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Sex, gender and power: young women's sexuality in the shadow of AIDS

Abstract While the incidence of HIV infection and AIDS amongst non drug injecting heterosexuals is currently low in the UK, epidemiological evidence suggests that this situation may be short lived. The sexual practices of young heterosexuals will then be crucial in determining the extent of the epidemic. Drawing on feminist theory, we argue that if we are to understand young people's sexual relationships we must attend to the power relations within which sexual identities, beliefs and practices are embedded. The social pressures and constraints through which young women negotiate their sexual encounters impinge directly on their ability to make decisions about sexual safety and pleasure. The power of young women to control sexual practices can then play a key role in the transmission or limitation of sexually transmitted diseases. From preliminary analysis of data collected by the Women, Risk and AIDS Project, we argue that the risks young women take in sexual encounters with men arise within a nexus of contradictions through which women are expected to negotiate safer sex practices. However well intentioned, public health campaigns aimed at women cannot be effective unless they recognise that men and women begin their sexual encounters as unequal partners in the battle against the sexual transmission of HIV.

Introduction

Media representations of the risks of AIDS in the context of a 'moral panic', have focused attention and opprobrium on the so-called 'high risk' groups. This has led many young heterosexuals to believe that they are in no danger of infection (COI 1986; Warwick 1987; Aggleton *et al* 1987; COI-DHSS 1987). More recent claims that heterosexuals in the UK currently run no real risk of HIV infection are based on specific

interpretations of official statistics. Lord Kilbracken, for example, has taken Department of Health figures on the incidence of heterosexuals with AIDS to mean that heterosexuals are not at risk and, therefore, that 'normal' sex is not dangerous. Fitzpatrick and Milligan have argued (1990:15) that 'the risks to heterosexual men and women who do not use intravenous drugs are statistically insignificant and for all practical purposes non-existent'. They ignore the heterosexuality of many IV drug users and base their argument on the assumption that the conditions which have led to the spread of HIV in heterosexual populations in, for example, Africa and New York City do not exist anywhere in Britain. Fumento goes further in implying that the risk to heterosexuals is a myth deliberately created by frightened homosexuals in league with 'the democratisers, the media, alarmist doctors and their unwitting allies the conservative moralists', in order to attract research funding and to reduce public indifference (Fumento 1990). Despite these claims that 'normal' people are not now HIV antibody positive nor at any significant risk from the AIDS epidemic, there is growing evidence that HIV is spreading among heterosexuals in the UK by a variety of means (Johnson 1988; The Collaborative Study Group 1989; Donoghue *et al.* 1989; Pye *et al* 1989; *AIDS Newsletter* 1990a:2) as it is spreading in the USA and Europe (Gross 1987; Heyward and Curran 1988, *AIDS Newsletter* 1990b:5). The epidemiological evidence is patchy and can be interpreted in different ways because of factors such as underreporting, the use of separate categories for bisexuals, IV drug users and the sexual partners of those at 'high risk', and variations in the populations studied (Stoneburner *et al.* 1990). Interpretation is hampered by a general lack of knowledge of the social complexity of sexual behaviour, and by the fact that the quantitative study of human sexual relationships is as yet little developed (Johnson *et al* 1990). As the number of seropositive heterosexuals increases, women's sexual behaviour will be a critical factor in the spread or limitation of AIDS (Elmslie 1989).

In a review of epidemiological data on heterosexual transmission obtained from the surveillance programme of the Centres of Disease Control (USA), from prostitutes sampled around the world, and from studies conducted in Africa and Haiti, Padian (1987) evaluated four major hypotheses about the efficiency of heterosexual transmission and its ultimate effect on the epidemiology of AIDS in the US. The hypotheses are that heterosexual transmission may (a) be less efficient than homosexual transmission, (b) become more apparent as the epidemic progresses, (c) be accounted for to a large extent by the presence of co-factors and non sexual modes of transmission, and (d) the epidemiology of AIDS may soon resemble the epidemiology of other STDs. These hypotheses are of course not mutually exclusive and some support was found for all four of them. Padian (957) states that ' . . . because AIDS is a lethal disease, even if only isolated cases occur in any segment of a community, that whole community

