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Learning stories through conversations: gaining insight into women's knowledge of and attitudes towards sexual health and the implications for the spread of HIV/AIDS in Trinidad

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Learning stories through conversations: gaining insight into women's knowledge of and attitudes towards sexual health and the implications for the spread of HIV/AIDS in Trinidad

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The Rising Rates

Women in the African Diaspora generally, and women in Trinidad specifically are contracting the Human Immunodeficiency Virus *(*HIV*)* and subsequently the Acquired Immunodeficiency Syndrome (AIDS) at a disproportionate rate to men and individuals of any other racial and ethnic category. Presently, the primary mode of transmission in Trinidad is through heterosexual intercourse in which women are largely contracting the disease from their male partners (UNAIDS/WHO 2004; UNAIDS/WHO 2008; UNGASS 2008). It is estimated that in Trinidad and Tobago women between the ages of 15-49 contract HIV/AIDS at a rate three to seven times that of their male counterparts (Camera, B. et al. 2003; Voisin and Dillon-Remy 2001; PAHO/WHO/UNAIDS 2001). The islands of Trinidad and Tobago have seen an unprecedented 500% increase in HIV/AIDS, with adolescents contracting the disease at disproportionate levels (Caribbean Epidemiology Research Center [CAREC] 2000).

Though these are alarming statistics, it is imperative to consider David Plummer's (2006) call to be cautious in regards to how HIV/AIDS researchers position our discussions of this epidemic in terms of the death toll. There has been extensive work done on the factors, outlined in my literature review, that are contributing to the spread of HIV/AIDS (Fraser 2000; Adegbenjo, 2001; Allene 2004; Oni 2005; Maharaj et al. 2009) and the impact this disease has on communities in the Caribbean. However, a repeated discussion of these factors alone is not enough if we are to move beyond discourses that focus on impact mitigation to those that foster alternative understandings of HIV/AIDS. Therefore, it is necessary to abandon considering HIV/AIDS as only a biomedical

problem to that of a social phenomenon that becomes embedded in human psyches, impacting how people think, feel and act in regards to their sexualities, bodies and those of other people. Statistical data is useful for generating numerical patterns that demonstrate trends in ideology and behavior. However, what it lacks from this discussion is a nuanced interest in the human elements of conversations that expose the cultural dimensions of why these this epidemic exists. Through conversations with Trinidadian women regarding their perceptions of sexuality and HIV/AIDS I gain more insight into their lived experiences which generated useful health information regarding the epidemic. My research considers the intersections of gender inequalities with self perceptions of sexuality and knowledge of 'safer sex' practices among Trini[1] women to deconstruct how these factors contribute to the disproportionate spread of HIV/AIDS among women in Trinidad.

Through an analysis of the conversations I had with Trini women seeking services at the Family Planning Clinic of Trinidad and Tobago (FPATT) I investigate the discrepancies between HIV/AIDS information dissemination in Trinidad and Tobago and the increased rate of HIV/AIDS infection among women. This investigation is geared toward discovering where women gained their knowledge of heterosexual sex and HIV/AIDS.

Using participant observation and by conducting interviews, I examine the relationship between local constructions of Trini women's sexuality, the spread of HIV/AIDS and public policy discourses regarding HIV/AIDS. My analysis demonstrates the existence of a disconnect between the rhetoric and policies used by official institutional bodies like the World Health Organization and the Trinidad Ministry of Health and how these discourses rarely take into consideration the lived experiences and voices of the women they seek to serve. Therefore, I look at the cultural contexts in which HIV/AIDS is unfolding in Trinidad and Tobago to understand how gendered cultural assumptions influence

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[1] Trini is the term used by Trinidadians to refer to themselves.

sexual behavior and how these understandings interact with initiatives geared towards HIV prevention. This analysis of women's experiences and stories contributes to an increased understanding of how to inform, through a gendered lens, educational initiatives and public health policies that seek to curb the spread of HIV/AIDS and de-stigmatize those living with the disease. I posed several questions, outlined in my methodology that sought to expose women's perceptions on the disproportionate spread of HIV/AIDS to women by having them discuss their experiences with sex education and HIV/AIDS knowledge acquisition.

Contextualizing HIV/AIDS in Trinidad: The Numbers

The prevalence of HIV in the Caribbean is second highest in the world and has become the leading cause of death among people age 15-44 (UNAIDS 2004). AIDS was first reported in Trinidad and Tobago in 1983, with only eight registered cases of AIDS, these cases being among homosexual and bisexual men (Newton 1994). By 1992, Trinidad and Tobago ranked 17th worldwide out of 164 countries with reported data on prevalence of AIDS per 100,000 people. Also, of the cases in Trinidad and Tobago with identified risk factors, 77.1% were among heterosexual individuals (Newton 1994). Women rapidly grew from being none of originally reported cases to a number approximately equal to men, and now the rate of infection in women in the Caribbean is surpassing men (UNAID 2004). The ratio of male to female reported cases has been declined steadily from 6:1 in 1985 to 1.3:1 in 1999. In 2003, of approximately 28, 000 HIV-infected adults in Trinidad and Tobago, an estimated 14,000 of them were women (UNAIDS 2004).

Estimates suggest that in the Caribbean Commonwealth Region (CARICOM), there are 240,000 people are living with HIV/AIDS, with new infections increasing. World Bank estimates differ claiming that there are approximately 400,000 HIV/AIDS cases in the Caribbean (2005) although statistics are uncertain due to lack of standard reporting. These discrepancies are attributed to the fact

that HIV/AIDS surveillance is considered to be inadequate, with actual prevalence and number of cases of HIV/AIDS throughout the region is thought to be under reported (Wycliff 2005).

The challenges faced by the World Health Organization (WHO), the Pan-American Health Organization (PAHO), and the Trinidadian Ministry of Health (MoH) in combating this epidemic are demonstrated by the Report of the Global AIDS Epidemic created by the United Nations Joint Program on HIV/AIDS (UNAIDS). The following table provides data on Trinidadian HIV/AIDS estimates come from UNAIDS/WHO regarding adults and children living with HIV/AIDS at the end of 2003 and 2005. These estimates include all people (tested) with HIV infection, whether or not they have developed symptoms of AIDS.

	2003	2005
Adults (15+) and children	25,000	27,000
Low estimate	14,000	15,000
High estimate	40,000	42,000
Adults (15+)	25,000	26,000
Low estimate	14,000	15,000
High estimate	39,000	41,000
Children (0-14)	<1000	<1000
Low estimate	N/A	N/A
High estimate	<2000	<2000
Adult rate (15-49) (%)	2.6	2.6
Low estimate	1.4	1.4
High estimate	4.1	4.2
Women (15+)	14,000	15,000
Low estimate	6,500	6,900
High estimate	23,000	24,000

WHO/PAHO/UNAIDS Report of the Global AIDS Epidemic (2006)

In addition, the same report estimates the number of adults (15+) in need of HIV/AIDS treatment has increased as well; however, the number of people receiving antiretroviral therapy (ART) has not consistently met those needs. The total number of adults needing ART of both genders in 2003 was 4,200 people while in 2005 that number rose to 5000. It is also important to note that the estimated number of people receiving ART in 2003 was less than 500 and in 2005 approximately 1500 (WHO, PAHO, UNAIDS 2006). This disparity is alarming because it demonstrates the limited capacity of

official government entities to simultaneously promote HIV/AIDS testing and prevention while also providing care for those living with the disease. This statistical data is useful for looking at epidemic trends that exist in Trinidad because they highlight the reality that HIV/AIDS is increasing among the population in general and among Trini women specifically. However, it is equally important to consider the socio-cultural factors that have been pinpointed by scholars as contributing to the spread of HIV/AIDS.

Research Rationale

The rationale of this project is that its completion will provide scholars and policy makers with specific information regarding the relationship between gender, sexuality and HIV/AIDS couched in terms of what Trini women espouse as their understandings of sexuality and their assessment of their own needs in regards to HIV/AIDS and sexual health information. HIV/AIDS is a disease where transmission and treatment are influenced by a complex web of gender inequality, misconception and inadequate governmental response. This is largely influenced by the fact that,

> Current AIDS responses do not, on the whole, tackle the social, cultural and economic factors that put women at risk of HIV, and that unduly burden them with the epidemic's consequences. Women and girls have less access to education and HIV information, tend not to enjoy equality in marriage and sexual relations, and remain the primary caretakers of family and community members suffering from AIDS-related illnesses (UNAIDS 2006, 5).

This assertion that women have limited access to various forms of social capital that help insure sexual autonomy is echoed by numerous scholars (see Thomas-Long and Balley 2007; Allene 2004; Fraser 2000). To address this lack of access to education, HIV information and economic opportunity that assist women in developing the psychological and social tools necessary to exercise autonomy it became evident that I must seek out the perspectives of the women that the literature sites as having limited access.

The Centre for Gender and Development Studies at the University of the West Indies (CGDS) claims in their report from the "Symposium: Gender, Sexuality and the Implications for Substance

Use and HIV/AIDS" (2004) that behavioral science has not taken the critical role necessary to aid in combating HIV/AIDS in the Caribbean. The CGDS states that "we need to re-examine why people knowingly engage in behavior that may lead to death. We must find the causes of risky behavior. Therefore, an examination of the social construction of sexuality and the environment of HIV/AIDS is also necessary" (2004:28). In my research I attempt to contribute to this re-examination of behavior as it relates to sexuality and the spread of HIV/AIDS by engaging in conversations with Trini women. David Plummer (2006), the UNESCO Education Chair for the Caribbean Commonwealth, outlines significant points of action for improving HIV education in the Caribbean. He recommends that additional attention should be directed to extra mural, informal and peer-based education settings; and that the social dimensions that serve to entrench HIV (e.g. peer group dynamics, gender roles, stigma and discrimination) need to be further addressed.

Therefore, by conducting this research I aim to positively contribute to the discussions surrounding how HIV prevention and de-stigmatization efforts should increasingly look to the knowledge of local women to inform new community strategies that are designed to take into account the variables of gender and sexuality. At the same time, this research provides a holistic approach to information gathering and management regarding HIV/AIDS epistemologies that are neglected by the entities that produce the official public health discourses that formulate HIV/AIDS prevention and treatment efforts, namely the WHO. Lastly, the primary motivation for this research is to amplify the voices of Trini women who have been impacted by HIV/AIDS or who are risk of contracting the disease.

Fieldwork Location

Trinidad & Tobago Country Profile

The Republic of Trinidad and Tobago, a twin island democratic republic, is the most southerly of the Caribbean islands. Trinidad and Tobago are considered a multi-ethnic, multi-cultural society. It is

estimated that 39.5 % of the population is of African descent, 40.3 % are of East Indian descent, 18.4 % are of mixed racial ancestry and the remaining are Caucasian, Asian, and others. The population based on the 2000 census is of 1,262,366 of which 95.72 % are located in Trinidad; 50.2 % are males; an estimated 70. 6% of the population is between 15-64 years old, 8.1 % are over 65 years and 21.4 % below 14 years. Population density was 246 km2. Approximately 74 % of the population is urban and net migration rate is estimated at -10.83 migrants/1,000 population for 2004. The population of East Indian descent predominates in rural and more agriculturally oriented localities (PAHO/WHO 2005).

According to the WHO Trinidad and Tobago is in a stage of advanced demographic transition. For 2004 the estimated birth rate is 12.75 births/1,000 population and death rate is of 9.02 deaths/1,000 population. Population growth rate is estimated at -0.71 births/1,000 population; total estimated fertility rate is of 1.77 children born/woman. This is in part due to the decline in fertility rates and crude birth rates since 1997. 15 % of live births were due to teenage pregnancies (PAHO/WHO 2005).

Life expectancy at birth is estimated at 69.28 years with 66.86 years for men and 71.82 years for female. However, much of the gain in life expectancy at birth has been in the under 15 year's of age group. Over the last twenty years the proportion of population below 15 years has declined while the proportion over the age of 60 years has increased steadily. Trinidad and Tobago's projected population growth is above 4 % annually peaking in 2005 at 9 % (PAHO/WHO 2005).

Unemployment rates have experienced changes since 2000. The overall rate was of 11.4 % and was estimated in 2002 at 10 %. In 2001, of the total unemployed population 8.8 % were men and 14.4 % were women. The percentage of the population living in poverty was 22 % in 1997. The highest levels of poverty were seen among the unemployed, particularly with women with the lowest education levels and female headed households 31 % of which 19 % are single parent female headed (PAHO/WHO 2005).

The major job generators include construction, services, and manufacturing sectors. Between 1995 to 2000 Trinidad's economy based on an open market–driven economy policy has grown positively with services accounting for an increasing 54 % of the GDP, it is sustained by the petroleum, natural gas, chemicals, tourism industry. GDP growth was 2.7 % in 2002 a decline compared to 3.3 % in 2001. Total public debt at the end of 2002 was 66 % of the GDP with an estimated decline to 55.9 % in 2003 (PAHO/WHO 2005).

Even though Trinidad's economic indicators are considered positive according to a capitalist model, health indicators indicate a degree of variability related to equitable access to services and behavioral issues as a common leading factor determining the health profile and burden of disease. Housing and public health related living conditions indicate that urban areas have the major amount of services provided with an overall availability of 96 % of sewage and waste disposal, 69.4 % of households with water piped into dwelling and or yard, 86% of the population have access to drinking water, 67 % have toilet facilities, 92 % have electricity and 35.35 % have a motor vehicle (PAHO/WHO 2005).

In 2003, adult literacy rate was estimated at 98.6 % (99.1 % for males and 98 % for females). However, the combined primary, secondary and tertiary gross enrolment, which is predominantly female, continues to drop since the last decade largely due to socio-economical factors such as structural adjustment, unemployment, and parent migration, among others (PAHO/WHO 2005).

Crude death rate increased from 7.2 per 1,000 population in 1997 to 7.8 in 1999. The five leading causes of deaths for 1999 in the country were: heart disease, diabetes mellitus, malignant neoplasm, cerebrovascular disease and HIV/AIDS; leading causes among the 15-34 age group were HIV/AIDS, transport accidents, assault, intentional self harm, and heart disease in the same order. Total deaths registered in mortality data over the last decade (1989-1998) indicate an increase in 10 selected causes (in descending orders by number of deaths): heart disease, diabetes mellitus, malignant

neoplasm, AIDS, suicides, pneumonia, motor vehicle accidents, homicides, cirrhosis of the liver and bronchitis/emphysema, and asthma (PAHO/WHO 2005).

The Family Planning Association of Trinidad & Tobago

The Family Planning Association was founded in 1956 by Dr. Beric Wright with the support of the then Shell Petroleum Company Limited. Upon his arrival in Trinidad, Dr. Wright immediately saw the need for medically approved methods of birth control to be made freely available to all sections of the community. Within a few months of his arrival, Dr. Wright set up the first family planning clinic. In 1961, the Family Planning Association of Trinidad and Tobago became the thirty-second member of the International Planned Parenthood Federation (IPPF), the second largest volunteer movement in the world (FPATT 2000).

The Family Planning Association of Trinidad and Tobago was the ideal field research location because of its dedication to responding to the need for improved sexual and reproductive health among underserved populations with particular emphasis on young people and their focus on the advocacy of family planning as an element of social change (FPATT 2000). This dedication to sexual health advocacy in conjunction with service provision provided a productive and supportive atmosphere for me to interview women seeking services at the clinic.

Contextualizing Public Health Discourses

The United Nations Policies and Women & HIV/AIDS

Here I briefly outline UN and WHO policies that directly address HIV/AIDS in Trinidad and Tobago. I outline these policies because they overtly maintain underlying assumptions about gender and class relations in Trinidad and Tobago. These assumptions contribute to an institutionalized health culture that seeks to produce effective sexual health reform, and in many ways does, but largely lacks the mechanism necessary to address Trini women's lived experiences. Considering the perspectives and knowledge bases of Trini women is paramount in continuing to strengthen the

services and programs that are currently reaching women between the ages of 15-24 who are in the most need.

My critique of United Nations and World Health Organization policy is not a rejection of HIV/AIDS policies, but is a critical dialogue with them and a consideration of how the consequences of these gender assumptions are manifested in the conversations I had with Trini women. I consider how official public health discourses are integrated in to, and transformed by the services provided by the FPATT to demonstrate how such discourses are limited in their ability to address the lived experiences of Trinidadian women. I argue that there is a gap between the official Trinidadian public health discourse, HIV policy and the incorporation of the resulting recommendations into the sexual decision making practices of women. My analysis of this gap acknowledges the accomplishments and contributions made by the WHO while also providing an opportunity to discuss the consequences of limited gender considerations in implementing policies that ultimately impact the efforts of organizations like the FPATT to promote HIV testing, prevention and de-stigmatization, particularly among women.

