Shaping Vulnerability

An Analysis of the Factors Creating HIV/AIDS Vulnerability among Women in a Garifuna Village

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Summary

The Garifuna are the largest ethnic minority group of Honduras, primarily living along the northeastern Caribbean coast. The Garifuna’s unique history and culture has separated them from mainstream Honduran society for centuries, both allowing them to maintain their unique way of life and marginalize them from the rest of society. Since the onset of the HIV/AIDS epidemic in Latin America the Garifuna have been targeted as one of the groups with the highest HIV/AIDS prevalence rates in Central America. This information caught my attention three years ago while I was working at a small clinic in the mountains of Honduras. The opportunity three years later to conduct field research on a topic of my choice brought me back to the HIV/AIDS situation among the Garifuna, and allowed me to develop a research project focusing on how women’s knowledge and perspectives of HIV/AIDS are shapes and how these notions relate to gender and sexuality constructs to impact women’s vulnerability.

For six weeks I worked in the small village of Rio Azul investigating what HIV/AIDS information women have access to and what factors contribute to their vulnerable position within society. A multitude of anthropologic methods were employed to carry out the research including participant-observation, informal conversation, a questionnaire, in-depth interviews, focus group discussions, and a review of documents. Through the use of interpretive medical anthropology, critical medical anthropology, and the “Three Bodies” concept I was able to interpret and analyze my findings in a way to focus on the aspects contributing to women’s vulnerability.

The research findings reveal that a multitude of factors affect women’s vulnerable position within Rio Azul and that women’s vulnerability is directly linked to the vulnerable position of men and the whole community. Vulnerability within Rio Azul is shaped by people’s understanding of HIV/AIDS, their perceptions of risk, and whether or not they accept the existence of the widespread HIV/AIDS problem. Gender roles, power relations, and sexuality also contribute to and shape vulnerability among women. Moreover, further reaching socio-economic and political factors influence how vulnerable the people of Rio Azul are to HIV infection, and how dependent women are on men for financial support.
Finally, this thesis gives multiple suggestions for altering the factors contributing to women’s vulnerability within Rio Azul. Some of these suggestions include increased general education, a more efficient health care system, increased infrastructure and job opportunities, women’s empowerment, promotional gender equality programs aimed at men, and increased HIV/AIDS awareness programs for both men and young people. By discovering what factors are contributing to vulnerability and finding methods to decrease these vulnerable factors, a path can be created to decrease the spread of HIV/AIDS.
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CMA</td>
<td>Critical medical anthropology</td>
</tr>
<tr>
<td>CONASIDA</td>
<td><em>Consejo Nacional para la Prevención y Control del Síndrome de la Inmunodeficiencia Adquirida</em> (National Council for the Prevention and Control of AIDS or Honduran National AIDS Committee)</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial sex workers</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IMA</td>
<td>Interpretive medical anthropology</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan-American Health Organization</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>PMCTC</td>
<td>Prevention of mother to child transmission</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
</tr>
</tbody>
</table>
1 Introduction

While working at a malnutrition center and orphanage in a small village near the shores of Lago Yajoa, Honduras’ largest lake, during the summer of 2006, I was astonished that the small clinic did not place an emphasis on the HIV/AIDS epidemic that was spreading through Honduras. Of course, HIV/AIDS was not the focused concern at this particular clinic, but I did not even hear one remark concerning HIV/AIDS mentioned throughout my four weeks working between the clinic and malnutrition center. The lack of emphasis placed on HIV/AIDS made me think that maybe the situation was not as severe as all the hype I had read before departing on my trip made it appear, however, with a little time and research I soon realized that the concern was not unwarranted.

Within Central America Honduras is believed to have the highest HIV/AIDS prevalence in the region, accounting for 60 percent of the region’s HIV/AIDS cases but only 17 percent of Central America’s population (McNamara 2005:1304; UNGASS 2005:7). In 2007 the HIV prevalence was estimated at 0.7 percent; however, there are specific groups including men who have sex with men (MSM), commercial sex workers (CSW), prisoners, and the Garifuna (Honduras’ largest ethnic minority) who have prevalence rates over five percent (UNAIDS 2008). The epidemic is mainly concentrated in urban areas and it is most prevalent among the younger population, with more than 40 percent of cases reported in Hondurans under the age of 24 (UNAIDS 2008).

From the beginning of the Honduran HIV/AIDS epidemic the virus has been predominately spread among heterosexuals, unlike the rest of Central America where the main spread of the virus was among men having sex with men (Smallman 2007:152). This has resulted in a growing number of HIV/AIDS cases among Honduran women (UNAIDS 2008) and has placed women, especially women with low education levels and in poor economic standing, in a vulnerable position. UNAIDS claims that the factors increasing women’s vulnerability to the virus include “early initiation of sex, taboo related to sexuality, high rates of STD, gender inequalities, violence, including sexual violence and” a large young
mobile population (2008). Moreover, gender inequality, discrimination, and stigma have been identified as factors that inhibit people from accessing counseling and treatment, as well as support (UNAIDS 2008).

My new found knowledge about the HIV/AIDS epidemic in Honduras, and its overwhelming influence on women, particularly Afro-Carib Garifuna women, sparked my interest. Why was the HIV prevalence among women so much higher in Honduras than in other Central American countries, and why was HIV disproportionately affecting the Garifuna community compared to the rest of the Ladino (mestizo) population? I decided to focus my attention on how women access information about HIV/AIDS and how the knowledge they are provided with influences their perspectives of the disease. My intentions were to look at how a woman’s knowledge, her cognitive comprehension, and perception, her valued and prioritized understandings, of HIV/AIDS are shaped by three layers of influence: individual influences, social influences, and wider political/infrastructure influences. Furthermore, I wanted to know how these perspectives, combined with gender roles and sexuality affects a woman’s vulnerability.

My curiosity took me to a small Garifuna village on the northeastern Honduran coast, Rio Azul. For six weeks I spent my mornings at the local centro de salud (health center) talking with the women and their children who had come to see the doctor for a variety of ailments, and interviewing Nanci, the centro de salud’s primary nurse. Within the first two weeks I set up interviews and focus group discussions (FGDs) with willing participants and was given a room at the health center to conduct my questionnaire. The next four weeks were busily spent carrying out the interviews, FGDs, and questionnaires, finishing in just enough time to present my finds to the centro de salud and offer my suggested plan of attack for altering the course the epidemic is currently taking.

The rest of this report is committed to describing how I conducted my research in Rio Azul and giving a detailed account of my findings. I start by giving a detailed description

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1 Vulnerability - a neo-Marxist analysis which argues that certain people are at greater risk of contracting a disease because of economic and/or social marginality (Moyer January 22, 2009). This concept will be discussed in more depth on page 43.

2 The names of the village and all the informants have been changed to ensure anonymity.
of the HIV/AIDS epidemic in Honduras, who the Garifuna are, and how the epidemic is affecting the Garifuna communities. Next I explain the theoretical perspectives that I used throughout the course of my research. In chapter five I discuss the different methodological tools that I used, how I analyzed the data, ethical considerations, and the difficulties I had throughout the research process. Chapters six, seven, and eight discuss and analyze my main findings. Chapter six focuses on accessing information, developing knowledge and perceptions of HIV/AIDS, and factors that prevent knowledge from influencing behavior change. The next chapter looks at how gender roles, women’s controlled sexuality, and infidelity contribute to women’s vulnerability. The last empirical chapter, chapter eight, centers on political, economic, and social aspects that affect not only women’s vulnerability within Rio Azul, but also men’s vulnerable situation within the community. My conclusions and recommendations for action and future research are presented in chapter nine.

Through my findings I will show how Garifuna women’s vulnerability is shaped by a multitude of factors, some factors which could be altered within Rio Azul alone and other factors that require larger societal, political, and economic transformations. I will demonstrate how women’s vulnerability is affected by their perspectives of HIV/AIDS and the perspectives of other people in the community, gender norms, controlled sexuality, poor infrastructure, politics and economics, and their position within Rio Azul and the wider Honduran community. Furthermore, my findings will show how women’s vulnerability is connected to the vulnerability of men and the whole Garifuna community.
2 Research Questions

My research questions were developed out of the background knowledge that I had gained about HIV/AIDS and its high presence among women in Honduras, specifically Garifuna women, and my own interests. I wanted to focus on how knowledge and perspectives of HIV/AIDS are shaped and how these notions relate to a women’s vulnerability. Therefore, my core research question developed into, **How are women’s knowledge and perceptions of HIV/AIDS shaped and how do these notions relate to gender and sexuality constructs to impact women’s vulnerability?** Through my core research question and my interest in analyzing my findings through the “three bodies” concept (explained below) I constructed the following sub-research questions:

1. What HIV/AIDS resources and information can and do women access?³
2. Do a woman’s personal experiences, beliefs, emotions, gender, and sexuality influence the development of her knowledge and perceptions of HIV/AIDS?
3. Do individual, social, and political/infrastructural factors influence a woman’s knowledge and perceptions of HIV/AIDS and how do they contribute to her vulnerability?
4. How do a women’s knowledge and perceptions of HIV/AIDS, and gender and sexuality influence her vulnerability?

Due to the limited amount of time I had to complete my research I was not able to focus on all the research questions that I laid out before hand. I did not focus attention on political and infrastructural factors that influence women’s knowledge and perceptions of HIV/AIDS; however, I did look at how political, economic and social issues affect a woman’s vulnerability, which will be discussed in chapter 8. Furthermore, I did not focus much attention on the church’s influence of women’s perceptions of HIV/AIDS. I acknowledge that the church and its messages have a great impact on how women of Rio Azul perceive HIV/AIDS, but I did not gather enough information in this specific area to make an efficient analysis.

³ Here resources and information refers to all forms of information, formal/informal, ‘biomedically’ true/not true, written/verbal, etcetera that affect how an individual understands the notions surrounding HIV/AIDS.
3 Background

3.1 The HIV/AIDS Epidemic in Honduras

Honduras has the fifth highest total number of HIV/AIDS cases on the American continent (UNGASS 2005:7), and despite the fact that only 17 percent of Central America’s population lives in Honduras, 60 percent of the region’s HIV/AIDS cases are present within its borders (McNamara 2005:1304; UNGASS 2005:7). UNAIDS estimates that the national HIV/AIDS prevalence was 0.7 percent in 2007 (2008), a relatively low percentage compared to other prevalence rates around the world; however, other data suggests that the prevalence may be higher in the general population and is higher in certain areas and among certain groups (UNGASS 2005; Flores 2000, Jheeta 2008). For instance in 1998 Sierra stated that San Pedro Sula was the epicenter of the epidemic followed by the capital, Tegucigalpa, with both cities having prevalence rates higher than ten percent (108).4 Moreover, information presented by the World Bank in 2004 suggests that the country’s HIV prevalence is between one percent and 3.2 percent (World Bank in Jheeta 2008). Despite the discrepancy of the actual prevalence of HIV/AIDS within Honduras, on a regional comparative basis it is safe to say that HIV/AIDS is disproportionately affecting Honduras and is an area for both national and international concern.

Within Honduras the main mode of HIV/AIDS transmission is sexual contact, which accounts for 93 percent of transmission, while mother to child transmission and blood transfusions account for 6.5 percent and 0.5 percent respectively (UNAGASS 2005:7). Currently the epidemic is concentrated in urban areas, particularly in the “central corridor, from Puerto Cortés on the Atlantic to San Lorenzo on the Pacific, Valle de Sula, the Caribbean coast and Tegucigalpa” (UNGASS 2005:8); however, with the increased mobilization of people to places offering greater job opportunity the virus has spread to rural areas (UNGASS 2005:8).

The age group most affected by the virus is quite young, with 40 percent of the cases appearing in people under the age of 24 (UNAIDS 2008). The effects that HIV/AIDS is having

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4 The information that Sierra presents may be considered old or out dated, and thus irrelevant, but it is unlikely that the prevalence rates have dropped dramatically in these areas in the past ten plus years due to the lack of intervention.
on the young productive population and the high mortality rate (10 percent of the national mortality rate is attributed to HIV/AIDS) have impacted on the national economy (UNGASS 2005:9). Levels of poverty have increased and particular social problems, including unemployment, due to the overall impact that HIV/AIDS has had on the national economy, and growing numbers of orphaned children, have developed due to HIV/AIDS (UNGASS 2005:9).

In recent years the Honduran government with the help of international organizations has taken an initiative to control the spread of the virus. In 1999 the National Council for the Prevention and Control of AIDS (Consejo Nacional para la Prevención y Control del Síndrome de la Inmunodeficiencia Adquirida - CONASIDA) was created to defend the human rights of people living with HIV/AIDS (PLWHA) and the groups most vulnerable to contract the virus (UNGASS 2005:10). “Between 2002 and 2006, the government declared HIV/AIDS as a national priority and the Health Secretariat designated the epidemic as one of its priority programmes” (UNGASS 2005:11). In 2002 antiretroviral (ARV) therapy, voluntary counseling and testing (VCT), and prevention of mother to child transmission (PMTCT) services became available free of charge (UNAIDS 2008); however, in December 2005, 12,000 people were estimated to be in need of ARV treatment, but only 4,305 people (36 percent) were receiving treatment (WHO 2005) and in 2007 MTCT plus was only covering 20 percent of women in need of treatment (UNAIDS 2008), despite the government’s aim for universal access. Even though treatment and VCT may be free of change PLWHA still incur user fees for hospital services, which disproportionally affect the lower economic class (Jheeta 2008), and they have to be able to afford transportation to health care facilities, time taken away from work, and food that provides the necessary nutrition to be taken with ARVs (Hardon et. al. 2007). All of these factors prevent PLWHA from accessing treatment and following their drug therapy schedules. Moreover, in 2007 the government was covering 70 percent of the drug treatment costs, but no long term plan or policy has been

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5 MTCT Plus program was initiated in 2002 “to meet the needs of every family member infected or affected by HIV/AIDS in resource-limited settings. The MTCT-Plus Initiative, recognizing the important roles that women and mothers play in their families and communities, built on PMTCT programs to include comprehensive treatment services for women throughout pregnancy and postpartum” (ICAP 2008).
put in place to sustain the ARV, VCT, and PMTCT programs (UNAIDS 2008). To counter the need for highly nutritional, expensive food that people taking ARVs encounter, a food basket program was introduced in 2003 to provide 300 people on ARVs with the needed nutritional support (UNGASS 2005:12).

