THE UNIVERSITY OF THE WEST INDIES
ST. AUGUSTINE CAMPUS

CENTRE FOR GENDER AND DEVELOPMENT STUDIES

SYMPOSIUM

GENDER SEXUALITYAND THE IMPLICATIONS FOR SUBSTANCE USE AND HIV/AIDS

11-13, MARCH 2004
LRC – ST. AUGUSTINE CAMPUS

ABSTRACTS

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GENDER EXPECTATIONS AND SEXUAL EMPOWERMENT WITHIN SEXUAL RELATIONSHIPS

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Gender, Racial, and Ethnic Differences in Gender Scripts Expressed Within Sexual Interactions.

by
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Introduction

Recent figures show that heterosexual intercourse is fast becoming the primary mode of transmission worldwide, and accounts for over 90% of the HIV infections in adolescent and adult females (NIAID, 2003). Researchers have highlighted the importance of gender as an organizing principle in understanding the sources of heterosexual risk (Gupta, 2000; Ehrhardt & Exner, 1991). Gender roles and related power dynamics have been identified as mechanisms through which gender has an impact on HIV risk. These roles are clearly delineated in heterosexual relationships, and represent expected masculine and feminine personality traits, attitudes and dating behavior (Lucke, 1998). Understanding the interactive components that underlie the decision making process in heterosexual relationships is an important step in exploring HIV issues as they relate to gender. Script theory (Gagnon, 1990) provides a framework for understanding how gender interactions are associated with HIV risk behavior. Gender scripts incorporate the concept of gender roles, while accounting for the interactive and sequential nature of interactions in relationships. These scripts are influenced by our construction of gender, sexuality, and relationships. As such, they reflect traditional gender roles that suggest that in heterosexual relationships men initiate sexual interactions and women, in turn, respond to men's sexual interest (O'Sullivan & Byers, 1992). Adherence to these roles is expected to differ across cultures in line with variations in the sociocultural emphasis on these traditional roles. This study explored ethnic and gender differences in gender scripts expressed within sexual interaction in a sample of 48 undergraduates, including West Indian-born Americans (n=8), US-born Black Americans (n=14),

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US-born White Americans (n=15), and foreign-born White Americans (n=10)) from Brooklyn, New York. (The term ethnicity, as used here, refers to the different cultural groups (based on region of birth), while race refers to classification based on skin color.)

In the US, there has been an increase in the number of women who have become infected through heterosexual sex, and African-American and Latina women are at greatest risk. New York City (NYC) leads the nation in both total number and rate of AIDS cases. Central Brooklyn has some of the highest cumulative AIDS rates in NYC (NYCDOH AIDS Surveillance Report, 2002) and is also home to a large number of West Indian immigrants, who are increasingly being affected by the AIDS epidemic. Most studies that include Black populations do not account for the ethnic diversity within this community in the United States. The paucity of research on this population contributes to a limited understanding of the unique challenges faced by Caribbean-born youth and limits our ability to develop effective interventions for them.

Method

Participants in this study were 18-24 years of age college students who reported being sexually active in the previous month in a primary, steady heterosexual relationship. Participants were trained to maintain prospective daily diaries of their sexual interactions over a 3-week period. Items assessed in this study included number of lifetime sexual partners, monthly income, number of sexual encounters (penile-vaginal, anal intercourse), which partner initiated sexual activity, pressure or coercion to engage in sexual activity, and control of the pace of the sexual activity. At the end of the 3-week period participants completed in-depth interviews about HIV risk-related experiences during this time.

Results

African American young men reported having more sex partners than African American women. Although not statistically significant, among women, Caribbean- born participants reported the most lifetime sex partners: Caribbean women's mean number of partners (M =6.8; SD=5.3) was twice that of African American women (M=3.1; SD=2.4). When the number of sexual occasions over the course of the study was assessed, White women (American and foreign born) reported more sexual intercourse than all other participants. Reports of who initiated sexual

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activity revealed that men were more likely to report that they were initiators and women also were more likely to report that their male partner initiated sexual activity. Women were also more likely to report that their partner was in control of the pace of the sexual encounter. There were no racial or ethnic differences in reports of who initiated sexual activity, or which partner controlled the pace of the encounter.

Very few participants reported experiencing pressure to engage in sexual encounters. However, there were striking gender and racial differences in the instances reported. Of the instances reported, 77% were from Black (Caribbean and American-born) participants, and 70% of these respondents were men. Similarly, 83% of the participants who reported they (tried to) exert some pressure on their partner to engage in a sexual encounter were Black Caribbean and American participants. Further, Black (Caribbean and American) women reported 73% of these instances.

Discussion

The current findings reflect some differences that conform to traditional gender scripts, while some results suggest deviations from traditional expectations. It is important to note at the outset that these findings are preliminary and based on small samples. Despite this limitation, these findings are important as they identify areas for further research on the intersection of gender, ethnicity, race and HIV risk. Qualitative data from interviews that were conducted with these participants to explore further the interactions between gender and ethnicity as they relate to HIV risk behaviors will be discussed in the findings we present. Illustrative quotes from these interviews will allow for additional insight into the interpersonal dynamics in sexual interactions in heterosexual couples.

These data suggest that departures from traditional gender scripts vary based on gender and on racial and ethnic background. It appears that whereas Caribbean women report a similar number of lifetime partners as White American women, White women report more frequent sexual intercourse in their intimate relationships. This difference might reflect African American and Caribbean American participants' ambivalence to share 'personal' information. Also, considering that these participants were all college students at a commuter campus, many of them might still live at home with family and the frequency of sexual activity might reflect opportunity to have time alone.

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In accordance with traditional gender scripts, men in this study were the primary initiators of sexual activity and were seen as being in control of these encounters. Further, African American men reported more lifetime sex partners than African American women. Surprisingly, however, men reported feeling pressure to engage in sexual encounters more frequently than did women, and women reported exerting some type of pressure to get their partner to engage in sexual activity more frequently than men. These findings deviate from traditional gender scripts. Illustrative quotes qualitative data will further elucidate the type of pressure used (control, power, verbal, physical, threat).

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Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium

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Discourse, HIV/AIDS, and the Social Construction of Black Sexuality

by

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This paper will compare recent media discourse around HIV/AIDS in Black communities in the US and the Caribbean to consider its implications for the social construction of sexuality. It argues that in the US case, Black sexuality is framed in one of three ways in the wake of the increased public attention paid to the disproportionately high numbers of African-American women currently infected with HIV/AIDS: victimized sexuality, predatory sexuality, and deviant sexuality. Undergirding these categories is a dichotomy of "deserving" and "undeserving" populations that has historically been attached in similar ways to the poor. An "undeserved" location within a particular social status implies that one's behavior cannot be blamed for one's predicament, while a "deserving" location within that same social status implies that one actively and knowingly participated in behaviors that are considered harmful and in opposition to the dominant culture. This framework, frequently implicitly invoked to differentiate low-income individuals to determine the worthiness of their claims to state and charitable resources, has moved into the realm of HIV/AIDS and is very much tied to questions of sexuality and gender politics, particularly in African-American communities. While the disease has affected traditionally marginalized segments of Black communities for decades – such as Black gay men, sex workers, and intravenous drug users – the increase among African-American women has encouraged some to now label the disease "an epidemic sweeping the black community."

Currently, AIDS is foregrounded in discourse on and in African-American communities, but in very particular ways. At the heart of present discourse about the increasing number of Black women currently infected is a preoccupation with their relationships to Black men who knowingly and

unknowingly transmit the virus through multiple heterosexual partners or through a combination of heterosexual and same-sex encounters. A discourse of victimized sexuality is emerging that juxtaposes Black women, who are constructed as a relevant constituency within the Black community, against some of the very Black men who remain marginalized within it due to their sexual behaviors. Black women therefore, become increasingly portrayed as potential and actual victims of Black male sexuality. Male sexuality is constructed as either predatory, as in descriptions of men in heterosexual relationships who have sex with men (i.e., "brothers on the down low") or heterosexual men with multiple partners, or as deviant, as in descriptions of black gay men. Gay men remain largely marginalized in the discourse, serving merely as "lures" of men who have sex with other men and subsequently "jeopardizing the health of black women," rather than foregrounded to consider their struggles and concerns around the issue of HIV/AIDS. Therefore, the discourse around anti-HIV/AIDS prevention efforts increasingly focuses on potential ways for women to place black men under surveillance in order to reveal their sexual proclivities, rather than furthering education programs about the prevention and treatment of HIV/AIDS, responding to the homophobia within the black community that makes sexual nondisclosure an attractive and in some cases necessary option, and the sociopolitical trends such as black mass incarceration, poverty, and public health disparities that are intricately linked to the disease. Preliminary comparative analysis will be presented to consider whether similar trends can be found in media discourse about the spread of HIV/AIDS in Caribbean countries.

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Sexual Gender Roles and Pregnancy Wantedness: Implications for Pregnant Women's Sexual Self-Efficacy

by

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Culturally sanctioned sexual gender roles are instrumental in defining human sexuality for both men and women. The social construction of masculinity and femininity shapes one's vulnerability to sexual expectations. Identifiable sexual expectations deemed feminine such as demureness, passivity and self-sacrificing may increase women's vulnerability to engage in sexual risk behaviors. An examination of the relationship between gender roles and sexuality, including precautionary sexual self-efficacy is necessary to determine implications for HIV risk. Specific study aims include: (1) to identify adopted "instrumental" non-traditional feminine gender roles versus "expressive" traditional feminine gender roles among pregnant women attending antenatal clinics in two districts in Trinidad, (2) to identify the extent that gender roles influence precautionary sexual self-efficacy (i.e. frequency of unprotected intercourse, number of multiple sexual partners) and (3) to test the applicability of a Behavioral-Attributable Risk Model (B-ARM) for understanding sexual behaviors by assessing how the association of sexual gender roles predict sexuality, including precautionary sexual self-efficacy among pregnant women attending antenatal clinics.

Lisa Jones

The B-ARM was developed to determine the relevance to pregnant women's sexual risk behaviors, including precautionary sexual self-efficacy within the context of two gender-related psychosocial variables in Trinidad. The districts of St. George West and St. George Central were examined in regard to gender role orientation (instrumental gender roles/expressive gender roles) and pregnancy intention as predictors. Based on previous work on Black and Latina Women's HIV/AIDS protective behaviors, it is expected that gender role orientation and pregnancy wantedness may be significant predictors of sexual self-efficacy. Therefore, this research tests the hypothesis that pregnant women who adopt expressive gender roles would engage in less precautionary sexual self-efficacy than pregnant women who adopt instrumental gender roles that lead to greater precautionary sexual self-efficacy.

A cross-sectional behavioral study was conducted among 1084 pregnant adolescent and adult women at various stages of pregnancy aged 15 and older (M= 17.3 yrs, SD= 2.7yrs) who attended one of 18 antenatal clinics in St. George West and St. George Central. The sample of pregnant women recruited was given structured interviewer-administered HIV risk questionnaires. Preliminary data of the sampled study subjects shows that the most prominent group of pregnant women was Afro-Trinidadian (n= 609, 56.2%), in common law relationships (n= 272, 39.0%), unemployed (n= 393, 56.3%); in the third trimester (n= 587, 62.31%) and described their current pregnancy as unintended (n= 447, 41.2%). More rigorous research on the relationship between gender and sexuality commands further scientific inquiry to determine the effects of sexual self-efficacy.

Abstract
Gender, Sexuality and the Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Inscribing HIV/AIDS as Contemporary Plague: Literary Representations of the Impact of AIDS on Caribbean Social Relations

by
Paula Morgan

The terms "plague" has traditionally been applied to any evil and calamity which threaten the social order, as well as to devastating diseases which threaten to decimate populations. HIV/AIDS which is associated with fatality, inexorability and inescapability, metaphorically and epidemically fits the bill with exactitude. From a developed world perspective, AIDS has been represented as a foreign "tropical disease" which originated in Africa and spread to the New World via Haiti. Hence it feeds into stereotypical and racist stereotypes replete with notions of insatiable, polluted, black sexuality and bestiality. (Sontag 1989) The Caribbean sensibility shares with the developed world, associations of HIV/AIDS with divine judgment intended to identify or expose transgressive populations.

