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HIV INFECTION AND THE MEANING OF CONDOMS

ABSTRACT. Present day meanings associated with condom use among drug-using women and their long term sexual partners include: loss of male protection; violations of constructions of intimacy, fidelity, conjugal bonding, and female identity; illness; and death. Efforts to change condom use patterns must be based on increased vocational, educational, and social opportunities for women. HIV prevention efforts might profit from the design of safer sex interventions informed by the above meanings; intensified mass media campaigns; and a re-contextualization of attitudes, behaviors, and beliefs.

INTRODUCTION

Condom use has been prominent in discourse about sexual behavior and the prevention of the human immunodeficiency virus (HIV) infection since the early 1980s when the sexual transmission of HIV was first described. Following recognition of the drug-related expression of the HIV epidemic, public health discourse conveyed discernable distress about the lack of condom use among heterosexual partners whose sexual and drug-related activities place them at high risk (Norbert and Spigner 1986; Brown and Primm 1988b; Fullilove *et al.* 1989; Sankary 1989; Lewis *et al.* 1990; Farr *et al.* 1990; Lindan *et al.* 1990; Wermuth and Ham 1990). Condom use has been described as equally infrequent even among HIV infected drug-using persons with knowledge of their infection (Pivnick *et al.* 1990). In the United States, it is important to note that heterosexual persons who are identified as being at high risk include drug users, partners of drug users, and persons of color living in east coast areas of high concentrations of drug use and urban poverty (Brown and Primm 1988a). Distress about the lack of condom use among these predominantly poor, urban residents is no doubt related to the fear that they will become the conduit for HIV transmission to the "general population" (read white middle class heterosexuals) as though populations in which there are presently high rates of HIV infection are less than general, that is, limited, set apart, and, by inference, less important.

These intimations of disappointment in public and professional discourse about the non-use of condoms among poor, urban-dwelling sexual partners are characterized, in addition, by a degree of incredulity. How is it that African American and Latino persons whose behavior, or that of their partners, places them at established levels of risk do not adopt the relatively simple precaution of condom use? Worth (1989) identified unequal gender relations and related

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constructions about reproductive decisions among African American and Latino sexual partners as major contributions to the non-use of condoms. However, although cultural values and norms are mentioned with some regularity in the condom use literature, the majority of the work around condom use has been conducted by health researchers whose purpose it is to identify attitudes which will predict the use or non-use of condoms (Valdiserri *et al.* 1989; Chapman *et al.* 1990; Forrest and Fordyce 1988). These studies convey the notion that attitudes (which often represent normative value constructions) are changeable through health education, that attitudes are independently operating influences on social and individual activities, and are not energetically mediated by social organization, social action, and related cultural constructions, i.e., differential access to resources and dependent gender role definitions. It has even been suggested that physicians, as individuals, through their powers of persuasion and position can be instrumental in changes in patients' condom use patterns (U.S. Preventive Services Task Force 1989).

This paper describes activities and constructions of meaning associated with condom use among a study population of 126 drug-using, African American and Latino female methadone patients. The statistics of condom use, marital status, and shared knowledge of HIV infection are presented first, followed by a discussion of the meanings associated with condom use conveyed in interviews with the informants.

THE NON-USE OF CONDOMS

The first published mention of condom use identifies its purpose as the prevention of the transmission of venereal disease from women to men (Valdisseri 1988). The central notion is that men were those to be protected, not their conjugal partners, their lovers, or the sex workers with whom they had sexual relations. This construction of men as the vulnerable sexual partners, and women as those from whom men are to be protected, persists in the present construction of women as those whose task it is to prevent HIV infection by negotiating condom use with their partners. The notion embedded in this construction of the woman as the partner responsible for condom use (i.e., disease prevention) is that women are responsible for HIV infection, and, therefore, those who are appropriately responsible for its prevention.

In accounts written prior to the HIV epidemic, Padilla (1958) and Ladner (1971) note that little or no contraception was used among the inner city residents whose communities they studied. In the mid 1980s, after the mailing of the Surgeon General's pamphlet, "Understanding AIDS" and mass media spots identifying the sexual transmission of HIV infection, researchers reported the persistent non-use of condoms among persons engaging in high risk activities –

mass mailings and media spots notwithstanding. More recently, Sullivan (1989) described a lack of condom use in a study of inner city fathers in three urban neighborhoods.

At the onset of concerns about the heterosexual transmission of HIV when observations of non condom use were first described, it was thought that inner city populations were inadequately informed about HIV and its transmission. It has since become clear that the non-use of condoms is not a function of lack of knowledge. The results of an AIDS knowledge test administered to 121 informants as part of the study under discussion demonstrated high levels of knowledge of HIV transmission modes.[1] Although methadone patients have been the subjects of unique HIV prevention education efforts, presently, in New York City, injection drug users in general are certainly aware of the sexual and needle-related modes of transmission. High levels of knowledge about AIDS prevention and the efficacy of condoms as prevention are well documented (Selwyn et al. 1989; Magura et al. 1989). It is likely that most adult residents of New York City are aware at least of the sexual transmission of HIV infection despite relatively passive prevention efforts on the part of general public health initiatives limited to small, publicly funded prevention projects, printed material, and an occasional poster or public service announcement.

