

Sexual Negotiations in Relation to Political Mobilization: The Prevention of HIV in a Comparative Context

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Based on ethnographic research in different sites of the global economy, in New York City, Puerto Rico, and South Africa, this paper examines the ways in which women, confronted with the spread of HIV/AIDS, describe their sexual negotiations with men. In each situation, women are found to adopt different strategies for prevention in relation to their level and forms of political mobilization. The research documents the dual role of the U.S. media both in providing information for populations around the world and in perpetuating misconceptions and cultural stereotypes about the spread of HIV/AIDS and women's sexuality. Overall, the comparative data overturns stereotypes of cultural invariability with respect to women's sexuality and demonstrates women's willingness to modify their sexual behavior to reduce the threat of infection from HIV.

KEY WORDS: HIV/AIDS; women; politics; media; condoms.

INTRODUCTION

The word "cultural" has been adopted in HIV prevention—in the focus on communities—in connoting respect for people's values and respect for communities. Clearly such issues are extremely important. Since the work of Benjamin Paul of the 1950s, anthropologists have labored to identify the local social organization and to point out to health workers and international agencies the significance of local experience for the development of effective public health measures and their adoption by communities. These conceptual battles have been fought over the imposition of birth control methods. Anthropologists and other social scientists demonstrated that people implemented birth control methods when they saw its significance for their own and their children's economic future, not simply when pills or implants were provided. The international agencies involved in population control have had to modify their strate-

gies and recognize the significance of women's work and general economic development in the limiting of populations.

Many other examples exist. However, when it came to HIV prevention, once again international agencies began with a reliance on making the technology available—the male condom—and with little else to offer. Justifiably, anthropologists (including myself) and others began to point out the problems in sexual negotiations and social organization, which made the distribution and acceptance of the male condom more difficult than it might at first seem. People in the scientific and social service community of HIV and public health listened to such criticisms as well as to the criticisms from many communities and began to talk about "cultural barriers" to condom use.

As readers are aware, the idea of "cultural barriers" can also be turned against a population [as in the problems with the victim-blaming use of the culture of poverty concept and with respect to HIV in discussions of risk groups (Farmer, 1995)]. In this paper, I examine the problem of the concrete and static application of the term culture as it has been played out in ideas about female sexuality and specifically, here in the United States with respect to the development and distribution of the woman's condom.

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Recent anthropological works have begun to examine the way the medical literature constructs women's bodies and the way women experience and conceptualize events such as menstruation, menopause, and amniocentesis (Martin, 1987; Rapp, 1999). Other analysts have examined historical changes in the construction of female sexuality and in medical descriptions of the female skeleton (Gallagher and Lacquer, 1987; Caceres, 2000). Women's views of their own sexuality and reproduction as well as their representation by others vary by class, cultural identity, and local experience, but also change over time (Ginsburg and Rapp, 1991; Stoler, 1991; Gupta *et al.*, 1996). This paper analyzes emerging concepts of femininity and female sexuality with respect to HIV prevention and specifically, here in the United States, with respect to the development and distribution of the woman's condom. It analyzes the dialectical interaction between local experiences and media representations and the changes which emerge over time both in the United States and in regions constantly influenced by the U.S. media.

The article draws on previous research (Susser and Kreniske, 1997; Susser and Stein, 2000; Susser, 1998) to compare these issues in three areas situated at different points in the global economy:

- (1) in a rural barrio in Puerto Rico, affected by HIV/AIDS from the United States but semiperipheral in the global economy (1986–1992);
- (2) at two sites in the emerging state of the new South Africa, apparently semiperipheral but with growing centrality in the global economy,
 - (a) an agricultural village outside the city of Durban, in KwaZulu/ Natal, in a region designated as the Zulu kingdom at that time (1992), and
 - (b) an informal settlement on the outskirts of Durban, on the borders of what was then the KwaZulu kingdom (1992, 1995); and
- (3) in the United States, in New York City, a center for global communications and the global economy, focusing on research among poor women in the prototypical dual city (1986–1998).