This paper explores literary representations of the impact of HIV/AIDS on Caribbean social relations as portrayed in Jamaica Kincaid's *My Brother* and Patricia Powell's *A Small Gathering of Bones*. It explores uniquely Caribbean metaphorical associations with AIDS and their interplay with global representational linkages. It interrogates constructions of masculinity and femininity which place individuals at risk for HIV/AIDS; explores the social dynamic which facilitates the spread of the virus, acceptance/rejection of the HIV/AIDS sufferer within traditionally close knit family groups, and the interactions between families, caregivers and AIDS patients. It also examines a transnational family's attempt to manage an AIDS sufferer, as a microcosm of first and third world attempts to ambivalently join hands over a virulent, border crossing, decimating virus, which remains stubbornly resistant to attempts at containment.

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BRIEF PROFILE

Paula Morgan is a lecturer in the Department of Liberal Arts, The University of the West Indies, St Augustine, and an Associate Staff Member of The Centre for Gender and Development Studies. Dr Morgan's primary focus of research and publication is women's literature of the Caribbean and of the African Diaspora. She has produced several distance courses and is currently doing research on the Language and Literature of violence.

GENDER ROLES AND YOUTH SEXUALITIES

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Gender and Adolescent Sexuality in the Caribbean:The Case of Jamaica

by
Michelle V. Davis

The Caribbean Epidemiology Centre reports that persons 14-25 years old are two to three times more likely to be infected with HIV than any other age group in the Caribbean, especially among young women. Adolescents tend to have high awareness of both HIV/AIDS and prevention methods but experience poor translation of this knowledge into practice. Why this is so has not been adequately analyzed using a gender lens. Female adolescents are at a further disadvantage than males since they are often involved with older men with whom they cannot negotiate safer sex practices due to power differences inherent in these relationships. In Jamaica, girls aged 10-14 and 15-19 had two and three times respectively higher risk of HIV infection than boys. This can be attributed to the practice of girls having unprotected sex with older and HIV-positive men and the high incidence of rape and sexual abuse of girls, which are gendered issues.

Using Jamaica as a case study, I will revisit the notion of adolescents as a group at high-risk for HIV infection in the Caribbean. I intend to examine adolescent sexuality to show what messages young persons receive about sexual identity and how young women and men negotiate this in Caribbean societies by situating this within a gender analysis. Also, I will review adolescent sexual and reproductive health and rights to discern what action has been taken to ensure such in the region. I seek to make recommendations that will inform not only policies and programs in the Caribbean but also critical thinking and, in particular, feminist theorizing and praxis on gender and adolescent sexuality.

Michelle Davis

Biographical Information

Michelle Davis worked at the Centre for Gender and Development Studies, Regional Coordinating Unit at the University of the West Indies, Mona as a Research Assistant from 2001 to 2003. She presently teaches part-time at the University of Toronto.

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
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Impact of gender roles on adolescent sexual decision making: Implications for HIV /AIDS prevention programs

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Understanding the sexual decision making process in adolescents is essential to develop effective prevention strategies. There could well be lifelong consequences with the decisions made by the adolescent. These could reflect in his /her physical health, mental health, career choices, social status of the adolescent. In the research world, there is a lot of information on many issues around adolescence including pregnancy, sexually transmitted diseases, and AIDS, however, there is very little understanding of the factors influencing sexual health decision making. The main aim of this study was to understand the factors that influence this process.

India, second only to South Africa in the number of HIV cases in a single country, had an estimated total of 4.2.million people living with HIV/AIDS at the end of 2002 (UNAIDS Report 2003). One third of those currently infected with HIV / AIDS globally are in the age group of 15 –24 years (UN AIDS Report 2001). The main route of transmission is heterosexual (86 percent). The sexually active age group of 15 – 49 years accounts for 89 percent of the infections.

Adolescents are one of the most vulnerable group to the AIDS epidemic, made more so by the combination of the desire for sexual

experimentation coupled with poor decision making skills and lack of knowledge of consequences of risk behaviours. Adolescents are a diverse group and their diversity must be considered when planning programs. The present paper describes a study that was undertaken in five night schools in the city of Mumbai. The sample of schools was randomly selected to represent a variety of communities and urban settings in Mumbai. A total of 10 discussion groups were held with the adolescents. As relatively little is known about the lifestyles of the night school students, a qualitative focus group discussions approach was selected in order to obtain in depth data keeping in mind the exploratory nature of the study.

A total of forty-eight boys and twelve girls took part in these focus groups. The age range of the boys and girls was between 16 and 19 years. The topics of the discussion groups included: 1) career choices and influences on their decisions 2) role of parents in decision making process; 3) problems faced by youth; 4) factors in sexual decision making; 4) role models; 5) relationship between boyfriends and girlfriends; 6) knowledge of AIDS and other sexually transmitted diseases 7) communications skills and peer pressure 8) role of night schools in their lives.

The study conducted with night school students in Mumbai, showed the prevalence of high-risk behaviours. A conceptual framework was developed based on the results to explain the major influences on the sexual decision making process. Gender issues, culture / traditions and tailoring programs to the setting were the important overarching factors leading to risk reducing or risk enhancing behaviours. Adolescent boys may face pressures related to proving themselves and creating a place for themselves in the community, thus creating peer and societal pressures. The girls on the other hand, may face intensifying restrictions, an example being, limited mobility. In the study, girls admitted agreeing with parents in spite of thinking differently, this may relate to being forced to conform to traditional gender roles.

The critical issues identified have important programmatic implications not only for these students but also for adolescents globally and particularly in the developing world. Gender roles, stereo typing adolescents and cultural traditions promote sex to be a taboo subject and as such not discussed with parents, family and teachers This can lead to lack of information on sexual health matters with adolescents being put in a situation where they are not able to access appropriate and essential information on sexual matters.

In spite of the many challenges, there is no doubt that investing in young persons is the best intervention strategy for the present and the long term. Recognizing the fact that adolescents are a diverse group with even more diverse needs, programmes need to have a multi sectoral approach, taking into consideration the different needs of adolescent girls and boys who are placed in different settings. The conceptual framework developed to explain sexual decision making process can be used to design prevention strategies for adolescents.

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Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
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Gender, power and condom use decision-making among Jamaican adolescents

by
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Assistant Professor

BACKGROUND: Approximately half of all Jamaican females ages 15-19 years and three-quarters of their male counterparts have had sexual relations, with most of these falling in the 18-19 age group. Furthermore, one-third of surveyed female teenagers had a child by age 20 years, which reflects a high rate of possible exposure to STIs and HIV/AIDS.

It is widely acknowledged that males and females behave differently in the sexual realm. Adolescent males initiate sexual activity at a younger age and have more partners than adolescent females (Alan Guttmacher Institute, 1994). Lux & Petosa (1994) propose that traditional sex role stereotypes may be responsible for gender differences in sexual behavior. With regard to condom use, men wear condoms and women, in general, do not. Therefore, women have less control in the use of condoms during sex than men do. Power relations between males and females are therefore integral to the ability of partners to fully participate in the decision to use condoms during sexual intercourse.

The concept of self-efficacy is central to Bandura's social cognitive theory (SCT). In terms of the cognitive mechanisms that people use to initiate a particular behavior, Bandura (1986) argued that beliefs about the outcome of an action impact the motivation to perform an act based on the response consequences. Furthermore, individuals use these outcome expectations to perform acts, and "sustain their efforts" based on their perceived capabilities. In other words, it is the ability to think ahead (*forethought capability*) in a symbolic way (*symbolizing capability*) that keeps one motivated to act in a particular way over a long period of time. He argued that self efficacy is necessary for the maintenance of preventive health behaviors (Bandura, 1977). Self-efficacy affects both the initiation and continuation of a behavior. Self-efficacy as defined in this analysis is not specific to condom use but in a feeling of control

and mastery over one's life and the ability to think ahead. Various measures of self-efficacy have been found to be predictive of condom use (Mahoney et al, 1995; Walter et al., 1993).

RESEARCH QUESTIONS: The questions to be answered in this paper with regard to Jamaican adolescents ages 15-19 years are as follows:

1. What is the relationship between measures of self-efficacy and assertiveness in condom use decision-making?
2. What is the relationship between measures of self-efficacy and resistance to using condoms?
3. What is the relationship between self-efficacy, coercion, resistance to condom use and the decision to use condoms?
4. What is the relationship between self-efficacy, coercion, resistance to condom use and the frequency of condom use?
5. What are the gender differences in questions 1-4 above?

HYPOTHESES:

1. As self-efficacy increases, the likelihood of requesting condom use increases.
2. As self-efficacy increases, the likelihood and frequency of condom use increases.
3. The experience of coercion against condom use decreases the likelihood of condom use.

METHOD: Using data from the 1997 Jamaica Reproductive Health Survey (JRHS), this paper will explore the role of gender, coercion and self-efficacy in the condom use decision-making of adolescents, ages 15-19 years. The JRHS is a cross-sectional, self-report, interviewer-administered survey of a stratified random sample of women of reproductive age (15-49). The sample for this study is the subset of males and females who were 15-19 years old in 1997. This age group is the only one in Jamaica for which the age-specific fertility rate (ASFR) has increased in recent years which implies a higher risk for HIV/AIDS (McFarlane et al., 1999).

VARIABLES: The dependent variables are any use of condoms and frequency of condom use with a steady partner. *Condom use* is a yes/no dichotomous variable that is defined as whether the respondent used condoms at last intercourse. *Frequency of condom use* is on a scale of 0-3: always (3), most of the time (2), sometimes (1), never (0). The independent variables are: 1)

assertiveness (asking a partner to use condoms); 2) *coercion* (use of threats, force or refusal to have sex or wear condoms) against a partner who requested the use of condoms; and, 3) *self-efficacy*. *Self-efficacy* is a summative variable, ranging from 0-5 (strongest perception of self-efficacy), that measures the total number of positive responses to the following; future orientation (whether respondent believed in planning for the future); individual locus of control (whether respondent believed that an individual can make decisions about their own life, whether life is mostly controlled by people with more power); ability to resist peer pressure (whether respondent believed that to get what they want they must conform to the wishes of others), and whether respondent believed that "when you get what you want, it is usually because you worked for it".

ANALYSIS: Data was analyzed using SPSS to conduct multivariate logistic and linear regression. Bivariate Chi-squares and bivariate ANOVA were used to examine gender differences in the categorical and continuous variables. Multiple regression models – logistic and linear – were used to test the relationship between independent and dependent variables. In order to keep as many constructs of the model as possible, a backward stepwise multiple regression model was used. Inclusion criteria was $p < .10$. This step was also useful in suggesting an 'ordering' of the constructs (Lux & Petosa, 1994). Odds ratios describe the relationship between self-efficacy categories, assertiveness and condom use. Odds ratios also describe the effects of gender, age, religiosity, class, culturally-specific beliefs. Beta levels are used to describe the relationship of self-efficacy and assertiveness to the consistency of condom use.

SUMMARY OF FINDINGS: The analysis of this data is ongoing and so only preliminary (descriptive) findings on these variables will be presented here. (This data subset of the 1997 JRHS was created and analyzed for the author's PhD dissertation, which was granted by UC Berkeley in 2002. Results have been presented at the 2002 annual meeting of the American Public Health Association and a paper using some of the findings is under review for publication in Social and Economic Studies). The final paper will present answers to the research questions and results of hypothesis testing.