There have been initiatives made to create a curricula on sexual and reproductive health that would be implemented in schools by the ministry of Education, but these initiatives have not yet developed into practice (UNAIDS 2008). Other programs have been more successfully implemented, for instance, a program was launched in Tegucigalpa and San Pedro Sula to prevent the spread of HIV among maquila workers (factory workers), particularly young and adolescent women (UNGASS 2005:16). Moreover, campaigns launched among CSW to increase the use of condoms during transactional sex have proven to be useful; a study conducted in 2005 found that 95.5 percent of CSW claimed to have used condoms with their most recent client (UNGASS 2005:6). These are only some of the initiatives that have been taken by the Honduran government and international organizations to try to control the epidemic. Some have proven to be successful and others have not materialized or have failed all together. With an increased understanding of how people conceptualize and understand the HIV/AIDS epidemic and their vulnerable position within the epidemic, more efficient programs can be developed and put in place to fight the spread of the virus.

Unlike the majority of Latin America, HIV/AIDS has been prominent in both males and females since the beginning of the epidemic. At the onset of the epidemic in Honduras, during the mid 1980s, males were more affected by HIV/AIDS than women, with a male to female ratio of 4:1, and with homosexuals and bisexuals accounting for 15 percent of the infected cases (Sierra 1998:106).6 However, by the mid 1990s the male to female ratio had dropped to 2:1 and the number of cases attributed to homosexuals and bisexuals fell to nine percent (Sierra 1998:106). Sierra explains that of the 92 percent of HIV/AIDS cases attributed to sexual transmission in 1997, 83 percent of those cases were transmitted through heterosexual sex and only 9.5 percent of cases were transmitted through homosexual or bisexual sex (1998:106). On a more current note, in 2004 47 percent of

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6 The figure most likely does not account for MSM who do not consider themselves to be homosexual or bisexual.
recorded HIV/AIDS cases appeared in women (UNGASS 2005:7). Therefore, from this information it is evident that HIV/AIDS cases among women have been on the rise and that women are as proportionally affected by HIV/AIDS as men. Despite this evidence, “there are no intervention strategies aimed at women in general” only programs for pregnant women and CSWs (UNGASS 2005:7).

Multiple reasons have been identified to explain the growing HIV/AIDS prevalence among women and their increased vulnerability to the disease. Besides biological factors that name women as being more susceptible to HIV infection, economics, social, and cultural dimensions affect a woman’s vulnerability. Economics, social, and cultural dimensions of HIV/AIDS vulnerability are connected to power imbalances and inequality, within Honduras, as well as elsewhere. A study conducted by the Pan-American Health Organizations (PAHO) looking at “gender-based roles, relationships of power and sexual behaviour in the spread of HIV/AIDS” in Latin American and the Caribbean, claimed that not only are women more vulnerable to contracting the virus than men, but “women with a low level of education and who are financially dependent are more vulnerable” than the average woman (PAHO in UNGASS 2005:8). In addition early initiation of sex, taboo related to sexuality, high rates of sexually transmitted diseases (STD), violence (especially domestic violence), and a young mobile population have been named as other factors contributing to the vulnerable position of women (UNAIDS 2008). During my study I investigated multiple dimensions of vulnerability including sexuality, gender relations, power, political, and economic dimensions. These aspects of vulnerability will be discussed and analyzed throughout chapters seven and eight.

3.2 Who are the Garifunas?

The Garífuna are an ethnic minority population living along the Caribbean coast in Central America, with a multitude of communities established along the northeastern coast of Honduras. The Garifuna, originally known by the British as “Black Caribs” are believed to have descended from West Africans living with Carib Indians on the island of St. Vincent during the 17th and 18th centuries (Chernela 1991:57). Black Caribs were first recorded by Armand de la Paix in 1646 (Chernela 1991:57). Two different theories exist as to how the West Africans arrived on the island of St. Vincent; one theory claims that they were slaves
traveling in slave ships that shipwrecked off the St. Vincent coast (Chernela 1991:57), while the other declares that they came to St. Vincent as runaway slaves from various neighboring European controlled islands (Chernela 1991:57, Cohen 1984:16). No matter how they arrived on St. Vincent, the Black Caribs mixed with the Antillean or Carib Indians (Davidson 1980:33), and fought for years against European colonizers who desired to take over the island. After losing a battle to the British in 1795, the Black Caribs were removed from St. Vincent and reestablished on the Island of Roatan, off the coast of Honduras (Chernela 1991:57). With time they moved to the more fertile soil of mainland Central America, where they now occupy land in Nicaragua, Honduras, Guatemala, and Belize.

The Garifuna are primarily fishermen and farmers, choosing to live near the sea and freshwater rivers or lagoons for easy access to multiple fishing areas. Historically fishing was the primary responsibility of the men, while horticulture and house work was the woman’s domain. Today, the women still stay in the home and carry out the daily chores, but farming is not as abundant. Moreover, men have branched out to other occupations other than fishing. Some men still hold jobs in the fishing industry or on commercial boats, including cruise liners, or engage in other forms of migrant work. The migrant live style of the Garifuna has allowed settlements to establish in some large U.S. cities such as New York, Miami, and Los Angeles.

The Garifuna have maintained the unity of their communities through their unique culture and language. The language, also called Garifuna, is an “Amerindian language that contains Arawak and Carib Indian elements” combined with French, Spanish, and English components (Cohen 1984:16). The Garifuna of Honduras are bilingual, speaking Garifuna and Spanish, and some are trilingual, also speaking English. In addition to the unique language spoken by the Garifuna, they also have their own cultural practices that differ from the mainstream Central American culture. Dance, song, and folk-tails are particularly important to Garifuna culture. Throughout the year different villages partake in traditional dance and song celebrations that honor the gods that their ancestors once worshiped. These are very lively and colorful celebrations, performed with wood drums, voluptuous women boasting out song, bare-chested men, and participants wearing brightly designed traditional dress. The dance that accompanies these celebrations requires one to be quick on their feet as they shuffled around the arena. Where I was working these celebrations are
no longer performed to honor the gods or reap bountiful harvest, but rather as a reminder of the community’s heritage.

Within Honduras there are 43 Garifuna communities, the majority lining the northeast Caribbean coast. Out of these 43 communities a multitude of them are located around the Bay of Tela, including the community I worked with, Rio Azul. Rio Azul is a community of approximately 2,500 inhabitants. The community consists of one main road running along the coast, starting at the lagoon and ending at the centro de salud. Many small houses line the road on both sides, and more branch off into the sandy plane moving away from the beach. These houses are made from a variety of materials. The more expensive, modern homes are made from concrete and cinder block, generally having a tin roof. Less expensive and more traditional housing is made from thatched palm leaves and wood, either with a concrete or dirt floor.

There is one general store in the village providing people’s daily needs, including beans, flour, corn meal, and bottled drinking water, a daily necessity only to foreigners and wealthy families. A few restaurants lay on the beach or along the main road, serving fresh fish and typical Garifuna dishes. These restaurants mainly cater to the tourists who have begun to visit the village on day trips leaving with outfitters from Tela. There are also a few small hotels and bungalows that provide overnight stays to adventurous tourist willing to spend a night away from the city.

Apart from the tourist industry that has just begun to bud in the past few years, job opportunities are scarce in the community, with the only real options being fishing or working on a fruit or African palm plantation. This factor pushes many Garifuna men to leave the community in search of work. Many work on commercial fishing or commerce ships, others on cruise liners or in migrant agricultural work and some even try to migrate to the United States, which has proved more difficult in past years with increased migration restrictions. Despite the lack of job opportunities in Rio Azul, poverty is not abundant in the community. Many families supplement their meager salaries with remittances sent from family members living in the United States. Women make extra cash by selling food good and beverages out of their homes or doing odd jobs for more fortunate neighbors. One woman explained to me that the money her mother sends from the United States is enough to pay for the water and electricity to keep the house running and she earns extra money by
selling soda from her front porch to buy food and goods for her family. The lack of job opportunity in Rio Azul has negative implementations that affect the growth of the village and individual families, as well as place women in a position of economic dependence.

3.3 HIV/AIDS Among the Garifuna

The Garifuna are believed to have one of the highest HIV/AIDS prevalence rates in all of Central American, ranking among CSW, MSM, prisoners, and military recruits. At the end of 2005 the estimated infection rate among the Garifuna population was between 8 and 14 percent, three to eight times higher than the national average of 1.0 to 3.2 percent (WHO 2005). Moreover, a study done by Dr. Sierra, a professor of medicine in Tegucigalpa, the capital of Honduras, found cumulative incidence of HIV cases greater than 20 percent in some Garifuna villages (Jackson 2002). His findings also noted that only 20 to 40 percent of sexually active Garifuna men regularly use condoms to protect against HIV infection (Jackson 2002), a factor that is greatly determining the course of the epidemic. Further findings from 2004 claimed that women have slightly higher prevalence rates than men, 8.5 percent compared to 8.2 percent (UNAIDS/WHO 2004). However, I was informed by a local doctor that the prevalence rates among Garifuna women on the northeastern coast are significantly higher than male prevalence rates, but this difference may be due to the higher number of women who opt for VCT compared to men; six months into 2009, 35 women had been tested for HIV at the centro de salud in Rio Azul, whereas only two men had been tested. Men’s unwillingness to take an HIV test has great implications for the spread of the virus especially since men are believed to be the ones bring HIV to the Garifuna villages.

Changes in labor patterns in recent decades are believed to be one of the main sources of the high HIV prevalence rates among the Garifuna communities. In the past decades Garifuna men have increasingly begun to engage in work which has taken them away from their communities, to placed as close as La Ceiba and San Pedro Sula, to as far away as New York and London (Jackson 2002). Returning migrants are openly welcomed back into their communities bringing gifts and fortune, but also spreading HIV that they contracted while away to their wives and partners (Jackson 2002). Stansbury and Sierra’s explain that “the severity of the epidemic in Garifuna communities is rooted squarely in the
economic realities of labor migration” (2004:458), and their research clearly showed that the Garifuna of Las Espinas, Honduras understand the role that migration is playing on the epidemic. The affects that labor migration have had on shaping the HIV/AIDS situation in the Garifuna communities is an overarching factor that has not yet appeared to influence the general epidemic in Honduras as it has among the Garifuna.

Despite the high prevalence of HIV/AIDS among the Garifuna of Honduras, PLWHA do have access to HIV/AIDS resources and treatment. I cannot speak for all of the Garifuna communities in Honduras, but VCT is available in Rio Azul at the centro de salud. Villagers are welcome to come into the clinic during any working day and receive a free HIV test administered by the primary nurse. The HIV test is accompanied by a short counseling session that tests the knowledge of the patient and provides them with information they are lacking. The test is a rapid test, which only requires a few drops of blood and about 15 minutes for the results to appear on the strip. If the result comes back positive the patient is sent to the hospital where another test is performed to verify the result.

In addition to free HIV testing and counseling, HIV positive people have virtually free access to ARVs. ARVs can be obtained at the local hospital, only a short drive from Rio Azul. Patients are asked to contribute what they can towards the costs of their treatment, but what they cannot afford is provided by the government or international organizations. I was informed that the average person taking ARVs in Rio Azul pays around 5 lempiras a month, roughly 25 US cents, which is very affordable seeing that a bottle of soda that nearly everyone in the village can afford on a daily basis costs 12 lempiras. Not only are ARVs virtually free, but the other tests that are required while taking ARVs, viral load tests and CD4 count tests, are also provided free of charge by the government. Patients are only required to pay 5 to 10 lempiras per hospital visit. The low costs of ARV treatment and the nearly free services that accompany it make it possible for all willing HIV positive Garifuna to receive efficient HIV treatment. The access to HIV treatment has greatly influenced the course of the epidemic as well as changed the view people hold of HIV/AIDS.
4 Theoretical Perspective

The core of my research focused on how people interpret and understand HIV/AIDS within their context and the meanings that they attribute to the disease. By looking at HIV/AIDS in this way I followed the interpretive medical anthropology framework (IMA). Through the IMA framework illness is looked at as a cultural phenomenon that is constructed by a culture’s (or an individual’s within a culture) interpretation and exploratory model of an illness (Good 1994:53); people explain an illness based on their own understanding and experience with that particular illness. Moreover, IMA has focused on the symbolic structures and processes that have been associated with certain illnesses and what influences within a society have created these associations (Good 1994:54). This focus was particularly important in my research when I looked at what information and aspects of society contribute to shaping a woman’s understanding of HIV/AIDS. Good explains that illness interpretations are influenced by historical discourses that shape interpretations, and “are always contested in settings of local power relations” (Good 1994:53). This brings me to the other theoretical lens that I used, critical medical anthropology (CMA).

