Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review

Gaelle Bombereau and Caroline Allen

Caribbean Health Research Council

Supported by funding from the European Union through the Pan-Caribbean Partnership Against HIV/ AIDS project on Strengthening the Institutional Response to HIV/ AIDS and STI in the Caribbean

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Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review

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Supported by funding from the European Union through the Pan-Caribbean Partnership Against HIV/ AIDS project on Strengthening the Institutional Response to HIV/ AIDS and STI in the Caribbean
“In the light of the experience gained, it is more and more widely recognized that the HIV/AIDS epidemic is not only a sector-based medical problem, but a multi-faceted issue which requires multidimensional strategies. Modern-type information / education / communication, promotion of condom use will not achieve the expected results, if the question is limited to medical considerations and its solution to pharmaceutical treatments.

It is, indeed, a complex socio-economic, societal and cultural phenomenon, to be considered in the perspective of sustainable human development. This is why the prevention and treatment of the epidemic require a cultural approach to face the issue in all aspects.”

Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review

Executive summary

Background

In the Caribbean, the behaviours that drive the HIV epidemic are mainly sexual. Consequently, fighting the epidemic means addressing private behaviours including behaviours that are illegal in most of the countries (such as homosexuality and forced sex); economic behaviours (such as transactional sex) and cultural norms (such as approval of men with multiple partners). The social and cultural factors that work against or improve the success of prevention interventions need to be understood to reduce the spread of HIV.

Methodology

An HIV literature review was undertaken covering the social and cultural factors driving the HIV epidemic in the Caribbean. Attention focused on the following sources of risk of HIV transmission:

- Age at first sex
- Multiple partnership
- Transactional sex
- Commercial sex
- Condom use
- Men having sex with men
- Interpersonal violence and aggression

Each article reviewed was analysed with a standardised tool, seeking to identify the main social and cultural factors underlying these sources of risk.

The review concentrates on publications relating to HIV/AIDS among Caribbean people. Some articles applying to other geographical regions have been used to develop understanding.

Results

There are several key social and cultural factors underlying the Caribbean HIV epidemic:

1. Caribbean cultural constructions of masculinity and femininity impose obligations and restrictions leading to risky sexual practices (e.g. early age at first sexual intercourse and multiple partnerships by men). Complying with gender expectations creates vulnerabilities for HIV in the general population and not just among people often thought to be at high risk, such as sex workers and men who have sex with men.
2. The economic environment and associated gender inequalities affect sexual practices. To access economic resources, men and, to a greater extent, women, put
themselves at risk by accepting multiple partnerships, not negotiating condom use and/or trading sex for money and goods. Adolescent girls and some boys may accept unprotected sexual relations with older men in order to access resources. These practices are supported by the cultural norm that men should provide financially for their sexual partners.

3. Young people and women are often exposed to sexual and physical abuse that put them at risk for HIV. Sexual abuse and violence create psychological as well as physical vulnerability. Forced sex at first intercourse or at some point in life often results from gender and age imbalance.

4. Unstable and unsupportive family environments, sometimes resulting from economic migration, create vulnerability and may explain some sexual risk taking.

5. The policy environment may undermine public health goals by encouraging new infections. Criminalisation of homosexuality and sex workers, lack of strong policies regarding sexual abuse, and differential access to care and treatment options put various sub-populations at risk for HIV.

The review found numerous studies documenting social and cultural factors driving risky sexual practices but only a handful that documented social and cultural factors that may have a protective effect in reducing risk of HIV transmission. Among these, a sense of “connectedness” with school (for young people) and strong and supportive family relationships appear to be important protective factors. Analysis of data from the Caribbean Youth Health Survey suggested that protective factors may have an even stronger impact on risk practices (such as early sexual initiation) than risk factors.

Overall, few studies undertaken in the region are documented in peer-reviewed journals. Moreover, disparities exist between the countries who document their studies in the peer-reviewed literature and those who do not. As a consequence, some countries (such as Jamaica) are relatively highly represented in the HIV literature.

There is a dearth of research demonstrating clear associations between social and cultural factors, sexual behaviours and HIV prevalence. This is important because changing sexual behaviour may not automatically translate into changes in HIV incidence; there are intervening factors such as the existing prevalence of sexually transmitted infections (STIs) and HIV and the extent of use of anti-retroviral therapy among people living with HIV/ AIDS. Biological markers have been used only in very few studies.

**Recommendations**

There is urgent need to combine social science and epidemiological methods to identify causal pathways and the strengths of association between social and cultural factors and changes in HIV prevalence and incidence. This would assist in developing interventions that are more likely to be effective. Rigorous evaluation of interventions is also needed, again combining epidemiological and social science methods to assess success in combating HIV. Combined behavioural and HIV/STI seroprevalence studies should be conducted and the results analysed using multivariate statistical analysis. To assist in the development of interventions, it is important to conduct more research into potential protective factors which could be strengthened in order to effect positive change.
The available evidence suggests that factors at various levels such as the couple, family, community and society may influence individuals’ sexual risk-related beliefs, intentions, and behaviours. Paul Farmer uses the term “structural violence” to describe systematic discrimination and differences in opportunities on the basis of socially assigned categories such as poverty, “race” and gender. This is a useful concept in understanding the socio-cultural factors that play a role in the HIV/AIDS epidemic. Policies and interventions should be addressed to the sources of structural violence.

Following are the main recommendations for policy-makers and practitioners:

- Programmes promoting gender equity, women’s rights and sustained poverty reduction should be strengthened in order to reduce vulnerability.
- Interventions should target especially vulnerable people who lack social and financial support and/or are exposed to violence and sexual abuse. They should pay attention to emotional and mental health while nurturing and enhancing negotiation skills.
- There is urgent need to review and/or develop laws that protect vulnerable and marginalised segments of the population (e.g. decriminalisation of sex work and sexual acts between men, legislation prohibiting discrimination including homophobia, strong penalties for sexual and domestic violence).
- Protective factors should be strengthened, such as supportive family and school relationships, by providing training, counselling and practical support to parents, other caregivers and teachers.

The review revealed several important areas where further research could strengthen the ability of Caribbean practitioners and policy-makers to combat the HIV epidemic:

- What are the links between, cultural and social factors, behaviour and HIV/ STI seroprevalence?
- How best can the research on social and cultural factors driving the epidemic be used to develop interventions to combat it? How should these interventions be evaluated? What are the conclusions and recommendations of intervention evaluations conducted to date?
- What are the social and cultural factors that offer protection against HIV transmission?
- What are the best techniques to map and identify communities, households and individuals at risk of abuse, and to develop HIV prevention interventions with them?
- What role do mental health issues, including self-esteem and anger, play in HIV transmission?
- How does the population manage disease risk in general (when does the population protect themselves, how and against what?) and HIV risk in particular?
- Among policy-makers, what are the barriers and facilitating factors to legislative and other changes to create a supportive policy environment?

Important sources of risk of HIV transmission that have not been included in this review include: alcohol and drug abuse; migration and population mobility; sex tourism, and stigma and discrimination against people living with HIV/ AIDS. Nevertheless, we believe that this review of literature on several key risk factors can assist in the development of more evidence-informed policies, programmes and practices to address the HIV/ AIDS epidemic in the Caribbean.
Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review

Background

The Caribbean Health Research Council has been awarded a grant from the Pan-Caribbean Partnership on HIV/AIDS (PANCAP) to compile and review literature and data on HIV/AIDS in the Caribbean. A major component of the project is to conduct literature reviews in a limited number of high-priority areas. These syntheses will be shared with stakeholders and are expected to result in more evidence informed policies, programmes and practice. They will also contribute to the identification in research gaps and ultimately inform the development of a research agenda. This report synthesises literature on one of the high-priority areas identified: social and cultural factors driving the HIV epidemic in the Caribbean.

In the Caribbean, which has the second highest HIV prevalence in the world (after sub-Saharan Africa), estimated HIV seroprevalence among adults ranges from 1 to 4% (UNAIDS, 2006). The behaviours that drive the HIV epidemic are mainly sexual. Consequently, fighting the epidemic means addressing private behaviours including behaviours that are illegal in most of the countries (such as homosexuality and forced sex); economic behaviours (such as transactional sex) and cultural norms (such as approval of men with multiple partners). The social and cultural factors that work against or improve 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.

Aims

The aims of the literature review were:

- To synthesize what is known about the topic as it pertains to the Caribbean situation
- To review critically the existing research on the topic, particularly with regard to appropriateness and rigour of research methods
- To make recommendations for policy, programming and practice for Caribbean people arising from the research
- To identify gaps in what is known and thus identify areas for further research and programme development

Methodology

A risk-factor approach

Epidemiological research has shown that the following behavioural variables are significantly associated with the risk of HIV transmission:
- Age at first sex
- Multiple partnership
- Transactional sex
- Commercial sex
- Condom use
- Men having sex with men
- Interpersonal violence and aggression

The review focussed on literature on social and cultural factors underlying these sources of risk. The main chapters of this report concentrate on each of these risk factors in turn.

**Method of analysis**

Bibliographic databases were searched online and in libraries. Online databases searched were:

- PubMed
- MedCarib
- Medline, 1966-2007
- ScienceDirect
- Web of Knowledge

Key words used for searching included HIV and/or AIDS and Caribbean or West Indies in combination with one or more of the following: condom, culture/ cultural factors, gender, homosexuality, MSM, risk, sex work, social factors, transactional sex, violence, young people, youth. Experts in the Caribbean were contacted to collect additional references.

The articles were selected according to relevance to the Caribbean and covered the following topics:

- HIV risk
- Sexual behaviour
- HIV, violence and sexual abuse
- HIV and men who have sex with men
- HIV and sex work

The data come from various fields including anthropology, education, epidemiology, gender studies, public health and sociology.

The review concentrates on publications relating to HIV/AIDS among Caribbean people. Some articles applying to other geographical regions have been used to develop understanding. Some documents that have not been peer-reviewed, such as documents by agencies involved in activities relating to the topic, were included.

Each article reviewed was analysed with a standardised tool, seeking to identify the main social and cultural factors underlying the sources of risk identified above. This tool collected the following information:
Remarks paid attention to:

- the strength and appropriateness of research design and methods (i.e.: the rigour of research methods and representativeness of study populations and samples)
- whether links with HIV/ AIDS were demonstrated by the research
- programmatic and policy implications of the findings
- whether policies or programmes were developed from the study
- (if applicable) results of any evaluation of these programmes

Limitations

The list of HIV risk factors providing the focus of this review is not comprehensive, comprising some sexual behavioural risk factors only, to the exclusion of biological risk factors such as sexually transmitted infections. Important sources of risk of HIV transmission that have not been included in this review include: alcohol and drug abuse; migration and population mobility; sex tourism, and stigma and discrimination against people living with HIV/ AIDS.

Our review prioritised the analysis of peer-reviewed articles. Some research not published in peer-reviewed publications may be missing from the analysis.

Other limitations of the study are presented in the discussion section below.
FINDINGS
Age at first sex

Background

Reviews of sexual behaviour surveys conducted across the region have shown median ages at first sex in the early-to-mid teens or, in the case of some studies with boys, at even younger ages (Allen et al, 2001; Bombereau, 2007). The age at first sexual intercourse is reported to be lower among males than females (Allen, 2002; Chevannes, 2001; Kempadoo and Dunn, 2001; Kurtz, 2005; Bombereau, 2007). Quantitative surveys (PAHO, 2001; CAREC, 2007; Bombereau, 2007) document that some youth were forced to have sex the first time they had sexual intercourse. Both males and females are exposed to sexual abuse, though females seem to be more exposed (PAHO, 2001; Bombereau, 2007; CAREC, 2007). Some girls are sexually initiated by older men, and age differences between girls and young women and their older male partners are often substantial (Allen, 2001; Barrow, 2004, 2007; Hutchinson et al, 2007; CAREC, 2007).

The largest English-Speaking Caribbean youth health survey to date was carried out among 15,695 in-school youth aged 10-18 in 1997-8 in nine countries\(^1\). Table 1 gives some key data on sexual behaviour from this survey. Thirty-four percent of these young people reported they had ever had sexual intercourse. Over half of sexually active boys and about a quarter of sexually active females said that the age of first intercourse was ten years or younger (Halcon et al, 2003).

<table>
<thead>
<tr>
<th>Table 1: Sexual behaviour of Caribbean adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
</tr>
<tr>
<td>First intercourse was forced (yes or somewhat)</td>
</tr>
<tr>
<td>Age of first intercourse</td>
</tr>
<tr>
<td>&lt;10</td>
</tr>
<tr>
<td>11-12</td>
</tr>
<tr>
<td>13-15</td>
</tr>
<tr>
<td>16 and over</td>
</tr>
<tr>
<td>Used a condom at most recent intercourse</td>
</tr>
</tbody>
</table>

Source: Caribbean Youth Health Survey, reported in Halcon et al (2003)

While this study had a very large sample size, it may not be representative of Caribbean youth as a whole. Out-of-school youth were excluded, and absence from school appears to be more prevalent among boys than girls, since 39% of survey respondents were male and 61% female. Seven percent of selected students were absent on the day of survey administration. The exclusion of out-of-school youth may partially explain why only one-third of youth surveyed reported they had ever had sex. Several other Caribbean studies have shown that over half of males and slightly under half of females report that first sexual intercourse took

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\(^1\) The countries included in the survey were: Antigua and Barbuda, the Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica and St Lucia.
place at age 15 or below (Allen et al, 2001). Nevertheless, the Caribbean Youth Health Survey remains important in showing that, among those who report sexual activity, considerable proportions report they had sex at a very young age (particularly males), coerced sex and sex without a condom.

According to the literature four main situations regarding age at first sex place people at higher risk for HIV infection. These circumstances may overlap.

(1) Youth who are **sexually initiated early are more likely to be subsequently involved in risky sexual behaviours such as multiple partnerships** (UNICEF/UNAIDS/WHO 2002; Barrow, 2007).

