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REPRODUCTIVE HEALTH AND RIGHTS: HIV/AIDS AND GENDER EQUALITY

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INTRODUCTION

The gender dimensions of the HIV/AIDS¹ epidemic are of increasing concern to Caribbean governments. Research has shown that risk and vulnerability to HIV are influenced by gender, and an important indicator of this is the rising infection rates among females. The disease, which in most countries started with higher proportions of men than women, is now growing at a faster rate among women. Gender inequalities render women particularly vulnerable to HIV infection, and the increasing infection rates among the female population have devastating consequences for women's morbidity and mortality, for the health and well-being of their families and the wider community, and for perinatal transmission. Women are the nurturers and caregivers within the family and, as such, bear primary responsibility for the health and well-being of future generations. An understanding of the gender issues that drive the epidemic is important for the development of policies and programmes to halt the spread of the disease.

1. AN OVERVIEW OF HIV/AIDS IN THE CARIBBEAN

(a) Incidence and prevalence

According to United Nations estimates, 430,000 men, women and children were living with HIV/AIDS in the Caribbean at the end of 2003. The Caribbean subregion also had the second-highest adult HIV prevalence rate² in the world (between 1.9 and 3.1 per cent), second only to sub-Saharan Africa. Prevalence rates nevertheless vary across the Caribbean; some countries are more affected than others. Several have generalized epidemics, and national estimates at the end of 2001 showed HIV prevalence reaching or exceeding 2 per cent in Belize, the Dominican Republic, Haiti and Trinidad and Tobago. Cuba, on the other hand, had a prevalence rate of less than 0.1 per cent (UNAIDS 2002; UNAIDS 2003). See also tables 1 and 2.

¹ The acquired immunodeficiency syndrome (AIDS) arises from the weakening of the human immune and nervous systems by infection by the human immunodeficiency virus (HIV).

² The proportion of adults aged 15-49 years living with HIV.

Table 1
REGIONAL HIV/AIDS STATISTICS AND FEATURES, END OF 2003

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS	% of HIV-positive women who are adults*	Main mode(s) of transmission for those living with HIV/AIDS*
Sub-Saharan Africa	25.0 - 28.2 mil	3.0 – 3.4 mil	7.5 – 8.5	2.2 – 2.4 mil	58	Hetero ^a
North Africa & Middle East	470,000 – 730,000	43,000 – 67,000	0.2 – 0.4	35,000 – 50,000	55	Hetero, IDU ^b
South & South East Asia	4.6 – 8.2 mil	610,000 – 1.1 mil	0.4 – 0.8	330,000 – 590,000	36	Hetero, IDU
East Asia & Pacific	700,000 – 1.3 mil	150,000 – 270,000	0.1 – 0.1	32,000 – 58,000	24	IDU, MSM ^c , Hetero
Latin America	1.3 – 1.9 mil	120,000 – 180,000	0.5 – 0.7	49,000 – 70,000	30	MSM, IDU, Hetero
Caribbean	350,000 – 590,000	45,000 – 80,000	1.9 – 3.1	30,000 – 50,000	50	Hetero, MSM
Eastern Europe & Central Asia	1.2 – 1.8 mil	180,000 – 280,000	0.5 – 0.9	23,000 – 37,000	27	IDU
Western Europe	520,000 – 680,000	30,000 – 40,000	0.3 – 0.3	2,600 – 3,400	25	MSM, IDU
North America	790,000 – 1.2 mil	36,000 – 54,000	0.5 – 0.7	12,000 – 18,000	20	MSM, IDU, Hetero
Australia & New Zealand	12,000 – 18,000	700 – 1,000	0.1 – 0.1	<100	7	MSM
Total	40 mil (34-46 mil)	5 mil (4.2 – 5.8 mil)	1.1% (0.9-1.3%)	3 mil (2.5-3.5 mil)	38.2	

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), AIDS Epidemic Update 2002 and AIDS Epidemic Update 2003, New York.

* End 2002

^a Heterosexual transmission

^b Transmission through injecting drug use

^c Sexual transmission among men who have sex with men

Table 2
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV/AIDS, END OF 2001, IN SELECTED COUNTRIES

Country	Adults and Children	Adults 15 - 49	Men 15 -19	Women 15 -19	Both sexes 15-19 prevalence rate (%)	Total population (thousands)
Bahamas	6,200	6,100	3,400	2,700	3.5	170
Belize	2,500	2,200	1,200	1,000	2.0	119
Cuba	3,200	3,200	2,370	830	0.1	6,121
Dominican Republic	130,000	120,000	59,000	61,000	2.5	4,561
Guyana	18,000	17,000	8,500	8,500	1.0	432
Haiti	250,000	240,000	120,000	120,000	6.1	4,053
Jamaica	20,000	18,000	10,800	7,200	1.2	1,376
Suriname	3,700	3,600	1,800	1,800	2.7	238
Trinidad and Tobago	17,000	17,000	11,400	5,600	2.5	748
Total	450,600	427,100	218,470	208,630	-	17,818

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2002 Report on the Global HIV/AIDS Epidemic, New York, 2002.