The recognition of high levels of knowledge about HIV transmission among high risk populations raised the question why women living in geographic areas with observed and dramatically high rates of HIV infection such as the methadone clinic neighborhood do not insist their partners use condoms (ignoring the equally important question as to why their partners do not). Most remarkable about these initial formulations was the identification of women as the solitary conveyers of safe sex, women as the protectors of their male sexual partners, women as the sole deterrents to perinatal transmission, and, as noted above, women as the stop-gaps of HIV infection between the inner city high risk population and the middle class heterosexual population. These exhortations to poor, urban women to protect their future offspring and their partners take place in the context of a singular lack of knowledge about the sexual behavior of American adults. As a result of limited research conducted during the past 30 years in this country, little is known about adult sexual behavior. The possible exception is that of gay, white males whose sexual practices have been the subject of extensive inquiry since the designated beginning of the AIDS epidemic in 1981 (National Research Council 1990).

Just as non-use of condoms is not a function of lack of knowledge about modes of HIV transmission, non-use is equally not related to lack of experience with the consequences of infection. Drug-using women who participated in the study which this paper describes have had extensive, tragic, personal and social experiences with HIV infection. Among the 126 women interviewed, knowledge of AIDS deaths among family members exceeded all reported deaths by violent

means.[2] Of 4927 known consanguineal and affinal relatives of all ages, informants identified 63 persons (1.3%) reported to have died of AIDS and 54 persons (1.1%) reported to be currently HIV infected, compared to 44 persons (0.9%) reported to have died of all violent means. Without adjusting for age or for the period of time the AIDS epidemic has been experienced by members of this community, it is clear the impact of the epidemic is even more severe than the already serious impact of violent deaths on these women's lives.

When these experiences with HIV/AIDS are examined from the perspective of each woman's experience – even only numerically – the impact of AIDS becomes more tangible: From among the 47 women who experienced the AIDS related deaths of family members, 35 experienced 1 death, 10 experienced 2 deaths, 1 experienced 3 deaths and 1 experienced 5 deaths among family members.

Further, when AIDS experience is stratified by generation, it is clearly demonstrated that at this point in the epidemic, the community's most profound losses are suffered by members of the informants' generation – persons from 25 to 45 years of age. From among the 126 women, a total of 58 AIDS deaths are reported from among: siblings, husbands, lovers, siblings-in-law, cousins, ex-husbands, and ex-siblings-in-law. When these losses from AIDS are coupled with losses to the community of members who have died from deaths by homicide, it is not difficult to understand the promulgation of theories of AIDS which rest upon a construction of AIDS as genocide.

Reminders of the toll which AIDS is taking on the community are vividly represented in the clinic. In the following quotation, Eulalie Eastman, an informant who has lost two family members to AIDS, describes her perception of the effect of AIDS deaths on her social network:

> I know Alan since 1969, you know, when he had so much vitality and spunk in life. And to see him on the [methadone] program doing fairly well, but then to see him just deteriorate from 205 pounds down to 100. And like my girl friend Sally, you know? One day I see her limping and I ask her what's wrong. She says her foot was bothering her. Six months later I see her and she has no leg or no foot, just a stub. And a month later she's dead.

In the methadone clinic, where people's health status has already been diminished by the effects of poverty, lack of access to health care, and the consequences of drug use, HIV infection takes dramatic forms such as the loss of Eulalie Eastman's friend's limb, or the wasting syndrome of her friend Alan to which she refers in the above quotation. The physical manifestations of HIV/AIDS are obvious to any observer. People are markedly thin, many cough continuously from various pulmonary infections including tuberculosis, and many have open, infected sores on their hands and arms from continued injection drug use. There are other reminders, too. The space allocated for primary care and clinical research has been expanded to care for the increasing

numbers of sick people. The medical care area has been augmented several times during the past three years, and now extends prominently into the waiting area.

The personal and social impact of HIV/AIDS on women's lives is further revealed in the following quotation from an interview with Alicia Gonzales, a woman who lost her husband, a brother, and three brothers-in-law to AIDS within a year and a half. She has a 12 year old son who lives with her mother and step-father. She is pregnant, and has been married to her lover of five years for the past five months. Alicia does not know whether the child she is carrying is the child of her dead husband or her present husband but she has decided to bear the child. She describes her response to her husband's death.

> People were angry with me, they says – people in the program and the other people I know – says what kind of woman are you, you don't even cry? Because I didn't cry. Because I didn't cry when he died. I didn't cry. I cried at home. I didn't cry. I says I don't cry for that. I'm happy he's out of pain. If you would've seen the pain he suffered you would be happy he passed away, too. Those last three hours, I was willing to kill him, he was in so much pain. He wanted me to. I had 17 stitches on my back cause of that. He had given me the knife kill me kill me kill me I can't take it no more. And then he stabbed me cause he was mad ... He was in the house both half with his parents ... Put our money together for that apartment, moved the father in with us ... Then one of the brothers came to live with us, then the other brother came to live with us during the same month they moved in, they lost their places, right? He died. They all died one by one. I moved out when he died cause I tried to paint the walls – I couldn't take it no more ...

Alicia is, herself, HIV positive. She has decided to bear the child she is carrying either in honor of the memory of her husband, or for her current husband. So far, she has sustained the loss to AIDS of her husband and three brothers-in-law.

Within a single year, Darlene Johnson lost her three year old son, her husband, her step-father, her brother, and her son's two godmothers to AIDS. Darlene was overwhelmed by grief and loss. At the end of the year, having suffered the death of her husband, brother, and her son's godmothers, Darlene's three year old son died and she was ultimately unable to function. She relinquished her other three children to foster care. At the time she gave custody of her children to CWA, Darlene says she cared for nothing in life, not even her children.