(2) Girls who are initiated by older men

*Girls are at particular risk for acquiring HIV if their first sexual encounter is with an older man, since older men have been sexually active for longer* and so are more likely to be HIV infected (Heise and Elias, 1995; Dupas, 2006). Girls are biologically susceptible to infection before complete genital maturation, and have generally not been provided with skills to negotiate the use of condoms, especially with more experienced men (Dunkle et al, 2004).

In an adolescent risk behaviour and communication study in public schools in the United States and Puerto Rico, Miller et al (1997) documented sexual initiation by older male partners by interviewing 150 Hispanic and black females aged 14-17 years old. Thirty-five percent of adolescent girls reported that their first partner was more than three years older than they were, while 65% reported that their first partner was closer to their own age. Respondents who reported an older first partner reported significantly younger age at first intercourse compared to those who had had a peer-age partner (average 13.8 years vs. 14.6 years). They were significantly less likely to report having used a condom last time (63% vs. 82%), or to report consistent condom use within the past 6 months (40% vs. 65%) and since they had become sexually active. They were more likely to mention ever having been pregnant (38% vs. 12%). Finally, they were more likely subsequently to be involved in risky behaviours compared to those who were sexually initiated by peer-age partners. However, those who had had an older first partner were no more likely ever to have been told that they had a sexually transmitted infection (STI).

(3) Boys and girls who were forced to have sex the first time

According to evidence from Jamaica, **youth who are forced to have sex the first time are more likely to be HIV infected during the sexual encounter(s)** (Steel-Duncan et al, 2004). Youth who have experienced sexual violence are more likely to be subsequently involved in risky sexual behaviours such as early voluntary sex, multiple sex partners, and trading sex for money or drugs (WHO, 2001; Dunkle, 2004).

(4) Girls who have sex with men who believe that having sex with a virgin can cure STI including HIV.

Reports from Tobago and Jamaica document the belief that HIV can be cured by having sexual intercourse with a virgin (Allen et al, 2002b; Steel-Duncan et al, 2004 ; Hutchinson et al, 2007). In Tobago, Allen et al (2002b) found that youth with more partners were more likely to believe that the best way to cure a STI was to have sex with a virgin. According to Steel-Duncan et al (2004) in Jamaica this belief may contribute to girl’s sexual abuse.
A combination of socio-cultural factors motivates girls and boys to become sexually active. In the following sections, we provide evidence from the literature on these factors.

**Becoming and being a man or a woman**

- **Gender socialisation**

In the Caribbean, as elsewhere, boys and girls are raised differently. Female sexual prerogatives are restricted compared to those of males. In an analysis of 268 qualitative studies worldwide, it was observed that “men are expected to be highly heterosexually active and women chaste – women’s virginity at marriage often has high social value. Vaginal penetration is perceived to be important in determining masculinity and marks the transition from boyhood to manhood” (Marston and King, 2006, p1583). Caribbean research echoes this, generally showing that different messages are sent to boys and girls. There is an acceptance of sexual experimentation, even at an early age, for boys and valorisation of abstinence for girls. Furthermore, males are esteemed for their virility and are granted a freedom that they are expected to exploit (Smith, 1956; Joseph, 1999; Barthelemy, 2000; Besson, 2001; Chevannes, 2001; Wilson, 2001; Bombereau, 2005).

These points of view are reflected in quantitative findings from the Caribbean where males report earlier sexual initiation than females. We need to be cautious with these declarations, since there may be a tendency among boys to over-report and among girls to under-report. Nevertheless, it is clear that in the Caribbean, despite religious discourse encouraging monogamy, society tolerates and in some ways rewards boys who are sexually initiated. Indeed, early male sexuality may be used to provide a testimony of virility.

Brown and Chevannes (1998) from their three Caribbean research fields (Guyana, Jamaica, and Dominica) confirm the idea of sexual activity as a rite of passage to manhood. In fact, “the sooner manhood is established, the better for a young male’s self-image and the sooner parents can stop worrying about this aspects of their son’s maturation” (Brown and Chevannes, 1998, p. 23). According to these authors, early initiation among boys is done with the discreet knowledge of parents and for some with their encouragement (Brown and Chevannes, 1998; Chevannes, 2001).

Hutchinson et al (2007) conducted qualitative research in Jamaica, focusing on cultural factors at the individual, family, and societal levels that influence Jamaican adolescents’ behaviours. They held focus group discussions with 41 adolescents aged 12-18 years old, 16 parents, 10 teachers and guidance counsellors in Kingston, Jamaica in 2004-2005. Boys reported that their mother and to a greater extent their father would approve of them having sex at this point in their life. Parental approval may be combined with an exposure to pornographic material, according to Chevannes (2001), though empirical studies of this have not been conducted.

Despite the general impression that males have a great deal of freedom, there are rules for male sexuality and one of the most important is to be heterosexual. Indeed, some studies show that boy’s early sexual initiation is used to prove that they are not homosexual. The Jamaican qualitative study by Hutchinson et al (2007) documents this:

Many boys cited their fathers and society in general as encouraging them to have sex to prove that they are ‘men’ and not homosexuals. Both male
and female adolescents echoed this theme and described how important it was for boys to prove their masculinity and refute any questions of homosexuality by having sex as often as possible and with as many female partners as possible (ibid., p.12)

Thus two of the leading motivations for early sexual activity among boys seem to be to prove that they are men and they are heterosexual.

 ➢ Peer pressure

For boys, the peer group appears crucial to acquiring information and knowledge about sex and satisfying sexual curiosity. In Hutchinson et al’s study (2007) Jamaican boys reported pressure to have sex from both male peers and female partners. They said they had sex the first time to “follow the crowd”, “to have fun”, and to experience pleasure, and believed that the majority of their peers had sex. Believing that sexual activity is the norm may be an important source of pressure for youth to become sexually active.

Kempadoo and Dunn (2001) conducted 18 focus group discussions among 170 in-school adolescents aged 10-19 years in three communities in Jamaica. This also shows peers play a key role. Boys felt that their male peers encourage them to have sex with girls in order to boost their image. This finding confirms observations made by Wyatt et al (1992) in Jamaica ten years ago.

Peer pressure among girls is also important and shapes the initiation of early sexual activity among adolescent girls. Kempadoo and Dunn (2001) note that efforts to be popular among peers may be important in motivating sexual activity by girls in the current generation. In their study, peer pressure was a strong motivating factor for sex by girls over 13 years old compared to younger girls.

Qualitative research in Barbados echoes the finding about peer pressure on girls to have sex (Barrow, 2007). The author, who focuses on vulnerable adolescent girls between 14 and 16 years old, argues that

Girls achieve a reputation among their friends by boasting about sexual encounters, while others with no such experience are left out of the conversation. Several described being motivated by curiosity and experimentation. Speaking of her first sexual experience, one girl said that she just wanted to know what it would feel like. She was curious because all her friends were talking about it. (Barrow, 2007, p.6)

Recent evidence suggests that girls are linking sexual activity with the acquisition of a female identity. Kempadoo and Dunn (2001) explain that girls have to be sexually active to claim their feminine identity, and they are doing this independently of a desire for children, love or money. Those findings highlight that for girls, losing virginity can be used as a tool to prove that they are “real women”. According to Barrow (2007), a sub-culture in Barbados known as “bashment” defines sexual activity as the norm:

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2 Focus groups were gender- and age group-specific (age groups: 10-12, 13-15 and 16-19 years old). Each group had approximately 10 girls or boys. The process of selection of participants was not described in the paper.

3 The author did not define “vulnerable adolescents”, nor describe the participant selection process.
For *bashment* girls, virginity and sexual inexperience are personal and social burdens, the mark of being an immature girl. Within sexual relationships, especially with older men, they have virtually no capacity to negotiate sexual practice, fidelity or condom use or even to ensure their own personal safety from sexual and physical abuse. They appear to be exposing themselves to maximum risk. At the same time as they seek to reject a prevailing submissive femininity, they also confront a Caribbean masculinity centred on dominant and aggressive heterosexuality (ibid., p.11).

According to these two qualitative studies, female values are changing in the Caribbean society. Nowadays girls identify themselves through sexuality more than motherhood. For previous generations, womanhood was strongly linked with motherhood; the new generation appears to bring an important shift in the perception and practices of sexual intercourse.

- **Pressure from school boys, boyfriends and older men**
  In the study by Hutchinson et al (2007), school boys and boyfriends were cited as sources of pressure on girls to have sex. In some cases, girls were afraid that their boyfriends would look for another girlfriend if they did not have sex with them or if they insisted on condom use.

  This kind of pressure appears to be more difficult to counter when girls are involved with older partner (Allen, 2002b; Barrow, 2007; Kempadoo and Dunn, 2001). Girls may not have the skills to refuse to have sex, especially since the first sexual partners of both males and females was often reported to be a family member or a “big man” – meaning an older adult, often with high social status (Kempadoo and Dunn, 2001).

- **Media as sources of pressure**
  Youth in Jamaica in Hutchinson et al’s (2007) study reported that messages from music, videos, magazines and television give the impression that “everyone is having sex”. As a consequence, having sexual intercourse appears as a norm, and abstinence as deviance.

- **The search for pleasure**
  Among Jamaican boys, pleasure was the main motivating factors for having sex. This factor was also important for girls (Kempadoo and Dunn, 2001).

**Economic needs and transactional sex**

Economic factors may play a role in the age at first sex, especially among girls (see transactional sex section of this report). In Kempadoo and Dunn’s (2001) study, *money to meet economic needs and wants emerged as a dominant motivating factor for girls’ early onset of sexual activity*. Having fashionable clothes and gifts but also more basic needs such as food and going to school were mentioned as motivations for transactional sex. Boys mentioned that they felt that girls often rejected boys as sexual partners in favour of older men with more money. According to the findings,

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4For further details, see the sub-section about sexual abuse and incest.
Boys expressed resentment about what they perceived as incursions on ‘their’ territory by older boys and men. Adult men were seen to hold a power over the boys by being able to take ‘their’ girls away, and the adolescent men seemed to feel quite powerless to contest this (Kempadoo and Dunn, 2001, p34).

Sexual and physical abuse

Early age at first sex may result from sexual or physical abuse (Joseph, 1999; Allen et al, 2000; Kempadoo and Dunn, 2001; Allen, 2002b; Barrow, 2007; Bombereau, 2007). In the Caribbean Youth Health Survey with in-school youth in nine countries, about a sixth stated they had been physically abused (15.1% of females and 16.9% of males), and one-tenth reported sexual abuse (10.9% of females and 9.1% of males). Abuse (either physical or sexual) was found to be a significant predictor of sexual activity, raising the odds of having had intercourse by 1.36 among boys and 2.14 among girls (Blum and Ireland, 2004). In Anguilla, a self-administered national adolescent health survey was carried out by Kurtz et al (2005) among 1225 school students aged 10-20 years old. Multivariate logistic regression analysis revealed that being sexually active was predicted by several factors including a history of physical and sexual abuse.

- Family members
  In Kempadoo and Dunn’s (2001) study, incest was found to be important, as revealed by both Jamaican girls’ and boys’ answers to the question; “Who do you think young girls have sex with the first time?” Most responses referred to someone in the family as girls’ first partners: father, step-father, cousins, uncles and brothers. The first partners of boys were also thought to be family members, such as sisters or cousins.

- Peers - boyfriends
  Chevannes (1992; 1993) highlights abuse of girls by Jamaican schoolboys, including gang rape. He notes that gang rape has been documented to be common in the urban ghettos of Kingston. Kempadoo and Dunn (2001) report that boys, including boyfriends, sometimes use threats of abandonment, ridicule or violence to put pressure on girls to have sex.

Family environment

- Barrel children
  Economic pressures often influence men and/or women in the Caribbean to seek a job away far from home or abroad, which may affect their contribution to child rearing and supervision (Wyatt, 1992). The terms “barrel children” and “Western Union syndrome” have been used to describe children whose parents are outside the country but send goods (often in barrels) and financial remittances to support the children (CAREC, 2007). While other members of the family or the community take care of the children, the lack of supervision by the parents may put youth at risk. In addition, the children may be solicited for sexual relations by their peers since parents regularly send them money, brand name clothes or gifts. Under this situation, there is an associated risk of sexual abuse by adults (family members, teachers).

- Relationship with parents

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5 Sample bias, mean age was 12 years old.
6 For instance: male gender, recent substance use, recent depression.
A quantitative study was implemented in the San Juan metropolitan area of Puerto Rico in 2002 among 425 youth aged 12-16 years in public schools (Vélez-Pastrana et al, 2005). This provides evidence of associations between sexual activity and parenting practices. A significantly greater number of the sexually abstinent teens, as compared with the sexually active teens, reported that they go home after school or that their parents were married. Conversely, a greater number of sexually active teens reported that they never discuss their problems with their families or that their parents frequently ignore them or act coldly/indifferently as a form of punishment.

The clustering of risk behaviours

Kurtz et al’s (2005) findings from Anguillan youth show that users of alcohol and drugs were more likely to have been sexually active. In their analysis of data from the Caribbean Youth Health Survey, Ohene et al (2005) show that young people who had early sexual intercourse, defined as initiating sexual intercourse at or before thirteen years of age, were significantly more likely to be involved in other practices that are potentially damaging to health or can be considered socially deviant. Table 2 shows odds ratios for those who had sexual intercourse engaging in other practices.

