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# YOUTH VOICES: GENDER, SEXUAL AND REPRODUCTIVE HEALTH AND HIV/AIDS IN THE CARIBBEAN

*Edited by*
*Leith L. Dunn Ph.D.*
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# GENDER, SEXUAL AND REPRODUCTIVE HEALTH AND HIV/AIDS IN THE CARIBBEAN

Edited by
Leith L. Dunn Ph.D.

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## FOREWORD

UNFPA, the United Nations Population Fund is pleased to support the Institute of Gender and Development Studies (IGDS) Mona Unit to publish the sixth in the series of Working Papers on 'Gender, Sexual and Reproductive Health and HIV/AIDS in the Caribbean'. This publication contributes to efforts to fill the urgent need for evidence-based research and information in order to increase awareness of sexual, and reproductive health and rights and the development challenges facing the region in these areas.

UNFPA aims to provide women and girls everywhere with the necessary information, services and tools to make informed choices about their health, their bodies and thus the future of their lives, families and communities. Providing spaces and opportunities for public dialogue and engagement on significant issues related to population and development is critical to realizing this goal. In addition, UNFPA has a commitment to creating opportunities for young people to fulfill their potential. An important part of honouring that commitment is providing support to training institutions and promoting the empowerment of their students by encouraging interrogation of the issues that impact development.

This initiative seeks to deliver well researched and documented insights into various dimensions of gender, sexual and reproductive health and HIV & AIDS in the Caribbean. Areas of focus include among others, a look at the different attributes and roles that societies assign to males and females that profoundly affect their ability to protect themselves against HIV and to cope with its impact within the Caribbean; the critical factors and risks of contracting HIV; stigma and discrimination and the change agents that are needed for increased awareness of the symptoms and causes.

Globally, 34 million people were living with HIV at the end of 2011. Of this population, 243,000 live in the Caribbean. Despite a 42 per cent decline in the number of people acquiring the HIV infection between 2001 and 2011, HIV remains a major challenge for the Caribbean. The high prevalence among young people ranging from 0.1% in Cuba to a high of 3.1% in the Bahamas, and particularly among girls where the prevalence reaches up to 3 per cent in the Bahamas is a major concern. So too is the fact that among persons 20 – 59 years old, HIV and AIDS is the leading cause of death. In addition, persons living with HIV are among the marginalized groups most at risk of stigma, discrimination and violence.

By partnering with the University of the West Indies, through the IGDS to publish this paper we are seeking to make a difference in people's lives by providing access to information to guide discussion, generate ideas, challenge societal norms and beliefs that promote stigma and discrimination, and to make choices for a better quality of life. This publication supports UNFPA's broader commitment to ensuring everyone's right to reproductive health.

***Sheila Roseau***
*Director,*
*UNFPA Sub-Regional Office, English and Dutch Speaking Caribbean*

# INTRODUCTION

Leith L Dunn Ph/D (Editor)

*Youth Voices: Gender, Sexual and Reproductive Health and HIV/AIDS* is the theme of Working Paper 6 published by the UWI's Institute for Gender and Development Studies (IGDS) Mona Campus Unit in partnership with UNFPA, the United Nations Population Fund, Sub-Regional Office for the Caribbean.

The publication is significant as it represents the 'first fruits' from undergraduate students in GEND3600: Gender Sexual and Reproductive Health and HIV/AIDS, a new gender course in the BSc Gender and Development programme developed in 2010/2011. The course responds to an urgent need to build awareness and technical capacity to understand how gender affects sexual and reproductive health and STI/HIV risks, builds capacity to mainstream gender in reproductive health policies and programmes. It supports the achievement of the goals of the 1994 ICPD Programme of Action, the Millennium Development Goals and other commitments. The course has been delivered successfully to three cohorts of UWI undergraduate students and 23 policy and programme staff in the Ministry of Health's (MOH) National HIV/STI programme. The MOH participants completed the course during Summer School sessions, with support of a European Union and UN Women project to enhance the Ministry's Gender and HIV AIDS programme.

The publication of Working Paper 6 is significant and timely for several reasons. It fills a gap in the literature, and highlights the voices and perspectives of young males and females who are most at risk of STI/HIV infection. Then, globally countries are preparing for the 20 Year Review of the ICPD Programme of Action and the Post 2015 Agenda. Preliminary results of this review process show that there are still many gaps between the principles of reproductive rights in the ICPD, and current sexual and reproductive health policies and practices. The need for increased awareness is urgent, given the reality that the Caribbean region has the second highest rate of HIV infection per capita globally after countries in Sub-Saharan Africa and the epidemic is increasingly feminised. The concept of the *feminization of HIV and AIDS* indicates that women and girls have an increasingly higher rate of infection than men and boys. This is largely the result of biological and social factors.

## IGDS 20th Anniversary

Publication of Working Paper 6 also coincides with the 20th anniversary of the IGDS an academic discipline within the UWI. The Working Paper reflects the Institute's strategic response to the need to build knowledge and technical capacity to mainstreaming gender in sexual and reproductive health and HIV/AIDS policies and programmes. In so doing it responds to an emerging gender and development issue in the Caribbean. This is consistent with the Institute's

mandate to support teaching, research/publications and outreach. The latter includes building public awareness and influencing public policy. Working Paper 6 also helps to disseminate evidence-based research findings to a wide range of stakeholders to increase awareness of gender-related HIV risks for both males and females throughout the life cycle. This can help to influence: decision-makers to develop gender-sensitive policies; young women and men to reduce the high levels of unplanned pregnancies and the high rates of HIV infection among marginalised and at risk population groups (MARPS). These include: Men who have Sex with Men; Women who have Sex with Women; Commercial Sex Workers (male and female); Adolescents and Persons with Disabilities who are underserved.

**Understanding Gender versus Sex**

Despite the Institute's extensive teaching, research, outreach and publications over the last 20 years, the concept of gender as a social construct as distinct from sex as a biological category are still not widely understood by the general public. Many people are still unaware that differences in the socialization of boys and girls by family church, school, peers and the media, result in distinct gender roles, responsibilities and power differences associated with masculinity and femininity. Working Paper 6 helps to explain how these differences and the resulting social economic and political inequalities that develop between the sexes impact on reproductive health. For example, gender roles and socialisation result in many women and girls having limited power in sexual decision-making which makes them vulnerable to STI/HIV infection and other reproductive risks. Gender role socialisation also poses risks for many boys and men. Some are forced to be sexually active to prove their heterosexuality and manhood while males who are forced to have sex with other males are unable to speak of their experience, for fear of being ostracized or stigmatized as being gay.

**Rationale for Gender Mainstreaming**

Working Paper 6 introduces readers to the concept and process of mainstreaming gender as a development strategy. This was adopted by the United Nations in 1995 to enable governments to assess the likely impact of any policy or programme on males or females to improve development planning. Gender mainstreaming supports effective development and implementation of sexual and reproductive health and HIV/AIDS policies and programmes consistent with the Programme of Action (POA) of the International Conference on Population and Development (ICPD). Gender mainstreaming also supports other global human rights commitments to promoting gender equality and development. Among these are: the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the Millennium Development Goals (MDGs); and agreements from the United Nations General Assembly (UNGASS) on HIV/AIDS. At regional level it supports the Caribbean Regional Plan of Action in HIV/AIDS and commitments to gender equality. At national level it supports implementation of Jamaica's National Policy for Gender Equality

(NPGE) approved by Parliament in 2011 and the country's long term strategic development plan Vision 2030 Jamaica.

**Careers and Capacity Building**

Despite these global and national commitments to mainstream gender in development policies and programmes, there is *limited human resource capacity* in Jamaica and most of the other Caribbean countries to support this process. The Working Paper builds awareness of the need for persons with the requisite skills and emerging career opportunities in this field to address critical issues of concern such as: high levels of maternal mortality, teenage pregnancy; gender based violence; early sexual initiation and forced sex; limited understanding of reproductive rights, and unmet needs for reproductive health services especially among sexually active adolescent boys and girl and rural women. There is need gender specialists to support the delivery of reproductive health education programmes that will explain how gender roles result in both males and females being at risk in different ways, hence the need to ensure that programmes are gender-sensitive to meet their specific needs of each sex. Gender specialists can help to ensure effective use of limited financial resources by targeting the specific needs of a sexually diverse population.

**Caribbean Parliamentarians and Policy Makers**

Working Paper 6 is an excellent resource for Caribbean Parliamentarians. It responds to the keen interest demonstrated by Parliamentarians who participated in a Regional Conference on Gender Based Violence hosted by UNFPA in 2011 at which IGDS staff made presentations. Policy makers highlighted their need for current evidence-based material, and resource materials to guide policy making on sexual and reproductive health and HIV/AIDS.

Among the expected outcomes of this Working Paper are:

a) Increased understanding of the linkages between Gender, Sexual and Reproductive Health and HIV/AIDS;
b) Increased awareness of gender mainstreaming as a strategy to support implementation of the ICPD Programme of Action;
c) Increased access to Caribbean research- based articles from the GEND3600 course that can help to inform public policies and debates, support public education and advocacy as well as encourage follow-up research.

**Personal and Political Interest**

This Working Paper also reflects personal as well as political interest. This is being shared to encourage students to take advantage of emerging opportunities to develop their careers. My personal interest in sexual and reproductive health was sparked during my UWI undergraduate years by researching and writing a paper on the Jamaica Family Planning Board's work and the

impact of their very successful campaign "Two is better than too many". The political interest was further developed through my involvement in the UWI's Women's Studies Group in the 1980s which led to formation of the Centre for Gender and Development Studies (CGDS) in 1993, which became the Institute for Gender and Development Studies in 2008. As a CGDS Research Associate I also documented case studies of men in the *Brothers for Change Programme*, which promotes behaviour change among men convicted of abusing women. This programme was a joint initiative between the Jamaica Family Planning Association (JFPA), the Department for Correctional Services, and staff of the UWI's CGDS and UWI Health Centre.

Opportunities to support advocacy and public awareness continued while employed as Projects Officer with Christian Aid in the UK funding HIV/AIDS projects in Latin America and the Caribbean between 1987 and 1992 and consultancy work in subsequent years. Employment with the United Nations Population Fund (UNFPA) Office for the English and Dutch Speaking Caribbean between 2003 and March 2006, first as Population and Development Strategies Advisor and Gender Focal Point and later as Assistant Representative provided valuable experience : managing three large OPEC funded HIV/AIDS projects in Belize, St Lucia and Guyana, working on the population census with CARICOM and mainstreaming gender. Membership in a UN Women (formerly UNIFEM) Caribbean Regional Advisory Task Force on Gender and HIV also provided opportunities for advocacy to promote gender analysis and gender mainstreaming in HIV/AIDS programmes at a regional level through participation in meetings of CARICOM's Pan Caribbean Partnership on HIV/AIDS (PANCAP). Conducting research with Jeanette Bell and Althea Perkins for UNIFEM resulted in the publication of a *Checklist to Mainstreaming Gender in HIV/AIDS* for use by National HIV/AIDS Committees across the region. Research funded by UN Women also resulted in a gender analysis of the National Strategic Plan on HIV/AIDS of the Ministry of Health in Jamaica which recommended recruitment of a Gender Focal Point and funding a national Gender and HIV/AIDS programme. This project was later implemented with support from the European Union and UN Women. Partnership with the Ministry of Health (MOH) has enabled the IGDS Mona Unit to participate as a member of the National Gender and HIV Advisory Committee, and to support training of MOH staff and stakeholders, advocacy, and publication of the MOH's Gender and HIV Training Manual. The journey to promote the ICPD Cairo Agenda has continued in my current post as Senior Lecturer and Head of the Institute for Gender and Development Studies Mona Campus at the UWI since April 2006. The course GEND3600 was therefore developed in response to findings of several research studies and the demonstrated need to build technical and institutional capacity to mainstream gender in health across the region.

**Overview of the Papers**

These selected papers from GEND3600 students reflect the research of an expanding group of GEND3600 students who have completed the course. Some repetition is evident but unavoidable and we ask readers to be understandable.

The first paper written by Kimberly Carr provides the foundation for gender analysis and gender mainstreaming which seeks to develop an understanding of gender as a social construct learnt through gender socialization. It examines the different roles, responsibilities and attributes that societies assign to males and females in the Caribbean and how factors profoundly affect individuals' sexual safety risks and their ability to protect themselves against the risk of HIV/STI infection and to cope with its impact.

The second paper by Karen Wade builds on the issues covered in the first paper and provides a gender analysis of the social, economic and cultural factors associated with the HIV/AIDS epidemic. It demonstrates how the unequal status assigned to the roles of males and females in Caribbean society contribute to the spread of HIV and AIDS.

The third paper by Chantae Brown provides a further analysis of how these gender roles can influence the development of risky sexual behaviours. It examines how the normalization of heterosexuality during the process of gender socialization can impact an individual's sexual behaviour and can pose risks for HIV infection. Dominant social norms can present barriers to an individual's expression of their sexuality. This she argues can result in the development of secretive sexual behaviours which become difficult to control and can contribute to the HIV/AIDS pandemic in the Caribbean region.

The fourth paper by Tania Brown, focuses on gender and sexuality. It also examines how the social construction of gender impacts on the development of an individual's sexual identity and their expressions of sexuality. It provides an important analysis of how gender influences sexuality and sexual behaviour and the susceptibility of males and females to HIV/STI infections and the related health risks and consequences for individuals.

The fifth paper by Brenda Sailsman focuses on risks linked to sexual orientation and stigma and discrimination against HIV positive persons. It also discusses the essential changes needed to build awareness of HIV, the causes of infection and expansion of services to a broad range of sexual groups.

The sixth paper by Ann- Marie K Virgo analyses how gender and power inequalities influence the transmission of HIV/AIDS in both heterosexual and homosexual relationships. It provides insight into the differential experiences of women and men who are infected and affected by HIV.

The seventh paper by Marla Phillips examines multiple gender-related risk factors for HIV transmission. These include: alcohol and drug abuse; migration and population mobility; sex tourism, and stigma and discrimination against people living with HIV/ AIDS. It continues the analysis of HIV risks for both males and females in heterosexual and same-sex relationships.

The eighth paper by Christina Stephenson continues the analysis of gender-related risks for males and females in heterosexual and same-sex sexual relationships.

The ninth paper written by Jehnell Spencer presents a gender analysis of a sample of safe sex advertisements in Jamaica and assesses their effectiveness in combating the spread of HIV and AIDS among males and females. The paper explores the messages and their potential impact on sexual behaviour of men and women. This paper can be further developed to have a positive impact on mainstreaming gender in communication and advertising campaigns to prevent HIV/STI infections.

The tenth paper by Ashli Rose provides a theoretical framework for understanding the linkages between gender, sexuality and HIV/AIDS. It examines some of the gender and development theories that explain the social, economic and political inequalities associated with masculinity and femininity and how these inequalities pose differential risks for both males and females and contribute to the spread of HIV. This paper will be particularly useful to UWI students doing this course from other faculties as well as general readers who have limited understanding of gender and development.

The eleventh paper by Coreen Stephens focuses on vulnerable groups and examines the gender differences in HIV infection among high risk groups such as: Commercial Sex Workers (CSWs), migrant workers, adolescent boys and girls and Men who have Sex with Men (MSM) including homosexual and bisexual men. This provides an introduction to the literature on Marginalised and at Risk Population Groups (MARPS) which is an important target group in the campaign to reduce HIV infections. In future other students doing the course can build on this analysis to fill the many gaps in understanding the gendered realities and HIV risks of MARPS.

The twelfth paper by Tanya Davis provides another analysis of how gender and sexuality separately and together determine the differential HIV risk factors for males and females in the Caribbean, in both heterosexual and same-sex sexual relationships.

The thirteenth paper by Kevon Kerr provides a male perspective on the experiences and HIV-risks for: adult and adolescent males and females in heterosexual and homosexual relationships; Men who have Sex with Men; women and sex workers. This paper will hopefully encourage more research, analysis and action by males who can provide a unique perspective on how gender impacts sexual and reproductive health and HIV risks. Increased involvement of males in gender and HIV-related research and action can fill important gaps in understanding the problem and guide the development of more effective policy and programme solutions.

The fourteenth paper by Denise Young provides additional insight into the impact of gender on HIV transmission. The paper highlights the most common ways of sexual transmission through vaginal anal sexual intercourse and how gender affects HIV transmission in heterosexual and homosexual relationships.

The fifteenth paper by Melaine Gobay explores the gender-related HIV risks that are shaped by biological and social factors for males and females in heterosexual and same sex relationships in

Jamaica. It focuses on the unequal gender power relations which increases the vulnerability of women in heterosexual relationships to HIV infections.

The sixteenth paper by Marlon Johnson provides a male perspective on adolescent sexual and reproductive health. It examines a number of factors that related to a profile of this at-risk population cohort that marks the difficult transition from childhood to adulthood and significantly impacts the health status of the population. It highlights the gaps between adolescents' knowledge, attitudes, practices and behaviour (KAPB) from a gender perspective and concludes with recommendations to reduce the risk of HIV infection among adolescent girls and boys.

The concluding section places the Working Paper in a global, regional, national, institutional and personal context and highlights possibilities for its use by various stakeholders.

In closing I wish to thank UNFPA for their partnership, the authors for their contributions, and all IGDS Mona Unit staff. Special thanks to Ms Kimberly Carr Research Assistant, Ms Ingrid Nicely Senior Administrative Assistant and Ms Ann Marie Virgo who contributed to 'birthing' this publication. Sincere thanks to the UWI's Management team and to SALISES which enabled me to have three months study leave followed by a four-month Fellowship to write.

**Leith Dunn Ph.D.**
Senior Lecturer/Head IGDS Mona Unit and Editor
December 2013

**Choices**

I was born my mother's child
So innocent was I
Not knowing what awaited me
In this cruel unforgiving world.

My mother, a higgler, was very poor
She gave all she could
But I wanted more.
All I saw was the glamour and glitter
Clothes I could not pronounce,
Phones that went on twitter

School wasn't my thing,
I thought I couldn't learn.
Yet still for the material things
My heart had a yearn.

And so with no idea,
With no plan inn hand
I took the night
In a strange unknown land.

I would do it all,
If the price was right.
The work was minimal
The money was just right.

But all "good" things come to an end
Just as all days turn to night
What once gave me joy,
Now turned into fright.

I was now positive,
Positively infected
Because of choices I'd made
And the road I'd selected.

Kevon Kerr

# Gender and HIV/AIDS in the Caribbean

KIMBERLY L. CARR

*"At the end of 2009 it was estimated that out of the 33.3 million adults worldwide living with HIV and AIDS, slightly more than half are women. The AIDS epidemic has had a unique impact on women, which has been exacerbated by their role within society and their biological vulnerability to HIV infection. Generally women are at a greater risk of heterosexual transmission of HIV. Biologically women are twice more likely to become infected with HIV through unprotected heterosexual intercourse than men. This epidemic unfortunately remains an epidemic of women*" (UNAIDS, 2010, p. 23).

## Introduction

UNAIDS (2010) reports that in 2009, an estimated 17,000 people in the Caribbean became infected with HIV, and an estimated 12,000 died of AIDS. After sub-Saharan Africa, the Caribbean has a higher HIV prevalence than any other area of the world, with one (1) percent of the adult population infected. Heterosexual sex is the main route of transmission in the Caribbean region. Women are particularly vulnerable to HIV infection and data show that more than half of the people living with HIV are women. Other vulnerable groups include Men who have Sex with Men (MSM). They are also at risk but are often overlooked in national programmes and services aimed at prevention, treatment and care. This imbalance persists despite national reports that HIV prevalence among MSM is 32 per cent compared to 1.7 percent in the general population. Gender roles and stereotypes contribute to discrimination that fuels HIV infection. The literature suggests that masculinity increases vulnerability to HIV infection and that gender roles and expectations contribute to a range of risky behaviours that increase rates of infection.

## The Context of Risk and Vulnerability

The issues of HIV infection remain complex, firmly grounded in obstinate and wide-ranging social problems. Perhaps the most damaging of these social problems are the enduring inequities in society, particularly gender inequities and issues related to sexuality. These inequities create groups which are more vulnerable to HIV. The view is that men want sex, some with many partners while women want love and commitment. Dominant social norms indicate that male sexuality is free, active and dominant while female sexuality is constrained, passive and vulnerable. Male sexual behaviour is often perceived to be driven by unrestrained biological urges which are to be promoted, celebrated and enjoyed. In the Caribbean, where male homosexuality is heavily stigmatized, early sexual initiation of boys is encouraged by some parents to promote heterosexual normality. Both males and females are socialized to adopt gender roles that define heterosexual masculinity and femininity.

These gender-based role expectations can increase vulnerability to HIV infection. For example, in many societies including the Caribbean, females are expected to be innocent and sexually submissive. This however prevents some females from accessing sexual health information and services. For many men, masculinity is linked to being sexually dominant, having multiple

sexual partners with taking risks. These behaviours can increase males' vulnerability to HIV infection and discourage them from taking HIV tests and seeking treatment.

The issues of HIV infection remain complex, firmly grounded in wide-ranging problems related to social organization. Of these, gender inequities and their impact on women's and men's sexuality and their sexual and reproductive health are among the most important. Gender inequities result in some social groups being more vulnerable to HIV infection than others. The inequities that contribute to the view that male sexuality should be free, active and dominant, while female sexuality should be constrained, passive and vulnerable increase HIV infection risks for both sexes. Male sexual practices are perceived to be driven by unrestrained biological urges and are promoted, as adorable. In contrast, female sexual practices are expected to be "innocent" and "submissive" which also contribute to sexual vulnerability and HIV risk. These gender role expectations and sexual practices prevent both males and females from gaining access to sexual and reproductive health information and services, thus increasing their vulnerability. According to UNAIDS (2010) gender-based expectations can increase vulnerability to HIV infection. They also note that masculinity is allied with taking risks and being tough, and explain that this can increase vulnerability to HIV infection and discourage them from seeking testing and treatment.

In addition to HIV risks associated with social norms, some groups are more at risk than others. Commercial sex workers are one of the most vulnerable at-risk groups. From her research in Guyana, Allen (2006) indicates that 30.6 percent of female sex workers were infected with HIV. Allen also reported that female sex workers are frequently thought of as being at a higher risk of HIV exposure. This is because they are often not in a position to ensure that their customers wear condoms. Men who have sex with men are another high risk group. An article on AVERT's website [1] notes that part of the HIV epidemic is the result of sex between men and notes that it is significantly high because it involves anal sex – a practice that, when no protection is used, carries a higher risk of HIV transmission than unprotected vaginal sex. These articles note the links between gender roles, masculinity and vulnerability to HIV infection.

**Gender Relations and Sexuality**

The International Council for AIDS Service Organizations (ICASO) (2007) notes that an "individual's gender and sexuality determine the extent to which he/she will be vulnerable to HIV and his/her ability to access services" and that "HIV vulnerability is influenced by male dominance, and HIV and AIDS are both thrust and entrenched by gender inequality" (ICASO 2007, p. 3). Power and gender relations are central to sexuality due to the unequal power imbalance in gender relations that favors men in heterosexual interactions. In these relationships male pleasure tends to overtake the importance of female pleasure. Men also tend to have greater control than women about when, where, and how sexual intercourse takes place. The underlying power relationship in any sexual interaction, determines how sexual expression is conveyed and practiced and whose desire is given priority. For example in most Caribbean societies, the prescribed sexual relationship is between a man and women. Any other sexual contact that society dictates is inappropriate is therefore scrutinized and this leads to discrimination.

[1] See http://www.avert.org/aids-hiv-epidemic.htm

## HIV Risks in Heterosexual Relationships

The International Labour Organization (2010), contends that the greater the gender discrimination in society and the lower the position of women, the more negatively they are affected by HIV (as a group) because of social and economic factors. Many women are economically dependent on men for financial support and as a result are unable to negotiate safe sex or no sex, even when HIV is a risk. Men tend to make the majority of decisions for both themselves and their female partners and as a result, if a man decides not to use a condom then his female sexual partner has to adhere to that decision. The power imbalance in these relationships, contributes to domestic violence and rape of women, increases the risk of HIV infection and makes it difficult for women to protect themselves.

The United Nations Office for the Coordination of Humanitarian Affairs (2007.) argues that the global HIV pandemic is strongly influenced by traditional ideas about masculinity (p. 2). Men they argue continue to exercise power in the majority of sexual relationships and that this imbalance often deprives women of the ability to make decisions about their health or status. Men's views about manhood are entrenched in attitudes and behaviours that are high- risk such as the idea that "real" men must have multiple sex partners and engage in risky violent behaviours. The stereotypical assumption that men are more sexually experienced than women prevents them from seeking information about sexual and health- related problems. UNAIDS 2010 report also noted that men, regardless of culture tend to have more sexual partners than women (p. 122).

## HIV Risks for Males in Same-sex Relationships

The United States Centers for Disease Control and Prevention (CDC) (2010) defines Gay and bisexual men, as Men who have Sex with Men (MSM). The CDC also notes that MSM continue to be the risk group most severely affected by HIV. The CDC also reported that "between 2006 and 2009, the number of new infections that occur each year increased among young MSM - driven by an alarming 48 percent increase among young, black MSM 13 to 29 years old" (CDC 2010, p. 1). The website AVERT in its article on HIV transmission states that it is easier for HIV to be transmitted through unprotected anal sex than through unprotected vaginal sex. the article also notes that if a man has another sexually transmitted infection (STI), this can be an extra biological factor that increases his risk of becoming infected with HIV. Readers are made aware that STIs are relatively common in MSM, and because men are not always encouraged to be tested for STIs that are present in the rectum, these infections often go undiagnosed and untreated, thus making the transmission easier among MSM.

## Conclusions and Recommendations

The papers shows that gender socialization creates a power imbalance between men and women, which favors men. This imbalance not only contributes to risks of HIV infection for both sexes but also makes females as a group more susceptible to HIV infection than males and contributes to unequal access to key resources which are needed for prevention and care. Men's vulnerability to HIV infection is linked to societal expectations about dominant forms of masculinity which

encourage risky sexual behaviours such as having multiple partners and having unprotected sexual intercourse. MSM are at very high HIV risk because their sexual behaviour is not considered normal, resulting in stigma and discrimination which in turn impacts their access to prevention programmes. Women as a group are also one of the most susceptible groups because they exist in an environment of inequality. In order to stem the HIV epidemic, existing gender relations and power imbalances need to be addressed. Gender needs to be mainstreamed in various policies in relevant sectors including in health to prevent HIV and AIDS. The result will be gender equity and equality for both men and women and reduce the risks of the most vulnerable population groups.