> I placed them away because after the baby – and me so depressed, I just didn't want to live any more and I didn't want the kids to be running in the street, to be hungry and be clothesless. So I placed them away.

Personal losses among clinic patients parallel losses suffered by war survivors. The impact of the HIV epidemic on the lives of the informants heightens the urgency of questions about why women and their sexual partners do not use condoms.

METHODS

Data were gathered over a period of two years through participant-observation of a weekly peer support group for drug using women in a methadone clinic administered by a teaching hospital in the Bronx, New York. Individual, in-depth interviews with 126 female patients were conducted in private, in counselors' offices in the clinic. Interviews lasted for two to two and a half hours. The study was designed to elicit both qualitative and quantitative data. All interviews were taped.

The quantitative data were derived from a researcher-administered questionnaire which included a kinchart-sociogram; demographics; and reproductive, drug use, marital, and residence histories. Qualitative data were derived from transcribed responses to open-ended questions about the meanings associated with contraception, partners, HIV infection, and child bearing; field notes from group observations; videotaped group sessions; and participant observations of informal gatherings in the medical center and the clinic.

POPULATION CHARACTERISTICS

The characteristics of the study population appear below in Table 1.

CONDOM USE, MARITAL STATUS, AND SHARED HIV STATUS

Fifty of the 126 informants are in residence with husbands, 24 are separated, and 52 are single, divorced, or widowed. Informants report being married an average of 8.4 years.

A quantitative analysis of informants' reported condom use with conjugal partners indicates that 32 (64%) of the 50 married informants never use any form of contraception with their husbands, 4 (8%) use condoms sometimes with their husbands, and 14 (28%) always use condoms with their husbands.

Twenty-one women report having at least one male lover. Eight (38.1%) report never using condoms with lovers, 2 (9.5%) report using condoms sometimes with lovers, and 11 (52.4%) report always using condoms with lovers.

There are 16 HIV positive married women among the informants. Fourteen of the 16 have informed their husbands of their positive serostatus compared to 1 of 6 HIV positive women who have informed their lovers. The two HIV positive women who have not informed their husbands of their positive serostatus report always using condoms.

These frequencies of condom use and shared knowledge of HIV infection

TABLE 1
Population characteristics

		N	%
Race/ethnicity			
Latino		78	62
African American		38	30
Caucasian		10	8
Religion			
Catholic		85	68
Protestant		38	30
Other		3	2
Age (mean)		34.9 yr. (22–63)	
Education			
Grade:	< 9th	15	12
	9–11th	67	53
	= 12th	44	35
Marital status			
Married		63	50
Single		35	28
Div/widowed/sep		28	22
Source of income			
Public assistance		104	83
Illegal activities		40	32
Employment		3	2
	Total	147[a]	
Current drug use			
Heroin		30	24
Cocaine		43	34
Crack		41	36
None		37	29
	Total	151[b]	
Methadone maintenance treatment program			
	(mean)	4.1 yrs.	
	(range)	(2 wks–8 years)	

[a] Some women cited two sources of income.
[b] Some women reported use of more than one drug.

demonstrate the following pattern: a greater proportion of informants do not use condoms with husbands (64%) compared to those (38%) who do not use condoms with lovers. In addition, HIV positive women are likely to have informed their spouses of their HIV infection, whereas they are less inclined to have shared their positive serostatus with their lovers. However, the analysis reveals that condoms are reportedly used more often in sexual encounters with uninformed lovers than with informed husbands.

This pattern of non-use of condoms with long term sexual partners is confirmed by other studies. Investigations by researchers of condom use patterns

among women attending health clinics (Valdiserri *et al.* 1989), female sex workers (Hookyaas *et al.* 1989), women in methadone treatment (Worth 1989; Pivnick 1990), and more general populations (Chapman *et al.* 1990) all confirm this pattern. The non-use of condoms with sexual intimates has been observed among men as well as women (MMWR 1990; Sotheran 1989). Similarly, investigators working in Africa report that, although condom sales have increased, they are generally used between casual sexual partners rather than between long term partners (Engel 1989). The same observation is reported by Handwerker (1991:4) from a study in Barbados where women's pattern of condom use "reflects the intimacy of relationships; they don't use condoms when they believe their current partner is loyal."

These findings prompted a further investigation of the meaning of condoms (and their infrequent use) among the female informants in this study. These women are well informed about the risk of HIV infection. Many are HIV positive or have partners who are HIV positive. All have histories of injection drug use. Some report smoking crack and engaging in exchanges of sex for money.

CONTRACEPTION

Informants describe having used many forms of contraception in the past, including: diaphragm, IUD, condom, spermicide, pill, foam, rhythm, and abstention from sex. Although many women describe having used one or more forms of contraception in the past, most report using no birth control at the time of interview. Those who do, however, identify HIV infection as the reason for the use of contraception (condoms) rather than the desire to prevent conception. This explanation for condom use is similar to that offered by women interviewed in the Kinshasa study (Schoepf, 1992:273).

In the following quotation, a woman whose lover is in jail describes her intention to insist that he wear condoms when he is released:

> Like the guy I'm with now. I told him I was going to start using condoms with him 'cause I've seen him use works [drug apparatus including needles] behind people. I don't like that. See, he's not on the program so he doesn't get the AIDS exposure like we do. And he's going back and saying about back in the days when there were shooting galleries, six and seven people used the same works. But AIDS wasn't out there.

