

CAROLINE ALLEN

Caroline Allen is a health sociologist working at the Medical Research Council on a UK Department for International Development programme of research on HIV/ AIDS in developing countries. Formerly she was Behavioural Science Advisor at the Special Programme on Sexually Transmitted Infections, Caribbean Epidemiology Centre, Trinidad and Tobago. Her publications on health and sexuality in the Caribbean include, 'Social Science Approaches to Sexually Transmitted Diseases in the Caribbean', in GD Howe and A Coble, eds., (2000) *The Caribbean AIDS Epidemic*, The Press, University of the West Indies, Mona, Jamaica, pp22-41; and 'Caribbean Bodies: Representation and Practice', in C Barrow, ed. (1998) *Caribbean Portraits: Essays on Gender Ideologies and Identities*, Ian Randle Press, Kingston, Jamaica: 276-93.

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Gender and the transmission of HIV in the Caribbean

Caroline F. Allen

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Abstract

In the Caribbean, HIV prevalence is estimated to be 2% in the general population age 15-49. This is the second highest rate in the world after sub-Saharan Africa. Among AIDS cases there is a predominance of males compared to females (sex ratio 2:1). However, the trend is towards a more rapid increase of HIV in women than in men with the ratio already close to 1:1 in territories including Haiti, Jamaica, Bahamas and Guyana. Among groups at risk (patients with sexually transmitted infections, female commercial sex workers, men who have sex with men), the prevalence is high in Caribbean countries, varying between 7% and 45%.

Quantitative sexual behaviour studies in the region show that in general:

- Males have more sexual partners than females, and have first sex at an earlier age than females
- Both males and females have their first sexual experience with somebody older, but the age difference between females and their first sexual partner is greater
- Significant minorities of both males and females report that their first sexual experience was forced
- Males are more likely to use condoms, though gender differences in condom use are not so great for people under 25 years old

Qualitative studies have revealed gender issues behind these patterns. Males are expected to have multiple sexual partners, making it easier for them to access and use condoms. Young women are especially at risk as they seek relationships with older men, partly in order to access material resources. Commercial transactions are an important feature of many heterosexual and homosexual relationships.

Systemic socio-economic and political factors that are associated with peripheral maldevelopment affect and combine with Caribbean gender norms to increase vulnerability to HIV:

- Income differentials between men and women, especially among the poor
- Dependence on tourism, especially sex tourism
- Gender ideologies contributing to homophobia
- The shifting sexual division of labour, with traditional areas of working class male employment contracting.

Introduction

In the Caribbean, as in many other parts of the world, HIV is most often transmitted via the most intimate type of personal contact: sex. As such the process of transmission is surrounded by cultural expectations regarding how males and females are supposed to behave in this primary arena for the enactment of gender roles (Weeks, 1986).

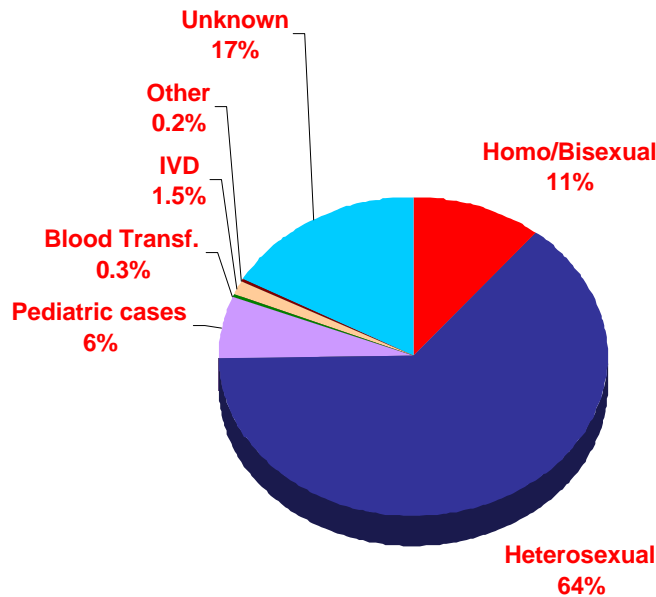
This paper describes the characteristics of the HIV epidemic in the Caribbean with special attention to the gender distribution of cases. From a review of Caribbean surveys, the major characteristics of sexual behaviour are outlined and comparisons made between females and males. These results are discussed in the light of studies of the social position and relationships between females and males in the region.