The assumption that men and women have equal input in regards to sexual activity is assumed in Trinidadian HIV/AIDS public health policy. This assumption shapes the formation and implementation of programs and services that seek to curb HIV/AIDS transmission through behavior change models. Heterosexual gender relationships as espoused by the women I spoke to and as described by the literature, are an ebb and flow of power differentials whose context is largely experienced in terms of status and power. Using the data I collected from the conversations with women I am able to highlight the elements of HIV/AIDS knowledge acquisition of the women I interviewed as well as locate where HIV/AIDS information is disjointed or misinformed.

Challenges and Opportunities: Considering Official Public Health Discourse

Policies and laws that either manifest HIV-related discrimination or do nothing to remedy discrimination actually constitute a threat to public health by discouraging HIV-positive and vulnerable populations from seeking out prevention, care and treatment – suspension of rights cannot be considered legitimate (Whelan 1998, 24). Therefore, to recognize the limitations of the strategies used by the WHO and the challenges such organizations themselves espouse is an invaluable first step in creating programs that first and foremost seek to break the silences surrounding sexuality and HIV/AIDS it is necessary to address the intersecting elements that impact the spread of HIV/AIDS among Trinidadians. A primary challenge to opening up Trinidadian social dialogue on sexuality and HIV/AIDS is the limiting language that is still extremely pervasive in international public health discourses. According to the WHO,

> In response to the changing environment, WHO, in collaboration with the World Association for Sexology (WAS), began a collaborative process (3) to reflect on the state of sexual health globally and define the areas where WHO and its partners could provide guidance to national health managers, policy-makers and care providers on how better to address sexual health. As in 1975, the process began with a review of key terminology and of the evidence, and culminated in the convening of a large group of experts from around the world to discuss the state of sexual health globally (WHO, 2009).

This announcement of purpose put forth by the WHO is useful for highlighting both the strengths and the weaknesses of the WHO as well as those organizations that take their queues from the WHO, namely the Family Planning Association of Trinidad and Tobago (FPATT). The first question that needs to be addressed for understanding the WHO framework is: Who are the primary individuals defining the key terminologies? Additionally: Who are the people considered experts and what traditions of knowledge creation are they prescribing to?

Karen M. Booth (1998) provides a useful insight into how we can begin to answer these questions in our efforts to develop HIV/AIDS responses that better cater to community needs. She provides critiques of how unequal heterosexual power dynamics are reinforced by the official doctrines of the

WHO. She argues that the effects of the WHO's statements on how people with AIDS or at risk of being infected by HIV are being perceived in terms of the contradictory dichotomies that prescribe to Western ideals of internationalism and globalism. These dichotomies are largely born out of the initiatives of 'femocrats', a civil servant, usually women, who is hired by transnational bureaucracies, because of her feminist credentials to serve as the voice of 'women internationally'. From this dichotomy erupts tensions surrounding how meaning is generated in terms of policy creation and how those 'femocrats' with the authority to create such policies often, though inadvertently, contribute to the continuation of gender inequalities that are born out of these policies seeking to indeed do the opposite.

The global trend is that women, particularly Trinidadian adolescent girls, are contracting HIV at a higher rate than any other population or age group of either sex. Booth exposes how this reality has been neglected by the WHO. This group gets left out because of the way that the WHO defines women. According to Booth the WHO has played a key role in pigeon-holing 'third world' women into the 'oppressed' groups of national mother (women defined only by their ability to have children) and global whore (women defined as promiscuous outsiders participating in an activity that is deemed 'bad', for example prostitution), a process that produces a stigmatized misrepresentation of 'Third World' women.

To remedy this misrepresentation it is necessary for the WHO to reevaluate how it discusses and presents women in documents and the media because these viewpoints perpetuate a Western double standard of womanhood. The WHO's position is problematic because it glorifies the ideology that 'good' women are sexually acquiescent where they are denied any autonomy or responsibility for their own sexual well being. This perpetual 'victimization' of 'third world' women makes it extremely dangerous for women to insist upon condom use, monogamy, or alternative forms of intimacy in relation to sexual activities with male partners (Booth 1998).

These misrepresentations are fostered by denying the social and historical agency of women, particularly in the context of their own cultural affiliations, which further contributes to the spread of HIV/AIDS. By neglecting to position women within their own lived realities the WHO continues to misrepresents the lived experiences of the women they aim to benefit by creating vast generalizations that serve their rhetorical marketing of public health concerns. Therefore, seeking to understand how Trini women in general and HIV positive women in particular are represented in policy literature can expose the consequences these representations have in terms of informing the types of HIV prevention and destigmatization services offered.

The ways 'Third World' women are misrepresented in WHO policy is evident in how the women I spoke with think 'other' Trinis perceive HIV positive individuals. In the discussions I had with Trini women I posed the question: What do you think Trinidadians in general think about people living with HIV? I posited this particular question because it provides an example of just one of the questions I asked to unearth how women understand their social surroundings, particularly as their perceptions of other Trinidadians can expose how women's representation in official public health discourse is imprinted upon the worldviews of the women I spoke with.

Exploring the Literature

There is a vast amount of literature that addresses sexuality, gender and HIV/AIDS individually and a large, but more limited canon that addresses all three. My review of the literature begins by highlighting the WHO's position on HIV/AIDS and develops into a description of the Trinidadian governmental entities who use the official discourse espoused by the WHO to inform their HIV/AIDS policies. I connect the literature present in this review to demonstrate how the WHO's top-down policy framework is missing a grassroots community needs assessment, particularly among women. A discussion of these organizations and their subsequent policies is an excellent entry point in to an

analysis of heterosexual gender relationships in Trinidad in which I couch my discussion of liming, Carnival and representations of Black women's bodies.

Deconstructing these cultural elements allows me to investigate the larger issues of how gender, sexuality and HIV/AIDS are contextualized by women and how their perceptions of these social phenomena hold up in relation to the factors that other scholars have outlined as contributing to the spread of HIV/AIDS.

The World Health Organization (WHO) & Official Public Health Discourses

The WHO's mission is to provide various forms of assistance internationally by taking the lead within the UN system on the global health sectors response to HIV/AIDS. The WHO HIV/AIDS Program provides evidence-based, technical support to WHO Member States to help them scale up treatment, care and prevention services, as well as maintain and increase access to drugs and diagnostics. This is to ensure a comprehensive and sustainable response to HIV/AIDS (WHO 2010). The WHO is an integral part of countries developing and implementing large scale public health interventions. As an entity that supports clinical services and community outreach, discussing the "WHO Trinidad and Tobago Country Cooperation Strategy (CCS): At a Glance" (2007) reports provides the context in which prevention and treatment programming takes place. Additionally, understanding the priorities outlined in these documents provides the foundation for recognizing how the development of the canon of HIV/AIDS research and gender analysis.

The "WHO Trinidad and Tobago Country Cooperation Strategy (CCS): At a Glance" (2007) outlines health and development initiatives which are highlighted as top priorities. These priorities are discussed in terms of those that have been successful in Trinidad and Tobago as well as the challenges to achieving such goals. This report recognizes that there has been significant progress in improving the health status of the population in T&T has occurred. However, Chronic Noncommunicable Diseases (CNCD), external and self-inflicted injuries, and HIV/AIDS

remained consistently as the leading causes of death with an increasing trend up to 2000. Additionally, the health sector development challenges identified include; the need for strengthened technical and implementation capacities in health systems, evidence based decision making practices and strategies for addressing the deterioration of social environments (WHO CCS 2007).

Trinidad Ministry of Health's National AIDS Coordinating Committee (NACC)

The HIV/AIDS Coordinating Unit is responsible for the monitoring and evaluation of the Health Sector's HIV/AIDS plan. It also provides an ongoing partnership, strategic framework, policy guidelines and protocols to improve the health status and delivery of health care to HIV/AIDS patients. The NAC seeks to provide assistant to people living with HIV/AIDS (PLWHIV), youth, prisoners, and commercial sex workers (Ministry of Health 2010).

Trinidad and Tobago's 'Five-Year National HIV/AIDS Strategic Plan 2003-2007' (NSP)

The NACC created the NSP in its efforts to prevent and control the spread of the HIV/AIDS epidemic. The NSP was developed as the guide to the Trinidad and Tobago national response to HIV/AIDS. The NSP (2003) indicates factors that contribute to the governments challenges to providing holistic HIV/AIDS services by outlining the following in the national HIV/AIDS response. For the purposes of my research I choose to highlight the first three points that are contributing to the challenges Trinidad is facing coordinating a holistic response to HIV/AIDS. It is suggested that there is a lack of integration of purpose, and action; there is a lack of resource commitment; and the public sector's health services delivery for HIV/AIDS has been fragmented as a result of the decentralization process (2003:10).

However this fragmentation is not progressing unaddressed. Based upon the literature review and internet searches I conducted in preparation for my field work in Trinidad I was able to locate several research based and/or community organizations that work specifically with HIV/AIDS interventions; Community Collaborative Youth-Focused HIV/AIDS Prevention (CHAMP), Women as Agents of Change Project, the Youth Advocacy Movement (YAM), the Red Initiative, the KPMG (operates as an international network of member firms offering audit, tax and advisory services) conducted by the 'The Audit of National Programs and Laboratories" study, the Caribbean Association for Feminist Research

and Action and the Centre for Gender and Development Studies at the University of the West Indies. There are also several government and international sponsored initiatives, The HIV/AIDS Prevention and Control Project for Trinidad and Tobago, funded by the World Bank and the National AIDS Coordinating Committee (NACC) a branch of the Trinidadian government and the baseline survey of Knowledge, Attitudes, Practices and Beliefs (KAPB) conducted by the University of the West Indies on behalf of the NACC.

I highlight these organizations because they also act as an excellent catalyst for recognizing the work that is already being accomplished as well as grounds for methods that can be used within these established initiatives to strengthen prevention and de-stigmatization efforts. This is relevant because these organizations have the capacity to operate on a grass root level that will allow them to reach and serve people in the community as opposed to a 'top – down' program methodology typically used by international organizations and government ministries. Understanding the functions and goals of these institutions provides the foundation from which I position my discussion of the literature that is relevant to understanding how these official discourses influence the FPATT and hence, are passed onto the women seeking services there.

The "United Nations General Assembly Special Session (UNGASS) Country HIV/AIDS Progress Report on Trinidad & Tobago", a document created by the WHO that outlines challenges that hinder multilateral and governmental plans to combat HIV/AIDS is a useful launching point for situating the significance of my research as well as shedding light upon my motivations for undertaking this project. I present the challenge as outlined by the report, followed by my perspective on why this might be the case based upon my review of the literature as well as my observations and data collected while in Trinidad.

Limited sites which provide youth friendly services

During my time in Trinidad I had the opportunity to work with the Youth Advocacy Movement (YAM), a youth-based and youth-led group that works to educate Trinidadian youth on sexual and reproductive health care. YAM is housed at 'De Living Room' a clinic that caters specially to individuals under the age of 25. De Living Room is a branch of the larger FPATT and was opened in 2005. From my

experience, this is the only physical facility that directly serves young people in regards to sexual and reproductive health.

Absence of a comprehensive surveillance system for HIV/AIDS which covers both the public and private sectors

In 2008, the government of Trinidad and Tobago contracted a Canadian organization, Terida, to help coordinate comprehensive response to HIV/AIDS. Terida specializes in designing and implementing adaptable, affordable expert solutions for chronic and epidemic disease management and surveillance. The solution includes business intelligence-surveillance tools, clinical systems, electronic health records, laboratory systems, blood bank systems, expert treatment protocols, as well as public education and counseling (Terida Systems Inc. 2008). Currently, there is no information regarding the outcomes of this surveillance model. However, I question the use of a 'business model' for addressing the complex nature of HIV/AIDS. Can a model that derives its mission from the premise of accumulating wealth successfully transfer to an initiative that seeks to decrease the spread of the disease?

Large numbers of persons particularly among the most at risk population segments remain reluctant to access testing and treatment and care services.

This reluctance is largely born out of the stigma surrounding HIV/AIDS in Trinidad. As an homophobic society, those who are living with HIV/AIDS are demonized because HIV/AIDS first appeared in homosexual men. Additionally, the misconception about how HIV/AIDS is transmitted leaves many people unsure of how they can contract it, creating the perceived need to physically and culturally isolate HIV positive people.

Policy guidelines for service delivery are not readily available nor diligently adhered to.

Marjan de Bruin (2006) examines the communication strategies for addressing HIV/AIDS by analyzing the National Strategic Plans (NSP) of Jamaica, Trinidad and Tobago and Barbados.

Her analysis concludes,

> Current local and regional HIV/AIDS policies - as expressed in National Strategic Plans and the Regional Strategic Framework - do not seem to recognize the complexity of HIV/AIDS as a multi-dimensional reality when designing communication strategies meant to be relevant and efficient. They do not appear to recognize the complexity of the communication process, or that communication is more than the simple dissemination of cautionary messages. " All of the policy

documents reviewed "mention prevention as one of the key areas for focus, and speak about HIV/AIDS as a multidisciplinary problem. However, at the same time, none of the plans elaborates on the use of communication in prevention: none tries to outline a coherent communications strategy at all levels, across all disciplines and sectors, and including a more diverse cast of actors (http://www.glocaltimes.k3.mah.se/viewarticle.aspx?articleID=59&issueID=6).

Additionally, the challenges of the limited availability and willingness of clinicians to provided HIV/AIDS care and treatment services, provider stigma is still evident and the fact that interventions tend to be targeted to the general population with limited interventions directed at high risk groups (UNGASS 2008, 23-4) can be attributed to the limited focus the UN and its subsidiaries have on considering the ways in which socio-cultural influences can be utilized in HIV education, prevention, and de-stigmatization, particularly in relation to women. However, it must be noted that this report does outline areas for further study that would be useful in combating the spread of AIDS in Trinidad.

These include: the role of the ethnicity; history of early sexual abuse; educational attainment and psychiatric illness in assessing HIV risk among substance abusers; homosexual and bisexual behavior and the types of sexual practices between men in Trinidad and Tobago; the role of sexually transmitted infections in HIV transmission; and sex workers. (UNGASS 2008, 3-4).

Though the UNGASS report recognizes the importance of ethnicity, the history of sexual behavior including sexual abuse, and educational attainment in regards to HIV AIDS transmission among substance abusers, I noticed that it neglects to pinpoint the importance of these elements in HIV transmission among the general population. Additionally, gender as a substantial area for further study in regards to the disproportionate way in which women are contracting HIV/AIDS in Trinidad is not included as a subject for further study nor is it listed anywhere in the report as a factor contributing to the continuing spread of HIV in Trinidad. The limitations listed above in conjunction with the report neglecting to highlight the areas for further study I have mentioned illustrate the problematic nature of official international public health discourse. The result is an overarching lack of gender analysis mainstreaming in both national priority setting and policy creation.

This lack of attention to gender as a social category contributing to the spread of HIV/AIDS is demonstrated by the fact that on the WHO web page, I was only able to readily locate the following in reference to women and HIV/AIDS:

> Women are physically more susceptible to HIV infection than men, and gender-based violence makes them even more vulnerable. Violence against women is well recognized as a violation of human rights and also now as a public health issue – one that dangerously intersects with the HIV/AIDS epidemic. For many girls and young women, their first sexual encounter is often coerced; the experience or fear of violence is a daily reality, and increasingly, so is HIV/AIDS (WHO 2010).

Evaluating the limited ways in which gender are discussed in conjunction to the underlying assumptions made about gender relationships that underpin HIV/AIDS policy internationally and in Trinidad specifically through the lens of Trini women's perspectives is the primary motivation for my research and informed my aforementioned methodological models.

Considering Culture

Stigma, discrimination, and cultural taboos pose many challenges for HIV/AIDS prevention and destigmatization in Trinidad. Within the health-care system, HIV-related stigma and discrimination reduce confidence in the privacy and confidentiality of those seeking testing, and related HIV treatment and care. Similarly, people living with HIV are often reluctant to publicly disclose their status when involved in activities to combat the epidemic (Fraser 2000). Additionally, the Caribbean maintains many homophobic ideas and by extension there is considerable ostracism of people who are known to be infected with HIV or who are assumed to have a life-style that would place them at greater risk of contracting HIV. This pervasive and pernicious stigma prevents persons from coming forward to be treated, and prevents the formation of support groups of people living with HIV/AIDS (PLWA) in many of the countries. Given the gender discrimination that exists in other forms and the stigma attached to HIV/AIDS, it would be surprising if these were not combined to the detriment of women with HIV (Alleyne 2004). This is especially the case as women are often not in a position to question their partners about extramarital affairs, to refuse sexual contact, or to suggest safer sex practices (Oni 2005, 44). Embedded within the societal fabric of Trinidad and Tobago are the prescribed social roles for men and women that allow for a mix of conservatism and sexual permissiveness (Voisin & Dillon-Remy 2001).