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## HIV/AIDS and the Caribbean

KAREN WADE

### Introduction

The 1994 ICPD Program of Action, states that everyone has a right to information and services to guarantee their reproductive health. Article 1 of the Universal Declaration of Human Rights (UDHR), adopted by the UN in 1948, also states that: All human beings are born free and equal in dignity and rights. Article 2 also states that: Everybody is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex and language. The Convention to Eliminate All Forms of Discrimination against Women (CEDAW) also advances women's human rights protection by applying a gender perspective to principles enunciated in the UDHR. CEDAW is the first international treaty to define discrimination against women. Women's and men's roles in society are shaped by socio-cultural expectations, which influence how HIV infection impacts on the lives of both sexes.

Many social, economic and cultural analyses of the AIDS epidemic show that among the factors contributing to the spread of HIV/AIDS are the differential and unequal roles and status of men and women in society. Women are often given less value and status than men and the behaviours and attitudes associated with womanhood are often considered less prestigious than those associated with manhood. These imbalances influence how HIV and AIDS impact on women's lives and threaten women's health. Our patriarchal society is male oriented and male dominated. This is the result of social construction of gender roles that adversely affect women's self-esteem and self-confidence. Male dominance has caused the subordination of women and has given men an inherent right to control women's sexuality, often leaving women (as a group) powerless over the right to control their own body. Gender inequalities are increasingly being understood as a significant factor in the transmission of HIV/AIDS.

Patriarchy has not only affected women but also men because there are men who are subordinated by other men. For example, society frowns on behaviours that go against accepted norms. MSM (Men who have Sex with Men) often experience violence and hatred because most people in society only accept heterosexual relationships as the norm. MSM are therefore degraded, discriminated against, and some are injured and killed because homosexuality is taboo in the Caribbean. These negative reactions against MSM as a group have resulted in them being afraid of exposing themselves as gays and denies them access to education and information that they need to protect themselves against HIV/AIDS. Negative attitudes towards MSM have made them susceptible to HIV infection and AIDS. People in Caribbean countries like Jamaica that do not accept homosexual behaviour, have to learn tolerance and respect for the rights of human beings including MSM so they can be educated to protect themselves from the risk of HIV infection.

Sexual norms are influenced by culture and also contribute to HIV risks. In the Caribbean, men are free to explore their sexuality while women are expected to relate to it defensively. Women's sexuality is policed by social and gender conventions that constrain their sexual behaviour which

are not equally applied to men. Notions of gender and sexuality are fundamentally shaped by culture. Through the process of socialization, people come to understand and internalize specific meanings of the body, of gender and sexuality, and establish the norms of socially acceptable behaviour. Many of these culture norms permit men to look at and to treat women in degrading ways. Many men look at women as sex objects, seeing only their breasts and legs-not the whole person. This is so because many men (and women) have been socialized to believe that women are comforters, nurturers and care givers. In our society, there is a lot of emphasis on the female body, resulting in many women also seeing themselves only as objects of male desire. In Jamaican society, some aspects of the social culture have taught women to use their bodies and sexuality to lure men into giving them what they want. Black feminist bell hooks (1984) argues that culture can devalue the status of women in society as women are often sexualized. Women she argues are often depicted as whores who are manipulative and use their vagina to conquer and exploit men. These women are exposed to HIV infection because men may use dominance and aggression in sexual relations, forcing the women to have sexual intercourse without using condoms. This type of unprotected sexual behaviour exposes women to HIV/AIDS because men are more likely than women to have more than one sexual partner.

The late UWI anthropologist Professor Barry Chevannes (2001) stated that Caribbean hegemonic masculinity has been characterized by men being virile and having multiple sexual partners. As a result many women lack power to negotiate safe sex which means consistent use of condoms, even among married women. However, if a woman carries condoms and states that she wants to use condoms, she may be labeled a prostitute, or may be accused of being unfaithful if she is in a committed relationship. In these situations she does not have the choice of protecting herself from HIV infection.

Reducing the risk of HIV infection means understanding that the social construction of gender roles and the impact on women's health. A review of the literature shows that women's health is not only influenced by genetics, biology and physiology but also by women's role in society. Inequalities in the social and economic status of men and women disproportionately deprive women of good health. Examples of these gender inequalities are seen in data which show that as a group, women earn less money, many are economically dependent on men and have fewer legal rights. This income disparity is linked to a power imbalance between the sexes, resulting in women (as a group) having an inferior status to men (as a group). The impacts of these inequalities are seen in diseases and conditions including in HIV and AIDS. They also infringe on women's reproductive rights, limit their access to health care and drugs, and their under representation in clinical trials in medicine. Unequal values placed on gender roles also influence health status later in life. Because femininity is often valued and given less prestige and status than masculinity and manhood, there are special risks for females who may start having children at a young age. Many drop out of school as teenagers and may not be able to complete their education. They may also not have access to education on reproduction, contraception and health care services. The prospect for the health of women is diminished because of these factors. Caribbean cultural constructions of masculinity and femininity impose obligations and restrictions leading to risky sexual practices. Information from UNAIDS shows that individuals are at risk of HIV infection when they have unprotected sex because they are exposed to sexually transmitted infection of all previous sexual partners. If they do not negotiate condom use every

time they have sexual intercourse they can contract the HIV virus. The risk is, especially high for sex workers and MSM.

HIV/AIDS is a global problem, but Caribbean countries have the second highest HIV prevalence in the world, (after countries in Sub-Saharan Africa). Data from UNAIDS Global Report (2012) [2] shows that the rate of HIV/AIDS infection among adults 15-49 years in Jamaica was 1.7 per cent. Reviews of sexual behaviour surveys conducted across the region have shown that the median age for first sexual intercourse was in the early to mid-teens. The age for first sexual intercourse is reported to be lower among males than females (Allen, 2002; Chevannes, 2001; Kempadoo and Dunn, 2001). The studies also show many children have sex below the age of consent which is 16 years. Barrow, (2004) reports that females are more at risk of HIV infection than males as some young girls are sexually initiated by much older men who would be more sexually experienced. Poverty has largely contributed to many of these young girls/women being dependent on older men for financial security, but older men are more likely to have had multiple sex partners, resulting in higher risk of HIV infection.

Risks of HIV infection are also the result of gender norms being deeply rooted in the socio-cultural context of Jamaican society and these are enforced by institutions and practices. Socio-cultural norms build notions of masculinity and femininity, which in turn create unequal power relations between men and women. This power imbalance curtails women's sexual autonomy and expands men sexual freedom and control over sexuality. The gender role that is assigned to women or "femininity" often demands that women adopt a submissive role, passivity in sexual relations, and ignorance about sex. These roles restrain many women from seeking and receiving information on HIV prevention. In the Jamaican society, motherhood is seen as a key aspect of femininity and this gender role is forced on women. Some women do not want children but society labels them if they cannot or do not want to have children. Some women use contraceptives including condoms, to prevent unwanted pregnancy. Others engage in anal sex to avoid pregnancy but this increases their vulnerability to HIV if condoms are not used.

Young girls are also more vulnerable to HIV infection because of several reasons. For many of them, their first sexual intercourse is likely to be forced (Kempadoo and Dunn, 2001). Biologically, they are also more at risk of STI/HIV infection because younger girls have softer vaginal membranes which are more prone to tear, especially if sexual intercourse is forced. Those having sex with older men are at a higher risk of HIV infection because of the man's sexual history. Women and young girl's unequal power also means they may be unable to negotiate safe sex and this is seen in the high rate of HIV infection among young girls 15-19 years.

Women's increased risk from sexual violence is also adds to their risk of HIV infection. Violence or the threat of violence against women affects women's ability to negotiate the conditions of sexual intercourse, especially the use of a condom during sex. Cultural stigmas and taboos also pose risks. If a woman carries condoms in her purse she is may be labeled a prostitute. Some women may avoid carrying condoms which increases their vulnerability to HIV infection. These

[2] http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf

taboos associated with sex and knowledge of sex act as barriers to women seeking information about HIV prevention. These and other traditional cultural beliefs and practices diminish the control that a woman has over decisions about her body, her reproduction and her life. These restrictions on women's behaviour and autonomy are not applied to men. Christine Barrow (2004) argues that power inequalities contribute to the spread of HIV/AIDS in the Caribbean societies. Unequal gender relations undermine women's ability to make informed and empowered decisions about their sexual relationships. Examples of this unequal power relationship are seen in higher levels of violence against women, subordinated men, children, sex workers, lesbians and homosexuals. These unequal power relations increase the risk of these groups contracting HIV/AIDS. They face discrimination in legislation, social policies and in the health system.

Barrow (2004) also states anti sodomy laws prevent gays from seeking welfare and deny them their human rights and citizenship. She further states that society need culturally relevant messages to target at- risk groups such as MSM and lesbians and that the stigma against same sex minorities needs to be rejected. Complying with gender expectations creates vulnerabilities for HIV/AIDS infections among these minority groups and not only for women in heterosexual relationships. MSM and lesbians are also susceptible to HIV infection as a result of current legislation and socio-cultural attitudes towards homosexuals. These factors have forced many gays to remain ignorant about HIV prevention strategies. Homophobia, according to Margaret Anderson (1992) is institutionalized as a system of control. In Jamaica it has resulted in violence and hatred towards homosexuals which has discouraged them from exposing their sexual preference. King (2005) notes that some homosexuals live secret lives 'on the down-low'. Socio-cultural behaviour towards homosexuals limits their access to education and information about HIV/AIDS.

MSM and lesbians also face HIV risks within their sexual relationships with each other. In same sex relationships as in heterosexual relationships there is more often than not a dominant and a subordinate partner; one partner may also be economically depend on the other and may be subordinated in the relationship. In this context, the subordinated partner may not be able to negotiate safe sex and consistent condom use, thereby increasing the risk of HIV infection. As in heterosexual relationships in a same sex relationship both partners may think that neither of them has HIV or other sexually transmitted diseases and may choose not to use condoms when having sexual intercourse. Making the decision not to use condoms makes them vulnerable to HIV/AIDS, especially if they are young, have unprotected sex with more than one sexual partner. For both same sex and heterosexual relationship not using a condom says 'trust and love' and asking that a condom be used in the context of a monogamous relationship suggests that one partner has been unfaithful.

Couples in both heterosexual and same-sex relationships that choose not to use condoms in their relationship because both partners are infected with HIV/AIDS are also at risk because they can pass on other strains of the virus or other STIs. This can make them particularly ill because their immune system is already weakened by HIV. They can also be re-infected with other strains of HIV which can counteract the benefits of other treatment. Some of the common HIV risk factors for both same- sex couples and heterosexual couples are therefore: poverty, gender inequalities, subordination, patriarchy, feelings of invincibility, and lack of education/information on STIs

including HIV and AIDS. Common barriers to reducing the risk of HIV transmission include legislation, socio-cultural attitudes and behaviours which reflect stigma and discrimination and reduce access to information about HIV which would help individuals to make decisions about their own body.

**Conclusions and Recommendations**

This paper shows that risks of STI/HIV infection are linked to both biological as well as social factors. It has focused on the how gender roles and inequalities contribute to risk of HIV infection among women and men in both heterosexual and in same sex relationships, although in different ways. Patriarchy, stigma and discrimination in social attitudes and biases in legislation are also important risk factors. The paper has also shown that all human beings have basic human rights including the right to reproductive health and services. Males and females in both heterosexual and same sex relationships should therefore have access to appropriate reproductive health information, education and services regardless of their race, class, sex, ethnicity or sexual orientation. Countries like Jamaica therefore need to work harder to eliminate stigma and discrimination and ensure that each person has adequate information to reduce their risk of STI/HIV infection.

The paper also showed the social, economic and cultural factors that contribute to the spread of HIV/AIDS and how the imbalance in power relations between hegemonic men and subordinate women poses special threatens not only the sexual and reproductive health of girls and women but also MSM. Caribbean societies therefore need to educate all citizens about the importance of HIV/AIDS which is a global health and development problem. More action is needed to change women's dependency which contributes to their vulnerability to HIV infection. More public education and legal reforms are needed to ensure that heterosexual and homosexual males and lesbians have the same human rights and access to knowledge and information on how to protect themselves against HIV and AIDS. Recommendations to address the risk factors identified include:

1) Increased access to information and education on sexual and reproduction health and family planning that will lead to self-empowerment for all;

2) Improved legislation to protect the rights of same sex couples and other vulnerable groups at risk of HIV infection;

3) Increased sensitization of health care workers on how to deal with same sex couples to encourage greater use of available information and services;

4) Programmes to eliminate gender inequalities that contribute to economic poverty. This would address the concern of Epidemiologist Jonathan Mann who suggested that although there are programmes that educate and motivate individuals to prevent HIV and /AIDS, and although condoms are available, these initiatives are often unsuccessful in preventing HIV/AIDS because of gender inequalities.

**5)** Gender awareness programmes to change unequal power relations, eliminate gender based violence, gender stereotypes and gender mainstreaming in policies

and programmes to value women as human beings, rather than as vehicles for pleasure can also help to reduce HIV transmission.

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## Sexuality and HIV/AIDS

CHANTAE BROWN

### Introduction

As Caribbean people we are exposed to the obvious inequalities between men and women. We see power differences, prejudices and reactions from society. Gender images in society generate cultural scripts that produce stereotypes about boys and girls, men and women. These images are pervasive and are often taken for granted. Some of the qualitative research from several Caribbean countries point to a lack of communication about sexuality, between parents and children as well as between sexual partners. The sexual practices observed in Caribbean society are embedded in gender constructs such as masculinity and manhood and femininity and womanhood. Importantly, Caribbean sexuality is widely believed to be operational around a gender binary which firmly attaches the biological to the social (Mohammed, 1995). This binary of sex and gender categories negates the existence of persons whose social identities, sexual practices or physical bodies do not adhere or conform to the dominant categories of masculinity and femininity. Caribbean sexuality thus appears as rigidly heterosexual and intolerant of sexual difference. These masculine principles have a serious effect on the rate at which the HIV and AIDS epidemic spreads throughout the region, as contemporary Caribbean studies of gender continue to emphasize informal polygamy and multiple partnering, and sex as linked to virility, fertility and procreation. They also link sexual expressions to violence against women and girls, material considerations for young people and women, and to pleasure, identity, and power for men (Kempadoo & Taitt, 2006).

### Gender and HIV Risks among Heterosexuals

Geeta Rao Gupta, in a review of studies about gender and HIV/AIDS in Latin America and the Caribbean, points out that multiple partnerships and unofficial polygamy were described as accepted behaviours for men within Haitian culture, as a way for men to prove their sexual prowess and virility. Discussions with Jamaican working women revealed that they were very concerned about the infidelity of their male partners but felt that trying to achieve male monogamy was a ‘pie in the sky’ (Rao Gupta, 2002). Masculinity is often viewed by men and society based on the number of women or baby mothers they have. Obviously there is acceptance of male promiscuity within the Caribbean society (Figueroa, 2006).

Brown, Anderson & Chevannes (1993) argues that the hatred of homosexuals is an essential feature of Caribbean masculinity. Boys are expected to be sexually active and to have many female partners to prove that they are heterosexuals. However the notion that homosexuals include the female sex is not always taken into consideration as Caribbean men are perceived as only feeling threatened or challenged by men who have sex with men. A male being promiscuous is expected of Caribbean men, hence accepting the presence of sexually active females may only encourage them to fulfill a sexual fantasy. These ideologies are introduced to

males from as early as the beginning of their high school experience, where older boys at the school, males within their communities and possibly their fathers, pressure these young boys to aspire and indulge in risky sexual behaviour in an effort to prove their masculine identity and most importantly, to prove that the boy is not a "sissy man" a sensitized term used to describe homosexuals.

Nicholson (2005) reported that Women's Media Watch presented information which showed that teenage boys and young men feel pressured to assert their masculinity through either sex or acts of violence. For most young males, sexuality implies copulating; they feel as if they must have sex to prove themselves. They convince girls that both girls and guys will become ill if they don't have regular sex, and many boys force girls to participate in sexual intercourse (Nicholson, 2005). The societal ideology that men should be polygamous and fertile proves to be very risky for society, and for women in heterosexual relationships. The belief in fertility will almost lead to the act of unprotected sexual intercourse. This belief in polygamy further negatively affects the situation. Many men aspire to have unprotected sex with as many women as they can, especially if the man is economically stable. This situation presents yet another expectation of Caribbean men being able to affect their HIV status. With a man being required to be rich or financially stable to fulfill an ideal form of masculinity, this presents opportunities to acquire power and wealth to control and provide for as many women as he can afford to support. In addition, many of these men seem to become more attractive to those women who seek to seduce him for economic gains.

For girls and women, sexual activity is the most common signifier of maturity, and is still often perceived by girls and women as attached to fertility. Having a child enables a girl to become a "real" Caribbean woman (Barrow, 2005). Leith Dunn asserts that women continue to face many social pressures to have children, become homemakers, establish their identity and be recognized as women. The expectation in some rural areas is that girls 14-16 years would 'make a child' for their mother to care, after which they are free to get on with their lives. Some girls get pregnant to merely prove that they can (Dunn 2001; Kempadoo & Taitt, 2006). Likewise, Eggleton et al. (1999) found that approximately one third of the girls in their survey agreed with the statement that a girl should have a baby while she is a teenager to prove her fertility (to prove she is not barren) (Eggleton, Jackson et al. 1999, p. 82). These ideologies strongly derive from historical social expectations and behaviours. In the generation known as the Baby Boomers which includes persons born between 1946-1964, it was common nature for young ladies to be procreating from their teenage years. However within this era there was little use of preventive reproductive methods, neither was there much information about reproductive and sexual health. Current beliefs are the result of limited reproductive information available especially in rural communities as well as the lack of reproductive health information being offered to young girls and boys.

In today's 21st century society, there has been a shift. Many Caribbean young women have become more focused on their career objectives as they mature rather than wanting to fulfill what are considered their womanly duties of motherhood. Mohammed & Perkins, (1999) note that "The importance of childbearing as a primary definition of femininity in the Caribbean may be simultaneously undergoing change among different groups of women in the society, and that woman of all ages and socio-economic groups are gradually shifting their concepts of femininity

to incorporate notions of self-fulfillment and self-actualization of their individual goals". Therefore for female college students the objective of their sexual orientation would be to seek pleasure or to seek economic gains. This is especially important if they are from a low socio-economic class and where money is needed to pay tuition fees or cover day to day expenses. The economic dependency of women on men is one of society's expectations of women. Positioning men in more powerful positions at work and in the society, and the decision to pay men more money than women for work of equal value, only contributes to this problem. It results in men becoming more powerful and women becoming even more economically dependent on men. As a result of this trend within our society, Lewis (2003) states that in the Caribbean, sexuality seems to be something that men have and are free to explore, while women are expected to relate to it only defensively. Women's sexuality Lewis argues is still policed by social and gender conventions in ways that do not seem to constrain the behaviour of men (Lewis, 2003). (See also Kempadoo & Taitt, 2006). Society's 'neighborhood watch' on Caribbean women, in an effort to regulate their sexual behaviour in accordance with ideological expectations, results in some women using their sexuality to obtain commodities, openly or on the 'down low'. The latter includes activities which are done in secret and are socially unacceptable. These women may refrain from informing their sexual partners about their polygamous behaviour because they fear being considered a whore or fear losing their partner's financial support. Their sexual behaviours may have serious implications for their sexual partners who may feel that they are the only person sexually involved with the individual and as a result, are likely to have unprotected sexual intercourse.

**Risks from Transactional Sex**

Some sexual-economic activities and relations are based on short term needs and desires for comfort and security and for material things. Some of the latter may be for "basic" or immediate needs like lunch-money or electricity, while others may be related to long-term economic goals such as owning a home and having economic security, or it may be for emotional security. Yet, as a result of gendered asymmetries in social and economic benefits, women and girls most commonly hold the weaker negotiating positions in comparison to men. The notion of "transactional sex" or "sexual-economic relations" also often carries a sense of moral opprobrium or shame. This is particularly relevant for young women, because transactional sex is often associated with "promiscuity" or undisciplined sexuality ("looseness" or "slackness"). This topic is often shrouded in silence. Women and girls are in particular danger of entering into sexual-economic exchanges from disadvantaged, stigmatized positions. They tend to hold little real power with which to negotiate safe sex. In addition, notions of love and intimacy may blur the economic definition of the relationship and foreclose the possibility using a condom as protection against HIV infection which is a real risk associated with engaging in sexual intercourse without a condom.

For most women and men, familiarity and intimacy with the sexual partner, or love, is reason enough not to feel at risk. Even in sex work relations, for example, while it is generally accepted that with clients condoms are necessary, with a lover, wife, husband, this is considered inappropriate (Kempadoo, 1998). Moreover, many women fear male violence if they insist on condom use within a steady union or marriage, as condoms are often taken by men as a sign of either a woman's infidelity or a lack of trust in her partner (Kempadoo & Taitt, 2006). Although

transactional sex reflects the act of prostitution, the individuals who participate in it may not regard it as such and do not condemn it because they see it as normal behaviour in society. The concept of "transactional sex" therefore captures those sexual-economic relationships that are not as clearly recognized by the actors as "prostitution," and are not based exclusively on notions of mutuality or an exchange of sex within the context of intimacy or love (de Zalduondo & Bernard, 1995).

A review of literature on Gender, Sexuality and the implications for HIV/AIDS in the Caribbean prepared by Kamala Kempadoo with Andy Taitt (2006), claims that sex in the Caribbean is often transactional, that is, sex is exchanged deliberately for money, material goods, or security. The review lists several forms of transactional sex activities: commercial sex work, sex work, or prostitution, "romance," sex work or prostitution in tourist settings, same-sex relations, "sugar daddy" and "sugar mommy" relationships that involve adult men and women, and teenage girls and boys, interactions between adult lesbians and heterosexual school girls. Each of these listed sexual activities has some form of power relationship involved. They place the person with less power at a disadvantage in protecting himself or herself from risky sexual behaviours. Females in heterosexual relationships are often the ones with less power.

**HIV Risks in Same Sex Relationships**

> *"Many men who have sex with men in the Caribbean do not identify themselves as gay or homosexual because of the stigma and discrimination they fear would occur if they did so (Tabet et al, 1996; CAREC, 1998; De Moya et al, 1999; De Groulard et al, 2000; Caceres,2002). In a qualitative study in four OECS countries, participants distinguished openly gay men from other men who have sex only with men and from bisexuals"* (Russell and Sealy 2000).

In same sex relationships among Men who have Sex with Men (MSM), there may be similar power struggles. Some men have sex with men do so in an effort to secure economic and material gains or to develop a better quality relationship. Power imbalances in MSM relationships are however far more dangerous as their sexual behaviour is more high-risk for HIV infection. Rates of HIV infection are highest in this group, accounting for approximately 32% of all HIV infections in Jamaica. As some MSM are bi-sexual, they spread the HIV virus to their female partners, who are usually unaware that their male partner is bi-sexual because of the stigma associated with diverse sexual orientation.

Despite the high risks associated with sexual practices among MSM previously discussed, a review of the literature highlights many excuses by MSM for not using condoms as a part of safe sexual practices. These include: concerns about the size of condoms, issues about their durability, discomfort, loss of sensitivity, allergic reactions, embarrassment when purchasing condoms and loss of partners' interest. A preference for skin contact and a feeling of trust and love are also some barriers to condom use reported.

**Women who have Sex with Women (WSW)**

Blackwood, (2000) reports that because of silencing, stigma, and discrimination that same-sex relations and behaviours face, public self-identification as "gay" or "lesbian" is not common.

Fewer studies, medical and epidemiological interventions focus on HIV and AIDS among Women who have Sex with women (WSW). As Gosine (2005) points out that the welfare of non-heterosexual women is of little concern in HIV/AIDS work, noting that these women are perceived to be a ‘low risk’ population. Stigma and discrimination against gays, lesbians, transgender and 'all sexuals' in Caribbean societies are supported by legislation that outlaws sodomy and other forms of same-sex intercourse. (Alexander, 1991; Figueroa, 2006). Kempadoo & Taitt, (2006) note that efforts to decriminalize same-sex relations are often met with vehement public opposition, and to date no CARICOM country has been successful in changing these laws.

**Conclusions and Recommendations**

In conclusion this paper shows the high HIV risks that are related to risky sexual behaviours, as well as the impact of stigma and discrimination associated with non-heterosexual sexual practices in Caribbean countries. It shows that a male or female's inability to act on his or her sexual feeling because of social barriers to sexual behaviour, may result in an individual developing secretive sexual behaviours which increase risks of HIV infection. Self-denial of sexual identity and low self-esteem also reinforce social vulnerabilities and risks for HIV infection. Stigma and discrimination are also barriers to MSM and LGBT accessing reproductive health information and services that can prevent HIV. such as: access for MSM to condoms and lubricants, counseling and testing, care and treatment.

Recommendations to further promote safe sex practices in diverse sexual relationships include tailoring condom promotion programmes to include condom negotiation skills for both heterosexual and same-sex relationships. There is also need to focus more attention on strategies to promote condom use in the context of long-term and steady relationships as opposed to those considered appropriate for commercial sex workers or males and females engaged in casual sex. Condoms also need to be promoted more as symbols of care, responsibility and concern in order to break the current association of condom use with infidelity or infection.

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## HIV/AIDS and the Caribbean: The Effects of Gender and Sexuality

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This paper discusses how gender roles and norms impact on sexuality and HIV risks in the Caribbean. The focus is on Jamaica, Barbados and Trinidad and Tobago. The paper will focus on the interconnected behavioral, socio-cultural and economic factors that explain gender-related HIV risks.

| **GIRLS** | **BOYS** |
|---|---|
| Passive | Active |
| Good | Naughty |
| Not sexual | Sexual |
| Objects of boys' sex drives | Having powerful sex drives |
| Weak | Strong |

The table above depicts some general ways in which boys and girls have been stereotypically positioned in many societies globally. For instance, in many cultures, the allocation of gender duties provides insight into differences between males and females in terms of roles and responsibilities. Femininity is polarized against masculinity. These social constructions of gender roles ultimately determine the various behaviours associated with masculinity and femininity, notions of gender differences and forms of exploitative gender relations. A review of available literature shows that gender is intricately linked to sexuality. Gender influences how sexuality and sexual behaviors are expressed and the related health risks for both sexes. Trying to adapt to the ideal gender norms and expectations of masculinity and femininity increases vulnerability to HIV infection.