HIV in the Caribbean

Since the first case of AIDS was diagnosed in Jamaica in 1982, the number of cases has risen consistently every year. By 1996, the annual number of new cases per 100,000 population was three times higher than in North America and six times higher than in Latin America¹. By the end of 1999, it was estimated that in the Caribbean 2% of adults in the sexually active age group 15-49 were living with HIV/AIDS. This rate is the highest in the Western hemisphere and second highest in the world after sub-Saharan Africa. It is now the leading cause of death in both male and female 15-49 year olds in the region.

In the Caribbean, HIV is primarily sexually transmitted. Intravenous drug use is rare and accounts for only 1.5% of cases reported since 1982. Fig. 1 presents the proportions of cases accounted for by various modes of transmission in the 21 member countries of the Caribbean Epidemiology Centre (comprising English and Dutch-speaking Caribbean countries). It shows that almost two-thirds of cases were reportedly transmitted heterosexually, while 11% resulted from homo- or bisexual behaviour. While the proportion attributed to male homosexual behaviour is thought to be an underestimate (De Groulard et al, 2000), the predominantly heterosexual character of the Caribbean is also evident from the fact that females have accounted for an increasing proportion of HIV and AIDS cases ever since 1985. This is similar to the pattern in sub-Saharan Africa, and contrasts with the pattern in North American and European countries, where homosexual transmission accounts for the majority of cases among nationals.

Fig. 1: Categories of Transmission in Reported AIDS Cases in CAREC Member Countries 1982 - 1999



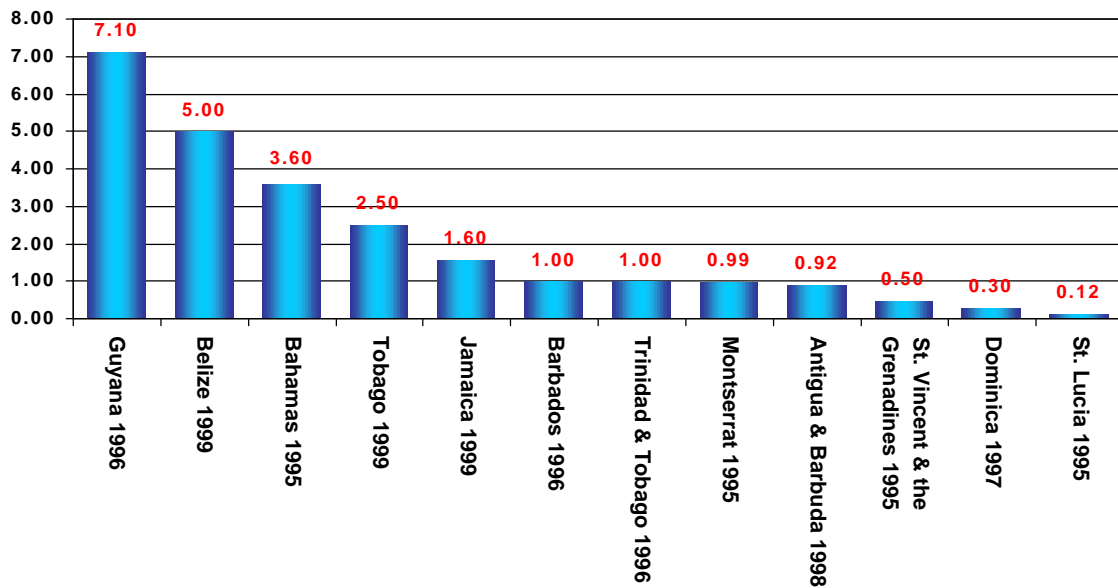
Source: Camara (2002)

Since 1982, there have been approximately two male AIDS cases for every female case in the Caribbean. From 1982-85, all cases were male and thought to be transmitted via sex between men. Since that time, female cases have risen consistently as a proportion of the total. Among AIDS cases classified as heterosexual, there are about 1.5 males for every 1 female (De Groulard et al, 2001). The trend is towards a faster increase of HIV in women than in men, with the number of male and female HIV cases roughly equal in several territories including Haiti, Jamaica, Bahamas, Guyana.

Young women are particularly vulnerable. In women 15 to 24 years old, HIV prevalence is two to four times higher than in all other female age groups and three to six times higher than in males of that age group.