The informant's association of condom use with AIDS prevention is mirrored in many women's responses to the question of whether their reasons for the use of condoms have changed from the time when they were first sexually active. Many respond that their present reason for the use of contraception (condoms) is related to venereal disease (including AIDS) whereas prior to the AIDS epidemic, prevention of pregnancy was the most prominent reason for the use of

contraception. Schoepf (1992) also notes the newly contructed meaning of condoms as HIV prevention in reports of interviews among women perceiving themselves to be at high risk in Kinshasa, Zaire.

Nonetheless, despite recognition of the role of condoms in HIV prevention, condoms are infrequently reported to be used by the long-term sexual partners of the women who participated in this study. The infrequency of condom use among this group of informants, the greater frequency of use with non-intimates, and the fact that informants describe contraception as a contested domain between men and women, make it unlikely that the informant whose intention it is to insist that her sexual partner use condoms will be successful.

CONTRACEPTION AND PATTERNS OF CONJUGAL AUTHORITY

A common source of dissatisfaction among both black and Latino women is their husbands' efforts to direct and control their behavior. Women regularly reported that their partners insist upon being "fathers" rather than "husbands." Being a woman's "father" means a woman's partner behaves toward her as though she were less than adult. He judges her incapable of making her own decisions, requiring that he, her partner, make decisions in her stead. Socioculturally influenced relationships of inequality between men and women (in informants' constructions, relationships which are characterized as adult-child relations), are expressed, among a multitude of other ways, in decisions about whether to conceive offspring or not. In the following quotation, gender inequality in spousal relations is conspicuously reflected in a decision concerning sterilization.

> Yeah. In a way I wanted it. [a tubal ligation] In a way I didn't, you know, because he [her husband] had me under psychiatric – I was a suicidal. He used to mistreat me so much that I wanted to die, you know. So the doctor suggested it, you know, told him, "Look, she's a suicidal, you know, and it's bad for her to keep on having kids, you know." So we had an argument and he said, "Well, if you ain't going to have my kid, you ain't going to have nobody's kid!" He signed ... No, I didn't have any choice. You know, like he was the man. You know, I told him once, "What you got married to me for, to be my father or my husband?" He says, "To be your father."

The power inequity obtaining between the informant and her long-term sexual partner is alluded to in terms related to physical abuse, reproductive decision making, and sexual fidelity and monogamy. If she were to be sterilized, her partner would at least be assured she wouldn't bear any other man's child.

Relations between informants and their sexual partners are also characterized as unequal in parts of their lives unrelated to sexual behavior and reproduction. In the following quotation, a woman describes her satisfaction with her current marital circumstance as well as her perception of her husband's efforts to control her behavior.

For now, I am [satisfied]. He's honest, he's clean cut, he don't take no drugs. That keeps me from doing it, you know. He's too jealous, over-protective. And when he's home, he times me to go to the store!

This informant has struck a bargain with her spouse, a not uncommon trade-off among drug-using women. In exchange for his positive influence on her abstinence from drug use, she has given up her independence. She accepts the fact that he regulates her time because she receives, in exchange, his protection of her from herself, from her desire to use drugs. The informant constructs her relationship with her partner in terms similar to those used in other informants' complaints about spouses. Her husband supervises her activities much as a parent would. He times her. He diminishes her autonomy. He behaves like her "father." Without his control, she might betray him.

The protection which men provide for women also includes financial support. Male partners typically contribute to grossly inadequate household budgets by buying food, and by purchasing diapers and clothing for children. For both African American and Latino women, the purchase of diapers and clothing by partners signifies an appropriate expression of paternal responsibility in perilous economic times. The phrase, "he buys the baby diapers," signifies that the man is properly fulfilling the role of husband. For poor, inner city women who are the recipients of public assistance, the protection provided by partners against economic disaster is critical for survival, even if, as is often the case, the partner's contribution is not the primary source of financial support. If survival needs contribute to women's acceding to men's wishes that condoms not be used, women may assess their risks in favor of immediate financial contributions rather than long term HIV prevention. Handwerker (1991:2) describes this process as one in which "selection favors any belief or behavior that optimizes resource access, and identifies power as emanating from the need of one person to access resources through another." Among study participants, partners are constructed as protectors, both from unwelcome influences and from financial ruin, and, therefore, if normative relations between sexual partners are constructed and legitimated without condom use, women are likely to choose culturally constructed intimacy and economic support over conflict-ridden safer sex – the positive effect of which is not immediately apparent and which, according to informants, is rendered absurd by the high probability they are, as IV drug users, already HIV infected.

In addition to the protection afforded women by financial support from long-term partners, women describe sex work in terms which make explicit the realities of their financial circumstances. The fifty year old informant quoted below explains her occasional sex work as the only means she has to provide food for her dependent children.

But they [her husband and children] don't know what I do to get the money ... I think it's really my fault. Because they know I'll go and get it. They know I won't wait until it

comes to me. I'll go out and get it. I don't have nobody to go to [to borrow money]. Oh, yeah, one daughter, one or two daughters. But they got kids and I feel bad asking.

Schoepf (1992:263) similarly observes about informants in Kinshasa, "Women often seek occasional partners, *pneus de rechange* (or "spare tires"), to meet immediate cash needs. As economic conditions continue to worsen, the social fabric is tearing apart, and sexual strategies that maximize returns become increasingly important."

Unequal spousal relations are also expressed through descriptions of drug use patterns. Another informant describes her reasons for using separate "gimmicks" (needles and other drug paraphernalia) from her partners.