An impressive 59% of girls who had had sex had asked a partner to use condoms. Of these 20% had a partner refuse to wear condoms, 5% had refused to have sex, only 1% threatened to leave and 0% of these girls had been threatened as a result. In contrast, 45% of girls who were not virgins had a partner suggest that they use condoms. Of this group 9% refused to let their partner wear a condom. Of boys who had had sex, 62% had asked a partner to

use condoms. Of this group, 9% had a partner refuse to let him wear a condom, 7% of their partners refused to have sex if he wore a condom, 3% of partners threatened to leave if he wore a condom and 13% of this group went "against their better judgment" and had sex without a condom. Of the boys who were not virgins, 81% had a partner who asked them to use condoms. In response to this request, 11% refused to wear a condom but "made" the girl have sex with him without a condom, 5% refused to have sex with their partner, 5% got angry at the request and 2% threatened to leave her as a result.

In terms of assertiveness in asking to use condoms, it could be argued that girls who are at risk of violence refrain from asking their partner to use sex and therefore only girls who consider it safe to ask, do so. However, given the commonplace association of condom use with infidelity, requesting the use of a condom or agreeing to use one may be perceived as a sign of distrust or an admission of infidelity.

Although qualitative data may be more useful in exploring the psychological mechanisms behind these behaviors, understanding the role of self-efficacy in the decision to ask a partner to use condoms or agreeing to have condoms used will begin to shed some light on these processes.

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Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
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Jamaican Adolescents' Sexual Behaviour analysed from a Gender Perspective

by
Dr. Marjan de Bruin

Sexual behaviour of adolescents (10–19 year olds) leading to sexual intercourse in Jamaica has become a serious concern. Before the age of 20, between 40 and 44 per cent of the sexually active girls have been pregnant al least once (The Policy Project 1999; CMS 2001) and most of these pregnancies were "unplanned." In the latest national survey on reproductive health (1997) only 13% of teenage-mothers (15-19 yrs.old), who had given birth in the previous five years, said the birth was "planned."

Most older teenagers (15 and 19 years) are sexually active: the figures vary between 76% and 83% for boys and 54% and 63% for the girls (Hope Enterprises 2000, CMS 2001). The 'out of school' youth start sexual activity later than the 'in school youth' (MRS 2001). Few youngsters are protected in their first act of intercourse and many continue to have sex unprotected. In the latest *Jamaica HIV/AIDS National Strategic Plan* early sexual activity is identified as one of the behavioural factors driving the HIV/AIDS epidemic (MoH 2002: 8).

High-risk sexual behaviour can lead not only to unwanted or "unplanned" pregnancies, but also to a variety of sexually transmitted infections (STI), including HIV/AIDS. STI among adolescents have increased precipitately: 41% of sexually active boys aged 15-19 are identified as at risk of STD/HIV/AIDS (CMS 2001). Researchers recognize "a strong correlation between the spread of convential STI and HIV transmission" (Brathwaite 2001:9).

Marjan de Bruin

The number of reported HIV/AIDS infections among adolescents has doubled every year since 1998 (Gebre 2000). The highest prevalence of HIV/AIDS is among the 15 – 19 and 25 – 29 age cohort (MoH January 2002), making them a prime target audience for behavioural interventions in HIV/AIDS prevention efforts. Understanding the behavioural drives of this target audience is crucial.

Understanding adolescents' sexual behaviour

In Jamaica, during the last ten, twelve years, at least 80 – 100 studies on the topic of Reproductive Health have been executed, among which a large portion focused on Adolescents' Reproductive Health.

A comparison between the KABP studies (on reproductive health of the general population and of adolescents specifically) and the large national surveys on reproductive health – demonstrates very similar sexual behaviour patterns with gradual and sometimes minor changes over the years. Various patterns, however, show obvious gender differences in behaviour.

In a region with an HIV/AIDS infection rate second only to sub-Saharan Africa, one would have expected that an Adolescents and Reproductive Health study, from a gender perspective, would already have been done – region wide as well as nationally. However, to my knowledge, such a study does not exist.

What does exist is this wealth of material on Adolescents and Reproductive Health with findings differentiating male and female behaviour, which give us some understanding of the multi-dimensional complexities in teenagers' reality (Chevannes 1994; Russell - Brown 1994; Bailey et al. 2001, 1998; Jackson, Leitch, Lee, Eggleston and Hardee 1998; Senderowitz, Le Franc, Sitrick 1998; Kempadoo and Dunn 2002; Leo-Rhynie and Pencle, 2002). Researchers tried to include the interactions between boys and girls, young men and women, in order to understand the inter-personal and gender dynamics of their sexual behaviour. However, no one study can be found anywhere. Which pulls together and analyzes these data from a specific gender perspective

Marjan de Bruin

In my paper I analyse from a gender perspective the existing findings of research over the last twelve years on this topic in Jamaica. I also analyse the research approaches, most of which show a heavy emphasis on descriptive studies of individual behaviour. The scope of the majority of studies is usually limited, certainly in the quantitative ones: 'high-risk sexual behaviour' is often defined as a single act – unprotected coitus. As a result, the research in these studies mostly focuses only on this isolated phenomenon. The study of adolescent sexual behaviour from an interdisciplinary perspective is still in the exploratory phase.

My paper focuses on the gender differences in the behaviour of adolescents in order to better understand the complex factors which influence reproductive health, and therefore drive the HIV/AIDS epidemic. In my analysis I draw attention to more puzzling and unresolved contradictions in adolescent behaviour.

My analysis shows gender differences at various levels and in various aspects. There are differences in emotions, in attitude, values and norms, and, not surprising after all of this, differences in behaviour. Boys and girls demonstrate different reasons for wanting sex, different ways of preparing for sex, different negotiating strategies and different interpretations of needs and desire. They describe different perceptions and expectations; relate different risk awareness. They seem to play a different game, and certainly with different rules, sustained and supported by the social fabric of Caribbean societies.

My paper illlustrates these differences and cites the evidence by referring to research findings of studies done between 1990 and 2002.

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VIOLENCE, POWER AND CONTROL

Abstract

Gender, Sexuality and Implications for HIV/AIDS Symposium
March 11-13, 2004

So Rape is Not a Crime?

by
Valerie Youssef
Dept of Liberal Arts
The University of the West Indies
St. Augustine

This paper examines the selected discourse of significant persons in our community, ranging from the judiciary to counsellors and police officers, all of whom deal with rape and domestic violence daily as part of their professions.

It draws from their attitudes and assessments, as they come through in both explicit and implicit reference, to suggest that we continue to accept rape, rather than come against it, and in so doing, create a burden for young women which renders them even more powerless in their struggle for survival.

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Sexual Violence and Women's Reproductive Health in Jamaica: A Communications Perspective

by
Nancy Muturi, Ph.D.

Theme: Violence, Power, and Control -- Sexual coercion, violence, and incest

Gender-based violence, whether physical, mental, sexual or otherwise, is a global problem that has existed throughout history. UNFPA (2002) reports that about 60 percent of women worldwide have been abused at some point in their lives and many more cases are unreported. The problem spans across all ages, religions, classes and ethic groups but it is more severe in the developing countries. In the Caribbean, domestic violence, rape and incest are the most prevalence forms of violence perpetuated against women (Fflokes, 1997). Such violent acts against women have negative consequences on women's sexual and reproductive and health including the risk of HIV/AIDS and other sexually transmitted infections. Other problems include unwanted pregnancies and complications related to pregnancies and childbirth of teenage mothers, as well as the risks of unsafe and illegal abortions that often result from sex abuse. Equally serious is the impact of such abuse on the women's lives affecting their psychological well-being, self esteem, bodily integrity, public participation, autonomy, sexual pressure and the well-being of their children.

In Jamaica, many women face violent situations and the ability to express their sexuality freely without the fear of rape, violence and the contraction of sexually transmitted infections particularly HIV/AIDS, which is fatal. According to police reports, there have been a total of 751 sex abuse reported cases (531 rapes and 220 carnal abuse cases including incest) between January and July of 2003. The figure has superseded the previous years having gone up from 684 and 617 in 2000 and 2001 respectively and continues to increase steadily. Such sex-related violence contributes tremendously to the increase of HIV/AIDS thus ranking the Caribbean only second to sub-Saharan Africa. While the Jamaican Ministry of Health tries to categorize factors causing this increase into STD history (36%), Multiple sex partners (43%), Sex with

prostitutes (21%), and Crack cocaine use (7%), these categories do not include sexual related crimes as a contributing factor and therefore not addressed adequately.

When rape and incest occur, both the offender and the victim are at risk of contracting the AIDS virus since the nature of the crime also does not allow condom use or taking other preventive measures. The biological nature of women puts them at a more risky position when that occurs. Younger women are at a higher risk because, as current figures indicate, majority of the victims are between the ages of 10 and 24 or younger while the proprietors are most often older men. The vaginal micro trauma and the unprotected vaginal intercourse make them more physiologically vulnerable when rape or other forced intercourse is involved.

Reproductive health programs, however, do not focus on men's behaviors that trigger violence against women, an issue that this study focuses on. The study seeks to understand the driving forces that contribute to the various forms of violence against women in Jamaica and the link of these forces to the increasing rate of HIV AIDS infection in the region. The paper contends that the increasing extent of sex related violence particularly among young women is contributing tremendously to the increase of HIV/AIDS in the country. The paper examines the application of the USAID's ABC (Abstinence, Behavior Change and Condom Use) model and its shortcomings in terms of addressing HIV/AIDS prevention.

Naturalistic inquiry was the method used for data collection. This involved used of a combination of methods including participatory observation, note taking, in-depth one-on-one interviews with the victims of violence, caregivers, and health professionals, review of existing published and unpublished documents and media clippings. Key findings indicate that a combination of social, cultural, economic and political factors contribute to the existing violence. These factors are reinforced by the lack of policies, legal or administrative system to condemns or punish gender-based violence. The study concludes that given the increasing risks particularly when violence is sexual in nature, there is an urgent need for reproductive health programs to focus more on the perpetrators of violence with sensitization and effective behaviour change communication strategies as one strategy for reducing violence-related reproductive health problems. This study will contribute toward formulation of such policies and the design of effective strategies for behaviour change among men as an intervention for HIV/AIDS prevention.

Abstract
Gender, Sexuality & Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

HIV/AIDS and violence against women: The intersection of two global epidemics

by
Tina Johnson

The recently released 2003 *AIDS Epidemic Update*[1] shows approximately 40 million people living with HIV, including 5 million new cases, and 3 million deaths due to HIV/AIDS-related causes during the year. AIDS is now the fourth biggest killer in the world, after heart disease, stroke and respiratory disease, and kills more people than any other infectious disease.

While AIDS was originally diagnosed in homosexual men, there has been a progressive shift towards heterosexual transmission as the epidemic has spread. Globally it is now estimated that 90 per cent of all cases of infection occur through vaginal intercourse, and infection rates are increasing in women. In sub-Saharan Africa women constitute 58 per cent of HIV-infected adults – which means there are more than two million more infected women than men – while in the Caribbean, the proportion has reached 50 per cent. More women than men are now dying of HIV/AIDS, and the age patterns of infection are significantly different for the two sexes, with teenage girls being infected at a rate five to six times greater than their male counterparts.

Although it does not receive anything like the same amount of publicity, there is also a 'global epidemic' of a different kind that is taking place around the world: violence against women and girls. According to the World Bank, this accounts for more death and ill health among women ages 15 to 44 worldwide than cancer, malaria, traffic accidents and even war. Some of the types of violence that women are subject to include spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, traditional practices harmful to women such as female genital mutilation (FGM), non-spousal violence, sexual harassment and intimidation, trafficking, forced prostitution, and violence perpetrated or condoned by the state (such as rape in prisons or in situations of armed conflict).

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[1] Joint United Nations Programme on AIDS (UNAIDS) and World Health Organization (WHO), December.

Tina Johnson

This paper aims to make explicit the connections between these two epidemics. It argues that while there is a greater *biological* likelihood of HIV being transmitted from men to women than of the reverse, it is women's relative lack of control over their sexual lives due to actual or threatened violence that is fuelling the spread of AIDS. This lack of control applies to sexually active females across the spectrum – from sex workers to monogamous married women. The experience of violence, or fear that it might take place, disempowers women in their homes, workplaces and communities and limits their ability to participate in and benefit from initiatives for HIV prevention and AIDS mitigation. The causes of the high incidence of the disease among women are thus less biological than economic, cultural and political.