In each of these settings the issue of HIV/AIDS prevention and female sexuality were addressed in different ways. The data demonstrate variations over time in the ways in which HIV/AIDS comes to be viewed and also changes in the way women perceive

the issues of sexuality in relation to forms of political mobilization. Each case documents continuing struggles over the construction of gender and sexuality. Views of femininity and sexuality were heavily influenced by local history and experience but also by the global information flow, mostly from the United States to the periphery. The paper examines conflicts over the U.S. media construction of women's sexuality and how perceptions vary by class and change in response to group mobilization. This is examined specifically with respect to the way in which the introduction of the woman's condom in the United States has been treated in the media and by social service providers whom we have interviewed. Such attitudes contrast with the more flexible attitudes among poor at-risk women in New York City who are in need of safe-sex alternatives.

PUERTO RICO: MOBILIZATION FOR THE PREVENTION OF HIV

The site of my ethnographic research in Puerto Rico intermittently for several months at a time over 10 years was the small town of Yabucoa. The population of the area in 1985 was approximately 40,000, with almost 50% of the population under age 19 and nearly 11% over 65.

Official unemployment for the region hovers around 18%. John Kreniske and I conducted research in this town from 1982 and stayed with several families in two of the barrios (villages) in the municipality. During this period we conducted randomized surveys concerning household composition, employment, migration, and health in one barrio (Bo. Ingenio). We also became familiar with the leaders and members of several community groups, in addition to the large group of people mobilized in the social movement against industrial pollution (the focus of the research begun in 1982 (Susser, 1985).

In our work in Yabucoa between 1987 and 1991, we questioned community activists about their views on HIV/AIDS caring and prevention and their views about gender roles. We also investigated the impact of the local Pentecostal Church groups and leaders of the local Catholic Church on appropriate behavior for men and women and their views concerning HIV prevention and attitudes toward the issue of AIDS. Since community organizing can have a significant impact on HIV/AIDS care and prevention in supporting care providers, promoting safe sexual practices, and working with drug users, one of our aims was to understand whether local groups were consciously undertaking

such functions. We were, also, concerned with understanding the extent to which the actions of these groups bear upon patterns of gender hierarchy and the ability of women to negotiate safe sex practices.

As of July 1991, there were 24 reported cases of AIDS in the community of Yabucoa. By 1987, AIDS had emerged as an issue on national television, and in Yabucoa, it was assumed to be connected with substance abusers and gay men. As one woman, Dolores (a pseudonym, as are all other names of informants mentioned here), argued, "We shouldn't go to the public pool—there are too many drug addicts and gay men there and we could get AIDS." By 1991, Dolores and a few other families and residents of Yabucoa were beginning to formulate ways to protect their own adolescent children from HIV/AIDS and had recognized that stigmatizing groups in the population was not an effective approach to the new epidemic.

Initially, in Yabucoa, reactions to HIV were based on discussions in the media. Few cases appeared in the community. Families did not discuss the problem, and men who were thought to be sick were automatically classified as gay by other people in the barrio. Information from national television stressed needle use and homosexuality as the vectors for HIV and reinforced a categorical stigmatizing approach to the disease. When, in 1987 and 1988, we asked people in the barrio about their perceptions of HIV infection, answers ranged from "It's only drug addicts and homosexuals" to "I know a man in the barrio who came back to live with his family and seems very sick. He was a nurse and I think he was gay but nobody talks about it." Consistently, answers expressed alienation from and a categorical approach to people with HIV or even the possibility of infection.

By 1990, at least two diverging perspectives on HIV had emerged. Many members of the Pentecostal Church associated the spread of HIV with sin and saw HIV infection as punishment for immoral acts. Only children who had been infected perinatally were absolved from this judgment. Among this group, stigmatization of categories such as "homosexuals" and "drug users" continued unabated. In extensive conversations with Juanita, an active Pentecostal, these opinions were expressed repeatedly. When we asked her about her views of people contracting HIV through heterosexual sex, even with a husband or wife, she remained adamant that the problem was previous "immoral" behavior. She insisted that if individuals followed religious precepts, avoided drugs, and never practiced sex outside marriage, no preventive interventions would be necessary. If they did not

follow such rules, in her opinion, they deserved to be punished, even by death.