The CMA framework takes into account many factors including historical, political, economic, societal, cultural, ecological, power relations, gender, etcetera that influence people’s health and the health care services that are available to them. CMA takes a “critical or neo-Marxist approach to the analysis of illness representation and medical knowledge”, looking both at the “mystifications of the social origins of disease” and the production of medical knowledge through social conditions (Good 1994:57). This point was important when I looked at what sources of HIV/AIDS information are available to my informants; in other words, who has access to information. Moreover, the neo-Marxist influence on CMA allows room for gender relations, power, and inequality to be taken into consideration and used to analyze a person’s health and his or her access to information and health services. This aspect of CMA was vital when I considered the vulnerability of women in Garifuna community and what factors place them in their vulnerable position.

In addition to the IMA and CMA frameworks, I also used the “three bodies” concept developed by Scheper-Hughes and Lock to interpret and analyze the influences that shape
women’s knowledge and perceptions of HIV/AIDS and their vulnerability. Scheper-Hughes and Lock explain that there are three different bodies or levels of relations to be considered during analysis (1998:348). These three bodies/levels include the individual body, the social body, and the body politic. The individual body can be “understood in the phenomenological sense of the lived experience of the body-self” (Scheper-Hughes et.al. 1998:348); an individual’s personal understanding of them self or a situation. The social body refers to the “representational uses of the body as a natural symbol with which to think about nature, society and culture” (Scheper-Hughes et.al. 1998:348). This part of the body is influenced by the norms and roles established within a society. The last body, the body politic, refers to the “regulation, surveillance, and control” of both the individual and the collective bodies (Scheper-Hughes et.al. 1998:348). Here relationships of power and control are taken into consideration. Through using the “three bodies” concept I was able to place the different factors that shape a woman’s understanding of HIV/AIDS into the “three body” diagram giving me insight into which individual, social, and political factors have the greatest influence on the individual body. Due to the short amount of time I had in the field I was not able to focus much attention on the body politic. However, I feel that many aspects of the individual and social body overlapped and influenced each other greatly. I will explain this in detail throughout the rest of the report.

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7 See “Three Bodies” Problem Analysis Diagram, appendix 1.
5 Methodology

This study was primarily an exploratory study that utilized qualitative research methods. The study focused on the micro level, while taking into consideration the influences that the meso and macro levels have on the micro level. The study was conducted over a six week time period, in a single Garifuna village, Rio Azul, in Honduras. More than 50 people participated in the study either through direct interviews, questionnaires, or focus groups, or through informal conversations. Multiple qualitative techniques were utilized during the study including, participant-observation, informal conversation, in-depth interviews, questionnaires, focus group discussions, and a review of HIV/AIDS information that is available to both the public and health care professionals.

5.1 Tools

Participant-Observation

Throughout the research process I was continually observing people in their daily lives. This observation began at the centro de salud in Rio Azul. For the first two weeks of my fieldwork I mainly spent my days in the centro de salud observing who came to the clinic, the different reasons people came to the clinic, how the patients and clinic stuff conducted themselves within the clinic, and the casual behavior that took place in the waiting area. Doing participate observation in the clinic gave me a glimpse into the medical facilities that are available to the people of Rio Azul and who utilizes these facilities. Moreover, due to the centro de salud’s casual and open environment I was able to observe people in a social setting where they felt comfortable and at ease.

While at the centro de salud I was also given the opportunity to observe two HIV testing and counseling sessions. This allowed me to see firsthand what information is given to a person seeking HIV counseling and how the nurse goes about delivering the information. Moreover, through the two individuals’ responses to questions and their anxiety waiting for the test results, I was able to witness how fearful they were of being HIV positive and that they knew they may have put themselves at risk of HIV infection through their actions.
In addition to my observations at the centro de salud I participated in two different educational group sessions held by a local organization for women in the community. The sessions focused on women’s health, sexuality, and the importance of family, while female empowerment seemed to be an underlying theme. The sessions took place once a week for approximately two to three hours and anywhere from 20 to 30 women came to the sessions. Not everyone participated, but everyone listened and had an opportunity to voice their opinion if they chose to do so. Observing and occasionally participating in the sessions was very useful, again because I was able to see firsthand what information and resources are available to women in the community and how women respond to the ideas and information being put forth.

*Informal Conversation*

During my time in Rio Azul I engaged in multiple informal conversations with people in the community, both people who were my informants and the average person on the street. Partaking in informal conversation allowed me to get to know my informants and build trust with them. Moreover, informal conversations gave me insight into topics that are of concern to community members. Because the people of Rio Azul associated my presence in the community with different organizations in the larger community and with the centro de salud, they told me about medical concerns they had that went beyond HIV/AIDS, which allowed me to place HIV/AIDS concern within the community on a scale with other health concerns and weigh its importance.

*Review of Documents*

Throughout my research I reviewed documents, pamphlets, and signs pertaining to HIV/AIDS that I found around Rio Azul and in the centro de salud. Some of these written materials were readily available to the community, but others were only available to certain people or to the health staff at the centro de salud. Specific locations, for instance the centro de salud and the patronato (village municipality center), contained multiple forms of HIV/AIDS information that a passing person could glance at or read more in depth. In other locations around the community you could see billboards or small signs with messages
about HIV awareness and prevention, and where to go to seek counseling, testing, and treatment.

Taking notice and analyzing these documents gave me insight into what messages (intended and unintended) about HIV/AIDS are conveyed to the community and what information is readily available to the people. Moreover, it shed light on what types of messages and information authorities think should be available to the public.

**Questionnaire**

I conducted a semi-structured, 36 question questionnaire with 24 women and one homosexual man who considered himself a woman.8 Before conducting the questionnaire I did some interviews with health professions and local individuals to get a better understanding of the HIV/AIDS situation in the community. The questionnaire was also tested with three individuals in the community to check for question relevance and understanding, and it was later edited for language usage and grammar by another community member. A few questions were added and others were changed following the interviews and the test.

All of the questionnaires were conducted in a private room at the centro de salud. Women who were waiting to see the doctor were asked to participate in the survey either by myself or by one of the nurses. Most of women asked agreed to participate but a few declined or said they would at a later time, but never returned. The majority of the women who participated seemed interested in answering the questions to the best of their ability and offered detailed responses during the opened ended questions, but others did not really engage in the questionnaire, and felt more comfortable only answering the close-ended questions.

I feel that the questionnaire was very useful because it allowed women in the community to get to know me better and to better understand my research. Moreover, it gave me insight into which topics I should focus on during the in-depth interviews and new topics that I had not considered discussing.

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8 An English version of the questionnaire can be found in appendix 2.
Questionnaire Demographics:

<table>
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<tr>
<th>Age</th>
<th>16-20</th>
<th>21-25</th>
<th>26-30</th>
<th>31-35</th>
<th>36-40</th>
<th>41-45</th>
<th>45+</th>
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<tbody>
<tr>
<td>Count</td>
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<td>4</td>
<td>8</td>
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<td>1</td>
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<table>
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<tr>
<th>Education Level</th>
<th>Less than 6 years</th>
<th>6 years (basic plan)</th>
<th>8 years (middle school)</th>
<th>High school</th>
<th>College / University</th>
<th>Still in School</th>
</tr>
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<td>5</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>Single</th>
<th>Stable Relationship</th>
<th>Married</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>11</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

In-Depth Interviews

Eight in-depth interviews were conducted with women from Rio Azul. At an evening education program for adults wishing to further their education, I asked women in the program if they would be interested in participating in my study through a one hour interview session that would take place at their convenience and in their homes. Nine women agreed to participate (in the end one woman could not be located) and I set up interview times and locations with each woman.

The interviews were conducted throughout one week, with two to three interviews taking place per day. Each interview was done in or near the interviewee’s home. Due to the hot temperatures in Rio Azul many women preferred to do the interview outside their homes either on a patio or in their yard under a shade tree in order to make use of the ocean breeze. This fact did cause some interviews to be interrupted by passing neighbors or community members, but in the majority of cases we were able to continue with the conversation without a problem.

The youngest interviewee was only 17 and the oldest was 39, with an average age of 27. Five of the women said they were married and three had stable partners. All the women, besides the 17 year old had children. Seven of them were housewives, some running small stores out of their homes, and the two youngest women, 17 and 22, were still taking classes at the high school.

The interviews lasted from 45 minutes to an hour plus. The time length of the interview depended on the woman’s interest in the conversation and her schedule. I had to
return to some interviewees later in the week to finish interviews or verify responses if the woman was too preoccupied or busy during the initial interview.

Only one of the interviewees allowed me to audio record our conversation, requiring me to take notes during the rest of the interviews. I took as few notes as possible to stay engaged in the conversation, usually just jotting down key phrases to jog my memory later. I did audio record my comments after the interviews in order to better remember the conversation when typing up the notes; this was especially useful if I had another appointment after the interview.

Seven out of the eight interviewees were engaged in the interview and seemed interested in the topic and providing me with their opinions. They gave lengthy responses and elaborated when I ask them to or said that I did not understand. The one interviewee who did not seem interested in the conversation was quite young compared to the rest and seemed uncomfortable talking to me about HIV/AIDS and sexuality.

Focus Group Discussion

The end stage of my study consisted of two FGDs. The FGDs were designed to verify the findings that I made throughout the other stages of the research. I arranged for the FGDs to take place in one of the empty offices of the patronate, during two consecutive afternoons. A woman who runs a HIV/AIDS support group organized the groups of women for me. The women’s involvement in the support group had both advantages and disadvantages. Their familiarity with HIV/AIDS as a topic of discussion should have made them comfortable during the FGD and allowed them to talk freely about the topic. On the other hand, this same factor made these women different from the rest of the women I had interviewed throughout the study. In the end, the women’s familiarity with HIV/AIDS did not necessarily make them more apt to discuss the topic with me, if anything I think it made them a bit bored and unwilling to focus during the discussion.

The first FGD was composed of seven women, eight including myself. The women were between the ages of 17 and 36, with the average age being 29. The FGD was very slow getting started and the discussion never really picked up. It was more of a question and answer session than a discussion. At first I was confused as to why the women did not want
to engage in the conversation, but during the discussion I discovered that one of the women in the group was HIV positive, and this made the others reluctant to answer the questions. They told me that she was the only one with HIV and therefore was the only one who really knew the appropriate answers to my questions. This factor discouraged me at the beginning, but now that I look back on the experience I can see other hidden details and messages.

The second FGD flowed much better than the first, and resembled an actual discussion, with the women talking between themselves and not only with me. This FGD only had four participants from the community. They ranged in age from 17 to 32, with an average age of 23. The small size of the group may have allowed the women to feel more comfortable discussing a sensitive topic. Moreover, one of the participants was an acquaintance of mine from earlier in my fieldwork, and she helped get the other women involved at the beginning of the discussion. The second FGD helped me to confirm my findings and shed light on new topics that I had not considered earlier.

5.2 Data Analysis

“The aims of most qualitative analysis are to both reflect the complexity of the phenomena studied, and to present the underlying structures that ‘make sense’ of that complexity” (Green et al 2004:175). In order to ‘make sense’ of the phenomena studied, analysis was used continually throughout the research process, in order to identify missing links. However, final themes and interpretations were not complete until coding took place after completing the study. I used a coding up system, allowing the empirical data to generate the codes and themes (Gerrits April 27, 2009). Through the continuous analysis process I was able to bring order to the data I collected and fasten meaning to my interpretations (Gerrits April 27, 2009).

5.3 Ethical Consideration
HIV/AIDS and the topics that accompany it are very sensitive issues, making it vital that people participating in research of this kind know the extent of the research, what it will be used for, and who will have access to the information once it is complete before they are asked to participate. Due to this fact I made my position as a researcher clear, explained the study topic, and my intentions for the research before I asked people to participate in the study. This time of explanation allowed people to decide whether or not they truly wanted to participate. I do not feel that anyone felt pressured into participating in the study. More than once women straight out told me that they did not want to speak to me and others made up excuses to get out of a conversation. In addition, I asked the women willing to participate for their consent to use the information gathered during our discussion in my thesis and explained that their names would not be included.

Moreover, I informed my informants that they were not obligated to answer any questions or reveal any information that they did not feel comfortable discussion. I tried to make my informants feel as comfortable as possible during our conversations. Sometimes it was necessary to probe the women in order to obtained in-depth information, but if an informant was unwilling to discuss a topic I let the issue go and continued in a different direction.

5.4 Difficulties and Limitations

Access

The most difficult and frustrating aspect of my fieldwork was getting access to a community. Before heading to Honduras I made arrangements with a micro-credit non-governmental organization (NGO). They intended to provide me with access to a Garifuna community on the Caribbean coast and find me a gatekeeper who could help me set up my interviews and FGDs. This NGO followed through with finding me a gatekeeper, Dilia, who lived in a village close to Rio Azul. Dilia and I agreed to contact each other at a specific date and time in order to begin making further arrangements. However, since our agreement I was not in contact with Dilia again. I made multiple phone calls to her mobile phone and to her home, but she never answered or returned my calls. There I was on the coast without any contacts in the city, and without a place to start.
I decided to visit a local organization, *El Enlace de las Mujeres Negras*, who works in the Garifuna communities specifically concentrating on women’s issues. A woman from El Enlace, Paula, was more than willing to help me gain access to one of the Garifuna communities in the area and invited me to go to an information session with her in the coming week. Now I had a contact but a week to kill before I could even meet with possible informants. I decided to keep looking for alternative options.

Fortunately I met a Peace Corp volunteer who had a friend, also a Peace Corp volunteer, in one of the Garifuna communities. This woman, Katie, was more than happy to assist me in getting access to willing informants in the community, and asked to meet me in a few days time. Katie and I met over licuados, a Latin American specialty of blended fresh fruit and milk, at a local smoothie stand. She informed me that she would be out of town for a week, but gave me the names and numbers of her contacts in Rio Azul and told me that the nurse at the centro de salud, Nanci, would be more than happy to get me started.