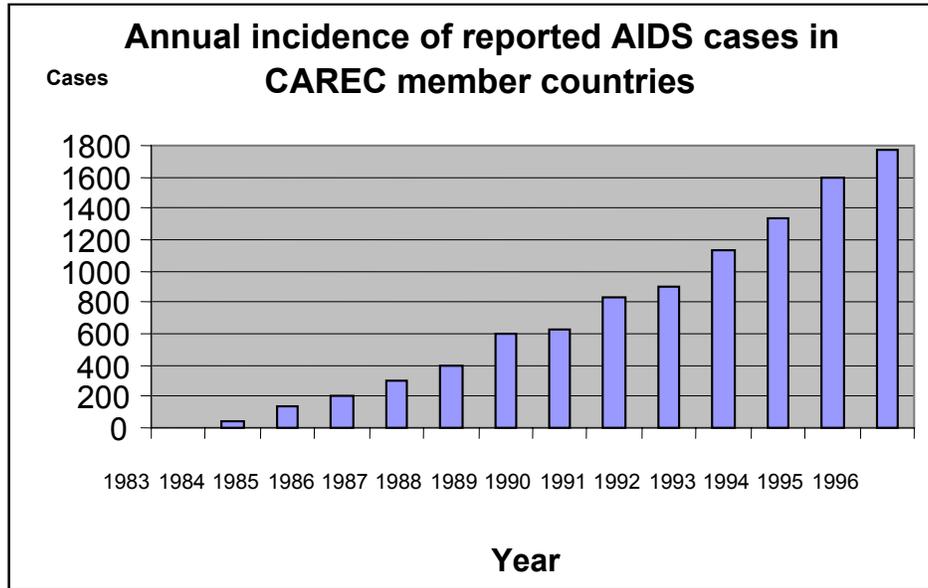
In the Caribbean, the most sustained efforts to capture data on HIV/AIDS have been made by the Caribbean Epidemiology Centre (CAREC), which has 21 member countries.³ The incidence of AIDS cases reported to CAREC rose steadily during the 1980s and 1990s (see figure 1). In 2002, the annual incidence of AIDS cases was 52.43 per 100,000 persons, compared to 13.6 per 100,000 in 1991, an almost fourfold increase.⁴ For 2002, HIV incidence rates also varied across CAREC member countries, with the highest rates per 100,000 persons being recorded for the Turks and Caicos Islands (344), Belize (173), the Bahamas (131), Suriname (131) and Trinidad and Tobago (93).

Despite the existence of strategic plans and policies designed to reduce transmission in the Caribbean, the epidemic is spreading rapidly, and infection rates among women have risen. The annual incidence of HIV infection among Caribbean females is from three to six times more than among males.

³ CAREC member countries: Anguilla, Antigua and Barbuda, Bahamas, Barbados, Bermuda, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts and Nevis, Saint Lucia, St Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands, and Suriname.

⁴ CAREC (2004, 1).

Figure 1



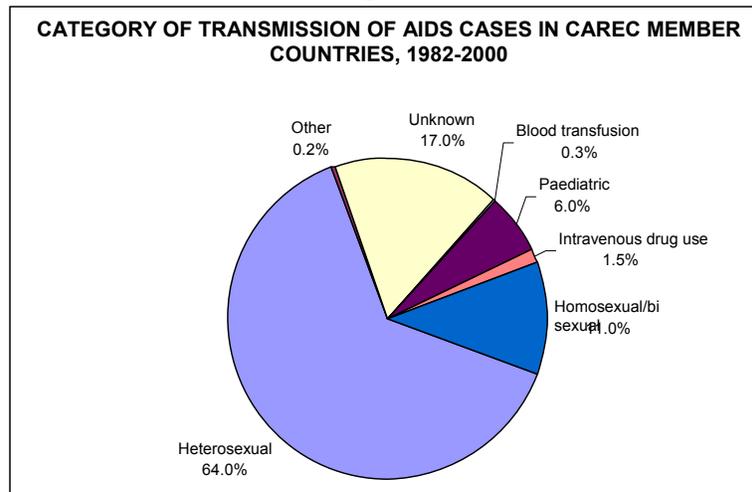
Source: Pan American Health Organization (PAHO), *Health Conditions in the Caribbean*, Washington, D.C., 1997.

(b) Transmission

The primary mode of HIV transmission in the Caribbean is heterosexual contact (see figure 2). Although the epidemic first manifested itself in the late 1970s among the homosexual/bisexual population, a rapid shift to heterosexual transmission occurred as the disease progressed. Heterosexual contact accounted for 27 per cent of HIV/AIDS cases reported to CAREC in 1986, increasing to 56.2 per cent in 1987 and to just over 60 per cent by June 1988.⁵ For the period 1982-2000, heterosexual contact accounted for 62 per cent of the cumulative total of AIDS cases reported to CAREC. Among women, heterosexual contact is a major vehicle of HIV transmission; in fact, it represents up to 90 per cent of cases among the female population (Camara, 2000).

⁵ Nahrain and others, 1989, p. 55.

Figure 2



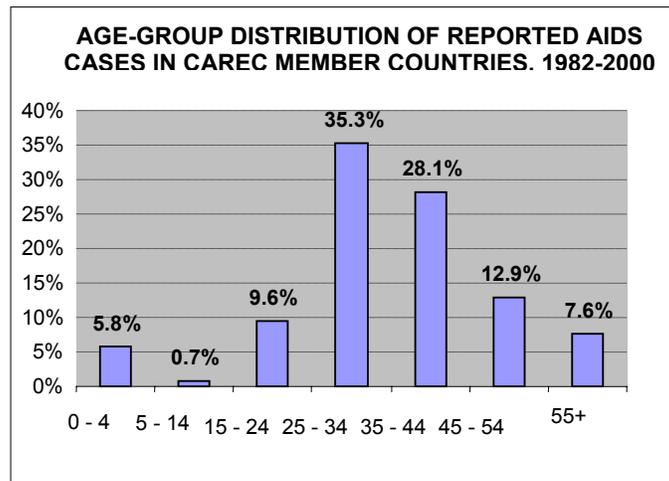
Source: B. Camara, "An overview of the AIDS/HIV/STD situation in the Caribbean", *The Caribbean AIDS Epidemic*, Glenford Howe and Alan Cobley (eds.), Mona, University of the West Indies Press, 2000.