The Caribbean is a culturally diverse region of twenty-nine nations and a population of 35 million people. Kempadoo & Kate, (2006) reported that the region had the highest adult HIV prevalence rate (0.9% - 1.1%) in the Americas and the second highest rate globally, after countries in sub-Saharan Africa. There were five new HIV infections in the region reported

daily. UNAIDS (2010) reported that by the end of 2009, a total of 260,000 persons were newly infected and 12,000 persons died from AIDS. The AVERT website [3] reports that in 2011 approximately 13,000 people in the Caribbean were infected with the HIV virus and an estimated 10,000 died of AIDS. The website also noted that this represented a 42 per cent decline in new infections when compared to 2001 and a 48 per cent decline in deaths since 2005.

According to literature surveyed, heterosexual intercourse is the primary route by which the HIV is transmitted within and outside the Caribbean. Heterosexual women were those most infected and affected by HIV and AIDS, especially young women. A large percentage of men who engaged in risky behaviors were also at-risk (Kempadoo & Kate, 2006).

The literature reviewed showed that the risk of transmission from males to females is between 2 to 5 times higher than the risk from females to males. Females were therefore at higher risk of infection than males This is because women are biologically at a greater risk because of the soft tissue in their reproductive tract, tears easily and this environment is ideal for the transmission of the virus. There are additional risks as vaginal tissue can absorb semen more readily and this fluid often contains a greater viral load compared to female secretions. The virus has the capacity to linger in the vagina for hours after intercourse (UNAIDS, 1998). The main routes of transmission of HIV are unprotected sexual intercourse, needle sharing and mother-to-child transmission. Many researchers have however attributed persistent gendered-based *risk behaviors*, especially unprotected sexual intercourse within and across both heterosexual and homosexual groups.

Globally, researchers, policymakers and planners have long pointed to the role that gender plays in the vulnerability of both sexes to HIV/AIDS. Gender is also considered to be one of the main socio-cultural factors that influence the spread of HIV. Kempadoo and Taitt, (2006) argue that the behaviors that fuel the HIV epidemic are linked to the region's socio-cultural environment of sex and sexuality. According to Gupta (2002), gender refers to socially defined and learned male and female behaviors that shape the opportunities that an individual is offered in life, the roles they may play and the kinds of relationships that they have. Gender is distinct from sex, which is biologically determined with a fixed set of physical characteristics for males and others for females. Gender is also distinct from - though closely linked to - sexuality, which is the social construction of a biological drive that is defined by how, why, and with whom one has sex (UNAIDS, 2010). Socio-cultural beliefs about maleness and femaleness are deeply entrenched in Caribbean society. Both men and women are impacted by gender roles and norms. Traditionally this results in gender differences, gender inequality in power and discrimination. Gender differences often mean gender inequality.

The ideology of power is fundamentally important to both gender and sexuality and the resulting social discrimination and gender inequality have contributed to the spread of HIV. In many societies, it is the norm for men to be considered superior to women and that men should have more decision-making authority control and access to economic and social resources than women. The construction of femininity in the Caribbean region endangers women's health and creates barriers for women who seek information about their sexual and reproductive health on issues such as pregnancy, contraception and sexually transmitted diseases, including HIV

[3] AVERT http://www.avert.org/aids-caribbean.htm

(UNIFEM, 2005). Social norms ascribed for Caribbean women and girls also create difficulties for them to protect themselves from HIV infection. These norms contribute to making women who are sexually naïve to be passive in sexual interactions. Studies conducted in Jamaica found that women knew little about these health issues (UNIFEM, 2005). Several studies have demonstrated that inadequate knowledge about sexual health has also encouraged the development of superstitions about condom use. For example UNIFEM (2005) reported that Jamaican women did not like condoms. There was fear that if a condom fell off inside the vagina, it could get lost, travel to a woman's reproductive organs. Such myths are based on inadequate knowledge about sex, sexual health information and HIV risks, which increase women's vulnerability to HIV infection. Lack of access to information makes it difficult for young girls, to be aware of prevention methods.

The fact that Caribbean women are placed in subservient roles in heterosexual relationships has also contributed to the feminization of the HIV epidemic. For example, women in heterosexual interactions often have little or no control with whom, why or under what circumstances they engage in sex or negotiate condom use. Their male counterparts are socialized to have sex with multiple partners, contributing to men's vulnerability to HIV infection. Power inequalities between men and women also translate into economic dependence for women. Roberts et al., (2009) noted that make a link between gender inequities and women's risks, a number of women put up with unfaithful partners because of financial problems and they cannot afford to leave them. Other research indicates that economically deprived women are less likely to end abusive relationships, to have access to information about HIV/AIDS, and to have protective sex. They are more likely to engage in high-risk sexual behaviors in the pursuit of income (Weiss & Gupta, 1998; Blank, 2001).

Caribbean culture also views motherhood as a key aspect of femininity. Consequently, the use of contraceptives is often sidelined and HIV acts as an obstacle for heterosexual couples to balance their desire for children against HIV prevention. The erotic imagery that surrounds the submissiveness and innocence of virginity also puts some young women at risk of sexual coercion, rape, forced sex and physical assault. These enhance girls' vulnerability to HIV. Gender inequality in marital relations, can also increase women's vulnerability to HIV transmission. Data on new HIV infections show that more married women and girls are being infected. In the Caribbean region, where motherhood provides access to financial resources from the father, in principle negotiating condom use is not widely practiced by women who are economically dependent on their male partners. Age mixing (for example sex between younger girls and older males) is another common feature often linked to sexual activities for economic reasons. This results in high rates of HIV infection among young women and girls compared to men and teenage boys. These trends are based on the perception that younger women are more fertile and that older men are more economically stable and have greater sexual experience. The latter however exposes them to the HIV virus which they transmit to young women and girls, who are biologically more prone to infection.

HIV is also transmitted through gender-based violence, which is linked to gender inequality and stereotypical gender roles. Many women experience or have fear of violence daily. Studies on gender based violence in the Caribbean region indicate that unequal power and control based on gender also place women at risk of HIV infection. Research conducted in Jamaica found that

women often avoid bringing up the issue of condom use for fear of triggering a violent male response Physical, sexual and psychological abuse and fear deprive women of their power, rights, choices and abilities to protect themselves. The fear of violence and stigma associated with HIV also acts as a barrier to women's ability to access HIV prevention services. The problem of violence among Women who have Sex with Women (WSW) is underexplored in the HIV literature because this group is considered to be at low risk of infection. However, there is risk of HIV transmission through sex toys, which are often used during their sexual interactions (Kempadoo & Taitt, 2006).

Like their female counterparts, boys and men are also at risk of HIV infection because social and cultural norms influence how men should act and feel based on the social construction of "masculinity" in the Caribbean region. These norms highlight the role of the male as provider, independent, strong, willing to face danger and dominant (Inter Agency Coalition on AIDS and Development, 2006). The dominant socio-cultural construction of masculinity defines male sexuality as heterosexual. The purpose of a man's anatomy is therefore to penetrate woman's body and the purpose of her body is to be receptive. Any sexual interaction which deviates from this belief is perceived as deviant. The ideals and dominance of machismo (male dominance) makes both heterosexual and homosexual men more vulnerable to HIV infection. From a young age, boys are socialized to demonstrate their sexual prowess and virility as an expression of their masculinity. Adolescent boys who do not comply with these ideals of manhood are often subjected to ridicule and their heterosexual masculinity is often questioned. Chevannes (2001) concludes that becoming an African Caribbean man privileges one to engage in all forms of sexual relations, from the promiscuous and casual to multiple partnerships (which in effect are unrecognized polygamy). A man is not a real man he argues unless he is sexually active UNAIDS (1998) notes that young people in the Caribbean, especially young men, are pressured to initiate sex at an early age and they often do so frequently without any protection in order to prove their maleness. The UNAIDS report also makes reference to studies conducted between 1990 and 1999 in Barbados, Jamaica and Trinidad and Tobago which showed that the median age of sexual initiation ranged between 13 and 15 years. The studies also showed that young men view women as sex objects and sex as a form of conquest and are more likely to engage in risky behavior. Caribbean cultural constructions of masculinity often assume that men are knowledgeable and experienced about sexual matters; that Caribbean men are often reluctant to seek out sexual health information or to admit that they lack knowledge about HIV risk reduction which increases the vulnerability of heterosexual and homosexual males to HIV and AIDS.

Research by Figueroa et al., (2005) shows that multiple-partnership is a demonstration of masculinity for young men and boys in the Caribbean. The results of Hope Enterprises (2008) Knowledge, Attitudes, and Behavior Survey in Jamaica indicated that informal polygamy and multiple partnerships are one of the main risk factors fueling Jamaica's epidemic; 75 percent of males 15 to 24 years of age reported multiple partnerships in the previous year. Patriarchy in many Caribbean countries encourages multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. These socio-cultural practices and norms make men and their female partners particularly vulnerable to HIV. Vulnerability to HIV in the Caribbean region is also influenced by practices of sexual minority groups such as Men who have Sex with Men (MSM), Women who have Sex with Women (WSW), Transgendered persons and Commercial Sex Workers (CSW). In the Caribbean, HIV

rates are significantly higher among MSM and vary across countries estimated at 32% according to 2008 data from the Ministry of Health in Jamaica. Data from the website of Global Health AIDS (2011) shows rates of HIV infection of MSM as a percentage of all the reported HIV cases in the Caribbean: Cuba, 80% ; Dominica (11%), Trinidad and Tobago (20%) and Jamaica (32%). In many Caribbean states, HIV/AIDS is still viewed as a "gay disease" and MSMs tend to conceal their sexual orientation because of the strong stigma associated with homosexuality. Homophobia in the Caribbean emanates from the entrenched cultural beliefs and gender norms and values. The heterosexual construction of Marianismo and Machismo triggers stigmatization of lesbians and bisexual men and women. Marginalization of homosexuals denies access to information, services, and appropriate HIV barrier methods (Rivers and Aggleton, 1998). Social stigma can also reduce some men's willingness to protect themselves from HIV. Effeminate males in MSM relationships often play the feminine, submissive role, which disempowers them and increases their risk of HIV infection.

MSM are often forced to be secretive and many develop sexual relationships with women who are unaware of their bisexuality. Gay men in heterosexual marriages are likely to have extramarital affairs, which put their wives at high risk of HIV infection. Sexual minorities have limited access to healthcare services because of social exclusion and lack of respect for human rights which puts them at risk of HIV infection. Also at high risk are male sex workers who provide services to young, old and married males seeking male sexual partners (Roberts et al., 2009). Both heterosexual and homosexual sex workers may be unable to insist on condom use when their partners are willing to pay more for unprotected sex. Unprotected sex in both groups has led to the growing rate of HIV transmission.

**Conclusions and Recommendations**

In summary, the paper shows that in the English-speaking Caribbean, gender inequalities, norms, roles and expectations increase the vulnerability of both heterosexual and homosexual men and women to HIV/AIDS. Heterosexual women are biologically and socially the most vulnerable for contracting HIV although males are more at risk because of their high risk sexual behavior. Factors related to unequal power in heterosexual and homosexual relationships also create risks across various social strata in the Caribbean. It is therefore recommended that prevention programmes should address the needs of both groups and gender must therefore be included in sexual and reproductive health programmes to reduce the risk of HIV infection among all sexually active people.

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## HIV/AIDS and Sexual Orientation in the Caribbean

BRENDA SAILSMAN

### Introduction

*The year 2008 was a bittersweet year for me. I received my letter of acceptance to read for my degree at the University of the West Indies and I was ecstatic. In a twist of chronological events, someone very close to me was diagnosed with HIV. This news left me and the rest of my family quite baffled with more questions than answers. When Mitzy* became ill, we all thought that the chronic diarrhoea and skin rashes were temporary and would go away eventually. The rashes cleared up but the diarrhoea could not be controlled. The symptoms of HIV/AIDS are sometimes unfamiliar to a lot of people and until Mitzy* was taken to the hospital for complications with her health, we would not have known that she was HIV positive. It is still unclear to this day how she contracted the deadly virus but she has been living with it. The lesson we learned was that HIV/AIDS is impartial to race, sex, gender and culture. Stigma and discrimination are the most overwhelming aspects of this epidemic. It is essential that as agents of change we must embark on a path to build greater awareness of the symptoms and causes.*

**Name changed to protect identity of the person.*

According to the United Nations Food and Agriculture Organization (1997) AIDS is the name of the fatal clinical condition that results from infection with the human immunodeficiency virus (HIV), which progressively damages the body's ability to protect itself from disease organisms. Thus, many AIDS deaths result from pneumonia, tuberculosis or diarrhoea. Death is not caused by HIV itself but by one or more of these infections. AIDS was first recognized in 1981 among homosexual men in the United States and HIV was identified in 1983.

### HIV Prevalence: The Facts

Data from UNAIDS (2010) notes that in 2009 in the Caribbean region, there were an estimated 240,000 people living with HIV an estimated 17, 000 people were newly infected and about 12,000 died from AIDS-related illnesses. Reports show that the Caribbean has been more heavily affected by HIV than any other region outside of countries in Sub-Saharan Africa and has the second highest level of HIV prevalence among adults. Rates of HIV infection vary considerably between and within countries in the Caribbean. Data for the same period shows that Cuba, for example, had the lowest HIV adult prevalence rate of 0.1%, while the Bahamas had the highest HIV adult prevalence rate of 3.1%. Apart from countries in Sub-Saharan Africa, the Caribbean was the only region where the proportion of women and girls living with HIV was higher than that of men and boys. Unprotected sex between men and women, especially paid sex, is thought to be the main mode of HIV transmission in the Caribbean. High HIV infection rates have been found among female sex workers in the region. Data for the same period showed 4% in the Dominican Republic, 9% in Jamaica and 27% in Guyana; one in five men who have sex with men surveyed in Trinidad and Tobago was living with HIV, and one in four said that they

regularly had sex with women. In Jamaica, an estimated 32% of Men who have Sex with Men were living with HIV.

**Gender-Related HIV Risks – Females**

Gender is referred to as the sum of cultural values, attitudes, roles, practices and characteristics based on sex. Unlike sex, which refers to the sum of biological characteristics that define the spectrum of humans as males or females, gender is a series of expectations, norms and behaviours which are differentially based on sex (UNAIDS, 2010). The report also noted that globally, more than 30 million people were living with HIV/AIDS and women accounted for half of all HIV infections. For women in the Caribbean region, the prevalence rate is highest among young women. Many identify their HIV status while attending antenatal clinics. Evidence suggests that in the Caribbean, the factors that drive the epidemic are mainly sexual behaviours and sexual activities such as: human trafficking of women and girls, forced sex, sex work and social and cultural norms such as having multiple sex partners. Gender inequality and violations of women's rights make women and girls particularly susceptible, leaving them with less control than men over their bodies and their lives. Women and girls often have less information about HIV and fewer resources to take preventive measures.

Heterosexual women are also more susceptible than their male counterparts to contracting HIV based on biological and physiological factors. The female reproductive tract is highly sensitive, and soft tissue tears easily, thereby creating a transmission route for the virus. In addition, vaginal tissues absorb fluids more easily. This includes sperm which has a higher concentration of HIV than female vaginal secretions and may remain in the vagina for hours after intercourse (Gender and HIV/AIDS, 1998).

Among Women who have Sex with Women including lesbians, HIV infection is relatively low but their vulnerability to other sexually transmitted diseases is high. The risk of HIV infection among lesbians relates to some who engage in unsafe sexual activities with men who are infected with the virus. Transmission may also be from drug abuse and sharing needles may result in blood which is a body fluid being transferred. Gender-based violence continues to be one of the major HIV risks for women as it encompasses a wide range of human rights violations such as rape and domestic violence. Article 1 of the Belem do Para Convention, defines violence against women as any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere (Belem do Para Convention 1992).

**Gender-Related HIV Risks - Males**

Gender socialisation is a risk factor. In the Jamaican context men are socialized to embrace the view that they should have "nuff gal and gal in a bungle" mentioned in the song "Nuff Gyal" (1996) of popular Jamaica music artiste Beenie Man. For many males, being a "one-burner" (having one sexual partner) is therefore not acceptable. In popular culture, having multiple sexual partners dispels any notion of being homosexual and proves sexual prowess. Interestingly, in Jamaica, same-sex relationships have become quite main stream and have contributed to the high rate of HIV prevalence among men who have sex with men. Gender-based norms of

masculinity as well as the intolerance of society towards same-sex relationships both contribute to increased risks of infection among the Jamaican male population. Risks for heterosexual males based on some reports, indicate that many adolescent boys are pressured into early sexual initiation by older men to prove their ability to "wuk a gal" (have sex with a female) or they face ridicule. In Jamaica especially, it is suggested that male promiscuity is the driving force for the high incidences of HIV infection in the island. Williams Green (2008) reports "men feel powerful when they can demonstrate multiple sexual encounters irrespective of the health dangers to themselves and their partners. This practice drives the spread of infection because less than half of these men use condoms consistently"[4]. Men are also more likely than women to be intravenous drug users, placing them at high risk of infection from contaminated needles and syringes. Other causes of the high prevalence rates for HIV/AIDS in the Caribbean include Men who have Sex with men (MSM). This group continues to be the most vulnerable and consistently face incredible social stigma because of their lifestyle choice.

Legislation also affects risks for HIV infection: The World Health Organisation's 2010 HIV Progress Report entitled 'Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector', states that anti-sodomy legislation in eleven of sixteen Caribbean countries pushes intolerance and homophobia, making it almost impossible for MSM to access HIV testing and counselling facilities and education services that would help to reduce the vulnerability to HIV. It notes that in Jamaica for example Section 76 of the Offences against the Persons Act refers to buggery as an unnatural crime and anyone found in violation would be liable to imprisonment for up to ten years. This law is used to criminalise homosexuality and in essence pushes the HIV prevalence rates among MSM to 32% versus 1.7% in the general population. The report also notes that Trinidad and Tobago and Guyana, which are countries with the same type of legislation, there are also high HIV high prevalence rates of 20% and 32% respectively. In contrast, other Caribbean nations such as Cuba, Suriname, Bahamas and Dominican Republic which do not have anti-sodomy legislation have low HIV prevalence rates for MSM ranging from 1% to 8% (WHO, 2010).

High prevalence rates among MSM is related to the fact that MSM include married men and their partners are mainly unaware of their bisexual practices which increase the risk of spreading HIV since the use of a condom in many of these relationships is non-existent. Research has also shown that unprotected anal sex poses a much higher risk of HIV infection than unprotected vaginal sex because of the physical vulnerability of the rectum and sphincter tissues.

## Comparative Analysis of Risk Factors

Critical assessment of the gender-related HIV risks for heterosexuals and homosexuals previously outlined requires us to pause and to examine the issues to get a clearer understanding of factors that contribute to HIV for both groups. One of the common risks for both heterosexual females and males in same-sex relationships is the biological risk factor. The risk of HIV infection in heterosexual women through unprotected vaginal sex and men who have sex with men (MSM) through unprotected anal sex is similar. However, as previously noted, for Men who have sex with men (MSM) there is a much higher risk of HIV infection when compared to

[4] http://jamaica-gleaner.com/gleaner/20081203/health/health4.html

women in heterosexual relationships and women who have sex with women (WSW). As previously discussed, the risk for WSW is relatively low, unless one of these women engages in unprotected sexual activities with a man or woman- who may already be infected. Heterosexual females who engage in sex work for economic purposes are also at risk from forced sexual acts, and they may be raped and/or beaten. Their situation is in stark contrast to heterosexual males who willingly engage in promiscuous sexual behaviour with many partners without using a condom. These practices heighten the risk of HIV infection for the male and his sexual partner.

Sexual violence is also a risk factor. Men are usually better able to protect and defend themselves from physical attacks and fewer women than men resort to sexual violence. In contrast gender-based violence affects women and girls more often. The earlier discussion on social norms which suggest that men should have more than one woman and if not he is a branded as a “fag” is a double standard for sexual behaviour of women and men. Society frowns on promiscuous behaviour among women but strongly encourages it among men, whether or not they are married. Inequality in women's and men's access to information about sex and reproductive health is also a risk factor. Society expects men to be knowledgeable about sex and preventing sexually transmitted infections, although reports suggest that men are less likely to seek information from health providers.

Women, in contrast to men, were not previously encouraged to be interested in sex and to seek information on reproductive health. As a result many women in heterosexual relationships face a number of barriers to HIV prevention. UNFPA (2002) in their fact sheet on Gender and HIV/AIDS highlights several barriers to HIV prevention for women. Among these is difficulty in accessing HIV testing and counselling which may be linked to fear of exclusion, embarrassment, rejection and stigma if they seek information. Their male partner may object to them asking for an HIV test. Those women who lack access to financial resources may not be able to afford transportation, to go for testing, time and transportation.

## Conclusions and Recommendations

This paper shows that there are different levels of HIV risk for both women and men and there are similarities as well as differences in the level and type of risk for each group. Without a doubt, women in heterosexual relationships and MSM share many similarities in terms of barriers created by attitudes to their sexual behaviour, which may restrict their access to information. This is true especially for adolescent girls and poor women who are dependent on a male breadwinner. Their dependency may increase their risk of exposure to sexual violence and may deny them access to sexual and reproductive health information treatment, HIV testing and counselling. Women who have sex with women (WSW) also face risks of HIV infection based on their sexual history. Heterosexual men face risks from social norms about having many sexual partners and inconsistent use of condoms, and high risk behaviour such as abuse of drugs including alcohol and sharing needles. Caribbean societies with out-dated anti-sodomy legislation are also at risk as these laws hinder universal access to readily available reproductive health information and services. Social stigma and discrimination against MSM and WSW and homophobia contribute to fear of disclosing their sexual orientation, which makes these groups less likely to access the resources that would help them to reduce their risk of HIV infection.

In order to combat the HIV epidemic Caribbean countries need to adopt a forward-thinking approach and take action to support Millennium Development Goal #6, which is to combat HIV/AIDS, malaria and other diseases by 2015. A lot of work has been done to prevent HIV and this has borne tremendous fruit. One achievement that should be expanded is increasing access to anti-retroviral treatment globally. UNDP (2011) reported that the global response to AIDS has demonstrated tangible progress toward the achievement of MDG 6. The number of new HIV infections fell steadily from a peak of 3.5 million in 1996 to 2.7 million in 2008. Deaths from AIDS-related illnesses also dropped from 2.2 million in 2004 to two million in 2008. Anti-retroviral treatment has expanded but continues to be outpaced by HIV.

Gender-based violence is still a major problem and must be eliminated in order to reduce prevalence among the most vulnerable (Gender Inequalities, 2011). In support of Article 6 of CEDAW, several measures have been implemented to address gender-based violence such as legislation, policies and public education and training. However, more must be done to reduce HIV infection and deaths from AIDS-related illnesses by eliminating gender –related barriers that prevent access to information and services on sexual and reproductive health and deny women and men boys and girls from accessing HIV prevention, treatment and care. Barriers that reduce women's access to and control over resources, restrict their mobility, reduce their equal access to employment because of limited access to child-care support and limit their participation in decision-making power must also be removed.

Socialization programmes are also needed to change gender stereotypes and gender behaviour of males and females that contribute to HIV risks and should include reducing stigma and discrimination. Community based programmes that improve access to low-cost reproductive health services for women and men boys and girls will also help to reduce HIV and AIDS. There is need for more tolerance and respect for human rights and a change in public attitudes to Men who have sex with Men as discrimination discourages them from seeking universal access to prevention treatment and care in public health services.

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## Gender Roles, Power and HIV/AIDS

ANN-MARIE K. VIRGO

### Introduction

The origin of HIV has puzzled scientists ever since the early 1980s. Although questions remain about the origins of the virus, we are aware of the impact of HIV and AIDS on persons living with the virus, and the consequences for the families, friends and communities of infected persons. The virus depletes the natural defenses of the human body as well as assets of families and communities. Social and health structures required to prevent infection and to provide care and treatment for persons living with HIV/AIDS have expanded. HIV/AIDS continues to infect millions across the globe and has been ranked among the top five infectious diseases[5]. HIV and AIDS have a serious impact on Jamaica's social, political and economic status and place a major strain on the country's health care facilities and budget. The virus affects all, irrespective of age, class, gender, race or ethnicity. The World Health Organisation (2000) noted the changing patterns of male and female infections around the world which showed that in many countries, most of the early cases of the virus were male homosexuals and intravenous drug users. Over the years the virus has progressively shifted to heterosexual transmission and rates of infection among females and young girls have increased. The growing trend is that globally, more women than men have been dying of HIV/AIDS as a result of the role that gender plays in the spread of HIV and the biological make-up of the female body (WHO, 2000).

As a young woman I think that the impact of HIV/AIDS is devastating. Learning about the debilitating illness and premature death the virus causes among young people especially during their prime years of life and the devastating impact on their families and communities is sobering. Then there are the challenges that HIV/AIDS creates for countries fighting poverty, and trying to improve health, and promote development. There is also the personal impact as the virus diminishes a person's ability to work and provide for his or her family. Treatment and healthcare costs related to HIV/AIDS consume household incomes. The combined effect of reduced income and increased costs therefore impoverishes individuals and households. Exposure to the gender dimensions of HIV and AIDS in GEND3600 also highlighted the deepening socioeconomic and gender disparities which increase the risk of infection. Women for example are at high risk of infection because many earn low wages and have limited power to negotiate safe sex with their partners. Children are also affected by HIV/AIDS. Some are born with the virus (although prevention of mother to child transmission programmes have been very successful). Others are affected as by illness or death of their parents. Infected and affected children are less likely to receive an education. They may have to leave school to care for ailing parents and younger siblings. HIV and AIDS strain the financial resources of countries and communities, affecting the operations of hospitals, social services, schools and businesses. The virus also affects human resources as health care workers, teachers, and business and government leaders are among the many that have been lost to HIV/AIDS.

[5] see http://science.discovery.com/life-earth-science/10-infectious-diseases.htm

GEND3600 increased awareness of risk factors for HIV transmission and these included:

- *Unprotected sexual contact*: The risk of transmission is high among people who do not practice safer sex by always using a condom; those who have multiple sexual partners; those who participate in anal intercourse; and those who have unprotected sex with a partner who has HIV infection or other sexually transmitted diseases (STDs); women who are sexually active with bisexual men; intravenous drug users, and women living in neighborhoods with a high rate of HIV infection among heterosexuals;
- *Mother to Child Transmission*: Pregnant women in advanced stages of the disease can transmit the disease to their child but improved antenatal services have prevented mother to child transmission. Breast feeding increases the risk of HIV transmission as HIV passes into breast milk and breastfeeding is discouraged among HIV positive mothers.
- *Exposure to contaminated blood*. Risk of HIV transmission among intravenous drug users increases with the frequency and duration of intravenous use, frequency of needle sharing, number of people sharing a needle, and the rate of HIV infection in the local population. This risk is low in Jamaica.