I had vaguely met the doctor in training who works at the centro de salud in Rio Azul, Mario, and he agreed to take me to Rio Azul the next morning to meet his nurse Nanci. Nanci was more than willing to provide me with all the information she could as well as introduce me to some other community members. After two weeks of trying to find a field site and make contacts I was finally at a place to begin my research. It did not continue exactly smoothly from this moment on, but now I had a base and someone to turn to if I needed assistance.

*Creating an Image*

At the beginning of my research in Rio Azul I had a difficult time creating an appropriate and ethical image for myself. Because I arrived at the centro de salud with the young doctor in training the women in the centro de salud took me to be his wife. This misunderstanding only took a few days to clear up, but it was followed by another misunderstanding. Someone in the community thought I was a new doctor who had come to work alongside Mario, and thus this second rumor started circling around the village. I could understand people’s confusion since I spent most of my days in the centro de salud with either Mario or Nanci; however, having this image made it difficult for me to explain my presence as a researcher who has very limited biomedical knowledge. These
misunderstandings required me to re-explain my situation and presence multiple days over to the women who frequented the centro de salud, and hope that my explanation reached other people in the community who I would meet later in my fieldwork. I feel that this false image that I was given may have made people respond to me in a more open manner, because the women would want to give a welcoming and open impression to a new doctor. Despite the benefits this false image may have had, it was not an honest portrayal of myself, nor an image I wanted to give to the community.

*Language Barriers*

As I explained before, the Garifuna speak their own language, Garifuna, as well as Spanish. Therefore, I did not have much difficulty speaking to a community member one on one, but when there was a group the situation was different. Even when the Garifuna are speaking Spanish to each other they often intertwine some of their own language into the conversation, which made it difficult for me to understand. Moreover, even though my interviewees mainly spoke Spanish to each other for my benefit, this is not common. During everyday conversation between two Garifuna women, they do not speak Spanish, but Garifuna. This factor made it very difficult for me to understand what was going on while making observations. Of course I could still observe the situation, but I could not understand the dialogue to go along with people’s actions, which limited my observation skills.

*Sampling*

I found my informants mainly through convenience sampling. The women who participated in the questionnaire were not chosen by any particular method, they were simply asked if they wanted to participate while waiting to see the doctor at the centro de salud. By choosing participants in this way many people were left out of the sample population, particularly people who did not visit the centro de salud during the days that I did the questionnaire. The participants for the in-depth interviews were chosen from a group of women who attend an evening education class for adults. Therefore, a similar problem arises to that of choosing people to participate in the questionnaire; only women who participate in the evening education program were considered as informants, leaving
out anyone who does not attend evening education. Last, the FGD participants were picked from a group of women who participate in a HIV/AIDS support group, and more than being picked the women who were available and willing were simply asked to participate. Therefore, only women who participate in the support group and were willing to participate were involved in the FGD. Due to the limitations in sampling, I do not claim my findings to be true for all women living in Rio Azul, and especially not for all the Garifuna communities of Honduras. My findings only pertain to the women who participated in the study; however, some general trends can be interpreted from the data and are presented below.
6 HIV/AIDS Knowledge and Perspectives

Within a few days of being in Rio Azul it was apparent that the villagers were quite educated about HIV/AIDS and that information was available from multiple different sources and locations. However, as time went on and I began doing in-depth interviews it became clear that knowledge and awareness does not influence behavior change in all cases. Moreover, I realized that a lack of concern and denial of a HIV/AIDS problem, or even the existence of the disease as a whole, causes people to be complacent about infection, thus increasing their chance of infection.

6.1 Obtaining Knowledge

“There are many organizations here who give charlas [talks] and condom demonstrations; it is a way for people to gain knowledge about HIV/AIDS and its consequences” - Gabi, 29.

HIV/AIDS information is presented in multiple different forms throughout Rio Azul from signs and posters providing awareness messages to formal discussions and meetings held by the patronato. The method for teaching HIV/AIDS awareness most commonly mentioned by informants was *las charlas*. Charlas are anything from casual discussions put on by a local organization, like El Enlace de Las Mujeres Negras, to formal meetings or workshops designed by foreign organizations, like Medicos sin Fronteras. Throughout the year different organizations or groups in the community put together charlas to provide HIV/AIDS information to the public. Some charlas are aimed at specific groups or certain age categories; others are more general and are open for anyone to attend.

During my time in Rio Azul no charlas specifically focusing on HIV/AIDS awareness were held; however, there were charlas for women teaching a whole manner of different topics. The topics discussed the two days I attended were women’s sexuality and sexual
satisfaction, the menstruation cycle, and the importance of family and family unity. The discussions were held once a week on the beach, under a thatched palm canopy, where the cool sea breeze could refresh the participating women. They were led by a woman from a local organization and any woman in the community could attend. The charlas were very open, going in whatever direction the conversation took it, and the leader encouraged all present to participate and voice their opinions. Even though these discussions were not focused on HIV/AIDS the leader explained to me that HIV/AIDS awareness campaigns run by the organization functioned in a very similar manner and that the discussions held by a community HIV support group, also held similar discussions with its 20 plus members.

Apart from charlas women in Rio Azul also receive HIV/AIDS education from the centro de salud. Many women named the centro de salud and specifically HIV/AIDS counseling sessions as sources of information. Eva, a 30 year old mother of two, explained to me that she received a lot of HIV/AIDS transmission information from Nanci when she went to take an HIV test and receive the complimentary counseling. The information that Nanci provides during the counseling is very basic at first, she uses posters to explain the main modes of transmission and how one can protect them self against infection. But if the patient seems confused or interested in knowing more, Nanci will provide her with a more in-depth explanation. Having information available in this fashion is very beneficial, allowing an individual the opportunity to receive information in a one-on-one scenario, in private, and ask questions that she may not have felt comfortable asking in front of others.

In addition to charlas and the centro de salud, there are two community based programs that provide HIV/AIDS information and put on awareness activities. One of these programs is a theater group supported by USAID that has created a radio novela (radio soap opera) that incorporates HIV/AIDS information into the story line. Currently the novela has over 200 episodes that can usually be heard during the late morning hours. The story line is very realistic and explains situations that many people in Rio Azul have experienced. I recall one particular episode where a woman was telling her friend that she needed to be tested for HIV, but that she was too scared to go to the doctor.

The second community based program is run through the village patronato and is supported by the World Fund. The program is called Uniendo voces para la Prevención de VIH/SIDA (united voices for the prevention of HIV/AIDS) and it has programs in five Garifuna
communities in the area. Throughout the year the patronato program puts on different events and holds meetings to promote awareness, prevention, support and sexual health. People can also receive free condoms through the program. A large cardboard boxed full of condoms is placed outside the patronato office every working morning and people can come and take them as they please.

Charlas, counseling at the centro de salud, the radio novela, and the patronato program are the four main sources of HIV/AIDS information in Rio Azul, but these are not the only sources of information. People also receive HIV/AIDS information from their church; specifically the Baptist church in Rio Azul holds support and awareness programs for its members. There is also a small support group for HIV positive people and people who have family and friends living with HIV. The support group holds meetings and discussions for its members as well as puts on small community projects.

The multiple forms of HIV/AIDS information that have become available in Rio Azul have been successful in reaching the majority of the public in one way or another. However, being informed and knowledgeable about HIV/AIDS does not mean that an individual will change her behavior. This particular scenario is over emphasized in Rio Azul, a place where 4/5 of the women I spoke to were very knowledgeable about the disease, but still placing themselves at risk of infection.

6.2 Knowledge Does Not Equal Behavior Change

“The people have sufficient information. They go to the charlas and they listen, but the moment they leave from there they do not remember anything. The problem reflect this” – Bella, 32.

During my time in Rio Azul I was told over and over again that the people of Rio Azul “tienen bastante información de VIH/SIDA” [they have sufficient information about HIV/AIDS]. If this is the case then why are more people being diagnosed with HIV every year when they know how HIV is spread and how to prevent infection?

For years social scientists have been looking at how knowledge and awareness of risk does not translate into behavior change. This is particularly true in the field of HIV/AIDS.
Vast amounts of HIV/AIDS research focusing on knowledge has looked at how being knowledgeable about HIV/AIDS, knowing the main modes of transmission, and understanding how vulnerable one is to contracting the virus, does not necessarily lead to behavior change nor a heightened perception of risk. For example Smith’s work in Nigeria with rural-urban migrant Igbo-speaking adolescents and young adults, showed that even though the majority of his informants where knowledgeable about HIV/AIDS and had the resources available to prevent infection, they did not always protect themselves because they did not see themselves as being at risk of contracting HIV/AIDS (Smith 2003:366). In this instance HIV/AIDS was seen as a disease of the other, and many informants held the “perception that the risk of contracting HIV is tied to morality” (Smith 2003:366-367). Therefore, despite the relatively high knowledge about HIV/AIDS and its sexual transmission, the majority of informants did not take precautions to prevent infection during all sexual encounters; thus, knowledge did not tie into behavior change or perceptions of risk.

A similar situation exists in Rio Azul. As shown above, people in Rio Azul have access to HIV/AIDS information. Moreover, the results from the questionnaire that was conducted with 25 informants revealed that 20 of the 25 women who took the survey are knowledgeable about HIV/AIDS, in other words they know the main modes of transmission, understand how to prevent infection, and have some knowledge about HIV characteristics and how the disease progresses. Despite the knowledge these women possess, less than half said they use condoms to protect themselves from infection. Furthermore, 15 women said it was necessary to use condoms during every sexual relation, but not all of these women claimed to use condoms to prevent personal infection. This may be a sign of “othering”, seeing HIV as a disease of the other, a disease that may touch people around you but one that you will not or cannot contract. “Othering” is a form a stigmatization where people make a distinction between “us” verse “them”, creating negative social labels that apply to “them” but do not apply to “us” (Link et. al. 2001:370); this allows an individual to separate herself from the people who are associated with the particular label.

Andra, a woman whose partner lives in the United States, explained to me that she feels as though the community is quite small and that people know who is infected with HIV and who is likely to be infected, and in this way people can protect themselves from being
infected with HIV. As Andra explained, this may be a strategy that people use to protect themselves from engaging in sex with a PLWHA or a person possibly living with HIV; however, it may also be another form of “othering”, a way for people to separate themselves from PLWHA, to separate their characteristics from the characteristics of someone with HIV, giving themselves a false sense of security. It is a way to see other people’s actions and characteristics as risky, but not associate yours or your partner’s as unsafe. In the end it boils down to the individual’s perception of risk and how they understand their own risk. People will interpret risk in different ways depending on their life experiences and their beliefs, as well as based on the influences coming from society and the wider political atmosphere. If an individual does not interpret his actions as risky, he will not avoid partaking in those actions, because he does not associate them as a threat.

As these examples express, a person may be completely knowledgeable about the spread of HIV/AIDS, but that does not mean that his or her behavior reflects this knowledge. Moreover, a person may even see his or her own types of practices as risky when performed by another person, but not associate that risk with his or her own practices, only associating risky practices with the “other”. Knowledge based on facts and perceptions of risk do not necessarily coincide, a problem that the people of Rio Azul are now facing. Furthermore, just because a person understands that her practices may place her in a vulnerable position, does not mean that she has the ability to escape that position, a topic which will be address in the following chapters.

6.3 Lack of Concern and Denial (Un-acceptance)

People use other strategies to separate themselves from being associated with HIV or seeing themselves in a position of risk. Two other tactics include lacking concern of infection and denying the threat of infection or the existence of the disease all together. Other people who are infected with HIV do not accept their HIV status or deny the fact that they are infected. These forms of denial exist in Rio Azul and have raised concern among certain people in the community.

*Lack of Concern*
An argument my informants used time and time again to explain why sexual behaviors have not changed with increased awareness is that people do not have the *conciencia* (consciousness) or the concern to change their behavior. HIV has become a common phenomenon in the village of Rio Azul, and its long presence has allowed people to feel complacent about the disease.

“HIV is seen as something *normal* by community members. Having HIV is like having a cold or a fever. It is not anything severe. This thinking has caused people not to take precautions” – Andra, 23.

Gabi had similar feelings to those of Andra, expressing her doubt and how she believes that people’s complacent attitudes have contributed to the current HIV situation in the community.

Not only have people in Rio Azul become complacent about HIV infection due to its long presence in the community, but the increased availability of ARV treatment has greatly reduced the number of people suffering and dying from HIV/AIDS, diminishing people’s concern of infection. Before ARVs were readily available to PLWHA in Rio Azul 18 to 20 people would die each year from HIV/AIDS related complications. Today, ARVs are easily available and free of charge to people diagnosed with HIV/AIDS, which has reduced the number of HIV/AIDS death to the low single digits. In 2008, only two people died from HIV/AIDS related infections. The low number of HIV/AIDS related deaths caused many of my informants to not even recall the two deaths the proceeding year, telling me that no one had died from HIV/AIDS the year before.

Now that HIV/AIDS is no longer seen as a fatal disease people’s fear of infection has greatly decreased, causing them to be less cautious and concerned about contracting HIV/AIDS. Julia, a 36 year old women living with HIV, expressed her concern saying

“There are people who take their treatment and they get better, and other people see this and then they do not worry about getting infected as much.”