Reported homosexual and bisexual transmission of HIV is relatively low, accounting for 11 per cent of the cases reported to CAREC over the period 1982-2000. It is nevertheless considered an important route of spread among the heterosexual population, primarily through bisexual contact. The social stigma associated with homosexuality also means that HIV/AIDS cases among this group will continue to be underreported. Other modes of transmission include intravenous drug use, transfusion of blood and blood products, and perinatal transmission. Transmission through intravenous drug use, with the exception of Bermuda (43 per cent), was insignificant at 1.5 per cent, while blood and blood products accounted for a mere 0.3 per cent. Over the period 1982-2000, perinatal cases accounted for some 6 per cent of reported cases (Camara, 2000).

(c) Age distribution

Young people are particularly vulnerable to HIV infection (see figure 3). Data for the CAREC countries for 1982-2000 indicate that just over 70 per cent of AIDS cases were diagnosed in people between 15 and 44 years of age, with 50 per cent being in the 25-34 age group (Camara, 2000).

Figure 3



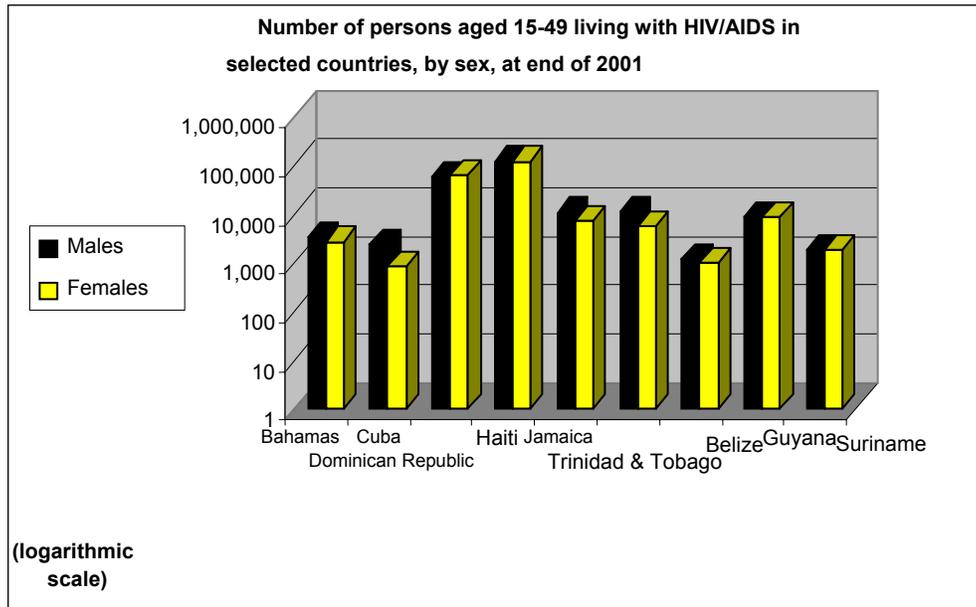
Source: B. Camara, "An overview of the AIDS/HIV/STD situation in the Caribbean", *The Caribbean AIDS Epidemic*, Glenford Howe and Alan Cobley (eds.), Mona, University of the West Indies Press, 2000.

Given that the time lag between infection and development of the disease may be 5-10 years, the data suggest a high rate of HIV infection among adolescents and young adults. Globally, about half of all the persons who become infected with HIV acquire the virus before age 25, and they typically die before age 35 of opportunistic infections associated with the disease. In the English-speaking Caribbean, AIDS is now the leading cause of death among young men between the ages of 15 and 44 (Camara, 2000).