In making the links between these two epidemics, the paper explores a number of different cases where violence leads to a greater likelihood of HIV infection. The first of these is forced sex, which directly increases the potential for HIV/AIDS infection because micro-lesions make it easier for the virus to enter the bloodstream, and indirectly increases it because there is evidence that victims are subsequently more likely to practice risky sexual behaviour. Next, intimate partner violence is considered since, although coerced sex may take place between either strangers or intimates, research consistently shows that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person. In such situations, it is extremely unlikely that 'safe sex' will be practiced. Numerous studies have also reported that women are unable to discuss fidelity or negotiate condom use in their relationships due to fear of violent repercussions or abandonment. Another connection between violence and HIV/AIDS is in the area of testing and treatment, as there is considerable evidence that if a woman takes an HIV test or tells her partner that she is HIV positive, she may face a violent reaction. The paper also looks at violence against girls, who are particularly at risk of contracting HIV in situations of forced sex due to their underdeveloped reproductive systems. They are also increasingly being sought out by men who believe they are less likely to be infected or can even cure the infection.

The paper draws for its examples both on international sources as well as on information more specific to the Caribbean, and particularly Trinidad and Tobago. In the latter case, reference is made not only to academic texts but also to newspaper articles and calypsos, and to the opinions of key informants in national governmental and non-governmental organizations (NGOs).

SEXUAL ATTITUDES, BELIEFS AND TABOOS

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Living with the stereotype: The impact of popular images on black Caribbean men's sexual health.

by
Laura Serrant

Sexual health behaviour and the choices people make are influenced by a range of factors including, social grouping, education, peer pressure and access to services/information (Aggleton, O'Reilly et al. 1994; Harding 1998; Ford, Sohn et al. 2002). Reports on the health of the public in Britain have shown that sexual ill-health is unequally distributed across British society (Department of Health 2001; Royal College of Nursing 2001). Quantitative studies form the main pool of information available in relation to sexual health and risk in Britain. They have demonstrated that in some areas of the country the infection rates for sexually acquired infections are up to twelve times higher in men from black Caribbean communities when compared with other ethnic groups (Lacey, Merrick et al. 1997; Hickman, Judd et al. 1999; Fenton and Wellings 2001).

Over the last few decades sexual health has begun to be viewed by British policy makers, politicians and practitioners as involving more than a physical act concerning individuals. Rather it is seen as an area of health need that requires planning, assessing and services to support it (Greenhouse 1994; Health Education Authority 1994; De Cock and Low 1997). The reliance on quantitative reports however has resulted in the current situation in Britain where evidence is available identifying who is likely to be at greatest risk of acquiring a sexual infection but gives practitioners little indication as to why or how best to address the issue.

In order to assist sexual health services to face the challenges of increasing rates of Sexually acquired Infections in minority populations, reliable and up to date information about factors affecting sexual health decisions needs to be readily available. The National Strategy for Sexual Health and HIV (NSSHH) published in July 2001 (Department of Health 2001) was developed in consultation with sexual health professionals from education, health. It also

highlighted that sexual ill health was more likely to be located among young people, members of minority ethnic communities and other socially excluded groups (Department of Health 2001; Department of Health 2003). In the NSSHH, the British Government expressed concern about the continued rise in sexually transmitted infection among minority groups and other socially excluded populations and stressed the need to improve the sexual health of the general population and minority groups in particular.

The significant differences noted in the infection rates for STIs across ethnic groups raises questions as to why men of black Caribbean communities were over-represented in the reported data. This highlighted a need to explore how personal decisions about sexual activity or expression made by Black Caribbean men evolved into the outcomes reflected in the rates of sexually acquired infection in this section of the British population. Investigation of these issues is to some degree compounded by a variety of influences pertinent to both researching sexual health in Britain and the focussing of such research on the experiences of Black Caribbean men. The politically and socially sensitive nature of the subjects ethnicity and sexual health that lie at the heart of investigation into Black Caribbean men and their sexual health, have historically influenced the types of British based research that have been conducted in these areas, and the willingness of researchers to select these as subjects of study. Attempts to conduct a national survey on sexual attitudes and lifestyles in Britain in the early 1980s for example were blocked by the government of the time as this was deemed inappropriate use of public funds and politically problematic (Adams 2000). In recent years however their has been increasing recognition in Britain Without a diverse evidence base for sexual health, encompassing both qualitative and quantitative information, the development of practices to implement the priorities set out in the National Strategy for HIV and Sexual Health strategy, will remain hampered. Research broadening the scope of sexual health research is anticipated to become more readily available in future.

This paper is based on my doctoral research entitled 'Black Caribbean men, sexual health decisions and silences' which focuses on the factors influencing the sexual health decisions of Black Caribbean men in terms of sexual health decision making and risk taking. In the study I utilised focus groups and individual interviews to identify some of the factors influencing the sexual health behaviour of Black Caribbean men, and explored how these factors may impact on their health seeking and risk taking behaviour.

The outcomes of the study suggested that the sexual health decisions of black Caribbean men in Britain take place in the context of the real or imagined expectations that society and their sexual social networks had of them. The sexual decisions of black Caribbean men continuously occurred in the light of the social and personal appraisal of relevant issues by an individual. This forms the context in which their sexual decisions took place. Within this context the negative stereotype of the black Caribbean male as sexually irresponsible and insatiable emerged as a key factor in the sexual and social experiences of the participants. This paper presents the findings from the focus groups and interviews. It includes excerpts from transcripts to explore the ways in which the stereotype influenced the sexual decisions, health care experiences and social relationships of the black Caribbean men involved and other key players in their sexual health. The issues raised in the paper provide a rare insider view into the context in which the sexual health experiences of black Caribbean men in Britain take place and the impact that beliefs or expectations may have on the sexual decisions.

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Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Religion, Society and the HIV/AIDS Epidemic in Trinidad-Tobago

by
Gillian L. Genrich
Fulbright Scholar

Introduction:

In the presence of illness, strife and turmoil, spiritual societies turn towards religion and religious leaders, to garner strength and hope, and brave trying times. Trinidad-Tobago is a spiritual society. In Trinidad-Tobago, over 30% of the population is Roman Catholic, 24% practice Hinduism, 6% practice Islam, and the freedom to celebrate these and other religious sects and denominations is exercised and respected. Unlike the clear demarcation of sacred religious and secular institutions in the United States, the sacred-secular boundary is blurred in Trinidad-Tobago; the sacred pervades and mingles harmoniously with routine daily life, and society's spirituality becomes a defining cultural characteristic.

Trinidad-Tobago is unique among its neighbors because the composition of society is remarkably pluralistic; however, the island republic shares with Caribbean member countries the second highest incidence of HIV/AIDS outside Sub-Saharan Africa. In Trinidad-Tobago, the virus is primarily transmitted during unprotected sexual intercourse. Religion may challenge efforts to improve HIV/AIDS education throughout society and among spiritual leaders because conversation about sex and sexuality is taboo. Meanwhile, HIV/AIDS opportunistically spreads in the silent void where open conversation about sexual risk behavior and disease prevention should resound.

For a faithful society, religion could facilitate healing and coping with HIV; for a society with a pervading conscious moral ethos interpreted from central religious tenets, HIV/AIDS could also evoke guilt, shroud denial and promote fear. The goal of the research project was to explore the dichotomous function of religion within Trinidad-Tobago's HIV/AIDS

epidemic, amongst a society that includes spiritual leaders, people living with HIV/AIDS (PWHA), women in their most reproductive ages, and sexually active youths.
Materials and Methods: Qualitative interviews and quantitative surveys were the primary means of data collection, conducted among four social groups in Port of Spain and the surrounding area: religious representatives, females ages 15-65 visiting the Family Planning Association of Trinidad & Tobago (FPATT), Port of Spain and rural clinics, form four male and female Laventille students, and people living with HIV/AIDS.

Does religious ideology pervade society's perception of the HIV/AIDS epidemic?
(1) What HIV/AIDS myths and misconceptions are harbored amongst Trinidad's youth? Three classes of eighty total male and female form four Laventille students completed surveys testing their knowledge about the modes of HIV transmission and the efficacy of condom use in preventing the transmission of STDs.
(2) What is the perspective of the HIV/AIDS epidemic among women from a variety of religious affiliations?
Interviews with over one hundred female FPATT clients of different religious affiliations were conducted throughout nine rural underserved communities in the FPATT Outreach Clinic, the Port of Spain Adult Clinic and the Youth Centre. Discussion was guided by an HIV testing survey, but intended to provide a safe environment free of societal taboos where women were allowed to express their opinions on the HIV/AIDS epidemic in Trinidad, their personal experiences with testing or with PWHA. The majority of clients interviewed were between the ages of fifteen and forty-five, which is the population that bears the highest risk of acquiring HIV.

What is the perception of HIV/AIDS among Trinidad's religious leaders?
Twelve representatives of Christianity (Roman Catholic, Anglican, Salvation Army, Pentecostal, Seventh Day Adventist, Unity, Open Bible, African Methodist) Hinduism, and Islamic communities were interviewed. Each representative described the tenets of their religion, their personal experiences and interactions with PWHA, and their opinion of the function of religion in mitigating the impact of HIV/AIDS in the community. Additional discussion covered the following topics:

- Promiscuity
- Homosexuality
- Condom use
- The origin of HIV
- Stigma

Gillian L. Genrich

- Arguments for HIV as a religious/spiritual problem, and as a medical problem
- Carnival, and the "carnival mentality" challenges efforts at HIV/AIDS education
- Mistrust of current scientific info (NOI), and suspicion that there is more to learn about HIV (Open, Unity)
- Breakdown of the extended family
- Strengths and weaknesses of the delivery of religious instruction and the perceived impact upon congregations
- Prescriptions and solutions

What is the function of religion in the lives of people living with HIV/AIDS?
Five men and women living with HIV/AIDS discussed their belief systems in qualitative interviews and described how the HIV diagnosis affected their belief systems. Participants also described experiences in church and with clergymen.

Results: *Society*
Youths-The myths and misconceptions surrounding HIV transmission and infection thrive amongst the youth in Trinidad. Of three Laventille government school classes, eighty total male and female students, the majority of students were not educated about the modes of HIV transmission, and the efficacy of condom use in preventing the transmission of HIV and other STDs.
Women-Among women from different religious denominations similar perceptions of HIV/AIDS, its impact upon society and the risk behavior contributing to its transmission were expressed. For example, women agree the sexual risk behavior contributing to HIV transmission is rampant despite the popular religious ethos.
Many women in the course of being surveyed on their opinion of HIV/AIDS identified a deteriorating connection among youths with their religious and spiritual beliefs.

Religious Representatives
Religious representatives and their institutions unanimously support compassion for people living with and affected by HIV/AIDS. However, representatives disagree on the perception that HIV is a homosexual disease and pivotal leaders in society harbor the unfounded view that open discussion about sexuality conveys an acceptance of unprotected sex and other risk behavior. Among some religious leaders there is mistrust of current scientific information on HIV/AIDS, while other leaders taks vigorous action to educate communities about the transmission of HIV/AIDS.

People living with HIV/AIDS

PWHA revealed the duality of religion in facilitating healing and coping, and creating an environment that promotes myth, denial and fear. For some people living with HIV/AIDS, it is important to resolve the disparity between the tenets of denominations. For others, the tenets of religious affiliations are less important than the emotive force of a praying environment, such as is felt in church or other place of worship.

Discussion

The present functional dichotomy of religion in HIV/AIDS and society in Trinidad may be in (1) promoting silence and myth about sexuality and the transmission of HIV; and (2) in facilitating the prevention of risk behavior, as well as healing and coping for PWHA. For a spiritual society, the HIV/AIDS epidemic poses a significant challenge: realizing and confronting the risk behaviors that promote viral transmission, and exercising compassion for individuals healing and coping with the virus, combating a deep-rooted stigma surrounding the mode of HIV transmission and PWHA.

