants had to be women between the ages of 18 and 49, have a known HIV-positive status, use public health care, be willing to participate in the study and be interviewed more than once. Ultimately ten research participants were available for follow-up interviews and able to give rich descriptions of what it is like to live with HIV. Multiple, in-depth interviews were conducted and tape-recorded, and notes were taken as back-up. The tape-recorded interviews were transcribed *verbatim* and word-processed as computer files. Interviews typically lasted between 40 minutes to an hour.

In addition, observation was used during visits to voluntary counselling and testing (VCT) and ARV service sites as well as at support

9 The methodology discussion is truncated for the sake of the article. Full details on the recruitment of volunteers, the fieldwork, interviews, observation and transcription are available upon request.

group meetings. The critical social framing of the study prescribed constant reflection on the difference between exploration and exploitation, or as Beaudry (1997: 83) cautions: "Friendships and camaraderie are tainted with the pragmatic uses that could be made of them". Some of these tensions between the emic and the etic roles were resolved by keeping a field diary, engaging in reflexive debriefing sessions with some of the participants, and being actively involved in assisting the support group for women living with HIV that formed as an outcome of the study.

The research proposal and ethical considerations of the study were submitted to the Ethics Review Committee of the Department of Sociology at UNISA. In addition, written permission to undertake the research was obtained from the Gauteng Department of Health. Informed consent was sought from each research participant and re-negotiated at each encounter. Participation was voluntary and the research did not interfere with the participants' ability to receive medical care at the public health-care facilities. Identities were protected and peer debriefing and member checks employed to preserve the trustworthiness of the data. Some discussions were distressing in nature, but emotional and informational support was given where appropriate. Follow-up discussions enabled research participants to be involved in the research and encouraged to participate in forming a support group.

### 3. HIV-positive diagnosis and living positively

For the research participants, receiving an HIV-positive diagnosis initiated a profound status passage — from being mothers, wives and women to being "women-wives-mothers-living-with-HIV". The diagnosis presented a biographical disruption that dislocated relationships, marriages, practical concerns and taken-for-granted assumptions about gendered embodiment and everyday life. The diagnosis also forcefully drew the women into encounters with public health care and set the moral context within which they had to negotiate their identities as women living with HIV.

Hegemonic conceptions of illness relate to moral judgements about personal integrity and competence, and therefore “living with HIV” requires the demonstration of a moral identity that is competent, knowledgeable, rational and reasonable, and has concern for the well-being of others. “Living with HIV” in the narratives of the research participants was articulated in the language of moral agency and compliance, and focused on gendered ideals of personal and/or maternal responsibility, for example:

At first this was a bad thing for me [the HIV-positive diagnosis]. Then I went for training to be a [an HIV/AIDS] counsellor and I started doing work in that area. Then I thought that I am good with this and that I am really helping people with this problem that is there for us all to deal with. I would never have thought to become a counsellor if this disease did not pick me. Now I see that this is what I can do very well. I feel that when I help other people, I feel happier and stronger and that my life was meant to be this way. [Poppy]<sup>10</sup>

... I used medicine to prevent my baby from contracting the disease ... My baby does not have HIV and he is healthy, because I am a good mommy ... I think that if I can look after my baby, then I'll be OK too ... [Selinah]

Before I knew my status, I was just living. I did not care what was happening ... So I knew that I was supposed to have changes in my life — you know, sometimes you must leave something that you like the most, just to sacrifice for your health ... My friends — I don't want to lie to you — before I knew my status we were having a group. So every month we would have this get-together. We would pool and top up money to buy the liquor and what. It would be a nice thing you know? Then after I was diagnosed with HIV, I told myself that I must stop living that kind of life. It would not help me — instead it would only make things worse ... A lot of things then started to change, because I started to have goals for my life-long term goals and short term goals. [Lerato]

Following a diagnosis, the majority of the research participants started focusing their energies on living with the disease and this paradoxically seemed to have become a relatively more controllable aspect of their lives. For some, it even entailed developing some future orientation. Deconstructing this notion, however, it seems that this “controllability” was elusive and bounded by what the rules (or field) of biomedical hegemony allowed. These women's illness careers and

10 Pseudonyms are used in all cases.

consequently the nature and extent of “control” they had over living with the disease were curtailed by their material circumstances and carefully calibrated for them by the assumptions inherent to the biomedical treatments and care to which they had to surrender. It could be argued that the research participants bought into an illusionary empowerment in terms of Bourdieu’s notion of symbolic violence. For the research participants, their particular accumulation and use of capital (in the field of VCT/ARV public health service delivery) regulated their identities as “women living with HIV”.