(d) HIV trends among women

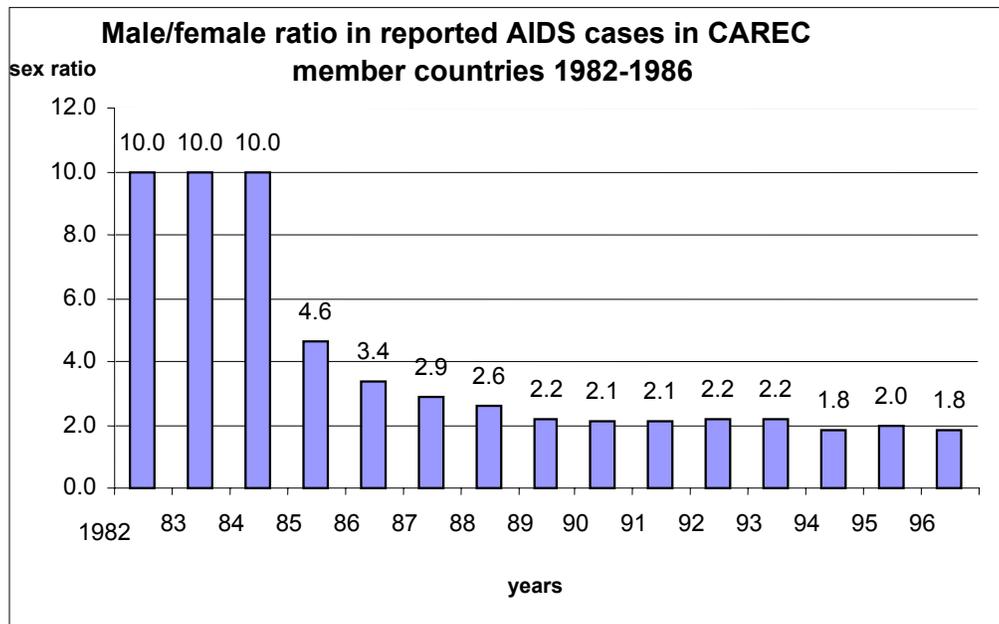
The number of males living with HIV in the subregion is still higher than the number of females. Nevertheless, as the face of the epidemic has changed to a primarily heterosexual one, infection rates have been growing among women, resulting in a narrowing of the gap between the numbers of newly infected men and women. The Caribbean currently has one of the highest rates of AIDS cases among women in the Americas and, in some instances, the average annual increase in new cases has been twice as high among females as among males. Accelerating rates of infection among females are also mirrored by the declining male-to-female ratios for reported HIV infection. In the early 1990s, the male-to-female ratio in the Caribbean was 2:1. By 1996 it had decreased to 1.7:1, and in some countries it is now close to 1:1 (see figures 4 and 5).

Figure 4



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of WHO Epidemiological Fact Sheets.

Figure 5



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2002 Report on the Global HIV/AIDS Epidemic, New York, 2002.

There are also significant age variations in the different patterns of infection of males and females. Among men, the majority of AIDS cases are in the 30-34 and 25-29 age groups. Among women, the majority of cases are in the 25-29 age category, followed by the 30-34 group. The epidemiological data for the subregion also indicate that females in the 15-19 and 20-24 age groups are increasingly more vulnerable to infection than their male counterparts. With the

exception of Cuba, the HIV prevalence rate in young people aged 15-24 is higher for females than for males in the countries shown in table 3.

Table 3

ESTIMATED NUMBER OF PERSONS 15-24 LIVING WITH HIV/AIDS, END OF 2001, IN SELECTED COUNTRIES				
Country	Low estimate - females 15-24 prevalence rate (%)	High estimate - females 15-24 prevalence rate (%)	Low estimate - males 15-24 prevalence rate (%)	High estimate - males 15-24 prevalence rate (%)
Bahamas	1.97	4.09	1.72	3.56
Belize	1.59	2.39	0.88	1.32
Cuba	0.03	0.06	0.06	0.12
Dominican Republic	2.22	3.30	1.69	2.51
Guyana	2.60	5.41	2.13	4.43
Haiti	3.22	6.69	2.64	5.48
Jamaica	0.69	1.03	0.66	0.98
Suriname	0.99	2.05	0.79	1.64
Trinidad and Tobago	2.09	4.37	1.56	3.27

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), *2002 Report on the Global HIV/AIDS Epidemic*, New York, 2002.

In some instances, the male-to-female ratio in the 15-19 age group has undergone a dramatic reversal, with females in that category now being from three to seven times more likely to be infected than males in the same age group.

2. GENDER AND THE IMPLICATIONS IN TERMS OF HIV/AIDS

This paper will explore the role of gender in the spread of HIV in the Caribbean. Specifically, it will examine how gender and gender relations affect women's sexual and reproductive health and their access to their rights in this respect and how this, in turn, increases women's vulnerability to HIV infection.

(a) Definitions

For purposes of the present analysis, the following definitions will be used:

Gender: Contemporary feminist theory distinguishes between sex and gender. It takes the view that sex is biological and gender is a social construct. Unlike the term “sex”, which refers to biological differences, the term “gender” refers to expectations, norms and behaviours that are differentially based on sex. The term “gender” may therefore be defined as referring to socially constructed identities as reflected in behaviours, attitudes and power relations between women and men and as reflected in notions of femininity and masculinity. Masculinity has always been ascribed a higher value than femininity. Gender therefore refers to a system of roles and relationships between men and women that is determined, not by biology, but by socialization.

The gender division of labour: Andaiye (2003) notes that a direct result of the gendering process “is the gender division of labour whereby women and men cluster in the different kinds of work for which they have been socialized. This socialization takes place first within the household and family and then in education, the wider society and the economy. Building on biological difference (the fact that women bear children and breastfeed) women are socialized into having the main responsibility for social reproduction, that is, child and family care, including housework, although there is no biological basis for this. The work is ascribed little value: it is unwaged when performed within the household and low-waged when performed for strangers (e.g. domestic work, nursing, and teaching).”⁶

Gender relations: Barriteau (1998; 2003) defines gender as comprising a network of power relations with two principal dimensions, one ideological and one material. She explains that the material dimension exposes how men and women gain access to or are allocated the material and non-material resources within a given community or society. The ideological dimension concerns the constructs of masculinity and femininity. Society constructs what it accepts (and contests) as the appropriate expression of masculinity and femininity. The two spheres, she argues, interact and reinforce each other. As such, the ideological relations of gender both structure and complicate gender relations in the private and public spheres alike.