should be educated as if it were at risk. Bidirectional heterosexual transmission is not only biologically plausible; it is established'. Numbers of reported cases of AIDS resulting from heterosexual transmission are still low in the UK, but there seems to be little to gain from a complacency which assumes that heterosexuals in the UK share neither sexual contacts nor risky sexual practices with heterosexual populations elsewhere (Positively Women and WOMB in *Guardian* 14.12.88; Larson 1990; Hooper 1990). Health educators face a challenge in alerting the heterosexual population to potential risk, and to strategies for safer sex.

AIDS, young women and risk

With the exception of the labelling of prostitute women as a high risk group, there has been relatively little discussion of women in the epidemiological literature (Richardson 1990). In the US, however, women are proportionately the fastest growing group of people with AIDS; in New York City, AIDS is the primary cause of death for women between 25–29; in Africa and the Caribbean 50 per cent of people with AIDS are women, and in Western Europe 9 per cent of reported AIDS cases are women (PWA Coalition 1988). On a global scale AIDS is clearly an issue for women.

We are not suggesting that, on the basis of this evidence, heterosexual women should now be identified as yet another 'high risk group'. Understandings of risk are contested, but have been shifting from a focus on membership of specific groups to a concern with the kinds of sexual and other practices which seem to be more or less effective in spreading HIV infection (Aggleton and Homans 1988; Aggleton *et al.* 1989). Safer sexual practice appears to be one of the main ways in which this epidemic can be limited. There is already evidence that the rate of HIV infection is falling where gay men and prostitutes have become well informed about sexual risks (Carne *et al.* 1987; Fitzpatrick *et al.* 1989; Johnson and Gill 1989; English Collective of Prostitutes 1988; Panos Institute, 1988; Plant 1990). A rational choice model does not, though, seem appropriate for young women's decisions about their sexual behaviour.[1] Much of the emphasis in public health campaigns around HIV/AIDS in the UK has been placed firstly, on the acquisition of knowledge in order to dispel ignorance, and secondly on condom use as protection against infection. These are strategies which take little account of the barriers which young women face in attempting to put this knowledge into practice in their sexual encounters. While women's sexual beliefs and practices are critical factors in understanding the nature of risk, and how it is managed, we argue that the very variable ways in which young women negotiate their sexual practices can be seen as responses to contradictory social pressures.

The *Women, Risk and AIDS Project*[2] is investigating the sexual

practices, beliefs and understandings of young women in Manchester and London in order to identify the processes and mechanisms through which they construct, experience and define their sexuality and sexual practice, together with the practical implications of these processes for the sexual transmission of HIV (see Holland *et al* 1990a; 1990b). In the first phase of the project we have constructed a purposive sample of a cross section of young women between the ages of 16 and 21. We currently have questionnaire data from 496 young women and have conducted 150 in-depth interviews. In addition a small number of young women are keeping diaries based on their relationships and sexual practice. A second round of interviews is underway with a sub-sample of the initial respondents. We are in the process of analysing this data using the Ethnograph package.

The AIDS epidemic has challenged our existing knowledge of sexual beliefs, practices and identities. Epidemiological studies and large scale surveys of sexual behaviour are necessary in order to describe the medical and behavioural parameters within which HIV/AIDS is occurring. But there is also a need for small-scale qualitative studies which can investigate the meanings of sexuality. Through in-depth interviews we can explore what is taken for granted in conventional notions of male and female sexuality, why women take sexual risks, and how barriers to safer sexual behaviour can be identified and changed. Information on young women's conceptions of personal risk and safety in sexual activities is critical for effective health education. We argue that the ways in which young women understand risk, negotiate sexual relationships and develop strategies for safer sex will play a significant part in the spread or limitation of AIDS.