Juanita's husband, who had also led the environmental movement and later joined the Pentecostal Church, was more flexible in his views. Although not active in HIV prevention in the barrio, he was willing to consider the need to develop community prevention programs and advocate condom use. He recognized the need to educate people about HIV/AIDS and practicing safe sex.

Juanita's opinions reflected religious teachings and the prevailing climate of opinion in the barrio, but we have no evidence concerning how she might relate to issues surrounding HIV in private, among her own friends and family. In observations over the past decade, we have documented many occasions where Juanita assisted and supported her kin as much as she could. However, in the case of HIV/AIDS, the vehemence of her condemnation and that of others associated with the Pentecostal Church stood in the way of community mobilization for prevention, if not in the way of individual care for people with AIDS.

A second perspective on HIV prevention began to emerge in Yabucoa between 1989 and 1991. A small group of college-educated people began to shift from categorical rejection of stigmatized groups to an understanding of the need for preventive measures. Some women recognized the need to develop grass roots approaches to prevention. In spite of continued discussions over three visits, no community groups emerged. Among the group's members, I talked most extensively with Dolores, a college-educated woman born in Yabucoa, with four teenage children. We discussed the necessity for women to work on prevention for themselves, and I asked Dolores to gather a few women to meet as a group so that we might begin to raise community prevention issues. Although Dolores appeared concerned, no group ever emerged and it was not clear that such an approach could be effective at that point.

In 1991, Dolores' husband, Carlos, a high-school teacher who was also a union leader and a local political figure, was told that 16 high-school students in Yabucoa were infected with HIV. Up to this point, Carlos had not focused on HIV as a community issue. He had, from the beginning, adopted a less condemnatory stance toward HIV than that espoused by the Pentecostal Church. He was a member of the Catholic Church with some participation in the local congregation and a belief in egalitarian reforms. He was shocked by the report of the 16 students with HIV and galvanized into action. Within a week he had

pulled together a small group of community members to discuss HIV prevention with us. Since both John and I had been raising the issues of HIV prevention and grassroots mobilization since 1987, we agreed to help in developing the group. After discussion with Dolores and Carlos, we invited two community organizers active in HIV work from San Juan to talk with the group.

At the meeting, only three husband/wife couples, all with teenage children, were present. The discussion turned immediately to how to address the problem of educating youth in the community about HIV. The unspoken premise of the entire discussion was that only teenagers were at risk; that stable couples should not be a focus of concern or education; that the way to reach community members was through concern over their children. Many interventions, such as a broad-based community event, the showing of videos, and the distribution of questionnaires about knowledge of HIV in the community, were discussed. Both men and women in the group demonstrated a high level of energy and commitment to the issues. However, in this setting at least, only high-school students were viewed as possibly engaging in risky behaviors.

Observation of the formation of this group might be fruitfully compared to an earlier analysis of gender and political mobilization in Yabucoa (Susser, 1985, 1991). In 1982, we conducted research concerning the emergence of the grassroots environmental movement opposed to pollution caused by a Union Carbide plant in Yabucoa. The dynamics of the movement were as follows. Women documented the supposed health effects of pollution, noting skin rashes among infants who crawled on dusty floors and increased asthma attacks in children. In response to the women's concern, men in the barrio, and later at the plant, organized to protest the pollution. Although women were active in generating and then supportive of the movement, the men took the public leadership roles in these activities³ for over 7 years. This should not be taken to indicate the women did nothing. One woman in particular, the wife of the leader of the movement, exercised strong influence not only over the women involved with the movement but also over the young men. But she did this from her kitchen. Only in the last few years, with the departure of Union Carbide

and waning interest in the protest, has a woman led what is left of this movement.

The activities initiated around HIV prevention may have been following a similar path with respect to gender roles. While some were aware of the problems and concerned with prevention since 1989, it was only in 1991, when a man who was a leading political activist espoused the cause, that concrete actions were taken. When a group did emerge it was clearly based on cooperation between men and women in a similar way to the Union Carbide protest. It was clear that the men were moving toward taking public roles and the women's discussion indicated that they were preparing a supportive "home-bound" participation. In neither instance did women and men form opposing or separate groups in recognition of gender inequality. On the contrary, in both instances the health issue was seen as a threat to the community and to families. It was perceived to be an issue which should be confronted by men and women working together, with men taking the public leadership roles.

