WHEN LOVE BECOMES DANGEROUS: AN IN-DEPTH LOOK INTO HETEROSEXUAL RELATIONSHIPS IN SAINT VINCENT AND THE GRENADINES AND THEIR LINK TO HIV TRANSMISSION AMONGST VINCENTIAN WOMEN

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Abstract

Understanding why persons repeatedly place themselves at risk for Human Immunodeficiency Virus (HIV), amidst the wealth of prevention information available is of profound importance. Presently, scientific research of this phenomenon has been dominated by the cognitive models of health behaviour, but these were criticised for ignoring emotional, social and cultural influences on sexual behaviour. This thesis explored and investigated some of these non-cognitive factors within the specific cultural context of St. Vincent and the Grenadines, with sole reference to women, to understand why women put themselves at risk and also help inform the country's efforts to tackle the problem.

This research comprised of four studies, each targeting women ages (18-40 yrs) and sexually involved in relationships. Study one was a qualitative study (N= 10), which explored women's perceptions of the socio-cultural influences which contributes to their decision to engage in risky sex. Study two was a quantitative study in which (N=75), HIV+ women were surveyed, on whether they contracted HIV from within their long term relationships. Study three was a qualitative Interpretative Phenomenological Analysis (IPA) study (N=9); in-depth interviews investigated the intricacies of long-term relationships that made them more likely to influence unsafe sexual practices. Study four was a quantitative study (N=60) women; used questionnaires to investigate the validity that tolerance to infidelity and non use of condoms in long term relationships, which contributes to HIV transmission amongst

Vincentian women. This research confirmed the existing limitations of the Cognitive models oh health when applied to sexual behavior and produced evidence that Vincentian women more at vulnerable to contracting HIV within their long term relationships.

Dedication

To my parents Dr Cynthia Miller and Mr. Albert Miller

Acknowledgement

I would like to express my sincerest gratitude to my supervisor Dr. Gerry A. Riley for his invaluable support, guidance and advice throughout the period of my research.

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CHAPTER ONE

OVERVIEW

1.1: Issue of interest

It is very important that the efforts made to tackle the threat of Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) are informed by scientific understanding of why people continue to put themselves at risk of infection through their sexual behaviour. Thus far, efforts to obtain this scientific understanding have been dominated by cognitive models of health behaviour, such as the Health Belief Model (HBM) and the Theory of Planned Behaviour (TPB); however, these have been subjected to increasing criticism for ignoring emotional, social and cultural influences on sexual behaviour. These criticisms were seen in few studies that showed that a significant amount of variance in sexual behaviour could not be explained by the models (Bryan, Fisher & Fisher, 2002; Sheeran, Abraham & Orbell, 1999; Gredig, Nideröst & Parpan-Blaser, 2006; Schwarzer, 2001; Webb & Sheeran, 2006). Additionally, other studies by Aggleton (1996); Kelly, Parker & Lewis (2001) Parker(2001; 2004) highlighted that motivations for sex were complex, ill-defined and obscured, and may not be thought through in advance.

To this end, the overall aim of the thesis was to explore some of these non-cognitive factors within the specific cultural context of St. Vincent and the Grenadines (SVG) and with specific reference to women. It is proposed that this will enhance our

understanding of why women put themselves at sexual risk, and thus inform the efforts to tackle the problem.

1.2: Background: - HIV/AIDS Statistics

To date, an estimated 33 million persons worldwide are infected with HIV. At the end of 2009, 2.2 million adults were newly infected with HIV and 30.8 million adults were currently living with HIV (UNAIDS 2010). However, the number of new infections has been falling; approximately 2.6 million [2.3 – 2.8 million] were infected in 2009, compared to 2.7 in 2008 (UNAIDS 2010).

The Caribbean region accounts for a relatively small share of the global epidemic — 0.7% of the population have HIV and 0.8% were newly diagnosed in 2008, with an estimated 240,000 people living with HIV at the end of 2009 (UNAIDS 2010). Women account for approximately half of all infected people in the Caribbean (UNAIDS, 2010).

Table 1: HIV/AIDS Prevalence Rate in the Caribbean (Amongst 15-49Year Olds)

Caribbean Countries	People Living with HIV	Adult prevalence rate (%)
Bahamas	6,600	3.1
Barbados	2,100	1.4
Cuba	7,100	0.1
Dominican Republic	57,000	0.9
Haiti	120,000	1.9
Jamaica	32,000	1.7
Trinidad and Tobago	15,000	1.5

Source: UNAIDS 2010

1.3: The HIV/AIDS epidemic in SVG:

St. Vincent and the Grenadines (SVG) is characterised as being a low-prevalence country with a prevalence rate believed to be about 1 %(St. Vincent and the Grenadines HIV and AIDS National Strategic Plan, 2009). It has been a quarter of a century since