The shock of the diagnosis also made these women involuntarily receptive to a socialisation process intended to inculcate in them the core values of biomedical technocratic control over the disease. During counselling sessions, they were encouraged to disclose their statuses (to at least) a confidant who can act as a “treatment buddy” when embarking on an ARV treatment regime. For the research participants, being poor<sup>11</sup> and dependent on a public health-care system spilled over into not possessing the symbolic capital to control their disclosure (cf Grove *et al* 1997). By being tested, diagnosed and labelled as HIV positive the research participants were pulled into the public health care services and their power relations which, to borrow from Foucault (1978: 44), “proceeded through examination and insistent observation” and “required an exchange of discourses, through questions that extorted admissions and confidences that went beyond the questions that were asked.”

For the women in this study, an HIV-positive diagnosis created a new trajectory of oppression situated in the nexus of biomedical hegemony and gender power relations. Biomedical hegemonic power was asserted by means of a labelling process — a process in which the woman was *named* as being HIV positive, being HIV positive and pregnant, being HIV positive and having TB, being HIV positive and having an opportunistic infection, being HIV positive and having

11 Unemployment, underemployment, financial hardships and financial dependency (on parents, other family members, partners, boyfriends, husbands or the state via a social disability grant), and poverty were defining conditions in the lives of the research participants. Four of the participants lived in shack dwellings in an informal settlement.

a given CD4 count or viral load, and so on. Testing and treatment regimes were tailored to fit these categorisations of HIV statuses, but once labelled as HIV positive the label was immutable and ineradicable. For some of the participants, they became their label:

... I hated the virus and I hated the disease. It was threatening me and it was threatening my baby. But then I thought — if I hate HIV then I hate myself, because I have the virus. [Betty]

... But I feel dirty — like a person with dirty blood ... because I have this virus in my blood. When I look at my blood, it looks like anyone else's blood. But I have a virus in my blood and sometimes I feel like I am the virus. [Mbali]

This shaping of subjectivity also enabled the determination of the “problematic” client/patient who did not follow strict guidelines for testing, living with the infection and treatment. All of the research participants were able to report on their blood tests results and used concepts such as CD4 counts and ARVs to situate their experiences in the biomedically defined trajectory of HIV/AIDS, for example:

I'm not yet on ARVs. I'm fine. But mostly today I have a problem with sore throat and blocked sinuses. That is the problem that I'm having now. With my last blood test, my CD4 cell count was 296. But with my second last blood test, in October 2006 it was 401. I am not too concerned with the last test, as I know I had an infection and was sick then. I am sure that my next test will show a higher count. [Lerato]

Biomedical labelling and economic need combined seamlessly to produce new forms of female vulnerability. A need by the health-care service providers to enforce compliance and to control new infections and a need by the service recipients to survive the ravages of illness and poverty polarised issues of woman's empowerment in new and complex ways. As women with HIV, the research participants had to comply with the diagnosis and treatment regimes in order to protect an unborn child against infection, access ARVs or a social disability grant. This allowed little space for contestation and reinterpretation of hegemonic discourses on what it means to successfully “live with HIV”. The encroachment of biomedical control over a life lived publicly as HIV seropositive was evident in many of the narratives. For example, Lora stated:

I have been living with this since 2005. When I think back over the two years, all I see is doctors and clinics and medicine and nothing else. I think this is my life now – pills and pills and pills.

It can be argued that the knowledge about how to deal (or live positively) with HIV as transmitted by the public health care facilities was not neutral but created by the field, its discourses and understandings of the disease and its policy emphasis on the containment of the spread of new infections. The research participants' therapeutic performances as women living with HIV were not measures of individual competence or of the lack of understanding of the disease, but rather indicative of their command of specific symbolic capital acceptable to the field. Poor command over the capital and resources in the field meant that resistance and evasion of the forces that sought to discipline the HIV-positive woman's habitus were restricted as was free choice on how to live with the disease. These women remained marginal to and trapped in the field.