Table 2: Odds ratios for risk behaviours associated with early sexual intercourse

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette smoking¹</td>
<td>4.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Alcohol use¹</td>
<td>5.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Marijuana use¹</td>
<td>7.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Ever been in a gang</td>
<td>3.5</td>
<td>3.1</td>
</tr>
<tr>
<td>Violence²</td>
<td>3.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Ever run away from home</td>
<td>3.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Skipping school³</td>
<td>2.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>


Notes:
1. Monthly or higher frequency of use
2. Carrying or fighting with a weapon
3. Skipped school three or more times in the past twelve months

The authors note that the association of sexual experience with other risk behaviours is stronger for females than for males. The cross-sectional design of this study prevented the attribution of causation (for instance, we do not know whether marijuana use was initiated before or after first sexual intercourse). Nevertheless, the findings are important in showing a constellation of risk behaviours among those who are sexually active, and, conversely, that “deviant” behaviours such as gang membership are less common in the sexually abstinent (who, in this survey, comprised 66% of respondents). There seems to be “a common denominator linking a syndrome of risk behaviours in adolescence” (Ohene et al, 2005: 98). In the Caribbean, there is a prevailing notion that early sexual initiation is the norm. These data challenge this notion, showing that it is associated with behaviours that are not generally

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¹ Ten public schools were selected. School selection is not described, nor is the participant selection process. Therefore, based on the paper, it is not possible to determine if the sample is representative of public school youth. Additionally, no detail was provided about the term “public school” (whether it denoted a government school or a fee-paying school).
socially approved. In terms of HIV interventions, the implication is the need to target those youth who are vulnerable to becoming involved in several risk behaviours.

**Protective factors**

In McBride’s study among in-school youth in St Maarten (2005)\(^8\), a “great” relationship with both parents was significantly associated with never having had sex, as opposed to a relationship classed as “OK” or “not good”. However, there was no significant association between sexual experience and relationship with either mother or father individually. The importance of familial relationships was confirmed in Lerand et al’s (2006) analysis of data from the Caribbean Youth Health Survey. They found that “family connectedness” was correlated with older age at first intercourse.

The most thorough-going analysis of risk and protective factors for sexual intercourse among youth was conducted by Blum and Ireland (2004) using data from the Caribbean Youth Health survey. Table 3 shows odds ratios by gender for being involved in sexual activity according to various risk and protective behaviours.

**Table 3: Caribbean Youth Health Survey: odds ratios for sexual activity by risk and protective factors**

<table>
<thead>
<tr>
<th>Risk-associated variables</th>
<th>Odds Ratio (p-value)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rage(^1)</td>
<td>2.93 (&lt;.001)</td>
<td>2.77 (&lt;.001)</td>
<td></td>
</tr>
<tr>
<td>Skip school(^2)</td>
<td>2.82 (&lt;.001)</td>
<td>3.41 (&lt;.001)</td>
<td></td>
</tr>
<tr>
<td>Abuse(^3)</td>
<td>2.14 (&lt;.001)</td>
<td>1.36 (&lt;.001)</td>
<td></td>
</tr>
<tr>
<td>Protection-associated variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family connectedness(^4)</td>
<td>0.41 (&lt;.001)</td>
<td>0.70 (.008)</td>
<td></td>
</tr>
<tr>
<td>Religion(^5)</td>
<td>0.78 (.002)</td>
<td>0.76 (&lt;.001)</td>
<td></td>
</tr>
<tr>
<td>School connectedness(^6)</td>
<td>0.04 (&lt;.001)</td>
<td>0.26 (&lt;.001)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Blum and Ireland, 2004.

Notes: The paper does not show how the variables were dichotomised for risk factor analysis

1. “Do you ever think about hurting/ killing someone?” Possible answers “Never”, “Some of the time” or “Always”.
2. Skipped school in past 12 months: “Never”, “Once or twice”, “Three or more times”
3. Ever been sexually or physically abused
4. Based on five items: “family pays attention to you”, “family understands you”, “can tell mom/ dad your problems”, “mom/ dad cares about you” and “other family members care”. Responses were along a three point scale: from “very little”, “some” to “a lot”.
5. Based on two questions, including religious attendance and the extent to which you see yourself as a religious or spiritual person
6. Based on two questions: “Do you get along with teachers”, “Do you like school?”

---

\(^8\) The sample consisted of 1,078 students (age range 14-18, mean 15.6). The data were collected by self-report survey in the Spring of 2001 in the classrooms of all seven secondary schools in St. Maarten. The survey instrument included questions derived from the Center for Disease Control’s (CDC) Youth Risk Behavior Survey (YRBS) to assess health risk behaviour prevalence, including tobacco, alcohol, and drug use and sexual activity. The survey also asked youth to rate their relationship with their parents.
The authors make several important observations. One is that, with the exception of skipping school, the associations between risk and protective factors and sexual activity were stronger for females than males. Females seemed especially responsive to differences in their social environments and experiences when it came to having sex. A second important finding (not shown in this table) is that increasing protective factors was associated with greater change in sexual activity than was seen by reducing risk. Youth who reported none of the risk factors (holding protective factors constant) were more likely to report having had sexual intercourse when compared with peers who report having all three protective factors (holding risk factors constant at their mean level). By implication, it may be more effective in reducing youth sexual activity to focus on strengthening protective factors, such as family and school relationships, as it is to attempt to reduce risk. Thirdly, the greatest reduction in sexual activity was when school connectedness was entered into the model. Thus improving the relationship between schools and their pupils may be an especially effective risk prevention strategy. The authors conclude that

The present analyses add weight to the findings of both evaluation and behavioural researchers, suggesting that attention needs to be paid to strengthening protective factors in the lives of young people and not solely to focus on risk reduction (Blum and Ireland, 2004).

**Conclusion:**
Several factors play a role in youth sexual initiation. Factors in the social environment have enormous bearing, with sexual and physical abuse and gender expectations playing important roles. Young people who start having sex at a young age are at risk for HIV both at the time of the early sexual encounters and subsequently, since a range of risk behaviours have been found to be associated with early sexual initiation. Supportive family and school relationships are important in protecting young people. Sexually active young people are not necessarily in the majority, but those who are active are also more likely to be involved in other high-risk activities such as weapon-carrying, drug use and gang membership. Attention needs to be paid to especially vulnerable young people in developing interventions.
Multiple-partnership

Background

Quantitative findings (Allen, 2001; Bombereau, 2007) document that, in the Caribbean, a non-negligible minority of the population is involved in multiple partnerships and a higher proportion of men report having more than one sexual partner than women. This gendered finding applies in surveys both of youth and adults (Bombereau, 2007).

Behavioural Surveillance Surveys (BSS) have shown large proportions of men with multiple partnerships. In 4 out of 6 Organisation of Eastern Caribbean States (OECS) countries that conducted BSS with youth in 2006, a majority of young male adults declared more than one non-commercial sex partner in the past 12 months (CAREC, 2007). The percentages of young males who reported more than one non-regular partner ranged from 45% in Dominica to 64% in St Kitts and Nevis and St Vincent and the Grenadines. In BSS with adults in 10 Caribbean countries, the percentage of males who reported having more than one non-regular partner in the past 12 months ranged from 9% in St Vincent and the Grenadines to 36% in St Kitts and Nevis (Bombereau, 2007).

Quite a number of people in the Caribbean who have more than one partner, especially adults, are in fact involved in steady multiple partnering arrangements (Simeon et al, 1999; ANRS, 2004). A quantitative survey with a sample of 3014 participants aged 18-69 years old in the French Caribbean (French Guyana, Guadeloupe, and Martinique) revealed that 33% of the men who reported having more than one sexual partner in the past year also mentioned that they were with those partners for more than one year (ANRS, 2004). Forty-six percent of the men had both recent and longer-established partnerships in the 12 months prior to the survey. In the past five years, 37% of men compared to 80% of the females reported serial partnerships. Conversely, 63% and 21% of male and females respectively mentioned concurrent partnerships. These findings show that many men report concurrent partnerships while women have a greater tendency to report serial partnerships. Again, there is a risk of over-reporting of partnerships by men and under-reporting by females due to society’s double standards of fidelity. Nevertheless, the data suggest a stronger tendency among men to adopt concurrent partnerships.

A national survey in Jamaica among men aged 15-50 years old (Simeon et al, 1999) documents interesting characteristics of men with more than one partner. One-third of the sexually active Jamaican men reported they were having sex with more than one person. According to the analysis, men with multiple partners had sex at an earlier age that those who did not report several sexual partners, and they were more likely to engage in other risky sexual behaviours such as having commercial sex partners and drug use before sex. Interestingly, the analyses showed that these men were also more likely to report that sex may be a method to control their partners.

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9 These figures do not exclude multiple partnerships among adults since they may have a regular-steady partner and one non-regular partner.
11 Recent means with in the past 12 months.
12 The overall sample was 769 men who were sexually active in the past 12 months prior to the survey.
Several socio-cultural factors may explain the high proportion of men involved with more than one sexual partner as well as the involvement of females in multiple-partnerships.

**Caribbean construction of masculinity**

- **Being hetero-sexually active as testimony of masculinity/virility**
  In addition to being sexually active and heterosexual, men should be involved sexually with more than one sexual partner (Joseph, 1999; Chevannes, 1992, 2001; Brown and Chevannes, 1998). For Chevannes (1992) relationships outside of marriage are not only tolerated but valued. Bombereau conducted a multi-method study on HIV/AIDS perceptions in Guadeloupe, including a review of HIV literature in the Caribbean, a review of Caribbean sociological/anthropological literature, participant observation over three years, focus groups, face to face interviews, and quantitative research among health care providers, the general population, and people living with HIV. These all supported the notion that men should be financially capable of supporting all their female sexual partners (Bombereau, 2004a and 2004b). Moreover, masculinity requires impregnating women. The number of children appears as a proof of manhood, whether it is within or outside a steady relationship (Andre, 1987; Allen, 1997; Bombereau, 2005; Brown and Chevannes, 1998; UNESCO, 2002). **Manhood is linked with the financial capacity to support several women and children.** Men need to achieve biological reproduction, family reproduction and social reproduction (Bombereau, 2004a).

More recently, qualitative research by Plummer (2007a) in Guyana, Trinidad and St Kitts on Caribbean masculinities highlights the current **valorisation of hard and risky masculinities**: what has been called “hyper-masculinities”. **Codes of masculinity have become harder** and men feel the pressure to ensure that their behaviours conform with prevailing masculine standards. Men earn their status by taking risks, including sexual risks.

In contemporary male culture, masculine status is enhanced greatly by displays of sexual prowess, physical toughness and social dominance. Having multiple sexual partners earned respect while being faithful meant losing face (Plummer, 2007a, p.6)

For many adolescent boys:

  The authority of the peer group at least competes and frequently exceeds the authority of any of the adults who feature in the boys lives (ibid., p.4).
  Meanwhile, the classroom no longer holds as much value for boys in establishing their masculine identity and it is therefore less attractive to them (a ‘flight from academic achievement?’). Indeed boys who do achieve in academic pursuits are at risk of being considered ‘suspect’ by their peers and of becoming the subject of gender taboos (ibid., p.1).

Bailey et al (1998) similarly documented that boys, and especially those deeply involved in street culture, need to develop several relationships with women and need to do it in “an expansive and expressive fashion so as to provide themselves with a reputation and with the symbolic values of the culture.” (Bailey et al, 1998, p. 13)
In Jamaica, Hutchinson et al’s respondents gave various reasons why males have multiple partners:

Boys reported having multiple sexual partners because ‘one girl cannot achieve everything he wants her to do’, and boys ‘like to think they’re pimps’ and achieve ‘the status of a player’. One young man summed it up as, ‘it’s all about the game’. Many boys reported that girls often do not know that the boys have more than one partner. Even if girls do find out that their boyfriend has more than one partner, they stay ‘for pleasure’, ‘for love’, ‘for money’, ‘because she wants a guy to defend her’, and ‘as long as she thinks she’s number one’ (Hutchinson et al, 2007, p.13).

Additionally, the belief that repression of sexual urges and abstinence may result in poor mental and physical health has been argued to lead men to have several partners (Joseph, 1999).

- **Evidence of not being homosexual**
  Homosexuality is judged deviant by the general population in the Caribbean (André, 1987; Chevannes, 2001; Pourette, 2002b; Bombereau, 2002, 2004a). Homophobia in the Caribbean is a central organising principle of the cultural definition of masculinity. As a consequence, the fear of being identified as a homosexual plays a critical role in the decision to be involved with several female sexual partners. As highlighted by Plummer,

  There was considerable social pressure to ‘take’ more than one sexual partner and this practice was bolstered by homophobic stigma for men who ‘failed to measure up’ (Plummer, 2007a, p.6).

- **Female acceptance of men with multiple partners**
  Based on her qualitative study in Guadeloupe, Bombereau (2004b) highlighted the tolerance among women of men with multiple partnerships. They accepted the male practice as a norm. In Barbados, Barrow (2007) echoed this analysis by documenting that adolescent girls expect their sexual partners to have other partners.

Research shows that **women may fear losing economic resources by breaking up with a man, so they are prepared to share him** (Le Franc et al, 1996). This sometimes even occurs if they are involved in relationships that they perceive to be risky, e.g. in which the man refuses to wear a condom and is having sex with other women and men (Jewkes et al, 2003). Some women cannot challenge their partner’s infidelity without putting their economic security and their physical safety at risk (Heise and Elias, 1995). Le Franc et al, in their qualitative study among female informal commercial importers and free trade zone workers in Jamaica, noted that willingness to accept that their male partners had other partners was related to the economic insecurity the women experienced in their own lives in terms of fluctuating income and lack of job security (Le Franc et al, 1996).

**Family environment**
Based on the results of a self-report survey, McBride (2005) shows that in St Maarten, young people with a “great” relationship with their father had a significantly greater average number of partners over the past 3 months than those without that relationship. On the other hand, a
“great” relationship with mother was significantly related to fewer lifetime sex partners. A “great” relationship with both parents was not significantly related to number of partners.

Leo-Rhynie (1998) mentions that some children are cared for by a succession of different people and have difficulty in establishing stable adult relationships later on. According to the author, the lack of emotional support in childhood may lead to a lack of self-esteem during adolescence and adulthood, resulting in involvement in serial or concurrent multiple-partnerships.

**Economic pressures on women to seek new partnerships**

Some studies document multiple partnerships among women as an economic survival strategy. Often, these multiple partnerships are established independently of love or pleasure seeking (Wyatt, 1992; Heise and Elias, 1995). Le Franc et al (1996), in their focus group study among working women in Jamaica, remind us that women with serial partnerships and several “baby-fathers” have been common in the Caribbean for a long time. Both Wyatt et al (1992) and Le Franc et al (1996) refer to multiple partnerships among women as a means to cover economic needs and provide additional support for children. As a consequence they expose themselves to sexual risk by having several sexual partners under conditions where condom negotiation remains difficult.