The rate of HIV among pregnant women is often treated as an indicator of the HIV rate in the general population². Fig. 2 shows the rates of HIV found among pregnant women in various Caribbean countries. It will be seen that there is no obvious correlation between rates of HIV and social and economic indicators. For instance, the rate is highest in Guyana, where income per capita is lowest of the selected countries, but the third highest rate is in Bahamas, where income per capita is highest. This suggests that a complex mixture of factors is at work in determining rates of HIV in each country.

Fig. 2: Prevalence of HIV among Pregnant Women in Selected Caribbean Countries



Source: Camara (2002)

High rates among pregnant women translate into high rates of mother to child transmission. Indeed, the proportion of AIDS cases accounted for by mother to child transmission, at 6%, is the highest outside sub-Saharan Africa. In the 21 CAREC member countries, approximately 3,000 children are born per year to mothers with HIV, and about 1,000 are infected (Camara, 2002).

Box 1:
1999 Estimate of Incidence of HIV Among Children in 4 countries

Belize: 105 children (15 per 1000 live births)
 Guyana: 420 children (21 per 1000 live births)
 Jamaica: 225 children or 5 per 1000 live births
 Trinidad & Tobago: 108 children (6 per 1000 live births)

Surveys have been conducted of prevalence of HIV in certain vulnerable groups, showing far higher HIV prevalence than in the general population. Comparing individual Caribbean countries, it has been found that HIV prevalence ranges from:

- 2 to 21% among patients with Sexually Transmitted Infections (STIs);
- 18 to 40% among men who have sex with men (MSM), and
- 3 to 45% among female sex workers (Camara, 2002).

Among males with HIV or AIDS, the proportions reported as homosexual and bisexual have generally fallen. However, at the same time, the proportion of cases classified as “unspecified” has increased. This suggests we should be cautious about interpreting statistics as indicating that sex between men has declined as a source of

transmission (De Groulard et al, 2000). Reporting of AIDS cases transmitted by hetero-, bi- or homosexual behaviour depends on the knowledge and discretion of doctors who report cases to the National Epidemiologist of each country. Given the climate of homophobia in the Caribbean, it is very difficult to generate reliable estimates of the extent of homosexual behaviour and the prevalence of HIV among men who have sex with men. Estimates of HIV prevalence have been conducted on samples of self-declared gay men who are a minority among MSM.

Sexual behaviour in the Caribbean

The Caribbean is an extremely diverse region, with a wide range of economic and social characteristics. This makes generalisations about sexual behaviour in the region quite hazardous. Nevertheless, there are some cultural similarities and by looking at quantitative surveys that have been conducted, it is possible to discern some general patterns. This section draws upon a review of results of quantitative sexual behaviour studies conducted among adults (age over 25) and youth (age 9 to 25) in the English-speaking Caribbean between 1989 and 2000 (Allen et al, 2001). Results of some qualitative studies are also presented.

With regard to quantitative studies, lack of uniformity in sample age ranges, sampling strategies, questions asked and methods of reporting made it difficult to make comparisons and determine trends. What emerged were the following general findings.

➤ Number of sex partners

Numbers of reported sex partners per time period are higher for males than for females. Females are more likely than males to report no partners (abstinence) or one partner (monogamy) in the last year.

One cross-national study enabled a picture of behaviour across 9 English-speaking Caribbean countries to emerge, as a similar methodology was applied across them: Antigua and Barbuda, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica and St. Lucia. The PAHO Adolescent Health Survey (PAHO, 2000) had a sample of 15,695 school students age 10-18 in these countries. The authors caution that the results represent youth who are less at risk, given that they are those who attend secondary school. The survey presents data on number of partners in lifetime (for those who had ever had sex) as follows, confirming the pattern described above.