GEND3600 also raised awareness that HIV is not transmitted by handshakes or other casual non-sexual contact, coughing or sneezing, or by bloodsucking insects such as mosquitoes.

It was interesting to learn from the UNAIDS (2008) Global Report on HIV/AIDS that the Caribbean Region has the highest HIV prevalence outside of countries in Sub-Saharan Africa; that an estimated 440,000 individuals were then infected and that HIV infection was predominately through heterosexual transmission; that females and young people are particularly vulnerable and that other risk groups included commercial sex workers, migrants, and gay and bisexual men. Reports also stated that 57% of persons living with HIV/AIDS in the Caribbean are men and 43% are women.

GEND3600 increased awareness of the difference between sex which is biological and gender which is socially constructed and explains what it means to be man or woman in society; the expectations, norms and behaviours which are differentially based on sex according to UNAIDS (2008). Women become "feminine" and men become "masculine" through processes of social, cultural and political socialization. Gender shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have. These social norms, beliefs and behaviours strongly influence the spread of HIV. The course explained the significant impact of gender on the transmission of HIV/AIDS in both heterosexual and homosexual relationships as gender shapes female and male sexual behaviour. Marcovici (2002) explains how the unequal social status of women places them at higher risk for contracting HIV/AIDS. Many women have less access to information about HIV/AIDS prevention, and are less able than men to negotiate safe sexual encounters. Around the world many HIV infected women have less access to treatment. The UNAIDS 2008 report also noted that the inequitable sexual interaction between men and women will continue to have grave consequences, and pointed to the need to address gender-related expectations and attitudes. From early ages, boys and girls are socialized to adopt specific ideals of femininity and masculinity. These socio-cultural norms have a significant impact on women and men's sexual behaviour, on their respective sexual responsibilities, on

their sexual education and on their ability to access information about sex and resources, including sexual health care.

Caribbean feminist Patricia Mohammed argues that in the Caribbean, sexuality is constructed by our culture, religion, language, music and dance. Male sexuality she states is awarded more value than female sexuality, and this inequality plays out in their sexual relations (Mohammed, 2002). Our sexual attitudes feelings and behaviors; our sexual identity, erotic feelings, sensual desires, choice of partners, ideas of what is sexually appropriate or inappropriate are all constructed by society Mohammed argues. Ideals of femininity portray the ideal woman as being modest, pure, dependent, weak, acquiescent, vulnerable and one who abstains from sex until marriage, at which point the woman becomes subordinate to and obedient of her spouse. Women are also encouraged to be innocent and self-sacrificing, placing the needs and desires of her male partner before her own. She is expected to remain silent about her sexual desires.

The social construction of 'ideal femininity' in the Caribbean region therefore endangers women's health and acts as an obstacle for women who are trying to become knowledgeable about their sexual and reproductive health, about their bodies, pregnancy, childbirth, contraception, and sexually transmitted infections. The social construction of 'ideal masculinity' in the Caribbean region, depicts the male as the provider, as independent, strong, dominant and the protector who is willing to face danger. This construction of masculinity defines male sexuality as heterosexual, virile and even promiscuous. The ideal Caribbean male must be knowledgeable about sex, aggressive and in control of his environment, including the women around him. There are gender-related risks for both males and females which are now explained.

**Gender related HIV Risks for Heterosexual Females**

The risks for females in heterosexual relationships are linked to unequal power relations between males and females. Risk taking and vulnerability to HIV infection are increased by norms that make it inappropriate for women to be knowledgeable about sexuality or to suggest condom use. Many reports note that women generally lack the power to negotiate safe sex with their male partners, which result in them having unprotected sex. Davis, (2004) for example states that during heterosexual intercourse, women are more biologically exposed to body fluids than their male partners, which places them at risk for many sexually transmitted diseases, including HIV. The large thin mucosal membrane of the vagina is vulnerable to microscopic tearing which increases the risk of infection. Vaginal tissue easily absorbs fluids (including sperm), which has a high concentration of HIV).

Perhaps the most disturbing HIV risk to females is the result of male violence against women. Rape puts women at increased risk. There are also myths such as one which states that men who are HIV infected can be cured by having sex with a virgin. Commercial and transactional sex also increase the risk of HIV infection. Women's economic dependency on men increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that some women will exchange sex for money or favors. In the resulting commercial or transactional sexual relationships females are less likely to be able to negotiate protection. It is also less likely that they will leave an intimate relationship that they perceive to

be risky. Some of these women are also less likely to have access to information about HIV/AIDS, to use condoms and may also resort to high-risk behaviours to secure income (UNAIDS, 1999). HIV risks from gender-based violence are also a major problem Women are more likely than men to be victims of sexual violence, which places them at risk. HIV risks from migration are linked to high levels of poverty in some countries. Many women migrate to other countries seeking employment to be able to meet the needs of their family back home. While separated from their spouse they may enter casual sex relationships when sexual urges arise and they may not be entitled to health care in their host country.

**Gender-related HIV Risk Factors for Women who have Sex with Women (WSW)**

Information on the website of the Centers for Disease Control and Prevention, (CDC) provides important insights on HIV risk factor for women in same sex relationships. The reports suggest that the risk is very low unless one sexual partner contacted the virus through sexual contact with a man. Some sexual practices among WSW do carry risks of HIV transmission and precautions therefore need to be taken to protect against infection. Information on the website of the International Organization Avert (n.d.) reveals that lesbians do engage in risky sexual practices such as;

- *Oral sex* - while the risk of HIV being passed on through oral sex is low, it is increased if a woman has cuts or sores in her mouth, or if the partner receiving oral sex has sores on her genitals or is having her period.
- *Sharing sex toys* - sharing sex toys can be risky if they have vaginal fluids like blood or faeces on them.
- *Rough sex* - any sexual activity that can lead to bleeding or cuts/breaks in the lining of the vagina or anus is risky, including 'fisting'.
- *Injecting drugs:* Women who have sex with women who inject drugs are at risk if they share needles.
- *Stigma against lesbians*: Intolerance of the society to the lesbian community forces many WSW to remain in the "closet" about their sexual orientation and their HIV status. WSW is often overlooked in the national response to the HIV epidemic, as some health care providers assume that women who have sex with women are at little to no risk for HIV infection.

**Gender- related HIV Risks for Men Who have Sex with Men**

Gender based norms increase men's vulnerability and risk of HIV infection. Risks result from men not acknowledging gaps in their knowledge about sexuality, pressure from social norms and expectations that shape men's opportunities, attitudes and high-risk sexual behavior. From a young age, boys are socialized to engage in early sexual activity to assert their heterosexual masculinity and expressions of sexuality define their manhood and place them at risk. Chevannes (2001) argues that real manhood in the Caribbean is premised on virility and hatred of homosexuality. There is also immense peer pressure to start having sexual intercourse early and to have children to prove manliness. Chevannes (2001) also explains three (3) concepts of manhood in the Caribbean which explain factors related to their HIV risks:

1. *Sexual identity*: manhood in the Caribbean is demonstrated by sexual prowess and is usually measured by the number of female partners the male has as well as the number of children he produces within or outside of steady relationships.
2. *Man's primary role as provider*: to be a man means that he has to be able to provide for his family or partners.
3. *Sexual activity:* Manhood is demonstrated through early sexual activity and promiscuity. Sexuality defines manhood, and has shaped men's sexual lives. Men are encouraged to seek out, or at least brag about having, frequent sexual intercourse as well as large numbers of sexual partners. This Chevannes notes, is considered to be one of the socially accepted and expected ways of expressing virility. Men are also more likely than women to be drug users and those injecting drugs are at increased risk of infection through contaminated needles. Drug and alcohol use are often associated with increasing the likelihood of having unprotected sex or violence. Other risks for males are associated with their reluctance to seek healthcare, and the relatively few specialized services available to meet their health needs.

UNAIDS (1999) also identified several factors that place men at particularly high risk of contracting HIV and these include:

- *Migration:* Men migrating for work, results in separation from their spouses or regular partners for long periods. This increases the likelihood of them engaging in casual, unprotected sex, including sexual relationships with sex workers. These action place the men and their partners at risk of HIV infection.
- *Sexual violence against men:* This is a reality that is commonly hidden and dissuades men from seeking information and help.
- *Living in all-male institutions*: In prisons for example, some men who may normally prefer women as sex partners may have sex with their fellow inmates. Men in prisons are also vulnerable to violence, as well as forced, coerced and unprotected sex.
- *Men in the military:* These men are often away from home and their regular partners may be at increased risk of HIV unprotected sex with other partners.
- *Male sex workers:* The activities of these men are often hidden and denied. Young male sex workers are especially vulnerable as they often lack the power to negotiate safe sex.
- *Casual sex with prostitutes*: Men who engage in unprotected casual sex with prostitutes are also at risk.
- *Prevailing norms of masculinity:* Males are expected to be more knowledgeable and experienced about sex than females. This puts men, particularly young men, at risk of infection because these norms prevent them from seeking information or admitting their lack of knowledge about sex or protection. It also encourages them to experiment with sex in unsafe ways at a young age, to prove their manhood.

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**Gender-related Risks for Men who have Sex with Men (MSM)**

A Centre for Diseases Control (CDC) Fact Sheet (2011) retrieved from their website, highlights several risk factors for Men who have sex with Men (MSM). These contribute to this group having the highest risk of HIV transmission compared to other population groups. The risk factors reported include:

- *Stigma and discrimination*: This can discourage MSM from seeking information and services to protect and care for themselves and their partners. MSM face social discrimination at work, school, in clinics, hospitals and in their own families.
- *Unsafe sex*: MSM may not use condoms which puts them and their partners at risk for HIV infection.
- *Lack of knowledge of HIV status:* Studies show that MSM who know they are infected are likely to take steps to protect their partners. Yet many MSM are unaware of their HIV status and may unknowingly be transmitting the virus to others. Some MSM may make false assumptions or have inaccurate information about their partner's HIV status.
- *Substance abuse*: MSM, who use alcohol and illegal drugs, increase their risk for HIV/STI infections, as substance abuse can contribute to risky sexual behaviors such as sharing needles or other injection equipment.
- *Complacency: F*eelings of contentment, self-satisfaction or complacency about HIV, especially among young MSM is reported as a risk factor as these men would not have personally experienced the severity of the early AIDS epidemic. Other challenges reported are that many MSM may not be able to maintain safe behaviors over time, may underestimate personal risk, or and the false belief that because of treatment advances, HIV is no longer a serious health threat.

**Conclusions and Recommendations**

In the context of HIV, risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate such risks, which may include unprotected sex with a partner whose HIV status is unknown, and having unprotected sex with multiple sexual partnerships. Risk arises from individuals engaging in risk-taking behaviour for a variety of reasons: migration, commercial sex work, lack of information on HIV; women being unable to negotiate safer sex, gender based violence and inconsistent condom use. Gender-related dynamics place both women and men at risk of negative health outcomes such as HIV/STI and violence (WHO, 2000). Power is fundamental to both sexuality and gender. The power imbalance in gender relations that favors men, translates into an unequal access to and use of power in heterosexual interactions. This results in male pleasure often superceeding female pleasure and men have greater control than women over when, where, and how sexual intercourse takes place.

Gender-based discrimination hinders women's ability to know about, access and negotiate use of effective protection methods and to respond to the consequences of HIV infection for themselves and their families. Analysis of these factors highlights the need to challenge the construction of sexuality that is based on male sexual prowess and women's sexual responsibility, so that both men and women see safer sexual practices as their personal responsibility. The analysis also shows that individuals need to be empowered so they can better negotiate safer sex, including the ability to refuse to engage in sex. This points to a need to expand reproductive health programmes that will teach skills, increase knowledge and build self-confidence that will encourage individuals to make informed decisions. HIV/STI programmes must consistently acknowledge the connections between financial security and sex. Many women and girls (and also boys and men) exchange sex to gain financial support for themselves and their dependents. Lower wages and higher unemployment for women despite the reality that more women in the

Caribbean are pursing higher education and receiving certification compared to men contributes to HIV risks from transactional sex.

Data on HIV shows that despite reduced rates of infection and improved access to treatment and care. HIV and AIDS continue to spread in the Caribbean. Far more needs to be done to change sexual behaviours and gender roles which are deeply rooted in the culture and will not change easily. Young women and men in the region need to better understand sexual behaviour and gender roles in order to control the HIV/AIDS epidemic. More young people need to be aware of their country's national plan of action to tackle HIV and the work of organizations such as the Caribbean Epidemiology Centre, UWI courses including GEND3600 offered by the Institute for Gender and Development Studies and the work of non-Governmental Organizations. They must also get involved in awareness and prevention programmes and can become effective advocates by learning about international conventions such as UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and important commitments to eliminating HIV at the level of the United Nations General Assembly (UNGASS). Finally, young women and men must also take the necessary action to protect themselves from HIV infection based on their improved knowledge of the various avenues of transmission and risk factors in both heterosexual and homosexual relationships.

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## Gender-related HIV/AIDS Risks for Males and Females in the Caribbean.

MARLA PHILLIPS

UNAIDS, (2008) reports that the Caribbean has the second highest HIV prevalence in the world (after Sub-Saharan Africa), and the estimated HIV prevalence among adults ranged from 1% to 4%. The report also states that sexual behaviours drive the HIV epidemic. Fighting the epidemic therefore means addressing sexual behaviours that take place in private. Some of these behaviours are illegal in most of the countries. These include: homosexuality; forced sex and economic activities (such as transactional sex). Others are cultural norms (such as approval of men with multiple partners). The social and cultural factors that influence the success of prevention interventions need to be fully understood to reduce the spread of HIV. Strengthening the HIV fight in the region requires a better understanding of the interaction between culture, society and the evolution of the HIV/AIDS epidemic (Allen and Bombereau, 2008).

UNESCO (2002) argues that the prevention and treatment of the HIV epidemic require a cultural approach to face the issue in all aspects. The article notes that HIV/AIDS epidemic is not only a sector-based medical problem, but also a complex, multi-faceted issue that includes socio-economic, societal and cultural factors that affect sustainable human development. As a result the problem of HIV infection requires multidimensional strategies that address modern information, education and communication strategies that promote condom use. Solutions require more than medical and pharmaceutical treatments to achieve the expected results.

Throughout the Caribbean both males and females in heterosexual and same-sex relationships are at risk of HIV because of sexual behaviours and biological factors. Risks are increased from alcohol and drug abuse; migration and population mobility; sex tourism, and stigma and discrimination against people living with HIV/ AIDS as well as males and females in same-sex relationships.

### Gender-related HIV Risks for Heterosexual Males and Females

The global trend in both developed and developing countries, is that heterosexual sex is now the main route of HIV transmission and that women and young people are particularly vulnerable to infection. In many countries women are less able to negotiate condom use because of a system of patriarchy which gives men more power and control over women during sex and limits their ability to negotiate condom use. Patriarchy (male rule) also means that females are more likely to be subjected to non-consensual sex. Culturally in the Caribbean, young people are also at risk from having sex at an early age makes them more exposed to contracting the virus. Some women engage in transactional sex for money to meet their economic needs because of their inability to get a job or their need to earn more money. They may feel they have limited options other than to engage in transactional sex. This action exposes them to HIV because they have more than one sex partner.

Reports on HIV estimate that more than half of the people living with HIV in the Caribbean are women and that there is a higher prevalence of HIV among men who have sex with men. For example, in Jamaica the HIV prevalence rate among MSM was 32 per cent. UNAIDS (2008), also states that the rate of infection among MSM may be higher because rampant homophobia in the region contributes to denial and under-reporting on the number of cases. The World Bank (2005) also identifies other factors that contribute to the spread of HIV in the Caribbean, such as: poverty, gender inequalities and a high degree of HIV-related stigma, and common migration between islands and countries. Poor availability of HIV and AIDS data they argue also makes it difficult to get an accurate picture of each country's situation.

Within the Caribbean there has been an alarming increase in the number of HIV infected women, who contracted the virus mainly through heterosexual sex. Young women are approximately 2.5 times more likely to be infected with HIV than young men in the same age group. Among the reasons cited are "men on the down low" and unprotected sex between men who have sex with men (MSM). In a situation of patriarchy, men on the "down low" and MSM, will have their same-sex relations in secret and also have sex with women to cover up their sexual behaviour with men because of the stigma which is attached to gay men within the Caribbean.. Heterosexual men who have sex with female sex workers also expose themselves and their regular partners to the risk of HIV infection.

**Gender-related HIV Risks for Males and Females in Same-sex Relationships**

UNAIDS (2008), reports a high HIV prevalence among men who have sex with men (MSM) across the Caribbean: 80 percent of all reported HIV cases in Cuba; 70 percent in Dominica; 20 per cent in Trinidad and Tobago and 11 per cent in the Dominican Republic. Homophobia is a major problem in the Caribbean especially in Jamaica, according to Inter Press Service (IPS) (2006). They note that homophobia and cultural taboos about sex between men are major barriers that prevent HIV campaigns from reaching this group. In Jamaica, groups attempting to provide HIV-related services to men who have sex with men have faced harassment from both the public and the police. The IPS (2006) reported that in November 2005, Steve Harvey, head of Jamaica AIDS Support, a group that works with gay and bisexual people affected by HIV was kidnapped and killed when it was discovered that he was homosexual. The article included data from an interview with Gareth Williams, of the Jamaica Forum for Lesbians, All-Sexuals and Gays (JFLAG) who said.

"*Gays and lesbians in Jamaica exist with the possibility that you might be chased, you might be run down, you might be killed because of your sexual orientation, and when a day ends when that does not happen, we give thanks."Garth Williams*

There are gender-related risks among Men who have Sex with Men (MSM) and Women who have sex with women (WSW). Similar to the heterosexual men there are many homosexual men who also have unprotected sex, despite the fact that they are well aware of the high risk their sexual behaviour. Some young gay men are particularly at risk of HIV infection because of unprotected anal sex, which can be especially risky. Anal sex involves a man putting his penis into the anus or rectum of another man or woman and if he does not wear a condom or use a lubricant to reduce friction during intercourse, there is a high risk of HIV transmission because

there can be small tears or cuts in and around the rectum which allows the HIV virus to pass from one person to the other. The stigma and discrimination against MSM in the Caribbean as some people in the Caribbean associate HIV with homosexuality, although the majority of infections occur through heterosexual sex.

Lesbians are women who have sex with women (WSW) and they are considered to be at low risk of HIV infection. They are just as vulnerable to certain sexually transmitted diseases (STDs) as women who have sex with men. Many women who claim that they are lesbians are also having sex with men in private. They, like many young heterosexual and gay men, are also likely to have numerous sex partners, and having unprotected sex without knowing their sexual history or using protection. Lesbian women therefore need to be aware that they are also at risk of contracting HIV as any other individual who engages in unprotected sexual intercourse.

Mercer et al (2007), and Diaz et al (2001), also cite ways in which lesbians can contract HIV and AIDS: unsafe (unprotected) sex with men based on a British study which found that 85 percent of women who have sex with women also reported that they were also having sex with men. Some lesbians also inject drugs and share needles and research on drug users has shown higher HIV prevalence among women who have sex with women, who inject drugs compared to heterosexual injecting drug users. Lesbians who have rough sex with each other are also at risk, as some sexual activities can lead to bleeding or cuts/breaks in the lining of vagina or anus. This includes 'fisting' or certain sado-masochism sexual activities.

**Conclusions and Recommendations**

The discussion shows that every sexually active male and female who does not use a condom is at risk of contracting HIV. This includes males and females in both heterosexual and same-sex sexual relationships. In the Caribbean, there are some groups of individuals who are at higher risk when compared to other groups of individuals because of their sexual practices and behaviour. To reduce the rates of HIV infection in the Caribbean, heterosexual women must share the responsibility of protecting themselves. They must also challenge prejudice and discrimination against young gay men MSM and young gay women (WSW) as well as heterosexual involved in transactional sex and unprotected sex. Individuals need to join in the campaign and become more active in promoting the message that prevention is crucial to minimize HIV risk. There is need to increase public education on HIV prevention particularly in schools, and promote abstinence or safe sex among sexually active boys and girls as well as adults. Individuals must also help to reduce stigma against young gay men especially to make it easier to target prevention programmes at this group as well as to every individual in society.

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## Gender, Sex and HIV

CHRISTINA STEPHENSON

Gender, is a well-known social construct that regards to masculinity and femininity. However, the term is frequently misinterpreted as many persons have the idea that it has the same definition as sex. This is misleading and gives a false impression as gender and sex have distinct meanings. According to Anderson and Taylor (2008), “Sex refers to the biological identity, male or female and gender refers to the socially learned expectations and behaviour associated with members of each sex” (p. 302). It is clearly outlined that sex has to do with the biological and physical characteristics of what makes an individual male or female. Various sex characteristics for women include breasts that are capable of producing milk, their ability to menstruate and reproduce. The sex characteristics for men are different such as their ability to produce sperm which a characteristic associated with women. As individuals develop they are socially constructed to adapt to specific roles that match the specific gender identities associated with masculinity and femininity. The most common gender characteristic is for women to wear dresses and skirts while men wear pants.

Society plays a major role in dictating the type of behaviour that is expected. It is however alarming to note how gender roles are changing. It was the norm for women to carry out certain domestic roles such as staying at home with their children, pursuing careers and engaging in forms of work outside the household that would not usually involve them getting dirty or doing heavy lifting. Today in Jamaica, occupational stereotypes are changing: more men are pursuing careers in hairdressing and do this job just as well or sometimes even better than many female hairdressers. Men pursuing this career are often not viewed by society as possessing traditional masculine characteristics and they sometimes face discrimination. Other examples of changing gender roles and occupations in today’s society are men who stay home while women go out to work and women working on construction sites - a male dominated space. Anderson and Taylor (2008) also stated that “A person is born male or female but becoming a woman or man is the result of social and cultural social expectations that pattern men’s and women’s behaviour” (p. 302).

According to Worrell (2002), Sigmund Freud’s psychoanalytic theory addressed gender as a psychosexual development in terms of the development of personality consistent with biological sex and achievement of a particular form of mature sexuality (p. 597). Due to changes in gender roles, discrimination is a major issue. On many occasions persons who take on the roles traditionally ascribed to the other sex are labeled as homosexuals. Many persons are not comfortable with these changes and based on personal observations, Jamaica is quite a homophobic country although there are individuals who accept them.

As the concept of gender and sex expands, other gender-related issues have emerged in Jamaica and among these is the debate on ‘male marginalization' first argued by Jamaican educator, Professor Errol Miller. Miller (1986) stated that at the beginning of the early twentieth century, the policy of the colonial government was to facilitate the elevation of women over men because the colonialists had a fear of black men. Though Miller argues his point, men are still seen as being dominant and more powerful in terms of their physical strength, and customs of the

society. On the other hand, there is Sigmund Freud's concept of "penis envy". Nevid (2009) states that "penis envy in Freud's view, leads girls to feel inferior or inadequate in relation to boys" (p. 483). This suggests that males see themselves as being more powerful, superior and having possession of something that would make females envious. Some men may have the same view as Freud because they see themselves as having the more powerful tool which they use to define their macho characteristics. However, one of the most alarming issues related to these unequal gender relations are the HIV related risks that exist among males and females in both heterosexual and in same-sex sexual relationships. Many heterosexuals and homosexuals are not practicing safe sex which means using a condom when they are having sexual intercourse.

Many questions arise on why sexually active persons are not practicing safe sex. Male and female condoms are distributed to various institutions free of cost. Condoms are also offered free of cost at health centers where persons regularly visit to get their check-ups or to be treated. However, it is known that some individuals deliberately refrain from using condoms when having sexual intercourse. This practice of unsafe sex does not only affect increased risk of STIs including HIV, but also causes unwanted or unplanned pregnancies. These behaviours also contribute to the spread of HIV among other STIs. High levels of HIV infection mean that there is need to compare and contrast the gender–related HIV risks for males and females in heterosexual and same sex relations. In Jamaica, there has always been the custom of heterosexuality while homosexuality is not legally or socially accepted by the majority of the population. There are risks in both groups. There are heterosexual and homosexual female sex workers and there are heterosexual and homosexual male sex workers who may not practice safe sex. Some of them may be engaged in the practice of oral sex through which HIV and other STI's can be transmitted.

Among MSM, there is a power imbalance among males who play the feminine role and the male who plays the masculine role. This is similar to the position of females and males in heterosexual relationships. The person who plays the masculine role is normally the one who displays power and authority and this is often achieved through fear. Men are normally the ones wearing the condom so if they decide not to put them on, there is increased risk of HIV. The male figure in the same sex relationship would display those macho characteristics which also results in a high risk of HIV/STI infection. Not all males and females in same sex or heterosexual relationships use condoms when having sex. There are men (and to a lesser extent women) who have multiple sex partners for the purpose of sexual satisfaction. For many males, having multiple sex partners is part of their masculinity.

There are various risks of HIV infection among heterosexuals and homosexuals. For some it is their lack education about how to protect themselves from sexually transmitted diseases. Some males and females in heterosexual and same sex relationships may be at risk because they live in rural areas. In some locations they may not have easy access to adequate health care; reproductive health information on HIV/STI's, and services to meet their needs for contraceptives. They may not have easy access to condoms because of distance to purchase or cost. Other men and women who are infected with HIV may also be afraid to seek help from health care services or counseling due to fear of discrimination. Then there are males and females in both heterosexual and same sex relationships who engage in oral sex without the use

of a condom and are unaware that HIV and other STIs can be transmitted through oral sex. In addition to gender-related differences among heterosexuals and homosexuals which result in the risk of HIV and other STIs there are also biological factors. For example, the make-up of the vagina makes women more susceptible to HIV infection than men. If sexual intercourse takes place when the female is on her back and the male is on top semen discharged by the male is more easily trapped in the vagina for a long period. (Pastorino and Doyle-Portillo, 2005). These writers also highlight the higher risk of women contracting an STI than men because of the warm, moist environment of the vagina. This they argue makes women more susceptible to infection than men.

Social attitudes also pose risks. Homosexuals may fear discrimination in purchasing lubricants to have anal sex which would reduce the risk of HIV infection compared to unprotected sex. Tearing of the anus may develop if lubricants are not used during anal sex as the anus was not designed for the penis to be inserted. Brooks et al, (2005) also indicate that high risks sexual behaviours are more likely among Men who have Sex with Men. They note that men are generally more aggressive and powerful and these characteristics are exhibited in sexual intercourse. Therefore, when MSM couples have sexual intercourse there is likely to be powerful, aggressive, volatile behaviour. This could cause tears in the anus which would increase the risk of HIV/STI transmission. The homophobic culture of Jamaica, discourages homosexuals from being frank about their sexuality. Some would have sex with both men and women which would make them bi-sexual. However, only their relationship with females would usually be known publicly. Having sex with both men and women increases the risk of STIs/HIV. Individuals can also be re-infected with the HIV virus which would make the immune system much weaker and would cause more damage to the body.