With all my husbands, I always use separate gimmicks ... because I want to get off when I want to get off. Usually the woman has to wait and I wasn't about to – for the man to get off first. I wasn't about to.

Gender distinctions are used to assure men the first "hit." The socially sanctioned sequence is that the male partner gets "high" while his female partner waits.

The characterization of spousal relations as adult-child relationships in the above quotations represents women's constructions of the unequal nature of power relations between their husbands and themselves. These inequities reflect general societal values as well as those which are specific to black and Latino cultures. Although African American informants characterize their partners' attitudes toward them as "fatherly," they do not ascribe this inequality to aspects of their own sub-culture. The tone of black women's complaints is one of annoyance rather than resignation; the source of their dissatisfaction is not identified by them as specific to African American culture but rather rests on more general notions of the societal oppression of women by men. Latino women, on the other hand, are more likely to ascribe unequal power relations between themselves and their husbands to Hispanic culture and the specific socialization of Latino men.

In spite of this difference in cultural perceptions of the sources of gender inequities in marriage, both African American and Latino women commonly report dissatisfactions related to decision-making rights in conjugal relations in areas of sexual activity. Condom use is such a behavior and the meanings which have been constructed around condom use in the context of AIDS have become the focus of a contest which continues to be configured in terms of gender. Condoms are an aspect of the contested domain of sexual activity and reproduction between women and men.

MEANINGS ASSOCIATED WITH CONDOM USE

AIDS education abounds in the methadone clinic. Health educators regularly

present day-long sessions of intensive AIDS education targeted at the entire clinic population and there are abundant written materials available on site. In addition, clinic patients who are tested for HIV infection receive individual counselling about both sex and needles as modes of transmission. Some clinic patients are highly motivated to learn about HIV infection, and a number are well educated in and conversant about specialized areas of HIV/AIDS research, e.g., the specific effects of AZT and other treatments on the immune system. Patients' efforts to integrate their personal and social experiences with HIV/AIDS, and the information available to them through the clinic and various media, result in a high level of awareness of issues related to infection and transmission.

The non-use of condoms and the associated transmission of HIV infection among black and Latino, inner city women and their sexual partners is neither the result of lack of AIDS knowledge, nor a function of women's withholding information about their HIV infection from their spouses. Contrary to some public perceptions, the long-term, male partners of HIV positive participants in this study are, with two exceptions, all informed of their partners' HIV status. The two HIV positive women who have not informed their partners have grown children. Both insist their partners use condoms with the explanation that they do not want more offspring.

When informants are queried about why they and their spouses do not use condoms during sex, the most frequent explanation offered is that their partners "don't like them." To this response is then added the comment that they, too, do not like condoms. These statements describing mutual dislike are often followed by further explanations.

> With my husband I mean that's a no no, definitely. Because he, he'll probably get so aggravated he'll start fighting with me! ... I don't feel that the person I'm having sex with has to put any you know for me to get to that point. Because I wouldn't go to bed with just anybody. I'm very particular. I think it is insulting [to the man] ... I don't like to use them but then again I think that it'll be insulting.

Following the informant's negative assessment of the probability of her partner's condom use, she suggests there is some risk to her, in her view, of physical abuse were she to ask him to wear a condom. She then reflects on the meaning of her demand. Were she to suggest her husband wear a condom, not only would he be angered, but she would be condemning herself. She would be acknowledging that she engages in casual sex and would be encouraging suspicions about her fidelity. For the informants in this study, intimacy and fidelity are confirmed by having sex with a partner without a condom.

The following is a response by an HIV positive woman to the question why she does not use a condom with her lover but does with casual partners.

> I don't know. He's my boyfriend. It's different. We want to get together ... It's intimate. The fucking [casual sex] is not – you know.

For this informant, the non-use of a condom with her intimate sexual partner further confirms their desire to become permanent partners. Their mutual desire to "get together," to commit to a long-term relationship, is expressed through the non-use of condoms. Were they to use condoms, the meaning of their relationship would be casual, non-committed, without expectations of a future together. This emphasis on intimacy and commitment supersedes the negative meanings related to their uncertain future inherent in her HIV infection and his risk.

The construction of unprotected sex as intimacy is most clearly expressed in statements describing conjugal bonding in the context of the possibility or actuality of HIV infection. For many informants, the purest, most intimate expression of conjugal bonding is demonstrated through the non-use of condoms.

In the following quotation, an HIV positive woman explains why she and her husband do not use condoms.

> You don't know, when I found out I had the virus, how I suffered trying to get this man to use condoms and everything. He said no. He said, if I'm dying, he's going to go with me, that he doesn't want to stay. He said maybe I gave it to you, or maybe you gave it to me, you know, or maybe we both got it from some – No, he says if I'm going to die, he says, if you're going to die, whatever happens to you, I don't want to stay ... He's thinking wrong, but – he said, if I'm not going to live, he don't want to live.

Introducing condom use in a long term relationship interposes emotional distance, implying that one partner will outlive the other. The possibility of both the informant and her partner having been infected through either dirty needles or sex is acknowledged by the informant's partner in the quotation. Her partner's potential use of a condom suggests he will live while she will not. And, because, according to the informant, her partner knows he, too, may be HIV infected, he chooses not to protect himself but to remain true to their mutual bond. Without having been tested, many informants relate the conviction that they are probably infected, that their partners are probably infected, and the proof offered for this conjecture is the large number of clinic patients who have died of AIDS or who are presently observably ill, an observation born out by clinical research.[3]

An understanding of why most women in the study do not insist their partners use condoms requires an examination of many aspects of relationships, not only those which are immediately associated with intimacy, betrayal, survival needs, and conjugal bonding.