According to my informants this is of particular concern among *los jóvenes* (young people) who have not witnessed the horrible deaths that HIV/AIDS causes. Helen, a 32 year old
nurse at the centro de salud, explained to me that people who have watched their family members suffer and die from HIV/AIDS are more worried about becoming infected and, therefore, take more precautions to prevent infection. Whereas people who have not witnessed the horrors of HIV/AIDS first hand do not realize the severity of the disease, especially now that treatment is available to mask this image of HIV/AIDS. This phenomenon of lacked concern and being complacent towards HIV infection, where one does not worry about becoming infected, is similar to one’s perception of risk; if a person does not associate risk, or in this case concern and worry, with HIV/AIDS infection, then he will not go out of his way to prevent infection. In the following passage Schepter Hughes explains how a constant feeling of fear and perceived risk need to be present for people to successfully change their behavior:

Education for behavior change regarding the most emotionally charged and highly valued aspects of human behavior requires a continuous mobilization of fear and panic that is difficult to sustain over time. Over-exposure produces a counter-adaptive but psychologically self-protective strategy of numbing. Routinization eventually settles in and people learn to accept as ‘normal’ and ‘expected’ even horrendous sickness and death when these are either endemic or epidemic in proportion. Moreover, the efficacy of safe sex education programs depends on people’s sense of perceived personal risk. The epidemic must be close at hand and visible for this to happen. [1994:996]

The lack of concern and the new complacent attitude that people have towards HIV/AIDS has greatly hindered progress to adapt behavior change, and it is allowing people who once changed their behavior to slide back into old habits. Some women voiced concern that this trend may bring a new wave of HIV infection to the community, a legitimate concern seeing the trend of increased infection rates that has developed in the United States since life saving ARVs became readily available.

Denial (Un-acceptance)
“HIV is a problem in the community because many people do not accept that they are infected, or accept its presence as a problem” – Andra, 23.

During my first few weeks in the larger city bordering Rio Azul locals repeatedly asked me what I was studying. When I explained that I was studying HIV/AIDS and its socio-cultural implications many people looked at me with surprised expressions on their faces. They understood that HIV/AIDS was present in the region, but they did not know the severity of the problem. Many seemed shocked and even horrified when I explained that they were living in the region with the highest HIV/AIDS prevalence in the country. Their ignorance to the HIV/AIDS problem that lay in their midst dumbfounded me, especially because of the abundance of HIV/AIDS prevention and awareness programs in the area. However, I soon learned that this was not only a misconception held by the Ladino population in the region but also one held by some Garifuna living in Rio Azul.

Despite the long presence of HIV/AIDS in Rio Azul there are still individuals who do not believe the disease really exists or do not recognize the severity of the problem. Julia used the words *mentira* (lie) and *duda* (doubt) when explaining why people do not changed their behavior even when they have been informed about HIV/AIDS time and time again.

“There are some who have changed [their behavior]. There are others who think it is a *mentira*... There are others that *duda* its existence” – Julia, 36.

This misconception creates a tremendous obstacle when trying to implement HIV/AIDS prevention and awareness programs to decrease the spread of the disease. Women told me that some men use the excuse that HIV/AIDS does not exist to escape having to use a condom during sexual relations. Whether or not these men truly believe this statement is beyond the scope of my research; however, this misconception prevents people from changing their behavior and protecting themselves from infection.
“... when people believe in HIV then they change, and they use condoms. If you do not believe in HIV or believe it is a problem, than you will not protect yourself or your partner” – Helen, 32.

Apart from people doubting the existence of the disease or the presence of a HIV/AIDS problem, some PLWHA do not accept that they are infected. As many of my informants stated, most PLWHA accept their HIV/AIDS status and disclose their status to their family and friends to gain support. However, there are other PLWHA who do not accept that they are infected or deny their status. Andra explained that if a man is infected with HIV and he wants to sleep with a woman who knows his HIV status, he will lie to her and deny that he is HIV positive. She went on to say that the woman can insist that the man use a condom to protect herself if she does not believe his lie, but then she faces all the obstacles attached to condom negotiation, which will be discuss in the next chapter.

Not accepting one’s positive HIV status does not only place other people at risk of infection, but it also inhibits that individual from receiving support and treatment. Furthermore, not accepting the existence of HIV/AIDS as a problem or as a disease prevents people from getting tested. As stated before, treatment and support are readily available to PLWHA in Rio Azul, but as Nanci explained, if a person is not willing to get tested then there is no way for him or her to receive either treatment or support and he or she will only continue to put him or herself and his or her partner(s) at risk.

People’s denial of the existence of HIV/AIDS or an HIV/AIDS problem and the denial of one’s positive HIV status may be influenced by people’s fear of the virus and stigma. By denying the existence of something, an individual can put the fear out of his mind, or at least mask the fear. Moreover, PLWHA may deny their positive status because they fear being stigmatized by the rest of society. Even though I was told that stigma no longer exists in the community due to the campaigns that have been implemented to eliminate it, the responses and actions of people in Rio Azul give a slightly different impression.

Stigma has been a main theme in HIV/AIDS research since the beginning of the epidemic, a focus that has shifted throughout the stages of the epidemic. Alonzo and Reynolds explain stigma by stating that “the stigmatized are a category of people who are pejoratively regarded by the broader society and who are devalued, shunned or otherwise
lessened in their life chance and in access to the humanizing benefit of free and undeterred social intercourse” (1995:304). Six characteristics of HIV/AIDS have been identified by Alonzo and Reynolds as stigmatizing elements of the disease: (1) association with deviant behavior, (2) responsibility of the individual infected, (3) religious connection to immorality or immoral acts, (4) perception of the disease being contagious and dangerous to the community, (5) association with undesirable and unaesthetic form of death, (6) not well understood by the average community member and viewed negatively by health care providers (1995:305). Some of these stigmatizing characteristics of HIV/AIDS are more prevalent in certain communities than in others, but in general they contribute to how PLWHA respond to their HIV status and the wider community, and how the wider community responds to PLWHA.

PLWHA in Rio Azul may not experience stigma in the same way that people did 20 years ago when the community did not understand what HIV/AIDS was, nor are they necessarily stigmatized for the same reasons. However, that does not mean they do not fear what other people think of them, and how people will react once they reveal their HIV status. In this way the individual body is influenced by the social body, the individual fears what the collect thinks and feels towards him and how they will treat him, influencing how he copes with his HIV status. Furthermore, it may not be stigma itself that prevents people from accepting and disclosing their HIV status, but the memories of how people with HIV/AIDS were treated in the past. Whichever the case, the fear of present stigma or the memories of stigma, peoples’ fears of how others will react to their HIV status is causing them to deny the existence of the disease and deny their status, preventing them from accessing treatment and support, and contributing to the spread of the virus.

The resistance to behavior change in spite of the vast amount of available information, and the lack of concern, and denial and un-acceptance of HIV/AIDS as a problem and as a disease are only a few of the aspects fueling the HIV/AIDS epidemic in Rio Azul. Sexuality, gender roles, power, socio-economics, and politics all shape how vulnerable a person is to contracting HIV/AIDS, a key factor in the spread of the virus. These aspects of vulnerability will be discussed in the next two chapters.
7 Sexual Culture: Shaping Vulnerability

On the outside the Garifunas of Rio Azul appear to have a very liberal acceptance of sex and sexuality. People seem to be open about their sexuality and sexual preferences, for instance a young man in the centro de salud felt very comfortable telling me in front of other people that he is gay and sees himself as a woman and not a man. Statements referring to sex and sexuality can be heard throughout the village while walking down the street or waiting in the centro de salud. People even demonstrate sexual activities or movements in the view of the public, especially during celebrations where women dance punta, a traditional style of dance and music originating in West Africa, consisting of the woman thrusting her pelvis and buttock into the man she is dancing with as she moves around him in a very sexual manner. Women in Rio Azul even claim that they have as much sexual power and liberty as their partners or men in general. Despite this display of an open and liberated sexual culture, Garifuna sexuality is actually quite traditional and to an extent regulated, and women’s claimed sexual freedoms are generally restrained by the men in their lives. This chapter will focus on how the control of female sexuality, combined with gender relations and power contribute to placing women in a vulnerable position within their community.

7.1 Vulnerability in the HIV/AIDS Epidemic

At the beginning of the HIV/AIDS epidemic there was an emphasis placed on risk groups and the people within these groups were labeled as the people most at risk of acquiring HIV/AIDS. With time the label of being at risk of acquiring HIV/AIDS proved to be problematic because it placed blame and stigma on certain groups within society and on
certain people who participated in certain risky behavior. Moreover, placing people in risk groups allowed people who did not associate with these groups to be complacent about their practices that may have placed them in a position to contract HIV/AIDS. Since these flaws in referring to risk groups were addressed, there has been a move towards looking at vulnerability and what factors in a society place people in a vulnerable position to contract HIV/AIDS (Moyer January 22, 2009).

Vulnerability is a form of analysis developed from neo-Marxism, which argues that certain people are at greater risk of contracting a disease because of economic and/or social marginality (Moyer January 22, 2009). Bronfman and colleagues explain that unlike risk, which “indicates probability and evokes a reference to individual conduct, vulnerability is an indicator of social inequality and demands responses at social and political levels” (2002:S43). Bronfman and colleagues further explain that, “social vulnerability is the relative lack of protection in which a group of individuals might find themselves... when faced with a potential threat to their health or to the satisfaction of their basic needs” (2002:S43). Certain people within society are seen as being more vulnerable than others based on socio-economic stance, power mobility, and policy implementations. Moreover, “those individuals who before the advent of HIV/AIDS were already marginalized, stigmatized, and discriminated,” have become those most vulnerable to HIV infection (Bronfman et. al. 2002:S42).

Within the Honduras context the Garifuna, as well as other ethnic minority groups, are seen as one of the most vulnerable groups of people to HIV/AIDS infection due to historical, socio-economic, and political factors. Moreover, the increased vulnerability of women has recently come to the attention of researchers studying the epidemic within Honduras. There has been an increase of HIV/AIDS infections among women in the past years which has lead to a male to female infection ratio of 1:1 (UNAIDS 2008). Many factors, both biological and social, contribute to the increased vulnerability of women. Quinn and Overbaugh explain that in addition to the biological factors that increase female vulnerability, there are multiple social determinants: gender disparity, poverty, cultural and sexual norms, lack of education, and violence, that contribute to the increased vulnerability of women (2005:1582). This information ties directly into the situation of the women in Rio
Azul who lack sexual freedom, have a low educational level, scarce job opportunity, and are depended on others, particularly male partners, for financial support. It is a combination of gender roles, power, sexuality, socio-cultural, historical, politics, and economic factors that determine a woman’s vulnerability and drive the HIV/AIDS epidemic. This chapter will focus on gender roles, power, and sexuality, while the next chapter will look at social, political, and economic dimensions of vulnerability within Rio Azul.

7.2 Gender Roles, Power, and Sexuality

A vast amount of female vulnerability is shaped by power relations and gender roles within a particular society and the amount of room a woman has to negotiate sexual relationships. Parker explains that in past years anthropological research has placed an emphasis on studying “cultural categories and systems of classification that structure and define sexual experience in different social and cultural contexts” in order to gain a better understanding of the emic perspective of sexuality (2001:167) and how these notions play into the HIV/AIDS epidemic. According to Garifuna women, they have sexual freedom and the ability to control their sexual desires within their relationship(s). However, through discussions focusing on sexuality and gender roles, it becomes apparent that not all Garifuna women have as much sexual liberty and power as they think.

“Machismo is very strong in the Garifuna communities, it creates problems for HIV prevention and awareness programs... and it influences a lack of respect for women” – Gloria, 36.

The Garifuna have adapted the Latin concept of machismo which influences people’s perspectives of sex and sexuality. Wood and Price describe machismo as “a social behavior pattern in which the Latin male exhibits an overbearing attitude to anyone in a position inferior to his, demanding complete subservience. This attitude is particularly marked when related to male-female interactions” (1997:45). In the machismo world the male is the superior, ruling over his wife or partner and children; he is the head of the household. This concept of ruling over one’s household does not truly exist in Rio Azul, because many households are run by women due to men being away for economic purposes. Despite the
fact that the Garifuna man has lost some power over his household, he still appears more powerful than his female partner and exerts his control over her, especially during sexual relations, reducing space for sexual negotiation.

Within relationships the man is the dominate actor and the initiator of sexual relations, while the woman plays the passive role and gives her partner what he desires. A study conducted among multiple Garifuna villages by Tercero and colleagues noted men explaining that a married man has liberties the same as a single man; he has the power to command and make his wife or partner obey his wishes, and he has the liberty to be in the street with multiple women if he so desires (2002:35). On the other hand, women in the same study were explained to have far greater commitment to their household and childrearing responsibilities, which denies them room to enjoy their own liberty: “tiene compromisos que cumplir y no goza de libertad” [she has commitments to fulfill and does not enjoy freedom] (Tercero et. al. 2002:35). Moreover, Tercero and colleagues explain that women who were unfaithful to their partners were often abandoned, while a woman was expected to understand and accept that her partner was having sexual relations with other women (2002:30). Through these social norms the man is given more power and liberty than his female counterpart.

Men do not only have the power to demand their partners to do as they please, they also have the physical strength to force their partners to be compliant. The Honduran Ministry of Health reported in 1999 that there is “widespread intimate partner violence (IPV) by Garifuna men against Garifuna women” (Sabin et. al. 2008:241). The study conducted by Tercero et. al. reported multiple reasons for the violent acts committed against women from improperly taking care of one’s children to accusing one’s partner of having an affair (2002). One interviewee explained that a friend of hers was badly beaten by her boyfriend when she asked him to use a condom during sex, while a young man said that women are often abused when they do not properly prepare the food for their partners (Tercero et. al. 2002:38). In this way men use violence or the fear of potential violence to obtain what they want from their partners. Furthermore, not only physical but also sexual violence has become extensive throughout the whole Honduran population; according to the UN Population Fund an estimated eight in ten Honduran women experience such types of violence during their lifetime (Sabin et. al. 2008:241). Moreover, Tercero and colleagues
noted that in some Garifuna villages sexual assault against women has lead to HIV infection in a number of cases (2002:38). Through these acts of violence and assault the man extends his power over his partner in a fashion to control her and make her submissive to his command.