This dualism is evident in the contradictory sexual messages inherent in Carnival and "liming," two cultural phenomena that I discuss in this document.

Chapter 2
Theoretical Framework and Methodology

It is necessary to investigate the cultural contexts that to understand the dynamic ways women conceptualize and engage in heterosexual practices. Social interaction, as the primary means of creating human meaning, must provide the basis for understanding perceptions of sexuality and their link to the application or rejection of behavior modifications aiming to reduce and destigmatize HIV/AIDS in Trinidad and Tobago. To critically consider the social dimensions of culture that entrench HIV/AIDS into the minds and actions of Trinidadians it is necessary to understand "that a sensible concept of culture must depict culture both as an aspect of concrete, ongoing interaction *and* as the meaning-context for the very same interaction" (Hyland Eriksen 1991, 127).

This means that it is necessary to comprehend both the processes in which sexual relationships take shape as well as the social meaning embedded in the actual interaction. Understanding the processes that lead women to engage in sexual activity can tell us something about the social circumstances that influence their choices and can also demonstrate the places where HIV interventions can be most effective. Additionally, discovering the larger context in which heterosexual acts create meaning for both individuals on a conscious level and the meaning their sexual activity has in terms of larger societal perceptions is crucial to understanding how liming and Carnival are cultural influences that can be factors that simultaneously contribute to the disproportionate spread of HIV/AIDS to women. However, these cultural signifiers are also the keys to disrupting the disease by providing the cultural spaces and tools that continue creating alternative understandings of HIV/AIDS that are not so ripe with stigma.

Social Constructionist Theory & Sexuality

To critically address how sexuality is perceived by both the individual and society I reference social constructionist theory which holds examines the social processes involved in generating concepts such as the self, gender and sexuality. This approach requires questioning taken-for granted notions, searching for how we come to establish knowledge, and determining what proof structures are used to validate knowledge (Travis & White 2000, 26). Therefore, from a feminist perspective, there is a need to develop

a social science for and about women, a medical and social science model that works in conjunction with the other to address the very real HIV/AIDS epidemic that disproportionately infects Black women.

In *Sexuality, Society and Feminism*, Cheryl B. Travis and Jacquelyn W. White (2006) recognize the gaps in feminist research regarding issues of how individuals and groups of people develop and understand their sexuality. They contend that,

> There is a woeful lack of dialogue or scholarship on the social context of sexuality. Absent, but badly needed, is a drawing back to look at sexuality in social context for evidence for both the individual and society. There is a pressing need for scholars to be actively involved in the formulation of conceptual models, the development of appropriate methods of inquiry, and the bringing forth of knowledge in this area (Travis & White 200, 7-8).

They describe a serious lack in scholarship about women's sexuality. I would like to emphasize this point because it is necessary to consider how the lack of such information exposes two things. First, that understanding women's sexuality in a cultural, economic and global context has only been considered an important endeavor for the last decade. This is evident from the lack of literature available before 1990 that specifically addresses female sexuality. Second, there are patterns that reveal that though women are not entirely without agency, the way they are discussed and portrayed in literature, media and reports represents them as such. Women, particularly in Trinidad, are experiencing their sexual debut at a young age, generally less than 15 years of age. This has serious implications for young women's social, mental and physical health. Additionally, the unequal power relationships between men and women in Trinidadian society often handicap women's access to health information and create internalized repression that can damage women's ability to negotiate safer sex practices (Lewis 2003).

The genesis of these patterns is evident in discourse used by the World Health Organization to articulate the international HIV/AIDS prevention agenda, an agenda that is steeped in predominately Western notions of health and biomedicine. To discover where the gap between HIV/AIDS health care prevention goals and the application of such goals to individual and community behavior, an analysis of the WHO's position on HIV/AIDS is necessary. Additionally, it is important to consider the influence and ultimately the impact of the WHO's official discourses on the Trinidadian government's HIV/AIDS public health programs, which necessarily inform the service provision of more local entities like the

Family Planning Association of Trinidad and Tobago. Mapping these connections exposes the contemporary status of how WHO policy and information dissemination is largely ineffectual in combating HIV/AIDS.

The ways in which HIV/AIDS is discussed in larger discourses, like those of the WHO, as well as in the more local contexts of the FPATT is telling of how HIV/AIDS is constructed in international framework's influence on local service provision and education. Considering how HIV/AIDS is talked about in the "Third World", especially in terms of public policy informed by official discourses, provides a vantage point that allows us to critically consider the following; how such discourse demonstrates power differentials in who gets to decide what is a priority in terms of HIV/AIDS awareness and prevention, how such priorities are translated into programs that seek to serve and ultimately improve the health of Trinidadians, and how such policies are embedded with covert oppressive mechanisms that actually hinder their self proclaimed goals of decreasing HIV/AIDS transmission.

The Social Politics of Disease

James A. Trostle (2005) in *Epidemiology and Culture* tackles the issue of disease patterns in a framework that proposes a partnership between epidemiology and medical anthropology. A partnership that can bring greater attention to the notion that "bodies and pathogens are determined not just by physical actions but by beliefs about what is important [in which] the influence of culture can be seen in how people care for symptoms before they [even] receive a diagnosis" (Trostle 2005, 2). These insights shed light on to the complex ways culture and disease influence each other in which "a cultural-epidemiological approach shows that local meanings and management strategies for a disease influence the number and severity of cases that come to the attention of epidemiologists and this helps to determine whose disease gets counted and how disabling the disease looks" (Trostle 2005, 10).

Brooke G. Scheopf's article *International AIDS Research in Anthropology: Taking a Critical Perspective on the Crisis* (2001) treats how the AIDS epidemic 'looks' from a biological and cultural anthropological standpoint. The globalization of trade in goods and neo-liberal ideologies has created the perfect atmosphere in which,

Many countries in the South, the [AIDS] crisis deepened in terms of trade for tropical products worsened and development funding dwindled. Structural Adjustment Programs (SAPs) imposed by the institutions of international finance (IFIs) as a condition for further borrowing contributed to deepening poverty. SAP measures included devaluation, debt reimbursement, "liberalization" of markets, privatization, and compression of government budgets. Agricultural and health services, education and social programs, which the poor depended on governments to provide, were sacrificed (Scheopf 2001, 343).

This situation was exacerbated by the fact that across the globe, this type of structural violence set people on the move (Herdt 1997). As a result of SAPs increased mobilization and stresses due to economic insecurity greatly impacted sexual behaviors, setting the stage for sex with multiple partners, gender violence, and wide dissemination of STIs, including HIV (Heis et al. 1994, Schoepf et al., 2000). The encroachment of SAPs and the resulting socio-economic consequences contributed to a cultural environment that "obscures the fact that many African women are able to demonstrate considerable negotiating strength in sexual relations. As a characterization, vulnerability denies the agency of the oppressed and the empowerment that many derive from participation in social movements" (Schoepf 2001:346-7).

Paul Farmer's (2006) book *AIDS and Accusations* provides a detailed account of not only the spread of HIV in Haiti but the variety of factors that have contributed to its transmission. Farmer accounts for the way the villagers of Do Kay construct their understanding of *SIDA* (AIDS). He makes the case that the epidemiology of HIV/AIDS in Haiti "maybe best understood as a pandemic of the West Atlantic System, a socioeconomic network centered in North America" (Farmer 2006, 149) in which the power dynamics of the 'North' versus the 'South' are made extremely evident. Farmer also presents a historical understanding of the worldwide spread of HIV and attempts to "postulate the trajectory of the virus in the Caribbean basin" (Farmer 2006, 260). He accomplishes this by critiquing AIDS and culture through an anthropological lens. He explains that "anthropology has much to offer those who seek a full and rich understanding of AIDS – which is of no small importance to the efforts to half the spread of HIV. One of the enduring strengths of the discipline is fieldwork, which helps to distinguish ethnographic texts form the most often arid analyses of economics, policy specialists, or epidemiologists" (Farmer 2006, 262).

Factors Contributing to the Spread of HIV/AIDS to Women

As in the rest of the Caribbean, the epidemic in Trinidad & Tobago is surrounded by a complex web of stigma, denial, taboos, socially rejected behavior, sexuality and fear. Many sensitive factors lay at the heart of the epidemic: religion, norms about gender equity and sexuality, sex trade, social inequities, and domestic violence are several driving factors that contribute to the spread of the epidemic in Trinidad & Tobago (UNAIDS 2005). The following factors have been explored by numerous scholars who have provided invaluable insight into HIV/AIDS research. I briefly outline them here to act as a catalyst for my own analysis because my goal is to expand on the existing work by interjecting the stories and perceptions of Trini women into the dynamic ways these factors may or may not hold true in their experiences.

Powerless to discuss safe sex

The ability for any individual to discuss sexual practices is wrought with social barriers that are influenced by culturally specific ideas of appropriate sexual behavior (Baird, Yearwood and Perrino 2007). These notions of appropriateness are informed by the ways gender categories are created, maintained and challenged. Trini women's ability or inability to discuss their sexuality and sexual health with care providers, partners, peers and family is interlocked with all the factors outlined below.

Morality

It is often argued that a lack of moral standards evidently promotes the spread of the disease. However, many feel that it is not practical to advocate sexual abstinence for the unmarried (Oni 2005). "This only leads to secrecy and shame by those participating in extramarital intercourse, making those involved hesitant to use safer sex practices" (Oni 2005, 44).

Sexual behavior

Multiple sexual partners is cited as the most frequent risk factor for HIV infection. Young women are particularly affected by the epidemic, as female HIV positive cases from 15–29 years of age made up 65% of the total cases for the same age group in Trinidad. According to Trinidadian government reports, there are high HIV prevalence rates recorded from among the high-risk groups such as men who have sex

with men, sex workers, injecting drug users and sexually transmitted infection clinic attendees (UNAIDS Supplement, 2005).

Early sexual debut is a commonly cited contributing factor. Many young women are susceptible to sexual coercion because of pervasive social ideologies that equate heterosexual intercourse with establishing 'true' womanhood and strenuous economic realities that make transactional sex appealing. In the Caribbean, unemployed youth and women tend to have a lower participation in the labor market, therefore, the problem of finding money to either buy condoms or treat the illness is a major issue to preventative measures. The problem is even more difficult for young women and single mothers who have little means of supporting themselves. In terms of socio-cultural sexual behavior, the emphasis on virility, hyper-sexual activities and promiscuity in the Caribbean (and Latin America) makes it difficult for youth to aspire to live a monogamous lifestyle. Thus, young men are forced to engage in sexual activity at an early age to prove their masculinity and heterosexuality (Thomas-Long, Bailey 2007 5). Additionally, the presence of sexually transmitted infections, especially in women, increases the risk of HIV infection by two to fivefold because of the anatomical makeup of the vagina, which is more susceptible to tears during intercourse (Oni 2005)

Another factor is young women having older partners, in that same FPATT (2000) study participants of these groups remarked on the phenomenon of young women having sex with older men, where materialism plays a role. The report points out that older men are usually able to afford more enticements. It notes that the men take advantage of their more favorable financial positions when they seek relationships with young girls. Unfortunately, a consequence of this age differential between males and females in sexual relationships is that the young women are more susceptible to HIV infection (Fraser 2000). High risk sexual behavior begins at home - the reason that young people, especially girls, assume high-risk behavior at an early age has to do with the failure of parents to speak with their children about sex, postponing the issue until the young people are all but out of their teenage years (Fraser 2000).

Additionally, adolescent complacency (Holcon et al. 2003) in terms of young people continuing to engage in unprotected intercourse even after they become knowledgeable about HIV transmission is a

highly recognized factor. This complacency is a manifestation of youth's inability to discuss sex with their partner. This is due, in part, to the pervasive attitude in the Caribbean, as elsewhere, that as far is sex is concerned, people just 'do it' but they don't talk about it (Durand, 1990) because they are limited by the aforementioned factors.

Poverty & Economic Limitations

Poverty creates a climate favorable to the spread of the disease. A lack of access to daily resources also presumes a lack of knowledge regarding the transmission of HIV (Oni 2005). It has also been noted that in developing countries, HIV/AIDS threatens decades of development because it attacks people in their most productive years, destroys communities, disrupts food production, and a places heavy burden on the already weak health services (UNAIDS/WHO, 2006). Marked gender differentials in income between male-headed and female-headed households, as revealed in the 1997/1998 Household Budget Survey (HBS), support the contention that many women are in situations of economic vulnerability. In 1997, single-parent households headed by females had the lowest household incomes and lowest expenditure: average gross monthly income in such homes was 19.6 per cent lower than the national average of TT$3,850 and 17.0 per cent lower than single-parent male-headed households. Single parent, female-headed households also had the largest average household sizes and the largest number of children and outnumber their male counterparts by a ratio of 4:1 (Chen et al. 2005).

Ignorance & Misinformation

A large number of people infected with HIV/AIDS are unaware of their status and those who are often find themselves reluctant to seek treatment because of the stigma attached to the disease (Adegbenjo 2001). In particular, Caribbean youth are engaging in sexual behaviors with minimal knowledge and many misconceptions about HIV/AIDS and other sexually transmitted diseases (Smith et al. 2003). These misconceptions are largely bred from the fact that "the biggest problem in Trinidad and Tobago relating to HIV/AIDS is the fact that many view the virus as a disease 'of them' and that they could never be affected by it" (Williams, 2002). Williams points to a socially pervasive denial of the extent to which HIV/AIDS has become a realistic public health concern in Trinidad and Tobago. The rapid rate at which

HIV/AIDS is being transmitted and the generalized idea in Trinidad that "it can't happen to me" is a misperception that is bound up in the multiple silences about women's sexuality and gender power dynamics. Therefore, to uncover the processes in which these silences and power dynamics are maintained and challenged an analysis the culture in which these processes are taking place will allow us to critically consider if these factors hold true via the perspectives of the women I interviewed during my time in Trinidad.

Women and AIDS: The Global Context

Jacobo Schifter and Johny Madigal (2000) make the global more local in their study of the sexual constructions of Latino youth and the implications of sexuality for the spread of HIV/AIDS in Costa Rica. This book is the result of a series of studies in Costa Rica exploring the very real social and cultural contexts in which young people live their lives. They evaluate why traditional approaches to sex education in Latin America are ineffective and demonstrate what culturally specific steps must be taken to teach Costa Rican youth how to protect themselves from contracting HIV/AIDS. Schifter and Madigal look at how the Roman Catholic Church stresses that condom use is immoral; how there is censorship by the media regarding safer sex practices including AIDS-related topics and the fact that there is no sex education for young people in Costa Rica. These realities are due to the fact that "fear, guilt, disgust, and shame are all used in an attempt to control a young persons' body and assure that all expression of sexuality are directly related to procreation" (Schifter & Madigal 2000, 34).

The United Nations General Assembly Special Session (UNGASS) Report, Gender and Women's Vulnerability in Latin America and the Caribbean (2002), outlines the Pan-American Health Organization's efforts to understand and curb the trends that have allowed the increased transmission of HIV/AIDS. This report claims that in 1999, the percentage of HIV positive adult women in the Caribbean was 30% of the total number of people infected with HIV, yet as of 2002 that number increased to 50%. Therefore the question remains: what factors are contributing to such a dramatic increase? The UNGASS report claims that gender has a significant impact on the transmission of HIV/AIDS, in which social and cultural definitions of gender shape female and male behavior, particularly in the realm of sexuality

(Marcovici 2002). To combat the spread of AIDS in Trinidad the social factors of gender, sexuality and risk behavior must be more closely examined. One such factor is "the expectation that women will be virgins and the stigma that is attached to female sexuality often prevent sexually active women from accessing health services and information" (Marcovici 2002, 5). The fear created by stigma is embedded in the reality that women in Trinidad and Tobago are more likely to be infected with HIV because of their weak stance against sexual abuse in which fear of violence or abandonment often prevents women from discussing fidelity or negotiating condom use with their partner, let alone seek out services at a health care facility (Bethel 2008).