An African American informant who is HIV negative and the mother of three daughters who are now 14, 12, and 11, all of whom have been legally adopted by foster parents, describes why she and her husband do not practice safe sex. She has not seen her daughters for seven years. During peer support group meetings, she regularly shares an agonized review of the circumstances under which she lost custody of them. She has not resolved having given up her

children. She feels she is prepared to deal with being HIV infected for the following reasons:

> Well, I would be okay. Know why? Because when it first came out, me and my husband went to took the test together. And we made vows that if either one of us had it, you understand, we would give it to the other person and die ... Because we love each other, yeah, and also I want a child ... And, like I said, if he was – say he messed up once and he got AIDS, you know. Oh, I'd be furious for him going out on me, but I would stick with him, you know, and he would stick with me.

In this woman's construction, conjugal bonding is the premiere reason for dying together. The non-use of condoms is implicit in the couple's decision to die together. However, she offers a secondary reason for not using condoms – her desire for a child. This is particularly poignant because the informant has lost three children first to civil authorities and ultimately to non-familial adoption.

Factors such as the meaning of children and relationships with existing children also contribute to women's contraceptive activities and reproductive decisions because cultural constructions of femaleness are predicated on the ability to bear children. If a drug-using woman's children have been removed from her because she is unable to care for them, or because civil authorities deem her unfit, or because others have conspired to remove her children from her, or because living on public assistance is too difficult in combination with drug use, she may be inclined, for her own identity reasons, to devise a construction of condom use that is passive and compliant relative to her partner's refusal. Not only does her partner gain in self esteem through the fathering of children, but she does, as well, through the bearing of children. When the desire for children is combined with the requisites of intimacy, the result is often a lack of condom use.

Values placed upon child bearing and constructions of femininity which are dependent on child bearing invoke the desire for children. Informants frequently voice their intention to "give" a new partner a child. The "giving" of a child to a spouse is a recognition of permanence, and of maleness and femaleness. The woman's task, at the onset of the relationship, provided she perceives it to be a stable one, is to bear a child for her husband. The following quotation is a response to a question about condom use:

> Well, for one, he wants me to have a kid. I started to tell you that before and I never did. And, on his side, I know he doesn't like it. And on my side, I know I don't get pregnant easy. So, it doesn't really – I guess it's not really that important to us ... I started to tell you before that he's got four kids and let's see, he's got one, two, three grandkids ... And he's been a lot in and out of jail you know before I met him and those are the two that are the oldest two they're the closest two but they're in Brooklyn and he's mainly in the Bronx and I know that he's kept in touch with them throughout the years and he's closer to them than the other two. I think he mainly wants – cause ever since he met me, he wants a kid. See, when I met him he had recently gotten out of jail, he was doing five years, and I think we spoke on it once. I think what he wants is to have a kid and to be able for him to raise it, not leave it behind with the mother or somebody. And my husband loves kids, every kid, everybody's kid ... And I would love to give him that

pleasure and I feel I can't or I haven't ... I don't know and condoms is definitely out.

This woman points out that her husband's desire for a child is directly related to his not having resided with his other children, a factor identified by previous research to be intimately connected to HIV positive women's decisions to bear children (Pivnick *et al.* 1991). Fathers as well as mothers feel deprived of their children when they don't live with them, and they, too, may attempt to repair that loss by having more children.

Latino women attribute the insistence of their partners on not using condoms to normative values having to do with Latino maleness and procreation, expressed precisely through the non-use of condoms.

Especially Spanish men. Because they feel they're not men. No, they're very – that's taking their male, you know, it's just putting their male ego down. What's crazy about it, is it's mostly Spanish men that are like that ... They believe a woman was here to bear kids, and that's all they want. If you can't have kids, let's say me, I'm considered less than a woman. Especially Spanish men. And it's bad because they just keep taking that along and they keep giving it to their kids and their kids give it to theirs.

The statement is a clear representation of the interaction of constructions of conjugal gender inequality and procreation. The quality of maleness associated with not wearing condoms is associated with the ability to procreate. Men are men if they father children. Women are women if they bear children. If women suggest men wear condoms they are rejecting the very essence of the male – his ability to procreate, and correspondingly, their own essence – the ability to bear children. In Hispanic society, women do not have the right or the power to interfere with men's male identity or to negotiate altered meanings of sexual behavior by requesting protected sex.

There are still other factors which contribute to couples' non-use of contraceptives, and consequently, to rates of conception and risk of HIV infection. Drug use in women often produces amenorrhea, a condition in which a woman does not menstruate. Many informants claim not to be aware of their pregnancies precisely because they never menstruate and believe, therefore, that they cannot conceive. Without the perceived risk of pregnancy, many women conclude there is not enough reason to counter men's demands to not use condoms. This is particularly true for women who do not wish to have children, and who do not perceive themselves to be at risk for pregnancy because they do not believe they are able to conceive.

It must be noted that the consequences to women of not using contraception are often severe, and among these consequences, are informants' accounts of second trimester abortions. There is the commonly stated idea among informants that once a woman has felt a baby move inside her (the end of the first trimester or the beginning of the second), abortion is a qualitatively different matter, a much more problematic decision, an active life taking. Abortion is counselled by the informants as a sanctioned solution to unwanted pregnancy early in preg-

nancy; but once the fetus has demonstrated palpable signs of life, abortion becomes a much more difficult act for women to undertake.