The formation of this sort of group, consisting of married couples, specifically to lead a community grassroots effort in HIV prevention may, in fact, have limited the topics which could be discussed. The concentration on the threat of infection to teenagers was safe and embarrassed no one. Not only migration for work but other aspects of life in the barrio created the context for a risk of HIV infection among married as well as single adults. However, the negotiation of safe sex among couples, adult drug use, or even the question of sex between men was never raised by this initial group—all of these were topics tabooed for discussion between men and women. It remains to be seen whether other grassroots groups may approach HIV prevention from a broader perspective. However, this early group opened the way for community cooperation among both men and women with respect to HIV/AIDS caring and prevention.

To explain the process of organization found in the protest against Union Carbide and mirrored again in the formation of a group to prevent HIV infection, two aspects of life in Yabucoa will be explored. The first concerns the centrality of women in addressing household health. The second involves the differential socialization of men and women and its implications for group mobilization. To restate these questions slightly differently, the first question concerns why women were the first to understand and worry about the general risk of HIV infection in the community. The second question explains why women alone could not organize a group to discuss the problems.

³The way in which not only men took the public lead and the way in which they selected a leader is suggestive of *caudillismo*—which refers to the institutionalized following of a charismatic leader. Leadership is on the basis of admirable personal qualities and, in politics, may have little to do with actual policies.

They were not able publicly to inform residents of realistic household concerns in opposition to general attitudes of categorically stigmatizing risk groups.

On the basis of previous research conducted with the environmental movement and our observation of changing women's roles over the decade of the 1980s and their emergence to leadership positions in the environmental movement (Susser, 1991), I had come to the conclusion that women would be central to organizing HIV prevention in Yabucoa. I mistakenly believed that a group formed by women would emerge on the basis of their understanding of the importance of HIV infection and the need to empower women to negotiate for safe sex.

It was only after 3 years of intermittent discussion and observation that I finally came to realize that effective organization in Yabucoa involves both men and women. Despite dramatic changes in the economic position of young women, their control over reproduction, and their access to education, effective mobilization at the grassroots level followed the same gender patterns as the mobilization efforts of the late 1970s and early 1980s. I realized that my own "feminist" analysis of political protest and the needs for gender negotiation in HIV prevention had misled me. In Yabucoa, organization was founded on cooperation between men and women, based on a history of gender differentials in socialization, spatial mobility, and access to networks. For the same reasons, however, it was still limited to a discussion of "others," i.e., teenagers, rather than the more problematic negotiations between men and women themselves. Nevertheless, cooperation between men and women was the basis upon which mobilization against stigmatizing stereotypes of people with HIV/AIDS and the foundations for effective community education and supportive care were built.

WOMEN AND HIV PREVENTION IN SOUTH AFRICA

Next, I discuss briefly two contrasting research findings in South Africa concerning gender issues, sexuality, and the prevention of HIV/AIDS. [This research is described in greater detail by Susser and Stein (2000)]. In 1992, I worked along with Dr. Zena Stein and a South African research team—Quarraisha Karim, Eleanor Preston-Whyte, and Dr. Nkosasana Zuma (a member of the national women's executive board of the African National Congress, ANC, later Minister of Health and currently Secretary of State for the new South African government)—in two areas in

Natal. The first area was a village about 70 mi outside Durban which was part of the area designated at that time under control of the Zulu king (KwaZulu). The chief in control of this village was also a member of the ANC. The second area was an informal settlement on the outskirts of Durban. The settlement has existed only since the pass laws which restricted freedom of movement for Africans were abolished. It was estimated that 1 million people lived in such informal settlements outside Durban at the time of the research. Access to both areas was facilitated by connections with the ANC.