#### 4. Embodying the ABC-prevention messages

HIV/AIDS disrupted the seemingly valued link between heterosexual sexual intercourse and procreation. In the absence of HIV, pregnancy manifested female fertility, male virility and the procreational success of the marital union. In the presence of HIV, pregnancy manifested a dangerous situation for the vertical transmission of a lethal infection to an unborn child.

Diane, who was 40-years old and abandoned by her husband after she had disclosed her status to him, explained how HIV/AIDS disrupted the link between heterosexual conjugal relations and the taken-for-granted nature of procreation:

I am happy that this [HIV] virus was not the problem when I was pregnant with my son [21 years ago]. You see, I did not even have to think on it. I was married and I wanted to have a child with my husband and I gave birth to my son. It is the way life goes — without thinking or worrying too much. A girl with HIV now, she must worry about things that were a normal part of a young married woman's life. I think that is very hard for them.

Consequently, taken-for-granted notions of heterosexual sexual agency collapsed under the demands for a new type of rationality. Within the current discourse of disease curtailment, a woman living with HIV becomes constructed as a potential vector for the spread of the disease, and the solution is reduced to the mechanical implementation of biomedical prescriptions. The burden of a personalised contraceptive-*cum*-prophylactic responsibility is gendered as being a feminine one, for example:

It is important that you understand that every time that you have sex, you must use a condom. You must keep condoms with you all the time, even if you are telling me that you no longer have sex, I want you to have them with you.<sup>12</sup>

Four of the participants claimed that they no longer had sexual relations since their HIV-positive diagnosis: two used both male condoms and the hormonal injection, three used only male condoms and one used no form of protection since she regarded her current same-sex sexual relationship as low risk for the transmission of HIV. Six of the respondents reported loss of libido which they attributed to the stress of living with HIV infection.

The key assumption in the ABC-campaign, namely that the disease can be controlled by applying rational knowledge about protective measures, was incompatible with the lived realities of the research participants. As far as a female-controlled barrier method was concerned, none of the research participants ever used a female condom, although three knew about it and two saw a demonstration of female condoms at a hospital.

The use of condoms moved contraception closer to the act of sex (as opposed to other forms of contraception such as hormonal methods). Sex for the woman living with HIV becomes a medicalised field in which she should approach intercourse with rational foresight and emotional detachment. Paradoxically, however, Betty, who was young and regarded two children as an ideal family size, spoke about her frustrations in being discouraged to adopt a non-reversible contraceptive method by the family-planning personnel:

12 Fieldnotes: Advice from a counsellor to a woman attending ARV treatment adherence counselling.

My husband and I, we use condoms and I also take Depo [Depo Provera injectable contraceptive]. I am adopting my late sister's child. She passed away last year and I am the only one who would look after this child the way that she should be looked after. My husband and I have decided that this will be our family — our boy and my sister's child. That will be enough for us. Child care is expensive and we have very little money. But now I was even thinking about sterilisation, because we really do not want more children, but at the family-planning clinic there at [the name of a district hospital] they say I am too young and I have only had one child and that this is not the method for me.

There seemed to be strange contradictions in the reproductive health-care messages given to women living with HIV: women living with HIV are counselled to use male condoms; female condoms are not actively promoted and are irregularly available in the public health care sector; women living with HIV are discouraged from falling pregnant without discussing it with their doctors first; women are discouraged from opting for surgical contraception (tubal ligation) due to youthful age and low parity, and women are not told how to deal with the possible failure of condoms.

The above contradictions represent fractured, non-coherent health-care messages given to women living with HIV. In addition, it seemed that in the setting of public health care for women living with HIV an open discussion about these issues was not actively encouraged, for example Mbali stated:

I split up with my daughter's father before she was born. I have met someone who is also HIV-positive and he is my boyfriend. We use condoms and I get the injection. But many times I feel like I don't want to have sex . . . I only do it because I don't want to be alone and I worry that he will leave if I refuse him. I also think that he will find another girlfriend. But I cannot talk at the clinic about what happens at home — about what happens in my bedroom.