**Sexual and physical abuse**

Women who experienced sexual abuse in early life (child sexual assaults, forced first intercourse) are more likely subsequently to have several sexual partners, including concurrent relationships (Dunkle et al, 2004). This review did not find studies of this phenomenon in the Caribbean.

**Migration**

Migration may put both the migrants and their sexual partners who stay at home at risk for HIV. Isolated from their family for economic reasons, migrants on sugar cane plantations\(^{13}\) (Brewer et al, 1998), farms (Gadon et al, 2001), gold mines\(^{14}\) (Palmer et al, 2002) and military installations (Kane, 1993\(^{15}\)) have been shown to be at high risk by having multiple sex partners, including commercial partners.

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13 HIV seroprevalence was 5.7% among women in sugar plantations in the Dominican Republic.
14 HIV seroprevalence among men in a gold mining camp in the Amazon region of Guyana was 6.5%.
15 Abstract only available.
Transactional sex

Background
In the Caribbean, poverty co-exists with consumerism. Under these circumstances, trading sex for material items, gifts, basic needs, security and money is encouraged (Bastide, 1996; Benoit, 1999; Barthélemy, 2000; Barrow, 2004). This occurs as an informal survival strategy for both sexes (CAREC, 1996; CAREC, 1998; De Groulard et al, 2000; Allen, 2002). However, since unemployment, insecure informal labour and poverty are higher among women than men, evidence of transactional sex among women is higher and more heavily documented. According to the international (Dunkle et al, 2004) and Caribbean literature there is a need to consider transactional sex within the context of both gender-based economic disparities and the high prevalence of gender-based violence in sexual relationships (Allen, 1997; Barthelemy, 2000; Dunkle et al, 2007). Persons involved in these relationships find it difficult to negotiate for condom use or to choose partners who engage in less risky practices (Barrow, 2004; Dunkle et al, 2004; Dunkle et al, 2007; Barrow, 2007; Hutchinson et al, 2007). In addition, they are at greater risk of physical and sexual violence, and may be unable to put an end to the relationship as they would like (Barrow, 2007; Dunkle et al, 2007; Le Franc et al, 1996). Exchange of sexual favours for money or goods may happen within the context of stable relationships (Allen, 1997 referring to Chambers and Mitchell-Kernan, 1993) or with “outside”, or additional, non-primary partners (Le Franc et al, 1996).

Data from BSS implemented in 2005 in the OECS show that transactional sex reports were higher in Grenada compared to the five other OECS countries. In fact, 19% of the boys aged 15-24 years old reported having received drugs in exchange for sex in the past 12 months prior to the survey compared to less than 5% in the five other OECS countries16. Anecdotal reports during the dissemination workshop mentioned that this may be related to difficult economic, psychological and emotional situations after the hurricane in 2005. This explanation underlines the link between economic issues and transactional sex (CAREC, 2007).

According to the Caribbean literature, various situations have been explored regarding transactional sex depending on the persons involved (girls or boys, older women or men), and also upon the nature of the exchange: material items, gifts, drug, cash, transport, basic needs. Economic vulnerabilities tend to reduce people’s ability to define the terms of the relationship and therefore influence vulnerability to HIV infection.

Material interest, security and identity construction
For some women and especially adolescent girls and young women, transactional sex may be a means to improve daily life.

Studies have documented this in Jamaica (Allen, 1997), in Tobago (Allen, 2002a, 2002b), in St Martin (Benoit, 1999) and in Barbados (Barrow, 2004, 2007) and refer to the culture of materialism to better understand the phenomenon of transactional sex. Allen (1997, referring to Chambers and Mitchell-Kernan’s study in Jamaica (1993), mentions what is referred to as “red-eye sex”: an exchange of sex to gain material items (fine shoes, jewellery, brand names.

16 Namely Antigua and Barbuda, Dominica, St Kitts and Nevis, St Lucia and St Vincent and the Grenadines.
goods, clothes, etc.) that are status symbols. Girls and women involved in this type of transaction already have their basic subsistence needs met but they seek extra money to strengthen or acquire a better social status.

Gender power and age imbalance are important. In Barbados, Barrow (2004) refers to the exchange of sex for material gains and documents the “sugar daddy” syndrome among girls.

Anecdotal evidence repeatedly speaks to the prevalence of a sub-cultural practice locally known as the ‘sugar-daddy syndrome’ – the involvement of school girls in regular, unprotected sex with older men in exchange for brand-name clothing and other material goods, even food and other basic necessities. The commodification of young girls’ sexuality is not new to the Caribbean. These older man/younger girl liaisons have a long history and are, in all probability, much more culturally embedded and widespread than is generally believed.

In further qualitative research (2007) the author refers to this type of relationship among Barbadian girls as being central to the “bashment” cultural complex. The findings show that young girls are involved sexually with men known as a “bad boy”, “gangster”, “thug”, “moneyman” or “ghetto man”. Those men enhance girls’ reputation and popularity but also provide physical protection. The researcher points out that:

The disruptive femininity of bashment may, for these girls, represent resistance to a highly restrictive and disempowering hegemonic femininity (and youth) that has dominated their lives. Perhaps, by crossing the boundaries into risk performance they are challenging feminine norms strongly encoded as passive, submissive, virgin and victim, and escaping from a social construct of adolescent girl that denies their sexuality and emerging adulthood, and condemns them to the dullness and boredom of being a good ‘li’l girl’ (Barrow, 2007, p11)

Research in Jamaica among adolescents (Kempadoo and Dunn; 2001) shows respondents referring to “big men” such as drug dealers or taxi drivers as attractive for some young girls by providing clothes, gifts, free rides, etc. This underlines the fact that older men provide, in addition to the transaction, higher social status and protection. Again, reference is made to the materialistic and “fashionable” aspect of the exchange.

Hutchinson et al’s analyses (2007) echo these findings, referring to “big men” and “dons” as common partners for adolescents girls. Interestingly, the authors point to the connivance of some parents who are aware of the unbalanced relationships but prefer to close their eyes because of the financial rewards involved:

Big men were defined as older male partners who had money and/or power; Dons were very powerful men in the community who may be drug lords and/or gang leaders. Girls reportedly engaged in relationships with big men to obtain things they wanted and needed such as clothes, money and favours. One group of students estimated that more than half of girls their age were involved with a big man.

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17 This term describes an older male who provides financially for his much younger sex partner (male or female).
Several groups mentioned that some parents knew their daughter had a big man, but they ‘look the other way’ because some big men may provide girls’ families with favours or money (Hutchinson et al, 2007, p.15)

Barrow’s research (2007) refers to the girls’ perception about ideal age of boyfriend. The girls, who were between 14 and 16 years old, indicated that the appropriate age of a boyfriend would be between 19 and 23 years. Girls’ answers confirm that they are not attracted to their peers, who according to them “act like two years old”, “get on like little boys”, are “always running ’bout and play wid marbles”, and were described as “little freaks” - “nasty”, “vulgar” and “immature”. A relationship with one of them would be “totally embarrassing” (Barrow, 2007, p.6).

Literature in the Caribbean also addresses transactional sex between males. Some men and boys have sexual intercourse with men for economic reasons and not because of sexual orientation or preference (CAREC, 1996; CAREC, 1998; De Groulard et al, 2000; Allen, 2002; Hutchinson et al, 2007). They may engage in sex for brand name shoes and other clothing (CAREC, 1998). Some of these boys and men provide sex to male or female tourists in exchange for goods and services (CAREC, 1996; CAREC, 1996; De Moya and Garcia, 1999). According to Hutchinson et al (2007) in Jamaica, boys who exchange sex for goods are usually homeless, and this situation is taboo and not often discussed.

Male-female relationships as an economic bargain

In the Caribbean, the concept of a relationship is commonly portrayed as a meeting between men’s sexual interests and women’s economic interests (Bastide, 1996; Benoit, 1999; Barthelemy, 2000; Chevannes, 2001; Barrow, 2004; Bombereau, 2005). Barthelemy (2000), based on his research in Haiti, notes that the concept of a couple is based on the idea of a “gift” and “counter gift” mechanism. The women are invited to offer sexual pleasure to men and women receive gifts and/or income in exchange. Gift and counter-gift are documented as an informal survival system for women, who may have several sexual partners to meet their perceived needs. According to the author:

These women do not express pleasure, nor do they desire sex, as such. Note that it is the women themselves who establish and maintain this image of their sexuality. They go as far as blocking or hiding their orgasms from their partners to give the impression that sex holds no intrinsic interest for them. When they are talking among themselves, however, this does not prevent them from recognising their own desires and from describing their experiences of pleasure in vivid terms. Thus it is only vis-à-vis their male partners that they refuse to share the intimate secret that they have their own sexuality. According to them, doing ‘that’ only for pleasure would be a waste and a frivolous act (Our translation of Barthélemy, 2000, p. 310)\(^\text{18}\)

\(^{18}\)French original: «Les femmes n’éprouvent pas de plaisir et ne désirent pas le sexe, en tant que tel. Notons que ce sont les femmes elles-mêmes qui établissent et maintiennent cette image de leur sexualité. Elles vont même jusqu’à tenter de bloquer ou de cacher à leurs partenaires leurs orgasmes afin de conforter physiologiquement l’idée que le sexe ne représente pour elle aucun intérêt en soi. Lorsqu’elles sont entre elles, cependant, cela ne les empêchera nullement de reconnaître éloquemment leurs propres désirs et de décrire leurs expériences du plaisir en termes brillants. C’est donc uniquement vis-à-vis de leurs partenaires masculins qu’elles refusent de partager
This renunciation of pleasure does not arise from a sense of propriety, as one might think. On the contrary, it is supported by a gamut of behaviour which aims to obliterate all signs of feminine pleasure in the eyes of the partner, thus rendering the man prisoner of his own desire. (Our translation, ibid., p. 313).

Thus the exchange of sex for goods or material items involves women in denying or hiding their own sexual pleasure so that providing sex appears to be a gift to men, for which an exchange of goods or money is necessary:

The woman who offers pleasure to a man as a gift, via her body, has to refuse it to herself, and it is in renouncing her own pleasure that she will acquire the power to initiate the process of gift-giving. (Our translation, ibid., p. 322).

Chevannes (2001) advances our understanding of this by mentioning that transactional sex may appear as a marker of masculinity. The male has someone dependant on him; he assumes his responsibility.

Studies in Africa echo these findings (Jewkes et al, 2003; Desmond et al, 2005). In fact for Jewkes et al, “after a night together it is quite common for a woman to be left money for cosmetics by her boyfriend.” In Tanzania, Desmond et al, document that transactional sex is not badly perceived by the population. Moreover, it helps identify a “good guy” who assumes his male responsibility by being a good provider.

**Violence**

Violence can be associated with transactional sex and thus increase risk for HIV infection. For further details, see the section on interpersonal violence and aggression.

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French original: « Cette renonciation à l’énoncé de plaisir n’est nullement de la pudeur comme on pourrait le croire. Elle est, au contraire, soulignée par tout un comportement qui vise à oblitérer aux yeux du partenaire toutes les marques du plaisir féminin, rendant ainsi l’homme prisonnier de son seul désir ».

19 French original: « Cette renonciation à l’énoncé de plaisir n’est nullement de la pudeur comme on pourrait le croire. Elle est, au contraire, soulignée par tout un comportement qui vise à oblitérer aux yeux du partenaire toutes les marques du plaisir féminin, rendant ainsi l’homme prisonnier de son seul désir ».

20 French original: « La femme qui offre, comme un don, à travers son propre corps, le plaisir à l’homme doit de refuser simultanément d’en prendre pour elle-même et c’est en renonçant à son propre plaisir […] qu’elle acquerra le pouvoir de mettre en route le processus du don. ».
Commercial sex work

Background

HIV seroprevalence surveys conducted in the region have demonstrated that commercial sex workers (CSW) are especially vulnerable populations for HIV (table 4).

Table 4: HIV seroprevalence estimates from surveys with female commercial sex workers

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Characteristics of sex workers</th>
<th>Percentage found to be HIV positive</th>
<th>95% confidence interval</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guyana</td>
<td>1993</td>
<td>Females in Georgetown recruited in sex work locations including streets, commercial sex establishments (brothels), hotels, bars and the port</td>
<td>25%</td>
<td>17 to 33%</td>
<td>Carter et al, 1997</td>
</tr>
<tr>
<td>Guyana</td>
<td>1997</td>
<td>Females in Georgetown recruited on the streets and in commercial sex establishments</td>
<td>46%</td>
<td>Not reported</td>
<td>Persaud et al, 1999</td>
</tr>
<tr>
<td>Guyana</td>
<td>2000</td>
<td>Females in Georgetown recruited in sex work locations including streets, commercial sex establishments, hotels, discos, bars and the port</td>
<td>31%</td>
<td>25 to 36%</td>
<td>Allen et al, 2006</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1995</td>
<td>Females in Montego Bay</td>
<td>25%</td>
<td>18 to 33%</td>
<td>Douglas et al, 1997</td>
</tr>
<tr>
<td>Suriname</td>
<td>1996</td>
<td>Females working on the streets</td>
<td>22%</td>
<td>Not reported</td>
<td>Suriname National AIDS Programme, 1996</td>
</tr>
<tr>
<td>Suriname</td>
<td>2005</td>
<td>Male and female</td>
<td>24%</td>
<td>19 to 30%</td>
<td>Maxilinder foundation, 2004</td>
</tr>
</tbody>
</table>

Behavioural and seroprevalence surveys have identified aspects of the social environment of risk-taking and risk factors for HIV among sex workers.

establishments were significantly more likely to report consistent condom use and at last sex with their clients than women working on the streets. However, no difference between street- and commercial sex establishment-based workers was found regarding the rate of HIV seroprevalence: roughly 46% of the surveyed women were HIV positive. Additionally, 28% had a positive serological test for syphilis. According to the analyses, the factors that were significantly associated with HIV infection included a positive serological test for syphilis and a history of having received treatment for syphilis.