The HIV/AIDS stigma pervades Trinidadian society and also festers within some religious communities, amongst some spiritual leaders. At the same time, some religious representatives are passionate and devoted to HIV/AIDS healing and prevention strategies. Research suggests that the more personal experiences religious representatives shared with PWHA, the more knowledgeable they were about the challenges facing PWHA, and the more willing to improve intervention strategies.

In Trinidad, religious leaders may contribute to education and extend the function of spirituality in avoiding risky behavior and facilitating coping for PWHA, as part of a multisectoral response to mitigating the impact of the virus. The church yields tremendous potential to "normalize" the discussion of human sexuality, which may resolve myths surrounding the virus and work to extinguish the debilitating stigma.

Personal histories and testimony from religious representatives and PWHA reveal that religion functions dichotomously in Trinidad's society, at times promoting compassion and healing and in other ways promoting ignorance and denial. For some people living with the virus, there is distrust of ministers and clergymen, for other PWHA there is great faith. The discrepancy between the role of religion in healing and coping with HIV/AIDS, and in promoting stigma and discrimination is resolved by removing religion as an organized structure of tenets and rules to live by, and understanding religion as a relationship with an all powerful higher being. For some people living with HIV/AIDS, it is important to resolve the disparity between the tenets of religious affiliations; while for others,

religion is a powerful relationship surviving spurious tides of stigma and discrimination and provides a foundation of strength and healing. Religious leaders must share the burden of transforming society's popular cultural beliefs; and begin with clarifying the importance for individuals to understand and discuss their human sexuality. Given the high esteem and worthy repute with which spiritual leaders are upheld in Trinidad's society, there exists enormous potential for spiritual leadership to form the catalyst for long-term HIV/AIDS prevention and coping initiatives and overall improved health status. Some clergymen are evoking change in the community in addressing the HIV/AIDS epidemic; beginning to meet the needs for dynamic spiritual education. The present research suggests that a cohesive and consistent response across other denominations and religious communities would significantly improve existing efforts.

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Parry Jus' Once: Gender Revelations from Liming Spots in Trinidad & Tobago

by
Dani Lyndersay, Ph.D

" Jus once, not twice, not three times...jus once!
Jus once a little spark could turn into a big fire and bun down yuh house...
Jus once... Jus once a driver could take he eyes of the road while driving and Bam! end up in an accident...Jus once. Jus once is all it takes to contract HIV... Maybe jus once we should take heed. Maybe jus once we should take some kind of precaution or maybe jus once we should realize that we have this life for only jus once...
Because jus once, is all that it take to lose out on something wonderful!"

Arts-in Action, the outreach unit of the Centre for Creative & Festival Arts at The University of the West Indies, St. Augustine began its mission to be "the premiere arts in action company the Caribbean". Using the interactive and participational techniques of theater-in-education and Forum Theatre, it performs in and for schools and educational institutions, seminars and conferences, museums, community centers, governmental ministries, NGO, multi-national corporations and foreign missions around the country and throughout the Caribbean.

Jus'Once! is an exemplary example of our on-going work. It was initiated in order to encourage Trinbagonians to look inside themselves and their environment for answer and strategies to reduce and control the growth of all sexually transmitted diseases, but particularly HIV/AIDS which is known to be at epidemic in the Caribbean, *Jus Once!* Seeks to present interactive and participational performances that explore the reasons and forces behind the continuing growth of HIV within rural and urban areas in Trinidad and Tobago. It attempts to correct negative stereotypes and myths about HIV/AIDS and to address the taboos applied to this disease.

Dani Lyndersay

The production opens with six similarly dressed characters incorporating plain black cubes or boxes to change levels and positions while creating typical 'freezes' of couples meeting and demonstrating their desires for each other. In the forefront, a seventh character, addresses the audience with the "Jus' Once...' opening monologue. The action then moves rapidly into seven distinct and individual stories each linked with vibrant, sometimes biting and prophetic, songs and music. Each personal story has its origins in historical fact and in the stigmas surrounding the disease: Cassandra's vengeance is to get rid of all promiscuous men; Stanton the owner of a gym, believes only skinny people are HIV/AIDS infected and that a good "sweat" (workout) can solve any illness; Susan promotes the idea that safe sex is guaranteed by pulling out the penis before ejaculation; Taye denies that the death of his best friend is related to their unsafe practice of "parrying" (otherwise known as initiation orgies); Derek speaks of his anger after his long-standing girlfriend requests that he begins using a condom; Judy, the innocent church-going girl, describes her very recent and first sexual experience and then the subsequent knowledge that her lover has died of AIDS; while Simon shares his fears after being tested HIV positive.

Through a financial grant from the Canada Fund and technical support from other organizations such as CAREC (Caribbean Epidemiology Centre), Arts- in-Action has been able to share their Jus' Once! Production in schools and diverse community settings known as "liming spots" through Trinidad & Tobago. The latter settings have included street corners, outside village rum shops or the general store, community basketball courts, low income high rise car parks, or busy through-ways. As a consequence, over the past five years, the production has reached more that 10,000 participants and a number of gender sensitive observations have been recorded.

This paper will identify and share some of those observations, specially those that relate to the character Taye and his experience of "parrying'. The participational element of *Jus' once!* invites the viewing audience to air their opinions and advice to the characters in the production through 'hot seating', replay or Forum theatre techniques. This often elicits stereotypical gender assumptions and attitudes towards the opposite sex.

Gender roles and relations have a significant influence on the course and impact of the HIV/AIDS epidemic. *Jus' Once!* has confirmed that young girls are particularly vulnerable due to their lack of power to decide when sex takes place and under what circumstances and that young men may often be the unknowing transmitters of AIDS in their sexual initiation

rites. An understanding of the norms associated with the practice of "parry-ing" may help to give further direction in reducing young people's vulnerability to HIV.

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Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Sexual Behaviour of Women in Trinidad and Tobago: Is it healthy?

by
Harry Singh[1], M. A. Rahaman[1] and Isaac Bekele[2]

The primary objective of this investigation is to obtain information about sexual behaviour of resident women aged 25 years and over in Trinidad and Tobago at the time of the survey. Two independent surveys were undertaken for the study: Trinidad survey involved 1450 households and was carried out in June 2002 and the Tobago one involved 156 households and was carried out in March 2003. The households were sampled from Central Statistical Office (CSO) household frame based on sample design for continuous population survey.

The study examined age at first cycle, age at first sexual intercourse, whether each woman was sexually active at the time of survey and in the case of Tobago the total number of sexual partners a woman had up to the time of the survey. Age at first menstrual cycle depends on ethnicity ($p<0.001$) where the onset of the cycle for women of African decent is 13.2 years (13.1 years for Tobago), for mixed and East Indian groups it is 12.9 and 12.8 years, respectively.

Age at first intercourse also varied with ethnicity ($p<0.001$), however, ethnicity to some extent is confounded with religion so the observed difference should not be attributed only to ethnicity. The mean age at first intercourse was 18.6 years (18.4 years for Tobago) for women of African decent, 18.9 years for mixed decent women and 19.6 years for women of East Indian decent. Age at first intercourse was also influenced by education ($p<0.001$). The average age at first sexual encounter increased as the number of years in schooling increased. Women with no education initiated sexual activity at 15.8 years whereas women with tertiary level education initiated at 21.5 years.

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In Trinidad, 60.4% of the women in the age group examined reported that they were sexually active at the time of the survey. The corresponding figure for Tobago is 62.1%. However, whether or not a woman was sexually active was dependent on age ($p<0.001$), Marital Status ($p<0.001$) and ethnicity ($p<0.001$). In Tobago, 26.4% of the women in the age group claim to have had only a single sexual partner. The median number of partners being 2 and the maximum number of partners reported is 10 men.

SEXUALITY, EDUCATION AND SENSITIZATION

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Gender Empowerment through Education for HIV/AIDS Prevention in the Caribbean: The Role of the UWI HARP[1]

Authors: Nancy Muturi, Maxine Ruddock-Small, Hope Ramsay, Jasneth Mullings Sanjana Bhardwaj, Brendan Bain and Marjan de Bruin

Gender empowerment is a core ingredient in women's reproductive health particularly in sexuality decision making and the prevention of sexually transmitted infections including HIV/AIDS. This has been recognized internationally leading to the development of multi-sectoral gender-sensitive programmes that address the socio-economic, health and development consequences of HIV/AIDS and other STIs, particularly among women, as a strategy for addressing the epidemic.

Globally, about one-third of those currently living with HIV/AIDS are aged 15–24, while more than half of all new infections are occurring among young people (UNAIDS, 2001). It is estimated that 1.8 million of all people living with HIV/AIDS are located in the Latin America and Caribbean (LAC) countries, representing approximately 5% of the global figure. The main mode of transmission in the Caribbean region is heterosexual in nature (MOH, 2002) thus linking it to the increasing number of women being infected. WHO reports that almost 50 percent of people infected with HIV are now women and that this population is the fastest growing segment of the HIV/AIDS population (Calderòn, 1997). Whereas men were most affected at the beginning of the epidemic, women's rates of new infection now surpasses men's, especially in countries where women live in poverty and have relatively low status (PRB, 2002).

Gender imbalance has been associated with the high rate of HIV/AIDS infection in the region among other factors where younger women are particularly at risk of infection due to their vulnerability associated with their lack of knowledge, understanding and empowerment. Biological, prevalence of STDS particularly among adolescents, socio-economic factors and their economic reliance on the older men equally contribute to their greater vulnerability to HIV/AIDS (Scott, 1999).

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[1] University of the West Indies HIV/AIDS Response Programme

Authors: Nancy Muturi, Maxine Ruddock-Small, Hope Ramsay, Jasneth Mullings Sanjana Bhardwaj, Brendan Bain and Marjan de Bruin

This paper addresses the role of the University of the West Indies HIV/AIDS Response Programme (UWI HARP) in empowering young people through education for awareness, understanding for informed sexuality decision-making and HIV/AIDS prevention. Recognizing that the youth, 15-24 age group, are especially vulnerable to HIV infection, the UWI HARP, launched in 2001, has established a project for the reduction of HIV transmission through education for awareness, knowledge and understanding for behavior change. With about 80 percent of the student body being women, gender-based education and empowerment is central in its curriculum development component of the SIRHASC[2] project. The project focuses on the curriculum gaps in addressing the epidemic in the region while addressing various issues related to HIV/AIDS transmission. This component of the programme was implemented after Education was identified as an important factor in sexual and reproductive health and in the prevention of HIV/AIDS (Bain 2003). The project is geared to helping the youth, particularly women to make informed sexuality decisions and act on those decisions for the prevention of particularly HIV/AIDS and other sexually transmitted infections while developing positive attitudes toward people living with HIV/AIDS (PLWHA).

Strategies used in achieving this goal include: Involving and sensitizing all stakeholders, training faculty to integrate HIV/AIDS components into existing courses; developing new courses and modules that address HIV/AIDS and related factors some of which are gender specific; keeping a clear focus on the epidemic the need for education for empowerment and behavior change as a crucial intervention.

Issues addressed in the courses: Sex/sexuality; Sexual and Reproductive Health, Gender and Health, Gender and HIV/AIDS STDs/STIs, Gender and Violence, Drug use/drug abuse, Human behaviour, Behavior Change Communication and gender-based health education and health communication.

Lessons Learned: Participatory learning not only increases knowledge but empowers young people of both genders, to make informed choices. These courses are across disciplines and campuses. Through informal learning young people can be assisted to build positive attitudes and their self esteem. The UWI HARP has seen that both Formal and Informal learning are important in the gender empowerment process and in strengthening sexual decision making, thereby strengthening the youth in the fight against HIV/AIDS. The

[2] Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean

Authors: Nancy Muturi, Maxine Ruddock-Small, Hope Ramsay, Jasneth Mullings Sanjana Bhardwaj, Brendan Bain and Marjan de Bruin

UWI HARP's educational initiative is one of the first of its kind in the world. This curriculum reform to effect behaviour change can be adapted in other similar settings.