Mbali's narrative shows a reading of the norms of heterosexual consensual relations as extremely vulnerable to a female-led imposition of conditions on sexual intimacy. Missing from the prevention discourse for women living with HIV is the woman living with HIV as an active object of sexual desire, and a person with active sexual expression. Yet, as demonstrated by the quoted narratives, sexual negotiation remained an affront to the taken-for-granted codes of



romantic attachment, true love and the successful heterosexual conjugal relationship.

Four of the research participants believed that they were infected with HIV by their husbands. Examples from the narrations are as follows:

My husband no longer sleeps with me. He does not want to get tested [for HIV]; although I know that he has given this to me. When he gets sick, I can see in his eyes how afraid he is that he has AIDS. But he is in denial and does not want to be tested. I see him watching me when I take my [ARV] medicine and he insists that I keep on taking it, but he does not want to test himself. [Lora]

My husband left two years ago. I think he must have given me this virus. I only slept with him and was never sick before I met and married him. But I don't see him anymore. I think men think that this is a woman's disease and that they can't get it. I wish I could know his status too. I should have asked him to get the blood test a long time ago, before he left. My youngest she is 5 years old and she has never been sick — never. So I don't think that I had HIV with my pregnancy. So now I think I got this virus later — after she was born. I think that is when I got it from my husband because he had many, many girlfriends. I even know about some of them . . . I think husbands must be tested, you know. Just look around you here. There are only women at the clinic — only a few men here and there — but there are mostly women, young women and old women and women with babies. [Funani]

These women identified themselves as victims of HIV infection rather than as vectors for HIV infection. Counselling privileged the self-sufficient woman living with HIV who has dealt with her anger. Some of the participants, however, voiced their anger at contracting the infection in what they regarded as not particularly risky sexual relationships. For them, risk-taking implied autonomy in action, but none of the women willingly exposed themselves to infection and did not want to pass the infection onto their children. Although the participants' experiences of heterosexual sexual relationships as revealed in the interviews were varied and complex, they were not indicative of promiscuous, high-risk sexual relationships. Although it was not possible to ascertain whether the blame put on husbands for being the infective partner or for their infidelity had any basis in reality, for many of the participants an economy of power in

reified notions of heterosexual relationships precluded dialogue or negotiation within their relationships. Their feelings of anger and disappointment also stemmed from expectations that being a wife or a partner to a man implied a contractual relationship in which the woman would bring her sexuality and reproductive power into a hierarchical heterosexual relationship and the male would reciprocate with economic support. Infection, abandonment, material neglect and rejection were brutal affronts to these expectations.

## 5. Counselling for VCT and ARV treatment

Bourdieu's concepts of symbolic capital, field and habitus enable a sociological reading of the processes of realignment that take shape forcefully within the field of HIV/AIDS health service giving and receiving. The service providers maintained monopoly over biomedical vocabularies (by for example talking about CD4 counts, viral loads and different types of medication) and demonstrated their professional familiarity which was beyond the reach of service recipients. They even concurred that, once a service recipient moved out from under their expert gaze and care, that person was likely to return to her bad old ways. For example:

You see, there was a woman here last month, and she stayed at [name of a community-based organisation]. They took her to the clinic and made sure that she took her medication. Her health improved and she went back home. When she was at home, something happened — no money to travel to the clinics and so on. But anyway she stopped her treatments. I think that she has since passed away. This is a big problem.<sup>13</sup>

You will see a person taking medication for 36 months, but when you ask that person what medication are you taking, she doesn't know the name. But it's three years now that she is taking the medication. So it seems as if they are not serious about their health. Because if they are serious then like now we would not see many patients taking second regime medication which is the last option of government to help people. And this is sad, because if the woman failed on the first regime, she would also fail on the second one.<sup>14</sup>