Table 1: Number of partners in lifetime, PAHO Adolescent Health Survey

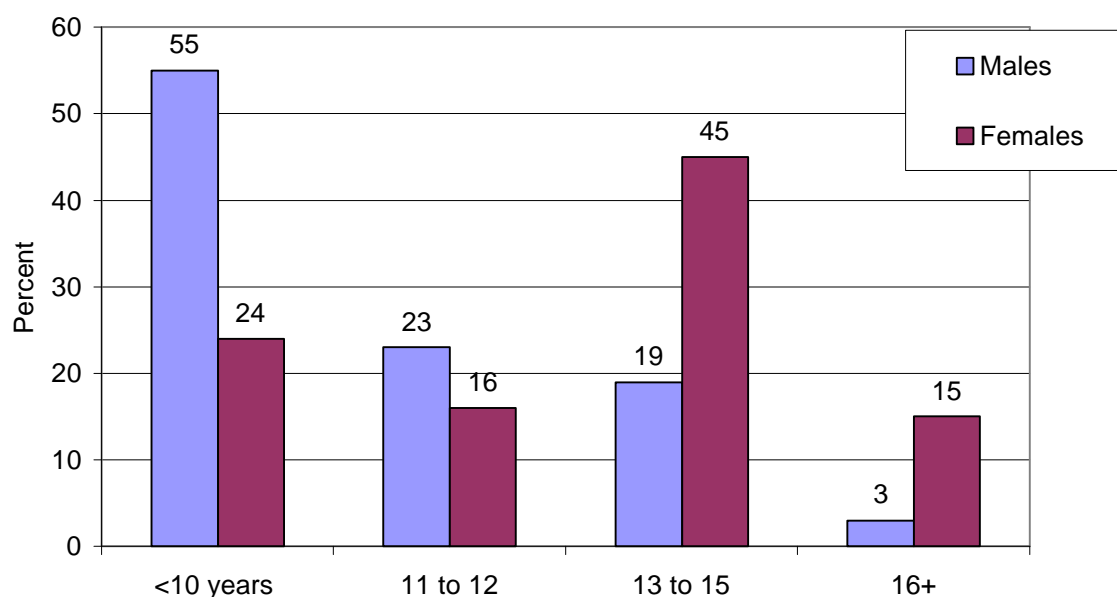
Number of partners in lifetime	Male %	Female %	Total %
1-2	36	73	49
3-4	25	14	21
5+	40	13	30

➤ **First sexual intercourse**

In both adult and youth studies, males invariably reported lower (average and median) age at first sex than females. The median age at first sex in youth studies ranged from 9 to 15 for males and 14 to 17 for females.

The PAHO adolescent health survey reports percentages of males and females having sex for the first time in four age bands, as shown in the following diagram. It demonstrates the pattern of males initiating sex at an earlier age than females. Remarkably, 55% of boys reported having had sex by the age of 10.

Fig. 3: Age of first intercourse among 10-18 year old youth in school in 9 Caribbean countries



Source: PAHO adolescent health survey 2000

In the 2000 Tobago youth sexual health survey, partners were on average 2.5 years older than respondents were at the time of first sex. Partners were older for both male and female respondents, but for female respondents the average age difference was much larger: 4 years as opposed to 1 year for males. At age 19.2, the girls' male partners (assuming most were male) would have had about 6 years of sexual experience. In contrast, the boys' female partners may have had little or no sexual experience.

These findings help explain the higher reported rates of HIV infection in Trinidad and Tobago among teenage girls than among teenage boys. Focus groups conducted as

part of the same study remarked on the phenomenon of young women having sex with older men. Materialism plays an important part; girls prefer men who drive cars and who have money to buy them fast food and clothes. The men seek status through relationships with younger women (Allen et al, 2000a and b).

Data from other studies support the notion that young people, both male and female, are having sex with older partners on average. A study in Bartica, Guyana, 2000, put the average age of respondents (not at first sex) at 13.4, while the average age of their current partners was 15.3 (data was not disaggregated by gender) (Cox, 2000). In Jamaica in 1996 among 9-18 year olds, 37% of males and 46% of females said their first partner was “older”, while only 17% of males and 5% of females said their first partner was “younger” (Hope Enterprises, 1996).

This may suggest sexual abuse of young people. In the PAHO adolescent health survey, 38% of young people said their first intercourse was forced (“yes” or “somewhat”). Almost half of females (48%) and a third of males (32%) said their first intercourse was forced. In Tobago, 12% of males and 14% of females answered “no” to the question, “Did you agree to have sex with that person?” (referring to their first partner). Seven per cent of first sexual encounters by males and 6% of those by females were apparently incestuous; these percentages answered “yes” to the question, “Was that person a member of your family?” (Allen et al, 2000a and b).