Abstract
Gender, Sexuality and the Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

HIV Infection Among Pregnant Women in North Trinidad

by
Evelyn Jameson and Gerard Hutchinson

Background:

HIV infection in pregnancy is becoming an increasingly important focus of attention in the HIV epidemic. There is also an impact on health care services for children being born with HIV and social services because of the likelihood that their mothers may be too ill to adequately fulfill their maternal responsibilities. Trinidad and Tobago in recognition of this has instituted the offering of routine voluntary testing for every antenatal admission to public health facilities and the provision of treatment for those found to be HIV positive (MTCT programme). We sought to establish the prevalence of HIV infection among antenatal patients in the St. George West region of Trinidad and identify the risk factors which were associated with their status.

Method:

An interview was conducted with each new attendee to the antenatal clinics in St. George West over a six month period after informed consent was obtained. Their HIV results were obtained from the MTCT programme. The interviews were conducted by retired midwives and included questions on demographics, known risk factors for HIV infection, mental health history and information on their partners. Women who had refused testing were also asked to give reasons for this.

Results:

There was a total of 541 women attending the clinic for the first time during the period. Seven of them refused testing. Of the remaining 534 women 37 were HIV positive (6.9%). Fourteen of the HIV positive women (37.8%) admitted to knowing of their status prior to becoming pregnant. Risk factors significantly associated with positive HIV status were earlier age of first intercourse, a history of sexually transmitted disease, mental health problems and homelessness. Regression analysis revealed that

early age of first intercourse independently predicted HIV status and this in turn was independently associated with experiencing childhood sexual abuse.

Discussion:

These findings reveal a high rate of HIV infection among pregnant women in North Trinidad (7% compared with the national estimate of 2%) and establish earlier age of first intercourse and sexual abuse in childhood as key determinants of this. Prevention efforts must therefore be targeted at identifying the factors which influence early sexual activity and mechanisms sought to improve the monitoring and support of sexually abused children. Responsible reproductive behaviour in the knowledge of one's HIV status also needs to be addressed among women in the reproductive age range.

Abstract
"Gender, Sexuality and Implications for Substance Use and HIV/AIDS" Symposium
March 11-13, 2004

ADOLESCENT SEXUALITY AND HIV/AIDS: *'RISK BEHAVIOURS'* AND *'RISK SITUATIONS'* AMONG TEENAGE GIRLS IN BARBADOS

by
Christine Barrow

The Caribbean has the second highest rate of HIV infection - second that is to sub-Saharan Africa - and AIDS is now the principal cause of death among young adults in the 15-44 age cohort. Within the region, the Barbados rate at 1.2 ranks third highest, following Haiti and the Bahamas. Since the first case of AIDS was recorded in 1984, the rate of infection in Barbados has escalated and the epidemic constitutes the principal health concern. It is rapidly developing from a human and personal catastrophe, to become a critical developmental problem, threatening to undermine socio-economic progress and political stability.

Of great concern is the spread of infection to females and to the younger generation. A total of 44 percent of all cases of HIV infection is to be found among the youthful section of the population aged from 15 to 34 years. Given the relatively long incubation period before the virus develops into full-blown AIDS, estimated at anywhere between 7 and 15 years, it is clear that a large proportion of infected persons contracts the virus during teenage years.

Adolescent girls, for both physiological and social reasons, are particularly vulnerable to exposure to HIV/AIDS and an alarming trend is appearing within this cohort. Although AIDS related mortality remains relatively low and is equal for males (3 deaths) and females (3 deaths), teenage girls predominate in terms of infection. While males carry a higher rate of HIV infection in the overall population, the reverse is apparent among adolescents. Teenage girls outnumber boys by 3.5 to 1 for HIV infection and by 1.7 to 1 for AIDS cases.

Research conducted in Barbados indicates that adolescents are generally well informed about sexuality and safe sex, reproductive health and STIs, including HIV/AIDS, but that a persistent disparity between knowledge and practice prevails. Approximately one-third of adolescents are

sexually active and engaging in *"risk behaviours"*. There is alarming evidence of early sexual initiation, multiple partnering and unsafe sex.

Among adolescent girls there are also reports of *"forced"* sexual initiation, and involvement in transactional sex. Anecdotal evidence repeatedly speaks to the prevalence of a sub-cultural practice locally known as the *"sugar-daddy syndrome"* – the involvement of school girls in regular, unprotected sex with older men in exchange for brand-name clothing and other material goods, even food and other basic necessities. The commodification of young girls' sexuality is not new to the Caribbean. These older man/younger girl liaisons have a long history and are, in all probability, much more culturally embedded and widespread than is generally believed. Within these relationships, females are often vulnerable and powerless to negotiate condom use. Furthermore, in Barbados officials of the Child Care Board claim that family members, mothers in particular, have withheld evidence and refused to press charges against the sexual abusers of their under-aged daughters and are opting to accept out-of-court financial settlements.

Policy and prevention strategies have, to date, concentrated almost exclusively on health education campaigns. Under-pinning these is the assumption that improved knowledge of sexuality, reproductive health and HIV transmission will reduce *"risk behaviours"*. In other words, the prediction is that, with accurate and appropriate education and knowledge, individuals will protect their lives by acting rationally, modifying behaviour and practicing safe sex or abstinence. These interventions have, in turn and somewhat paradoxically, been informed by Knowledge, Attitudes, Beliefs and Practices (KABP) questionnaire surveys, and the facts and quantitative data on **what** adolescents do and think about sexuality and reproductive health derived from these surveys reveal high levels of knowledge.

This study of adolescent girls in Barbados attempts to push forward the agenda for HIV/AIDS research and intervention: firstly, as regards research questions and methodologies and secondly, by broadening the research focus to investigate psycho-social and environmental variables, thereby suggesting a shift from educational campaigns to interventions that examine and take on board *"risk situations"*. The research uses an in-depth methodology (focus groups and intensive open-ended interviews) in order to shift the central research question from **What?** to **Why?** – specifically to ask: Why it is that *"risk behaviours"* persist despite

knowledge of the disastrous consequences? In addition, knowledge-based prevention strategies have been increasingly criticised as overly simplistic and as failing to promote behaviour change. It has become increasingly clear that information, while necessary, does not alone bring about behaviour modification, even in cases where persistent practices are potentially fatal. This is primarily because these campaigns ignore the *"risk situations"* within which people conduct their lives and which may heavily influence their choices. This study, therefore, adopts a multi-level, engendered conceptual framework to examine the *"risk situations"* of adolescent girls who practice unsafe sex by encompassing the following perspectives: individual psycho-social and cognitive variables, relationship dynamics, youth subcultures/friendships, family/household, and community/social institutions/socio-economic environment.

Note: The research is on-going – focus groups and interviews in schools have been completed. I am planning that, by the end of January 2004, sufficient data will have been collected and processed to provide the necessary material for this presentation.

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

The Awareness of HIV/AIDS Prevention PSAs on Television Among Students of the University of the West Indies St. Augustine Campus

by
Nickesha Smith and Dr. Godfrey Steele

The situation in the world regarding the HIV/AIDS virus is dramatic and devastating. Worldwide, young people are at the centre of this epidemic as some 60% of all new infections include persons between the ages of 15 and 24. Even more alarming is the fact that young women within this age group account for two-thirds of all HIV-positive young people, as they are undeniably more vulnerable to this disease (UNICEF, 2002).

In attempting to evaluate how television, and more specifically Public Service Announcements (PSAs), can be used to promote healthy behaviour among young people, research has shown that many pertinent factors affecting young people's ability to adopt healthy lifestyles are sadly lacking from many PSAs (Andager, Austin and Pinkleton, 2001; Agostinelli and Grube, 2001; Lee, 2003). Studies have also shown that gender-specific PSAs (Roth and Hogan, 1998; Bruyn et al, 1995), as well as PSAs that target specific behaviour change rather than just presenting information (Worden and Flynn, 2001; Flanagan, 2002; Dejong et al, 2002), can be very helpful and useful.

Three (3) models were thought to be pertinent to the study: the Elaboration Likelihood Model (Agostinelli and Grube, 2001), the Health Belief Model (Hochbaum, 1958) and the Message Interpretation Process Model (Andager, Austin and Pinkleton, 2001). Some basic assumptions of these models were reviewed and discussed in relation to the characteristics of PSAs and their influence on young people.

This thesis is based on the premise that a segment of the student population of the University of the West Indies (UWI), which comprises young persons within the 17 – 24 age bracket and 70% of whom are female, is being overlooked as a target for specific awareness and prevention strategy. As such, this study primarily examined UWI students' awareness of and attitude toward HIV/AIDS PSAs found on campus and aired on local television, and reviewed the relationship between this awareness of and attitude toward HIV/AIDS PSAs and the students' social and sexual behaviour.

Twenty-eight female students and 12 male students participated in a survey carried out among the students of the UWI, St. Augustine Campus. Although the participants were selected randomly, the researcher attempted to maintain the gender distribution of the campus, which was 70% female and 30% male. This survey formed the basis of the research as respondents were asked about their knowledge, attitudes, perceptions and behaviour pertaining to HIV/AIDS, as well as their reception and processing of HIV/AIDS PSAs. The survey instrument used was a questionnaire, which was distributed to students at strategic points on the campus.

Not surprisingly, the findings of the study suggested that students *are* placing themselves at risk for infection. Although, more female students were found to have only one sexual partner compared to males who tended to have two or more partners, the underlying implication is that many more females are at risk because of sexual contact with males who have had multiple sexual partners.

What was more disturbing, however, was the implication that PSAs were not reaching the students who were placing themselves most at risk, as it was found that these PSAs did not reflect their lifestyle. Notably, an assumption of the Message Interpretation Process Model was recognized here as it posits that messages must meet young persons' standards for personal relevance through a process known as perceived similarity. As such, the suggested use of more gender specific PSAs is indeed valid. Moreover, PSAs were found to be lacking, not in the information itself, but in addressing other important issues that can empower young people to adopt a healthier sexual lifestyle. This recalls the view posited by Dejong et al (2002) that while PSAs exploit the use of fear of the disease to encourage safe sexual practice and promote condom use, they do not fully address key reasons why people fail to use condoms, for example concern about sexual pleasure and reduced sensitivity, embarrassment about obtaining condoms and lack of skills to negotiate condom use with partners.

This study was, by no means, conclusive and could be used as a stepping stone to further research that will examine the psyche of the youth population as a whole and also examine more profoundly the features of the PSAs being aired and how they affect this population.

KEY WORDS: HIV/AIDS, PSAs, safe sexual behaviour, risky sexual behaviour, television, young people, UWI students.

SEXUAL-ECONOMIC EXCHANGE

Abstract

Gender, Sexuality and the Implications for HIV/AIDS Symposium
March 11- 13, 2004

Sex, Gifts, Money, and Health: Sexual-economic Transactions and Implications for HIV/AIDS

by
Dr. Kamala Kempadoo, Associate Professor,
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Abstract

In this paper, I review the main trends in Caribbean sexual-economic relations and transactions (in predominantly English, Dutch and Spanish-speaking territories), with particular emphases on prostitution/sex work and sponsoring/transactional sex. I argue that the myriad of sexual-economic arrangements and networks that exist today through the region are integral to Caribbean understandings of sexuality as well as to the maintenance and survival of many a household, community, business and transnational industry. Nevertheless, heteropatriarchal standards of sexuality and cultural anxieties about sexual "looseness," relegates Caribbean sexual-economic relations to criminal or clandestine spheres. Implications of this marginalization and criminalization for the treatment of HIV/AIDS is far-reaching. In much of the research and policy work on HIV/AIDS in the region for example, it is women whose sexual agency is neither attached to one man nor constrained to the home, men who move outside of the dominant norm of heterosexual polygyny, sexually active young people under the age of 16, and women and men who cross national borders in their search for economic survival, who are defined as social problems and are identified as the "risk groups." Through such definitions they are the primary targets for surveillance, education, and behavioral change programs.