Sexuality, femininity and power

By sexuality we mean not only sexual practices, but also what people know and believe about sex, particularly what they think is natural, proper and desirable. Sexuality also includes people's sexual identities in all their cultural and historical variety.[3] This assumes that while sexuality cannot be divorced from the body, it is also socially constructed (Turner 1984). The negotiation of desires and practices occurs in social contexts in which power is embedded. Age, class and ethnicity are examples of sites of power differences, but what is particularly significant in the negotiation of safer sex in heterosexual encounters is the power which men can exercise over women. Sex, as it is currently socially constructed in its various forms, cannot simply be understood as a pleasurable physical activity, it is redolent with symbolic meanings. These meanings are inseparable from gendered power relations and are active in shaping sexual interaction.

Identifying the relevant power relationships is no easy task since young people engaging in sexual encounters may well be unaware of what Foucault has called the 'best hidden things in the social body' (1988:118).

Some of our informants are well aware, although in differing ways, of the existence of men's power over women, and of a double standard in sexual activity. But the disovery of hidden power relations is particularly difficult because, however they are experienced, they must be conceptualised in order to be recognised. Young women are encouraged to attach themselves socially to young men in order to succeed as conventionally feminine women, but they are then inhibited from seeing this desired and expected relationship as a structurally unequal one.

The control which young women can exercise over the risks or safety of their sexual practices is constrained by the confusion of their notions of sexuality with their expectations of romance, love and caring. Just as we lack a clear discourse for 'normal' heterosexual practices, so there is a lack of a clear female heterosexual identity. Sexual identity for heterosexual women is ideologically constructed in a context which defines sex in terms of men's drives and needs (Jackson 1978, Jackson 1984). Women tend to be seen, and to see themselves, as passive receptacles of men's sexual passions. Sexually active women are in constant danger of having negative identities attributed to them (Lees 1986). The positive identities available to young heterosexual women tend to be linked to their social relationships with men as girlfriends, wives, or objects of love. Our respondents tended to explain their sexual activity in other terms than those of sex or sexual pleasure.

We have used young women's own accounts of the social processes involved in their sexuality and sexual experience to conceptualise the particular processes through which the power relations embedded in sexual relations are produced and reproduced and through which they become part of individual sexual identity. We have found wide variations in knowledge and experience of sexual matters amongst the young women in our sample, but, with few exceptions, they lack a positive sense of their own sexual identity. Women who seek their own sexual pleasure with different partners were seen by some of our informants as 'slags' or as 'doing what lads do'. Others saw sex primarily as what you do to keep your boyfriend happy or, more negatively, what you do to keep him. It is difficult for young women to insist on safe sexual practices, when they do not expect to assert their own needs in sexual encounters.

The prevailing definition that heterosexual sex is penetration of the vagina by the penis, was accepted by most of the young women we interviewed. This definition in terms of men's 'natural' sex drive, and men's need for sexual fulfilment left little space for the 'normal' and successfully 'feminine' woman to assert needs and desires that might differ from those of men and which might imply an active, and therefore 'unnatural' female sexuality. Women who challenge male definitions by revealing their own needs and desires for sex have negative images as rapacious and devouring, or as sluts. 'Sex' was very generally taken to mean vaginal intercourse with male orgasm, although it was acknowledged

that the term also has other meanings. Some young women were clear that vaginal intercourse was not particularly pleasurable for them but, with few exceptions, they assumed that this was what men wanted. A number said that they had never experienced orgasm through penetrative sex and that they much preferred other sexual activities. Their definition of heterosexual sex in terms of male objectives impeded their capacity for making their own desires known, or even recognising what these might be. Most of our respondents felt unable to ask for what they wanted. Their reluctance to express their desires and needs was sometimes explained in terms of superior male knowledge about sex, or their own embarrassment.