➤ **Condom use**

Condom use is a primary HIV prevention method for people who are sexually active, particularly if they have more than one partner. The review showed that younger adults were more likely to use condoms than older adults, whereas the reverse was true in youth studies. Reported consistent condom use for adults ranged from 7 to 29% and for youth 16 to 56%

Among adults with regular partners or when the type of partner was unspecified, females were less likely to report using condoms consistently than males. There was no consistent gender pattern in condom use among young people. Younger adolescent females and girls are particularly vulnerable because of their low propensity to use condoms.

The Tobago youth sexual health study showed that fewer girls than boys felt that they had access to condoms and control over their use. Common opinions revealed in focus groups were that girls in love will give in to not using a condom, that it is the man's responsibility to get the condom and that girls feel more embarrassed to purchase them. Despite the attribution of responsibility to males, they showed no greater propensity to use condoms than females (Allen et al, 2000a and b).

➤ **Sex between men**

It is important to acknowledge that while anal sex without a condom between men is highly risky in the context of high HIV prevalence among gay men in the Caribbean, homosexuality in itself is not a risk factor. Quantitative information on types of sexual practice between men in the English-speaking Caribbean is lacking. The social stigma attached to homosexuality in the Caribbean means that estimates of the extent

of homosexual behaviour are of dubious reliability, as shown by contradictions in the data.

A qualitative study carried out among men who have sex with men (MSM) in 9 English-speaking Caribbean countries revealed that some adopted elaborate strategies to avoid the negative consequences of public disclosure, including sexual relationships and marriages with women. Many who were discovered or suspected to be homosexual suffered attacks and humiliation. Some had been physically, emotionally or sexually abused in childhood. Steady homosexual relationships were difficult to sustain, there was substantial fear and mistrust among MSM themselves and it was difficult to talk about sexual history and feelings. Some got involved in MSM activity for economic need rather than sexual orientation or preference, with some trading sex with tourists. Some men who were identified as heterosexual at home travel to other islands to meet male partners. Self-esteem is generally low. In this climate, the probability that MSM will adopt safer sexual practices such as condom use is low. It was found that condom negotiation skills were minimal and condoms would rarely be used when a man “got to know” his partner³. The necessity to hide sexual orientation places the men and their partners (of both sexes) at high risk (Russell-Brown and Sealey, 1998; De Groulard et al, 2000).

De Moya and Garcia (1999) reviewed studies of men who sell sex in Santo Domingo, Dominican Republic. They noted that there is a long history of lower-class male youth trading sex for money or gifts from politically, economically or religiously powerful older men. In the 1980s, foreign gay residents began to open accommodation and recreation facilities for middle- and older-age gay tourists from North America and Europe. Payment for sex was understood, both by the tourists and the mostly adolescent partners, as a necessary token of gratitude for the good time spent together in the context of poverty and true financial need. It could take the form of a shirt, a pair of jeans, tennis shoes, two or three dollars, or a night’s entertainment. Accompanying the fear of AIDS in the 1990s, there was a fall in the number of “gay zones” (parks, cinemas, night clubs and bars) and receptive oral sex became more widely practised. Men who sold sex primarily to tourists became far more oriented to selling sex to women.

➤ **Commercial sex work**

As the study above highlights, commercial sex is by no means restricted to women in the Caribbean, and men are not the only clients. With tourism, the commercial demand for sex from Caribbean people of both sexes has grown.

In countries less oriented to tourism, commercial sex takes the more traditional form with mostly female clients providing services to mostly local males. This is the case in Georgetown, Guyana, where a survey was conducted among female sex workers. A third (35.6%) of women said all their clients are Guyanese, 6.7% said they were all foreigners while 57.4% said they were mixed Guyanese and foreigners.

Thirty-one per cent of the women were found to be infected with HIV. Only 45% of the women interviewed were able to show the interviewer that they had a condom with them. It was found that HIV was statistically associated with socio-economic status, history of other sexually transmitted infection, anal sex and substance abuse:

•Location of interview

–Women interviewed downtown (poorer area) had higher rate of HIV (36.2% were HIV+) than those interviewed uptown (13.3%)

•Where sex workers find their clients

–Street and brothel based workers had higher rate of HIV (37.2%) than those who find clients in discos and other places (15.5%)

•Alcohol use

–Women who regularly get high on alcohol more likely to be HIV+ (51.2% vs. 28.2%)

•Coke/ crack use

–Women who have used crack cocaine (regularly or sometimes or have tried it) more likely to be HIV+ (45.3% vs. 27.1%)

•Anal sex

–Women who have had anal sex (regularly or sometimes or have tried it) more likely to be HIV+ (42.9% vs. 29.2%)

•Syphilis

–Those who reported they had treatment for syphilis in the last year had higher rate of HIV (52.9% vs. 28.6%) (Allen et al, forthcoming).