In this paper, I therefore also argue that a perspective that reinforces stigmas and increases policing and control of vulnerable, already-marginalized social groups, obscures sexual activities and responsibilities of the socially, politically and economically powerful groups in Caribbean societies, and reduces the significance of factors other than sexual activity in the transmission and treatment of HIV/AIDS. The paper concludes that an alternative to the popularized "risk group" approach is appropriate for the Caribbean, and suggests that existing projects

among women in countries such as Haiti and Guyana, which stress a structural, yet culturally-specific approach to HIV/AIDS, may provide a relevant frame of reference.

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Abstract
Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

HIV, population mobility and gender in the Caribbean

by
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This paper is a call for research on the associations between HIV/AIDS vulnerability and the mobility of populations in the Caribbean, and how gender mediates these associations.

Population mobility is a major contributor to the HIV/AIDS epidemic as it increases the number of sexual partnerships as well as contacts with high-risk groups such as sex workers. Loneliness, insecurity, and freedom from social norms provide an impetus to risky sexual behaviour; these are compounded by economic hardship that may force people to trade sex for money or favours. Epidemiological studies have defined mobile populations as 'high risk' or as 'bridging populations', transmitting HIV/STI to lower risk groups in countries/regions of origin as well as destination. Further, partners left behind may engage in higher risk behaviour for emotional or financial support.

Because of cultural and linguistic differences, lack of awareness, fear of stigma and blame, or for some, because of their illegal status, foreign citizens generally have limited access to services for the national population, including HIV/AIDS and STI health services. Discriminatory policies can accentuate these inequalities. For short-term travellers within and between countries, length of stay can present a further barrier to access. Hence mobile populations rarely get included in planning activities for HIV/STI prevention and control.

The sexual division of labour affects mobility patterns, with women or men tending to predominate amongst those of a particular occupation seeking economic opportunities abroad. In the Caribbean, men predominate among migrant agricultural labourers, miners and construction workers. Generally these workers are on fixed term contracts and accommodated in close proximity to each other, sometimes in barrack style accommodation. Men also predominate among professionals in managerial positions working abroad or travelling for short periods on business assignments, though women

are increasingly taking up these positions. Female (and sometimes male) sex workers provide sexual services to male migrants, with their modes of operation, including the extent to which they are willing and able to protect themselves against HIV/ AIDS using condoms, varying according to factors such as the economic status of the men, competition with other sex workers and the location of sexual negotiation and activity.

Women bear a large burden of responsibility for social welfare in the Caribbean. Migrating and moving between countries is an important strategy used by them to maximise economic resources for their families. Petty traders travel between countries on a short term basis and may become involved in trading sex, for example with customs officers, to improve their economic opportunities. Women travel from poorer to richer countries within and outside the Caribbean to do domestic work and are rarely protected from sexual abuse by their employers. Many women travel to more prosperous or tourist destinations on a long or short-term or revolving basis (e.g. at weekends or around Carnival time) to practise sex work. Some countries, e.g. the Dominican Republic, derive considerable economic benefit from the export of sex workers throughout the Caribbean and beyond. Women predominate in social service occupations including nursing and social work. Many migrate from poorer countries of origin, depleting the human care and prevention resources for HIV/ AIDS.

Homophobia is an important contributor to the HIV epidemic. One of the ways is by contributing to increased frequency of travel by men who feel unable to express their homosexuality in their own countries. Richer men may travel to seek partners, often using short business trips as opportunities to engage in sex with or purchase sex from other men. Men offering sexual services often do this outside their country of origin to avoid disruption to relationships at home.

Caribbean people have a long history of geographical mobility, and the region now exports more of its people in percentage terms than does any other. The percentage is even higher if we count intra-Caribbean migration. There are also significant population changes arising from tourism, business and student travel. Despite these facts and the gender-specific vulnerabilities to HIV/ AIDS outlined above, there have been no major studies of the contributions of Caribbean population mobility to the epidemic, and no transnational interventions to address the issues. Indeed, transnational and regional research and approaches to addressing the HIV/AIDS risks of mobile population are rare worldwide. Research on mobile populations such as mineworkers in Southern and Eastern Africa has generally been concerned with the risks associated with mobility within countries. Moreover, there has been little co-ordination of the inputs of various agencies interested in HIV/AIDS/STI interventions among

different mobile populations such as migrant labourers and sex workers.

A research agenda on HIV, population mobility and gender in the Caribbean might address the following objectives:

1. To collate, analyse and summarise existing data on
    a. Gender-specific patterns of mobility within and between Caribbean countries
    b. Sexual behaviour of mobile populations
    c. HIV/ STI prevalence and incidence in mobile populations
    d. Health services available to non-nationals in Caribbean countries, with an emphasis on sexual and reproductive health services and interventions
    e. Immigration and social security policies and practices bearing on the welfare and living conditions of mobile populations in the Caribbean
2. To situate the Caribbean situation in global context via a review of literature on HIV/ STI and mobile populations
3. To identify the key mobile populations that may be at risk of HIV/STI both for the Caribbean as a whole and for individual countries
4. To provide a regional overview of the social, economic, political and cultural factors that may influence the vulnerability of mobile populations to HIV and STI infection
5. To enable policy-makers in government, NGOs and regional/ international agencies to place the experiences of particular countries with regard to HIV and mobile populations in regional and international context
6. To review literature on interventions to promote the sexual health of mobile populations, to glean the lessons learned for intervention development in the Caribbean
7. To foster relationships between stakeholders who can assist in the development of interventions to promote sexual health among mobile populations at regional and national levels. These stakeholders will include NGOs representing the mobile populations themselves
8. To foster cooperation between countries of origin and of destination so that joint sexual health strategies may be developed with mobile populations
9. To develop a regional research agenda on HIV and mobile populations, which may include:
    a. Identification of sexual and health-care seeking behaviours which may place mobile populations at risk of HIV/ STI in selected Caribbean countries. Qualitative research may explore locations and times of high-risk activity, characteristics of sexual behaviour and patterns of mobility. This may be followed by quantitative behavioural surveillance surveys.

b. Collection of primary data on the experiences of mobile populations and health care providers with regard to the quality of sexual health services in countries of origin and destination
c. Development and evaluation of interventions. This may involve the development of generic tools for intervention and evaluation which may be applied in a variety of settings across the Caribbean
d. HIV/STI prevalence surveys[1]
e. Development of research and intervention tools and "good practice" examples for rolling out to other Caribbean countries
f. The development of channels for the regular dissemination of information on mobile populations and sexual health in the Caribbean (e.g. newsletter, webpage, email list)

The author is interested in collaborating with researchers in the Caribbean to further define and fulfil a research agenda on HIV, population mobility and HIV in the Caribbean.

[1] The implementation of HIV and/or STI prevalence surveys would require careful ethical consideration given that it could result in aggravated discrimination against people from particular countries, areas or sectors.

ABSTRACT
"Gender, Sexuality and Implications for Substance Use and HIV/AIDS" Symposium
March 11-13, 2004

The situation of commercial sex work in Trinidad and Tobago in the context of the HIV/AIDS epidemic

by
Dr Brader Adaleine Brathwaite

Commercial sex work is illegal in Trinidad and Tobago. Hitherto, newspaper articles have emphasized reports on commercial sex work that was negotiated on the streets by both male and female commercial sex workers and gave accounts on raids by the police on venues such as clubs, brothels and bars where sex workers were either resident or where they were allowed to ply their trade undercover. The increasing numbers of teenagers as commercial sex workers in schools and on the street had also triggered some alarm.

This study sought to estimate the situation of commercial sex work in Trinidad and Tobago in the context of the HIV/AIDS epidemic. The methodology followed the directions of grounded research since no comprehensive study of commercial sex work had been conducted previously in Trinidad and Tobago. At first, stakeholders who had formerly intervened with commercial sex workers were convened to address the problems evoked by HIV in the commercial sex trade and to advise a research team on possible directions that could be taken in approaching the study. Among these were immigration, police, social and health care workers, and no-government organizations. At another tier, focus group discussions were conducted with key informants from these agencies, who provided specific advice on a suitable research strategy. The ensuing qualitative methodology then involved the recruitment and training of field interviewers who gathered data in a number of recommended locations on the segments of commercial sex work in Trinidad and Tobago.

Newspapers articles had been the main sources of information on commercial sex work previously but during this study 15 segments of commercial sex work have been identified. The segments are strung out from the activity on the street to personal advertisements in the print and electronic media. The situation of commercial sex work in Trinidad and Tobago is extremely intricate. This intricacy prevents an estimation of the numbers of male and female participating in this area of economic

activity. The segments of commercial sex work have however been captured as follows:

- Street prostitution: confined to a number of locations and involving women, teenagers, street children, 'sprangers' (drug addicts), drag queens, transvestites, and homosexuals
- Commercial sex work among men who have sex with men
- Sex workers marketing themselves at hotels
- Club prostitution: domiciled or non-domiciled sex workers, entertainers, local and foreign women organized and club and casino employees
- Residential commercial sex work: with bonded women, in prisons with prisoners and packaged arrangements at households
- Escort service: packages involving local and foreign women and school girls
- Sex tourism: involving foreign women and local beach boys
- Local and foreign mobile women and local beach boys
- Local and regional mobile sex and entertainment workers
- Advertised business fronts involving massage parlors, sex toy stores, modeling agencies, newspapers and the Internet
- Tertiary level foreign students as commercial sex workers
- School student activities as commercial sex workers
- A network involved in filming sexual activity for pornography

Findings suggest that the healthcare of commercial sex workers appeared to be handled individually by street workers themselves and there was evidence that those who work in clubs and escort services need to demonstrate their HIV/STIs status to employers through test reports with attendance at doctors for check-ups. Several street workers are aware of their risk for HIV and claim to be using condoms to prevent infection. Their information however, does not appear to be always accurate though appearing to be shared among peers; those who work individually however, would not have the advantage of peer education. Those commercial sex workers who are impoverished, such as the street children may not be able to afford to equip themselves with condoms.

It appears that the legal system that attempt to control commercial sex workers in themselves corrupt or weak, and that it would be difficult to prevent commercial sex work through the existing legislation. This is compounded by the fact that many involved in commercial sex work see it as a sensation seeking activity that will be removed by legitimizing it. The existing legislation opens the persons involved to many risky

transactions. Other persons involved also become more creative in the means of pushing it further underground into clandestine business ventures. This feature is seen in the ways in which front offices portray legitimate business as a veneer for the commercial sex work business that is conducted covertly. The exploitation of commercial sex workers and the violence perpetrated on them and by them in defense, as occupational hazards associated with commercial sex work, will not be suitably addressed in the existing legal framework. In the meantime, the human rights of the commercial sex worker are not protected when their activities remain illegal.

The study was executed by CAFRA, Trinidad and Tobago, and sponsored by UNDP

SEXUAL ECONOMICS AND THE YOUTH

Abstract
"Gender, Sexuality and Implications for Substance Use and HIV/AIDS" Symposium
March 11-13, 2004

Examining and Addressing the Vulnerability of Children Engaging in Transactional Sex to HIV/AIDS

by
Aziza Ahmed

This paper examines a child's increased risk to HIV/AIDS when engaging in transactional sex. Transactional sex is defined as an exchange of sex for money, goods or services and can be more broadly defined to include emotional support. This paper begins to dissect those forces that encourage children to become involved in transactional sex while seeking to understand how policies and programs can evolve to address the factors that place children in vulnerable positions to contracting HIV/AIDS. The paper has a particular focus on gender as an influencing factor in a child's decision and decision-making ability. This paper utilizes a vulnerability analysis framework in order to identify individual, societal and programmatic factors contributing to a greater risk of HIV/AIDS for a child engaging in transactional sex. The paper is based on research conducted in Jamaica, however, its conclusions can be applied more broadly in the Caribbean.