Unequal power between the sexes also means that many females are unable to negotiate consistent condom use and this is also another factor which causes the risk of HIV. Before the existence of the female condom, females relied solely on the use of the male condom to protect them from STI/HIV infection and from unwanted pregnancies. If men do not use a condom during sexual intercourse then both partners are at risk. Even though there is now a female condom, females may still be more comfortable with the use of the male condom for sexual intercourse. If condoms are not used, then the risk of HIV infection is increased.

Male health behaviour can also pose HIV risks. Males are generally not the ones to do regular check-ups with a doctor and if they are ill they may rely on home remedies because many men see going to the doctor for treatment as weakness. Females however, visit the doctor more regularly and would therefore get treatment more quickly for any illness detected. Men may therefore be living with the HIV virus for years but because of stubbornness and their refusal to do regular check-ups, they could be transmitting the virus from one sexual partner to another. Then there is the fact that many females take contraceptives to prevent pregnancy. Some may be unaware that these contraceptives do not protect against the risk of getting HIV and other STI's.

Socio-economic status can pose risks. There are men and women from poor economic backgrounds who are taken advantage of by powerful men and women in society. In some communities these include areas where there is "Don Leadership." Discrimination against women can also pose risks of HIV infection. Tomasevski (1993), highlighted definitions in the

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979) which explain the term 'discrimination against women'. This means "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field" (p. 54). Women who are seen by society as inferior often face discrimination not only pertaining to sex but also in work and education. CEDAW is the Women's Rights' Convention and it clearly states that females have equal rights as men and they are free to make decisions and play equal roles in society. Today, in Jamaica, some men feel inferior to women because of the roles being carried out by women in tradition professions such as medicine and engineering. Some levels of discrimination still exists against women although this is changing. There is also evidence that men and women are being abused within and outside of heterosexual and same sex relationships. Children are also at risk in today's society, many girls (and some boys) are being raped in Jamaica which increases the risk of HIV and other STI's. There are also cases where married couples become infected with HIV because a partner is having extra-marital sex.

**Conclusions and Recommendations**

Given the various HIV/STI risks among both heterosexual and same sex partners, there is need for increased action to implement the provisions of CEDAW and other conventions that aim to protect women's rights against all forms of discrimination and promote gender equality. If measures are implemented effectively, these would result in the abolition of certain practices such as men being forceful towards women. This would then decrease the risks of HIV and other sexually transmitted infections. Countries like Jamaica need to increase their response to HIV given the observation by Tomasevski (1993), about the World Health Assembly (WHA) who had recorded concerns at the slow progress in improving women's health and safeguarding their rights. The close relationship between equal rights for men and women was also noted (p. 64).

Tomasevski (1993) also noted that Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) obliges governments to create conditions which would guarantee medical service and attention to all who are sick. These and other conventions promote the rights of women and equality between men and women. They also seek to fight against sexual, cultural and economic discrimination.

Greater efforts must be made to ensure that all males and females are more aware of gender-related HIV risks in both heterosexual and same sex sexual relations in Jamaica. Everyone must take more responsibility to ensure safer sex behaviour at a personal level and this will impact the wider society. Expanding information and services on reproductive health can help to reach the most vulnerable especially those in rural areas and young women and men, children and sexual minorities and sex workers.

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# Gender Analysis of Safe Sex Campaigns: Strategies to Improve their Effectiveness in Combating the Spread of HIV/AIDS in the Jamaican Society.

JEHNELL SPENCER

## Introduction

Since its discovery in the early 1980s, the Human Immunodeficiency Virus (HIV) has increased rapidly among both heterosexuals and homosexuals. This has changed from the popular view that the disease only affected homosexual men. Lack of information about the virus and the development of the AIDS disease, allowed the disease to become a pandemic. Global regional and national efforts have however reduced rates of infection though the epidemic is still a challenge to the development of many countries. Today, heterosexual relationships are the most common medium through which the virus is spread. As a means of combating the disease, countries with funding from international agencies have implemented large safe sex campaigns. After realizing that the safe sex campaigns were not proving as effective as had been hoped, the concept of safer sex campaigns was introduced. Despite this new approach, the rate of HIV/AIDS is still high among Jamaicans in the age group 10-29 years. Dr. Fenton Ferguson Jamaica's Minister of Health, in speaking on Thursday February 9, 2012 at an open-day symposium to showcase current HIV and AIDS training interventions for health-care workers, confirmed a worrying trend: younger females within the age group the 10-29 years accounted for the largest rate of increase with those aged 15-19 years being most at-risk. (Ferguson, 2012).

If the safe sex campaigns were as effective as had been hoped, this trend would not have been so worrying but targeted age group had been practicing safer sex. The aim of safe sex campaigns in Jamaica are to reduce the spread of HIV/AIDS by appealing to heterosexuals to participate in protected monogamous relationships. Analysis of the campaigns about safe sex practices, show that they fail to acknowledge concrete and palpable reasons that contribute to the spread of HIV/AIDS. Although the foundation of these campaigns stems from sexuality which Weeks (1995) describes as an “abstract noun that refers to the quality of being sexual” (p. 13). They do not acknowledge other gender-related factors that contribute to the HIV/AIDS pandemic. Given the continuation of high risk sexual behaviour, it is evident that much more work needs to be done to make the campaigns more effective. A gender analysis of the campaigns needs to be done. Dunn (2008) describes this as a process that helps to assess the impact of differential policies and programmes on groups of males and females to conduct a gender analysis of safe sex campaigns to assess their effectiveness, one would have to consider the gender related issues that these campaigns ignore that if identified and addressed, would make safe sex campaigns more effective. These issues would include:

- Men as the source of information which reflects a masculine culture;
- The rejection or lack of acceptance of other sexual minorities such as LGBT, sex workers, Women who have sex with women (WSW) and Men who have sex with men (MSM).
- Implicit consideration of the socio-economic conditions of both women and men.

- The reality of gender relations and domestic violence.

This paper therefore aims to provide a gender analysis and recommend changes that will seek to enhance safe sex campaigns and other HIV/AIDS education and prevention initiatives.

**Men as Sources of Information and Power**

Strong, aggressive, dominant, assertive, promiscuous are a few of the words that are often used to describe the masculinity of the ideal Jamaican male. To fully understand this phenomenon of man as the source of information and the masculine ideal, one must understand the gender identity of a typical male. Gender is described as "the social organization of sexual difference and refers to the social and cultural differences between the sexes" (Francis-Brown 1995, p 11. One of those differences is the power of information. Males tend to have more power in the society than females. The Jamaican culture is predominantly heterosexual which Richardson (1996) describes as, "coherent, naturally fixed and stable, universal and monolithic" (p.2). Davis (2004) also indicates that masculinity is also associated with "sexual prowess, multiple female partners and fathering of many children" (p. 570). Lewis (2004) argues that "masculinity is the vehicle through which patriarchal domination is normalized" (p. 257). HIV campaigns use this ideology to give males greater access to information and power to be in charge of their own sexuality as well as that of the woman.

Safe sex campaigns are targeted at men as men are perceived to be dominant in sexual relationships. The campaigns are therefore considered to be andocentric. We live in a masculine culture and it is noted that when women appear in these advertisements they are either in the shadows or one of the many women of the promiscuous man. In these campaigns women are not the source of information although they are 51 per cent of the Jamaican population (STATIN, 2012). Lewis (2004) explains that the masculine nature of the state reflects policies and practices that are male-dominated while women and other gender minorities are left out. As a result, male gender biases are reflected in safe sex campaigns. This lack of access to first-hand information increases the risk of HIV among women and this contributes to the spread of the virus in both men and women. Women, due to their physiological make up, are more biologically susceptible to contracting HIV and other STIs because the "mucosal membrane of the vagina is a large, thin area that is vulnerable to infection" (Davis 2004, p. 564). However, physiology alone does not account for women being more at risk of infection than men.

There is a common perception that men already possess more information about sex than women. Safe campaigns suggest that men do not need to know about sex since "men are expected to know a great deal about sex" (Harcourt, 1993, p. 25). This lack of information from a woman's point of view, Barriteau (1998) argues gives men control of their sexuality, body, conception and sexual decisions and also gives them control of women. This control exposes women to HIV infection as they oftentimes receive second hand information that may not be accurate and as such limits their ability to properly protect themselves. On the other side of this debate is the fact that women and men ascribe to particular gender norms which can work against men being the source of information. For many people, there is the view that for women to be considered feminine, they must appear chaste, reflect purity and display sexually innocent

characteristics. Davis (2004) sated that “so young women may not possess accurate information about sex and sexuality” (Davis 2004, p.568).

Men on the other hand should know everything about sex and sexuality. This misguided ideology that men should be the source of knowledge, places them at risk of contracting the virus. Boys for example may engage in risqué sexual behaviour because they lack the proper knowledge and information on “sexual health since it is often assumed that they have that knowledge” (Davis 2004, p. 568). The outcome of these results suggests that men will not seek information about sexual health because of fear of being ridiculed, because it is assumed that they already have that information. Young girls and women may not seek information because they fear being labeled as “loose” or promiscuous if they ask relevant questions. Gender analysis of the safer sex campaigns suggests a double standard for men and women acquiring information about safe sex practices and sexual health.

**Sexual Minorities**

Heterosexual contact is said to be the most common medium through which HIV infections occur. Despite this one must also consider other sexual minorities and at- risk groups. Most, if not all safe sex campaigns or programmes do not accommodate other sexual minorities such as Lesbians, Gays, Bisexuals and Transgender persons (LGBT), Men who have sex with men (MSM), women who have sex with women (WSW) and sex workers. This lack of acknowledgment of sexually diverse groups may result in safe sex campaigns being less effective than planned. The homophobic nature of the Jamaican society adds salt to a sore wound on this matter. Homophobia according to Foucault (1979) is the fear of gay men or homosexuals. This fear is reflected in the campaigns since they shy away from mentioning them as a part of the HIV epidemic. A review of current safe sex campaigns shows that they are geared towards heterosexuals and every other sexual minority is excluded. What tends to be shocking is that MSM accounts for the highest rate of HIV infected persons and persons living with AIDS. Jamaica's Minister of Health, Dr. Fenton Ferguson speaking at an open day symposium to showcase current HIV and AIDS training interventions for health care workers on February 9, 2012, confirmed that HIV infections among at risk groups are higher than in the general population: MSM, accounted for 32% and sex workers, 4.9% (Ferguson, 2012). Hopwood, (1994) indicated that 11 per cent of HIV positive persons are infected through LGBT sexual contact.

Barriteau (1998) highlights some of the factors that explain the imbalance in information campaigns. She explains that “legislations, social policies and laws such as anti-sodomy laws prevent gays from seeking welfare and deny their human rights and citizenship” (p. 189). Based on current policies, the safe sex campaign in Jamaica neglects the reproductive rights of LGBT, MSM and sex workers. Homophobic attitudes to sexual minority groups leads Davis (2004) to assert that “in many communities men engage in ‘invisible lives’, maintaining public heterosexual relationships while also having secret sexual relations with other men” (p. 571). *The main point is that by neglecting the existence of sexual minorities or at risk groups, safe sex campaigns may be contributing to high rates of HIV and AIDS.*

Sex workers and sexual minorities are both considered high risk groups for HIV infection. As soliciting sex for gifts, favours or money is illegal in Jamaica, national safe sex campaigns tend to exclude sex workers. The Ministry of Health therefore uses alternative methods to transmit sexual knowledge on HIV/AIDS risks, and how HIV is passed on to both male and female sex workers. They use second hand sources of information about HIV which include other sex workers/friends. As the information is transmitted second hand, it may not always be accurate and misinformation can contribute to the spread of the virus. A gender analysis of the lives of sex workers and their knowledge about HIV was the focus of a study conducted by Penelope Campbell and Ann Marie Campbell (2001). The study revealed that eight out of ten of the women believed that unprotected oral sex is not a medium through which one can be infected with HIV. An earlier study by Hope Enterprise Ltd (1996) also reported similar data, indicating that some 26 percent of the female commercial sex workers consulted, believed that oral sex was a safer sex practice. The beliefs expressed by sex workers in both studies could have been easily corrected if they had been included in designing safer sex campaigns targeted at this high risk group. Jackson (1996) also notes that in the Caribbean, most of the work on HIV/AIDS focuses predominantly on heterosexuality and penile/vaginal sex although other forms of sexuality and sexual behaviours exist. An exclusive focus on heterosexuals therefore impedes the effectiveness of safe sex campaigns. Greater efforts must be made in future to ensure that campaigns target sexual minorities to promote their sexual and reproductive health.

**Safe Sex Campaigns and Socio-economic Conditions**

Safe sex campaigns suggest that if one practices monogamy or uses condoms in these relationships, the spread of HIV can be reduced. An important gap in this message is that it eliminates socio-economic factors that feed the HIV epidemic. Irwin, Millen and Fallows (2003) point to how differences in access to resources affect decision-making on education and other factors in societies with high levels of poverty. This is evident in the Jamaican society as HIV/AIDS is more prevalent among persons in the lower income groups and those below the poverty line (UNAIDS, 1999). Both men and women are affected by socio-economic conditions and gender also affects social roles and occupational choices which influence women's and men's access to and control of economic resources. Davis (2004) in her gender analysis of HIV/AIDS points to multiple factors that "shape vulnerabilities to infection and the personal, social and economic impact of the endemic" (p. 566). Poverty is universally feminized. This means that as a group, more women than men are poor. As a result more women than men are vulnerable to HIV because of their socioeconomic status. UNAIDS reports however show that women of all ages and socioeconomic backgrounds are being affected by HIV/AIDS, not only those who are poverty stricken.

Hopwood (1994) noted several factors that contribute to the spread of the HIV/AIDS epidemic among heterosexuals. These included: the inability of many women to protect themselves due to their lower social and economic status and their lack of influence on their social relations (p. 23). This would suggest that the lower a woman's socioeconomic status and influence in her relationship, the more at-risk she is as she is not always able to negotiate safer sex practices. Safe sex campaigns do not acknowledge women's socioeconomic vulnerability. As the safe sex campaigns are targeted towards men, they do not consider women's socio-economic vulnerabilities, and gender inequalities in power and decision-making. UNIFEM (2001) states

that “women are not increasingly represented among vulnerable, infected and affected groups, simply because they are women, but because of the discrimination and inequality that distorts and impairs every aspects of their lives” (p. 2). In the Jamaican society, women in low socioeconomic conditions, are at an increased risk from poverty. and culturally accepted gender roles make it possible for men to solicit sexual favours from women in exchange for gain. Hopwood (1994) also noted that women frequently end up with little or no control over their own lives and their bodies, and therefore cannot protect themselves from HIV/AIDS. Safe sex campaigns do not always acknowledge these realities which undermine the effectiveness of their efforts to combat HIV/AIDS. Also absent from these campaigns is the fact that some women are promiscuous and have multiple sex partners. Davis (2004) explains that some women engage in promiscuous behaviour because of financial constraints and this behaviour increases their risk for HIV and other STI infections. Safe sex campaigns are biased as they tend to focus on men as the only ones who are promiscuous. Future campaigns should however focus on HIV risks from multiple partnering by both males and females as this is the reality.

**Gender Relations and Domestic Violence**

Safe sex campaigns must also in future consider HIV risks associated with gender relations and domestic violence to be more effective. Women and men’s relationships can be difficult at times, but usually increase when unequal power relations between the sexes, HIV/AIDS and gender based violence are considered. Weeks (1985) describes sexuality as “words, images, ritual and fantasy as it is about the body: the way we think about sex fashions the way we live it” (Weeks 1985, p. 3). Harcourt, (1993) notes that analysis of gender relations explain how we acquire knowledge about our bodies and socially sanctioned behaviours, including sexual relations. Since power is associated with men and masculinity, women will tend to be affected more negatively. Women who are in sexual relationships and lack equal power with men are more at risk as this undermines their ability to practice safe sex. Most safe sex ads in Jamaica show men initiating condom use and willingly taking HIV tests to know their status. Women’s position in these ads often reflects subordination and powerlessness. Hopwood (1994) therefore argues the need to “identify these obstacles faced by women as they affect the AIDS epidemic before there is any hope of controlling this epidemic” (p.31). Unequal power in gender relations subordinates women, increasing their vulnerabilities to HIV. Subordination of women can also make them irresponsible in the process of sexual decision making.

Hopwood (1994) further suggests that the subordination of women in Jamaica denies and limits their ability to practice safe sex. In sexual relationships between women and men it is noted that a woman’s role in that relationship is to reproduce, which is consistent with the norms of femininity posit that a woman's role is to reproduce. This Miles (1993) argues, contradicts safe sex practices as safe sex behaviour also prevents pregnancy. Safe sex campaigns are again communicating mixed messages of safe sex practices that contradict the essence of femininity. In order for women to negotiate safer sex practices some degree of power and skills are necessary to do so without fear and retaliation from their male partners. Many women who assert this power are often the victims of domestic and gender based violence. The latter is defined as “a host of harmful behaviours directed at women and girls because of their sex, including wife abuse, sexual assault, marital rape, forced prostitution and sexual abuse of female children” (Ellsberg and Heise 2005, p 11). Gender based violence contributes to the HIV/AIDS pandemic

and women are the ones who are most often at the receiving end, which makes them vulnerable to HIV infection.

Davis (2004) explains the challenge faced by many women who propose condom use. Their male partner she argues "may see it an accusation of infidelity and /or lack of trust" (p. 570). Many women are therefore afraid of suggesting condom use as they fear repercussions from their male partners. The threat of violence prevents many women from seeking health information, going for HIV tests, treatment and counseling. Safe sex campaigns also disregard the reality that married women are also affected by HIV. Ignoring married women feeds into the belief that they are 'safe' from the virus. The Human Rights Watch (2008) in its report 'Just Die quietly: Domestic violence and women's vulnerability to HIV' explains marriage related HIV risks. HIV/AIDS programmes they note focus on fidelity, abstinence and condom use. These approaches do not account for the ways in which domestic violence inhibits women control over sexual matters within their marriage relationship. Analysis of the safe sex campaigns in Jamaica from this perspective show that they fall short of protecting this group of vulnerable females. Future HIV/AIDS campaigns and programmes must therefore address women and girls' susceptibility to gender based violence and risks in marriage.

**Conclusions and Recommendations**

Gender analysis of safe sex advertisements in Jamaica show that they are male-focused and ignore important vulnerable groups. If these remain unaddressed they will undermine the effectiveness of the national programme to promote safe sex behaviour. In response to the findings of this analysis, several recommendations are made to ensure the success and effectiveness of future advertisements. The following factors and issues must be taken into consideration:

- Gender-related values and attitudes of the Jamaican population must be taken into consideration before programmes or campaigns can be launched as the attitudes and values of the women and men can contradict what the safe sex campaigns and programmes are expressing;
- Gender should be viewed as a cross cutting issue that has implications for all aspects of the epidemic (United Nations Division for the Advancement of Women, 2000). Consistent use of gender analysis tools can better assess the impact of HIV/AIDS on those infected and affected;
- Gender related psycho-social factors need to be included in assessing HIV prevention and sexual health education programmes;
- Safe sex campaigns must encourage men to be more involved and assume greater responsibility in the fight to prevent and control the spread of HIV/AIDS;
- HIV prevention programmes must target issues of gender relations, gender based violence, socioeconomic factors and unequal power relations between males and females as areas for intervention;
- Safe sex campaigns and HIV programmes must mainstream gender , adopt gender sensitive legislation and also meet the unmet needs of sexual minority groups.

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## HIV- The Sexual Theoretical Perspective

ASHLI ROSE

HIV and sexuality issues help to explain the large numbers of HIV infected persons in the Caribbean. Against this background it is important to increase knowledge and awareness about the factors that contribute to HIV infection. Theories on sexuality and sexual behaviour in various disciplines can help to improve awareness and guide education and other interventions. It is well known that the majority of HIV infection is transmitted through heterosexual sexual relationships. Heterosexuality explains sexual feelings or behavior directed toward a person or persons of the opposite sex. Rates of HIV transmission are highest resulting from sexual intercourse between homosexual men especially. Homosexuality describes sexual desire or behavior directed towards a person or persons of one's own sex. In Jamaica being in a homosexual relationship is not illegal, but the sexual act of "buggery" is what is considered as illegal. Buggery is the legal term given to sexual penetration of the anus. Although not socially accepted, homosexual relationships do exist and there are cases of buggery. In Jamaica the automatic response of most persons to any mention of buggery is negative not only because it is considered illegal and morally wrong but also because of the health issues associated with buggery. Men and women in both heterosexual and homosexual relationships who engage in the sexual act of buggery face health risks. Heterosexuals are at risk because their normal sexual practice is penetration of the penis in the vagina. So with or without using a condom, if penetration occurs in the anus and directly afterwards there is penetration of the vagina, the bacteria from the tissues in the anus will be passed on to the vaginal walls. There, constant secretions of this bacteria will occur and facilitate transmission of the virus. Although the sexual acts between heterosexuals and homosexuals have been differentiated, the risk of contracting the virus is still high and affects both males and females differently.

**Masculinity**

According to Hofstede (2001) masculinity is a very distinctive social gender role. Men are supposed to be assertive, tough and focused on material success, while femininity is associated with the opposite. However, some social roles are similar for both men and women. Theoretically, a prime example of men's assertive trait is dominance in sexual activities which result in women not having equal decision-making power in sexual relationships. The decision to use a condom as protection during sexual intercourse, is usually left up to the male.

I have conceptualized the term Male Condom Decision (MCD), hoping that this concept and acronym can open women's eyes to the reality those sexual decisions that affect their body cannot be left to their male partners. They must be involved. Promoting this concept would encourage women to realize that leaving such important decisions to a man is reckless as they have no assurance that their male partner is not having sex with other women or even men.

Gender and development theories help to explain the gender-related risks in sexual intercourse. Theories related to masculinity in the literature show that the concept of the ideal man is one who is expected to display "prescribed" traits and behaviours associated with hegemonic

masculinity. Connell (2005) first introduced the term Hegemonic Masculinity to refer to a dominant form of masculinity within the gender hierarchy. Hegemonic masculinity is competitive and reflects a tendency for males to seek to dominate other males and also subordinate females. The oppression, exploitation, power and social control that is received from obtaining traits of hegemonic masculinity, allow men to be more powerful in society. Connell argues that although hegemonic masculinity subordinates other masculinities and femininities, it can be challenged by them. In most Western societies Connell also notes, hegemonic masculinity is associated with whiteness, heterosexuality, marriage, authority and physical toughness. As this "prescribed" hegemonic masculinity speaks specifically to heterosexuality and marriage, men who defy this gender norm face other HIV risks that also need to be understood.

**Types of Masculinities**

Connell (2005) indicates that masculinities can be divided into four groups: *hegemonic masculinity, complicit masculinity, marginalized masculinity and subordinate masculinity* Hegemonic masculinity as previously discussed is considered as the dominant form of masculinity in Western society and is most valued. Complicit masculinity Connell indicates includes men who may not be able to live up to the ideals of hegemonic masculinity but they don't challenge it. They also benefit from its dominant position in the hierarchy of masculinities. Marginalized masculinity he notes, explains groups of men who would like to fit the requirements of white hegemonic masculinity but their non-white racial or other characteristics and background makes them less highly ranked on the spectrum of masculinity. Subordinate masculinity Connell states is the opposite of hegemonic masculinity. These males may be effeminate, show emotions and the concept would include homosexual men as a group although there are variations within this group. This is a taboo form of masculinity in Jamaican society.

**Masculinity, Sexuality and Reproductive Health**

Data on the reproductive health of homosexual males, shows that they have the highest risk of HIV infection. This is because many are forced to hide their sexual preference and therefore lead double lives as bisexuals. Male bisexuality means that homosexual men are having sex with both men and women. Bisexuality explains romantic or sexual attraction or behavior towards both males and females. Bisexuals normally impact the family as most family members do not understand this sexual behaviour. To most people, sexuality is a simple choice of a preference for either a male or a female. Because homosexuality is not considered as the norm, families usually find it hard to accept and it creates communication barriers between lovers, families and friends. For example, a male homosexual may have a stable and steady relationship with a man behind closed doors and may not be using condoms as protection. He may then marry a woman who has no idea of his bisexuality. His sexual behaviour puts both his wife and male partner at risk as they may all be having unprotected sex. If the bisexual man were to come out and let everyone know his sexual preferences many people would not be accepting of him. The high risk of HIV may also result in discrimination against any child he may have with his wife. Both the man and his wife (and his male partner) would not know their HIV status unless they get tested. The mother may be infected but may not be aware, and could pass on the virus during childbirth or while breastfeeding her baby. In Jamaica the statistics show a significant reduction in mother

to child transmission of HIV, as pregnant mothers are required to do HIV tests in the antenatal clinic.

**Femininity, Sexuality and Reproductive Health**

Females face higher biological risks from HIV because of the genital makeup of the female body. This is because semen contains more HIV virus than vaginal fluids and semen and vaginal fluids are exchanged during heterosexual intercourse. MSM have the highest risk of HIV infection because of sexual intercourse in the anus which often takes place without protection.

**Conclusions and Recommendations**

Gender theories explain the unequal social power and sexual relations between males and females which contribute to HIV infection. Understanding gender theories that explain social behaviour can increase awareness of males and females in heterosexual bisexual and homosexual relationships. Regardless of sexual preference there is risk of HIV infection if individuals have sexual intercourse without using protection.

Understanding gender and development theories can help to guide information on reproductive health. This knowledge can help Jamaicans and people in other countries to reduce the spread of the HIV virus. Gender-sensitive programmes can promote the message that sexual health can be maintained by always using protection, and getting regular HIV tests. Gender-sensitive education programmes can also help to increase understanding of different types of masculinity. In so doing they can make HIV campaigns more effective and help to change the sexual behaviour of both sexes.

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## Gender, HIV and Vulnerabilities

COREEN STEPHENS

In the Caribbean region HIV/AIDS is one of the main factors contributing to deaths among persons aged 25-44 years (Figueroa, 2008). Kempadoo (2004) also notes that about 70 percent of Caribbean people between the ages of 15 and 44 years are living with HIV/AIDS. The prevalence of HIV/AIDS in the Caribbean is a growing cause for concern and Caribbean research suggests that particular groups of persons are more vulnerable to HIV than others. These groups include: "sex workers, migrants, adolescents, and gay and bisexual men" (Kempadoo, 2004, p.168).