It is interesting to note that the factors above proved to be more significant in determining HIV status than the reported characteristics or behaviour of male clients.

Sex, HIV risk and Caribbean gender relations

Sexual practices have multiple, complex, and, perhaps by definition, not always rational explanations. Nevertheless there have been some studies which help explain the patterns outlined above.

Income differentials between men and women in the English-speaking Caribbean are at their highest among the poorest, working class group. Studies have demonstrated the vulnerability of poor women to commercial exploitation in several Caribbean countries. Handwerker, (1992a, b and c), using evidence from Antigua and Barbados, showed that men's higher access to resources is associated with a range of extreme manifestations of male power, such as domestic violence, child abuse, physical and emotional abuse of members of the family and use of commercial sex workers. Studies in Haiti (Ulin et al, 1993) and Jamaica (Chambers and Mitchell-Kernan, 1993), likewise found that male control over economic resources related to the belief that men have the prerogative to have more than one partner, thus potentially multiplying risks of spreading disease, particularly among women. While the norms themselves presumably result from a complex range of historical factors, control over resources related broadly to male ability to impose sanctions on women. The Jamaican women appeared more assertive than the Haitians in seeing material goods as a direct compensation for the risks they took, indicating that such findings are likely to be influenced by local conditions.

Nurse (2002) has noted that in the middle-income strata, the economic privileges of Caribbean males are being eroded. The participation of women in industrialisation in the region has been followed by the expansion of the service economy, in favour of further female employment and at the expense of traditional forms of male employment. One of the new employment areas for men is as sex providers (e.g. beach boys), especially in the tourist economy. A phenomenon associated with

increased travel opportunities and rising income among women is that female tourists are able to adopt the position of prostitute-users (Sanchez-Taylor, 2001).

Sanchez-Taylor (1997) shows that commercial sex work replicates and reinforces many of the worst features of the plantation system. She conducted structured and semi-structured interviews among local people involved in the sex industry and their foreign clients in Cuba and the Dominican Republic. Her findings show that the sex tourists view “difference” as part of what they have a right to consume on holiday, and that ideas of difference are constructed from racist colonial binarisms such as “natural” vs. “civilised”, “exotic” vs. “mundane” and “sexual” vs. “repressive”. While there is a long history of sexual exploitation under colonial rule,

the long-haul tourist industry is turning this kind of lived colonial fantasy into an item of mass consumption. (Sanchez-Taylor, 1997: 3)

Her interviews revealed that

Male sex tourists like traveling to “Third World” countries because they feel that, somehow, the proper order between the genders and between the “races” is restored. Women and girls are at their command, Blacks and Hispanics and Asians are serving them, shining their shoes, cleaning their rooms etc. All is as it should be [sic]. In... restoring the “natural” racialised and gendered order sex tourists also feel that their masculinity and racialised power is affirmed in ways that it is not at home. (ibid: 4)

Interviews with both female and male sex workers revealed an internalisation or at least a cynical exploitation of colonial fantasies about hot-blooded Caribbean peoples. She points out that the tourist industry operates and reinforces the “pigmentocracy” of Caribbean society, with employment for the darker-skinned restricted to menial jobs and those which promote the fantasy, such as dancing salsa. An interview with a male sex worker showed that he

does his best to live up to the Western women’s racist fantasy of the “Big Black Dick”.... By accepting and normalising his behaviour in tune to these discourses he could use his Blackness and the sexuality attributed to it to experience immediate power and status over others. However this was the only option available to him because he was effectively shut out from other forms of employment within the formal tourist sector because he was black. (ibid.: 6)

Thus the fragile gains which have been made in post-colonial times by some Caribbean people seeking to assert their independence from colonial discourse are seriously eroded by the development of tourism, and, more particularly, sex tourism. The replication and reinforcement of plantation psychology and power relations has serious implications not only for sexual health, but for mental health (Fanon, 1982) and for consumption patterns associated with health such as preferences for Western products.