The article *AIDS Costs in Trinidad and Tobago* by Ralph Henry and Elizabeth Newton (1994) discusses the disease patterns that have emerged in countries with high transmission rates. Henry and Newton argue that the cost of AIDS is so dramatic because it greatly impacts young adults who are in the prime of their productive years. This has a devastating impact on communities as a whole because "the costs of AIDS are, therefore, enormous purely in economic terms, since there is a near certainty of death for most sufferers, long before the end of normal working life…. most HIV positives require substantial medical attention which may curtail their person-days in labor market participation, and can lead to the reduction in participation" (Henry and Newton1994, 68). They also note that the National AIDS Program of Trinidad and Tobago, established in 1987, acts as the primary provider of condoms which "may arrest the speed with which the epidemic would have spread otherwise, but it has not succeeded in reversing the spread of the disease" (Henry and Newton 1994, 86).

HIV/AIDS Education and Intervention in Trinidad and Tobago

The number of women and girls living with HIV in the Caribbean is on the increase. Adesoji A. Oni (2005) provides further insights into the systematic analysis of appropriate theories that can lead to insights into the HIV/AIDS epidemic in her article "Education: An Antidote for the Spread of HIV/AIDS". She stresses the need to reevaluate current strategies used in educational programs that are geared towards prevention and intervention. She explains "the AIDS epidemic is having a devastating

impact on productivity and most of the victims are students or people in the prime of their lives in terms of productive capacity" (Oni 2005, 41).

Another example of current educational initiatives is the outreach project undertaken by the Family Planning Association of Trinidad & Tobago in conjunction with researchers from the University of Illinois has and continues to collaborate on HIV prevention programs. In 2002, these two entities created the Collaborative HIV/AIDS Prevention and Adolescent Mental Health Project (CHAMP). This programs primary focus was to analyze the psychosocial factors that contribute to the spread of HIV/AIDS among teenagers, particularly girls. CHAMP is unique because it focuses on how entire families can work together to combat the spread of HIV/AIDS as opposed to strictly targeting young people (Bapiste et al. 2007, 906-7).

Feminist Theory

I use multiple feminist theoretical frameworks that place the gendered inequalities of HIV/AIDS transmission at the forefront of my research. Feminist theory offers recommendations for re-evaluating HIV/AIDS education and awareness, particularly in its potential for benefitting women's sexual health in the Caribbean. Feminist approaches to HIV/AIDS research are necessary because they can provide an alternative perspective that can provide insight into the intersections of gender, sexuality and HIV/AIDS as well as other social categories that impact human interactions.

I address these intersections by focusing on documenting the experiences of women who participate in disseminating and receiving HIV information. One of the goals of feminist research is to sensitize people to the different realities of women's lives, including sexism and social injustice (Jayaratne 1983). This sensitization has the capacity to shift paradigms that marginalize communities based upon socially constructed characteristics; being able to locate how these paradigms inform and shift along lines of individual and group identities can provide an analytical entry point in deconstructing the intersectional cultural elements that influence the spread of HIV/AIDS to Trinidadian women.

Kimberlé Crenshaw (1994) explains that sexuality research requires an 'intersectional' perspective in which gender is not treated separately from sexuality, class or 'race'/ethnicity. Anna Bredstrom (2006) in

A Challenge for Feminist HIV/AIDS Research uses concept of intersectionality to point to the fact that, scholars and activists need to critically engage in a discussion of the factors that contribute to the increased HIV transmission among women. It is necessary to look at "the social, cultural and theoretical co-dependency of gender and the erotic [which] is more significant than [only addressing] the relations among age, 'race', dis/ability, class, nationality" which she argues is largely diametrically opposed to considering the intersections of "either gender or the erotic" (Bredstrom 2006, 233). If these intersectionalities are not critically considered such feminist theories can reproduce already existing racial, ethnic and classed social relations that hinder the processes of creating culturally specific HIV interventions and awareness, rendering it important for feminist scholars attempting to study the 'so-called Third world women' to be cautious not to make culture an indicator of 'otherness' (Bredstrom 2006).

To combat their categorization as 'other' Caribbean feminist have created a vast body of literature that address issues such as women's work, economic stability or the lack thereof, women's health, women's artistic and literary movements, etc. One such critical collection is *Gender in Caribbean Development* (1999) edited by Patricia Mohammed and Catherine Shepherd. This pivotal book brings to light the fact that "women's scholarship [in developing countries] was forced to grow outside of official educational institutions, to link academic researchers with women's experience" (Mohammed & Shepherd 1999, 9). In considering the position of 'women's studies' in the context of the developing world, those of us interested in researching phenomena like sexual health and HIV/AIDS must understand the different historical frameworks that create Caribbean feminisms.

Considering 'Third World' Feminism: Positioning Feminist Theory

As with any politically charged expression the word 'feminist' is often a loaded term that many women from the so-called 'Third World" countries find difficult to identify with because of its Western presumptions. Therefore it is important to take into consideration Lizabeth Paravisini-Gerbert's cautions when she recommends,

Caribbean nations and anti-colonial struggles have most clearly shaped the island's political movements, particularly throughout the twentieth century…however [they] have managed to remain profoundly insular despite the colonist onslaught (Paravisini-Gerbert 1997, 5).

These insular factors are exposed in Chandra Mohanty's, *Cartographies of Struggle: Third World Women and the Politics of Feminism* (1991) in her re-construction of third world feminism. Mohanty explains that it is essential to consider,

The simultaneity of oppression is fundamental to the experience of social and political marginality and the grounding of feminist politics in the histories of racism and imperialism; the role of hegemonic state in circumscribing Third World women's daily lives and struggle; the significance of memory and writing in the creation of oppositional agency; and the differences, conflicts, and constructions internal to Third World women's organizations and communities (Mohanty1991, 10).

Considering these factors I am able to locate cultural values that simultaneously contribute the spread of HIV/AIDS and explore those elements of Trinidadian social systems that are currently contributing to combating the epidemic as well as those productive elements that can be strengthened.

Mohanty's first assertion is crucial in constructing an understanding that recognizes that "gender ideologies are culturally specific identities, norms and symbols associated with social constructions of masculinity and femininity and that they are not fixed, although some aspects can be extremely pervasive and difficult to change" (Reddock 1998, 189). For instance, the pervasive understanding that the Caribbean Feminist Movement is entirely Afrocentric or that 'globalization' is a phenomenon that is not being resisted and influenced by Caribbean women, are both matters that I argue are not the case by espousing the various types of agency that are present in the insights Trini women shared with me.

Considering the power dynamics of the nation-state is a useful entry point into Caribbean feminist activism as a way to think about revisiting histories involved in silencing voices of those who were left out, so as to begin reconstructing a past that has given priority to one type of citizenship over another. The hegemony of the state, particularly as it relates to economic liberalization or globalization, creates difficult economic waters to navigate by controlling populations with taking into consideration the needs of the people, hence the use of racial and gender separations to use as a distraction from economic circumstances.

As noted in Mohanty's third point, memory and expression are essential to the formation of feminist theory that gives credence to a personalized agency that can be used as a forceful tool for both examination and change. Stories are a means to make change real, to understand social change and then to make sense of it. Writing, oral histories as well as other forms of expression can act as an outlet, an awareness mechanism, particularly for those who are not able to 'speak' out. Recognizing the importance of voice and agency in the form of stories greatly informed by methodological choice and research topic, therefore I ask: What is feminist theory, if not a compilation of stories used to generate an understanding of women's lives so that arguments can be made and in turn solutions discussed or further investigation developed?

The feminist scholarship that has resulted from interpreting these issues leads to a feminist model more appropriate for those of us interested in 'Third World" feminist thought which is so eloquently captured when Paravisini-Gerbert reminds scholars,

> That the realities we seek to understand as scholars are often much larger than the scholarship we pursue, and that the understanding we off is at times just an approximation, theory based on various fragments of changing truth (Paravisini-Gerbert 1997, 3).

Rhonda Reddock, founding member of the Caribbean Association for Feminist Research and Action (CAFRA) definition of feminism helps me position the achievements and challenges of HIV/AIDS education, prevention and de-stigmatization. Reddock defines feminism as:

> The awareness of the oppression, exploitation, and/or subordination of women within the society and the conscious action to change and transform this situation (Reddock 1998, 53).

The construction of this particular feminist awareness is useful because it begins to shed light on the political, social and economic realities that make it difficult for women attempting to generate change in the sexual health and reproductive rights movement, particularly as it relates to HIV/AIDS. Thus, it is crucial to determine the appropriate launching point that explains the necessity of including women's lived experiences in using theory to discuss the process of social change.

Methodology

I had the opportunity to conduct interviews at the FPATT from May 16th to July 7th, 2008 in the capital city of Port of Spain. It is the FPATT's emphasis on 'Intensifying education programs on HIV/AIDS/STD prevention' that drew me to the clinic. The FPATT provided an excellent opportunity to dialogue with women seeking services there. As is the reality internationally, family planning clinics are predominately frequented by women seeking various sexual and reproductive health services. I was also motivated by the fact that the FPATT is a pro-active presence in their community as demonstrated by their goals. The clinic's mission "to advance sexual and reproductive health and rights, through advocacy and the provision of quality services to men, women and young people in Trinidad and Tobago" speaks to the fact that their practices are largely founded in principles that align with feminist and human rights based ideologies and that my investigation into the intersections of gender, sexuality and HIV/AIDS could be of use to their initiatives. In conjunction, the clinic, as the locus for my fieldwork, is one of the many institutions were the implications of policy become evident through the services provided to the community

To scratch at the surface of the vast ways gender, sexuality and HIV/AIDS overlap, I argue that we must listen to the people that are most affected by this disease, the women of Trinidad and Tobago. Deborah Tolman and Tracy Higgins illustrate this point when they recommend understanding the importance of women's cultural stories. They explain,

> This [feminist] method takes women as authorities on their own experiences. We listen to
> what they say and how they say it so that our role as interpreters of their words is clear; that is, we do
> not claim the authority to say what they are saying but convey how we understand the stories they
> tell, given our perspectives on the issues (Tolman & Higgins, cited in Women Health 2004, 392).

Hence, I had the opportunity to discuss with 16 Trinidadian women, 3 young men and a group of young people who were members of the Youth Advocacy Movement (YAM) some of the most intimate parts of their lives: their perceptions of sexuality and HIV/AIDS. These discussions arose out of the motivation to explore the beneficial and damaging aspects of how women understand their sexuality and what factors influence this understanding. Gaining greater insight into women's knowledge of

HIV/AIDS is accomplished through tracing how these women's perceptions are influenced by gender inequalities that exist in Trinidad and how these dynamics impact the disproportionate ways in which women are contracting HIV.

The stories and the human interactions I encountered during my fieldwork in Port of Spain, Trinidad, highlight the increased need for humanitarian ethnographic work that considers the agency of those individuals being 'researched' and 'talked' about. It is often forgotten that the goal of an anthropologist is not only to espouse certain kinds of 'truths' but to do so in a fashion that recognizes the inherent power differentials that exist between 'us', the expert, and 'them' those individuals and communities that we seek to understand something about. Therefore, it is with this caution that I take the opportunity to critically engage with the discourses I was privileged enough to collect during my time in Port of Spain.

Ethnographic principles with foundations in feminist theory, then, were most useful for informing how I would collect, analyze and interpret my data in a fashion that seeks to align itself with the principles championed by Deborah Tolman and Tracy Higgins (1996). I chose a methodological path that merges qualitative and feminist theories and practice because while interrogating the intersections of gender, sexuality and HIV/AIDS it is also essential to position my own experiences and perceptions of these intersections so that I can remain aware of how they are informing my analysis. It is also important to note that there is not one type of feminism that can satisfy this aim, therefore, as demonstrated in my review of the literature, many vantage points are necessary to develop a theoretical structure that informs my choice of methodology and vice versa. Participant observation, then, as the primary mode of cultural anthropological investigation is an ideal methodological choice for being able to understand and articulate the perspectives of Trinidadian women, in as much as one who is not a continual resident of Port of Spain Trinidad can.

My choice of research questions are informed by my recognition of the important overlap between qualitative and feminist approaches. Therefore, to give Trinidadian women an opportunity to articulate their perspectives on gender, sexuality and HIV/AIDS I posed a series of questions found in Appendix A.

Women's responses to these questions are interspersed throughout this document in a fashion that correlates with the subject matter at hand. The questions that I posed to Trini women are grounded in the reality that heterosexual intercourse has been documented as the primary mode of transmission of HIV in the Caribbean (Camera, B. et al.2003; Voisin, Dillon-Remy 2001; PAHO/WHO/UNAIDS 2001). This reality simultaneously fostered my interest in working with Trini women and motivates for my critiques of United Nations and subsequent official public health discourses. My analysis of the connections between official health discourses and the lived experiences of Trinidadian women, a deeper understanding of how my understandings of the intersections of gender, sexuality and HIV/AIDS in Trinidad were initiated is useful.

Chapter 3
Cultural Knowledge and Perceptions
Women's Stories

Gender Relations in Trinidad

   Gender relations in Trinidad and Tobago are closely bound up in other forms of identity politics that

are both specific to the individual as well as prescribed by society at large. The historical context of

colonial legacies is also important to gender relations in Trinidad and Tobago. These legacies are

significant because they ground contemporary ideas about 'Third World' development. Trinidad, as a

'developing' country, is now subject to the ideologies and practices that seek to progress and ultimately

ensure its development. Gender mainstreaming, in terms of public health policy, has become one of these

ideologies, as it is a priority for the United Nations. But gender mainstreaming as a mechanism to

improve the lives of women can be problematic as well as an opportunity. I take my cues, then, from

Barriteau (1998) who recommends that,

> Theorizing on women in the context of development approaches in the Caribbean region, posits
> gender as a social and psychological construct characterized by unequal ideological and material
> relations between women and men and which are reproduced within institutions and systems of
> patriarchal societies. Gender-based categories are therefore not homogenous, but intersect with
> differences of age, race, class, sexuality and other social variables, factors which, in the context of
> health development, must be explicitly addressed in health analyses and interventions (Barriteau
> 1998, 149).

   The 'unequal ideological and material relations' Barriteau refers to are those pieces of sexual health

information and services that are or are not available to women in Trinidad. As I discuss at length later in

this chapter, but I introduce here, women are variously able or unable to access sexual health information

and services, particularly as it relates to HIV/AIDS. This issue of access is bound by the fact that

HIV/AIDS policies I critique assume gender equality between Trinidadian men and women.

   Take, for example Sonia, a young woman aged 20, with whom I spoke. Sonia's *perceptions* of her

own social circumstance does not allow her to comfortably purchase condoms, though she is well aware

of their benefit and would like the opportunity to be able to do so comfortably. This sentiment is not

Sonia's alone; many of women I spoke to share this hesitancy. Analyzing the social pressure to not buy

condoms is useful for unmasking how power operates along gendered lines in Trinidad. Thus, I use Kate Young's (1999) notion of power as "a slippery concept, used here in the sense of [the] 'ability to restrict the options of [someone, in which] men have the ability to shape women's lives and to obligate women to adapt their lives so as to accommodate men's personal projects" (1999, 94), to frame how the women I talked to articulate their perceptions of how gender operates in their lives and the lives of other Trini women. Power, then, becomes a focal point for contextualizing the conversations I had with women in regards to where they learned about sex relationships, either in formal or informal settings, and their perceptions of Trinidadians living with HIV/AIDS. Additionally, I use this notion of power to inform my critique of the policies that inform where women receive their sex education and the types of information they get in regards to the realities and misconceptions of HIV/AIDS.

Deconstructing the dynamics of who holds power in the arena of policy creation and tracing that sphere of influence to who holds power in heterosexual relationships provides a foundation for pinpointing the various socio-cultural elements present in Trinidadian society that influence women's perceptions of sexuality and access to medically accurate and unstigmatized HIV/AIDS information. Power is not a static abstraction; it is a social phenomenon that has very real applications and consequences to health and experiences of Trini women. Gender relations, or any socially constructed identity marker for that matter, are "structured sets of social behaviors enacted between men and women, which are guided by norms and values, underpinned by ideology, sanctioned by a range of mechanisms from social opprobrium to death, are what are referred to by the term [gender relations]" (Young 1999, 93). To understand the significant way Trinidadian understandings of appropriate gender relations impact the disproportionate spread of HIV/AIDS to women, I develop a critique of policy that teases out how colonially hegemonic ideologies of health, gender and sexuality are ingrained in public health policy. These ideologies at minimum impede upon slowing transmission and at worst contribute to the further oppression of women by making assumptions about gender equality and the social realities that are tied up in ignoring this factor.