While both genders are at risk for contracting HIV, risks factors often differ based on gender characteristics. Initially, HIV was considered to be a homosexual disease in Caribbean territories such as Jamaica, Haiti and Trinidad and Tobago. However, the situation has changed and "HIV/AIDS transmission in the region was quickly acknowledged to be predominantly heterosexual in nature" according to Camara (as cited in Kempadoo, 2004, p. 167). High levels of economic dependency among some Caribbean women puts them at an even greater risk for contracting HIV and other sexually transmitted infections. According to Figueroa (2008), the sexual patterns of individuals within the Caribbean contribute to an increase in the number of persons infected with HIV. Moreover, Figueroa notes, "gender roles and stereotypes play an important part in influencing sexual behaviour and a reluctance to use condoms with a steady partner which puts many persons especially women at risk of HIV infection" (Figueroa, 2008, p. 199). Women are also at higher risk based on the notion that men should exercise dominance. As a result of stigma, men who have sex with men (MSM) may engage in heterosexual relations to avoid discrimination. In such cases, the problem is further compounded because of the high prevalence of HIV among homosexual men which can result in the transmission of HIV to heterosexual persons (Figueroa, 2008).

Gender based violence also plays a major role in the spread of HIV within the Caribbean region. Dunn (2001) indicate that women (especially young women and girls) are particularly vulnerable to HIV as a result of gender based violence as they may not always be in a position to determine whether or not their partners use condoms. Sadly, some women become tolerant of gender discrimination and sexual abuse (Dunn 2001). Young women and girls are particularly vulnerable to HIV as they may be unable to negotiate condom use. A study of adolescent sexuality conducted in Jamaica, revealed that "incest and the demand for sex by boys and men in exchange for a meal, gifts, money, or a drive in a flashy car were forced upon many girls" (Kempadoo, 2004, p.171). The study also revealed that in many cases of forced sex, incest and sexual abuse, males were considered "to be exercising their sexual rights" (Kempadoo, 2004, p.172). Adolescents girls are also at HIV risk from having sexual relations with older men due to their "sexual and social vulnerability" (Kempadoo, 2004, p.172). Established gender roles in the society play a major role in the transmission of HIV among Caribbean persons. Dunn (2001) argues that the inequity between men and women is linked to socially ascribed gender roles. As a result of male dominance in the Caribbean, adolescents and young girls are not usually in a position to negotiate condom usage or determine if their partners are indeed faithful. Barriteau

(as cited in Lewis, 2003) explores the treatment of women in the post-colonial years which restricted them from accessing state resources and employment in some sectors. Barriteau asserts that "The ideological belief in the inferiority of the woman as a citizen was supported by the economic realities of restricted access to or allocation of public and private resources" (p.42). Preventing Caribbean women from having equal access to economic resources, increases the risk of spreading HIV. This results from their high levels of dependency on men.

Male violence against women in the work place in the form of sexual harassment is also a contributing HIOV risk factor. Then there are women in high risk occupations such as female commercial sex workers. They are at extremely high risk as they sometimes agree not to use condoms if clients are willing to pay more for their services (Dunn, 2002). The subordinate position of women in society therefore contributes to many of them being at a greater risk for contracting HIV. The main mode of HIV transmission in the Caribbean is through heterosexual sexual contact and accounts for about 60 per cent of cases reported to the Caribbean Epidemiology Centre (CAREC). About 15 per cent of cases result from homosexual or bisexual transmission and approximately six (6) percent of cases stem from vertical transmission (Figueroa, 2008). Considering this data, the risk of persons contracting HIV through same-sex sexual relations must not be underestimated

USAID, (2011) states that only four of twelve Anglophone Caribbean countries, "publicly collect HIV prevalence data among MSM" (p.1). Data collected in Jamaica, Guyana and Trinidad and Tobago, they note, shows that the HIV prevalence rate among men who have sex with men (MSM) exceeded 20 per cent. This makes MSM in the Anglophone Caribbean the most-at-risk population group (MARP) for HIV (p.1). This is rather alarming. The lack of data collection in other Anglophone Caribbean territories makes it impossible for persons to know the number of MSM who have HIV and this contributes to spreading the virus. USAID (2011) also suggests that an estimated 89 percent of HIV infections among men in Trinidad and Tobago each year could result from men having sexual relations with other men.

The homophobic nature of the Caribbean society contributes to the spread of HIV by homosexuals, especially MSM. One interesting observation made in the USAID (2011) report is that MSM often refer to themselves as heterosexual or bisexual rather than homosexual, as some engage in sexual relations with both sexes. Homosexuals the USAID report notes, are vulnerable to HIV not only as a result of "unprotected anal sex but also to other contextual health and rights issues such as poverty, youth, migration, sex work, drug use, gender identity, homelessness" and the possibility that MSM are marginalized and are victims of violence (p.2). Some persons are very hostile toward homosexuals and so men who engage in homosexual practices may conceal their sexual identity. They may also have limited or no access to much-needed health services which could reduce the spread of HIV. In addition, the USAID (2011) report states that most countries are not fully aware of the number of men at risk for homosexual infection or who require "HIV-related health services" (p.2).

Caribbean research indicates that men and women who engage in same-sex sexual relationships commonly participate in heterosexual relationships as a result of social discrimination and their desire to have children. Much of the research in the Caribbean focuses on the risk factors for MSM with limited analysis of HIV transmission among women who have sex with women

(WSW) and transgender persons. These two groups are often ignored as they are considered to be low risk. Melles & Nelson (2010) argue that the illegal nature of same-sex sexual relationships in many Caribbean territories makes it easier for homosexuals and their partners to become infected. This is unfortunate because it gives MSM and WSW limited access to necessary reproductive health services as they fear experiencing discrimination. USAID (2011) also states that "The success of HIV programming depends on people's freedom to seek services and support without encountering discrimination, blackmail, violence, and criminalization" (p.4). These factors must be considered and changed if the region is to successfully reduce the rate of HIV transmission. White and Carr (2010) report that persons involved in same-sex relations in Jamaica, admit that "homophobia and HIV-related stigma discourage them from seeking testing, treatment, and care services, and make individuals who are living with HIV less likely to reveal their seropositive status to their sexual partners" (White and Carr cited in USAID, 2011, p.4). This reality poses another problem as persons may become infected by persons having HIV who are both aware and unaware of their status.

Prevailing gender norms at times make it difficult for persons involved in same-sex relationships to avoid being stigmatized. Within the Caribbean context, gender socialization encourages a culture of promiscuity among men. This issue is not to be taken lightly as prescribed gender norms may lead young men to participate in risky sexual practices which puts them and their sexual partners at risk of contracting HIV and other STIs. Chevannes (1992) notes that the peer group is very instrumental in shaping the early sexual initiation of males. Boys Chevannes states, often engage in sex at an early age as they fear being labelled as homosexuals. Persons who engage in sex at an early age are more likely to be in casual sexual relationships. Girls are also at risk of being sexually exploited by several males (Chevannes, 1991) (as cited in Chevannes, 1992). The society expects females to take on the roles of nurturers and caregivers. As a result some girls participate in sexual activity at a young age as teenagers and become pregnant (Melles & Nelson, 2010).

Females are more prone to contracting HIV than their male counterparts because of several common factors: their biological makeup makes it easier for them to contract HIV from men than for men to become infected from their female sex partners. AMFAR AIDS Research (2008) notes that " Physiologically, women are more susceptible to HIV than men because of greater mucous membrane exposure during sex, a larger amount of fluid exchange from male to female, and higher viral content in male sexual fluids"(p. 4). A woman's risk is increased if she experiences genital trauma as blood and body fluids may be exchanged. The World Bank (2001) also confirms women's physiological risks as well as risks from social and cultural norms. These include male domination or machismo and unequal power relations between genders which prevent many women from being able to adopt safe sex practices.

High levels of poverty and dependency among women force some women to engage in illegal activities such as sex work in order to support themselves and their family members. Unfortunately, young girls and women are also at risk from human trafficking for commercial sexual exploitation which increases their risk of HIV infection. Sex work within the Caribbean is said to be related to tourism and other economic activities such as migrant farm workers and mining (World Bank, 2001). The World Bank (2001) cites a CARICOM report which recognizes that HIV prevalence among sex workers is increased due to the social marginalization of this

group and the failure of many countries to regulate the sex trade. This puts commercial sex workers and their clients at HIV risk. There are very limited social and reproductive health services for commercial sex workers across the region. Kempadoo (2004) referred to a study conducted in Guyana which indicated that not only are female commercial sex workers (CSWs) greatly at risk of contracting HIV, but they contribute to the spread of HIV to the general population, primarily in areas where heterosexual contact is the main mode of HIV transmission.

Tourism within the Caribbean region also contributes to the spread of HIV. This is possible as the Caribbean is highly dependent on tourism as a means of generating revenue and employment. Tourists, who visit the region, include "sex tourists" who may engage in sexual practices with locals (including commercial sex workers), other visitors and even children. This feature has been evident mainly in the Spanish and Dutch Caribbean as well as in the English speaking Caribbean. Such an issue is problematic because a country needs to be able to generate revenue while at the same time limiting the spread of HIV and other infectious diseases (World Bank, 2001).

**Conclusions and Recommendations**

Despite the many challenges faced by the Caribbean to control the problem of HIV/AIDS which have been discussed in this paper many good policies have been implemented to promote human rights for all. Many support the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) which all Caribbean countries have ratified. Article #5, focuses on the need to eliminate stereotyping sex and gender stereotyping and prejudice. The article calls on persons to challenge existing gender norms in order to eliminate prejudices towards individuals on the basis of their gender roles. Laws that have been implemented such as the Child Care and Protection Act in Jamaica can also help to reduce HIV infection among girls and boys. This law requires all persons to report acts of sexual and other forms of abuse against children or face stiff penalties.

To improve the reproductive rights and reduce HIV risks for all, more policies need to be implemented to protect men as well as whose diverse sexual lives places everyone at risk of HIV infection. Much work has been done to combat the spread of HIV and much more work is still to be done. The onus therefore lies on all groups in the population to practice abstinence, engage in safe sex practices consistently and to get tested for HIV to reduce their vulnerability to HIV infection.

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# Gender and HIV: The Risks for Males and Females in Heterosexual and Same-sex Relationships.

TANYA DAVIS

HIV is primarily a sexually transmitted disease. Anyone who is sexually active irrespective of their demographic profile (age, race and ethnicity etc) is at-risk of contracting the virus, if they have unprotected sexual intercourse. The Caribbean region is at high risk which requires more serious measures by all to reduce the rate of infection in the region. Gender and gender roles perpetuated in the Caribbean have implications for HIV risk factors for both males and females. Gender roles are learnt through socialization and learnt behaviours influence how both sexes interact and behave socially and sexually. There are different HIV risk factors for males and females in the heterosexual or same-sex sexual relationships. While the rate of HIV infection has reduced in recent decades females are becoming infected at a faster rate than males. It is important to understand how gender influences risks for heterosexual as well as homosexual males and females to significantly reduce the rate of HIV infection.

More than a decade ago Cobley (2000) reported that HIV infection had spread to an estimated one in 100 people in the region by 1996 (cited in Roberts, Reddock, Douglas, & Reid, 2009). These and later studies have highlighted the increased vulnerability of women in heterosexual relationships. The links between gender and HIV have become more consistent over time as almost 50 percent of those living with HIV and AIDS were women. (Bridge, 2002; UNAIDS, 2002 cited in Roberts et al., 2009). Understanding social and behavioral patterns which contribute to the HIV epidemic in the Caribbean are becoming better known. Some of these patterns can be associated with the poor economic conditions of both sexes which leaves them poverty stricken and jobless, with limited opportunities and financial resources. Economic problems, cause some men and women to explore high risk options to earn income. In a culture that is increasingly tolerant of sexual freedom and infidelity, both women and men engage in unorthodox sexual relationships, which pose risks and increase the spread of HIV infection.

Gender is learnt behaviour associated with masculinity and femininity that indicates what is considered appropriate for males and for females. This behaviour is acquired during the process of socialization, which makes gender a social construct. Power, resources, opportunities and social attributes are assigned according to gender roles for both sexes. For example, boys in the Caribbean are generally taught to be robust, and to take charge, while girls are taught to be gentle and to be caregivers. The very construct of gender not only lays the foundation, but also facilitates social economic and political inequality between males and females. This is seen in the allocations of jobs and occupations to both sexes, and differences in access to and control over power and other resources. In the Caribbean, emphasis is placed on men being the main breadwinner of a household and women being family caretakers. There is inequality in the type of responsibilities that are allocated to each sex in the family and also in male/female sexual interaction. Practices that are ideal to prevent HIV are often difficult to adhere to, given the roles and positions of both men and women in society. It is assumed that both men and women are free to make decisions about whether or not they will remain in a monogamous relationship, use

a condom whenever they have sexual intercourse, or decide to remain celibate. Women are however more vulnerable to contracting the virus than men because of their gender roles and gender inequalities and economic factors that make some women dependent on a male breadwinner, even if they are working, because they earn lower wages.

Gender socialization norms say that women in the Caribbean should have only one sexual partner. Although Caribbean women do not universally accept infidelity in men, many acknowledge and accept that their spouses have polygamous relationships and choose to remain in these relationships usually for economic and social reasons. These reasons often have an adverse effect on women's power to negotiate the use of condoms during intercourse. The use of condoms for protection is not considered appropriate in stable heterosexual relationships such as marriages, common law relationships and other long-term relationships. A women asking or demanding that a man to use a condom would be indicative of a man's unfaithfulness. Some women are in denial but some are aware but are unable to enforce condom use. The lack of power to negotiate when to have sex and under what circumstances, makes a major difference in efforts to prevent STIs/HIV. Women's lack of power to negotiate and insist on condom use also exists among women who are economically independent.

Gender norms also dictate that women should have one male partner for procreation and companionship Chevannes (2002) states that while women are socialized to achieve academic and economic success, they are cautioned not to become too self-sufficient, in order to meet social expectations that women should defer and be docile to men in personal and sexual decision-making. Men are expected to be dominant in relationships.

Some women who are marginalized due to the lack of economic opportunities and lack of resources may offer sex in exchange for "something" - a practice called "transactional" sex. In Jamaica's 2002 National Strategic Plan on HIV/AIDS, girls aged 15-19 years, and those in transactional or coercive relationships, are included among the six most vulnerable groups, (Jamaica National Strategic Plan on HIV/AIDS 2002). In my view, a more conventional form of transactional sex can be identified in stable heterosexual relationships. In marriage, women offer sex to their spouses in exchange for material things. Prostitution is another form of transactional sex which increases HIV risk. A number of women resort to selling sex for money to alleviate poverty and provide for themselves and their families. Bridge Bulletin (2002) reports that pressing concerns for short-term survival may lead to poor women engaging in survival sex which paradoxically can expose them to long-term risk of illness and death through HIV infection. They cite cases where younger women solicit older men and readily respond to sexual advances of these men for material benefits. Women particularly those who engage in transactional sex and women who are dependent on a man for economic reasons, are especially vulnerable to sexual violence and have a higher risk of contracting HIV infection. These women are more likely to be forced to have sex without protection. Chuck (1994) suggests men feel they have an inherent right to sexual satisfaction and the woman's consent is secondary. This compromises the HIV/AIDS status of women. During sexual, domestic and other forms of gender based violence women may be wounded which can increase their risk of STI/HIV infection. These include women who are raped and physically abused. They have an increased risk of contracting these viruses.

Gender roles also determine masculinity and ideal forms of Caribbean masculinity highlight virility. Many young boys are therefore initiated into having sex at an earlier age than girls. This early initiation is often to prove their heterosexual masculinity and manhood. According to reports from studies cited in Roberts et al., (2009) the median age for first sex was 13 years for boys and 14 years for girls; 12 per cent of females and 54 per cent of males between the ages of 10 and 12 years were having intercourse; boys and men who were not sexually active were deemed as "soft" and a "wuss", which means they were impotent.

Both boys and girls are involved in transactional sex with older women and men. Like women who become involved with older men for financial reasons, young boys are also becoming more involved with older women (cougars) for economic reasons. The wider society expects men to realize certain levels of accomplishments and acquire tangible assets earlier than women. Young boys and men will therefore enter into a business-sexual contract with older women to be able to afford material wealth. This in essence exposes the younger males who have had fewer partners, to a woman that may have been exposed to STIs and HIV for a longer period, making him/her more susceptible to the virus.

Figueroa (2006) states that masculinity is often viewed by some men in terms of how many women or baby mothers they have. It is clear that the practice of men having an 'outside woman', that is one outside his main partnership, is a deeply ingrained cultural practice. Men in the Caribbean who have multiple partners are seen among their peers as being a "gallist"; a "player"; a "stud" a position revered and a title coveted by other men. While in the Caribbean it is the status quo for women to be monogamous, it is widely accepted as a part of the culture that men have multiple partners. Men are expected to know more about sex and as such be capable of maneuvering their multiplicity of partners which puts them and their partners at risk. This also prevents them from seeking sexual health advice (Bridge Bulletin, 2002). Men are reportedly more reluctant than women to find accurate information about STI and HIV. When infected they do are not always readily seek treatment, and some do not seek any treatment at all. Men are also more likely to self-medicate as they are socialized to be strong and to endure the pain for as long as possible. Going to a medical doctor may not be viewed as masculine but as a sign of weakness associated with femininity. Sexually, men may opt not to use a condom for purely sexually pleasurable reasons. This view is supported by research conducted by Dr Peter Weller and others who reported that in the Jamaican context the search for sexual pleasure was the reason given by 26 percent of respondents for not using condoms.(cited in Roberts et al 2009). The reports suggest that men believe that as the dominant sex and as the breadwinner for their families, they are at liberty not to use protection when having sex with their partner (s). Men are socialized to expect that they are the sole partner of their spouse. Despite having several sexual partners some men think it is safe to have unprotected sex with each of them but this behaviour puts the man and his multiple sex partners at risk.

UNAIDS (2006) reported that there is substantial transmission of HIV/AIDS occurring among men who have sex with men (MSM). Sexual relations between men in the Caribbean are not considered acceptable as a normal mode of sexual conduct. Boys in the Caribbean are specifically socialized to be anti-homosexual. White and Carr (2005) reported that in addition to religious stand point on homosexuality, there are other factors that contribute to homophobia, and strong anti-gay sentiments. These may relate to definitions of masculinity that emphasize

sexual prowess with women and eschew 'softness' in a man. Homosexual relations are not accepted by the general public and are often met with much aggression. As a result, MSM are driven underground. Ostracizing homosexual behaviour discourages MSM from getting tested, and getting treatment for STIs/HIV. Some MSM are bisexual and also have sex with women (see Gosine 2005).

## Conclusions and Recommendations

Reports from several studies show how gender roles and relations are developed through socialization and these pose many risks of HIV infection among heterosexuals and homosexuals. Socialization also results in unequal gender relations which increase HIV risks particularly for females and males. In response to the gender-related risks and the high rate of HIV infection in the Caribbean it is recommended that new efforts be made to adopt gender perspectives in HIV policies and programmes and increase efforts to radically change gender relations to remove the imbalance of power between the sexes. The literature reviewed also shows that greater efforts are needed to remove or reduce stigma and discrimination against MSM and other high risk groups including persons involved in transactional sex. Eliminating stigma and discrimination can help to reduce risks for both heterosexuals and homosexuals as bisexual males also have sex with women. While homosexuality is not accepted in Caribbean societies including Jamaica, there is need for more public awareness to build understanding of sexual difference to enable sexual minorities to have equal access to reproductive health information and services and can help to reduce gender-related risks of HIV infection.

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**Comparison of Gender-related HIV Risks for Males and Females in Heterosexual and Same-sex Sexual Relationships in the Caribbean.**

KEVON KERR

HIV, the Human Immunodeficiency Virus, is a retrovirus that can lead to AIDS (Acquired Immunodeficiency Syndrome). AIDS is a condition that weakens the body's immune system and makes the individual more vulnerable to life threatening, opportunistic infections such as pneumonia and tuberculosis (UNAIDS, 2011). Transmission of the virus occurs through the transfer of infected blood, semen, vaginal fluid, pre-ejaculate, or breast milk from one individual to another. The majority of infections occur through unprotected sexual intercourse, with anal sex carrying the highest risk. Mother-to-child transmission can occur during the pregnancy, at childbirth or through breast-feeding. The use of non-sterile injecting equipment, especially by intravenous drug users, can also put individuals at risk of contracting HIV. The Caribbean region has the second highest HIV prevalence in the world with an estimated 240,000 people living with the virus (USAID, 2011). Epidemiological data indicate that the levels of infection and patterns of spread are more varied in the Latin America and Caribbean region than in any other geographical region of the world (PAHO/WHO/UNAIDS, 2001).

The gender-related HIV risks for males and females in heterosexual and same-sex sexual relations in the Caribbean vary significantly. The Pan American Health Organization (as cited in ICASO, 2007) describes gender as the roles that men and women play and the relations that arise out of these roles, which are socially and culturally constructed, not biologically determined. Gender prescribes a set of qualities and behaviours, which are socially determined, expected from a female or male by society. Gender roles are learned and can be affected by factors such as education or socioeconomic status. They vary widely within and among cultures and can evolve over time. Typically, gender norms ascribe greater access to productive resources and decision-making authority to men as compared to women, which results in an unequal balance in power and gender relations that favours men (International Center for Research on Women, 2002).

Sexuality, though distinct from gender, is intimately linked to it. The sexuality of an individual is defined by whom they have sex with, in what ways, why and under what circumstances, and with what consequences. 'It is more than sexual behaviour; it is a multidimensional and dynamic concept' (ICASO, 2007). Sexuality is governed by explicit and implicit rules imposed by society, as defined by one's sex and gender. A heterosexual is a person who has sex with and/or is sexually attracted to members of the opposite sex. Heterosexual sex is the main route of transmission for HIV throughout the Caribbean. A homosexual is a person who has sex with and/or sexual attraction towards persons of the same sex (UNAIDS, 2011). Homosexuals may be further divided into men who have sex with (MSM) and women who have sex with women (WSW). It should be noted that these terms describe persons who have sex with persons of the same sex, regardless of whether or not they have sex with persons of the opposite sex or have a personal gay or bisexual identity. In other words, they include persons who self-identify themselves as heterosexual but have sex with persons of the same sex. The difference in the level

of risk for contracting HIV for different groups of people is due to the influence of various factors such as socioeconomic status, perceived views of masculinity and femininity, occupation, discrimination, religion and age, just to name a few . Homosexuals, in particular men who have sex with men, women, commercial sex workers, adolescents and the homeless represent the persons with the highest risk of contracting the virus.

HIV is becoming increasingly "feminized" within the Caribbean region. Women now account for half of all infections and adolescent women have markedly higher prevalence rates than their male counterparts (USAID, 2011). For example, in Trinidad and Tobago, HIV/AIDS rates were five times higher for girls than for boys in the 15-19 age groups (PAHO/WHO/UNAIDS, 2001). There are several reasons for this occurrence. Gender norms related to masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women (World Health Organization, 2011). Men are usually socialized, and sometimes even encouraged, to see having several partners as proof of their masculinity. Even in their old age, men see satisfying a woman sexually, especially a younger female, as a milestone achievement. Courtenay (2000) notes that for men, gender is often obscured, and some men see risks as a natural part of manhood. This leads to men having an earlier sexual initiation than women do and puts both the man and the women at risk. However, women are more vulnerable to infections due to their biological makeup and therefore have a higher risk of becoming infected than men. This is because they have a larger surface area for sexual intercourse to take place which also means a larger surface area through which viruses and bacteria may be transmitted more efficiently from male to female. In fact, according to the Centres for Disease Control (CDC) (as cited in Bowleg, 2011), 85% of newly diagnosed infections in 2009 were among women exposed to the virus through heterosexual transmission - the leading cause of HIV infection. So, while men take part in more high risk behaviours than women do, women are still the more vulnerable group.

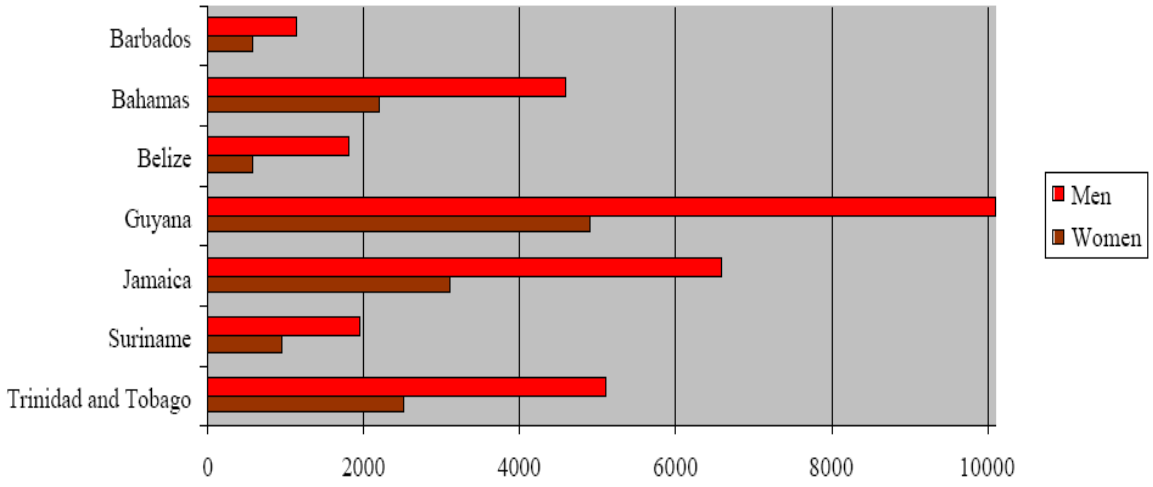



*Figure 1*. Estimated Number of Men and Women Living with HIV/AIDS, 1999 (selected countries). From [The UNGASS, Gender and Women's Vulnerability to HIV/AIDS in Latin

America and the Caribbean, Anderson, Marcovici, & Taylor, 2002, Washington DC: Pan-American Health Organization.

Excluding biological makeup, several other factors contribute to the vulnerability of women to HIV. Throughout the world, women are at a disadvantage with respect to access to information about HIV/AIDS prevention, the ability to negotiate safe sexual encounters and access to treatment for HIV/AIDS once infected (Anderson, Marcovici, & Taylor, 2002). Femininity often requires women to be passive in sexual interactions and ignorant of sexual matters, limiting their ability to access information on the risks of sex or to negotiate condom usage. In fact, according to a study carried out in Guatemala by Bezmalinovic, Skidmore, Duflon, & Lundgren (1994), both male and female respondents felt that women should be uninformed about sexual matters as an unmarried woman who knows about sex is viewed suspiciously. This lack of knowledge on sex and its various consequences put these women at a higher risk of contracting HIV.