Gender, like class and race, is a criterion that structures most societies around the world (Johnson, 2001; Mukhopadhyay, 2003). The main axis of power in this gender order is the overall subordination of women and the dominance of men, the structure referred to as “patriarchy” (Johnson, 2001). Paragraph 4.24 of the Programme of Action of the International Conference on Population and Development notes that men exercise preponderant power in nearly every sphere of life, from personal decisions regarding the size of their family to the policy and programme decisions taken at all levels of government. Gender relations are thus social relations and interact with other relations of domination and subordination.

Gender inequality: This concept is thus inextricably bound to these relations of power between men and women. As a category, gender inequality cannot be measured, but it is

⁶ Andaiye (2003, p.7)

manifested in many complex ways which are organically linked. Lack of access to sexual and reproductive rights, gender violence, the clustering of women in the low-waged sectors of the economy, the significant wage gap that exists between men and women, the relative absence of women from economic and political decision-making, sexual harassment and all other forms of discrimination against women are but some of the manifestations of gender inequality.

Gender equality: This type of equality can exist only when women and men enjoy the same level of power, when the different roles they play and the different work they do are equally valued, and when both can equally contribute to and benefit from political, economic, social and cultural development.⁷

Sexuality: The term refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors.

(b) Reproductive and sexual health and rights and HIV/AIDS

(i) The international context

The Programme of Action adopted at the International Conference on Population and Development and the Beijing Platform for Action situate reproductive health within a human rights framework, representing a significant departure from an earlier maternal and child health focus. The definition of reproductive health articulated in these consensus documents is rooted in the premise that all women have a right to reproductive health, and that this extends to the right to regulate their fertility, the right to understand and enjoy their sexuality and the right to protect themselves from disease and death associated with their reproduction and sexuality. Reproductive health is therefore broadly defined to include sexual health.

Paragraph 96 of the Beijing Platform for Action expressly links reproductive health to women's human rights by stating that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

Caribbean governments have subscribed to these consensus documents and are therefore committed to protecting women's sexual and reproductive rights.

⁷ Andaiye (2003, p.12).

(ii) Gender inequality, access to reproductive health and rights and their implications for HIV/AIDS

Notwithstanding the human rights guarantees accorded to women in terms of access to their reproductive and sexual health and rights, the reality is that women generally lack the autonomy to make decisions about their own bodies, their sexuality and their fertility. This reality is made explicit in the Beijing Platform for Action, which acknowledges that social vulnerability and the unequal power relationships between women and men are obstacles to safe sex (Beijing Platform for Action, paragraph 98).

In her analysis of women's lack of access to their sexual and reproductive rights, Charles (2003) notes that an important aspect of hierarchical gender relationships is body politics. She writes that in most societies, powerful forces are at play regarding the regulation and control of women's bodies, generally based on widely shared conceptions of gender associated with ideas and beliefs about femininity and masculinity. Control over women's bodies is seen to be central to this gender construct. The construct has allowed women's rights to sexual and reproductive health to be appropriated by their husbands, the State and other institutions within society.

Women in the Caribbean, as is the case the world over, engage in the business of "social reproduction" on a daily basis, clothing, feeding and nurturing their families. This reality is rooted in the gender division of labour, which, as noted earlier, stems from the assumption that reproductive responsibility constitutes a natural extension of female biology. It is this construct and the same set of assumptions that underlie a woman's lack of autonomy to make decisions about her body. It is also this construct which confers on a husband proprietary rights over his wife and, by extension, her body — rights which were, and in some instances still are, protected by law. A husband's legal entitlement to sexual intercourse and the inability in law of the wife to refuse are a striking example of how English law (inherited by most of the Commonwealth Caribbean) has reinforced dominant constructs of masculinity and heterosexual power relations within the family. The corollary of a husband's right to sexual intercourse was his immunity from prosecution for rape of his wife, an immunity abolished only relatively recently in some Commonwealth Caribbean countries and still applicable in a few. Male authority for sexual and reproductive decision-making is an integral part of this construct. Embedded within this ideology is also the idea that men are responsible for when, where and how sex will take place (for example, whether sex is protected or not) and the expectation that men are knowledgeable about sex. Women were and are expected to defer to this authority and therefore have little power to negotiate around issues of sex.

This ideology remains pervasive in the Caribbean and underlies all forms of conjugal relationships or relationships which involve some degree of commitment. Masculinity and femininity continue to be constructed around ideas and beliefs of male proprietary access to a woman's body. Challenges to this authority, as, for example, if a wife or female partner were to engage in an extramarital relationship, can lead to violence and even to murder. For women to insist on protected sex or even to attempt to negotiate safe sex also challenges this authority.

The association of condom use with infidelity further inhibits women from safeguarding their sexual and reproductive health. In a study on cultural attitudes impacting on HIV transmission in Trinidad and Tobago, Voisin and Dillon-Remy (2001) interviewed 10 HIV-positive females. Donna, age 24, one of the interviewees in the study, related:

“I suspected my husband was having sex with other women. I asked him to use a “rubber” when we were having sex and he beat me. I took my two children and went to my parents’ home. My mother told me a woman has to put up with a lot to make her marriage work and that I should go back to him.”

The foregoing analysis of women’s limited enjoyment of their sexual and reproductive health and rights within conjugal relationships raises the obvious question: What makes women vulnerable to HIV infection in these relationships? The answer hinges upon accepted notions and expressions of male and female sexuality. It has been argued that constructions of masculinity in Caribbean society bestow privileges upon men by valuing “hyperactive virility” and male sexual prowess as reflected in such behaviours as womanizing, maintaining a sexual relationship with another woman while married, or fathering children with different women (Senior, 1991). Johnson (2001) notes that a man who lacks enthusiasm for pursuing women may have his masculinity questioned, if not attacked, especially by being accused of being homosexual.