Young women's strategies for achieving safer sex then develop in social contexts characterised by gendered power relations, sexual hierarchy and male dominance. Feminist theory from the 1960s initially asserted women's common experiences of male domination, but the current focus is on the diversity of women's experience, cut as it is by other social divisions such as race, class and sexual orientation (Ramazanoglu 1989). We would not suggest, therefore, that young women's experience of heterosexuality is a unified phenomenon, but would argue that while their experiences, and the strategies which they adopt will vary, the discourse of 'normal' heterosexuality through which they must negotiate safer sex has many common contours.

We have also to recognise that patriarchal power is not necessarily unified, coherent and centralised. It should more properly be seen as 'dispersed constellations of unequal relationships' (Scott, J. 1986) which leaves spaces for human agency, in contrast to a conceptualisation of patriarchal power which suggests a unified subordination of women. While we argue that sexuality is a socially constructed rather than a wholly biological phenomenon, it is not our intention to imply by social construction that young women's sexuality is passive and simply moulded by patriarchal power relations. There is certainly evidence from our interviews that young women can be very active in resisting men's power, but their resistance may not necessarily be effective (see also Halson 1987). It is clear from our respondents' accounts that young women are actively engaged in constructing their femininity and sexuality, but it is also clear that the negotiation of sexual encounters is a contradictory process in which young women generally lack power.

Sex and violence – giving way to risk

We have argued elsewhere (Holland *et al* 1990c) that taking a sociological perspective on the AIDS epidemic can shift understandings of safe sex from a focus on fragmented individual responsibility for personal behaviour change, to seeing safer sex as located in the context of social relationships. One of our initial findings is of the amount of pressure from men which

many women experience as part of their sexual relationships. The control which young women have over the progess and content of heterosexual relationships appears to be quite limited. Where women have adopted passive feminine sexual identities which assume male superiority, men can control sexual encounters without exerting pressure. Feminist theory, however, has used women's experiences to show the very general exercise of power, aggression and violence which structures social relationships. Male control over female sexuality is then taken to be a crucial mechanism for the reproduction of sexual hierarchy, and male violence against women an important instrument in maintaining that control (Hanmer and Maynard 1987). Both form an essential part of the construction of masculinity and masculine sexual identity. Feminist research has established the extent of male violence against women, and the power that this violence has to control women's lives (Stanko 1985; Hanmer and Saunders 1984; The London Rape Crisis Centre 1984).

Our informants indicated a wide range of pressures in operation, and reported quite frequently being coerced by men whose objective is penetrative sex. Some of these stresses were more obvious to them than others, but they range on a continuum (Kelly 1988) from mild persuasion to give way sexually or to accept unprotected intercourse, through varying degrees of force, to assault and rape. While women have some power to identify and resist these pressures, they do not necessarily want to resist, when love, romance and the fear of losing a boyfriend are critical issues. Only a handful of young women managed to develop relationships in which their needs could be asserted and given importance, including the need to refuse intercourse at times. (As only young women were interviewed in this study, this proportion might well increase in samples of older women). In these rare cases, some women had been able to define safe sex as non-penetrative and to teach their male partners how to give pleasure as well as to experience it. Yet they were often frustrated by their treatment by their partners and their inabilities to put their own beliefs into practice. These young women were characterised by the stance they had taken in relation to what they perceived as unsatisfying sex. They had to be assertive in defining their own desires and had to be prepared to lose their boyfriend if their definition of a satisfactory sexual relationship was not achieved. Some of these women had been subject to sexual pressures in previous relationships and one had been raped in very violent circumstances.

We do not want to suggest that all male sexual partners are personally dominant or violent. Young men, like young women, have many personal styles of coping with the uncertainties of sexual encounters, and many degrees of learning from experience. What we are suggesting is that we can locate these styles in the context of an institutionalised heterosexuality which defines male dominance as normal, defines sexual intercourse in terms of men's satisfaction and turns sexual encounters into potential power struggles. Even when violence is overt, it only becomes a social

problem when it is named and resisted by women. It is clear from preliminary analysis of our data that while some women can redefine their femininity so that they are able to make choices at least with some sexual partners, most women do not resist pressure from men most of the time, even when they object to what is happening (Holland *et al* 1990a, 1990b).