Violence against women (physical, sexual and emotional), which is experienced by 10% to 60% of women (ages 15-49 years) worldwide, increases their vulnerability to HIV (World Health Organization, 2011). Women who live in fear or experience violence sometimes lack the power to ask their partners to use condoms or to refuse to have unprotected sex. Many of these women are completely dependent on their partners for survival and are not in the position to reject any orders made by them. They remain in these situations due to their dependency on their partner and abide by their rules, lest they be put out of their house. Several of these women come from poor socioeconomic backgrounds and lack the level of education and skills required for them to sustain themselves while some may be able to take care of themselves but remain in violent relationships due to a fear for their lives. Fear of violence and lack of economic security can prevent women from learning and/or sharing their HIV status and accessing treatment.

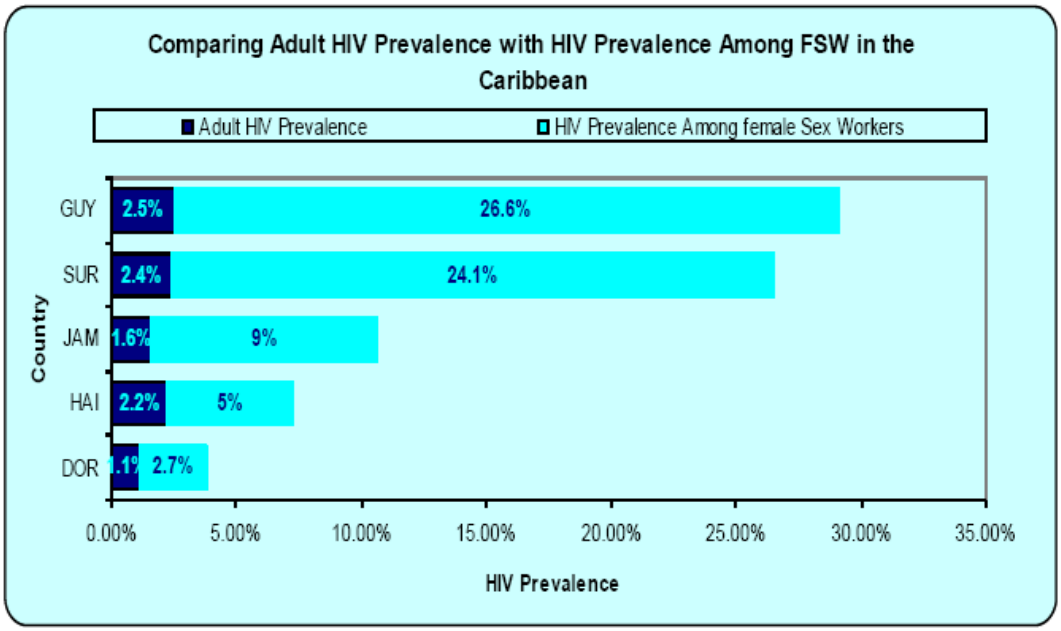
The physical abuse of women is usually accompanied by sexual abuse. According to Heise (as cited in International Center for Research on Women, 2002), one-third to one-half of physically abused women also report sexual abuse and they were abused on multiple occasions. Forced sex can contribute to HIV transmission due to tears and lacerations resulting from the use of force. As a condom is not used in most cases of sexual abuse, tears and lacerations provide a pathway for seminal fluid to enter the body via blood and significantly multiply the chances of becoming infected with the virus. Traditional views on the roles of males and females in society seem to advance more violence against women. Studies have shown that men who believe that a woman's most important role is to take care of the family and that "men should have the final word in household decision making" were more likely to be violent against women and engage in high risk sexual practices (International Center for Research on Women, 2002).

Evidence shows that there is a link between low economic status and HIV prevalence. Studies show that women with lower income are less likely to use condoms during sex than those with higher income. This is the same case for men. Persistent poverty and unemployment can cause crime and violence levels to escalate in an area. While some individuals who are unable to find a gainful and lawful means of providing for themselves, and their families turn to stealing and looting, there are others who turn to one of the oldest occupations in the world – sex work. Sex workers consist of consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or

occasionally (UNAIDS, 2011). Children who sell sex under the age of 18 are considered victims of commercial sexual exploitation, unless otherwise determined.

Persons may sell sex full-time, part-time or to meet some specific economic need such as tuition for school, to pay for rent or to help in a family financial crisis. While some voluntarily sell sex, others are trafficked and forced to do so against their will, usually by someone who is able to exert some level of power over them. Children overall are a group that is exploited for sex. However, girls are more at risk than boys are to be sexually exploited. According to Dunn (2001) (as cited in Quamina-Aiyejina & Brathwaite, 2005), “the majority of children involved in sex work are girls and that there is a gender division of labour in some activities". Dunn also notes that, “Numerically, girls are more exploited than boys, although there are groups of boys who are severely sexually exploited. Among the most exploited and vulnerable children were: street and working children (mainly boys) who exchanged sex to meet basic survival needs; girls who work on the streets as prostitutes; girls who work as go-go dancers and girls who work as massage parlour workers” (Dunn, 2001).

Sex work puts individuals at a high risk of contracting HIV due to them having multiple sex partners. Commercial workers can have more partners in one night than some people have in a year. Another factor that puts sex workers at risk is the high level of stigma attached to the occupation. The majority of sex workers are females. Sex workers are sometimes blamed for the spread of HIV. In fact, many HIV positive women hide their status in fear of being labelled as sex workers. However, without a demand for sex by several persons, mostly males, sex work would not exist. According to Foreman (as cited in UNAIDS, 2001), “Without men, AIDS would not be an epidemic. Further, men are involved in sex work and in almost every case of sexual transmission; perhaps one in every 10 cases is the result of transmissions solely between men.”




*Source: UNAIDS Report on the global AIDS epidemic, 2008*

Due to the stigma attached to sex work and HIV many persons fear being tested and do not seek counselling if they suspect they are infected. Furthermore, sex workers face the risk of violent encounters with clients in which they may be unable to negotiate the use of a condom. Many of them do not have knowledge about safe sexual practices and may be willing to go 'bareback" for the right price. In many Caribbean countries such as Jamaica, laws, policies, discriminatory practices, and stigmatizing social attitudes drive sex work underground, impede efforts to reach sex workers and their clients with HIV prevention, treatment, care, and support programmes. Sex workers frequently have insufficient access to adequate health services; male and female condoms and water-based lubricants; post-exposure prophylaxis following unprotected sex and rape; management of sexually transmitted infections, drug treatment and other harm reduction services; protection from violence and abusive work conditions; and social and legal support.

In the Caribbean, sex workers face further risk of exposure to HIV as countries such as Trinidad and Tobago, Jamaica and Guyana are reporting a rise in infection rates due to sex tourism in certain areas. Migrants can introduce new, unfamiliar and more virulent strains of the virus into the population and thus pose a high risk. While it has been identified that sex workers are a high-risk group in terms of the spread of HIV and other sexually transmitted infections, international response has devoted insufficient attention and resources to efforts to address HIV and sex work, with less than 1% of global funding for HIV prevention being spent in this area to date (UNAIDS, 2009).

Another group of persons who are at a particularly high risk of contracting HIV and dying from AIDS related deaths are the homosexuals, in particular men who have sex with men (MSM). Sex between men occurs in every society. Sex between men is in particular high risk because it involves anal sex. The anus is more prone to tearing than the vagina and thus can get infected more easily. Several men who have sex with men may also have sex with women – some in an attempt to conceal their homosexuality. If infected they can transmit the virus to their female partners or wives. There is a high level of stigma attached to homosexuality in the Caribbean, as it is perceived as being immoral and going against the views of masculinity. Homophobia is rampant within the Caribbean region, especially in countries such as Jamaica where it is often promoted in music and even by some elements in government.

HIV prevalence among men who have sex with men (MSM) varies between Caribbean countries. In Cuba, MSM account for 80 percent of all reported HIV cases. Dominica (70 percent), Trinidad and Tobago (20 percent) and the Dominican Republic (11 percent) report a high percentage of infection among this group (Avert.org, 2011). However, since most men who have sex with men in the Caribbean do not identify themselves as homosexuals due to fear of stigma, these statistics may be inaccurate. This is a barrier for some men to try and receive treatment as they are afraid of possible violent discrimination. According to Gareth Williams, president of the Jamaica Forum for Lesbian All-Sexuals and Gays "Gays and lesbians in Jamaica exist with the possibility that you might be chased, you might be run down, you might be killed because of your sexual orientation, and when a day ends when that does not happen, we give thanks." (cited in Avert.org, 2011).

Serial monogamous partnerships or concurrent multiple-partner relationships of short duration are quite common among MSM. This is due to the fact that many MSM fear that being in a long-

term relationship would attract attention towards them. Some men are involved with both male and female sexual partners. They appear to adopt a socially acceptable heterosexual lifestyle. Marrying women and fathering children are, strategies that some use to avoid negative consequences of public disclosure of homosexuality and can be used to help dispel doubts about masculinity (Bombereau & Allen, 2008). The male heterosexual ideology of Machismo is a prominent cause of the high HIV risk for both heterosexual and homosexual males. According to (Anderson, Marcovici, & Taylor, 2002):

*"From a young age, boys are socialized to associate prolific sexual activity with masculinity and they are encouraged to be sexually active and knowledgeable regarding sexual issues. A study in Nicaragua reported that adolescent boys are pressured by older men to have sex as early as possible. In fact, there have been numerous documentations of fathers arranging for their sons to initiate sexual activity with a sex worker. Boys that do not comply with this expectation of sexual prowess often face ridicule and questioning of their masculinity. As a result, boys and men are more likely to engage in risky behaviour, and less likely to seek information about their sexual health because it involves admitting their lack of knowledge, an indication of their sexual inexperience. When compared to any group, young men have the greatest number of sexual partners and feel least at risk from HIV/AIDS."* (Anderson, Marcovici, & Taylor, 2002)

Marianismo is the female version of machismo in which women are socialized to be passive and somewhat obedient to their male partners.

**Conclusions and Recommendations**

Males and females in heterosexual and homosexual relations face different HIV-related risks. The most at risk persons include adolescents (both male and female), men who have sex with men, women and sex workers. Women are most at risk due to the prevailing views of masculinity and femininity within the region. If the rate of infection of HIV is to be reduced, policy makers need to take a gender sensitive approach and target reproductive health education and services mainly at the high-risk groups which are often ignored or given less emphasis in local programmes.

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## Gender and the Impact of HIV Transmission

DENISE YOUNG

### Introduction

The Human Immunodeficiency Virus (HIV) has become a global epidemic as it has spread to almost every country in the world. Gallant (2008) stated that this is the virus that results in AIDS or the Acquired Immunodeficiency Syndrome (p. 12). According to Anderson, Marcovici and Taylor (2002) globally, it has been reported that there are approximately 40 million men, women and children who are living with HIV and AIDS. After Sub-Saharan Africa, the Caribbean has the second highest infection rate in the world (p. 4). UNAIDS (2010), reported that there were then approximately 240,000 adults and children living with HIV in the Caribbean; this figure has remained steady. There were also a reported 1,700 newly infected adults and children in that same year. This is just 3000 less than the 20,000 that were newly infected in 2001. The adult prevalence is considered to be high at 1.0% (UNAIDS, 2010, p. 21).

There are only a few ways in which HIV can be spread. The most common way is by sexual transmission – vaginal or anal - when semen, vaginal fluids or blood pass from an infected person to and uninfected person. It can also be passed through oral sex if infected blood, semen or vaginal fluid enters the mouth of the uninfected person while performing oral sex. Exposure to infected blood by transfusion, sharing of needles by drug users or direct exposure to open wounds of an infected person is another method of transmission. Infected women may pass the virus on to their children during childbirth or breastfeeding. An infected male cannot directly infect the child during conception so it is done indirectly by infecting the mother. Contrary to popular beliefs, HIV is not transmitted through saliva, urine, sweat or feces, exposure to intact skin, kissing, hugging or holding hands (Gallant, 2008, p. 19). USAID (2011) noted that the main route of HIV transmission in the Caribbean is through heterosexual contact.

Gender has had a significant impact on HIV transmission. It has affected how it is transmitted in both heterosexual and homosexual relationships and also the differential experiences of infected and affected women and men (Anderson et al., 2002, p. 4). Gender is defined as:

> *Cultural values, attitudes, roles, practices and characteristics based on sex. Unlike sex, which refers to biological differences alone, gender is a series of expectations, norms and behaviours which are differentially based on sex. Women become "feminine" and men become "masculine" through processes of social, cultural and political socialization. (Anderson et al, 2002, p. 7)*

Anderson et al. (2002) consider gender to be instrumental in defining human sexuality for both men and women. They define sexuality as the core dimensions of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment or love and reproduction. They explain that our gender relations are an essential component of the socio-cultural fabric of society. Girls and boys are raised to think that they need to conform to

the ideals of femininity and masculinity. These norms have an impact on their sexual behaviour, sexual responsibilities, sexual education and their ability to access information on sex as well as sexual health resources (p. 7). Gender inequities, such as the unequal distribution of power and economic and social resources further exacerbate this situation (p. 5). Anderson et al. (2002) stated that both men and women have been affected by the social construction of gender. However they believe that while men's risk of HIV infection is primarily determined by their own behaviour, women's vulnerability to infection is largely beyond their own control (p. 5). Heterosexual males risk for HIV infection is perpetuated by a system called patriarchy. Baden and Reeves (2000) define patriarchy as:

> *Systemic societal structures that institutionalize male physical, social and economic power over women. The main 'sites' of patriarchal oppression have been identified as housework, paid work, the state, culture, sexuality, and violence (*Baden and Reeves, 2000*, p. 28).*

Men are expected to be strong, virile, sexually potent, natural leaders - dominant figures in the society. Those who conform to patriarchal ideologies are accepted within the society. From a young age, boys are socialized to associate prolific sexual activity with masculinity and they are encouraged to be sexually active and knowledgeable regarding sexual issues. Boys who do not comply with this expectation of sexual prowess often face ridicule and questioning of their masculinity. As a result, boys and men are more likely to engage in risky behaviour, and less likely to seek information about their sexual health because it involves admitting their lack of knowledge, an indication of their sexual inexperience (Anderson et al., 2002, p. 10). In order to validate their masculinity, men may have multiple sex partners and engage in unprotected sex. Within Caribbean society, men are applauded for having many women. Anderson et al. (2002) further noted that men are less likely to seek medical attention than women. This is because they have been socialized to believe that men do not get sick. Men are of the belief that it is a sign of weakness to complain about illnesses or go to the doctor often. This results in less regular use of health services. Despite this, they continue to engage in activities that are high risk which place them and their partners at greater risk for HIV infection (p. 11).

Women are very vulnerable to infection. At the end of 1999 women made up 30% of HIV positive adults in the Caribbean. This figure has since increased to 50% of persons living with AIDS. In some of the worst affected countries in the region newly-infected women in certain age groups now outnumber men. For example, in Trinidad and Tobago HIV/AIDS rates are five times higher for girls than for boys aged 15-19 years. Men and women are unequal in status. As mentioned earlier, men are the dominant figures within the society and women are expected to live according to the dictates of men. This unequal status places them at a higher risk for HIV infection (Anderson et al., 2002, p. 4). Women who are unable to provide for themselves or their families are more likely to end up in a violent relationship and able to negotiate safe sex. Women are also vulnerable because of unstable employment. Fewer women than men are employed. Some women are also paid less than men in the same positions and they tend to work in jobs which have less job security. All of this indicates that they are more likely to engage in high risk behaviour to provide for themselves and their families. Some women feel that there is no other choice but to rely on men for economic assistance. In such a relationship the man's decisions are likely to become the priority. This includes decisions on sexual intercourse, whether or not they use condoms for protection during intercourse and decisions about access to health care. When

women do not have the option to rely on these methods of protection then they are even more at risk of infection (Anderson et al., 2002, pp. 11-12).

Gender-based violence is also an extremely damaging form of female disempowerment. It leads to women's increased susceptibility to HIV infection by limiting their physical and mental freedom. The relationship between physical violence and HIV is often indirect. As many women have less control than their male partners over decision-making on the use of protection, distribution of resources and access to health and social services, these factors make it more difficult and dangerous for them to refuse unsafe sex. As demonstrated by one Jamaican study, many women will tolerate a husband with multiple sexual partners, or they themselves will have multiple sexual partners in order to guarantee financial stability for themselves and their children (Anderson et al., 2002, p. 12).

Gender-based violence contributes to women's vulnerability to HIV infection. Gender-based violence is any harmful act that is perpetrated against a person's will, and that is based on gender differences between males and females (Betron & Gonzalez-Figueroa, 2009, p. 1). The objective is to use violence as a way of maintaining power and control. As a result, women may be unable to negotiate sexual terms or share their opinions on safe sex practices. They may feel that they have to keep the male happy so that he will be less likely to exert power over them in a harmful manner. Another way in which this violence may be manifested is through rape. Many women are overpowered by men and are sexually assaulted. This can also result in the virus being passed on to women because of the direct contact with possibly infected semen as well as blood which may be as a result of tearing of the vaginal walls or anus due to roughness during entry.

Leith Dunn speaks about socialization and the roles that are ascribed to men and women. She maintains the position that these roles encourage inequality between the sexes and can even result in the creation of dependency and sexual exploitation between older men and younger girls (cited in Kempadoo & Taitt, 2006, p. 20). These cases are another manifestation of unequal gender relations and are very prevalent in the Caribbean. Older men are of the belief that younger women are more passive, more fertile, and less likely to be infected than older women. Being able to 'handle' a young woman also validates the masculinity of some older males. Many young women become involved with older men because they believe that they will be better providers than young males. Although most men are initially infected before the age of 25, older men have generally been sexually active longer and are therefore more likely to be already infected than younger males (Anderson et al., 2002, p. 11). Young women are put at an increased risk of infection in these cases. Some have children for men and are at their mercy financially. They are unable to properly negotiate safe sexual terms and are oftentimes taken advantage of.

Anderson et al., (2002) make the point that:

> Gender influences the effects of HIV/AIDS prognosis and treatment medically and socially, in both women and men. Women face a number of barriers to HIV prevention, testing and counseling, including embarrassment, fear of rejection and stigma, partner's objection to testing, and lack of access to financial resources, reliable, accessible information, time and transportation. These obstacles deter women from taking preventive measures, accurately

assessing their own risks and from seeking early diagnosis and treatment of HIV (Anderson et al., 2002 p. 18).

Men, on the other hand, face the pressures of the patriarchal society. They feel that they have to live up to masculine expectations or else face ridicule, violence and exclusion. This leaves many heterosexual males vulnerable to infection. Men who have sex with men are also vulnerable to HIV infection but face different risks than heterosexual men. In the Caribbean, homosexuality is not widely accepted. It is gradually becoming more visible in society but it is still seen as an abomination by many persons. In Jamaica, for example, homophobia - or the fear and hatred of homosexuals - is evident. This reaction stems from the need to prove heterosexual masculinity within the society. Males feel that homosexuality is a threat to the dominant masculinity which dictates that heterosexuality is the only acceptable form of sexual orientation. Anything outside of that is wrong. Some men also feel threatened by the fact that other men are attracted to the same sex.

Many men in the Caribbean who engage in sexual intercourse with other men do not identify as gay or homosexual. This is because of the stigma attached to homosexuality and also how society links that to HIV transmission. Even though homosexuality is not the only means by which the virus is transmitted, many people tend to link HIV to homosexuals. This, in addition to religious beliefs against homosexuality causes these men to fear discrimination as well as violence from their peers. There is also the issue of homosexual activities being illegal. There are laws within many countries in the Caribbean that place homosexuals in a vulnerable situation. This is another example of how gender ideologies permeate the society. Even within the justice system, the idea of men engaging in sexual intercourse is illegal. Highly stigmatized by both religious and social norms, practices are driven underground. Both self-denial and low self-esteem may reinforce social vulnerabilities. Moreover, access to prevention, counseling and testing, care and treatment remain difficult. Fear of breaches in confidentiality and a lack of privacy aggravate lack of access. Health care providers are perceived as judgmental and unable to respect confidentiality (Allen and Bombereau, 2008, p. 41). These factors contribute to some homosexuals engaging in relationships with women to cover their tracks; and others not seeking proper protection or lubrication which would make intercourse safer. This is as a result of the backlash faced by persons who engage in sexual relations with those of the same sex.

Woman to woman transmission of HIV is an issue that is ignored by many persons within the medical field and society as a whole. It does not seem like a big risk to others because there is no major penetration. Most people look at intercourse between women as just oral sex and these same people do not realize that oral sex puts people at risk. When compared to heterosexual intercourse and males who have sex with males, this route of transmission is not seen as relevant. This can be looked at from the perspective that because it is two women having sex there is no real threat to anyone. It is not just the lack of major penetration that is an issue for society but the lack of relevance that sex between two women holds within the society. Sex between males is a risk to masculinity but the risk to femininity is not a big issue. It is not something that worries males very much. Besides the religious backlash, women who have sex with other women are left alone. They are not harassed in the same way that men are. Their issues and existence are not as big a ‘problem’ in society as those of men who have sex with men. They are largely ignored and this is evident in the lack of information on this aspect of HIV risks.

Women who have sex with women are often overlooked because the risk of transmission for HIV is very low. However they also engage in high risk sexual practices as well as social ones. This includes unprotected sex with men, an increased number of sexual partners, the use of injection drugs and exposure to fluids known to transmit HIV such as blood and vaginal fluids. Three sexual activities were labeled as high risk behaviors for HIV. They included oral sex, sharing sex toys and fisting. Actual documented cases of HIV transmission through these activities are very few, if any at all. A lot of the information on female-to-female transmission fails to mention that unprotected oral sex can involve HIV risk if the female receiving oral sex is in the beginning, middle, or end stage of her menstrual period. This may put the woman performing oral sex at risk for HIV transmission. Women who have sex with women, while more tolerated than men who have sex with men, still sometimes remain in the 'closet '. Much of this has to do with the ways in which sexual minority groups are overlooked in the epidemic, and the assumption on the part of health care providers that women who have sex with women are at little to no risk for HIV transmission (Women's Institute, 2009, pp. 1-4).

**Conclusions and Recommendations**

Different groups of people are affected by the risk of HIV in different ways within our society. Heterosexual men and women as well as men and women who engage in intercourse with persons of the same sex, have different risks and these risks are perpetuated by the gender norms and stereotypes within society. These norms increase the risk for infection because they prevent these at risk groups from seeking information, testing and assistance. Infected persons continue to engage in risk behaviours with uninfected persons causing the virus to be spread.

Changes recommended to solve the problem of high HIV transmission and dramatically reducing infection, include challenging gender norms and stereotypes, transforming ideologies that perpetuate gender inequality and change how people think within the society. Unless this happens then stigma and discrimination will continue to be perpetuated within the society. People will continue to engage in risky behaviour to satisfy gender ideals or even to challenge them and this infection will continue to spread.

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## HIV Risks in Heterosexual and Same-sex Sexual Relations in Jamaica.

MELAINE GOBAY

### Introduction

Gender-related HIV risks are shaped by biological and social factors for males and females in heterosexual and same sex sexual relationships in Jamaica. From the sex of the individual to their sexual orientation and practice, the risks for HIV infection are equal. Biological make up, sexual practices, gender norms and values, as well as hegemonic and subordinate masculinities are also factors that affect HIV vulnerability. Traditional gender norms in Jamaica favour heterosexual couples and hegemonic masculinities. In contrast, persons with alternative sexual orientations such as Lesbians, Gays, Bisexuals and Trans-sexual (LGBT) and Men who have sex with men (MSM) are considered subordinate to hegemonic masculinity and heterosexual sexualities. Heterosexual women experience unequal gender power relations and are often unable to negotiate safe sex because they lack of power to negotiate equally with their male partners. Limited attention is usually given to lesbians and women who have sex with women (WSW) because they are considered to be a low risk for HIV infection. More attention will be given to understanding risks among heterosexual couples, and MSM.

The biological makeup of the sexes puts women more at risk for HIV than men. The mucus membrane of the vagina covers a large area and is thin which makes it more susceptible to viral infection than the small exposed area of a penis. Vaginal tissue absorbs fluid easily, including sperm, which has higher concentration of HIV than vaginal secretion. Therefore, transmission of HIV from male to female is easier because the mucosal membrane of the vagina is large, absorbent and open to pathogen (HIV) than the penis (PAHO, 2002). Young girls are at a higher risk of infections because their reproductive tract has fewer epithelial (Squamous) cells in their vagina, than those of adult women (PAHO, 2002). This makes early sexual initiation a great concern for the Jamaican society's battle to reduce HIV as stipulated in the Millennium Development Goals (MDG). As females are far more vulnerable than males to HIV because of their biological makeup, why is it that they are not the main target in the Jamaica's effort to reduce the HIV infections? The patriarchal nature of the Jamaican society has placed the sexual and reproductive health of women in the hands of men.

The social factors which place women and girls at more risk of contracting HIV than men are rooted in the unequal gender power relations which women face in heterosexual relationships which leaves them very vulnerable to HIV infections. These power inequalities are created by a patriarchal system and one of the results is early sexual initiation for both girls and boys. The age for girls is approximately 15.9 years old and for boys it is earlier at 13.9 years. (Planning Institute of Jamaica, 2001).

Early sexual initiation for boys is also linked to encouraging heterosexuality which is a marker of hegemonic masculinity. Barry Chevannes and Janet Brown (1998) state that the sexual exploration of boys brings a relief to parents, who are anxious to know from early, the sexual orientation of their son. If boys do not have sex from early, some parents fear whether their son is homosexual. Girls on the other hand are discouraged from having sexual relations at an early age but on the other hand they are only considered as a woman when they bear a child

(Chevannes & Brown, 1998). These contradictions pose many questions: if boys are to have sex early and girls are to abstain, who should the boys have sex with? If the average of sexual initiation for boys is 13.9 years old, he must be having sex with a girl, because if he is having sex with a woman, it would be a criminal offense. The result is that girls are often forced into having sex under the age of 16 years through rape and or incest. There have been numerous reports in the Jamaican media about the sexual violation of the nation's youth. In response Simms, (2012), and many others seek urgent answers to the problem as rape and other forms of sexual violence contribute to the spread of HIV. Policy makers must seek a gendered response to the problem to reduce HIV among women and girls and men and boys.

Gender based violence is another high risk factor for HIV infection. The World Health Organization (WHO) defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advances, or acts to traffic, or otherwise directed, against a person sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to the home and work" (see Muturi, 2009 p.87). Eliminating gender based violence is important as the biological make up of females increases women's risk of HIV infection two to four times compared to males. (UNAIDS, 2001).