Lewis (2003) argues, however, that not all Caribbean men can be so categorized and, while it is certainly true for some, it clearly does not apply to all men in the region. Chevannes (2002) also points out that data for Jamaica suggest that the “outside” woman is not as prevalent as the stereotype would suggest, namely as a practice of all or most men, and its highest distribution in Jamaican society is found among younger men.

It may nevertheless be argued that such constructions of masculinity make it possible for men to have multiple partners, a contention supported by studies in the region. For instance, the findings of a Haitian study on women’s role in sexual decision-making and its relationship with the spread of HIV showed that both men and women believed that it was the prerogative of men to have more than one partner (Ulin, Cayemittes and Metellus, 1993). An adult sexual survey conducted in Trinidad and Tobago (Camara and others, 2001) reports that 35.4 per cent of the males in the survey had engaged in casual relationships (a “one-off relationship” or “one-night stand“, not expected to last) compared to 5.3 per cent of the females, and that multiple partnering was more prevalent among men.

On the one hand, female sexuality is constructed in keeping with the notion of a husband’s proprietary rights to his wife’s body. Girls and women are thus socialized to be monogamous, and their sexuality is guarded within the family and watched over by other structures within society, such as the community, religion and the law. Contravention of this norm attracts negative social sanctions. Senior (1991) writes that while adolescent girls are being watched and confined and are being threatened and warned against having sexual relations with the opposite sex, their brothers are usually given no instruction regarding their relations with girls or the possibilities of and responsibilities of paternity. The male’s pursuit of sexual favours

during dating/courtship is acceptable evidence of his masculinity. On the other hand, the female's acquiescence to such favours is usually met with strong disapproval.

Women's ability to safeguard their sexual and reproductive health is further eroded by some of the concepts upon which marriage is based. Marriage, in the Caribbean, at least, is premised upon concepts of monogamy and procreation. As such, sex within marriage is deemed safe whether or not this is the case, and protected sex is therefore not a frequent practice within many marriages. Responsibility for contraception is usually borne by women, who tend to rely on methods other than protected sex. It may be noted that, in relation to women, there is a convergence between socialization practices regarding monogamy and similar expectations within marriage. For men, however, there is a divergence between socialization practices (which prioritize male sexual prowess) and the practice of monogamy within marriage. As such, extramarital affairs are usually shrouded in secrecy, and the charade of safe sex continues with the marital partner, with increased transmission risks for a monogamous partner, usually the woman.

It is clear, therefore, that for many women, monogamy does not protect against HIV infection. Globally, many women have been infected by their husbands or long-term partners through heterosexual sex. Similar trends are being observed in the Caribbean, where the heterosexual transmission rate for females (90 per cent) far exceeds the corresponding rate for males; this suggests that many HIV-positive women are being infected by their short-term or long-term male partners.

Childbearing, as a cultural expectation, and the socialization of both men and women in respect of childbearing also need to be explored as a factor that may increase women's vulnerability to HIV infection. Traditional roles of wife and mother are deeply internalized, and a high cultural value attaches to them. A great deal of symbolic significance is also assigned to these roles in many religions, and many Caribbean women are deeply religious. McKenzie (1982), in her analysis of the findings of the Women in the Caribbean Project (WICP) in relation to the family, asserts that it is in the domains of "sexual and emotional involvement with men, the fathers of their children... that [Caribbean] women appear to be the weakest".

Childbearing also enables women to gain social rewards and social recognition. This is sometimes the only route open to them, and it is particularly implicated in teenage pregnancy. Chevannes (2002) notes that both womanhood and manhood are fully achieved, not by the act of intercourse, but by reproduction. For the woman, pregnancy and childbirth are the fulfilment of womanhood; for the man, impregnation is the proof of manhood.

This author further posits that, as social action, sexuality is subject to relations of power insofar as it takes place between unequal parties; in this regard he refers not so much to the use of sex to assert dominance, as in rape, but rather to sex as an arena for playing out gender relations as power relations. He notes, "in keeping with the imagery of hunting, male (especially young male) expressions of the act of intercourse are aggressive, as any survey of popular songs would confirm". He notes further, however, that "women, too, are not content with the role of victim. They are 'employers of labour' and can dismiss men for not being able to 'do the work'".

Men are particularly vulnerable in this respect; as such rumours and accusations strike at their self-image and the way they are perceived by other people.”

The actual extent to which women in the Caribbean can negotiate safer sex practices or refuse sex is not known precisely, and research across age groups, classes, ethnicity and religion, among other factors, is needed to determine this. Research is also needed to ascertain the extent to which women in short-term or casual relationships can insist on safe sex practices.

(c) Poverty, sexual and reproductive health and rights, and HIV/AIDS

Although, because of factors such as childbearing and motherhood, it is not clear whether economic independence within heterosexual relationships empowers women to more successfully negotiate safe sex, it is perhaps the case that women in situations of economic dependence are less likely to do so and are also less likely to terminate relationships that place them at risk of HIV infection. The findings of the above-mentioned Haitian study on women’s role in sexual decision-making and its relationship to the spread of HIV and the study on women and AIDS⁸ carried out in Trinidad and Tobago support this contention. In the Haitian study, where 70 per cent of the women in the two communities that were examined had no independent income, women had the right to refuse sex only under certain circumstances, such as illness, and then only for short periods. Women in stable relationships or marriages in these communities did not have the right to insist that their partners use condoms, nor did women who had no children or whose partners wanted more children (Ulin, Cayemittes and Metellus, 1993). Participants in the Trinidad and Tobago study (carried out in four lower-income urban communities) reported that they felt totally disempowered in their relationships and were very dependent on their male partners for material and emotional support.