It is clear from our informants' accounts that being able to achieve some measure of sexual safety in a particular relationship, or at a particular stage of a relationship, is no guarantee that the same protection can be ensured with another partner or as the relationship develops. Safer sex is not just a question of using protection or avoiding penetration, it is also an issue of trusting the one you love. Sexual strategies which assume that your partner could be a source of infection become hard to sustain in longer term relationships. At the same time, brief relationships or one night stands can counter mistrust with passion, spontaneity and hopes of love. It is these contradictory pressures which make it so difficult for young women to take responsibility for sexual safety.

Contradictions in the negotiation of safer sexual encounters

Contradictions arise in sexual encounters because women are pulled in different directions by conflicting social pressures. Passion, romance, trust and what you should be prepared to do if you really love a man are inconsistent with mistrust of strangers, social subordination to men, fear of unprotected sex, the use of physical force and concern for reputation. Feminine identity and expectations of sexual passivity pull against the need to be assertive in order to enjoy sex and to ensure personal safety.

The imbalance of power in sexual negotiations coupled with social pressures on young women to guard their reputations, reduces the amount of control which young women have over the practice of safer sex. This renders their decision-making about sexual safety somewhat unpredictable. If, for example, a young woman feels that she should not be engaging in sexual activity, or at least not planning it in advance because of an ideology of femininity which equates sex with romantic love and being swept off your feet, then she may well reject the arguments for carrying condoms. On the other hand, if fear of pregnancy is a prime concern, she may reject condoms in favour of the pill. For many of the young women we have spoken to the immediate risks to their reputation from being seen to be sexually active, or from becoming pregnant, were much more real than a fear of AIDS.

Public education campaigns which equate safer sex with condom use would appear to have been highly successful at the level of information, as almost all our respondents identified safer sex with using condoms. This connection, however, tells us nothing about whether the use of condoms can actually be negotiated in any given sexual encounter. Our evidence is

that condom use and safer sex more generally is not a simple matter of making rational decisions based on a knowledge of the facts (see also Watney 1990). Condom use is unpredictable because of the contradictory pressures operating in sexual encounters. Women who can achieve safer sex by using condoms with one partner cannot necessarily negotiate their continued use as the relationship progresses, nor ensure that they can be used with subsequent partners.

Many young women seem to have internalised a negative view of condoms. They argue that condom use 'breaks the flow', makes you 'lose the moment', spoils the romance and turns the event into a mechanical, physical activity. These views can be understood as a product of a dominant ideology which equates sex with men's needs for penetration and ejaculation. A number of our respondents express negative feelings about condoms from what could be defined as a male perspective. Many argue that condoms are unacceptable to their current partner, or are generally rejected by men, because the male sexual drive brooks no interruption. This view embraces a mechanistic and biological understanding of sexuality but one which is equally resistant to the 'rational' decisions which are assumed by public health educators. Women's resistance to condoms can also come from young women having experienced sex as a somewhat alienating experience, as something which is done to them.

If, however, a young woman does make a decision to use condoms in order to protect herself from HIV, then she must find a way to negotiate their use with her male sexual partner or partners. Our data suggest that this is no easy matter and that there are a number of barriers to be negotiated along the road to safer sex. Many of the young women we spoke to viewed 'sex' as something which you do only if you love someone, love having taken the place of marriage as a justification for sex. Indeed sex is often seen as a *means* of demonstrating that you love and trust someone. Several of them commented that they would not be sleeping with their partner if they did not trust him. The expression of this sentiment though did not indicate any common degree of trust. It was the expression of love that defined the nature of the relationship (see also Abrams *et al* 1990).