The Rural Village

The village was scattered over a series of hills, a 3-hr commute by bus from Durban. Both men and women went to town for work. However, transportation was expensive and difficult and the common pattern was for men to go to town for the week and return on weekends. Most women participated in a communal gardening project 3 days a week when the irrigation was turned on. Although women earned money by selling fruit, vegetables, and old clothes, and through child care and domestic work, many relied on contributions from men (Karim and Morar, 1993). At the time when the initial fieldwork was conducted, laundry and personal washing were done in the river at the bottom of a hot dusty hill upon which the mud and ashbrick homes were built and drinking water was carried up by women and children from the same source. Over 1991 to 1992, a public works project was instituted which introduced electricity and running water to the village.

Residents of the village were represented at civic council meetings. All members of the tribal court were men, and these are many of the same men who represent the village in ANC regional meetings. Although there were 120 organizations among the approximately 10,000 residents, women did not often speak publicly. In 1991, when the women's branch of the ANC tried to recruit women ANC members to run for office in the village, many women were reluctant to accept such positions and none stood for election.

Through the questionnaires and in public discussions which I observed outside the one clinic, it became clear that AIDS was sometimes associated with witchcraft and attributed to a disease a man contracts if he sleeps with another man's partner. In addition, at the meetings outside the clinic, women scarcely spoke, and the few men on the periphery of the group of women actually attending the clinic were much more

vocal than the women themselves. Field researchers reported that women were not expected to speak up in front of men in this rural community which was at that time under the control of the Zulu king and hereditary chiefdoms.

We did a survey of 200 households in the village. The women did not know how to identify sexually transmitted diseases or any names of such diseases. The men were very well informed (Karim and Morar, 1993). It appeared very difficult in this setting to involve women in meetings or for women to negotiate safe sex with men or even to talk about their own health issues.

The Informal Settlement

In 1992, the informal settlement north of Durban consisted of about 5000 shacks inhabited by an estimated 30,000 people. No sanitation, running water, public services such as garbage collection, roads, or lighting existed in the area. People walked and drove along narrow and precipitous winding dusty footpaths. As a result of the women's community organization's efforts, seven faucets had been built in scattered locations around the settlement. People could collect water for use in their households from these faucets. Children had to travel to neighboring municipalities to attend school and educational levels are low. Most residents spoke Zulu and most spoke some English. Among this large population of disenfranchised, a vibrant economy existed in the informal sector. Bricks were made in the settlement and houses were built. Women made candles, baskets, and clothes and sold them locally or in the markets in Durban. By 1995, under the postapartheid regime, water and electricity were introduced in this settlement and schools and clinics were made available to the population.

However, in 1992, although the informal settlements lacked electricity, the nearby townships served as important sources of information and television. People in the area were tied into U.S. media through such networks as CNN. Thus, in spite of apparent isolation from world news, one group of adolescents and young people with whom I spoke was familiar with the section of Manhattan where I was living: Washington Heights. They asked me about the riots that were occurring there at the time I was talking with them. In Southern Africa, the U.S. and local media provided crucial information as well as framing issues that people on the local level had to address. My later research in Namibia (with Richard Lee, Pombili Inpinge, and Karen Nashua) also confirmed the impor-

tance of the local radio in informing care providers about HIV/AIDS. Rural Namibian women told us that they learned only from the local radio station that HIV/AIDS could be transmitted from the bodily fluids of the people with AIDS for whom they were caring. As a result of local radio, cable communications, and television, many people in Southern Africa were aware of HIV/AIDS and other issues. Like the residents of Yabucoa, they received international media interpretations of a wide variety of topics.

The researchers made contact with the community of the informal settlement in Durban through a sewing cooperative organized by and for local women. As noted above, this cooperative had also worked to bring water to the community. They had begun to weave baskets for sale and were concerned with developing ways to tie into the informal economy. In terms of discussion of sexuality and HIV infection, the women in this cooperative presented a contrasting picture to the women in the rural community.

In 1992, I observed a meeting in which Dr. Nkosasana Zuma came with other members of the research team to discuss HIV with the women. About 50 women and 3 or 4 men attended the event. Even before the meeting started the room was in an uproar as the local woman community organizer brought in copies of the ANC constitution translated into Zulu. Dr. Zuma spoke to the group in Zulu about the importance of HIV and the need for women to protect themselves. Next a representative from the U.S. foundation which funded the research project spoke briefly in English and then American researchers mentioned the development of the woman's condom.