Stigma: Perceptions of People living with HIV/AIDS

Gloria, a 25 year old woman, from a suburb of Port of Spain who is employed as a Nurse's Aid and is attending school to become a caterer, shares her insights on people living with HIV. Gloria shared with me that her mother died four years prior from breast cancer; this is why she thinks it is so important to get regular gynecological exams and HIV tests. She also informed me that she has a boyfriend with whom she has been with for the past three years. She explains,

> My neighbor, they [her neighborhood community] say is HIV positive, I'm not sure. They scorn him, as much as people say that they would not.

Though Gloria is talking about her community's perceptions of a man, it is still useful for discovering why he is scorned even though Gloria and potentially those members of her community 'are not sure'. The stigmatization of people living with HIV/AIDS is not a phenomenon particular to Trinidad, however the entrenched nature of stigma in Trinidad is so extensively limiting in terms of seeking treatment or creating an open dialogue about one's status. For instance, a study conducted by the Department of International Health in Trinidad and Tobago concluded that many adolescents resist getting tested for HIV because it would result in 'people knowing their business,' which would lead to stigmatization and possible alienation by their families and/or communities (Baird et al., 2007). This is dangerous ground for young people, particularly young women, to tread on. If they are receiving HIV transmission information and still succumbing to the cultural pressures strong enough to convince them that alienation is the greater of the two threats then program interventions will likely remain largely ineffectual in promoting 'risky' behavior change. Gloria continues,

> [The perception is] you know you wouldn't get AIDS from HIV [Here she is explaining that many people don't think you can get AIDS from HIV]. [The people who maintain this misconception, justify their actions as follows] So I was really bad [in reference to having heterosexual intercourse without a condom]. Generally as a human being, they lose form [a justification for not using condoms – apathetic towards using condoms] people have a way of course during [sex and if the] condom happened [if a condom is used] and it [HIV] couldn't be that from that [regardless of condom usage I still can't get HIV].

Clearly, there are contradictory ideas being espoused here. One is that, according to Gloria, many of her community members do not believe that HIV is a precursor to AIDS. This misconception is extremely

dangerous because the complete lack of this knowledge fuels the increase in HIV/AIDS transmission. If people are unaware of the connection between HIV and AIDS, then there is no hope of program interventions to change behavior, when the behavior at hand is not understood to be a factor in contracting HIV/AIDS. Second, and herein the contradiction, if people understand that they have been 'bad' there is some recognition that their sexual behaviors may have unintended consequences that are deemed negative. The capacity of why these consequences are deemed negative can not be espoused from this particular conversation, but, it is evident that individuals Gloria is referring to make excuses for their bad behavior by chalking it up to 'losing form'.

The simultaneity in which Gloria perceives her community's ignorance of HIV's connection to AIDS while also recognizing that their own 'bad' behavior has the potential for unintended and negative consequences is where the heart of the gap between public health discourse and the application of sexual health information come to a head. Additionally, it is important to note that this contradiction is also intertwined with an apathetic regard of any information that may be useful for sexual health decision making. This paradox is further complicated by the fact that these misconceptions and disregard for any sexual health information, accurate or not, by how people who are or who are thought to be HIV positive are perceived and therefore treated. Gloria sheds some light onto how this paradox operates,

> I mean we look at them [HIV positive people] and the thing is, when someone is HIV positive, especially in the neighborhood where I live, it's not [that] everybody knows [in my community], it's not like this [Trinidadian] society where everybody knows, but they would not show it [the community's knowledge of your HIV status] to your face and scorn ya or anything ...but behind their back, they would do it, and they know, ya know, which I know is really sad.

Stigma and respectability seems an odd pair in terms of how perceptions operate, but as Booth (1998) points out, Western double standards manifest themselves in policy, policy that necessarily influences the bits and pieces of information that trickle out into communities. Gloria's community is reluctant to overtly display their stigma, but, they are willing to demonstrate their stigma in closed spaces. However, Gloria's recognition that 'they would not show it [stigma] to your face' suggests that ideas of propriety and respect are operating to protect the community from HIV/AIDS through stigmatizing the perceived HIV positive individual while not doing so 'publically'.

Violence Against Women

The spread of HIV/AIDS in Trinidad is fuelled by violence towards women. Women in Trinidad are more likely to be infected because of the prevalence of sexual abuse. The fear of violence or abandonment often prevents women from discussing fidelity or negotiating condom use with their partner. It is generally socially recognized that men are usually the ones with the financial power, physical strength and the ability to demand sexual relationships with women (Bethel 2008). A study conducted in 2006-7 by the faculty of Medical Sciences at the University of the West Indies showed that 11% of the 16-49 year olds in Trinidad were forced to have their first sexual encounter. Violence against women is endemic of the unequal status women hold in Trinidadian society.

This violence contributes to women's increased risk of HIV infection both directly through forced sex and indirectly by constraining women's ability to negotiate the circumstances in which sex takes place and the use of condoms. The WHO convened a meeting in 2000 that sought to look at existing research that tied together VAW and HIV. The "Violence Against Women and HIV/AIDS: Setting the Research Agenda" was created out of this meeting, to look at what gaps existed in terms of the intersections of VAW and HIV" (WHO/RHR 2001, 7).

Both the fear of and actual violence affects women's expectations in relationships, ability to negotiate terms and conditions of sexual intercourse, and whether a condom is used (WHO/RHR 2001). Therefore it is necessary for future research to address the following:

- Forced sex may directly increase women's risk for HIV through physical trauma.
- Violence, and threats of violence, may limit women's ability to negotiate safe sexual behavior.
- Sexual abuse as a child may lead to increased sexual risk taking as an adolescent/adult.
- Women who test for HIV and share test results with partners may be at increased risk for violence (WHO/RHR 2001, 12).

This tragic reality is largely due that fact that violence against women and girls is relatively widespread in Trinidad and Tobago. These multitudes of 'silences' hinder productive conversations about women's sexuality and agency, limitations that are greatly echoed by the discourses of international health agencies.

Liming & Carnival

Liming

Thomas Hylland Eriksen (1990) in *Liming in Trinidad: The Art of Doing Nothing* explores the Trinidadian pass time of 'liming' which can roughly be equated to "hanging around… there is no exact linguistic or cultural equivalent to liming in the cultural context with which most of us are familiar" (25). Eriksen spent several months in Trinidad exploring the connection between 'liming' and masculine ideas of respectability. He considers the ways in which Trinidadian morality impacts individual's perceptions of leisure, 'good times' and ultimately the impact such perceptions have on informing 'productive' labor and the value placed on social interactions taking place while liming. Eriksen's assessment of liming is a useful segue into contextualizing how Trinis create social meaning. During my fieldwork I was consistently invited to go 'lime'. Initially, I was unaware of the importance of this social interaction and brushed it off as any other type of invitation to 'go do something.' However, after several weeks I realized that liming is an integral part of Trinidadian life and hence deserved closer attention. I was fortunate enough to have the opportunity to lime with many people, experiences that proved to be crucial to my understanding of how casual interactions simultaneously created rapport and allowed me to gain powerful insights into romantic heterosexual interactions.

Cultural allowances for liming are dictated by the social networks one maintains. These are the same social networks that have the potential to provide opportunities to discuss or dismiss sexuality. Thomas Hylland Eriksen (1990) provides a vantage point into Trinidadian culture that exposes one mechanism by which Trinidadians generate and maintain social meaning. Hence, engaging in an analysis of liming as a cultural imperative presents another entry point into understanding the gender disparity in HIV/AIDS transmission. However, before I engage in a discussion of the ways in which this reality manifests itself, I believe that a brief preface is in order. I am in no way suggesting any causal connections between the transmission of HIV/AIDS and liming. I am however considering the ways in which the generalized attitudes inherent in liming necessarily impact how heterosexual individuals engage in and perceive sexuality. A link that is significant for the application of HIV/AIDS prevention and de-stigmatization

information but that is also full with opportunity to engage in a candid conversation about how the 'art of doing nothing' can be integral in 'improving' the way HIV/AIDS is conceptualized and therefore addressed on an international, national and local level.

I quickly learned that you can not just lime with anyone. A group of women liming together was acceptable, but the several attempts I made to lime on my own, to go out and meet people, was met with mixed responses. On several occasions I was able to befriend a sole man or woman sitting at the bar or sitting on a bench at Queen's Park Savana. However, more often than not I was met with quasi-hostile looks or more often looks of confusion as to why a woman would be venturing out, particularly at night, without companions. This realization made me hyper aware of my gender and the fact that it appeared odd to many people that a young woman would be attempting to lime by herself. My clear misunderstanding of the appropriate ways to lime was quickly remedied once I began establishing friendships. Liming has greatly changed since Thomas Hylland Eriksen wrote his article. His experiences and observations lead him to recognize that liming is "a largely male activity [where] liming covertly contributes to the reproduction of principles for social reproduction of ideology, ethnic organization and domestic organizations" (1990, 27). The reality that Trinis generally lime with people who are like them, be it economically or linguistically, is representative of my experience, however, the gender dynamic of liming has shifted. Eriksen explains that "liming expresses availability as a positive value [that] entails that one is open to suggestion in a very wide sense [in which liming] allegedly contains no end" (1990, 27). The freeness and flexibility associated with liming captures a sense of space and time that is boundless, not impacted by 'other' obligations such as work or family. My experiences liming definitely included what us Westerners would call a 'care free' attitude but still maintained an element of a subconscious realization that 'this too shall pass'. Perhaps liming can best be described as 'living in the moment' while at the same time recognizing that when and where one chooses to lime is necessarily impacted by the factors that inform one's social location. It is possible that my liming experience included a recognition of an inevitable conclusion because I made my identity as an anthropologist and my

motivations for being in Trinidad very clear to those people I was liming with. Therefore, I assume that it became evident I was 'unauthentically' liming.

The overt way in which I declared my intentions provided both opportunities and challenges. In many instances the transparency in which I declared my reasons for being in Trinidad aided my ability to discuss sexuality and HIV/AIDS with individuals I met outside of the confines of the clinic. In the reverse, my disclosure made many individuals feel uneasy and unsure about engaging in any type of conversation with me for fear that they might unwittingly become a 'subject'. The details of these experiences are the subject of how social processes of liming necessarily influence men's and women's perceptions of sexuality. All of my experiences liming contained elements of 'flirting' with men (who assumed my heterosexuality). Liming, as I experienced it, has shifted away from Eriksen's depiction of a largely male based exercise. However, liming still maintains gendered undertones that still dictate appropriateness, I primarily limed with women or mixed gendered groups and I did notice that there tended to be many groups of women liming together as well as men. However it is important to note that the 'types' of liming I largely engaged in tended to be in establishments that were frequented by what Westerners would define as the 'middle-class' and that the people I limed with tended to be college educated and 'gainfully' employed. Therefore, my perceptions of liming are wholly influenced by the fact that my location as an 'educated' researcher dictated the areas in which I limed. This class distinction in socializing practices falls in line with Eriksen's observations that liming happens largely along class lines, a norm that is closely bound up in identity formation through the ways in which individuals perceive their class status. Eriksen notes,

> Urban Trinidadians regard the ability to enjoy oneself, and the tendency not to worry about tomorrow, as characteristic of themselves (Eriksen 1990, 40).

Eriksen evokes several excellent points for analyzing the cultural elements that impact the spread of HIV/AIDS among women. First, his assertion that liming is predominately a man's activity, one that fosters 'the ability to enjoy oneself' in a manner that is irrespective of obligation. This point presents a dilemma in characterizing how gender relationships operate in Trinidad because it assumes that Trini

men, as they are the primary actors in a lime, promote a lifestyle that disregards all forms of social order. If by his very own definition, social interaction develops and maintains cultural meaning, then does not the process of liming dictate, unconventional as it may be, compliance to the social order of liming? Additionally, caution must also be taken in regards to equating 'the tendency not to worry about tomorrow' with the 'art of doing nothing' as the article's title would imply. Eriksen's assessment of liming does provide useful insights into the significance of conflicting ideas of respectability and reputation in Trinidadian life, however, his arguments contain presumptions that assume 'lower class' Trinidadian men who partake in liming completely reject 'middle class' standards of respectability in favor of maintaining a reputation that they find far more valuable. This generalization can be useful in locating the ways class informs how Trinis choose with whom and where to socialize, however, such generalizations must be cautious of their ability to pigeon hole individuals in to categories that have the potential to further stereotype the motivations for their actions.

He continues,

> The most spectacular example is, of course, the carnival, which is an immensely erotic, rhythmic and colorful party with hundreds of thousands of slightly dressed and equally slightly intoxicated participants. The sexual element is very dominant during carnival, and not only then: sexual themes are omnipresent in Trinidadian discourse throughout the year. Sexual infidelity is evaluated as partly legitimate, but there is always a minor scandal whenever a "respectable" man or woman is "caught at it", and such news sometimes reach the weekly press. An indicator of the extent of extramarital sex, is the rapid spread of Aids among heterosexuals in the East-West Corridor; further, the expression "deputy" is used casually about women with whom one has sex while married to another (Eriksen 1990, 40).

Gendered ideas about sexual appropriateness and respectability heavily influence the ways that Trini women perceive how they are able to make sexual decisions on a subconscious level. Eriksen (1990) explains that contradictory behaviors are exemplified in negotiating respectability and reputation along gender lines; from this premise he concludes that 'sexual infidelity is evaluated as partly legitimate'. This observation is one that I share with Eriksen. Through the conversations I had with women it became exceedingly clear that there is a general consensus, though highly lamented, among Trini women that 'men will do what a man do', meaning that male promiscuity is an accepted and promoted defining characteristic of masculinity. Though a similar sentiment was articulated by all of the women I spoke

with, it was not taken passively. Often after women expressed this understanding of Trinidadian masculine sexuality maintaining free rein in society that women would follow this sentiment with statements like "that doesn't mean that I don't have a say too" or "he may think I don't know [but] I'm wise".

Among the women I spoke with there seemed to be a conflicting sense of self autonomy in which women made blanket statements about what most Trinidadian 'do', yet many women made it apparent that they were wise to the game and largely rejected it. How then can the agency demonstrated by these women in terms of their affirmations that they know what's really going on be brought to the forefront of HIV/AIDS prevention and destigmatization? Clearly, the women I spoke with understood that because they are women they maintain some disadvantages because they are women, yet the tone many women took in explaining, in their various ways, that they knew what was going on with men in Trinidad, they felt empowered enough to articulate that they were resisting in some fashion by just articulating that they knew about how Trinidadian men act generally. The contradiction inherent in how women understand the social limits imposed upon them and how they demonstrate their agency regardless can be further explored in how Trini women participate and are represented in Carnival.

Traditions and the Challenges of Emancipation

Natasha Barnes (2000) analysis of Trini women's sexualized representations in Carnival provides a compelling contradiction that deserves exploration. Carnival, she explains, is a period where the reversal of the gendered social order is promoted, where women's subversion and appropriation of male-identified forms of sexual display actually serve to reinforce the patriarchal structures that they otherwise critique. During carnival women's aggressive and overt sexual displays are championed and promoted, a phenomenon that has been largely argued as a form of women's expression of their sexual liberation. However, Barnes (2000) suggests that this display is quite the opposite, where women's appropriation of men's coded forms of sexual objectification greatly re-inscribe hegemonic notions of violent sexuality that embody patriarchal stereotypes that both value aggressive masculine sexualities and situate these stereotypes as the acceptable and expected norm.

Embodying this particular type of sexuality is problematic because it revisits historic colonial notions of black women's bodies and sexualities. Hyper-sexualized notions of the black female body are born out of the ambivalent ideas about black women's bodies that contribute to the large scale way that the global community grossly ignores black women and AIDS. The politics of respectability has greatly influenced the silence women of the African Diaspora have created around their bodies and sexuality. This is largely the result of self protective measures instituted during slavery when black women's bodies were exploited for capital gain, a response that was a historic act of resistance against the white oppressive gaze. The remnants of this exploitation and the unforeseen consequences of this protective measure linger in contemporary representations of black women's bodies and their sexualities (Monroe 2008).