Both male and female perspectives of sexuality and their position within their relationship are influenced by the wider social perspective of what roles both sexes should play. In other words, the individual understanding of sexuality is controlled by the social influences of what it means to be a man or a woman. Moreover, the individual body is influenced by the norms and characteristics of a machista society, which makes the woman inferior to her male partner. Of course this is not the case in all situations but it is the norm in Rio Azul.

Even though women told me that they enjoy sex as much as their partner and they feel they have the ability to control their sexual relations, they are not as demanding and forceful as men when it comes to sex. Bella explained to me that when it comes to sex the man is more intense than the woman, he enjoys it more, está inflamado (he is inflamed or ignited), while the woman is more reserved and conservative, in this way making the woman more feminine while the man appears more masculine. The woman’s reserved and conservative attitude influences her ability to voice an opinion about sex and sexual practices.

My informants and my disagreement of what it means to have sexual liberty and power within one’s relationship most likely stems from our different backgrounds. Within the past few decades the women of Rio Azul have been educated about the power and control they should have in their relationships and how they should be treated by their partners. This training has increased the role that the women play in their relationships and allowed them to have more control over their sexuality than they had in the past. In this sense the women feel more liberated and powerful when it comes to their relationships, sex, and sexuality. However, being from a western nation where women’s rights and sexual equality have been pushed since the early-1900s, I do not view the limited power the Garifuna women hold as sexual liberty and equal power in their relationships. Instead I see the average Garifuna woman as domineered and subjected to the will of her partner, her subjectivity limiting her ability to experience sexuality and sexual relations as she desires.
To better explain my reasoning I will use an example from an interview conducted by Stansbury and Sierra in a Honduran Garifuna village. A Garifuna female interviewee stated: ‘But I’ve always told him [her partner]: ‘The day that you go out on me – tell me – ha?’ I told him that yesterday. So, daddy, we women take care of ourselves, but the men don’t’ [Stansbury et. al. 2004:465].

The woman was explaining that she tells her partner that she wants to know if he is having sex with other women, so she will know to protect herself when having sex with him. The woman’s ability to say this to her partner and demand that he be honest with her shows that she has enough power in her relationship to voice her opinion and demand that her partner is honest with her. However, she does not have enough authority to demand that her partner be faithful and refrain from having sexual relations with other women. In this example it is apparent that the woman has some authority in her relationship but her authority is not equal to that of her male partner. The power she is lacking continues to place her in a vulnerable position where she cannot entirely negotiate the type of relationship she desired.

**Negotiating Safe Sex**

During the second focus group discussion I asked the women if they thought it was important to use condoms to protect against HIV and other STDs, even with a stable partner. The women unanimously responded yes, saying that you never know where your partner has been or when he’s been in the calle (roaming the street looking for women). Next I asked if they can ask their partner to wear a condom during sex. They all replied “yes”, but when I asked them if they do, there was a bit of mumbling and shuffling of feet, while everyone avoided my gaze.

Condom negotiation has been a prime theme in HIV/AIDS research for many years. An ethnographic study was conducted in a different Honduran Garifuna village, Las Espinas, in 2004 by Stansbury and Sierra focusing on conceptions and understanding of HIV/AIDS, with an emphasis on women’s negotiation of safe sex (2004). Stansbury and Sierra found that the community members were familiar with HIV/AIDS and its sexual modes of
transmission (2004). Moreover, there was a general connection drown between male migrant work and increased vulnerability to HIV infection, causing Garífuna women in the village to blame men for the spread of HIV/AIDS within their community (Stansbury et al. 2004:465). Despite the fact that HIV/AIDS is associated with migrant men, women refrained from requesting their partners to wear condoms, even though they knew that condom use would prevent HIV/AIDS infection (Stansbury et al. 2004:465). However, within the community condoms were seen as an excuse for infidelity and a faithful relationship had no need for condom use (Stansbury et.al. 2004:465). Moreover, women worried about negative and angry reactions from men when it came to negotiating condom use, reinforcing the decision to have unprotected sex (Stansbury et al. 2004:468). Thus, even though the Garífuna women in Las Espinas were aware that their sexual behavior may put them at risk of HIV/AIDS infection, other factors prevented them from pursuing safe sex practices.

This is precisely the situation in Rio Azul, where free condoms are easily accessible at a multitude of locations, but negotiating safe sex is no easy task. Similar to the situation in Las Espinas women in Rio Azul do not want to use condoms in stable relationships because it would suggest that one of the partners were being unfaithful. Helen explains to me that when a woman is in a long term relationship “she wants to trust her partner or she does trust her partner. She will say ‘es mi marido’ [he is my husband]” and this will prevent her from asking him to use a condom. Other women expressed similar feelings, saying they trust their partner, they believe he is faithful, even though they know many men in the community are not, a topic which will be discussed in the next section.

Women do not only refrain from requesting safe sex because they trust their partner, but also because they do not feel comfortable asking for a condom to be used.

“In general, women do not insist that condoms be used. There are many different reasons why. Even if they think of the risk, they do not ask because they are scared or they are ashamed” – Clara, 24.

As Clara explained some women are scared or ashamed to ask their partner to use a condom, and, thus, they avoid the topic. Heise and Elias reveal it is common for Latin women to sustain from conversations about sex, because a “‘good woman’ is expected to
be naive about sexual matters’” (1995:936), which makes it difficult for her to require or even ask her partner to use a condom. In this way, Garifuna women, and Latin women in general, are silenced from negotiating safe sex with their partners.

Furthermore, some women claimed that their low level of self-esteem and lack of confidence in a relationship prevents them from requiring their partner to use a condom. One woman told me that she would be reluctant to ask a man to use a condom at the beginning of the relationship, because she would be afraid that he would leave her for another woman who would not require him to use one. Therefore, even though she knew the risk of possible HIV infection, she was unwilling to discuss condom use with a man because she was afraid he would leave her.

The ability of a woman to negotiate safe sex ties back into the idea of knowledge influencing behavior change. Scheper-Hughes explained that in order for HIV/AIDS education to work, people, particularly women, need to have the ability and the power to negotiate safe sex; if she is unable to do so then her HIV/AIDS knowledge cannot be put into practice (1994:996). Moreover, Scheper-Hughes invested in the idea of sexual citizenship meaning “a broad constellation of individual, political, medical, social, and legal rights designed to protect bodily autonomy, bodily integrity, reproductive freedom, and sexual equity” (1994:993). In this sense being a sexual citizen implies having “the ability to negotiate the kind of sex one wants, freedom from rape and other forms of pressured, non-consensual, or coercive sex, and freedom from forced reproduction and from coerced abortion” (Scheper-Hughes 1004:993). Thus, in order for women to put their HIV/AIDS knowledge to practice they have to be recognized and give the rights of sexual citizens, providing them with the power to demand the type of sex relations they desire.

7.3 Infidelity

“Infidelity is one of the causes of the disease [HIV/AIDS], it would not exist if the first couple who got HIV were faithful, they would have died and it would not have spread” – Bella, 32.

The abundance of unfaithful partnerships has caused many women to blame infidelity for the spread of the HIV/AIDS epidemic in Rio Azul. As Wood and Price explain
men in machismo societies have a duty to protect and defend their “male virility by engaging in extramarital relationships” (1997:45). In Rio Azul men are not the only ones having sexual relations outside of marriage, women also have extramarital affairs; however, it is more common for a man to have multiple partners than for a woman. A storyline often repeated to me by my informants explained that frequently a man will have three or four women, in addition to this wife, which he is having sex with during the same time frame. One of the individuals in this sex circle will have HIV and within time everyone in the circle will become infected including his wife, the man would eventually infect all the women he was sleeping with and bring HIV into his own house. Of course spreading HIV through extramarital affairs would not be a concern if people regularly used condoms, but as I discussed above, this is not the case in Rio Azul.

People in Rio Azul are unfaithful to their partners for a variety of reasons. Gabi explained that people are unfaithful and go to the calle looking for other partners when they do not find love, support, or caring in their marriage or partnership. Eva said that being unfaithful is a generational issue, stating that now sex is so liberal and people lack the moral responsibility to avoid having so much sex. Maria also explained infidelity as a generational problem, but claimed that infidelity was more common and acceptable in the past, and people who are still being unfaithful are just tied to the past. Last, Helen claimed that infidelity stems from the lack of respect men have for women, if men respected women more than they would not be having sexual relations with multiple women at the same time. No matter what causes infidelity, the women I interviewed recognize it as a factor that places them at risk of HIV infection.

My informants recognized infidelity as a risk that places them in a position of increased vulnerability. Maria expressed her concern saying:

“Unfaithful men put their families at risk, especially their wives. They know that they are putting them at risk but they do not change their behavior.”
Even though the women I spoke to said that they have confidence in their marriage and trust their partner, they explained that a woman never knows what her husband/partner is doing when she is at home cooking and cleaning, she never knows when he has been in the calle with another woman. Due to this uncertainty, a few of my informants said that they use condoms with their partner even though they have been married for many years. However, I think these women may be an exception, because of the barriers to condom use explained above. As Scheper-Hughes explains poor women in Brazil know “their husbands are not monogamous but they feel powerless to do anything to remedy the situation” (1994:994). The same situation exists in Rio Azul, where women do not have the power or liberty to request safe sex or a change in behavior from the person supporting them and their children.

Women explained to me that it is complicated for a woman to leave an unfaithful partner, and that she will have multiple reasons for staying with him. Many women said that having children is a primary barrier. Women are afraid to raise children on their own, and they worry about not having the resources to support them alone. Others mentioned support, even though an unfaithful partner is not always there for the woman, sometimes he is and when he is he may even provides her with the emotional and economic support that she needs. Another reason is love, just because he is having sex with other women does not mean he does not love his main partner and it does not erase the love she has for him. Last, economics and finances were listed as a reason to stay with an unfaithful partner, a topic that will be addressed in the coming chapter.

The majority of my informants felt that in order to change the HIV/AIDS situation in Rio Azul, both men and women need to be more faithful to their primary partner, or that condom use has to become a regular practice.

“In order to change the situation, you have to change infidelity. You have to be faithful and careful. When one has a partner, one is going to marry, they need to take all the exams [HIV/STD examinations], the same for the woman and the man, and if they do not take the exams they always have to use a condom. Because if you are with someone
with HIV you have to use protection and you do not always know who has HIV. There are people who do not like this, but this is what has to happen” – Bella, 32.

8 Marginality: Creating Vulnerability

The people most vulnerable to HIV/AIDS infection were usually stigmatized and marginalized before HIV/AIDS ever developed into an epidemic. Scheper-Hughes uses this reasoning to explain the event of the HIV/AIDS epidemic in Brazil: “long before the AIDS epidemic poor bodies in Brazil were untouchable and stigmatized, as well as medically neglected” (1994:993). A similar chain of events stimulated the onset of the HIV/AIDS epidemic among the Garifuna, who have been marginalized from mainstream Honduras society since their arrival on the Caribbean coast over two hundred years ago. Today minimal health care, poor education and scarce job opportunities place the Garifuna of Rio Azul in a perpetual state of vulnerability.

8.1 Marginality, Minimal Health Care, Poor Education, and Scarce Economic Opportunity

For over two hundred years the Garifuna have inhabited the northeastern coast of Honduras, however, it has only been in the past few decades that they have begun to see improvements and support from the wider Honduran society. Since the Garifuna first settled in Honduras the population has been marginalized from mainstream society due to their unique cultural background stemming from their African and Carib Indian decent. Despite the adoption of a modern democratic government, the Garifuna still remain socially
excluded and neglected, both by the rest of society and the government. Not only have the Garifuna been excluded and neglected, but they have also faced stigmatization and discrimination from the larger Honduran community, further marginalizing the communities. The neglect and marginality that the Garifuna have experience have begun to diminish in past years; however, their affects are still present. Minimal health care, low education levels and a lack of job opportunities continue to place the inhabitants of Rio Azul in a state of vulnerability.

As mentioned earlier PLWHA in Rio Azul have access to ARV treatment and other necessary testing once they are diagnosed with HIV; however, treatment for opportunistic infections and for other diseases are not as readily available. Multiple times during the six weeks I spent in Rio Azul I would trek the mile and a half from the bus stop to the centro de salud and find the clinic closed for the day, without a sign stating when it would be reopened or that it was closed for such and such a reason. Moreover, Nanci, the head nurse at the centro de salud, informed me that the clinic had been closed for two months during the spring when she was on holiday and a doctor was not assigned to the village.

When the clinic is closed people are forced to go to either the hospital or a neighboring clinic to seek medical treatment, but unless it is an emergency many just wait until the local centro de salud opens once again, prolonging their sickness with the potential of making it more severe. Furthermore, many treatments are not available at the centro de salud and others are not accessible at the regional hospital forcing people to go to one of the public hospitals in San Pedro Sula, a two hour journey from Rio Azul. The minimal amount of medical treatment and the inconsistent opening hours of the centro de salud have caused many people to disregard their health taking it as it is and living with it, a very problematic position when it comes to HIV/AIDS testing and treatment. The lack of concern for one’s health prevents them from seeking treatment, which in the event of a communicable disease places other community members at risk.