At this meeting, the women were very outspoken in front of the men. Women in the audience stood up and argued with the men in the back of the room who claimed that the young girls hanging around the harbor were "asking for it [sex]." Women talked in public about the lack of economic alternatives which lead women to sell sex. One woman explained that when a person has spent the entire day in Durban unsuccessfully looking for work and returns exhausted to the settlement with no money, she might exchange sex for 10 Rand to buy sugar for their children that night. The women did not see these situations as being restricted to a group of "sex workers" or "prostitutes" but rather talked about the sale of sex as one last option available to women whose families were in desperate need of money and food. Similar findings in urban settings in South Africa have led researchers to talk of "survival sex" (Preston-Whyte *et al.*, 2000). The women were explicit about economic

needs and said that the best method they could imagine for preventing HIV in the settlement was to provide work for women. They requested that the project consider funding a candle making factory. They pointed out that since there was no electricity in the settlement, this would be an extremely profitable concern in the informal economy. In addition, when the women were asked if they would use the female condom, they became enthusiastic. They said that they would definitely use something like that, over which a woman had control. They asked when the woman's condom might be available and requested that the U.S. researchers provide them samples as soon as possible. Thus, only a few miles removed from their previous existence, women's experiences and their perspectives on sexuality—as well as their willingness to speak in public—dramatically altered.

I must add here that, when Eleanor Preston-Whyte and I returned to this informal settlement and talked with some of the same women in 1995, they wrote a letter and signed a petition to the Minister of Health requesting that the woman's condom be made available to them. When a man who was an ANC official walked in on this discussion, which was held in the newly constructed community center, he drew a male condom out of his wallet, to demonstrate his approval, and then said that he would prefer that the woman had her own access to a woman's condom in her own home. Similarly, in research conducted by Pombili Ipinge in Namibia in 1998/1999, men said that they would prefer that women used a woman's condom and could then cooperate in the responsibility for safer sex (Ipinge, 2000).

MEN, WOMEN, AND THE MEDIA PRESENTATION OF HIV/AIDS IN THE UNITED STATES

Now I briefly review a third case, in the United States. In Puerto Rico and Southern Africa views of femininity and sexuality were heavily influenced by local history and experience, but also by the global information flow, mostly from the United States to the periphery. In Puerto Rico the television interpretations of HIV/AIDS were derived directly from the United States. In the South African townships, people followed U.S. events and media interpretations on cable television, specifically CNN. It is only appropriate, therefore, to examine both the local experience and the media interpretations in the United States and view these in terms of global interactions.

Since 1987, I have been working with poor women and men in the homeless shelters and hotels of New York City around HIV prevention (Christiano and Susser, 1989; Susser and Gonzalez, 1992; Susser, 1998). Interviews and group discussions revealed that a major concern among the women was their lack of alternatives in negotiations with men. As the woman's condom became a reality, I talked with counselors and case workers in the shelters about the possibility of introducing it to women in residence. Uniformly, in three shelter contexts, I was informed that women would not be interested, and would not use the woman's condom. Counselors stated that the women they worked with were not willing to use diaphragms or anything that required manual insertion. They argued that it was culturally insensitive to expect such women to try a woman's condom. After some discussion, I was invited to meet with women in two shelter settings. In both settings I attended and observed women's groups convened to discuss women's health. In both settings the audience response was positive; women asked for samples of the woman's condom and reiterated the need for protection that women control.

At this time, some students at Hunter College, a public university in New York City, tried the woman's condom and Erica Gollub, a researcher and woman's health activist, distributed them to patients and staff at a clinic at a municipal hospital in New York City. In each case women were willing to try the device with their male partners and comment on their experiences. Most comments were positive. A staff member from Harlem Hospital and two Hunter students remarked that they and their partners preferred the woman's condom to the regular male condom. Several of the Hunter students came to my office asking for samples, as they and their boyfriends preferred to use it and the device was not yet on the market. In general, although women said that the woman's condom was not easy to use the first time, most users found it comfortable and effective.