Many feminist scholars recognize the continual encroachment of patriarchy on a global scale, particularly as it relates to the construction of the black female body in public health discourse. The body as an entity engaged in social constructions of representation, influenced by both conceptions of the self and communal influences on that self provides an excellent entry point into looking at the connections between the body and the sexual activities of the body. Patricia Hill Collins' (2000) critique of contemporary representations of American Black women's bodies in pornography is useful for contextualizing how these representations have crossed borders. Additionally, Collins' critique of the representations of American Black women's bodies exemplifies Booth's critique of how 'Third World' bodies are represented in the rhetoric of the United Nations. Though these scholars are critiquing two different cultural institutions, American pornography and UN documents, the powerful parallels are telling of how damaging the influence of historical biases can be not only on the representation of Black women's bodies but also on how these representations, which are still pervasive today, can be embedded in the language and philosophies used to create programs and policies dedicated to providing and promoting sexual health services.

In her critique of black women in pornography Patricia Hill Collins (2000) articulates how contemporary and pervasive conceptions of the black female body make it out to be the source of a multitude of problems. The same could be said of public health policies where much of the discussion

surrounding women's sexual and reproductive health focuses on the **problem** of infant mortality, the problem of over population, the problem of unplanned pregnancies, the problem of sexually transmitted diseases, HIV/AIDS in particular. The primary discourse coming out of organizations like the WHO consistently relies on the problematic Black female body to situate its discussions on global world health. The Black female body is largely conceptualized in terms of the consequences to that very body when it moves beyond the limitations of what is considered appropriate for that particular body. Collins describes such limitations as having their foundation in

> The distinction between "objects" and "animals" is crucial in untangling gender, race, and class dynamics in pornography. Within the mind/body, culture/nature, male/female binaries in Western social thought, objects occupy an uncertain interim position. As objects, White women become creations of culture – in this case, the mind of White men-using the materials of nature-in this case, uncontrolled female sexuality. In contrast, as animals, Black women receive no such redeeming does of culture and remain open to the type of exploitation visited on nature overall (Walker 1981, 138-9).

The binary opposition between Black and White women's sexual bodies in pornography in terms of a culturally constructed awareness that devalues both in conflicting ways embodies how the separation of the human entity from the body is represented in pornography. This separation contributes to the subjugation of women's bodies while also shedding light on how such separations can impact how women choose to engage in sexual encounters. The language used by the WHO and similar organizations to discuss problems associated with the female body, especially the 'brown', 'third world', 'other' body, is characteristic of the naturalization of White women being creations of culture and Black women being creations of nature, since Black women's sexuality is more akin to that of an animal. Aminatta Forna (1992) explains,

> Black women's portrayal in pornography as caged, chained, and naked creatures who possess "panther-like", savage, and exotic sexual qualities reinforces this theme of Black women's "wildness" as symbolic of an unbridled female sexuality (Forna 1992, 104).

The 'wildness' of the Black female body transcends national boundaries as made evident by images that pervade popular media in the United States and abroad; this is especially pertinent as the American media strategy of sex sells is implanted internationally. Consequently, a dualistic expression of Black

womanhood is internalized by many Black women that promotes mixed messages about sexual appropriateness.

The dualistic nature of this simultaneity of gender role allowances and disallowances is useful for beginning to unpack how concepts of the Black female body, both in the context of how individual Black women view their own bodies and how social institutions at large inscribe notions upon those bodies, are created and recreated in the discourse of international health care organizations like the WHO. Cultural imperatives, like Carnival, demonstrate the dualistic nature of what is considered appropriate and inappropriate in regards to the sexual activities of the body. As noted by Barnes (2000) many feminist scholars equate the masquerading of Trini women's bodies at Carnival to be an empowering experience which promotes an agential display of female sexuality. However, this display of power is lacking in the everyday practices of Trini women. Sophie, who is 24, explained to me that,

> My belief is that because our ability to not…put on condoms or protect ourselves [where] the condom is usually everything… I am sexually active, I never once went and buy a condom in my life. I am just too frightened to go and do that…safe sex, when you are having sexual intercourse. I would demand my boyfriend use a condom, but I would not go and buy a condom myself.

This young woman's assertion that she is sexually active but is afraid to purchase a condom is telling of the contradictory messages she has received from her social surroundings. As demonstrated by her admission of to being sexually active, she recognizes the fact that she is indeed a sexual being. Additionally, she also recognizes that it is important, for the purposes of 'safe sex' to use a condom to protect her self from both pregnancy and disease. However, this agential understanding is limited by her inability to actually be the agent who is responsible for providing the protection. She is afraid to buy a condom because she fears the negative repercussions such an act would have on how her community views her. The contradiction, there in, lies in the fact that she understands her role as girlfriend, to be sexually available to her male partner and she understands that within sexual intercourse there is a need to 'protect' her self from the potential negative consequences of engaging in sexual intercourse. Yet, the social pressures that she feels to hide her sexual activity outweigh her ability to actually have access to the tools she needs to protect herself.

This same contradiction surfaced later in our conversation when we where discussing how Trinidadian culture looks at women, their sexuality and what this might have to do with the spread of AIDS. She explains, in reference to television advertisements,

> To me I think things just happen, I think they [ads] promote sexuality… if you want to sell a look, just put boobs on…that's how you know, so it just safe to have sex…if you ever give a child…give a child a condom, or anything with sexuality or having sex, everybody just thinks that child would go and have sex. I don't think it's true it's just that when it's time come [to have sex]…a responsible decision needs to be made, so to me you have sex to enjoy…everybody is free about their bodies…it[s] obviously nice to have sex.

This young woman is quite aware of the fact that female sexualized bodies are used as an advertising strategy in Trinidad as well as the fact that this message is promoting sexual activity. What I find surprising and alarming is that she interprets this objectification of women's bodies as promoting a sense of safe sexuality. Additionally, she is aware of the concerns of the Trinidadian community that promoting the use of condoms, as means to combat the spread of HIV/AIDS, is problematic for many because such promotion equates to advocating for sexual activity. How then are young women, who see hyper sexualized representations of themselves in popular culture, supposed to navigate their sexual agency in conjunction with the messages they receive in regards to hiding that agency?

There are clues to this answer when she asserts that "everybody is free about their bodies…it[s] obviously nice to have sex". She clearly has a sense of self-efficacy that permits her to express and appreciate her sexual desire and activity by claiming that "it's obviously nice to have sex". She has determined that it is acceptable for everybody to be "free about their bodies", however, this freedom is missing a gender component. When she makes reference to "everyone" is she including both men and women, or is "everyone" a pejorative term or is it similar to how constructions of 'humankind' necessarily being 'mankind 'and therefore "everyone" which is in reference to men? If everyone includes both men and women, then perhaps the category of "everyone" has a gender dynamic that simultaneously allows "everyone" to be free with their bodies. However if this perception of freedom is limited by gendered ideas of appropriateness influenced by the hyper-sexualized notions of women's bodies, then are women as gendered beings able to be included in "everyone"? These gendered expectations are

visible in this young woman's inability to comfortably buy condoms while also being able to confidently assert her ability to engage in sexual activity.

Many women I spoke with discussed the challenges they had in regards to discussing sex with friends, family, health care providers or a variety of combinations of the three. This is largely due to the fact that many young people in Trinidad find it difficult to discuss sex and sexuality with their parents or primary care takers (FPATT, 2000) because of the contradictory ideas surrounding sexuality embedded in Trinidadian society. If it is difficult for youth the discuss sexuality with parents, there is most likely no communication mechanism in place to discuss the potential outcomes of being sexually active, i.e. pregnancy. Silence surrounding sexual activity in general and HIV/AIDS specifically is the primary barrier to combating the spread of HIV/AIDS and to begin the process of de-stigmatizing individuals who are currently living with the disease. This realization was articulated by every Trinidadian woman I had a conversation with and is made explicitly clear by the fact that "we don't speak out about sex."

In the UNGASS Country Progress Report for Trinidad & Tobago (2008), one of the key indicators of the practice of HIV risk reduction is postponed initiative of sexual activity wherein the median age of initiating sexuality activity is 18. This particular declaration tells people who do engage in sexual activity that they are some how abnormal because they are not prescribing to the behaviors that being advertised as 'in their best interest'. Therefore, if one of the keys to curbing the spread of HIV/AIDS is to increase the age of first sexual activity, where then are the spaces for those who do not?

Knowledge Acquisition

Sex Education & Knowledge of HIV Transmission

The current HIV/AIDS prevention and education protocol that exists are programs that seeks to address both behavior and cognitive approaches to addressing this epidemic. Predominate rhetoric considers the elements that comprise societal vulnerability or the social influences on individual behavior and its modifications (Whelan 1998). This model is useful in creating individual and group risk reductions in HIV/AIDS pubic health initiatives, however, this model contains gaps in its ability to get at the nuanced features to gender inequalities engrained in most cultural realities. Therefore, an expanded

response has been called for in terms of reframing both the discussion about and implementation of HIV/AIDS prevention and education programs. Daniel Whelan (1998) suggests that the normative pubic health framework lacks the tools necessary to address determinates of societal vulnerability to HIV. The FPATT through their human rights based approach and their creation and mantainance of community initiatives demonstrates how they embrace innovative strategies that have proven to be quite beneficial. The following outline of the various initiatives undertaken by the FPATT will demonstrate the dualist nature of their services, as both those that adhere to an 'official' discourse and those programs that seek to reframe the public health discussion on HIV/AIDS.

Sex Education and Policy in Trinidad: Traditional and Innovative Approaches

The women I interviewed had varied experiences in terms where, when and how they received information about the mechanics of sex as well as those pieces of information that informed how women view their own sexuality. My critiques of key HIV/AIDS public health policy documents is motivated by the necessity of understanding the processes in which bases of knowledge are created and valued in relation to sexual health and HIV/AIDS transmission. By considering these policy discourses I can continue to unpack the aforementioned assumptions and how they are embedded and rejected by both formal and informal sex education mechanisms.

Western ideologies about health have been transcribed onto international notions of sexuality. These hegemonic ideologies are rooted in the historical realities of colonialism that consider Western methods of knowledge creation and transmission to be the most valuable. As such, many former colonies have educational systems that are modeled after those of the hegemonic ideology. Clarifying this historical model for policy creation and the resulting educational initiatives is important for resolving the gap between official public health discourse, sexual health information dissemination and application of information to behavior change.

It is useful to look at Trinidad's "Education Sector Policy on HIV and AIDS of the Ministry of Education" (2008). This document was created in response to the startling trend, discovered by the

Trinidadian Ministry of Health, that younger people where increasingly contracting HIV/AIDS. The

policy outlined in this document is,

> Predicated on the International Labor Organization's (ILO) Code of Practice on HIV and AIDS and the world of work and other supporting legislative and policy documents including The Education Act, Occupational Safety and Health Act, School Health Policy and the Ministry of Education's Schools Policy on Drug Abuse and Prevention. It also ensures participation, collaboration and involvement of its internal and external stakeholders including the employee representatives, Community-Based Organizations (CBOs), Non-Governmental Organizations (NGOs), other Government Ministries and professional organization as well as international partners (Trinidad and Tobago Ministry of Health 2008, 1).

This policy highlights useful protocols for increasing services that seek to provide HIV/AIDS

education, prevention, and treatment in the context of public schools and work place environments. There

are also useful elements that demonstrate progress towards an education and prevention initiative that

looks to:

> This policy supports the preparation, delivery and evaluation of comprehensive, evidence-based, needs-oriented, age specific and gender sensitive educational programs which will bridge the gap between knowledge and behavior change so as to reduce the spread of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and minimize the impact of the disease (Trinidad and Tobago Ministry of Health 2008, 3).

However, the gap between knowledge dissemination and how Trinidadians apply such information to

their lives is evident in a number of instances. The policy explicitly outlines the need to provide sexual

health and HIV/AIDS information to the Trinidadian public through educational institutions and work

places; however, the policy directly states that:

> The Ministry of Education shall not support access to condoms among its student population on the school compound. However, students requiring support shall be referred to the Student Support Services of the Ministry of Education for the necessary counseling and intervention (Trinidad and Tobago Ministry of Health 2008, 10).

This is clearly contradictory in nature as the premise of the policy is to increase awareness and hence

decrease the spread of HIV/AIDS, however, by explicitly stating that the Ministry will not support

handing out condoms, one of the primary tools in combating AIDS, further demonstrates the disconnect

between international public health discourse and the resources needed to assist sexually active individual

assert their agency. Therefore, the Ministry of Health is in essence saying, we want you to practice safe

sex, but we will not condone or proved access to the means to do so. It is also of significance to note that

the policy does recognize that gender is a reality that impacts the spread of AIDS. As such, the policy

states:

> HIV and AIDS affect and impact women and men differently due to their biological,
> socio-cultural and economic circumstances. Application of all aspects of this policy
> should be responsive to the different needs of men, women, boys and girls (Trinidad and Tobago
> Ministry of Health 2008, 5).

However, this is the extent to which gender or any social marker is addressed as impacting AIDS

initiatives in education. On the other hand, the Trinidadian government has asserted in the "National

Policy on Gender and Development: Situational Analysis" (2007) the necessity of gender mainstreaming

into governmental policies. Though, perhaps, unintentionally this document exposes an element of the

history behind contemporary knowledge dissemination practices and sex stereotyping in Trinidad and

Tobago.

> Commitment to education has always been significant in Trinidad and Tobago and for the colonial
> powers; education in English language was one way of establishing British values. By 1921,
> therefore, a Compulsory Education Ordinance was passed for Port of Spain and St. James, although
> not implemented until 1935. By the 1940s compulsory primary school attendance for both sexes was
> in force, although not always in practice and by 2000, universal secondary enrolment was put in
> place.

> The Education Code of 1935 facilitated the more systematic implementation of sex stereotyping in
> educational opportunity for girls and boys. For example, increased attention was paid to the .provision
> for instruction in domestic science for primary school girls at special approved centers, while boys
> were prepared for a wider range of technical and academic pursuits (Trinidad and Tobago Ministry of
> Community Development, Culture and Gender Affairs 2007, 12).

Reminiscent of colonial powers in Trinidad and Tobago are evident in the Western model so championed

in the aforementioned policy documents. This colonial presence is also prevalent in the international

rhetoric that frames educational and health care practices in 'developing' counties as espoused by

transnational agencies like the United Nations. The "National Policy on Gender and Development:

Situational Analysis" (2007) explains:

> Gender and development is guided by several international mandates. These include *inter alia*, the
> Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW); the Inter-
> American Commission of Women of the Organization of American States (CIM/OAS) Plan of Action
> and the Belém do Para Convention for the Prevention, Punishment and Eradication of Violence
> Against Women; the Beijing Declaration and Platform for Action; the Commonwealth Plan of Action

for Gender Equality 2005-2015, and the United Nations Millennium Development Goals (Trinidad and Tobago Ministry of Community Development, Culture and Gender Affairs 2007, 8).

Considering the influence of these transnational agencies in respect to informing 'top down' policy that seeks to impact sexual behaviors that contribute to the spread of HIV/AIDS is an excellent entry point into examining how the Family Planning Association of Trinidad and Tobago is both influenced by these international bodies of knowledge informing policy creation as well as how the FPATT is diverging from such discourses. A look at the goals and services provided by the FPATT will provide the framework for fusing the responses given to me by women seeking services at the FPATT as well as how their reflections demonstrate the discursive gaps inherent in policy, information dissemination and individual sexual health practices application.

To educate an individual or group of people is an exercise that is highly selective of what 'it' includes in its knowledge dissemination. In the context of Western perceptions of education, to be educated is to acquire specialized, culturally determined pieces of information that carry with them varying degrees of value. As demonstrated by the adage "education is the key to success". This highly segregated endeavor is extremely valued as demonstrated by the fact that most international development discourse touts education as one of the primary means to elevate a people's and their nation out of 'poverty'. However, this process is varied as the result of a myriad of factors that can simultaneously promote and limit access to educational opportunities. Additionally, the primary educational model employed to 'improve' economic opportunity is a rigidly structured endeavor that places primary value on the Western institutional 'class-room' model. However, there are alternative educational models which place knowledge sharing, retention and creation in the broader context of experience by considering the trilogy of mind, body and spirit in the learning process. Laura Joplin (1981) explains "that anytime a person learns, [s]he must 'experience' the subject—significantly identify with, seriously interact with, form a personal relationship with, etc." (1).