The quotation which follows describes the feelings of a mother of eight children who has been pregnant fifteen times. Seven of these fifteen pregnancies were terminated.

> See those abortions, I consider a few of them births cause I seen what the kids would've looked like if they were here. I think I had about three of them ... and two sticks, right? The laminary – where they put the sticks up you and you back the second day – and I had one suction and one just came down ... You know, after them abortions, them salines, I said, Oh my God, no more. If I ever get pregnant again, I will never do it again.

For some women, one of the consequences of the use of abortion as birth control is a limit to the number of abortions an individual woman will decide to have. Some informants report bearing children, not because they choose to have more children, but precisely because they do not want to experience another abortion.

In spite of cultural constructions of intimacy, conjugal bonding, and meanings associated with child bearing and children, condom use is presented by some women as a facet of the contested domain of contraception – a locus of health conflict between the woman and her partner. In the following exchange, an HIV positive informant describes her reasons for not using condoms with her lover. In response to the question "Do you always use condoms?" she replies:

> Oh, yes. Except with my old man, because he doesn't want to use them ... Because he doesn't like that ... He doesn't like it. And like he says that he already got the virus, so what the hell? I tell him, "Yeah, but you keep on infecting me, you know, and it's worse." He don't want to listen.

The informant – already infected – is concerned about being re-infected by her HIV positive partner. In the following quote, another informant, who is HIV negative, relates a similar reason for her partner not using condoms.

> Now my boy friend tells me he wants to use condoms so he could protect me but I told him that we already been together, we had intercourse without the condoms so if he has the virus and I'm going to get it, we got to get treatment or whatever but I don't agree with him on using condoms now ... Cause I don't want to. He wants to use condoms to protect me if he has the virus. If I have it, I have it ... I don't want him to feel that I'm – I want him to feel that I really love him and just because he has the virus don't mean that things are going to change. Things are always going to be the same with us ... He fights with me every day because he wants me to protect myself but I don't want to.

In the first of these two quotations, the informant's male lover refuses to use a condom because he doesn't "like" condoms, and he doesn't care if he re-infects his partner. In the second, the informant doesn't want her partner to use condoms, reiterating the theme of the violation of intimacy implied by condom use; however, the debate this couple has over condom use is noteworthy. It is difficult to believe that the woman in the second quotation has enough power (persuasive, physical, or emotional) in her relationship to actually prevent her lover from using a condom. The story is related as though she is the locus of

decision-making about an action which is his to take. Inherent in at least some informants' explanations for the non-use of condoms are veiled expressions of their inability to change the normative power relations and decision-making processes in their relations – sexual and otherwise – with men.

Beyond the associations of non-condom use with protection, intimacy, fidelity, conjugal bonding, and child bearing, the following quotation expresses the final and most prominent aspect of current meanings associated with condoms. Responding to a question about what would happen were she to ask her husband to wear a condom, the informant replies:

> He'd raise hell. You didn't have a tubal ligation, you didn't think about that! And now, what, you think I got AIDS? Or he probably say what you think that I'm doing things out in the street with a woman and maybe I got something I'm gonna to give it to you? If I haven't done it in five years, why now?

The informant reports her husband's view that had she been worried about bearing more children, she would have had a tubal ligation rather than now suggesting he wear a condom. The responsibility for avoiding pregnancy is hers. Her suggestion that he wear a condom is tantamount to accusing him of being HIV infected, and of infecting her. The informant's view is that the enactment of prevention (the use of a condom) would be interpreted by her partner as confirmation of the disease called AIDS and its ultimate consequence, death. This, then, is the most recent extension of meaning. Condom use does not signify birth control, venereal disease prevention, or, as many had hoped, HIV prevention. Condoms do not suggest the now relatively benign, non-fatal venereal diseases. Rather, condoms have come to signify the presence of AIDS, and therefore death.[4] In the Bronx, among poor, urban women, condoms have come to signify exactly that which they are intended to prevent.

Having related her partner's view of her request that he use a condom, the informant further explicates the problem: having not used condoms during the first five years of their marriage, how, she asks, can she possibly introduce them now? Were she to do so, she would be suggesting that she, or possibly he, had had other sexual partners and contracted HIV infection. Implicit in her question is a recognition of the benefit of HIV prevention, but her anticipation of her partner's response stops her from suggesting they change the nature of their five year long sexual relationship.

The conflict over condom use is complicated and involves many dimensions of interaction and meaning which evolve in as well as remain rooted in cultural and social structures. When asked what the meaning of condoms is in a relationship, most female informants state lack of intimacy and the presence of suspicion about sexual fidelity, but, according to a small number of informants, condom use represents a mutual concern of partners for one another.

This association of condom use with concern and love is in direct opposition to the other meanings conveyed – those related to disease, illness, and death.

Women who identify the use of condoms as an expression of love and concern express conflicts between asserting themselves in circumstances of male oppression, thus protecting themselves (and their unborn children) from fatal infection, and diverting their needs for culturally defined intimacy and bonding:

> Yeah. I think they care [couples who use condoms]. When you really look at it, if everybody's telling you to do this, and you're not doing it, it means fuck it, right? And that's what I'm doing and it's not right and a lot of people do it ... Yeah. It's hard – it's kinda hard for us – how I'm going change into that already? All of a sudden now this comes up like that. I didn't even know they – how I'd even ask him something like that?