Three years later, another cross-sectional study was conducted in 2000 in Georgetown, Guyana (Allen, 2002; Allen et al, 2006) among 299 female sex workers (FSW), sampling a greater number of locations of sex work across the city than the 1997 survey. The profile of the HIV positive women was as follows:

- HIV infected sex workers were more economically vulnerable than those who were HIV negative: they lived in poorer, downtown areas, and had poorer and Guyanese (as opposed to foreign) clients.
- They were more likely to be involved in risky behaviours such as cocaine use, regularly getting ‘high’ on alcohol, exchange of sex for drugs, anal sex, and not changing condoms during group sex.

In multivariate logistic regression analysis, significant positive associations were found between HIV infection and having a vaginal ulcer in the past 12 months, getting condoms from public sector STI services, not going back for HIV test results and getting tested for HIV more than six months ago. Having had a vaginal ulcer was associated with use of cocaine. Results suggest the need to integrate STI screening and treatment services with substance abuse services. Condom promotion services are reaching sex workers at high risk, but HIV stigma may prevent them from accessing HIV test results (Allen et al, 2006).

A survey by Alegria et al (1994) among 127 Puerto Rican sex workers documented the need to examine the psychological conditions of FSW in order to tailor risk reduction strategies for them. The authors explored associations between SW’s psychological status, their HIV serostatus and risk behaviours. The majority of FSW were found to suffer from depressive symptoms and those with high depressive symptomatology were more likely to report behaviours that placed them at risk for HIV infection (i.e. drug use, unprotected intercourse with clients). The paper documents higher levels of depression symptoms among:

- Street-based sex workers compared to those based in commercial sex establishments,
- Women who engaged in inconsistent condom use compared to women who engaged in protected sex, and
- Women who tested positive for syphilis compared to those with negative results.

The results suggest that mental health issues, such as depression and addiction, should be considered in interpreting HIV risk behaviours among sex workers, and in behavioural interventions with them.

Factors that influence the vulnerability of CSW include the following.
Illegality and stigmatization of sex work

Commercial sex work is illegal in almost all the Caribbean countries. In addition, strong social and religious stigma exists against sex workers (IHAA, 2003). This reduces access to prevention, care, and treatment services.

Illegality and underground activity may add to vulnerability. In Trinidad, the International HIV/AIDS Alliance found evidence of exploitation of sex workers by police, including sexual abuse and corruption. Legal systems do not provide protection for CSW and their sexual activities put them at a risk of discrimination and isolation and eventually further risk of infection (IHAA, 2003).

The health outcomes of such a situation have been documented by IHAA (2003) and by Allen et al (2006) by highlighting that accessing information, condoms, services and care is difficult due to high level of stigmatisation and discrimination against FSW. Thus they are hesitant to come forward for HIV testing. Limited access to services is a particular problem for foreign sex workers who do not speak the local language and may be in the country illegally. In some countries, acquiring key commodities such as condoms and lubricants remains difficult and some STI clinics remain unfriendly to CSW users (IHAA, 2003).

Economic insecurity and migration

CSW are often in situations of extreme economic insecurity, increasing their migration and movement, weakening their access to services and increasing their sexual contact with partners from different countries and geographical areas (International HIV/AIDS Alliance, 2003; CAREC, 2007). Clients may be locals, migrants, tourists or visitors, including business travellers (Allen, 2004).

Based on their survey in Puerto Rico among 311 women between 18 and 34 years old recruited from low-income urban neighbourhoods of visible drug traffic, Hansen et al (2002) documented how CSW worked under pressure to meet basic material needs. A direct consequence of this survival situation is that getting HIV is not their primary concern.

With money earned from clients, they fed and clothed their children, helped their parents, and maintained themselves. In this context, often their fear of HIV and AIDS seemed less immediate than the day-to-day survival of their families and themselves. The women interviewed were aware of the HIV risk that their drug use and sexual practices presented, as reflected in the reasons that they gave for their estimation of their chances of having HIV (e.g. sex without condoms, sharing needles or injection equipment). Yet HIV/AIDS was, for the majority, not perceived as the most important risk that they faced in their daily lives, but rather one risk among others such as murder, rape, overdose, or other diseases. (Hansen et al, 2002, p6)

Negotiations with clients focused on the amount of payment and the specific sexual services to be provided. Only a few women reported condom negotiation up front (before sex) (Hansen et al, 2002).
Perception of risk and condom use

There is evidence that some sex workers estimate their risk of getting HIV using their own evaluative criteria. In Puerto Rico, Hansen et al (2002) document how FSW established a classification based on clients’ perceived characteristics. Clients who were married, well-groomed, smart, young and/or physically attractive were seen as more likely to be HIV negative. Additionally, using condoms with regular clients was thought to symbolise mistrust.

Sex workers may be unwilling to use condoms within relationships they regard as private and emotional. Unprotected sex appears to be a way to introduce a distinction between work and emotional relationships with non-paying partners (Heise and Elias, 1995).

Hansen et al (2002) document another aspect of condom use among sex workers. Referring to the work of Kane (1998) in Belize, the authors note that whether or not the women are comfortable with being defined as sex workers influences their decisions about whether to use condoms.

Local women who work from bars do not define their sex-for-money exchanges as sex work because they want to avoid the stigma attached to prostitution. They define themselves as being in intimate relationships with their clients. Because condoms are associated with prostitution, they do not use condoms with these clients. (Hansen et al, 2002, p3)

According to CAREC’s review of BSS among sex workers (Bombereau, 2007b), only 20% of FSW in Jamaica (2000) and 37% in Guyana (2004) mentioned having consistently used a condom **with a non-paying or regular, non-commercial partner** in the 12 months prior to the survey. In 4 out of 5 surveys (Jamaica, FSW, 2000; Guyana, FSW, 1997; Guyana, FSW, 2000; Guyana, FSW, 2004), over 60% of the females in each country reported having used a condom consistently **with clients (commercial partners)**. In the remaining survey (Suriname, male and female sex workers, 2004), only 25% of sex workers reported consistent condom use. The highest percentage of consistent condom use with clients was among female sex workers in Jamaica (77%).

Interventions to address HIV risk among commercial sex workers

There is very little peer-reviewed literature documenting the development and evaluation of interventions to reduce the vulnerability of CSWs to HIV infection. A notable exception is the work of Kerrigan et al (2003 and 2006) in the Dominican Republic.

Efforts to reduce sex workers’ vulnerability to HIV have frequently relied on individual-level interventions such as condom promotion and management of STIs. Kerrigan et al (2006) tested the idea that implementing “environmental-structural” interventions would increase condom use and decrease STI prevalence.

Two “environmental-structural intervention” methods were implemented over a one year period:

1. **Mobilisation to build community solidarity** for prevention. Activities included workshops and meetings with sex-workers, owners and managers of sex establishments and other employees such as doormen and deejays in an effort to strengthen and support sex workers in persuading their partners, paying or non-paying, to agree to use condoms. The
gatherings explored issues of intimacy and trust in condom use negotiation. Establishment owners were encouraged to create a supportive environment using methods such as putting up posters to promote condoms, providing condoms in glass bowls and deejay messages about safer sex.

2. **Government policy to mandate condom use in sex establishments** (the 100% condom use policy). Sex establishment owners were told that they, not the sex workers, were responsible for ensuring compliance with the policy. For those who did not comply, government officials imposed a graduated series of warnings, fines, and sanctions, including closure of the establishment.

In Santo Domingo, the capital city, the community solidarity model was implemented. In Puerto Plata, a tourist city, the community solidarity model and the 100% condom use policy were implemented simultaneously. Both were evaluated via pre- and post- intervention cross-sectional behavioural surveys, STI testing and participant observation.

In both cities, there were increases in condom use with new clients as well as other improvements in the study’s key outcome variables. However, only in Puerto Plata:

- Consistent condom use rose significantly for regular paying and non-paying partners.
- The proportion of sex workers who rejected having sex without a condom rose significantly
- The proportion of women testing positive for one or more of three STIs fell significantly
- Compliance with project elements by sex establishments increased significantly,

Multivariate statistical analysis showed that:

- Observed compliance with the intervention was the only variable significantly associated with lower STI prevalence.
- A high level of exposure to the intervention was the only factor significantly associated with consistent condom use with all partners

The authors concluded that interventions combining community solidarity and government policy to mandate condom use demonstrate positive effects on the reduction of HIV and STI risk among female sex workers. The gains in Puerto Plata were probably linked to the ability of the combined model to achieve higher levels of compliance with elements of the intervention.

Kerrigan et al’s study was impressive in its methodological rigour and the achievements of the intervention. However, such an approach to reducing HIV risk may not be acceptable and appropriate in all Caribbean contexts. Implementation of such a policy requires acknowledgement by policy-makers that commercial sex establishments exist and willingness to work with, and where appropriate penalise, owners of these establishments. This entails a shift in focus away from the sex workers as the sole sources of risk of HIV in commercial sexual encounters. On a practical level, many sex workers work from the streets and a variety of other locations, such as bars, that are not (at least on the surface) primarily in the business of selling sex. Imaginative ways would need to be found to involve the owners of other types of businesses. Outreach activities should aim to reach street-based CSW and those who operate independently, as well as their clients. Interventions should be designed and evaluated according to the way sex work is organised locally.
Studies evaluating interventions as rigorously as Kerrigan et al.’s for their effects on risk behaviour and STI are rare in the Caribbean. Our findings suggest the need to conduct more research to design and evaluate interventions addressing aspects of sex worker experience including mental health, acceptability and accessibility of testing and treatment services (especially for migrant sex workers) and perceptions of risk with different types of partner.
Condom use

Background

A review of Caribbean HIV BSS and Knowledge, Attitudes, Practices and Belief (KAPB) surveys (Bombereau, 2007a) found 8 surveys conducted between 2000 and 2006 in which young people aged 15-24 reported on condom use at first sex. In 5 out of the 8 surveys, over half of respondents reported using a condom during their first sexual encounter. The percentage of youth who reported using a condom at first sex ranged from 35% in St Vincent (2006) to 76% in Dominica (2006).

The same review of 8 surveys showed that more males than females knew a place to find condoms. The highest gap was found in Haiti, where only 6 out of 10 females aged 15-19 years old knew a place to find condom compared to 9 out of 10 males (Bombereau, 2007a).

Thirteen surveys with young people asked them about consistent condom use over the past 12 months. In 10 of these 13 surveys, less than half of the surveyed youths indicated that they used condoms every time they had sex in the past 12 months. In 8 of the surveys, a third or less of the youth indicated using a condom consistently. In Haiti, St Kitts and Nevis, St Vincent and the Grenadines and St Lucia, only about 2 out of 10 youths, regardless of gender, declared having used a condom every time they had sex with a non-regular, non-commercial sex partner.

Similar findings were found in reviewing 7 surveys among adults. Across all 7, over half of the respondents indicated that they did not use a condom every time they had sex in the past 12 months.

There is limited evidence of increase in condom use among adults and young people. In Jamaica, repeated surveys among young adults aged 15-24 years old show a rise in condom use among males only. Condom use by females did not increase between 1996 and 2004 (Norman et al, 2007). However, among women reporting sex with a non-regular partner, condom use at last sex reportedly increased from 37% in 1992 to 67% in 2000 (Figueroa et al, 2007).

Available evidence suggests that at first sex, condom use is more common among girls than boys. The reverse can be observed among young adults and adults, where condom use (at last sex and consistently) is greater among males (Norman, 2003; Bombereau, 2007a) and within non-regular relationships (Norman, 2003).

These patterns may be explained by various factors and, as shown in this section, some of these go far beyond the simple concept of individual risk perception.

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21 The 8 studies were conducted in 7 countries.
23 Data were from 7 surveys in 7 countries: 6 OECS, 25-29 years old, 2006; Haiti, males, 25-49 years old, 2000.
**Taboos concerning discussion of sexuality**

According to various pieces of qualitative research, in several Caribbean countries there is a lack of communication about matters of sexuality, between parents and children and between sexual partners. In particular, discussion about use of condoms is rare (Allen, 2000; Kempadoo and Dunn, 2001; Bombereau, 2003; Mc Bride et al, 2005; Hutchinson et al, 2007; Barrow, 2007). These findings echo the analyses of Marston and King (2006) based on their worldwide meta-analysis of qualitative studies. Intergenerational communication about sex is rare.

In Tobago, Allen et al (2000) found that this culture of silence exists at various levels of the society. There is a lack of communication between males and females within a relationship, between parents and children, between religious leaders and their congregations, between teachers and students. According to youth respondents, adults often condemn and criticize sexual activity without showing understanding or support.

Research in Jamaica (Hutchinson et al, 2007) echoes some of these findings. Though all parents reported that they had spoken with their adolescents about abstinence, only half of them reported that they had spoken with their children about HIV/AIDS, and a similar proportion reported that they had enough information on HIV/AIDS to talk with their children about it. Though most adolescents reported talking to their mother about sex, few indicated discussion on birth control and condoms. Similar findings regarding poor communication about sexual matters within the family are reported by Kempadoo and Dunn (2001) in Jamaica, Mc Bride et al (2005) in St Maarten and Barrow (2007) in Barbados. Barrow notes that

> The messages they [girls] received from their parents and families, teachers, guidance counsellors and priests effectively either denied or condemned their sexuality, thereby silencing their questions and concerns, and failing to provide them with alternative choices and, perhaps, a safer sexual culture (Barrow, 2007, p.8).

The lack of discussion with parents is not compensated by open discussions between sexual partners. Despite assertion of claims for sexual pleasure among many young people, there is a lack of open communication between the sexes. For Brown and Chevannes (1998), male-female relationships are characterized by high degrees of distrust and disillusionment.