Although both men and women are affected by poverty, women are affected in specific ways because of existing gender inequalities. The organization of Caribbean and other societies along gender lines ensures that the burden of housework, childcare and other dimensions of the domestic workload continue to be seen as the sole responsibility of women; this is perhaps the single most important factor that pushes poor women into situations which make them vulnerable to HIV infection.

Poverty and lack of employment opportunities, for instance, have forced some women and girls to resort to direct and indirect sex work as a survival strategy. Sex (usually unsafe) may be exchanged for money, food or other necessities. In a study carried out in Trinidad, Lee and Felix (1995) found that poverty was the primary reason why women entered the sex trade. In a Guyanese study of female sex workers carried out by the Red Thread Women’s Development Programme (1999), a majority of the 23 women who were interviewed reported that poverty was their single most important reason for entering the sex trade. Paul (1997), in her study of prostitution among women in Barbados, noted that many women (both from Barbados itself and from other Caribbean countries, such as the Dominican Republic, Guyana, Haiti, St Lucia and Trinidad and Tobago) who engaged in the sex trade in Barbados had consciously decided to enter prostitution as a consequence of domestic or economic troubles and that the majority

⁸ NAP (n.d.).

continued to do so as a way to support their families. The vulnerability to HIV caused by poverty and unemployment, when linked to commercial sex work, brings into sharp focus some of the associated problems that relate to the spread of the disease and the subpopulations that are affected.

Several studies in the region indicate that sex workers are subject to high levels of infection (Kempadoo, 1999). Cleghorn and others (1995) found that the fact of having engaged in commercial sex work emerged as an independent risk factor for the retrovirus HIV-1. Female sex workers are infected by their male clients, and high rates of infection suggest a low rate of condom use. Some clients resist using condoms and may be willing to pay more for unprotected sex. In these situations, risk-taking by the sex worker may assume secondary importance to the need to feed herself and her children:

“When you are hustling in order to feed yourself and your children, the extra money that a man offers for unsafe sex lets you take the chance and forget about any disease.”⁹

Howe (2000) notes that, in the official discourse about controlling HIV, it is the so-called prostitutes rather than the men who infect them who are specified as the high-risk group and the conduit for the spread of [HIV] across the line of moral demarcation into “healthy society”. The study carried out by Red Thread, however, suggests a heightened awareness of the risks associated with unprotected sex among commercial sex workers: 20 out of a total of 23 women reported that they used condoms.

For perhaps the majority of women who work in the sex trade, their vulnerability to HIV is rooted in the fact that they are economically disadvantaged and that their poverty is related to systemic class and gender inequalities.

(d) Gender-based violence, access to sexual and reproductive health and rights, and HIV/AIDS

Gender-based violence is another manifestation of gender inequality which affects women’s ability to safeguard their sexual and reproductive health. The relationship between domestic violence and vulnerability to HIV infection is often indirect, and women in these situations are also less likely to negotiate safe sex practices. All forms of coerced sex directly increase the risk of microlesions and therefore of STI/HIV infection (WHO, 2000). In a study on the experiences, behaviours, perceptions and needs of adolescents living with HIV/AIDS in Trinidad, rape was implicated in HIV transmission for 3 of the 21 female respondents (Okoye, 2000). There is also evidence which suggests that child sexual abuse is frequently a precursor to female adolescent prostitution or may be a precursor to sexual behaviours that increase transmission risks (Lee and Felix, 1997). Trafficking of women and girls and the violence they experience as a result also increase vulnerability to HIV infection.

Many feminist analyses locate gender violence within the context of unequal power relations between women and men. As noted earlier, this is but one manifestation of a complex

⁹ Antonius-Smits et al (1999, 251).

and interrelated set of values that place women in a subordinate position in society. The 1990s saw a great deal of effort focused on the eradication of gender-based violence, particularly domestic violence. Legislation on domestic violence was enacted in many countries of the subregion, and shelters, hotlines and other support services were established (Gopaul, 1994, Clarke, 1998, Pargass and Clarke, 2003). However, despite this intense focus, the incidence of domestic violence in the Caribbean remains high. Applications for protection under domestic violence laws have steadily increased in many countries. In Trinidad and Tobago, for the period September 2001-July 2002, applications totalled 8,852 and, in Puerto Rico, applications exceeded 50,000 in 2002. Police statistics also suggest that sexual violence both within and outside the home may be increasing.

(e) Adolescents, access to sexual and reproductive health, and HIV/AIDS

Young people represent the most rapidly growing component of new HIV infections. As noted earlier, persons aged 15-24 constitute the most vulnerable age group, and it is estimated that half of such infections occur among adolescents and young adults. Throughout the region, females within this group are increasingly vulnerable to HIV.

Sexual encounters in the Caribbean often begin at a relatively early age. By age 18, the vast majority of Caribbean youth have had their first sexual encounter (Blount and others, 1996). Young males in the region tend to have their first sexual encounter earlier than females, with the average age for males being before completion of their fourteenth year and the average for females being before they complete their sixteenth year (Chevannes, 2002). Nevertheless, trends in the region are reflecting rapidly accelerating rates of infection among adolescent females.