The contradictory set of meanings assigned by the women to the use of condoms by their partners suggests that the overriding, operative factor in the non-use of condoms is male dominance and women's related needs to access the resources, protection, and identity provided through relations with their male partners. Gender inequities based upon cultural norms and unequal access to resources seem to be the factors which most contribute to the practice of unsafe sex among informants and their partners.

CONCLUSION

Both the population of urban, African American and Latino sexual partners targeted by public health efforts for condom use, and the population of urban health educators (often African Americans and Latinos) attempting to change the attitudes and sexual behaviors of persons engaging in high risk activities, express through their activities and analyses, constructions of gender inequality which are generic to American culture and society. In the case of the female informants in this study, constructions of gender inequality are often embedded in constructions of intimacy between long-term sexual partners. Among health educators (whose curricula are designed by largely non-African American, non-Latino, middle class researchers), constructions of gender inequality are expressed through efforts to induce condom use between sexual partners by exhorting women to persuade or pressure their male sexual partners to use condoms (Chapman et al. 1990).

Presently, in biomedical studies, "behaviors" and "attitudes" are constructed as discrete units, independent and de-contextualized. Unable at present to discover a cure for or vaccination against HIV infection, biomedical research has included social science investigations of attitudes and beliefs as predictors of high risk behaviors. These social science methodologies are included in clinical research protocols in order to illuminate reasons for people choosing one mode of action and not another, one form of sexual expression and not another. This inclusion is limited for the most part, however, to studies of discrete attitudes and isolated behaviors.

The results of these research efforts are then translated into interventions which mirror the original de-contextualized behaviors upon which the studies were based. Most health educators, armed with these interventions, ignore their own experience and institute narrowly conceived HIV prevention efforts based on a biomedical view of sexual behavior and sexual relationships which not only excludes considerations of the social, economic, and cultural contexts and determinants of behavior, but which utterly disregards the differing perceptions of the meanings of condoms and their use held by the sexual partners whose behavior is intended for change.

Given the persistent meanings associated with condoms – betrayal, infidelity, lack of procreative identity, illness, and death – it is not surprising that little headway has been made by health educators and public health officials in their efforts to convince inner city women to negotiate the use of condoms with their male partners.

From the broadest perspective, in order to change condom use patterns, the sources of the negative meanings associated with condoms must be addressed. Recognizing that meanings associated with human activity both derive from and engender such activity, if the goal is to change patterns of use, the social inequalities which engender these meanings have to be addressed. There will have to be residential, educational, and employment opportunities created for women which generate feelings of accomplishment, independence, and personal worth.

As the feminization of poverty escalates, and women are further deprived of employment, educational, and social opportunities, the need for financial support from men achieves even greater significance. In a time of economic depression, social disorganization, and increasingly polarized political solutions, both broad social transformations and improved, specific personal circumstances are necessary in order that women have opportunities for conflict resolution beyond the constricted, limited ones they now experience.

Public health programs which attempt to "teach" inner city residents about condom use do so in a social and cultural vacuum. Condom use is embedded in the nature of culture-specific, socially mediated, unequal gender relations, which exist, in turn, within broader unequal social and gender relations ultimately determined by unequal access to resources. Condom use threatens the accumulated meanings of both the specific and more general gender relations. Efforts to change condom use practices must take at least some of these issues into account through outreach and education which is framed in the language and culture of the recipients, and which addresses their formulation of the problem.

Perhaps condom re-acculturation education which includes both sexual partners would address some of the power inequities between spouses in terms specific to their relationship rather than focusing exclusively on the efforts of the female partner. The use of widespread slogans and billboard advertising similar

to those employed by African governments might raise levels of public awareness about condom use and HIV prevention. Consistent, frequent, national radio and television announcements might also be effective. The creation of age-appropriate sex education for all educational levels modelled on, for example, Sweden's highly successful sex education curriculum would insure young people the necessary preventive knowledge.

Finally, the HIV research community might consider reconstructing attitudes and behaviors as dynamic aspects of social, cultural, and economic fields. By re-contextualizing attitudes, behaviors, and beliefs, interventions might be designed which reduce risks of HIV infection as well as point the way toward social change.

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NOTES

[1] The AIDS knowledge test is a 16 item, true-false questionnaire developed by the National Institute on Drug Abuse. The instrument contained questions related to sexual, transfusion, needle use, and perinatal transmission. Each correct answer received a score of 1. The informants' mean score was 13.89 (range 10–16).

[2] In the course of constructing the kincharts-sociograms, women volunteered information about relatives (consanguineal and affinal) who had died by violent means, including: accidental death by fire, drowning, electrocution, or motor vehicle accident; murder by shooting, stabbing, battering or being pushed into or from a subway train; drug related deaths (overdose); and suicide.

[3] AIDS case rates among methadone patients enrolled in the Montefiore Methadone Maintenance Treatment Program reflect the growing numbers of HIV infected drug users. In a study described by Selwyn et al. (1989b), the number of deaths from AIDS increased from 3.6/1000 in 1984 to 14.7/1000 in 1987, and deaths due to bacterial

pneumonia/sepsis from 3.6/1000 to 13.6/1000. The incidence of AIDS went from six cases per 1000 in 1984 to 20.4 per 1000 in 1987.

[4] Joyce Ladner, in *Tomorrow's Tomorrow*, p. 256, observed a related connection when she noted that ideas about disease and illness were associated with the use of contraception.

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