As a result of this view there is a tendency to go on the pill as a means of indicating the seriousness of a relationship. Some even say 'I went on the pill for him'. As love and trust develop, women may then be safely carried away as far as pregnancy is concerned, but still be engaging in unsafe sex in relation to STDs and HIV. There seems to be an assumption of monogamy regardless of whether this is realistic. Young women who are already on the pill sometimes conceal this from new partners in order to justify asking for condoms to be used. Condoms tend to be used in situations where partners are not to be trusted. The transition from condom use with new partners, to the pill in steady relationships is highly symbolic and can be used to signify the seriousness of a relationship (see also Elmslie 1989). It can be the passage of time which enables trust to be built up and changes

the basis for negotiating condom use. There is however, a great deal of pressure on many young women to define relationships as serious in order to justify sex, and the passage of time may be brief. Trust therefore, while carrying symbolic meaning, may offer little protection from HIV. Our data indicate that while condoms are seen as the best protection from HIV infection, and while they may be used in the early stages of a relationship or in the context of brief encounters, the barriers to the negotiation of their long term use are significant.

Education for safer sex which assumes that women have a positive sexual identity, and that they are in control of the negotiation of sexual encounters will pass most young women by. Public health messages need to be couched in terms of images with which women can identify, and strategies which are realistic in contradictory situations. The effectiveness of health education for women will depend on the effectiveness of education for men.

AIDS, young women and the promotion of public health

The promotion of public health in the area of sexual risk and danger comes up against a number of difficulties raised by sexual politics. Little is known at present about private sexual practices (although research, as other contributions to this issue show, is underway) and beliefs about sex and risk, and about sexual freedom in the twentieth century, are confused with an ideology of male sexuality that is dominant but generally unacknowledged. The current ideological emphasis on individual responsibility for personal health links sex and death, but diverts attention from connections between risky practices and social relationships.

The link between sex and disease and death is not a new phenomenon, there have been a number of peaks of anxiety about sexually transmitted diseases over the past two hundred years (Weeks 1985). The public image of sex has, however, been increasingly disentangled from danger as a result of antibiotics, the pill and legal abortion. The private reality is of course rather different when unwanted pregnancies; cervical cancer; ill health resulting from contraception, and the effects of sexual violence are realities for many women. For women the 'era of sexual freedom' has been something of a myth (Coveney 1984), as they continue to take the main responsibility for managing the public face of heterosexuality, in the form of contraception; abortion; pregnancy, and child rearing, whereas men continue to be able to separate sex from reproduction, and, with the exception of STDs and HIV, from health issues more generally. During the twentieth century there has been a more general acceptance of sex as part of women's lives than was the case in the preceding period. But, as Lucy Bland has pointed out, women's sexual pleasure came to be located within

'meaningful' relationships, and seen as an extension of their maternal instinct, and as a means of controlling men's baser desires. Thus 'respectable' women, came to be seen as 'guardians of the nation's health' (Bland 1982). This safe version of female sexuality has been produced in direct contrast to the public vilification of prostitute women as spreaders of disease.

We would argue, following Foucault, that knowledge of sexuality in the twentieth century should not be seen as an evolution of ideas about sexuality from the previously repressive to the currently permissive. Rather there are a multiplicity of often contradictory discourses. While rhetoric on AIDS tends to locate women as either guilty and dangerous (prostitute women; promiscuous women), or as innocent victims (sexual partners of haemophiliacs or bisexual men), we would argue that these divisions are unhelpful. They render invisible the contradictory reality of most women's lives and the power relations which shape this reality.

For ideological reasons, AIDS continued to be portrayed as a gay men's disease long after the epidemiological evidence ceased to support this position (Treicher 1988). With the exceptions of prostitute women, IV drug 'abusers' and women from Central Africa and Haiti, women were invisible in the public health debates about HIV and AIDS until the epidemic was well established (American Medical Association 1986). As women became more central they tended to be referred to, both by scientists and by the media as 'promiscuous females'. This label reinforces the peculiar understanding that it is the number of sexual partners which produce the risk status rather than the type of sexual practice. Our data would suggest that this is a label which women are very unlikely to identify with, even if they have had several sexual partners, thus producing an attitude towards HIV that 'it can't happen to me'.