In contrast to the positive response of the initial users, who were poor women and students, the initial media response to the woman's condom was universally negative. *The Village Voice*, *The New York Times*, and *The Daily News* all published funny condemnations of the new device. The major concern of these magazine and newspaper articles was the way the device looked. These concerns were hardly mentioned by students, women in the shelter, or women at Harlem Hospital.

The New York Times article stated, "The external edge of the sheath . . . dangles from the vagina,

an unexpected bit of polyurethane in an oval shape reminiscent of the gaping mouth in that Edvard Munch painting "The Scream" (Kaye, 1993). *The Village Voice* headed their remarks "Reality Check: Condom Con Job?" (Houppert, 1992) and began with, "Some of us are having trouble visualizing. Smaller than a breadbox, bigger than a Trojan?" *The Daily News* article concluded with the following statement: "It is horrifically ugly. It costs too much. And it is cumbersome to use. I tried to test it and couldn't figure it out" (Female Condom, 1993).

In response to the negative outpourings in the media, Dr. Erica Gollub worked with Dr. Zena Stein, myself, and the manufacturers of the female condom (Wisconsin Pharmacal Inc.) to present a more balanced view. We hosted a press conference at Hunter College, and following that, a Hunter student was invited to appear on CNN, describing her use of the female condom and her own and her partner's reactions. This was particularly interesting in light of the fact that the men and women of the Durban township were in this way once again brought directly in touch with events in New York City. Within 6 months of these efforts, Dr. Gollub was quoted in *The New York Times* and by the Associated Press in various local newspapers with favorable comments concerning the female condom (Navarro, 1993). The battle is not yet won, as the 1995 ridicule in *The Ladies Home Journal* indicates. *The Ladies Home Journal*, following an autobiographical approach to journalism also apparent in the earlier articles in the newspapers quoted above, complained, in a piece entitled "I Tried the Female Condom" (Mettenburg, 1995), that the device was "unwieldy, ugly, uncomfortable and not conducive to romance." Nevertheless, since December 1993, news coverage of the woman's condom has contained somewhat less ridicule although few positive statements. In *Vogue* a report entitled "Brave New Contraceptives" mentioned "the revolutionary female condom" (Pike, 1994). *Glamour* conceded that the female condom had received "both positive and negative reviews" but that "nevertheless, women who are concerned about AIDS and pregnancy have a new option" (Raeburn, 1995). However, it took a concerted information campaign, including the participation of feminist organizations around the United States, to reinsert the needs of poor women and women at risk for HIV into the news coverage of the new device (Gollub, 2000), and while ridicule is less prevalent, silence about the new device is still a problem.

As the cases represented here demonstrate, the U.S. news media, including CNN and other cable net-

works, are important in phrasing issues of gender, sexuality, and HIV transmission in both Puerto Rico and South Africa as well as in the United States. For this reason, the controversy over the woman's condom is more than a local issue. Women in the South African settlements and at the Central Harlem clinic, and even Hunter students, were not overly concerned with appearances. *The Village Voice*, *The New York Times*, and *The Daily News* all focused on the appearance of a device that they were not accustomed to seeing. This may reflect U.S. views of femininity and sexuality. Indeed an in-depth study of the fear, ridicule, and stereotyping of femininity contained in these articles would be particularly revealing. In addition, even care providers for poor women were unwilling to introduce the woman's condom into counseling sessions, presenting cultural sensitivity as their major concern. However, poor women were willing and eager to use the device [as other research has since documented (Mane and Aggleton, 2000; Elias *et al.*, 1996; Susser and Stein, 2000)]. The mobilization of women's groups around this issue, including panel discussions and other forums, has been important in changing the representation of the woman's condom as an option in the American print and television media.

CONCLUSIONS

The cases explored here suggest a linkage between women's involvement in political mobilization and their ability to consider, if not necessarily implement, negotiations for safer sex. In the cases presented here, we find changing cultural attitudes as well as continuities, and it is important to examine where the change occurs.