The article "Pregnant teens in school" in the Trinidad Guardian (June 19, 2005) demonstrates this point by discussing how young pregnant women are informally required to leave school during the

duration of their pregnancy. The article explains that the case of pregnant and sexually active students of a Form Two class [United States equivalent to the 8th grade] is not exclusive to Malick Secondary Comprehensive. But that nobody knows the extent of the problem, least of all it seems, the Ministry of Education. "It has been happening across the board," explains Bernice James, manager of an abstinence club at Malick Senior Comprehensive school in Morvant. "Everything is accepted. We are moving the goal post all the time so nobody has to make an effort to keep values," she said. Once a girl begins to show signs of her pregnancy, the principal calls in her parents or guardian. In most cases, parents are asked to take the girl out of school until she gives birth. After childbirth, young moms can return to school, but they get no special treatment. "They don't come back in where they left off, they have to try and catch up. You don't get extra time...it is not like they are on maternity leave," she explains.

Though in this particular article, the previous Minister of Education was not interested in sharing statistics I was able to locate a figure. According to the WHO teenage pregnancy rates in Trinidad are high in urban areas in which 13.5% of all live and stillbirth deliveries were to teenagers (WHO Country Health Profile 1998). Young motherhood, largely defined by the women I spoke to ranges from age 13-21, happens internationally. What is of particular interest here is that the circumstance of young motherhood is simultaneously culturally acceptable and shunned. The paradoxical nature of a young woman needing to hide her pregnancy in the public arena of school while also 'showing off the baby' once it is born in more informal settings exposes a variety of conflicting messages in regards to women's bodies, sexuality and how social ideas of respectability impact these self-reflections. The significance of this declaration lies in how the 'consequences' of heterosexual sex, pregnancy and similarly HIV/AIDS is constructed in terms gender.

Sophie articulates a plethora of reasons why teenage pregnancy occurs, reasons that I argue also contribute to the disproportionate spread of HIV/AIDS to Trini women. The most insular factor outlined by both Sophie and this Guardian article is the impact that fluid notions of respectability have on women's, particularly young women's, perceptions of sexuality. Multiple scholars have discussed ideas of respectability in the Caribbean specifically (Edmundson 2003) and Trinidad specifically (Hylland

Erikson 1990). Though the vantage point from which respectability is referenced differs with each

scholar, an overarching theme is apparent – that establishing cultural regulations in regards to the

respectability of women is crucial to maintaining control over women's sexuality and hence a primary

form of social capital.

Currently, an unidentified number Trinidadian secondary schools offer "Health and Family Life

Education (HFLE)" which takes a life-skills based approach to addressing the challenges facing many

Caribbean societies today, such as HIV/AIDS, rising levels of violence, and health problems. I was

unable to locate a definitive number or approximation of Trinidadian schools that have or currently

implement the HFLE curriculum. However, the Ministry of Education document "Education Sector

Policy on HIV and AIDS of the Ministry of Education" (2008) has outlined an extensive strategy for

implementing HIV/AIDS awareness and prevention in its schools. The curriculum approaches state in

regards to such programming:

1.1   The Ministry of Education shall provide accurate information on HIV and AIDS that is
      evidenced-based, gender appropriate, sensitive to religious and cultural diversity, age and
      developmentally appropriate, relevant and delivered using **user**-friendly approaches.

1.2   The Health and Family Life Education (HFLE) curriculum will be the major vehicle for the
      delivery of HIV education supported by other education programs. The delivery of these
      curricula should be facilitated with other key stakeholders (Trinidad and Tobago Ministry of
      Health 2008, 10).

This policy declaration provides the framework from which the Trinidadian government seeks to

implement HIV/AIDS education. Yet, as previously stated, I was unable to locate any specific assessment

of the HFLE model in Trinidad nor any specific reference to the number of schools actively implementing

this model. I did locate a newsletter "Children In Focus" published by UNICEF in 2002 that provides

insight into the HFLE model and its implementation in the Caribbean. This document notes:

Caribbean countries have identified a plethora of threats to the health of their young people, many of
which can be prevented – obesity, HIV infection, unintended pregnancy, violence, substance abuse
and suicide…. It is a fact that health education makes a significant contribution in promoting healthy
lifestyles if begun in the early years and is continually reinforced as the child moves through
adolescences into adulthood. The recognition of the need to incorporate 'healthy lifestyles' in school
curriculum had varying success in disseminating 'safer sex' practices in Trinidad (UNICEF 2002, 3).

The challenge of disseminating health care information that can be realistically applicable to ideological changes that can ultimately influence sexual practices are made evident by the experiences shared with me by several of the women I spoke with at the FPATT.

Unequal gender dynamics operate in educational institutions in a variety of ways. First, classroom structured sex education in Trinidad is based upon the HLFE curriculum that informed the previously discussed Educational Policy on HIV/AIDS. The HLFE model provides a basic framework for generalized health practices and some discussion of sexual health. However, its primary focus is on abstinence, a focus that has consequences in terms of how young Trini women view their bodies and sexuality. This is evident in a conversation I had with Sophie. Sophie explains,

> …so many young children that are having babies…okay, she gets pregnant, and you hide it for awhile, and then okay, she has a child…everything just moves on..and it's wrong, nobody don't spend time anymore…we don't speak out about sex, it's still taboo… a lot of maturity of woman don't speak about sex because what happens, the thing is in Trinidad we have different cultures…we have wage margin, so obviously they can't speak to the husband, she can't talk to the family…I have a friend, whatever happens in the home stays in the home.

The contradictory ideologies surrounding sex are tightly bound up in how young pregnant women are stigmatized based upon the fact that they did not conform to social ideologies of respectability as evidence in young women to "hide it [their pregnancy] for awhile". Sophie mentions that 'we have wage margin[s]", clearly she recognizes that there is an inequality between economic earning power between men and women and in this, equates this margin with limiting women's ability to speak to their husbands or male partners. Sophie's last statement "I have a friend, whatever happens in the home stays in the home", though a bit cryptic, situates all other forms of silence (not being able to talk to partners and families) in the realm of the domestic sphere. Herein lies a fundamental contradiction, Sophie understands that it is inappropriate to discuss sex with her family, because "whatever happens in the home stays in the home".

Nadia and Jacqueline stated that they had not had any formal sex education in school. Silvia, a woman in her late 40's, explained that when she was in primary and secondary school it was considered highly inappropriate to discuss such things, particularly in the context of a public forum like school.

Silvia's experience may be due to, in part, the fact that she attended school in Trinidad during the early eighties before HIV/AIDS had become a nation wide health issue. Additionally, she explains that the climate in those days was such that any discussion about having sex or talking about one's sexuality was relegated to coming from one's "general environment, ya know, the environment were you'd hear the kids talkin' bout it" in which any discussion about sex did "not come from my parents" but sometimes information would come from "the television", or other periphery sources. She continues "at my age at that time it [discusses about sex] was never coming out." Silvia explained, quite candidly, that she never really understood 'what sex was' until she began engaging in heterosexual activity at the age of 15. This lack of any knowledge, misinformed or otherwise, of sexuality in terms of desire, physical processes, potential benefits or damages, and the skewed gendered power dynamics inherent in heterosexual relationships, is a reality that was consistently present throughout the conversations I had with women.

A similar sentiment is articulated by Gloria whose perspectives are demonstrative of how the rhetoric of the WHO and the FPATT has indeed been successful in disseminating certain parts of information, but lacking the ability to apply this information to actual sexual practices. Gloria articulates a definition of health sexuality that has been greatly informed by official discourses, when she explains "sexuality to me is sharing one's relationships and contact with another person…whether it be a man or woman. Sexuality to me is being aware of disease, in the sense of using protection, both partners should be doing health check ups, as well, and using contraception". Clearly, Gloria has all of the 'right' answers as defined by international public and sexual health discourse, however she is astutely aware of the fact that many of her female peers do not have the same information. During her time in secondary school she did receive sex education in which

> They had a room of females [at] my school…what they noticed was a lot of girls were having sexual intercourse without using protection and what they found out was that engaging in sexual interactions, the girls, and I think one had HIV or they said…so that's why they had done a test and then we had to do practices to educate us…which I think is wrong because in school [they] should educate at a young age instead of letting it happen, because a lot [of] them will have sex [and then it will be] too late".

Gloria's experience demonstrates the fact that within the last decade there has been an increase in sex education initiatives in secondary schools. This clearly has been beneficial in HIV/AIDS knowledge

dissemination; however, these successes have missed several key elements. For instance, Gloria notes that it was only after school official noticed that young women were contracting STI's and HIV at an increasing rate and therefore became the targets of sex education. However, this targeted effort neglected to address the gender dynamics of why young women where increasingly presenting with disease. Additionally, Gloria pinpoints the fact that such educational efforts may be too little to late, as there was at least one individual, speculatively, who was HIV positive. The Collaborative HIV Prevention and Adolescent Mental Health Project (CHAMPT) in particular is making strides in helping both children and their parents develop the tools and language to discuss sexual behavior and HIV/AIDS.

Collaborative HIV Prevention and Adolescent Mental Health Project (CHAMP)

CHAMP, an education and prevention strategy aimed at family inclusion was initially launched in 1994 as a researcher-community partnership to address increasing rates of adolescents HIV exposure in urban minority neighborhoods in Chicago (Baptiste et al., 2006:906). In an effort to address the target area put forth by Caribbean and international agencies of preventing the transmission of HIV among your people, the CHAMP program was adopted, on behalf of the FPATT, in Trinidad and Tobago. The intervention is designed to strengthen family-level characteristics such as parental monitoring, parent/child communication about sensitive topics, discipline, conflict-resolution, and support. It also targets young teens' social problem-solving abilities by championing the important role of parents in providing information, structure and values to help youth cope with sexual situations (Baptiste et al. 2000, 337). The pilot CHAMP study conducted in 2002 found that "both parents and youth report significant improvements in HIV/AIDS knowledge and awareness and this information is a basic building block for decreasing HIV/AIDS risk" (Baptiste et al. 2007, 350) after the intervention was completed.

The successful aspects of this particular intervention mirror my argument for an increased effort to promote accurate HIV/AIDS transmission information to young people, particularly to young women. There exists simultaneity in the social problem solving skills of Trinidadian youth that demonstrates that many youth *understand* the urgency of practicing 'safer-sex' while also struggling with making sense of how to accomplish this amidst the contradictory and confusing cultural messages constantly bombarding

them. Such measures of clouded understanding are evident in a conversation I had with Maria, a young woman of 25, who was from one of the smaller urban cities on the island. Maria suggests that one of the primary obstacles faced by Trinidadian youth is a lack of comfort discussing sexuality with family and friends. When asked if she was comfortable discussing sexuality with anyone close to her she responded that 'such things' were not discussed as "we don't speak about sexual education…I'm talking about [the presence of] religion in the family…no we don't speak about sex", however, she did mention that her comfort level was quite high in talking about sexuality with 'everybody else'. She explains, "yes, I could speak to anyone about it, they [her family] are more enclose". The ebb and flow of comfort level is telling of where young Trinidadian women get their ideas of when it is appropriate to discuss sexuality. What are the characteristics that inform certain comfort levels?

These dialogues demonstrate the opportunity for an increased focus on improving access to HIV-related information, education, and skills, not only taking place in the traditional sense of classroom instruction, but also for community based and grassroots initiatives. Therefore, In order to facilitate women's inclusion in these processes, HIV/AIDS policy makers must support and host forums at the national and international levels at which community-based organizations (CBOs) and AIDS service organizations (ASOs) can meet to share their views of AIDS as a development issue and discuss the feasibility of integrating HIV/AIDS services into other development programs, many of which are key to building successful interventions to reduce the vulnerability of women that is fostered by societal factors. More specifically, policies and programs must strengthen national and international networks of women infected with or affected by HIV/AIDS (Whelan 1998, 29). When public health policy and then in tandem country level programs are better able to facilitate this inclusion other social improvements will necessarily follow because when a program addresses HIV/AIDS in a more holistic fashion it will also be looking at all of the factors that contribute to the spread of HIV/AIDS. Therefore, the right to have a family, to have equality in that family and any associated relationships in the family, right to decide freely and responsibly on the members of one's family, including the number of children will be addressed as well. Developing community based approaches to further ensuring these familial rights for women must

be addressed by understanding culturally permissive ideas about sexual behavior that are influenced by gender norms.

Sexuality

Early sexual debut is a highly cited factor for contributing to the increased transmission to women, a survey of 679 young adults (10-29) in Tobago in 2000 by the Family Planning Association, the Tobago AIDS Society, the Caribbean Epidemiology Center, with support from the Dutch Embassy in Trinidad and Tobago, and the German Technical Cooperation Agency in Tobago. The study found that sexual activity starts as early as 10 years old, the average age being 14 years old for boys and girls combined. Thirteen percent of those 10–14 years old had had sex (Fraser 2000). The comprehensive review "Health risk behaviors among adolescents in the English-Speaking Caribbean" (2009) pinpointed twenty-two papers that address high risk sexual behavior. The authors of this review, deciphered the following trends in relation to factors contributing to early sexual debut,

> Of the adolescents who had early initiation of intercourse, many (38%) indicated that the initial encounter was forced. Indeed a history of physical or sexual abuse was found to be a predictor of having sexual intercourse as an adolescent (Blum et al. 2004, 10, Kurtz et al. 2005, 22). Additional risk factors were 'less family stability', single-parent family households, low socioeconomic status, and poor knowledge of STIs (Wyatt et al, 1999 43) as well as male gender, recent substance use, recent depression or attempted suicide (Kurtz et al. 2005, 22). Higher levels of sexual activity were reported if there was little adult supervision, adolescents had no specific household chores or homework or sleeping facilities were shared (Bain et al. 1993, 44). In females, increased parity and experiencing menarche at an earlier age were also associated (Wyatt et al. 1999, 43).

A conversation I had with Gwen, a 23 year old young woman from Port of Spain, she explains to me her viewpoint on an appropriate age for engaging in sexual activity,

> There are several things...but what I can say is I don't necessarily have a right age, that they should [start having sex], I would say probably when you know yourself and you can be responsible. You have [to be] mature enough to know right from wrong and know what is going on... I wouldn't put an age limit on it or age because I think you should be educated first before you have HIV; before you have sex. If I had to give a number, it would be at least 20, 21 or longer, but at long and your educated on what is going on before you do have sexual relations.

Gwen's understanding of the significance of being 'educated' before engaging in sexual activity is useful for highlighting the fact many of women I spoke with explained that sex education was important, however, very few were able to recall how or why they knew it was important. Clearly, this knowledge

had to come from somewhere. What I see happening here is that many women are getting sporadic messages about sexual safety and health. As demonstrated by Gwen, she knew that it is important to be educated in terms of safer sex practices like, condom use and monogamy. However, when I posed a follow up question to better understand where she learned this information and why she thinks being in your early 20's is 'better' than say being 16 when a women engages in sexual activity, she said she didn't know. Therefore, to discover where Gwen and other women I spoke with are getting some of their messages it is necessary to critically look at the discourses of official public health entities like the WHO.

How women are located in terms of 'official' public policy discourse is telling of the way in which the labor, consumption, and domestic patterns are differentially valued via the constructions of gender expectations and performances.[2] Andaiye[3] in an article by David Scott (2004) notes a significant departure from the popular discourse on how to conceptualize the ways in which the interactions, behaviors and attributes of women are devalued. The rhetoric used to explain and champion public health initiatives aimed at improving the sexual and reproductive health of women is outlined in terms of generalized principles that are born out of conferences, meetings and house-hold surveys that rarely seek to consider the interconnected elements that impact the experiences and choices of women, an inconsistency that further re-inscribes the socio-political context of unequal gender power relations that exist in heterosexual relationships.

The PAHO, a subsector of the WHO, also produced a document outlining the successes and struggles of healthcare on the islands of Trinidad and Tobago. This document is an excellent example of the problematic language Booth (1998) discusses. The PAHO/WHO Country Cooperation Strategy Report on Trinidad and Tobago, 2006 -- 2009 champions the following:

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[2] For an in-depth discussion of the cultural politics of women, labor and development in the Caribbean see "Women, Gender, and Development in the Caribbean" (2003) Patricia Ellis & "Producing Power: Ethnicity, Gender, and in a Caribbean Workplace" (1995) Kevin Yelvington

[3] Andaiye is a labor and women's rights activist from Guyana who has been interviewed and sited in many publications related the activists movements in Latin America and the Caribbean. Andaiye only goes by her first name, this is why there is not last name given for her.

The overarching objective is "to create an environment where citizens can enjoy an enhanced quality of life in their education, health, housing, and personal security, comparable to the highest standards obtained in modern states" (PAHO/WHO 2006, 6).

This declaration of productive health in the context of the modern nation-state reveals vary interesting perspectives about the context in which the notion of a 'well body' is conceptualized. A normalized discourse regarding individual and communal health in relation to the goals of organization like the WHO that influence the doctrines of a country's Health Ministries, and the governments at large, demonstrates how dominant ideas about health and wellness, perspectives born out of a Western development model, are simultaneously co-opted and forced upon those countries coined as 'developing' by the WHO and similar organizations.