A 1998 survey on adolescent health in the Caribbean conducted by the Pan American Health Organization (PAHO) in 100 schools in Antigua, the Dominican Republic, Grenada and Jamaica, together with out-of-school youth, found that more than 40 per cent of those who reported being sexually active said they had their first sexual encounter before age 10 and that a further 20 per cent reported that they had their first sexual encounter at age 11 or 12. Very early sexual initiation is, however, suggestive of sexual abuse.

Condom usage among adolescents in the subregion is reported to be low (Jagdeo, 1986; Russell-Brown, 1988), and high levels of HIV/AIDS awareness do not appear to have had a significant impact on condom use among adolescents (Joseph, 1999). Adolescent sexuality is not homogenous but is instead shaped by complex social and cultural factors including gender, class, religion, ethnicity and family. The taboo and secrecy that surround sex in society are perhaps most deeply felt by adolescents, who are “possessed of powerful sex drives that remain throughout most of [their] adult, mature [lives]” (Chevannes, 2002).

Cleghorn and others (1995) found that sexual intercourse at an early age emerged as a significant predictor of HIV-1 status in women. Biological factors may provide one explanation for the increasing vulnerability of young girls. recent studies across the Caribbean also suggest that young girls are engaging in sex with older men in exchange for money to satisfy material needs, a phenomenon referred to as “transactional sex” (Stuart, 2000). Young people in the Caribbean have internalized the societal segmentation of gender roles, and this finds expression

in the dynamics of transactional sex. Another explanation that has emerged is the need felt by some girls to identify with a father figure.

A study carried out in the Bahamas in 1999¹⁰ to identify the socio-economic factors that increase women's vulnerability to HIV/AIDS also points to the existence of the phenomenon in that country. Participants in the study were of the view that older men in such relationships would be under less pressure to make a commitment, would experience less harassment and disturbance and would be able to protect their male egos. They also believed that a young woman was less likely to have the virus. They, too, thought that the preference of younger girls for older men was probably based on material gain, security and a "father image".

Unemployment and poverty may also be a factor driving sex between young girls and older men. There was a consensus among young people who participated in the first of the two studies that women lacked economic power and used their sexuality to obtain money from men as part of their survival strategies. The option of looking for a man was the only one identified for women with children but without financial means.

It is not uncommon in the Caribbean for women to enter into a pattern of serial relationships in order to secure financial support for their children. Teenage mothers are particularly vulnerable in these situations. Senior (1991) notes that not only first, but also second and third children, are being born to teenage mothers. The chances are that the teenage mother will have to terminate her schooling. Unschooling and unskilled, she will then join the ranks of the unemployed, which are already the highest for her sex and age group. Stuart (2000) notes that recent focus group discussions among young people aged 17-20 conducted in Barbados and Jamaica revealed participants' internalization of these gender roles. The participants had internalized the idea that the economic conditions of women's lives predispose them to a life of sexual exploitation and often accept this as part and parcel of the established pattern of life.

Studies in the subregion have also revealed that low educational status is linked to early age at first intercourse.¹¹ Early sexual activity and pregnancy tend to be linked to an affirmation of status for girls in the lower socio-economic strata, while for boys early sexual activity is linked to the "macho-conquest" image.

Although there may be other factors driving the sexuality of adolescent males and females, gender and gender relations play a key role in the expression of adolescent sexuality. There is nevertheless a need for further research across class, religion, educational status and ethnicity, *inter alia*, to achieve a deeper understanding of adolescents' vulnerability to HIV/AIDS.

¹⁰ Ward and Samuels (1999).

¹¹ Singh et al (2004) ; Jagdeo (1986).

3. THE WAY FORWARD

Gender inequality has severe implications for increasing HIV infection levels among females and for the spread of HIV in general. Nonetheless, gender does not appear to be a major focus of the various plans and policies for dealing with HIV/AIDS in the subregion.

Efforts to reverse the epidemic must address the underlying structural and cultural factors that sustain gender inequality. The experience of domestic violence over the past one and a half decades and the inability to stem its occurrence despite intense efforts to do so clearly illustrate the inadequacy of discrete measures that do not address the underlying structures. The same obviously holds true for dealing with gender inequality in the context of HIV/AIDS.

The HIV/AIDS epidemic has become part of the development discourse; a closer examination of the social and economic divisions within countries, together with a deeper analysis of poverty, income distribution and social, political and economic exclusion, is imperative. Central to these issues and to the HIV/AIDS epidemic is the issue of gender. In any analysis of an economy or society, at either the micro or macro levels, gender must be taken into account. This is because, as noted earlier, men and women have different social and economic roles, differential access to income and resources, and different economic behaviours. This points the way to achieving the gender equality which is so critical to reversing the HIV/AIDS epidemic.

Policy directions:

- (a) Gender must be seen as central to economic planning and sustainable development, and women's economic empowerment is critical to this process.
- (b) Gender should be mainstreamed in all HIV/AIDS policies and programmes and across all sectors, and gender analysis and assessment of national plans of action, policies and programmes for addressing HIV/AIDS should be undertaken across the countries of the subregion.
- (c) Gender training needs to be undertaken at all levels of the public and private sectors, and there should be an expanded role for the trade union movement in this regard.
- (d) Critical analysis of past and present responses to efforts to achieve gender equality and equity needs to be undertaken with the aim of transforming the deeply entrenched patriarchal culture of the Caribbean.

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