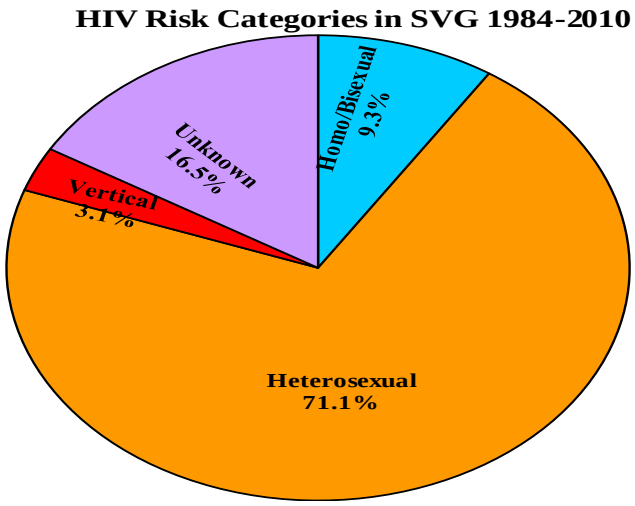
the first case of HIV was reported, and at the end of April 2011, the cumulative number of persons living with HIV was 1227, and, of that number, 734 were males and 475 were females. From the accumulative total, 648 (52.7%) people have so far progressed to AIDS and 575 (89.6%) of those who progressed to AIDS have died. The age group 15-49 years is driving the epidemic in SVG, since 85% (1042) of the accumulative cases reported were in this age group.

In recent years, the incidence of HIV incidence has generally decreased. Since the peak of 108 reported new cases of HIV in 2004, the annual incidence has remained between 62 and 85 reported new cases each year In 2010, 63 new cases were reported and of those, 41 were males and 22 were females. Similarly, AIDS cases have declined since 2004, showing an annual average incidence of 38 cases. It should be noted that 28 deaths were recorded in 2010.

In a country with an approximate population of 107,000 persons, HIV/AIDS has made, and is still making, a serious impact on the productive sector of these relatively small islands: Of the cases reported, the majority fell within the economically-productive age range (20-44 years). The main mode of HIV transmission in St. Vincent and the Grenadines (SVG) is heterosexual contact (CAREC, 2005-2006). Statistics from 2008 reveal that 71% of the people infected acquired the infection through this route. Only 9% of cases have been reported as being spread through homosexual/bisexual

contact, commonly referred to as men who have sex with men (MSMs). Significantly, 16 % of all cases were reported as unknown, and interestingly, all these unknown cases were registered as males. Vertical or mother–to–child transmission accounted for 3 %.

Fig 1: Pie Chart Outlining the Different Transmission Categories for HIV in SVG.



Heterosexual sex was identified as the main mode of transmission, there was not any way of knowing whether these contacts were regular contacts within relationships or casual encounters. This current research explores the context within which risky sexual practices have manifested among Vincentian women. It also focuses on the intricacies of long-term relationships, such as issues relating to trust, faithfulness and infidelity, which challenge the sexual safety that is expected between partners.

1.4: The Present Study

- Non-Cognitive factors:

Cognitive processes are generally regarded as the process of thinking. It encapsulates a process of weighing both the pros and cons of all variables within a situation, before making a decision. These processes look at the performance of some composite cognitive activity; and are seen as an operation that affects the mental contents of the individual. Consequently, the cognitive models of health related behaviour propose that the beliefs and attitudes a person holds about specific health behaviour, for instance 'their belief about the effectiveness of using condoms' should have a direct influence on their decision to have safe sex. This study however, is hinged on the perception that for many Vincentian women, the decision to perform certain sexual acts is more influenced by those non-cognitive influences within society; which is classified for the purpose of this research as being 'non-cognitive/ socio-cultural', rather than the rational process dictated by the cognitive models of health.

This study points to those non-cognitive/socio-cultural factors which weigh heavily on the mental processes involved, when a person engages in risky sexual activity. These factors include things such as music, personality traits, relationships, emotions, alcohol, stigma, trust, peer pressure, gender inequality, tolerance to infidelity, just to name but a few. Whilst they are not specifically focused on any health-related behaviour, these factors maintain profound importance in their ability to influence

choices made in their relationships, which in turn has health implications; for example- power imbalances in male and female relationships may make it difficult for females to insist on condom use within a relationship.

- Why the focus on women?

  Having worked in the area of HIV within the Vincentian society, the researcher became concerned that many Vincentian women "appeared" to be unable to negotiate their sexual safety within their relationships. To this end, women were chosen as the focus of this research, to examine the impact of social and cultural factors within St. Vincent, which perpetuated this threat of HIV transmission on women.

  These socio-cultural factors are very convoluted and are likely to vary according to gender; hence in order to reduce the complexity of the study, it was decided to focus exclusively on women.

- What is rational thinking as it relates to this research?

There are two senses in which decisions can be considered rational. The first refers to the cognitive process of weighing up the advantages and disadvantages of the different courses of action before deciding which one to select (Richetti & Tregse, 2001). The second refers to a judgment about whether the behaviour engaged in by the person is in their best interests. Behaviour may be preceded by the cognitive process of consciously considering different courses of action, or it may not. For example,

applying for a new job is very likely to be preceded by consideration of different possibilities, whereas getting undressed to go to bed at night is a habitual behaviour that is not usually preceded by such consideration. Likewise, behaviour may be considered to be in the best interests of a person (rational) or it may not be (irrational). For example, deciding to leave one's job before finding an alternative form of employment would be considered by many to be irrational. The description of someone's behaviour as rational or irrational in this sense is an evaluative judgment, rather than a factual one. People may disagree about whether behaviour is irrational or not, and this disagreement is based on values rather than facts.