> Men generally defend their rights to, or need for multiple partners, while it is unacceptable for women to have more than one partner. The relationship is a power relationship in which the man tries to dominate and feels this is his God-ordained right. Much of the stability of the relationship, however, depends on a man's earning power. When he cannot provide financially, he often leaves or is pushed out of the family (Brown, 2002).

As noted by Joseph (1999), such “power imbalances between men and women make sexual communication difficult”.

A study of predictors of consistent condom use was implemented in Kenya, Tanzania and Trinidad (Norman, 2003). Based on hierarchical regression modelling, the researcher showed that factors positively associated with consistent condom use were:

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24 The sample was 4293 adults from Kenya, Tanzania and Trinidad.
• having non-steady relationships,
• being male,
• living in Africa (vs. Trinidad),
• higher educational level,
• perceived ease in requesting condom use and
• making requests for condom use.

Notably, people who reported asking their most recent sex partner to use condoms were four times more likely to use condom at every sexual intercourse than persons making no such request. **Findings highlight the importance of communication within the couple in order to increase condom use.**

**Misperceptions of risk based on Caribbean sexual norms**

➢ **Protection by not belonging to identified risky sub-populations**

In the Caribbean, assessment of personal risk for HIV may be unrelated to sexual activities. Risk management or the feeling of immunity may be influenced by a coherent cultural system rather than rational medical knowledge.

In Guadeloupe, Bombereau (2002; 2004a) found that, in the view of the general heterosexual population, HIV in the Caribbean is more prevalent among people who fall into any of four stereotypes considered as deviant: sexual vagrants\(^\text{25}\), men who have sex with men, unfaithful women and female sex workers. Most people do not recognise themselves in these profiles and therefore do not perceive themselves at risk for HIV (Allen, 1997; Bombereau, 2002, 2004a; White et al, 2005). A notable finding of Bombereau’s research was that men with multiple partners were not seen as deviant except if they failed to be emotionally involved or to provide financial support for their partners. **Caribbean men recognized heterosexual HIV risk only among men they regarded as sexual vagrants – men who had casual partners without any ties or strings attached** (Bombereau, 2003; 2004a).

Another example of risk misperception was documented by Barrow (2007) in Barbados. In the view of girls in her study, **serial monogamy constitutes safe sexual practice**. Women involved with more than one partner at the same time are thought to be at risk, but not those who are successively faithful to one single sexual partner.

These findings appear to result from the cultural validation of men with multiple partners and women who have a series of partnerships successively. As noted above, such partnership patterns have a long history in the Caribbean and may be related to the need to demonstrate virility among men and the need for economic security among women.

Additionally, Bombereau (2002) documents how people justify not using condoms by referring to concepts of immunity. Young adults and adults reported that they did not need to use condoms because they were already “protected”. Immunity criteria used to judge the safety of potential partners included:

\(^\text{25}\) This expression denotes “promiscuous” men who have one-night-stands and casual sex, without financial or emotional involvement.
1. **Social profile.** For instance, if a sexual partner belonged to a “good” family, meaning a wealthy, well-known and “rich” family, there was no risk of getting HIV from this person.

2. **Proximity.** Knowing the person for a while, for instance if s/he lived in the neighbourhood, appeared to offer immunity.

3. **Physical characteristics.** If a persons is good-looking, looks wealthy, and has no disease symptoms (e.g. thinness, skin marks), s/he cannot be HIV infected.

These findings echo analyses by Marston and King (2006), who note that youth evaluate their own risk based on unreliable indicators (e.g. how well they know their partner socially, partner’s appearance, and social position).

**Condoms as symbolising mistrust or infidelity**

Studies have shown that suggesting condom use can introduce distrust into relationships (Maman et al, 2000; Jewkes et al, 2003; Steiner, 2005), or will signify that the relationship is not a serious one. Condom-use will damage intimacy between partners. For some women, requesting condom use may jeopardize the future of the relationship (Allen, 1997). Moreover, the “exchange of fluids” is important in establishing a relationship (Hutchinson et al, 2007).

**Lack of skills**

- **Fear and misinformation**
  As reported earlier, condom use at first sex is reportedly lower among boys compared to girls. Male sexual insecurities may explain this in part, such as: fear of losing one’s erection by using a condom (Bombereau, 2007; Plummer, 2007a); fear that condoms might be “too large” and/or fear of not being able to keep condom on during sex (Hutchinson et al, 2007).

- **Lack of confidence that the method works**
  Studies in Jamaica have observed lack of confidence in condoms. First, Kempadoo and Dunn’s study (2001) among Jamaican adolescents documented the view among youth that condoms are not 100% safe. Steiner et al (2005) interviewed 314 men aged over 15 who presented with urethral discharge at Jamaica's largest STI clinic. The men were worried that the method would not work, and that their female partners feared getting allergies, that condoms would get stuck inside the vagina or that they would tear the vagina.

- **Availability and quality of appropriate services providing condoms**
  For young girls, having or seeking a condom indicates that they are sexually active (Joseph, 1999; Jewkes et al, 2003). Consequently, young girls may prefer not to suggest condom use for fear of appearing too experienced. For older females, seeking, discussing and/or negotiating condoms are regarded as signs of promiscuity (Marston and King, 2006).

Several studies mention barriers to accessing condoms for young people, including:

- Lack of confidentiality among health care workers (Joseph, 1999; Allen, 2000)
- The perception that family planning services are designed for females, limiting access by males (Allen, 2001; Allen, 2002b)
- The perception that purchasing condoms is a male’s responsibility (Allen, 2002).
• Facilities and services designed for adults
• Lack of respect demonstrated by health care workers of young peoples’ right to choose (Allen, 2000).
• The unwillingness of schools authorities to provide vending machine in schools for fear of encouraging sexual intercourse (Jewkes et al, 2003).

Loss of sensation by using condoms
Focus groups in Jamaica showed some boys believed that sex would not feel as good if they used a condom. Responses such as, “want raw feeling,” “bareback is better,” and “lack of pleasure” expressed this view. Most agreed that, “Sex feels unnatural when a condom is used” (Hutchinson et al, 2007, p.11).

Desire to have a baby
Barrow (2007) reports that for a minority of girls, the desire for pregnancy and child-bearing may prevent condom use, especially when the baby is seen as a way to leave the parent’s home and environment.

Interventions to promote condom use
Some Caribbean governments have implemented condom social marketing campaigns to increase the availability and use of condoms to prevent HIV/ AIDS/ STI. This has resulted in increases in the supply of and demand for condoms. In Jamaica for instance, condom distribution increased four-fold from 2.5 million in 1985 to 10.8 million in 1999 and 9.4 million in 2002 with an increasing proportion being sold (from 20 to 70% in the same period) (Figueroa et al, 2007). Despite this, evidence above suggests that interventions need to be made to improve their acceptability and use in a variety of social contexts. Very few studies have evaluated interventions designed to improve skills to use condoms.

In Jamaica, Steiner et al (2007) conducted a six-month trial among men who presented with urethral discharge at the largest STI clinic in Kingston in order to:

1. assess whether providing a choice of condoms would increase condom acceptability and self-reported use, and decrease incident sexually transmitted infection
2. better understand the circumstances of condom breakage and slippage.

Both quantitative (seroprevalence and behavioural surveys) and qualitative (in-depth interview) approaches were used.

Participants were provided with a demonstration of proper condom use with a penis model, counselling about condom use and STI prevention and condoms free of charge. Urine specimens were taken for STI screening and baseline questionnaires were administered. One week later, participants were enrolled to a control group (provided with the Unidus condom) or the intervention group (who were given a choice of 4 types of condom). Follow-up visits at 1, 2, 4 and 6 months included a self-completion questionnaire, counselling on STI risk reduction, treatment for STI and urine specimen for STI.
Results showed that **a choice of condoms increased perceived acceptability but did not lead to increased condom use or lower sexually transmitted infection rates.** The condom breakage rate was reduced by more than 50% by the counselling and condom demonstration intervention. However, condom failure remained unacceptably high – just below 10%.

Based on these data, Steiner et al (2006) supported the current practice of providing a low-cost male condom in resource-poor settings such as Jamaica. They noted that, among men with STIs, correct condom use may be promoted by condom demonstrations and counselling. There is room for improving the quality of condom counselling to reduce the failure rate further.

In Managua, Nicaragua, Egger et al (2000) assessed the impact on condom use of providing health education materials and condoms in motels that rent rooms for short times for discreet commercial and non-commercial sex. The researchers tested three different condom promotion methods:

1. Health education materials such as pamphlets
2. Putting condoms in motel rooms, and
3. Handing condoms to motel clients face to face.

Surprisingly, health-education material failed to increase condom use. However, when condoms were available in rooms, their use increased for both commercial and non-commercial sex. Directly handing condoms to couples had a similar effect for commercial sex but was less effective for non-commercial sex. The authors argue that for those couples “unsolicited distribution of condoms may have led to lower frequency of condom use compared with the more discreet provision of condoms in rooms.” The authors concluded that making condoms available in rooms was the most effective strategy to increase condom use. On the other hand, use of health education material was ineffective.
Men who Have sex with Men

Background

Studies among men who report they have sex with men have estimated HIV seroprevalence to be 7% in Suriname (CAREC, 2004), 20% in Trinidad and Tobago (Lee, 2005) and 21% in Guyana (Ministry of Health, 2004). However, since many MSM do not identify themselves as homosexual or bisexual, HIV seroprevalence figures may be inaccurate (Tabet, et al, 1996; Caceres, 2002).

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 (CAREC, 1998). In the Dominican Republic, Tabet et al (1996) found evidence of five main sexual identity groups:

- cross dressers (men who dress and act in a feminine manner),
- homosexuals,
- gigolos (men who accept money and gifts from female tourists and who may engage in sex trade with male tourists),
- bisexuals, and
- heterosexuals (men who engage in sex predominantly with women and occasionally have sexual contact with other men but still self-identify as heterosexual).

The researchers highlighted two scenarios under which MSM may identify themselves as heterosexual:

1. MSM who exclusively practice insertive oral and/or anal sex.
2. Men who engage in sex predominantly with women and occasionally have sexual contact with other men.

Among MSM, there are strong social class and age divisions, making communication and social interaction limited (CAREC, 1998; De Groulard et al, 2000). According to De Groulard et al, (2000) there is a stronger sense of identity and communication among younger and more educated MSM.

In the Caribbean, there is a shortage of research on MSM. The difficulty in collecting necessary social, biological and behavioural data remains a critical barrier. This is particularly true for the small islands such as those in the OECS where there is a lack of social anonymity (Bombereau and Oggunnaike-Cooke, 2007). The available data point to the following risk scenarios.

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26 In this case, the receptive man takes the posture of the woman. Men should penetrate and women should receive. Receptive MSM are thought to break with their male identity and to be like women. Men who are passive and receptive are the ones most targeted for condemnation (Bombereau, 2002).
Illegality of homosexual behaviour and health outcomes of stigma and discrimination

The practice of sex between men remains a criminal offence in most Caribbean countries. Conservative religious beliefs are strongly against homosexuality and appear as key to better understanding the sexual norms and taboos in the region (De Groulard et al, 2000; Bombereau, 2005). Highly stigmatized by both religious and social norms, practices are driven underground. Both self-denial and low self-esteem reinforce social vulnerabilities. Moreover, access to prevention (condoms and lubricants), counselling and testing, care and treatment remain difficult. Fear of breaches of confidentiality and a lack of privacy aggravate lack of access. Health care providers are perceived as judgmental and unable to respect confidentiality. Reluctance to seek care from heterosexual medical practitioners has been observed (CAREC, 1998; De Groulard et al, 2000). There is also evidence of preference for private physicians and hospitals and/or for services outside their home country. Some MSM go abroad to get an HIV test.

Multiple partnership
Serial monogamous partnerships or concurrent multiple-partner relationships of short duration are quite common among MSM. Steady homosexual relationships are difficult to maintain because of fear and mistrust among MSM themselves (Allen, 2002a).

- **Bisexuality**
  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, for some, a strategy to avoid negative consequences of public disclosure of homosexuality and can be used to help dispel doubts about masculinity (CAREC, 1998; De Moya and Garcia, 1999; De Groulard et al, 2000; Allen, 2002a; Caceres, 2002). By having female sexual partners, MSM fulfil traditional gender roles (Bombereau, 2002).

- **Transactional and commercial sex**
  Among MSM with both female and male partners, some men have sex with other men only in exchange for money or goods, including illicit drugs (CAREC, 1998). De Moya and García (1999) document the bisexuality of male commercial sex workers in the Dominican Republic, and show that many initiated homosexual relations when they were around 14-15 years old because of economic need.

  Also in the Dominican Republic, Tabet et al (1996) implemented a cross-sectional study of MSM among 354 males over 13 years old. The findings showed that many male commercial sex workers identified themselves as heterosexual and accepted money from both women and men. For Caceres (2002), “compensated sex” is important to a variety of types of MSM. For instance, “transvestites will often sell sex to men in the popular or lower-middle classes who pretend they mistook them for women or recognize that they like their femininity and sexual expertise” (Caceres, 2002, p28).

Condom use
Tabet et al (1996) note low levels of condom use among MSM interviewed. Less than a third reported condom use with female partners or during insertive anal sex or in receptive anal sex. Similar findings were found by De Moya and Garcia (1999). Male commercial sex workers
reported low consistent condom use both with clients and female partners. Nevertheless, protected sexual intercourse was higher among commercial sex workers (both professional and occasional workers) than among MSM who did not sell sex.

➢ **Reluctance to use condoms**
As for the general population, concerns about the size of condoms, about durability, discomfort, loss of sensitivity, allergic reactions, embarrassment when purchasing condoms and loss of partners’ interest are highlighted by MSM (CAREC, 1996). De Moya and Garcia (1999) refer to preference for skin contact. Feeling such as trust and love were also mentioned and appeared to be barriers to condom use.

On the positive side, findings from qualitative research in 4 OECS countries (CAREC, 1998) showed that, for MSM, neither condom access nor cost was a problem.