Not only has inconsistent health care affected the vulnerability of people in Rio Azul, but the inconsistent education system has also taken its toll. Near the center of Rio Azul, just across from the patronato, lays a nicely organized and modern courtyard, surrounded by small buildings and a cement wall that encloses the whole compound. This compound makes up the school of Rio Azul. During my six weeks in the community I never once saw
the school yard full of children or saw students dressed in their school uniforms retuning from classes. It was not summer holiday, seeing that the Honduran school schedule requires children to go to school throughout the summer months, allowing them holiday during the winter months. Classes were supposed to be in session, they just were not. My informants explained to me that the school is often closed for a multitude of reasons, from teacher strikes to the present earthquakes, or simply because of rainy days when teachers and students do not want to go to school, a problematic scenario seeing that the rainy season runs from September until February. Due to the erratic school schedule students only went to school for a total of three months the proceeding year, only a third of the required number of school days. The school system is not as unpredictable outside of Rio Azul in the predominantly Ladino town, where children go to school more consistently throughout the year, and obtain a more comprehensive education. The inconsistent school schedule and the minimal number of days classes are actually held, prevents Garifuna children from receiving an adequate education, which diminishes their job opportunities for the future.

Even if Garifuna children had better educational opportunities and were more efficiently educated, their community would still lack job opportunities to provide them with lucrative careers and stable futures. Rio Azul has very limited infrastructure and virtually no enterprise. The only traditional enterprises that still exit are conch diving and fishing. Agricultural production was once prominent in the area but has now moved to various locations further inland. Some women try to make a living selling pan de coco, sweet bread made from coconut milk, and braiding tourists’ hair in the traditional style, however, these activities produce a very minimal income. The emerging tourist trade does bring a small amount of revenue into the community, but the majority of tourists come with an outfitter who provides them with what they need during their trip. Furthermore, the low education level of Garifuna youth and their marginal position in society prevents Garifuna men and women from finding skilled labor jobs in mainstream society. These factors have pushed most young men from Rio Azul to leave the community in order to make a living through migrant labor.

Many young Garifuna men leave their communities to make a living in the fishing industry of the Bay Islands, aboard merchant ships, or by migrating to the United States (Stansbury et al. 2004:459). The migrant nature of their occupations take them to large
cities with relatively high HIV/AIDS prevalence rates, including La Ceiba and San Pedro Sula in Honduras, and foreigner cities such as New York, Los Angeles, and London. While away from their communities some migrants contract HIV, which they later spread to their wives and partners while returning for visits. As Stansbury and Sierra explain the spread of HIV/AIDS in the Garifuna communities replicates “the well established relationship between economic migration and disease transmission” (2004:468). The migrant characteristics of young Garifuna men has been identified as an important factor in the spread of HIV/AIDS among the communities, a characteristic that was established because of scare economic opportunity in and around the Garifuna communities and their position as unskilled laborers.

Despite the fact that both outsiders and the Garifuna themselves understand that HIV/AIDS is being spread through migrants returning to their home villages, communities depend on the income being made by migrant workers. According to Stansbury and Sierra within some Garifuna communities 49 to 53 percent of households depend on remittances sent from abroad (2004:459). The majority of my informants said they survive on remittances sent from family or supposes living in the United States; without the support from abroad these families would not be able to carry on. Thus, the lack of available wage labor has forced Garifuna men to partake in migrant labor, a factor that has become vital in the spread of HIV/AIDS within the population. This factor greatly influences the state of the community and places women in an even more vulnerable position.

8.2 The Vulnerable Woman

The economic and political dimensions of vulnerability that affect the whole village of Rio Azul place women in an especially precarious position. Cosminskey and Scrimshaw explain that economic, cultural and biological constraints keep Garifuna women “from economic independence and assure male domination”, requiring women to “depend on men to satisfy their and their children’s economic needs” (1982:44). Unlike men who have the ability to leave Rio Azul and work in fishing or commercial shipping, or migrate to the United States or beyond for wage labor, the traditional way of life that governs Garifuna gender roles expect the woman to stay at home raising her children and taking care of the household, while the man leaves to earn a wage to support his family. Women are left
behind in Rio Azul without an education to find a skilled labor job or the infrastructure needed to provide unskilled labor jobs in their village or the surrounding area. This predicament places women in the hands of the men who may or may not support them.

One of my key informants, Eva, told me a story of a young girl she knew that vividly expresses the hardship of many women from Rio Azul:

A young, beautiful girl decided to date a young man who was not very attractive. Their relationship was full of love and happiness and within five years they had three beautiful children. The girl had to stop going to school to take care of her children, but the man continued with his education. He went on to university, became very educated, met important and powerful people in his community, and improved his social status. The girl, now a woman, did not improve her life; she stayed home and raised their kids, gained weight from child birth, and did not take good care of herself from all the stress of raising three children. Eventually the man decided to leave her because they no longer had the same life and she did not fit into his social class or status. The woman ended up without a job or a way to support herself or her children, and without an education to find a job.

Eva does not know what happened to the woman and her children once her partner left her, but she figures they were living a very difficult life if they were even still alive. She explained that the story demonstrates a vicious cycle that will probably repeat itself when the women’s children reach childbearing age. Moreover, the story reveals how difficult it is for a woman to continue with her own life improvements once she has children, and how this situation makes it almost impossible for her and her children to survive without a willing man to provide for them. The quandary explained through the story places women in a vulnerable position, not only concerning HIV infection, but concerning their livelihood and health in general, and that of their children.

Women’s dependence on male financial support causes them to go to many lengths to keep or gain a partner. As I explained in the previous chapter, women will stay with an
unfaithful partner, who may be putting her at risk of HIV/AIDS/STD infection, because she needs his support both financially and emotionally. Furthermore, it is very difficult for a woman to resist a man coming back from sea or abroad who has money, money that could sustain her and her children. Gloria explained to me that desperate women will have sexual relations with men only for monetary reasons when they are not financial stable. She explained that it is considered a type of “work” in Rio Azul, and that she considers it to be no different than prostitution, something she will admit but many other women would be cautious about saying.

The conditions which force a woman to use sex as a means of monetary support, places the power of the relationship firmly in the hands of the man. She becomes submissive to his every beck and call, a very problematic position for a woman when it involves sexual relations. Women in this predicament will be less inclined than before to request safe sex from their partners, especially if they know he does not desire it. The position of both the woman and the man in this situation places them at risk of HIV infection, because the woman is unable to resist a man who has money to support her, while the man is unable to resist a willing poor woman. In other words, the economic inequality between men and women places them in a position of risk because they both want something that they can obtain through sexual relations; the woman wants monetary support and the man wants pleasure from a woman willing to have sexual relations with him.

Economic inequality and monetary dependence caused by low education and limited job opportunity have placed women in Rio Azul in a particularly vulnerable position. This sort of vulnerability does not only affect women but also ties men into a position of vulnerability and risk. One way to reduce the vulnerable position of women would be to create education programs and job opportunities for women, a goal of my first contact in Honduras, a micro-finance organizations based in San Pedro Sula. Increasing the education programs available to women and creating a job market either in Rio Azul or in neighboring villages would reduce the dependence women have on male financial support and allow

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9 I thank Eileen Moyer for this idea.
them to be self-sufficient, thus, reducing their risk and the risk of the men they have sex with.

9 Conclusions and Recommendation

Through the analysis of the above findings it is apparent that women’s vulnerability to HIV/AIDS in Rio Azul is affected by a multitude of factors. These factors are wide ranging and verify depending on the situation of each individual women. Despite the diverse manner that vulnerability takes towards individual’s and each individual’s position, there are certain components that appear to be predominate in Rio Azul, and affect a fairly significant proportion of the community. These factors include a lack of behavior change, gender roles and power, sexuality, the political-economic situation, and women’s dependence on men.

9.1 Information, Knowledge & Perspectives, and Vulnerability

As my findings show women have access to a wide variety of HIV/AIDS information and resources. Information pertaining to HIV transmission and prevention, condom use, signs and symptoms, and access to ARVs is readily available throughout Rio Azul and is presented to women in a variety of ways, including through charlas, the radio novela, information provided during VCT, the community patronato, support group meetings, and church discussions.

A woman’s knowledge and perspectives of HIV/AIDS are influenced by both individual and social aspects. The HIV/AIDS information people receive is interpreted by
each individual through their personal understanding of the virus, their experience with HIV/AIDS, their perception of risk, and their acceptance or denial of the HIV/AIDS epidemic. Furthermore, their perspectives of HIV/AIDS are affected by society norms, including gender roles and sexuality. The role that a woman is suppose to play in her society and social views of sexuality contribute to shaping her perspectives of HIV/AIDS and how she views herself within the epidemic.

These same notions do not only affect how a woman interprets and understands HIV/AIDS and how she sees herself within the epidemic, but they also contribute to shaping her vulnerability. Women’s vulnerability is shaped through individual, social, and larger institutional aspects. Her individual understanding of the epidemic will determine her perception of risk, which will affect how she does or does not choose to protect herself against infection. Furthermore, gender roles, power relations, and sexuality, aspects influenced by societal norms, shape the amount of control a woman has in her sexual relationships, which in turn determines which type of sexual relationships she can and cannot have, particularly her ability to insist on safe sex practices. Institutional aspects including politics and economics also shape a woman’s vulnerability by determining her level of education, career opportunities, health, and economic dependence. All of these factors combined contribute to and shape women’s vulnerability.

9.2 Factors of Vulnerability

As was discussed in chapter six, being knowledgeable about HIV/AIDS, how it is transmitted, and how to prevent infection does not mean that an individual will change her behavior. Moreover, knowledge does not necessarily create a perception of risk. Every person holds his or her own perception of risk, which allows him or her to decide how vulnerable he or she is to being infected with HIV/AIDS. The idea of “othering” also affects an individual’s perception of risk, allowing him or her to see his or her behaviors as different or less risky than people’s behaviors that he or she associates with HIV/AIDS. Stigmatization is connected to “othering”, as well as, a person’s denial of the HIV/AIDS problem or of his or her own HIV status. Stigma prevents people from accessing VCT, which may ultimately prevent them from obtaining live saving treatment. Furthermore, not seeing one’s own
behavior as risky or refusing to accept HIV/AIDS as a problem within one’s community, does not only place that individual in heightened risk of HIV infection but it also places his partner at a higher risk of infection. Lack of behavior change, denial, and un-acceptance of the HIV/AIDS problem and individual’s HIV/AIDS status places not only women from Rio Azul in a vulnerable position but it places men in the position as well.

Some factors that place women in a greater vulnerable position than men include gender inequality, power relations, and women’s controlled sexuality. Chapter seven explained that women do not have complete control over their sexuality and they are faced with issues of gender inequality that affect their vulnerability. Rio Azul is a machista society where men disproportionately hold the power in their relationships. Women’s subordinate position often places them in a position where they cannot negotiate safe sex with their partners. Despite power imbalances, other factors also prevent women from negotiating safe sex, including shame, embarrassment, and a lack of self confidence. These barriers to condom negotiation are vital to the spread of HIV/AIDS, especially in a community where infidelity has been the norm for decades. Moreover, women have to worry about the physical and emotional consequences of upsetting their partners, particularly when he is the person who supports her and her children financially.

Low education levels, minimal health care services, the Garifuna’s marginal position within Honduran society, and scarce job opportunity have places both women and men of Rio Azul in a vulnerable position within the wider Honduran society. Low education levels combined with scarce job opportunity has lead to vast numbers of Garifuna men leaving their home villages to partake in a form of migrant labor to support themselves and their families. The increased amount of migrant labor within Rio Azul is believe to be one of the main factors contributing to the high HIV/AIDS prevalence rates among the village and other Garifuna villages in the area. Furthermore, scarce job opportunity for women in and around Rio Azul leaves many women reliable on their partners for economic stability for themselves and their children. These circumstances leave women in a position to use sex as means for obtaining and keeping an economically supportive partner. Furthermore, it places both men and women in a vulnerable position because financially unstable women cannot refuse wealthy men coming home with money nor can wealthy men refuse poor, willing women.
The factors mentioned above are contributing to HIV/AIDS vulnerability in Rio Azul, creating a vicious cycle of vulnerability where vulnerable factors that affect one generation continue and sometimes are exasperated when affecting the next generation. Furthermore, as has been addressed throughout this report, many of the factors that shape women’s vulnerability also affect men’s vulnerability. In order to reduce and hopefully eliminate the vulnerable factors that are affecting women, and others that affect both men and women, certain key issues need to be addressed that may influence other factors in due time.

9.3 Recommendations for Action

Educational requirements for children living in Rio Azul need to be increased and once increased implemented efficiently. Increased education will better allow children to enter the mainstream job market that is available to the better educated Ladino population. Greater job opportunity will decrease the number of young men who leave the community to work in migrant labor in order to support themselves and their families, which in turn should reduce the number of HIV infected men who return to the village and transmit the virus to their partners.

Not only is more efficient education needed but also better infrastructure in and around Rio Azul is required to increase job opportunities. With increased infrastructure more businesses, both national and international, will be drawn to the area. This has already started to take place as a multi-billion dollar tourist development project begun being built years ago along the bay where Rio Azul is located. When the project is completed in a projected five to ten years, the job market around Rio Azul is expected to boom with both skilled and unskilled job opportunities. An opportunity like this one is just what is needed to keep young men from leaving for migrant work and allowing women the opportunity to find both skilled and unskilled jobs close to home.