In Yabucoa, Puerto Rico, women were informed about and concerned with health issues. They even instigated political action. However, in spite of major changes which had occurred in women's employment and reproductive choices and their knowledge of the growing rate of heterosexual transmission of HIV/AIDS, mobilization around HIV/AIDS care and prevention focused first on "others" and did not become a reality until men took the public role. However, men and women cooperated effectively and opened the way for the provision of care and community education. In Puerto Rico as in South Africa, the media played a central role in education as well as in framing the issues addressed. In some instances, in stereotyping people with AIDS, the media distanced the issue and possibly contributed to people's sense of invulnerability and lack of attention to

HIV/AIDS as well as to the stigmatization of minority groups.

In South Africa, in the rural village, women were not active in political mobilization. They refused to talk in front of men and were poorly informed about sexually transmitted diseases. The men were active in both tribal politics and the ANC and well informed about sexually transmitted diseases. It is possible that women's reticence in this context was related more to the violence and political turmoil which characterized this region during the 1990s than to traditional patterns of gender hierarchy, and this too demands further examination. Similarly, research among women sex workers near the gold mines of South Africa suggests that even women earning money may lack the power to enforce safe sex practices in contexts of extreme male violence and conflict (Campbell, 2000).

In the informal settlement close to Durban, women were politically mobilized around the formation of a new African state, the ANC constitution, and a sewing cooperative. They were informed about global issues and interested in the changes in the United States and Africa. The women were explicit about sex work and spoke in front of men. Their active political involvement seemed to contribute to their ability to address HIV/AIDS in an open and direct way. They also asked for the woman's condom or barrier methods for women as soon as possible, and men also said that they would find them useful. Our recent research in Namibia has found that many men would prefer women to take responsibility for safer sex and use a woman's condom (Ipinge, 2000; Lee *et al.*, 2000; Susser *et al.*, 2000).

In summary, these cases document continuing struggles over the construction of gender and sexuality. For both men and women, views of appropriate sexual behavior are emerging, not static, as people find themselves confronted with neighbors with AIDS, possibly caring for relatives with AIDS, and striving to protect themselves, their partners, their children, and their communities from HIV/AIDS infection.

Media representations on a global level combine with specific experiences on the local level to shape views of sexuality and concomitantly views of HIV/AIDS. Our data suggest that media presentations provided people with life-saving information about HIV/AIDS care and prevention but also, in some cases, contributed to stereotypical ideas of people at risk and undermined the use of possible available strategies, such as the woman's condom. Discussions

of the woman's condom that stereotype women's views of sexuality, gender negotiations, and willingness to change fail to take note of the clear examples of agency, political mobilization, and people's ability to deal with sexual issues. They obstruct the development of focused, cost-effective, programs for HIV/AIDS care and prevention [for an analysis of the cost-effectiveness of the woman's condom, see Marseille *et al.*, (2000)].

With respect to HIV/AIDS, as in most issues concerned with women's sexuality and reproduction, there is a fine line between cultural sensitivity and static stereotypes. As is evident from research in Puerto Rico, South Africa, and New York City, approaches that characterize women's views of sexuality as limited and unchangeable miss the redefinitions which people themselves are forging—in both the periphery and the center of global capitalism—when confronted with the challenge of HIV/AIDS. Women are frequently at the center of caring for people with AIDS as well as central to local education and possibilities for political mobilization. They are now among the most vulnerable to HIV/AIDS infection and often the most ready to act to protect themselves, their families, and their neighbors. Especially in Southern Africa, women are struggling to access information and cope with the devastation of their communities.

Although in Africa today and possibly in parts of Asia too, the epidemic has spread far beyond target groups of sex workers and truck drivers, to reach many married women, many men are still unwilling to use the male condom with their wives and long-term partners. For these reasons, we need to build support both in the media and among organizations on the international, national, and community levels for the ongoing efforts of local men and women to negotiate sexual boundaries through the use of the two available methods, the man's and woman's condoms. In addition to the need for appropriate and affordable treatment, barrier methods must be made available to women to assist most effectively both men and women in developing strategies for HIV/AIDS care and prevention.

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