➢ **Perception of risk**
Some MSM use their own risk-assessment scale in sexual decision-making. Caceres (2002) mentions that MSM may choose not to use condoms when having sex with:

1. Men they regard as heterosexual, or
2. Men who look good or do not look sick.

As noted in our review of condom use in the general population, social criteria may be used to assess whether a person is HIV positive and the decision to use condoms will be made accordingly. De Moya and Garcia (1999) found that male commercial sex workers often did not use condoms with clients they perceived as “clean, known and trusted”.

**Sexual abuse**
Several studies in the region have shown that high proportions of MSM have experienced sexual abuse either at first sex or in the past 12 months (Lee et al, 2005; MOH Guyana, 2005; Bombereau, 2007). Lee et al’s (2005) survey among MSM in Trinidad documents that almost 20% males were forced the first time they had sex with a male partner. Among HIV positive participants, this percentage was 31%, showing higher vulnerability to infection among persons who were exposed to violence during childhood or adolescence. Involuntary sexual relations in the past year were mentioned by about 20% of MSM in Trinidad (Lee et al, 2005), and over 30% of MSM in Guyana (MOH Guyana, 2005).

**Substance abuse**
Alcohol may be used to remove sexual inhibitions for men who want to have sex with another man. Alcohol consumption is sometimes used as an explanation (or excuse) by men who have been found to have had sex with other men, as well as for lack of condom use during these encounters (Caceres, 2002; CAREC, 1996).
**Interpersonal violence and aggression**

**Background**

Violence, including sexual abuse, is a global issue. According to WHO (2002) in a study in 35 countries, up to 30% of adolescent girls reported that their first sexual intercourse was forced. Victims are most commonly young and female but older persons and men are at risk too. The majority of acts of violence are perpetrated by men on women. Violence by a sexual partner is the most prevalent form of violence against women. Sexual violence has serious impacts on physical, mental and reproductive health. According to a review of quantitative surveys implemented in the region, sexual abuse at first sex ranges from 4% to 38% (Bombereau, 2007b). In the Caribbean Youth Health Survey, 38% of young people reported that their first sexual experience was forced (see table 1 in this report). Studies with Caribbean adolescents have shown a history of physical and sexual abuse to be associated with sexual activity (Blum and Ireland, 2004; Kurtz et al, 2004).

Direct links between violence and STI/HIV/AIDS have been identified in surveys in the region. In the Dominic Republic, the percentage of women who had an STI 12 months prior to the survey was 3.7% among those who had suffered violence compare to 1% among those who had not suffered violence (Kishor and Johnson (2004) *Profiling domestic violence: a multi-country study*. ORC Macro, Maryland. This study was quoted in a PAHO fact sheet).

The WHO report on domestic violence (2005) and other international surveys on sexual and domestic violence (Dunkle et al 2004; Maman et al, 2000) show that there are various links between interpersonal violence and aggression and the HIV epidemic. Violence against people in the region makes victims vulnerable to HIV through four main mechanisms:

- **Forced sex, or rape** without a condom with an HIV infected person may result in HIV transmission (Gage and Hutchinson, 2006).

- **Fear of suggesting condoms because of anticipation of violence** increases risk (Gage and Hutchinson; 2006).

- **Experience of sexual violence** and more broadly **child sexual abuse** may increase HIV risk by encouraging the adoption of risky behaviour in adolescence and adulthood (Allen, 1997; Blum and Ireland, 2004; Joseph, 1999). Dunkle et al (2004), from research they conducted in South Africa, note that women with a history of violence may be more likely subsequently to engage in transactional sex, having multiple sex partners, having casual sex partners, trading sex for money or drugs. Additionally, according to the authors, abusive men are more likely to have HIV and to impose risky sexual practices on partners.

- **Cycle of intergenerational violence**: Children who are victims of violence or witness violence between their parents are more likely subsequently to use violence or to be victims of violence (FHI, 2005). According to Gage,

> Those exposed to intra-family violence in childhood may form mental representations of relationships that increase their vulnerability to violence exposure in intimate relationships (Gage, 2005, p. 357).

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27 There is a need for research in the Caribbean on female violence against intimate male partners.
People may construct attachments based on models of dominance-subordinaison and victim-victimizer and therefore replicate or put themselves in similar situations.

In the Caribbean, Sexual and Domestic Violence (SDV) is explained by several cultural and social factors.

**Gender inequalities in access to resources**

Men may use violence against women who refuse to have sex. Women are not supposed to refuse sexual intercourse with their intimate partner. They may be allowed to refuse sex only under certain circumstances such as illness and then for a short period of time. Additionally, refusing to have sex may have serious economic outcomes for women. Men may refuse to give money or withdraw their financial support if a woman refuses sexual encounters (Allen, 1997). More broadly, poverty and dependency expose women to risky situations, because the need to keep a man remains higher priority than practising safer sex (Jewkes et al, 2003; Le Franc et al, 1996).

In Haiti, Smith Fawzi et al (2005) sampled women accessing a women’s health clinic between June 1999 and March 2002 in order to estimate the prevalence of forced sex among women accessing services, and factors associated with forced sex in this population. The research design included:

1. a case-control study examining risk factors for chlamydia and gonorrhoea
2. a survey using a standardised study questionnaire, and
3. ethnographic research including open-ended interviews in patients’ homes and focus group discussions.

Fifty-four percent of female participants reported forced sex in their lifetime. Multivariate analysis showed that the following factors were positively associated with forced sex:

- age (30 years or less)
- length of time in a relationship (involved in a relationship over 4 years)
- occupation of the woman’s partner (construction workers)
- STD-related symptoms, and
- Factors demonstrating economic vulnerability (e.g.: having problem with transportation).

The author concluded that gender inequalities and economic dependency by women played a significant role in sexual and domestic violence.

Also based on research in Haiti, Gage (2005) notes that two opposite situations may lead to intimate partner violence. By asking about which person within the couple has the last word about large household purchase, Gage found a positive link with violence either when women dominated decision-making or when men dominated decision making. According to the

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28 The clinical services included: general pre-natal care, family planning services, screening for and treatment of STDs and women’s health services more broadly. There may be participation bias since only women who attended the clinic were included. The situation of women who are not attending the health clinic may be worse.

29 According to the findings, women whose partners were construction workers were twice as likely to have been forced to have sex. Authors surmised that construction work, which was, at the time of the study, one of the more stable occupations in the area, may be an indicator of economic dependency among women.
author, in both situations, men may use sexual violence as a way to maintain power and/or to react to their perceived powerlessness in financial decision-making. Thus, male’s need for power and control is a determining factor in violence against women.

Bailey et al (1998), reporting on research in Jamaica, Barbados and Dominica, echo some of these findings. The authors identified three situations that lead to violence:

1. Male difficulty in fulfilling their prescribed gender roles (i.e. being the principal provider). In this case, financially insecure men resort to violence to maintain their position and keep control in the relationship
2. Suspicions about the female partner’s infidelity. Males may fear that their partners will have sex with more attractive males
3. Males fear that non-violent responses may give the impression that they are soft and weak. Conversely, being violent may enhance sexual attraction and respect.

Bailey et al refer to Wyatt et al’s survey (1995). This shows evidence from Trinidad and Jamaica that the economic empowerment of women may exacerbate male violence against women. This may be explained by increasing male anxiety about their ability to fulfil the role of main breadwinner.

Literature from outside the Caribbean region may assist in understanding this phenomenon by showing some nuances. Jewkes et al (2003) note that gender inequalities do not always lead to higher vulnerability among women. The authors conducted a cross-sectional study in South Africa with 1164 women aged 18-49 years old who had a husband or boyfriend in the past year. They found some gender inequities play a positive role in term of HIV prevention. In fact, analyses show that women who did not receive financial support from their partner were more likely to suggest condom use. The authors argue that the women who do not receive financial support do not feel obligated to have sex on their partners’ terms and so feel empowered to suggest condom use.

Acceptance of violence

Studies on the perception of violence in the general population highlight a high level of tolerance and acceptance of violence in Caribbean countries. Bailey et al (1998) conducted qualitative research on cultural beliefs about men’s rights and privileges in relationships in Jamaica, Barbados and Dominica. They showed that, for both girls and boys aged 8-20 years old, violence is part of normal life. In fact, according to the girls’ perception, violence-free relationships are difficult to find. For the boys, it appeared that conflicts are inevitable between men and women since they perceived girls to be materialist. Findings from a study among 2240 woman aged 15-49 years old in Haiti (Gage, 2005) echo these findings, showing among other things a high level of acceptance of wife-beating.

In Jamaica, Hutchinson et al (2007) note that sexual and physical abuse of girls by boys may be commonplace. Several of the boys studied reported that they had forced a girl to have sex. Boys reported that some boys hit girls in relationships to “make her listen,” “to create a sense of fear,” and to be “domineering” (Hutchinson et al, 2007).
**Family environment**

Gage’s (2005) study in Haiti indicates that the family environment and more specifically **a large number of children may increase violence against women**. According to the author, this situation may be explained by the fact that women with a large number of children may be in relationships where negotiation about sex and birth control are uncomfortable or difficult (Gage, referring to Vaughn, Wiemann, Harrykissoon, Berenson, and Kolb, 2002).
DISCUSSION
**Findings on social and cultural factors underlying the HIV epidemic**

This literature review has found that a range of interconnected risk factors drive the HIV epidemic in the Caribbean. For instance, there is evidence that physical and sexual abuses in childhood lead to increased likelihood of having multiple partners and engaging in transactional sex. Some people are involved in several risky behaviours and scenarios and are at especially high risk. For example, some women may exchange sex for money or goods and be willing to accept that their partners have “outside” partners in return for economic security. Some young people are at especially high risk because not only are they sexually active, but they also take drugs and experience violence. These findings suggest that groups of people at especially high risk should be identified and that interventions with them should seek to address a constellation of risk factors. To date, interventions for groups of people at high risk have tended to focus on youth, MSM and CSW. Our analyses confirm that this is critical but suggest that it is also important to identify groups of people in the so-called “general population” who are at especially high risk, such as poorer women and people in communities with a high incidence of domestic and other forms of violence.

In this review we have focussed on a limited number of behavioural risk factors for HIV, and identified social and cultural factors underlying these. The most important factors identified are as follows:

**Gender construction in the Caribbean**

Males in the Caribbean are subject to a set of cultural norms that increase the likelihood that they will engage in risky behaviour. The belief that having more than one partner is a mark of manhood is one example of this. A less obvious one is the belief that men should provide financially for all of their sexual partners and children. Poverty and economic insecurity mean that this is impossible for some. Under these circumstances, relationships become unstable and sometimes break up, leading men and women to seek new partnerships. Risks of HIV infection for females are affected by the belief that it is necessary to “have a man” who provides economic support.

Perceptions of risk illustrate that these beliefs have become “normalised”. Concurrent partnerships by males and “serial monogamy” by women are common relationship patterns in the Caribbean, and there is evidence that people do not regard these as high-risk scenarios. Men with concurrent partners are regarded as at risk only if they transgress social norms, for instance if they do not provide financially for these partners or if they have sex with other men. Norms prohibiting homosexuality lead many people to blame MSM for the epidemic, failing to recognise the risks in which they engage themselves.

It is clear that complying with gender expectations creates vulnerabilities for HIV infection in the general population, and not just among people who are regarded as deviant, such as MSM and CSW.
**Economic insecurity**

Risks arising from beliefs that men should provide and women should receive economic support are compounded by the poverty and economic insecurity experienced by many people in the Caribbean. Research in the region shows that risk practices, such as not using condoms, multiple partnerships, transactional sex and inter-personal violence, are more frequent among people who perceive their economic situation to be tenuous and inadequate.

**Sexual abuse and violence**

Sexual abuse, rape and violence create vulnerability, both by increasing the physical risk that the HIV pathogen will be transmitted, and by creating psychological trauma that may lead to risky sexual behaviour. Failure to act and speak out against sexual abuse and domestic violence places many people at risk.

**Supportive relationships and family environments**

Some children in the Caribbean are living in environments characterised by instability, insecurity and child abuse. Sometimes these result from economic migration or break-up in the relationship between parents. The physical and psychological impacts of abusive and unsupportive relationships at home increase HIV risk. Strong and supportive relationships with both parents and with teachers have been shown to be important in protecting young people from becoming involved in sexual activity.

**Policy environment**

Criminalisation of homosexuality and sex workers, lack of strong policies and institutions to detect and penalise sexual abuse, and poor access to care and treatment options put various sub-populations at risk of HIV.

**What we don’t know**

A fairly consistent set of findings emerged from the wide variety of qualitative and quantitative studies on social and cultural factors underlying the HIV epidemic in the Caribbean. However, there are important limitations in the research in this area.

**Protective factors**

The review found numerous studies documenting social and cultural factors driving risky sexual practices but only a handful that documented factors that may have a protective effect in reducing risk of HIV transmission. Analysis of data from the Caribbean Youth Health Survey suggested that protective factors may have an even stronger impact on risk practices (such as early sexual initiation) than risk factors. It is important to strengthen knowledge about positive influences that may be incorporated in programme design.
Evaluation of interventions

This review was not designed to include all the literature on evaluations of behavioural interventions to prevent HIV. Nevertheless, it is remarkable that very few of the papers reviewed on social and cultural factors driving the HIV epidemic present clear recommendations or guidelines on how interventions should be designed to address the problems identified. It is hardly surprising therefore, that few innovative interventions have been designed to address underlying problems such as economic dependency among women and sexual abuse.

Very little research appears to have been conducted that measures the impact of interventions to address social and cultural factors on key outcomes including behavioural risk factors and STIs. A rare example of a study that has done so is the evaluation of “structural-environmental” interventions to reduce HIV risk among sex workers in the Dominican Republic (Kerrigan et al, 2006). However, as noted in the section on commercial sex work, the methodology and findings of this study may be of limited applicability in other Caribbean settings.

Policy-makers and practitioners therefore have insufficient information about which types of intervention are likely to be most effective in reducing HIV risk in the Caribbean context.