Discussion and conclusion

The erosion of self-esteem and increased materialism of Caribbean societies are key to understanding why Caribbean people continue to expose themselves to risk of HIV through their sexual relationships and behaviour. Tourism, branding and advertising have played their parts in reinforcing “plantation psychology” whereby both female and male bodies are commodified and sex seen as an avenue for personal advancement. Racialisation as well as gender stereotyping are key to understanding forms of commercial sex in the region.

Males struggle to maintain their sense of masculinity in the face of economic and symbolic change by maintaining the double standard whereby they have multiple partners but women should not. Women fail to protect themselves from HIV because they are more interested in maintaining their femininity by playing the passive sexual role (though their roles in the rest of their lives may be at odds with this). Health promotion programmes which seek to reduce the numbers of sexual partners, increase condom use and raise age at first sex are up against gender roles which are changing but which maintain their deep historical roots.

However, experience has shown that it is possible for countries to turn the tide of the HIV epidemic. In countries as diverse as Uganda and Thailand there have been significant and sustained falls in levels of HIV in both males and females (UNAIDS, 2002). Keys to their success include the following:

- Political leadership at the highest level. For instance, President Museveni of Uganda made the fight against HIV a cornerstone of his regime, talking about the disease and debating responses at political and public gatherings on any subject.
- Nurturing an expanded response to the epidemic, moving beyond health to encompass the full range of sectors of the society. For instance, each public Ministry (Education, Security etc.) should develop an HIV/ AIDS policy, encompassing staffing and recruitment as well as approaches to prevention, care and support of client groups. As happened in Uganda, the government should also actively seek to encourage non-governmental organisations, the private sector and faith-based organisations to become involved in and sustain their response to HIV/ AIDS. For instance, these organisations should be included in bodies formulating national AIDS policy, and resources should be made available to support their HIV work (Taylor et al, 2002)
- Targeting prevention efforts and providing comprehensive care for sexually transmitted infections for high risk groups, including young people, commercial sex workers and men who have sex with men (UNAIDS, 2002).

The need for top-level political leadership is particularly acute in the Caribbean given the deep-seated causes of the epidemic described in this paper. In addition, non-governmental organisations are predominantly voluntary and part-time and there is little evidence of concerted efforts being made by the private sector. The conservatism of most faith-based organisations in the region has held them back. Women’s organisations have preferred to focus on issues of political representation and labour.

It has been a long time in coming, but there are signs of change in the response of Caribbean leaders to the HIV epidemic. At the February 2001 meeting of the region's Heads of State, the Pan-Caribbean partnership on HIV/ AIDS was launched, operating as part of the Caribbean Community Secretariat (CARICOM) and linking the resources of governments and regional partners such as the Caribbean Regional Network of People Living with HIV/ AIDS, the Caribbean Epidemiology Centre and the University of the West Indies. Among initiatives are a regional application to the UN's Global Fund for AIDS, Malaria and Tuberculosis for reduced cost anti-retroviral drugs for people living with HIV/ AIDS in the region. The governments of Barbados and St Kitts and Nevis have followed Uganda's example: Barbados has placed the co-ordination of the National AIDS Programme in the Prime Minister's office and St Kitts and Nevis has expanded its National AIDS Advisory Committee to include trade unions, religious organisations, the private sector and people living with HIV/ AIDS. The challenge will be to mobilise across sectors of society. A crucial aspect will be the engagement of organisations representing females and males of all ages in debates on sexual behaviour and the potential for change.

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¹ The number of new AIDS cases in North America started to fall from a high of 27 per 100,000 population in 1992 following the introduction of anti-retroviral drugs. In 1994, the rate in the Caribbean began to surpass that in North America. By 1996 the rate in North America stood at 10 per 100,000 while that in the Caribbean was 33 per 100,000.

² This is an imperfect estimate as it does not take into account the different sexual behaviour patterns between the sexes and between those women who are pregnant and those who are not, nor the higher biological susceptibility to HIV among females. This indicator is often used because it is the most accessible as the blood of pregnant women is routinely screened. There is not a similar “captive population” for screening among males.

³ Many studies among heterosexuals have also found that condom use is restricted to the very early phase of relationships.

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