13 Interview with a VCT and ARV counsellor.

14 Interview with a VCT and ARV counsellor.

During counselling an attempt is made to transform the habitus of the woman living with HIV by means of shaming and instruction. The habitus is to be brought in line with a diligent, self-aware and compliant HIV-positive other. Hegemonic representations of idealised compliance construct a woman living with HIV as preferably possessing extraordinary courage and self-discipline coupled with a keen ability to absorb and access specific forms of knowledge. In addition, she should be able to readily produce a support system in the form of a treatment buddy and deploy such a social resource (or such a symbolic capital) in such a way that she could be recognised as confident and composed. She should be a master at negotiating safer sex practices with a sexual partner and at planning a future pregnancy in perfect teamwork with her partner, doctor and counsellors. In terms of the actual experiences of the research participants, much of their lives was beyond individual control as they lacked secure housing, were unemployed or suffered job insecurity, struggled to stay in a marriage or a relationship, and battled with negotiating for contraceptive protection of their choice. The “control” they were able to express in their talk about living with HIV mostly centred on adopting a positive orientation, improving nutrition, handling stress and avoiding further infections or unplanned pregnancies.

## 6. Changing the field: contesting and rejecting objectification

The research participants evaluated, negotiated, resisted, ignored and renewed their identities as women living with HIV. For many of them, rejecting objectification and forcefully changing the power dynamics of the field meant a first-time break with repeated gendered performances and unquestioning subservience.

Contestation took the form of quitting a treatment regime or dumping pills, questioning the therapeutic insistence on compliance, complaining about bringing a “treatment buddy” along, criticising the practice of pill counting, bemoaning unsympathetic treatment or being dehumanised, objectified, stereotyped or judged, and complaining about nurses acting in self-interest to show their commitment to Masakane without embracing its spirit.

These complaints were mentioned in the interviews and aired and discussed at support group meetings. The treatment received at public health facilities were, however, not regarded as fundamentally unjust or disempowering, but rather as a symptom of the “naturally given” order of an inbuilt inequality. For example, Diane and Lora explained:

For now we must just put up with this - the pill counting, the waiting and so on. This is better than having no ARVs. [Diane]

We are poor people without medical aids. We cannot really change the public health service. So it is better that we grumble here and when we go back to the doctors we smile and nod. Then they mark on their forms that you are adjusting and they leave you alone. [Lora]

Bemoaning “the way things are” also extended to the research participants’ understanding of their relationships with male partners. Men absconding, having sexual liaisons that endangered the reproductive health of spouses or refusing testing were regarded as symptoms of naturally given gender inequality and disadvantage. For example:

We cannot change the men just because we have HIV. The government must insist that the husbands get tested. We cannot do this by ourselves, it will be dangerous. [Funani]

The research participants tended to undervalue their own role to act and present decisive, self-informed knowledge. Some women were thus implicated in the oppression of other women and maintained a stake in the continuation of the *status quo*.

Within the field of public health care-giving to women living with HIV, the government, via its policy directives, became a subtle, yet commanding force. The research participants regarded state support as critical to counter a series of injustices and inequalities that befell the disadvantaged before the transition to democracy and still have not been properly addressed. As service recipients they saw the usefulness of the VCT and ARV services and possible access to state support via social grants based on CD4 counts. For example:

I often think: God what have we done to deserve this? We have gone through a lot in this country and now we have this disease as well. We didn't deserve this. [Mbali]

The problem I see is that I understand that when your CD4- count is above 200, then the government stops the grant. But now people are poor, and they cannot live without that grant money. They were poor even before we had AIDS. [Lerato]

Back in the time when I was first diagnosed [this was 1994], many people saw HIV as a death sentence. Now things are a lot different, but I think people are still uninformed and they wait a long time to get tested. When they get tested they are already stage 2 or stage 3. If you get tested sooner, you can deal with this disease and learn to live your normal life with it. Also, we have the ARV-treatments now. But some people are still being left behind by the government, because they are not being educated about these things. The government should give education so that there is not so much fear around the issue of being tested. [Poppy]

Like Poppy, other participants also recounted the disease containment rhetoric and regarded the government's most important role as educating people to prevent further infections. For example:

People must be educated not to get this in the first place – especially the young ones. No, but people must prevent this from happening in the first place you see. People must be educated. [Lora]