Associations between social and cultural factors and HIV incidence and prevalence

Demonstrating that an intervention is successful at changing individual sexual behaviour does not necessarily mean it is effective at reducing the transmission of sexually transmitted infections (Hallett et al, 2007, p. i59).

As noted by Hallett et al, the effects of changing sexual behaviour, such as condom use rates, on the epidemic are mediated by factors including the existing prevalence rate and use of anti-retroviral therapy. There is a dearth of research demonstrating clear associations between social and cultural factors, sexual behaviours and HIV prevalence and incidence. Most of the studies reviewed did not include biological markers of HIV/STI. Thus they fall short of demonstrating which interventions will be effective in reducing HIV seroprevalence in the Caribbean context.

At the same time, the methodological challenges of conducting research incorporating HIV seroprevalence measures must be acknowledged.

Blood testing may be unacceptable to some potential respondents, partly because many Caribbean people are uncomfortable with the use of syringe needles. Other testing methods have become available, such as saliva testing, but these may have different levels of reliability and ease of administration.

Ideally, evaluations of HIV prevention interventions should use HIV incidence as the “gold standard” measure of success, since they all aim to curb the number of new cases of HIV infection. HIV incidence has been successfully used as the principal outcome measure in HIV prevention trials in Africa, demonstrating, for instance, the effectiveness of male circumcision in preventing new cases of HIV infection in trials in Kenya, South Africa and Uganda (Auvert et al, 2005; Hargreaves,2007). However, the underlying HIV incidence rate is considerably
higher in these countries than it is in most countries of the Caribbean. This means that much larger sample sizes would be needed in the Caribbean to demonstrate the same percentage decreases in incidence. Given that Caribbean population sizes are comparatively small, trials using HIV incidence as the measure of success may not be feasible. Instead, it may be necessary to use proxy measures such as STI incidence (selecting STIs with comparatively high incidence) or behavioural risk factors such as changes in the proportion of people who used a condom at last sex or changes in the median age at first sex. Epidemiologists and statisticians can advise on the outcome measures that are most suitable to use to measure success in combating the epidemic in the Caribbean.

**Methodological limitations in the Caribbean research**

The Caribbean studies reviewed relied on a limited range of research designs. Quantitative studies were predominantly cross-sectional surveys. Longitudinal studies were rarely used, making it difficult to attribute causation and to measure the impact of new events and interventions. Of the qualitative studies reviewed, only a few authors attempted to validate their findings on a particular topic, “triangulating” them by consulting with and observing a range of different types of people or comparing them with quantitative findings.

There was a reliance on self-reporting, which may be subject to heavy social desirability bias. This may be especially true in the Caribbean given that open discussion of sexual matters is rare. This review did not uncover any studies that sought to use biological markers such as STI and pregnancy to validate self-reported behaviour. These markers are not sensitive to the frequency of sexual practices or partner change, but they can be used to refute claims of abstinence, for example (Plummer et al, 2004). Nor did most of the studies make other attempts to validate the data, for instance by triangulating findings on sexual behaviour by using partner reports or a variety of research methods (Allen et al, 2007).

Several articles did not specify the sampling methodology used to select participants. Most did not present refusal rates or profiles of those who refused to participate, nor did they present a justification for the sample size used. Some utilised small samples without drawing attention to the limitations in generalising from the data. These weaknesses are crucial since it is difficult to establish the representativeness of the findings or to generalise them to the overall target population. At the global level, efforts are being made to improve sampling methodologies for vulnerable populations, and this body of research should be utilised in the Caribbean, for example in studies with MSM, CSW and people exposed to sexual abuse (Camara et al, 2002; Magnani et al, 2005).

The use of convenience sampling in some studies may also have led to bias. For instance, health clinics are a convenient entry point to access potential participants within a small budget. However, patients accessing services may be systematically different from those who do not.

A small range of statistical techniques was used for the analysis of quantitative data. Studies tended to rely on descriptive statistics such as means and percentages and univariate tests of association such as Chi-squared or t-tests. Multivariate methods, including logistic regression, were rarely used. Such methods are better able to identify the strength of associations between variables, controlling for interactions between variables in their association with particular outcomes. Internationally, multivariate logistic regression analysis is widely accepted as an effective way to identify risk factors for HIV infection.
Remarkable consistency was found in the findings on the social and cultural factors underlying the epidemic. Comparing studies provided a kind of validation of studies against each other. Nevertheless, there is no doubt that the employment of more rigorous research methods would be helpful in providing a stronger evidence base for public health action.

**Limitations in the scope of this review**

This review concentrated on selected behavioural risk factors. It excluded other important risk factors that have been identified in research, including: STIs; alcohol and drug abuse; migration and population mobility; sex tourism, and stigma and discrimination against people living with HIV/AIDS.

Our review prioritised the analysis of peer-reviewed articles; some research not published in peer-reviewed publications may be missing from the analysis. This is important because few studies undertaken in the region are documented in peer-reviewed journals. Many pieces of research in the region are written up as research reports for a particular institution with little time or resources being devoted to publication to ensure that they are accessible to a wider audience who may benefit. Disparities exist between the countries who document their studies in the peer-reviewed literature and those who do not. As a consequence, some countries (such as Jamaica) are relatively highly represented in the HIV literature. Consultations with HIV professionals and researchers around the Caribbean gave us access to only some of the studies which have not been published in peer-reviewed journals and books.

The review concentrated heavily on the Caribbean literature, with only a few pieces of literature from other parts of the world being used to supplement and clarify some issues. It was not within the scope of this review to place each of the issues identified in Caribbean research within the context of global research on these issues. As such, Caribbean challenges have not been systematically analysed by comparing with worldwide research on these issues. Furthermore, the review did not attempt to relate the findings to social and cultural theory, or to place the findings within historical context. These are critical limitations, since the Caribbean may benefit from experiences gained elsewhere and over time and from theoretical understanding in addressing some of the problems identified. It is hoped that experts in various fields can use the information in this paper and enrich it with their own knowledge of the HIV epidemic and its socio-cultural context in other places and times.
RECOMMENDATIONS
The available evidence suggests that factors at various levels such as the couple, family, community and society may influence individuals’ sexual risk-related beliefs, intentions, and behaviours. There is a need to combine strong advocacy, policy, tailored programmes and behavioural research to address various vulnerabilities. For this purpose the wider society, including various ministries (Education, Labour, Tourism, Gender Affairs, etc.) should be engaged in responding to HIV. As highlighted by Farmer (2006) and Heise and Elias (1995), law reform and investments outside the health sector may do more to reduce HIV transmission than the most sophisticated education campaign.

**Policy**

**Youth sexuality**
- Ensure that health services are accessible to both male and female adolescents in and out of schools. Ensure free and confidential access to counselling, sexual health information, care and treatment services. STI treatment and condoms for adolescents should be supplied without parental consent.

**Condom use**
- Promote greater access to condoms, especially for vulnerable groups (with special emphasis on girls and women, MSM and CSW), in a variety of locations (including schools, hotel bathrooms, commercial sex establishments, bars and tourist areas).
- Work with owners and managers of commercial sex establishments by providing health promotion materials and condoms to managers, running workshops with commercial sex workers and imposing penalties on managers who do not comply (Kerrigan et al, 2006).
- Develop outreach services to provide condoms to CSW not based in commercial sex establishments, as well as their clients.

**Vulnerable populations**
- Review and/or develop laws that protect vulnerable and marginalised segments of the population (e.g. decriminalisation of sex work and sexual acts between men, legislation prohibiting discrimination including homophobia, strong penalties for sexual and domestic violence).

**Gender-based inequalities and violence**
- Promote gender equity and women’s human rights in order to reduce women’s financial vulnerability.
- Address sexual and domestic violence issues by:
  1. reviewing and/or developing the laws on incest, paedophilia and rape;
  2. ensuring that personnel and facilities are in place in order to support enforcement of these laws,
  3. sensitising various stakeholders, such as headmasters, teachers, counsellors, associations of parents, religious leaders and the wider society,
  4. developing communication campaigns to fight the acceptance and tolerance of sexual and domestic violence.
- Provide assistance (medical, legal, psychological and financial) to victims of violence.
- Provide psychological counselling to perpetrators of violence.
Programmes

Overall, interventions should target especially vulnerable people who lack social and financial support and/or are exposed to violence and sexual abuse. They should pay attention to emotional and mental health while nurturing and enhancing negotiation skills.

Youth sexuality
- Protective factors should be strengthened, such as supportive family and school relationships, by providing training, counselling and practical support to parents, other caregivers and teachers.
- Education programmes should be developed for children to ensure safer behaviour from the time of sexual initiation, including discussion of sexual pleasure, issues of coercion and the need for consent\(^{30}\). These programmes should be led by trained counsellors. Sexual responsibility for both males and females should be actively promoted.

Gender-based inequalities and transactional sex
- Programmes promoting gender equity, women’s rights and sustained poverty reduction should be strengthened in order to reduce vulnerability.
- Provide microfinance\(^{31}\) and skills training (including condom negotiations skills) to poorer women to reduce exchange of sex for money or goods.
- Health and family life education programmes should include promotion of the idea of female economic independence and the advantages this may present for both sexes.

Sexual and Domestic Violence
- Sensitise and educate the general population through public awareness campaigns challenging the acceptability of sexual and domestic violence.
- Train health care providers and police officers to detect sexual violence at an early stage and to collect testimonies. Interventions should involve the entire family.
- Implement standard protocols for young victims of sexual abuse including: post-exposure prophylaxis for HIV, treatment for STI, counselling and (where age appropriate) emergency contraception.
- Use reproductive health services as entry points for identifying women in abusive relationships and for delivering referral and support services.
- Strengthen formal and informal support systems for women living with violence.

Condom use and HIV prevention strategies
- Tailor condom promotion including condom negotiation skills according to type of relationship. Strategies to promote condoms in the context of long-term and steady relationships may be very different from those appropriate in the context of commercial sex, or casual sex.
- Condoms should be promoted as symbols of care, responsibility and concern in order to break the current association with infidelity or infection.

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\(^{30}\) Plummer’s (2007c) review of 83 sex and HIV education programmes around the world show that those programmes did not lead to increased sexual behaviour among youth.

\(^{31}\) Microfinance is a programme that provides loans to poor households for income generation (e.g. by developing a retail business or selling fruit and vegetables). For further details of such programmes, see the paper by Pronyk et al (2006) based on research in South Africa. Authors document evidence that a microfinance and training intervention can have health and social benefits including reducing the level of violence reported by participants.
Promotion of condom use among commercial sex workers should emphasise building skills to use condoms with regular commercial sex partners and non-paying partners. Condoms might be promoted as an essential part of hygiene maintenance with clients; safer sex might be promoted as a way to protect one's family.

Men who have sex with men
- Develop community-based interventions with MSM tailored to the needs of groups with particular sexual practices.
- Continue to strengthen NGOs representing and providing services to marginalised populations (e.g. MSM, CSW).

Research
Strengthening research methodology
- There is urgent need to combine social science and epidemiological methods to identify causal pathways and the strengths of association between social and cultural factors and changes in sexual behaviour, STI and HIV prevalence and incidence. This would assist in developing interventions that are more likely to be effective.
- Rigorous evaluation of interventions is also needed, combining epidemiological and social science methods to assess success in combating HIV. Randomised control trials should be conducted to evaluate interventions.
- Combined behavioural and HIV/STI seroprevalence studies should be conducted.
- Longitudinal studies are important to identify factors leading to changes in key outcomes.
- Multivariate analysis techniques should be used to uncover which risk factors are associated with HIV status and which are “cancelled out” by other factors.
- Strong sampling methodologies should be designed in collaboration with statisticians in order to ensure representativeness of the findings to the target population.
- Technical support should be provided to strengthen skills in writing for peer-reviewed publication.

Protective factors
- To assist in the development of interventions, it is important to conduct more research into potential protective factors which could be strengthened in order to effect positive change.

Perceptions of risk
- Anthropological research can assist in understanding, “How does the population manage disease risk in general (when does the population protect themselves, how and against what?), and HIV risk in particular?”

Violence
- Research should seek to identify the epidemiology and determinants of sexual and physical abuse.
- Techniques to map and identify communities, households and individuals at risk of sexual and physical abuse should be developed.

Mental health

32 For further detail see Hansen et al, 2007
Research should seek to answer the question, “What role does mental health (including self-esteem and anger) play in HIV transmission?”

Economic factors
- Research should explore the links between poverty, economic inequality, consumerism and transactional sex and the Caribbean HIV epidemic.

Operational research
- Among policy-makers, research should seek to identify barriers and facilitating factors to legislative and other changes to create a supportive policy environment.

Evaluation of interventions
- Research should seek to determine how best the research on social and cultural factors driving the epidemic can be used to develop interventions to combat it, and how these interventions should be evaluated.
- Literature reviews should seek to summarise the conclusions and recommendations of intervention evaluations conducted to date.

Literature reviews
- Literature reviews should be conducted on social and cultural factors underlying other sources of risk of HIV in the Caribbean, including alcohol and drug abuse, migration and population mobility, sex tourism, and stigma and discrimination against people living with HIV/AIDS.
- The Caribbean literature should be analysed by comparing with research on similar topics from other parts of the world.
- Social and cultural theory should be utilised to analyse the findings of literature reviews and to develop appropriate interventions.

Conclusion

To our knowledge, an exercise to review literature on a broad range of social and cultural factors driving the HIV/AIDS epidemic across the Caribbean region has never been attempted before. In 1993, Barry Chevannes published a review on Jamaican literature focussing on cultural issues underlying sexual behaviour. Some of his results find echoes in the current literature, e.g. different social treatment of men involved in casual relationships and those involved in multiple-partnerships, stigma and discrimination against sex workers and homosexuals. Our review revealed some important new developments or discoveries, such as the importance for girls of sexual experience as a rite of passage to womanhood, the importance of materialism and transactional sex and of sexual and physical abuse. It is hoped that the evidence in this literature review can assist in the development of effective, cutting-edge policies and programmes to combat the HIV epidemic in the Caribbean.
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