The vulnerability analysis concludes that several societal factors contribute to a child's involvement in transactional sex and in turn their vulnerability to HIV/AIDS: gender norms, economic vulnerability, age and cognitive ability, and interaction with foreign elements such as in case of sex tourism. These societal factors allow children engaging in transactional sex to be placed in risk generating situations including: lacking ability to negotiate condom use, lacking access to sexual and reproductive health services, lacking ability to negotiate sexual boundaries, being placed in sexually violent situations, or attempting to access a physical or emotional connection with another person. Risk generating situations are those in which a child may not be able to make a decision, a risk generating behavior is a behavior done by a child increasing his or her risk to HIV/AIDS. The issue of child agency is raised throughout the paper in regards to the various power dynamics that occur in sexual negotiation and transaction. Further the role of

The analysis points to several programmatic and policy level changes which much be made including those around ending stigma and discrimination, understanding stigma and discrimination around same sex sexual interaction and men as victims of sexual violence, addressing challenges around the age of sexual consent, shifting policy as appropriate around child prostitution, making adolescent sexual and reproductive health care services appropriate for children engaging in transactional sex, addressing sex tourism, and addressing sexual violence in transactional sex.

By understanding the elements contributing to risk generating behavior and risk generating situations policies and programs can better address vulnerability to HIV/AIDS for children on the individual and societal level. In keeping with the goal of improving existing programs and policies this paper will also utilize the vulnerability analysis to identify current gaps in appropriate policies and services in order to better understand steps forward in decreasing children's vulnerability to HIV/AIDS.

Author

Aziza Ahmed is currently living in Barbados where she is consulting for DAWN (Development Alternatives for Women in a New Era), UNICEF and UNIFEM on the related topic of HIV/AIDS, sexual and reproductive health and women's health in the Caribbean. The research for this paper was Aziza's master's thesis work at the Harvard School of Public Health.

Abstract

"Gender, Sexuality and Implications for Substance Use and HIV/AIDS" Symposium

March 11-13, 2004

PROSTITUTION AMONG YOUTH IN PORT of SPAIN TRINIDAD

by

Ann Lee

There has been a long-standing connection between prostitution and sexually transmitted diseases and drug abuse in Trinidad and Tobago. This link has normally been associated with middle aged persons and was confined to curable sexually transmitted diseases. Within the last three decades the fatal HIV/AIDS virus has become a part of ordinary life in Trinidad and Tobago. It is quite possible that the threat to the youth in this society is directly reinforced by another scourge – the development of a sex trade industry in Trinidad and Tobago. The primary focus of this paper is therefore the growing youth prostitution industry in Port of Spain, Trinidad.

This paper represents a preliminary exploration of prostitution among male and female youth in Port of Spain. It is essentially descriptive focusing on some of the routes that the youth follow to enter into prostitution, their philosophical perspectives, the structures that facilitate their entry into sexual-economic exchange and the push and pull factors that influence their decisions. Given these focal areas, the paper will attempt to highlight the international and national impact of social and cultural influences on what appeared to be a burgeoning sex trade industry in Port of Spain, Trinidad in the mid-nineteen nineties It will also examine the link between youthful prostitution and drug use and sexually transmitted diseases, especially among young women.

The main data are taken from research into child prostitution and pornography and the sale of children which was conducted some six years ago. At that time, while there was little evidence of pornography or sale involving children under sixteen (females) and fourteen (males), there was sufficient evidence of prostitution among children of the legally stipulated age and certainly, among young adults under age twenty-five.

The data suggested that both male and female youth were drawn into sexual-economic exchange as a means of meeting material and financial needs created, in part, by a youth sub-culture associated with brand name clothing and footwear, jewelry and financial liquidity. Prostitution was, therefore, a form of innovation in response to unemployment or low-paying work. In this regard, it was similar to car theft or pick-pocketing.

However, the available data revealed differences in approach to sexual-economic exchange between the genders. Among both there were street prostitutes who take up strategic positions on street corners and "hustle" clients. Like their male counterparts, they tend to operate in small groups.

Among females, on the other hand, a clear pattern of organized prostitution that was not found among males emerged. It is quite possible that male prostitution was as well organized as female prostitution but is far more covert.

For females, there was a network of night clubs, fashion houses and dating and escort services in addition to video productions. Each of these operations could be discrete but there was communication and cooperation among them. This paper will outline the operations of the networks and will attempt to highlight the thinking of some of the managers of these operations and the young women who engage in sexual economic exchange .

This paper outlines the operations of youth prostitution in Port of Spain, Trinidad.. Using profiles obtained in the course of the survey, it will attempt to make explicit the impulses that drive youth to become involved in sexual-economic exchange. Additionally, it suggests socio-cultural influences that propel young people into the world of sexual-economic exchange.

Abstract

Gender, Sexuality & The Implications for Substance Use and HIV/AIDS
11-13 March 2004

Sexual Encounters and Drug use among a cohort of Young Haitian Youth in Miami
The Haitian Adolescent Project

by
Ida Vintes Tafari, (Project Consultant)

The Haitian Adolescent Project has focused on two studies over the past five years. The Haitian Gang Project, and The Haitian HIV Project. Out of both studies important data has emerged around the issue of sexuality and other coming of age issues, including the age of onset for using drugs. A total of 596 youth, male and female, between the ages of 13 and 22 years old have been systematically interviewed along with their families to assess their risk for HIV as well as their engagement in transnational drug sales. In this paper, I will report on ethnographic data collected centered on the issues of sexuality, and the age of on-set for drug use among male Haitian youth in Miami. Comparative analysis will be made with local North American Black populations sharing adjunct communities and the increasing numbers of Jamaican youth residing in Miami-Dade and Broward when available. The shared predicament of drugs as a revenue in inner city communities coupled with failing inner city schools puts male youth in particular at risk for finding a living in the informal economy at an early age. A relationship is demonstrated between drug use and age.

By middle school, Haitian youth are being exposed to the informal society of drugs. Marijuana is the predominant drug for males, and 'black n mild' (tobacco) for women, although both smoke herb. Male youth begin to apprentice for a position as drug salesmen early in their high school years, and the process of working with an older person and becoming informed about the runnings of the street trade ultimately informs male youth about other coming of age issues, including which women are most vulnerable to giving up their sexual pleasures. The maturation street culture offers boys include how to be a man with respect to women. In their need to be critical and analyze personalities on the street, young boys learn to assess women, and even exploit women. They learn to differentiate the vulnerabilities of young women's needs and desires. They learn to manipulate young women's needs. Young girls

Ida Vintes Tafari

13-14 years old often look the attention of young men to embrace them and give them confirmation, especially if they are "mutts" (i.e. girls in need, lacking self assurance, perhaps lacking fathers, or group identity). Her acceptance by the young group of men, the one she likes and his friends, allows her to extend the favor of sexuality to the boy she likes, and if asked by him, to his friends as well. This often constitutes a first sexual encounter for some of the young men, one that may not occur without the help of friends. Although these situations of 'trains' (consecutive sex with a number of boys) appear to be a behavior that further maturation diminishes, the consensual nature of this behavior among girls is an important point from which to intervene.

At this level of maturation (13, 14, 15 years old) ethnicity is not important, nor is 'epidermal' politics. Young men like women, so she can be African American, Latin Haitian or White. The paper will present some of the data on youth drug use and sexuality currently being assessed in an on-going project. It has revealed how little we know about youth sexuality, and the need for comparative analysis.

TRANSGRESSIVE SEXUALITIES

Abstract

Gender, Sexuality and Implications for Substance Use and HIV/AIDS Symposium
March 11-13, 2004

Inmates and HIV/AIDS – How a Specific Attempt to help to prevent HIV/AIDS Transmission for a High Risk Population has been hampered by prevailing norms regarding Gender Performance

by:
Lisa A Crooms

In August 19197 then Commissioner of Prisons Lt. Col. John Prescod publicly called for condoms to be distributed in Jamaica's men's prisons to help address the growing problem of HIV/AIDS within the prison population. Warders walked of the job to demonstrate the offense they took at the Commissioner's having implied they were having sex with inmates. With the guards gone, the inmates seized two prison (St. Catherine District Prison in Spanish Town and the General Penitentiary in Kingston), and three days of rioting ensued. Sixteen inmates were killed and more that 40 were injured. The guards returned to work only after the commissioner publicly apologized for implying that were having sex with inmates and the government abandoned any plans to distribute condoms in the prisons.

This proposed paper considers three stories about the events of August 1997 that were told between 1997 and 2002. The first story was told by the media as the events unfolded. It casts the actions of both the warders and the inmates as being anti-gay and homophobic. The inmates, like the warders, acted because they were offended by Commissioner Prescod's suggestion that prisons were sites where men have sex with other men and their presumed heterosexuality was challenged by such a suggestion. Those killed in the melee were targeted because of their alleged homosexuality. The story is consistent with Jamaica's cultural script regarding homosexuality, which features virulent and at times violent, homophobia. The second story was told during the commission of Enquiry convened by the government over the months that followed the strike and the riots. This story makes explicit what Prescod implied. That is, warders and inmates were having sex and this was not only what Prescod's proposed condom distribution sought to address but also the cause for the inmate riots. In this story, however, the inmates did not riot to support the warders. They rioted to protest the favoritism allegedly shown by the warders towards their

sexual partners. Here, those killed and injured were not targeted because of their homosexuality as such but rather because of the benefits their sexual identity and /or practices apparently yielded them. In this way, the riots were facilitated rather that caused by Prescod's condom distribution proposal and only the warders seemed to be motivated by the challenge posed to their masculinity and presumed heterosexuality by Prescod. The third story is found in a recent book, Shower Posse: The Most Notorious Jamaican Criminal Organization. According to Vivian Blake who was both locked up in Kingston's General Penitentiary when the riots occurred and transferred to St. Catherine's District prison soon thereafter, the inmates rioted for reasons that had little if anything to do with either the proposed distribution of condoms or alleged favoritism shown toward the warders' sexual partners. Rather the inmates' rioting was opportunistic in that they took advantage of the warders' strike to settle existing political (both real and perceived) scores. Here, those killed and injured were targeted because of politics, personal grievances, and jockeying for authority and power among the inmates.

Using these three different stories of the events of August 1997, this proposed paper considers the broad issue of how this specific attempt to help to prevent HIV/AIDS transmission for a high risk population has been hampered by prevailing norms regarding gender performance as a matter of appropriate sexual partners and proper sexual relations that are at odds with the reality of HIV/AIDS transmission of this particular population and those with whom they have sex upon release, i.e. the mostly women who risk being infected by formerly-incarcerated sexual partners.

Among the things it will examine is why, in light of the second and third re-telling of the story, the first has retained its currency and continues to allow the inmate riots to be cast as a violent and homophobic reaction to the assumptions apparently underlying Prescod's original suggestion, which include the notion that prisons are sites where men, particularly warders, have sex with male inmates. It will consider how the apparent negative views of most Jamaicans regarding homosexuality and its accompanying homophobia might contribute to the continued validity for the first story and its elision of the boundary between the motives and actions of the warders and those of the inmates which are more pronounced in both the second and the third stories. It will also look at how gender, particularly as a matter of performance , is present in all three stories and the extent to which the same gender norms, as a matter of construction, are helpful to understanding how Jamaica's race/color/class variant masculinities may be a common thread that runs through all there stories. While condom distribution is but one

proposal, it can be viewed as perhaps being based on a view of Jamaican manhood and masculinities that acknowledges the centrality for sex and sexual performance and seeks to accommodate this by facilitating safer sex for the incarcerated. In other words, the views of masculinity and manhood thought to challenged by the proposal may, in fact, be the basis for the proposal, particularly as advanced by members of the Ministry of Health who see condom distribution as part of a program of necessary prison reforms designed to reduce risky sexual behavior within the prison population. Finally, it will consider the role gender and the hierarchy of masculinities at work within the prison system as a way to understand the warders' reaction to Prescod's suggestion and the absence of any comparable reaction to the Ministry of Health's support for condom distribution within prisons and the acknowledgment of warder-inmate sex by tow top-ranking police officials.

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