Better education and increased infrastructure would greatly benefit young women and allow them to be more financially stable, reducing their dependence on their male partners. Increased education should allow young women to access skilled labor jobs outside of Rio Azul, which would permit them to support themselves and their children independently. However, increased education and infrastructure alone will not diminish the
gender inequality that exists in Rio Azul. Women need to be empowered through community projects and organizations. Efforts have already begun in this direction, but it is going to take time and increased effort to see the results in future generations. However, women’s empowerment by itself will not decrease gender inequality; men have to be addressed as well.

Multiple HIV/AIDS and empowerment programs exist in Rio Azul that focus on women, but there are not as many that directly address men. Men need to be better incorporated into the HIV/AIDS programs that already exist, and some new programs need to be developed that focus directly on the roles that men play in HIV infection. Furthermore, the role that gender inequality and sexual domination play in the spread of HIV/AIDS needs to be addressed in these programs for men and men need to learn to treat women with respect and equality. This is a large step that has to be taken and one that will likely take generations to take form, despite the long process every step along the way will be a step in the right direction.

In addition to programs directed at men and women’s empowerment, new condom programs need to be developed and introduced into the community. Condom use has increased in Rio Azul since the onset of the HIV/AIDS epidemic; however, it is by no means universal or even a norm within society. People need to be taught the importance and benefits of using a condom and how it will not only protect them against infection, but that it will also protect the person they are having sexual relations with, and possibly their future children. Furthermore, women’s empowerment must teach women that they have a right to safe and consensual sex, a factor that will be more easily facilitated once men engage in awareness and gender equality programs.

Young people of Rio Azul also need to become better informed about HIV/AIDS and sex education. There is a lack of HIV/AIDS awareness programs that specifically address young people, and the program designed through the public school system is virtually nonexistent. In order to curb the course of the epidemic the next generation to be infected must to become aware of the risk and consequences of HIV/AIDS infection. Moreover, condom use needs to be discussed at a young age before children start having sexual relations. Sex and awareness education programs for young people should not only be
addressed outside of the home, but parents need to take a role in teaching their children about sex and sexuality and the pros and cons of being sexually active.

Last, general health education is needed and medical services need to be more readily available to the people living in Rio Azul. Community members need to become more aware of their personal health and the steps that are required to maintain a healthy lifestyle. Increased health awareness will come with increased education, but it will be difficult to make use of this knowledge without the increased availability of medical services. The centro de salud needs to be open on a more consistent basis or general open hours must be implemented, allowing people to know when they will and will not be able to access treatment. Furthermore, medical treatment for severe conditions has to become more readily available to people living in rural settings. It is not feasible for a sick person to afford, both financially and physically, a two hour trip to the hospital in San Pedro Sula and then spend days waiting for treatment while out of work. Again, this is a very difficult task to achieve, especially in a poor country like Honduras; however, it is a task that has to be strived for in order to improve the health of the population.

These are only a few of the possible steps to be taken to reduce the spread of HIV/AIDS among the village of Rio Azul. Many of these suggests are far reaching and will be difficult to implement, but action has to be taken somewhere to make improvements. It is evident that the easier and earlier steps that have already taken place have not been completely successful, therefore, new and farther reaching ideas have to be put in place, and then one can only wait and see what the outcome will be, and what future actions are required.

9.4 Course for Future Research

Further research is needed among the Garifuna in order to make a more thorough and in depth understanding of the HIV/AIDS epidemic and suggest more efficient means of curbing the spread of the virus. One area that requires more research is gender norms and power relations. I took a step in this direction during my fieldwork, however, when conducting the analysis it becoming evident that there are some gaps in my findings. More insight is needed on how a woman runs her household while her partner is away but then
falls back into his submission when he returns, and how both men and women cope with
the vast amount of infidelity that exists within Rio Azul. Moreover, I did not focus on how
men perceive and understand the HIV/AIDS epidemic. In order to take effective action in the
future, both men and women’s perspectives of HIV/AIDS need to be analyzed. Furthermore,
it is vital to understand women’s and men’s sexuality from the male perspective. I feel that I
touched on the ideas that women have about male sexuality and their own sexuality but I
did not looking at the situation from the male’s point of view.

Another area that needs further insight is the historical and political dimensions of
the Garifuna existence on the Honduran coast that affect their vulnerable position in
society. During my research I looked into consideration current situations and factors that
are contributing to the vulnerable position of the Garifuna, both in terms of HIV/AIDS and in
general health and livelihood terms. However, further analysis is needed looking into the
historical dimensions that have and still are affecting the Garifuna and the historical-political
and contemporary political issues that are influencing the wellbeing of the Garifuna
communities. Additional research into these aspects of Garifuna life and their position
among the wider Honduran society will provide further insight into the dimensions that are
shaping Garifuna vulnerability and the steps that can be taken to reduce the spread of the
virus.

The current vulnerable position of the Garifuna woman of Rio Azul is very complex
and determined by a multitude of factors. The components affecting woman’s vulnerability
are far reaching and stem from both inside and outside the village, some are directly tied to
the Garifuna way of life and others have been influenced by their socio-economic position
within the larger Honduran society. Regardless of where the factors of vulnerability stem
from, they are contributing to the spread of HIV/AIDS among Garifuna woman, as well as
contributing to the vulnerability of men and the whole society. Despite the negative
appearance of these conclusions, identifying the factors shaping vulnerability is a step in a
positive direction, a step that will be beneficial in reducing the spread of HIV/AIDS within Rio
Azul.
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Appendix 1: “Three Bodies” Problem Analysis Diagram
Appendix 2: English Version of the Questionnaire

Questionnaire: HIV/AIDS Knowledge

Male / Female
Age
Level of Education
Current type of relationship Single / stable / married / open union / divorced / widowed
General Questions

1. Do you know what HIV/AIDS is? Yes / no / I don’t know
   Please explain

2. Do you think HIV/AIDS is a problem in Honduras? Yes / no / I don’t know
   Please Explain

3. Do you think HIV/AIDS is a problem in your community? Yes / no / I don’t know
   Please Explain

4. HIV/AIDS is a disease?
   a. Mild
   b. Moderate
   c. Grave
   d. Fatal

5. Can you tell if someone has HIV/AIDS by their appearance? Yes / no / I don’t know

6. The majority of people with HIV/AIDS show symptoms that they are infected? Yes / no / I don’t know

7. Do you know what antiretroviral therapy is? Yes / no / I don’t know

8. What do HIV/AIDS medicines (ARVs) do for an HIV/AIDS positive person?
   a. Cure infected people
   b. Sustain an HIV/AIDS positive person’s life/health
   c. Make an HIV/AIDS positive person non-infectious
   d. I don’t know
   e. Other

Access to Information

9. How/Where have you obtained information about HIV/AIDS?
   a. Programs in school
   b. Family and/or friends
   c. Church and/or pastor/priest
   d. Television
   e. Articles, magazines, news papers
   f. Health center, clinic, hospital
   g. Billboards
   h. Other forms of media
Knowledge of HIV Transmission

10. How is HIV transmitted?
   a. Vaginal Sex
   b. Anal Sex
   c. Oral Sex
   d. Blood Transfusions
   e. Through used needles and syringes
   f. During pregnancy, birth, and breast feeding – mother to child
   g. Eating in a restaurant where the cook has HIV/AIDS
   h. Mosquito bites
   i. Sharing tooth brushes / razors
   j. Sharing bathrooms
   k. Mutual masturbation
   l. Other

11. Can a person with HIV/AIDS transmit the virus when they do not have symptoms?

12. Do you know what an open period is?

13. Can the HIV virus pass through a condom?

Prevention Measures

14. What do you do to protect yourself against being infected with HIV?
   a. Abstinence
   b. Faithful
   c. Use condoms
   d. Use birth control methods
   e. Don’t have multiple partners
   f. Other

15. When is it necessary to use condoms to prevent the transmission of HIV/AIDS?
   a. During vaginal sex
   b. During anal sex
   c. During oral sex
   d. With stable partners
   e. With casual partners
   f. Other

HIV Testing and Counseling

16. Do you think everyone should know their HIV status?

17. Have you taken an HIV tested?

18. Do you have any intention to take an HIV test?

19. Are/were you scared to take the HIV test?

20. Do you know where you can get an HIV test?

21. Can you ask your partner if he has taken an HIV test?
22. Have you taken tests for other sexually transmitted diseases (STDs)?
   Yes / no / I don’t know

**Stigmatization**

23. Do you associate HIV/AIDS with any particular people or groups?  
   Yes / no / I don’t know
   Which people or groups
   a. Heterosexuals
   b. Homosexuals
   c. Bisexuals
   d. Prostitutes
   e. Certain ethnic/minority groups
   f. Prisoners
   g. Military personal
   h. Drug users
   i. Other

24. Are you scared or anxious when around people with HIV/AIDS?  
   Yes / no / I don’t know

25. Do you know anyone with HIV/AIDS?  
   Yes / no / I don’t know
   Please Explain

26. Have you cared for someone with HIV/AIDS  
   Yes / no / I don’t know
   Please Explain

27. Do you think people with HIV/AIDS should blame themselves for being infected?  
   Yes / no / I don’t know
   Please Explain

28. Do you think someone with HIV/AIDS has a responsibility to disclose their status?  
   Yes / no / I don’t know
   Please Explain

**Gender Relations**

29. Is it normal for men to have sexual relations with women other than their partner?  
   Yes / no / I don’t know

30. Is it normal for women to have sexual relations with men other than their partner?  
   Yes / no / I don’t know

31. Are sexual relations between people of the same sex acceptable?  
   Yes / no / I don’t know

32. Can a man have sexual relations with his partner when the woman doesn’t want to?
33. Do you think condom use is accepted in your community?  
Yes / no / I don’t know

34. Can a woman ask her partner to use a condom?  
Yes / no / I don’t know

35. Do women have enough power in their relations to insist that a condom be used during sexual relations?  
Yes / no / I don’t know

Knowledge/Information Needed

36. Do you need more information about any HIV/AIDS aspects? Which aspects?  
Yes / no / I don’t know

a. Modes of transmission
b. How the virus affects the body
c. HIV test
d. Transmission of HIV from mother to child
e. Condom Use
f. Antiretroviral therapy
g. Prevention measures
h. Flight against HIV stigma and discrimination
i. Where to get HIV/AIDS information
j. Where to get an HIV test
k. Where to get counseling
l. Where to receive treatment
m. Nothing
n. Other

Appendix 3: Key Informant Background Information

Gabi is a 29 year old woman who has lived in Rio Azul for her whole life. Her husband lives in the United States, which is difficult for Gabi since she is alone raising her four year old daughter. However, the family survives off of remittances that her husband sends from the U.S. Gabi is a housewife who spends her time cooking and cleaning as well as raising her daughter.

Adriana is 22 years old. She still attends classes at the local high school, and hopes to finish sometime in the near future. Adriana is married to a local man and they have one daughter together. Their daughter is three years old. Adriana was very timid and quiet throughout our time working together, which made it difficult for me to develop a relationship with her.
Andra is a 23 years old who still lives in the house of her parents, a common practice in Rio Azul. Andra’s partner lives in the United States and supports her by sending her and her family money when he has extra cash. Andra does not yet have any children of her own, but her immediate family is very large and she has smaller siblings to care for. At the moment Andra does not have a job but she helps her mother with the daily house chores and helps care for her siblings.

Maria is a 32 year old housewife. From the appearance of Maria’s house I would say that out of my interviewees she was the wealthiest woman I talked to. She lives in a new house with her two children, an older son and a younger daughter, and her husband, whose occupation she did not reveal. The house was very modern made of cement and cinder block, which helps keep the inside of the house cool against the outside heat, and it is nicely furnished with fairly new looking couches in the living room. Maria takes care of her children and does the daily tasks of most women living in Rio Azul. Her family is supported by her husband’s job and money sent from family members living in the U.S.

Rebeca was my youngest informant being only 17 years old. She still attends the local high school; if everything goes as planned she will be finished with her classes in two years. She lives in a house with her mother, female relatives, siblings, and cousins. It is a larger, but older house on the edge of the main part of the village. Rebeca does not have any children, but she has a boyfriend who lives in a neighboring village, which Rebeca explained is a problem for her since she does not know what he is doing or what other girls he is with since he does not live in Rio Azul.

Eva is 30 years and she has two children. Both of them are girls, the oldest is 12 years old and has finished her first course (elementary school), the other is eight years old and is in the third grade. Eva lives with her two daughters and her younger brother stays with them when he is in Rio Azul. Eva has had a stable partner for the past three years, but she explained to me that it is not a serious relationship. Her partner does some type of migrant labor work and therefore is not around very often. Despite this fact he would still like to
have a child with Eva, but she does not feel ready for that kind of commitment at the moment. When her partner is in Rio Azul he helps Eva with her two daughters and provides financial support to the family. Eva and her daughters are supported from money sent from her mother who lives in the U.S. and she makes extra cash by selling beverages and snacks from her front porch.

Gloria is a 36 year old and has five children, three girls and two boys. The oldest two are 16 and 14 years old. The oldest attends classes at the high school while the younger four are still in grade school. Gloria lives with her five children and her husband that she has been married to for the past 16 years. Gloria is a housewife who is supported by her husband’s occasional jobs and money sent from family living in the United States.

Bella is 32 years old. She runs a small tienda (store) from a stand she has set up outside her house. The tienda sells a variety of snacks and beverages, including sweets, soda, chips, and ice. Bella also raises chickens in her backyard that provide her family with eggs and an occasional chicken dinner. She has a daughter with her husband of seven years. Their daughter is seven years old and is attending classes at the local school. Only having one child has allowed Bella and her husband to live a fairly stable life which is supported by the tienda, her husband’s fishing job, and the sporadic hours Bella assists at the centro de salud.