Within public health discourse on AIDS, as in health debates more generally (Scott, S. 1986; Graham 1984) there is little intrinsic concern for women as women (Treicher 1988). Women tend to be described in relation to their sexual partners, as mothers of babies who may be born HIV antibody positive, or as carers for people with AIDS. This lack of a separate identity for most of the women in the world who are at risk from HIV appears to be being reinforced by the focus of the 1990 World AIDS Day on women as carers.

Some recent public health campaigns have attempted to address the realities of heterosexual practice and the contradictions which young women face. For example, The Health Education Authority's HIV/AIDS campaign, aimed at young women, which was launched in the Spring of 1989, took up the theme of embarrassment in relation to putting knowledge about the appropriateness of condom use into practice. This campaign is clearly a positive attempt to incorporate some of the difficulties women face in introducing condoms into sexual encounters, but the fact that it still does not address the complexity of the pressures

experienced by women raises questions about the ultimate value of this method of education.

One of the images in the campaign is a close up of a man and a woman, both young and conventionally attractive, apparently at the height of sexual passion, with the tag line, 'and she's too embarrassed to ask him to use a condom'. The small print under the picture reads: 'Not surprising. What a time to be discussing it. Wouldn't it have been easier to talk about it earlier . . . ' The implication seems to be that 'talking about it earlier' would have been relatively straightforward. The text continues ' . . . So if you choose to have sex (and remember it's your choice) make sure he uses a condom. Talk to him about it today. And never, ever feel embarrassed . . '. The language of rational choice is used here, presumably with the positive intention of affirming women's right to sexual autonomy. But such injunctions do not take into account the element of power in sexual relationships and the consequent problems of using condoms which our data illustrate (Holland *et al.* 1990a). This campaign can be understood as a positive step in AIDS public health education, for at least it addresses some of the difficulties which sex with men raises for women, but no advertisement can simply sweep these difficulties away.

The focus on condoms as the means to safer sex has in itself reinforced dominant male understandings of heterosexual sex and as a result has constrained the development of AIDS education for women. Rather than viewing sex as a complex social process, public AIDS education tends to present sexual encounters as a set of acts, leading up to penetration, into which condoms must be inserted at the right moment. Prevention then becomes a simple matter of punctual intervention. We would suggest that this Taylorisation of sex (Bardeleben *et al* 1989) is likely to increase the alienation which many young women already feel. Many of our respondents value non-penetrative sexual practices. While demands for an end to penetrative sex are unrealistic, and not necessarily appropriate, public education which gives value to a wide range of safer sex practices could help to increase women's confidence rather than increase their alienation.

Public health campaigns have followed convention in expecting women to take responsibility not only for their own reptuations, and their own bodies, but also for policing their partners' male sex drive. Health education has not yet addressed the need to change the behaviour of heterosexual men. Coward (1987) has argued that the AIDS epidemic has afforded us a positive opportunity to reassess heterosexual practice in the context of feminist knowledge, but this challenge has yet to be taken seriously. From our data it appears that often the main thing standing between young women and safe sex is the men they are with. Asking men to carry condoms will not of itself ensure safer sex. The relations between women and men must be reassessed. If public health campaigns are to be at all successful in curtailing the heterosexual spread of HIV, then they must address the complexities of heterosexual encounters and acknowledge that

negotiation is shaped through the inequalities inherent in gendered power relations.

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Notes

1 For the purposes of this paper we are considering only heterosexual young women and their sexual relationships with men.
2 The project is staffed by the authors working collectively, and is currently funded by the ESRC. We have been greatly helped by our transcribers, Jane Preston and Janet Ransom, and by Polly Radcliffe. Our mailing list is held by Jan Holland, Department of Sociology of Education, Institute of Education, Bedford Way, London, WC1H 0AL.
3 Since sexuality is culturally and historically variable we are generalising here only about the dominant form of western sexuality. Further research is needed on variations in this form of sexuality.

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