I think that the government should help many more people to be working in the community telling people to get tested and not to think that this will not happen to you. But maybe people would not like that — to be bothered in their flats and houses with the story of AIDS. [Mbali]

This wholesale belief in the power of information and education to prevent new HIV infections or to change behaviour seemed strangely at odds with the lived realities of the women in the study. When responding to the question of whether HIV/AIDS education would have prevented their own infections, both Lora and Mbali responded in the negative, claiming that they would not have regarded themselves as being “at risk” at the time, thereby acknowledging the flaws in the current information on the transmission of HIV. They felt, however, that young people might be more receptive to the idea that everyone is potentially at risk for contracting HIV. For example:

I think it will be different for the young ones now, because they can be told about these things at school still. They can be told that you are not safe and that you must be tested before you have sex. It can be different for them, because they see what is happening around them with people getting sick and dying. [Lora]

But I think many young people must understand that this can happen to anyone. [Mbali]

Preventing new infections, however, could not prevent poverty or alleviate the burdens of care that were already placed upon these women as caregivers. The research participants were aware that the formidable task of dealing with the consequences of HIV/AIDS morbidity and mortality falls on the already overburdened shoulders of women. The sheer amount of voluntary (“invisible”) labour that this required was already disempowering, as illustrated in the following excerpts from the narratives:

I was looking after my sister. She was sick and when she died the doctors at the hospital said that she had AIDS. Then I got tested. People said that I looked ill. I was sick like her. I used to wash her — I did not know about the bloods and everything. Nobody told us. Now my younger sister will have to look after me when I get too sick. We sisters we look after one another, because no one else is there to help when you get too bad. [Gita]

I hear them talk about women’s rights and to stop women abuse and what not. There were people in a rally shouting about these things where I stay. But I can tell you that the women take care of orphans, old people and the sick. But we are invisible to the politicians. So many of the people I grew up with are becoming sick and dying. [Funani]

Funani’s comment about the rally shows poignantly that women’s empowerment to transform the field of reproductive care requires more than a voice and a vote. Like other women, she felt unable to transform the repressive circumstances of her everyday experience. Through the vote, South African women obtained formal citizen status, but in their lived realities many participants still experienced problems of citizenship in practice and felt unable to exercise their rights and capacities to be representative and to have a voice.

Foucault (1980: 133) reminds one that, through “the arts of government”, power contours both the nature of people’s experience and their ability to make sense of it, so that “The problem is not changing people’s consciousness — or what’s in their minds — but the political, economic, institutional regime of the production of truth.” This article demonstrated the aim of the policies of disease containment, namely to refashion the habitus of the woman living with HIV into

a compliant agent accepting her fate and protecting others from contamination. This shields the unpalatable truth that poverty has been, and will continue to be a profound feature of these women's lives, and that they are incapable of shouldering the burden of disease containment and caring for the sick and the vulnerable on their own.

## 7. Conclusion

For the research participants the collectively experienced features of their lives were treatment compliance and taking up the burdens of uncompensated labour for the sick and vulnerable. Power was discursively part of the structures of knowledge and technological practice in the field of reproductive care so that VCT and ARV therapies became disciplinary apparatuses in the medicalisation of the official fight against HIV/AIDS.

Following their HIV-positive diagnosis, all of the research participants became subject to very direct state-led biomedical control. Due to their poverty, they were excluded from certain consumer practices. As political agents, they did little more than vote during local elections and complain (in the safety of private meetings) about perceived public health service inadequacies and the regulatory discourses of counselling. The notion of empowered health consumers who are free to choose and take responsibility for their own health as envisaged in the responsibility rhetoric thus obfuscates the constraints faced by women living with HIV and accessing public health care.

The woman living with HIV as created within the hegemonic discourse of public disease containment and treatment adherence is a woman devoid of all her subjectivity, biography and social connectivity — a woman unable to alter the field. This study provided a trajectory for research that attempts to enter and understand the experiences of women with HIV. In order for women to change the field of reproductive care in South Africa and to, in the words of Lather (1991:8) “imagine otherwise”, a new women-centred empowerment model should be embraced which pays attention to women's bodies, the resources needed by women and the social support required for those affected and infected with HIV.

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