Sexual 'grooming' of young girls is also a risk factor and is an offense under Jamaican law and specifically the Offenses Against the Person Act (Campbell, 2009). Grooming explain the power dynamic when an older man provides economic support to a young girl but there is an unspoken agreement that as she gets older the man should be her sexual partner.

Differing occupational roles for men and women and the unequal value given to them also pose risks for HIV infection. According to Davis (2009), the differing values given to occupational roles for men and women shape the socio-economic conditions which often place women at a disadvantage in their sexual relationships. Women's economic insecurity often leaves them weak to negotiate safe sex in heterosexual relationships and limits their ability to govern their sexual and reproductive health (Muturi, 2009). Men as a group have more economic power than women and women who lack the financial resources to take care of their children, are more likely to depend heavily on men.

Despite Jamaica's attempt to level the gender wage gap through legislation on equal pay for work of equal value, women tend to earn less than men as socialisation contributes to the idea of a male breadwinner. A mother for example would ask her daughter if the guy she is involved with has money and would make comments such as, "Nuh tek up nuh man weh caan mine yuh." Similarly a boy who shows interest in girls at a young age will hear his parents asking, "yuh 'ave money? bout yuh want wooman?" This shows that both males and females socialized from an early age to accept their socio-economic position of men having financial independence and women being economically dependent on men. The situation reflects a male partner in the driving seat and his female partner in the passenger seat. In this situation he can control her sexual and reproductive health, leaving her little or no room to safely negotiate in sexual matters. The female is at high risk of HIV infection especially if either she or her partner are cheating.

Social risk factors for Jamaican men include the construction of masculinity which promotes and encourages men to be risk takers and to be sexually virile. Davis (2004) states that male sexual prowess is to be demonstrated by having of multiple children The culture also sanctions polygamy as noted by Chevannes,(2002), which fuels the spread of HIV. So imbedded is polygamous behaviour in our culture that even advertisements for safe sex campaigns play on polygamy when promoting the use of condoms (The Gleaner, 2010). In my view this message is a contradiction. May be the safe sex campaigners have bought into the idea that sex sells, but selling safe sex by encouraging unsafe sexual behaviour will be detrimental to all.

MSMs have a much higher rate of HIV infection from having unprotected sex (Covington, 2000). Consistent condom use can reduce the risk of HIV among MSM but for safer sex MSM must use lubricants as condoms could burst easily during anal sex. This is because the anal muscles are tight and the anus does not produce its own lubricants. More reproductive health education is therefore needed among MSM to reduce biological risks . Reports in Science Daily, (2010) state that HIV risk from unprotected anal sex is 20 times higher than unprotected vaginal sex.

Among the social factors which contribute to MSM vulnerability to HIV infection are Jamaica's anti-homosexual culture and the discrimination faced by sexual minorities which has pushed many of them to operate underground (Kempadoo, 2009). This makes it difficult to determine the true level of HIV infections among MSM and Women who have Sex with Women (WSW). Gosine (2009) states that WSW are usually left out of debates on sexual rights because transmitting HIV from female to female is thought to be low risk sexual behaviour.

**Conclusions and Recommendations**

In our fight to reduce HIV infection, the biological and social risks faced by women and men of all sexual orientations and sexual practices must be considered and reproductive health programmes must address their needs. Mainstreaming gender in HIV programs will also help to meet these needs and reduce stigma and discrimination against sexual minority groups. As a result they will have better access health facilities, resulting in better detection and treatment of HIV infections, which will help to reduce the spread of the virus. As women as a group are more vulnerable to HIV because of biological factors, social and economic inequality and sexual violence, there must be more focus on educating men to reduce violence and make women less vulnerable to HIV. HIV prevention programmes must have an increased focus on how to increase men’s awareness about their sexual behaviour such as having many sexual partners, as part of their masculine identity. Programmmes must also educate women to increase their power in sexual decision and reduce socio-economic vulnerability. Together, these actions if backed by the government to improve legislation and allocations for HIV programmes, can further reduce HIV risks for all and contribute to Jamaica's growth and development.

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# The Reproductive HIV Risks of Adolescent Males and Females 10- 14 years and 15-19 Years in Jamaica.

MARLON JOHNSON

## Introduction

Adolescents are males and females aged 10-19 years and "youth" are those between 15 and 24 years. The term "young people" covers both age groups between 10 and 24 years. This period of an individual's life is associated with physical, psychological and social maturity from childhood to adulthood. The growth and development of adolescents will vary . Some achieve biological maturity long before they mature psychological or socially. In terms of their reproductive capabilities, adolescents develop at an earlier age than previously and as such they are always curious, searching for information relating to their reproductive health (UNICEF,1989).

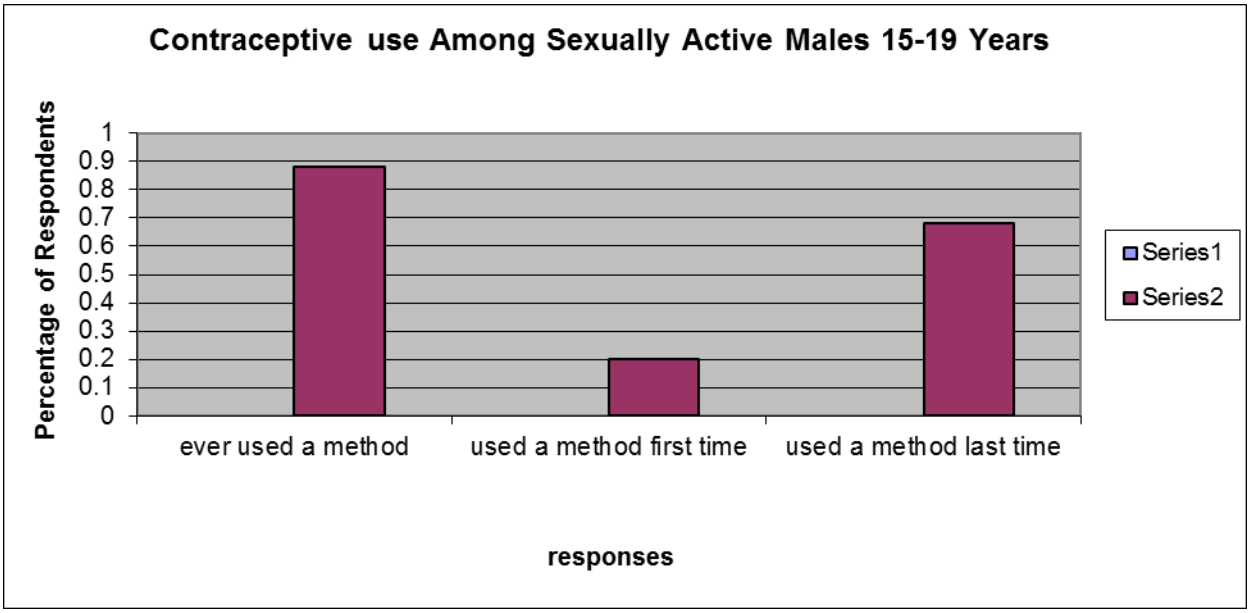
The 1994 Programme of Action of the International Conference on Population and Development states that reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. This relates to all matters that affect the functioning of the reproductive system . Reproductive health implies that people are able to have a satisfying and safe sex life. It also assumes that women and men have the freedom to decide when, with whom and how often they have children. The ICPD Programme of Action helps men and women to access their reproductive rights by having access to reproductive health education and services which ensure safe, affordable and acceptable methods of family planning to regulate their fertility. These services will ensure that women can go through pregnancy and childbirth safely and that couples can have the best chance of having a healthy infant (United Nations, 1994).

This essay focuses on adolescents' reproductive health; factors related to their knowledge, attitude, behaviour and practices (KAPB) and recommends solutions to improve their reproductive profile. This topic was chosen after I read a 2002 report by Dr Gebre at the Ministry of Health entitled , "Understanding risk: Promoting healthy behaviour in adolescence presented at a workshop on HIV/STIs and adolescents. The report showed that adolescents 10-19 years had the highest rate of STIs; the rate of syphilis in girls 10-14 years has increased three folded when compared to 1992; and that adolescent females aged 14-15 years and 15-19 years had twice and three times higher risk of HIV infection respectively than boys of the same age. This raised several questions: what is the age of sexual debut for our adolescent males and females? What are the factors contributing to the high HIV prevalence and the reproductive health risks facing this young cohort of our population? Further reading provided many other disturbing facts. For example, many Jamaican teens begin sexual activity at an early age and boys start earlier than girls. Many of these youngsters have unprotected sex for the first time with a partner who is at least 10 years their senior , and many of them continue to having sex without the use of a condom.

A study conducted in 2001 showed that 13.2 years was the average age of first sexual intercourse for males between 15-19 years. This was often accepted as family members wanted to be

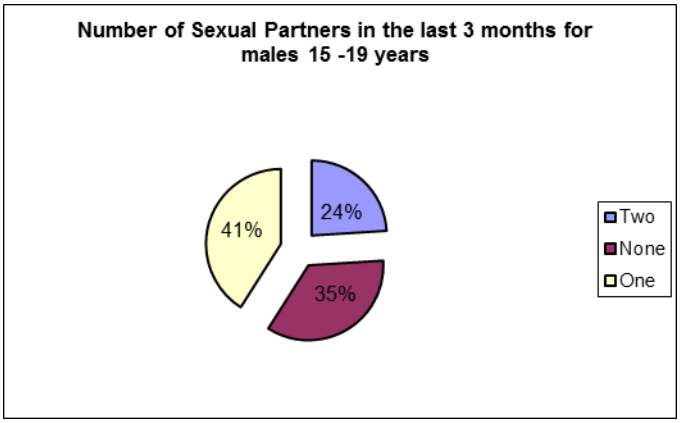
confident that the boy is heterosexual. Chevannes and Gayle (2000) in a study conducted in rural, suburban, and inner city communities, reported that: most young men, had sexual intercourse by the time they reached age 19; young men from the inner city areas were more likely to have sexual intercourse between the ages 10-14 years; most young men said abstinence did not pertain to them and it quite difficult to abstain. The table below presents data from Chevannes and Gayle's (2000) study which shows that among the males aged 15-19 years who said they were sexually active, only 88% reported that they ever used a contraceptive method; 20 % used a contraceptive method the first time and 68 % used a contraceptive method the last time. This showed high HIV risks for adolescent males.

Figure 1: Data on Adolescent Contraceptive Use from Chevannes and Gayle (2000)




Source: Chevannes & Gayle, 2000.

Figure 2 Data on Sexual Partners of Adolescents from Hope Enterprises study (2002)




Source: Hope Enterprises 2002

HIV high risks among adolescent males aged 15-19 were also indicated in a Hope Enterprises (2002) study which showed that in the sample: 41% of males had one partner, 24% had two partners. Some 35% had no partner. Data from other studies confirmed adolescents' reproductive risks. A study by McFarlane (2002) showed that: 41.7% of sexually active adolescent males, admitted to having multiple sex partners. The 1997 Reproductive Health Survey of Jamaica showed that only 36% of adolescents' males age 15 to 19 years, and 27% of men ages 20 to 24 years used a condom every time they have sexual intercourse. Tables 3 and 4 below present data from Fox and Strachan's (2005). Youth Risk and Resiliency Behaviour Survey. The survey showed the percentage of sexually active adolescent males and females aged 10-15 years who used a condom the last time they had sexual intercourse. Table 3 presents protective factors inside the home and Table 4 presents protective factors outside the home.

**Table 3: Percentage of Sexually Active Adolescents Aged 10-15 years who Used a Condom at Last Sexual Intercourse by Sex and Protective Factors In the Home.**

| Presence in Home of Adult Who: | Male | | Female | |
|---|---|---|---|---|
| | % | N | % | N |
| Expects you to follow rules | | | | |
| Sometimes or never | 47.3 | 55 | 0 | 21 |
| Always | 47.4 | 230 | 67.2 | 67 |
| Is Interested in your school work | | | | |
| Sometimes or never | 41.4 | 87 | 66.7 | 39 |
| Always | 49.7 | 199 | 70.8 | 48 |
| Talks with you about problems | | | | |
| Sometimes or never | 46.3 | 175 | 71.4 | 56 |
| Always | 49.6 | 113 | 60 | 30 |
| Is too busy to pay much attention to you | | | | |
| Sometimes or never | 51.5 | 237 | 70.3 | 74 |
| Always | 30.6 | 36 | 0 | 12 |
| Listens when you have something to say | | | | |
| Sometimes or never | 45.7 | 116 | 63.6 | 44 |
| Always | 47.6 | 170 | 73.2 | 41 |
| Always wants you to do your best | | | | |
| Sometimes or never | 50 | 66 | 64.5 | 31 |
| Always | 45.6 | 217 | 71.9 | 57 |
| Believes you will be a success | | | | |
| Sometimes or never | 41.8 | 98 | 60 | 35 |
| Always | 51.3 | 183 | 75.5 | 53 |

Source: Fox, & Strachan, (2005). Youth Risk and Resiliency Behaviour Survey

**Table 4: Percentage of Sexually Active Adolescents Aged 15-19 years who Used a Condom at Last Sexual Intercourse by Sex and Protective Factors Outside the Home, Jamaica 2005.**

| Presence Outside Home of Adult Who: | Male | | Female | |
|---|---|---|---|---|
| | % | N | % | N |
| Really cares about you | | | | |
| Sometimes or never | 41.2 | 102 | 0 | 21 |
| Always | 51.4 | 179 | 67.2 | 67 |
| Notices when you are not there | | | | |
| Sometimes or never | 48.7 | 158 | 72.3 | 47 |
| Always | 49.5 | 111 | 69.4 | 36 |
| Notices when you are upset about something | | | | |
| Sometimes or never | 44.9 | 147 | 63.3 | 30 |
| Always | 52.9 | 119 | 71.7 | 53 |
| Is mean to you | | | | |
| Sometimes or never | 49.8 | 225 | 69.2 | 30 |
| Always | 45.2 | 42 | 0 | 7 |
| Listens when you have something to say | | | | |
| Sometimes or never | 43.3 | 120 | 56.7 | 30 |
| Always | 51.6 | 161 | 77.2 | 57 |
| Tells you when you do a good job | | | | |
| Sometimes or never | 47.6 | 126 | 65.9 | 41 |
| Always | 50.76 | 146 | 71.1 | 45 |
| Always wants you to do your best | | | | |
| Sometimes or never | 37.1 | 89 | | 23 |
| Always | 53.8 | 186 | 73.8 | 61 |
| Trusts You | | | | |
| Sometimes or never | 42.9 | 105 | 51.6 | 31 |
| Always | 49.7 | 109 | 81.1 | 53 |
| Believes you will be a success | | | | |
| Sometimes or never | 47.4 | 95 | 63 | 27 |
| Always | 48.3 | 176 | 73.3 | 60 |

Source: Source: Fox, & Strachan, (2005). Youth Risk and Resiliency Behaviour Survey

The report generally showed that sexually active adolescent boys were more likely to use a condom when they had sexual intercourse if there was a supportive adult inside their home. None of the productive factors in the home significantly influenced the prevalence of condom use among sexually active girls. Protective factors outside the home for sexually active adolescents girls was having an adult who always listened when they have something to say and believed the child would be a success. (Fox & Strachan, 2005).

Adolescents and young people are at high risk of HIV infection. Among an estimated 22,000 persons living with HIV in Jamaica reported by the Ministry of Health, (2004), about 10% of reported AIDS cases were children under 18 years and 20 per cent were young people aged 20-24 years. *Adolescent girls aged 10-19 years were almost three times more likely than boys of the same age to become infected with HIV*. This was because of early sexual initiation, sexual relations between young girls and older men who are HIV – positive; high rates of forced sex and the prevalence of unsafe sexual practices among adolescents.

Sexually transmitted infections (STIs) are also a problem among adolescents. Gebre (2000) reported that teenage girls and inner-city residents are disproportionably affected. The rate of primary syphilis in girls 10-14 years increased three fold by 1999 compared to 1998, and the number of reported new HIV infections in adolescents had doubled each year. More education on symptoms of STIs is needed as the Hope Enterprises (2002) study reported limited awareness of STI symptoms among both sexes. Some 55% of men between 15-19 years could not identify a single symptom of STIs in women. Awareness of STI symptoms in men was almost equally low: 45% of the male teenagers and 53% of the men between 15-19 years said they do not know any of the symptoms.

Teenage pregnancy in Jamaica is also a major reproductive health risk and is a major development problem as only one third of teenage mothers go back to school. UNICEF (2001) regarded this as an epidemic hidden beneath many layers of denial, ignorance and social and cultural misinformation and low use of condoms. The Registrar General's Department reported that in 2003, 5,249 girls aged 15-19 years had their first child. This was a decline when compared to 6,245 in 2002 and 7,395 in 2001. The RGD figures also revealed that 1,328 girls in that age group became parents for the second time in 2003 compared to 1,517 in 2002 and 1,730 in 2001. In 2003, 21 girls in the same age group had their fourth child before they reached their 19th birthday. Though the information is somewhat dated it highlights the problem of adolescent fertility.

Campbell (2004) in an article on 'Teenage Pregnancy' in The Daily Gleaner of November 22, 2004, notes that “although there has been a reduction in teenage pregnancies during the past three years by the National Family Planning Board the number of teens becoming parents at an early age in Jamaica remains high and this is a major concern especially in rural areas. Hardee et al., 1998) highlighted several factors associated with the sexual and reproductive health status of adolescents: curiosity, peer pressure, breakdown of the family as well as the ineffective and inappropriate methods used to convey sex education to adolescents. There are also gender differences. Curiosity is one of the motivating factors for boys and girls wanting to have sex. Girls under 15 years reported that love would be strongest reason to have sex but boys never mentioned love as a reason to have sex. (Young women (15-19 years) were more likely to say

that they have sex to make their boyfriends feel good or so he would love her more. For boys losing their virginity was important to establish their manhood and according to Barry Chevannes has also reported that the first sexual activity for boys is seen as a male rite of transition to manhood.

Several studies highlight the need to improve access to reproductive health information and services. Hardee et al., (1998) reported that most young men and women receive health information from schools, homes, and the streets and that young men from inner city communities are more likely to obtain information from the streets. In Hardee's survey of students aged 11 – 14 years, less than 11% of boys correctly identified the point during the menstrual cycle when a girl is most likely to become pregnant, and only 50% knew that pregnancy was possible at first sexual intercourse. Goldberg et al. (1999) reported in their study that about 26% of boys believed that oral contraceptives could protect them against STIs. There were also old myths: 44% of the boys believed that sex with a virgin could cure STIs, and 49% of the youths were not aware that oral contraceptives were very effective as a method of preventing pregnancy.

There were also myths among adolescent girls which resulted in some not using contraceptives. For example, some believed that folk remedies can cause late menstrual periods to begin. This included: drinking boiled Pepsi, adding rusty nails to boiled Pepsi, and drinking herbs boiled in drinking water and that sex in the sea would prevent pregnancy. On April 27 2004 the Daily Observer reported on a study conducted by Audrea Oritheneer and Rose-Marie Isaacs entitled "Factors Contributing to the High Level of Teenage Pregnancies in Secondary/High Schools in Mandeville" (Daily Observer April 27 2004). The study cited statistics from the Women's Centre of Jamaica Foundation which reported 236 in 2003 and included information on teen mothers in Junction in St Elizabeth. It was also reported that in trying to hide her pregnancy one girl went as far as to dilute her urine each time she visited the doctor so that the test showed that she was not pregnant. (The Daily Observer, 2004). As result of teenagers' early sexual activity, their low or no use of contraceptives, multiple sex partners, as well as myths associated with contraceptive use and pregnancy they had many reproductive health problems: sexually transmitted diseases and HIV/AIDS, and the girls were at risk of teenage pregnancy.

Media advertisements and television programmes also expose teens to risks through sexual activity and conflicting messages about sex. Young girls are encouraged not to have sexual relations and pre-marital pregnancies, yet some messages are communicated by unmarried mothers, who were teens when they became pregnant. Girls also see a growing number of females who are sexually active with multiple partners to satisfy their financial needs. Chevannes also states that powerlessness and the associated need to manipulate relationships to meet economic needs could be one explanation for the persistence of unsafe sex. Reports of families who rely on their young girls to exchange sex for subsistence: school fees family needs, day to day support, and other basic provisions are also common. Keddie (1992) states that the absence of a father figure and low self-esteem are considered risk factors for adolescent sexual activity and teenage pregnancy. Teenage girls who live in urban areas without a father figure were almost three times more likely to have been pregnant than those living with adult male relatives (Keddie,1992).

Hope Enterprises, (2000) notes that information on reproductive health is not always communicated effectively to adolescents by educators, providers of health and social services, religious youth leaders, and parents. These persons who commonly influence adolescents' behaviour, often lack awareness of or sensitivity to the special problems of young people because of a lack of training, misinformation or simply embarrassment in discussing matters relating to sex and sexuality. There is also need for physical and psychological maturity and wellbeing as well as to establish social relationships before parenthood.

**Conclusions and Recommendations**

The current state of adolescents' reproductive health calls for immediate action to change high risk behaviours. Recommended proposals usually include: ensuring that the family, church and school play a role; good communication about sex; teaching life skills that help to postpone sexual initiation; setting education and career goals; promoting good health and spirituality as well as abstinence until they are mentally and physically mature to deal with sex; promoting involvement in sports and extra curricula activities to develop their mind, self-esteem and team work skills; reducing the economic vulnerability of young women and promoting independence will significantly reduce the level of teenage pregnancy. Other recommendations include providing a stable home environment with good family values and attitudes to help adolescents function effectively in society. Parents must also make every effort to educate teenage girls to the tertiary or vocational level to reduce their risk of depending on men for economic support as this can lead transactional sex and teenage pregnancy.

Social institutions like the church and school must also continue to play their respective roles, promoting moral and religious values and guiding adolescents who are sexually active. Guidance counseling sessions in schools should foster holistic development and the school curriculum should be broadened to include social, psychological, and economic issues that affect adolescents. Sex education should help adolescents to deal with their sexuality and should address STIs/HIV, abstinence, contraceptive use and sexual responsibility so they are more equipped to decide what is best for them. Peer education is also important. Adolescents should actively participate in the delivery of reproductive health information to their peers. . This means promoting adolescent-friendly reproductive health policies and programmes that encourage healthy lifestyles among young people. Public information campaigns in the community should also target parents, teachers, health and social service workers, religious and youth leaders and make them more aware of basic reproductive health needs of adolescents.

Adolescents also need more specialised reproductive health services as they may not feel comfortable visiting regular health clinics. Special training in adolescent reproductive health and in communication skills are needed for primary health care workers to make them open and non-judgmental of the adolescents who seek their assistance. Media personnel should be encouraged to continue promoting safe sex campaigns and advertisements targeted at adolescents and should involve more popular music to promote reproductive health.

In conclusion it will take a collaborative effort among the families, communities and health service providers to build a broader network to better inform, counsel and educate young people about sexuality. This would seek to meet the needs of youth and build on their physical, social,

vocational and moral competence as the most effective strategy for preventing reproductive health risks. Reproductive health programmes and services must be adolescent friendly, gender-sensitive, age-appropriate as well as culturally sensitive.

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## CONCLUSIONS AND RECOMMENDATIONS

LEITH L DUNN Ph.D.

Working Paper 6 celebrates students' achievements as part of the 20th Anniversary of the IGDS in 2013-2014, and marks a major historical milestone. It represents the first publication of IGDS' undergraduate BSc Gender and Development students and aims to encourage future students to strive for academic excellence in research and writing. Its central message is the importance of mainstreaming gender in sexual and reproductive health policies and programmes to reduce vulnerability and risk of STI/HIV infections.

**Development Agenda**: Working Paper 6 supports the global agenda of the 1994 Programme of Action of the International Conference on Population and Development (ICPD POA); the ICPD +20 Agenda; and the UN's Post-2015 Development Agenda. It also supports national priorities such as Jamaica's National Policy for Gender Equality (NPGE) which provides a mandate to mainstream gender in all sectors, to promote gender equality. It is consistent with the Ministry of Health's National HIV/STI Programme and their Gender and HIV/AIDS programme.

**Policies:** Working Paper 6 also supports several UWI policies and programmes: the UWI Strategic Plan 2012-2017; the IGDS' mandate of teaching, research, publications, outreach and public service; the UWI's Sexual Safety Policy on HIV/AIDS and Sexual Harassment, and UWI Mona's Gender Action Plan to mainstream gender and promote gender equality.

**Programmes:** 'Youth Voices' reflect the power, passion and ability of young women and men to use gender as a tool of analysis to reduce the HIV/AIDS epidemic in the Caribbean. The papers have been edited to enhance clarity, coherence, critical analysis, and recommendations, but the content reflects the hard work, and creativity of these youth champions for behaviour change. The publication promotes peer education and targets students within and outside the UWI. General audiences, gender and HIV advocates in the public and private sector as well as the media will also find it useful as a basic introduction to the material and ideological dimensions of gender. It demonstrates how socialisation shapes gender roles, gender identities, attitudes, behaviour, and power inequalities which can influence vulnerability to STI/HIV infection and undermine reproductive health. The articles highlight the negative impact of stigma and discrimination on Marginalised and at Risk Population Groups (MARPS) and will hopefully encourage policy makers and development planners to implement more gender-sensitive programmes which will maximise the impact of scarce financial resources and reduce the spread of HIV.

**Career Opportunities**: Working Paper 6 highlights opportunities for young graduates to fill gaps in various sectors, shape their graduate research agenda or identify employment

opportunities to create a more enabling environment to ensure reproductive health and rights for all.

**Advocacy and Behaviour Change**: Working Paper 6 will hopefully motivate readers to join advocacy campaigns to reduce gender based violence, adolescent pregnancies, and the feminisation of HIV as well as improve access to services for marginalized and sexually at risk population groups. It will also make readers more aware of their personal vulnerabilities, and risks of HIV infection and encourage them to practice safer sex.

**Research:** Many research opportunities are highlighted to better understand gendered realities in the Caribbean such as: masculinities, the impact of the current economic crisis, high debt burden and Structural Adjustment Polices on reproductive health and HIV. Research is also needed on how climate change in Small Island Developing States is likely to influence gender-related risks for HIV infection.

Publication of this first volume and its companion Working Paper 7 on Gender Climate Change and Disaster Risk Management (with the Friedrich Ebert Stiftung) during the IGDS' 20th anniversary in 2013-2014, will hopefully encourage students to improve their academic research, writing and referencing skills to promote development.