The 'development' doctrine has been problematized by many scholars[4] in reference to "developmentalism as an ideology generated in the context of the persistent inequalities of the post colonial world" in which the "need to reexamine local histories and diversity of products of our common global history and scrutinize the language and practice of development as a modes of domination" (Connelly et al. 2000) become imperative to redressing such covert inequalities. This call for a new approach to implementing international development goals, as outlined by the UN, WHO and PAHO, is pertinent to establishing a system of policy creation, implementation and execution that is based on both statistical and epidemiological data *and* the priorities, realities and capabilities of the people such policies seek to influence.

As a result of an increased awareness that population growth is indeed a development issue, the WHO articulated a need to pay attention to the Sexual and Reproductive Health (SRH) of women in 1994 at the International Conference of Population and Development, an initiative that was born out of demographers and family planning experts who were concerned with looking at the relationships between population growth and change and their impact on social and economic development. It was during this particular

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[4] See "Gender in Caribbean Development: Papers Presented at the Inaugural Seminar of the University of West Indies, Women and Development Studies Project" (1999) Elsa Leo-Rhynie, Patricia Mohammed, Catherine Sheperd and "Engendering Development or Gender Mainstreaming? A Critical Assessment from the Commonwealth Caribbean." In Feminist Perspectives on Gender and the World Bank. (2004) Eds. Edith Kuiper and Drucilla Barker

convention that advocates for women's health as a human right began to champion an ideology of health as "a concept bounded by a positive vision of good health, well-being, equity and social justice, and not by specific disease, pathology or set of organs" (AbouZahr, Vaughan, 2000).

The Way Forward: Towards a Gender Dynamic

Though the WHO has created several documents like "Integrating Gender into HIV/AIDS Programs: A Review Paper" (2003) only generating sporadic documents and special sessions does not adequately address the gender dynamics of HIV/AIDS. Therefore, it is necessary to beg the question; where is gender?

The Gender Review and Assessment on HIV/AIDS Programming in the Caribbean (2005) documents a similar lack of gender analysis in two Trinidadian documents that outline HIV/AIDS policy and programming implementation; 'The Five-Year National HIV/AIDS Strategic Plan", which I have discussed briefly, and the "Comprehensive HIV/AIDS Prevention, Treatment and Care". In regards to these two documents it is noted,

> The assessment reveals a partial awareness of gender issues in the situational analyses that provide the foundation for the responses… While [these documents] reflect some concern and understanding of the gender issues at work in the creation of risk factors for the spread and contraction of HIV/AIDS, the analysis misses many other equally important gender factors that are relevant.

> In this regard, neither the documents under review, nor Situational and Response Analysis, on which the Strategic Plan draws much of its information, conduct a holistic or complete assessment of the gender factors at work in the spread of HIV… The strategic plan does not, therefore, present in its situational analysis a discussion of issues of gender-based violence; the construction of gender identities; and the relationship between high-risk behavior and cultural norms based on gender socialization [in Trinidad and Tobago] (ECLAC 2005, 38).

The missing gender dynamic in these two documents that are the foundation for all HIV/AIDS policy in Trinidad and Tobago is reflective of the unequal power relationships that exist between men and women in heterosexual relationships. Because these policies inform and fund programs that directly engage with the public, there can be little expectation that these programs will have the necessary tools to incorporate "issues of gender-based violence; the construction of gender identities; and the relationships between high-risk behavior and cultural norms based on gender socialization" (ECLAC 2005, 38). The Global Gender Gap Report 2008 notes that out of 130 surveyed that year, Trinidad and Tobago rank 19th

in the gender gap index, 1st place being the country with the greatest gender inequality across all societal realms. Some categorical ranks that highlight why Trinidad and Tobago has such a low rank: Economic Participation and Opportunity, 52nd; Educational Attainment, 39th, **Health and Survival, 1st**; Political Empowerment, 24th. The 'Health and Survival' ranking of 1st, (Hausman et al. 2008) is unfortunately no surprise.

Chapter 4
Conclusion

Since the epidemic unfolded in Trinidad in 1983, the public health sector has dominated the response to HIV/AIDS, disseminating important information about how the disease is transmitted and behavioral change strategies for prevention and access to care. But these efforts can be strengthened by focusing even more on the human dimension of relationships and sexuality, as well as strategies to shape people's positive behavior and skills early in the life cycle. The education sector, which plays a central role in the transmission of culture and customs, can and must play a significant role in protecting the health of young people and women in the fight against HIV/AIDS—especially since research has repeatedly shown that reproductive health education does not lead to earlier or increased sexual activity among young people and can in fact reduce sexual risk behavior (Whitman, 2004).

Considering the complex relationships between sexuality and social, cultural and psychological life in terms of sexual health is important because the interplay of these factors is significant for informing HIV/AIDS praxis that can more effectively address why Trinidadian women are increasingly contracting HIV/AIDS. The majority of research conducted in regards to women's sexual health has focused primarily on the analysis of statistical data. Though statistical data is useful in generating patterns that demonstrate trends about sexual ideology and behavior, it often lacks an interest in the humane elements of conversations that expose the socio-cultural dimensions of why these patterns exist. By engaging in conversations with women on issues regarding their sexual health a researcher will gain far more insight into the lived experiences of the respondent. More specifically, this increased focus can provide uniquely useful health information as opposed to relying on statistical data alone, which appears to be the norm.

To get at the root of the phenomenon of sexuality, specifically women's sexuality, we must consider three interconnected issues that affect how women experience their sexuality via communication, education and women's agency. We must look at the lack of communication that exists in sharing sexual health information particularly as it relates to the spread of HIV. Reexamining the trends in educational campaigns that focus on changing 'risky' sexual behavior among adolescents in an effort to hinder the

spread of HIV is important for understanding the roles identity formation and culture play in constructing

female sexualities as they are manifested among women in the Caribbean. It is necessary to draw

attention to the increased need for recognizing agency in women's experiences to inform programs and

services created to address the sexual health needs of women in Trinidad.

As Paul Farmer notes in his ethnography *AIDS and Accusations, Haiti and the Geography of Blame*

(2006),

> Throughout the world, but particularly in what is termed the "Third World," much of human suffering is caused or aggravated by social forces, and social forces should be studied by medical anthropologists. Suffering is a legitimate subject of ethnographic investigations, with important intellectual and ethical provisos. One of these provisos… is that the *lived experience* of disorder is paramount" (Farmer 2006, 259).

Suffering, as a human condition, is unavoidable, but the degree to which it is exploited and tolerated

along the lines of a 'first world' and 'third world' dichotomy is telling of how human health is valued

along those very same lines. Women's sexual health and its relationship to the spread of HIV/AIDS

parallels that line all too well; causing the highest rates of HIV in "peripheral", "developing," and

"colored" countries. A universal trend that fuels this inequality is the lack of communication on a variety

of levels, from patient/client interactions to general knowledge about the functions and processes of one's

own body.

This lack of communication is characterized by women feeling incapable and powerless to discuss

safe sex, even when they recognize the risk of unprotected sex (Baird et al., 2007). Adolescent

complacency plays a crucial role in this disregard for safer sex practices. This has been made evident in

the fact that adolescents continue to engage in unprotected intercourse even after they become

knowledgeable about HIV transmission (Halcon et al., 2003). This blatant neglect of health care

'information' exposes one of the many barriers both health care providers and social scientists advocating

for improved understandings of sexuality continue to face. Clearly, the means by which this information

is shared is ineffective.

Ignoring such pertinent health information is symptomatic of the way many health care organizations

influenced by the hegemonic discourses of the UN and WHO neglect to understand that before they are

able to promote sexual behavioral change it is necessary to create a dialogue that is culturally relevant based upon needs expressed by the people themselves. The Brooklyn AIDS Task Force (BATF) has experienced similar boundaries in relation to their work with Haitian immigrants. Yannick Durand explains "as far as sex is concerned, people do it, but they don't talk about it. It's considered normal for Haitian men to sleep with many women... Gender roles are very strong. The man is perceived to be sensual, to have sexual needs and woman to have feelings" (1990:86). Since similar gender norms appear cross-culturally, the first order of business must be to deconstruct the historical, political and economic realities that perpetuate these understandings. This is, by no means, a short order but it is necessary to begin the process of change.

The bigoted attitudes surrounding gender functions within a social reality often receive little analysis in regards to how breaking these stigmas could be addressed. For instance, a study conducted by the Department of International Health in Trinidad and Tobago concluded that many adolescents resist getting tested for HIV because it would "result in 'people knowing their business,' which would lead to stigmatization and possible alienation by their families and/or communities (Baird et al. 2007, 25)." This is dangerous ground for young people, particularly young women, to tread on. If they are receiving HIV transmission information in the first place and still succumbing to the cultural pressures strong enough to convince them that alienation is the greater of the two threats, there needs to be some serious investigation into the nature of cultural ideology formation and how it impacts health care judgments among young people.

To scratch the surface of this vast and complex problem, I argue that we must listen to the people that are most effected by this health hazard; the women in Trinidad and Tobago. To initiate this process, educational campaigns need to be reformulated to fit into a context that addresses the needs of the target population. A large part of educating people about sexual health is getting them comfortable with hearing and saying words like 'condom' and 'intercourse.' As explained by the director of BATF, "to have an impact on the Haitian community (as in any culture) you have to go to the women. They're the ones who carry on the traditions" (Durand 1990, 45). Education is considered by many a weapon for escaping low

socio-economic situations, commonly followed by the sentiment "we want better lives than we had for our children." But the question remains; Who generates the knowledge dispensed in educational initiatives? And what is the underlying motivation?

An opening to these answers lies in the self-efficacy theory that states youth can be taught to solve their own problems. Yet, information alone is not enough to bring about behavioral change (McDermott 1998). BATF workers note that in their efforts to combat the spread of HIV among Haitian immigrants, "we can not offer education only about HIV and HIV prevention, we also have to teach about the health care system itself and how it works (Durand 1990). The quality of information exchange between providers and patients and educators and the recipients of information effects women's satisfaction with health care impacting their trust in the health care system, and compliance with treatment programs (Khoury et al. 2004). When educational and health care systems fail to provide accurate information, none at all or are institutions of questionable merit to the people it becomes increasingly difficult to provide holistic care that can produce effective change.

The "Be Proud! Be Responsible! Campaign initiated by the Department of International Health in Trinidad and Tobago exposes similar concerns. The study had successful outcomes in pinpointing patterns in regards to adolescent sexual beliefs and behaviors. Outlining how young people felt about themselves, their sexual attitudes and perceived risk in contracting STIs (Baird et al. 2007). These discoveries are significant in their contributions to educational campaigns and increasing respondents overall consensus that they would critically consider changing their sexual behavior if it was considered 'risky.' Yet, the more striking conclusive feature is that in the post-intervention feedback, study participants indicated that they would have liked to hear real-life stories of people as a primary source of their 'risky behavior intervention education.' Respondents also seemed most engaged and to 'come alive' when participating in role-playing exercises in which they were allowed to create HIV dramatizations around their personal experiences (Baird et al. 2007). The young participants call for real-life stories and interaction further exposes the cultural, emotional and educational necessity of establishing dialogues that

move beyond instruction and into a comprehension that is seen as applicable to their lives from their own point of reference.

It is also noted in this study that the major task of adolescence is discovering one's own identity separate from that of family and peers (Baird et al. 2007). The need to gain a sense of identity can be both hazardous and beneficial to sexual health initiatives. Identity politics is a major factor impacting sexual health disparities, particularly as it relates to the creation of the 'Third World Other.' Identity consists of a myriad of factors that mesh the influences of the community at large as well as the individual themselves; this is especially true for racial and ethnic identity. Demonstrated by the following,

> *Race/ethnicity* is a social rather than a biological category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations justified by ideology. One group benefits from dominating other groups and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (e.g., skin color) (Kriger 2004, 89).

The reality and social implications of such constructions of identity give us an excellent vantage point to complicate this notion of 'other' and how it relates to issues of identity and representation. The 'othering' of people has been a categorical tool of entities (i.e. nations, corporations, groups of people) wielding particular types of power over others. The 'other' has proved useful in maintaining these dynamics as it provides a space to create socio-cultural assumptions that support a domination model. This is relevant for two reasons. Initially, because those living in 'developing' countries have largely been on the receiving end of the dominate discourses that influence many of the sexual health conditions I have mentioned thus far. The second and most important point is that Western feminist analysis of the conditions of 'third world' women has often, though unbeknown to it, supported and reinforced such cultural imperialism.

Chandra Mohanty discusses this discursive colonialism as a mean to reinstate relationships of power that are a subjugation of women (1991). Most international sexual health initiatives are couched in terms of family planning models shaped after a Western biomedical system that greatly fragments women's bodies and has its historical roots in eugenics. This is problematic because the Western model of sexual health is not capable of satisfying the needs of either men or women internationally. This discursive

colonialism operates through feminist scholarly writings ability to re-inscribe colonial power by often representing 'third world' women as hopeless, destitute, and lacking agency. These representations construct realities that not only reestablish biased gender norms but support the internalization of these power dynamics. The internalization of oppression greatly informing how women view themselves and their place in society, more specifically knowing what is required and expected of them (Mohanty, 1991), which reinforce unequal value judgments about women's sexuality which prove to be damaging.

However, there has been a dramatic increase in Western feminists critiquing their contributions to this discursive colonialism and there have been considerable actions to reform it. Feminist theory and understanding will be crucial to contributing to the endeavors I have mentioned throughout this essay. A critique of Western feminist bias and the predominance of a North American focus of much of the work in the anthropology of reproduction and sexuality is prevalent as seen in the following,

> The discipline's feminist epistemology has not escaped the related silencing of globally representative Other voices… While reproductive health continues to be the primary focus of hegemonic international feminist discourse, state-sanctioned "development" programs which threaten public health, i.e., the health of women, children, and men, remain relatively neglected. Their programs are rarely the objects of analytical scrutiny in the socio-medical literature. Instead, preferential consideration is given to women's [general] reproductive health (Lock et al. 1998, 23).

Deconstructing the 'other' in the context of feminist methodology is most effective when two things occur. First, when Western feminist scholars take on the battles of 'third world' women they must engage in them with insightful caution to avoid generalizations that further damage the ideologies they are championing. This is particularly important in establishing effective social mechanisms by which physicians, social scientists, and activists can continue to address the complexities of improving women's sexual health. Secondly, researchers who are not trained in the social sciences need to reconsider the power and effectiveness of the cultural stories of women. When we engage in reciprocal conversations with those we are 'studying' we get pieces of information that no 'scientific' methodology can truly touch. Listening to what women, themselves, proclaim they need and want is the only way to productively combat the disparities that exist in regards to women's sexual health and the consequences of neglecting this intrinsic part of life.

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Appendix A
Port of Spain, Trinidad Interview Questions at the Family Planning Association of Trinidad and Tobago

1. Please tell me a bit about yourself.
2. What do you do for a living?
3. Who do you live with?
4. What do you define as sexual activity and/or behavior?
5. What do you consider healthy sexual activity?
6. What do you consider risky sexual activity?
7. Where did you receive sex education?
    School? Church? Family?
8. Tell me about that learning experience.
    Was it beneficial?
9. Where do you think sex education should be taught? Why is that a good place?
10. If you could create a sex ed. Program for your peers/other people what would you include? Why are these components important?
11. What do you know about HIV/AIDS and how it is passed from person to person? Can you list the ways?
12. Where did you learn about HIV?
13. Who do you think is at risk of getting it?
14. What do you think your family/friends know about HIV/AIDS?
15. Do you talk about your sexual health and behavior with anyone? Like your parents, siblings, friends, doctors? Why or why not?
16. At what age to you think it's ok to be having sex? Why is that an appropriate age?
17. Do you know how to use a male condom? A female condom?
18. If so, where did you learn how to do this?
19. When places like the FPA do sex ed. Programs what do you think are the most important things for them to include?
20. What do you think Trinidadian society tells you about sex?
21. What kind of messages do you get from T.V., movies, radio, music?
22. Do you know anyone with HIV/AIDS?
23. What do you think about them?
24. Did you know that currently young women in Trinidad are getting HIV/AIDS at a rate that is estimated to be anywhere for three to seven times more than men? Why do you think this is happening?
25. Have you been tested for HIV/AIDS? Why or why not?
26. Anything else you would like to share with me?