These two senses of rationality are conceptually distinct. Engagement in a process of rational deliberation does not guarantee that the decision is rational in the sense of being in the best interests of the individual; and failing to engage in a process of rational deliberation does not mean that the outcome of one's behaviour is going to be irrational. Humans are fallible decision makers, and engaging in rational deliberation does not guarantee that the best choice will be made even, within the framework of the person's own valuation of what is in their best interests. Most people have, at some time in their life, engaged in a process of rational deliberation, chosen a course of action and then later regretted their choice.

The focus of the current thesis is on rationality in the sense of the process of deliberating which course of action to take. The socio-cognitive models of health behaviour, such as the theory of planned behaviour, and the health belief model,

assume that important behaviour that has an impact on our health is based on this process of deliberation, and the theories address what factors the individual considers in that process. Others have questioned this assumption and argued that people may not engage in this process, even when faced with decisions that may have an important impact on their health.

Four studies were undertaken:

- Study one: This was an exploratory study that investigated the non-cognitive factors, which may lead women to engage in risky sexual behaviours in St.Vincent and the Grenadines. This qualitative study focused on women between the ages 18-35 years and on the significance of the Carnival season as a factor in unprotected sex.
- Study 2: Study 1 highlighted that being in a long-term relationship may place women at some risk of HIV infection. To investigate this possibility further, a survey was carried out with HIV-positive women in SVG, to investigate how often the source of the infection was a long-term partner. The results showed that this was very frequent.
- Study 3: Given that being in a long-term relationship appeared to be a major risk factor for women in SVG, a further qualitative study was conducted to explore in more detail why being in a long-term relationship puts women more at risk.
- Study 4: On the basis of the qualitative data provided in study 3, a model was proposed of how being in a long-term relationship may put women at increased risk. The model focused on the tolerance of infidelity within the relationship, and the non-

use of condoms. The final study was a quantitative study, using questionnaires that investigated the validity of this model.

1.5: Overview of thesis

The layout of the thesis is as follows:

- Chapter One: Overview of research paper.
- Chapter Two: The cognitive models of health and their application to safe sex practices
- Chapter Three: A review of some of the socio-cultural factors that may lead women to engage in risky sexual behaviours and the cultural influences on sexual behaviour in St.Vincent and the Grenadines.
- Chapter Four: Methodological issues.
- Chapter Five: A description of the first qualitative study,"An investigation of the non- cognitive factors that lead women to engage in risky sexual behaviours in St.Vincent and the Grenadines, with specific focus on the Carnival festival.
- Chapter Six: Steady long term relationships and their impact on unprotected sexual behaviour.
- Chapter Seven: Presentation of the survey study (Study 2),"Women in long-term relationships and their risk of HIV."

- Chapter Eight: A description of the second qualitative study (Study 3), "An examination of steady long term relationships and its implications for HIV transmission amongst Vincentian women."

- Chapter Nine: An account of the final questionnaire based study (Study 4), "When love becomes dangerous: Accepting infidelity, denying the use of condoms amidst the presence of HIV."

- Chapter Ten: General discussion of studies.

CHAPTER 2

THE COGNITIVE MODELS OF HEALTH AND THEIR APPLICATION TO SAFE SEX PRACTICES

2.1: Introduction:

According to the Journal of Health Psychology, there has been a remarkable growth in studies in health psychology. The Health Belief Model (Rosenstock, 1966), and the Theory of Planned Behaviour (Ajzen, 1985), have been popular approaches to researching how 'social cognitions' influence health behaviour and how human preparedness to act is a consequence of a complex range of variables and/or stages.

The models were developed to explain, predict and influence health behaviours and outcomes, and are based on the assumption that people make behavioural decisions on the basis of their beliefs. In the two models, analyses of the relations between health beliefs and health behaviours have focused on identifying the kinds of belief that should be measured, the rules by which beliefs are integrated or combined in linking them to behaviour, and the conditions under which strong or weak links between beliefs and behaviour should be expected.

The subjective expected utility assumption underlying these models suggests that behaviours result from an explicit weighing up of the potential costs and benefits of

that behaviour. Behaviour, according to these cognitive models, is a result of explicit and conscious information processing and emphasizes individual cognitions and not the social context of that cognition.

These social-cognitive theories have been found to be valid and useful, especially within the contexts in which they were designed (that is, within Western societies), (Deshpande, Basil & Basil, 2009). However, they cannot be applied blindly in all circumstances, or to all problems. This is particularly apparent in developing countries, where factors beyond the individual have an impact that warrants special consideration. Social-cognitive theories recognize the relevance of factors beyond the individual. However, they tend to emphasize personal processes and the subjective aspects of social influences, to the neglect of the objective aspects of social influences and the distal societal and cultural context (Eaton et al., 2003).

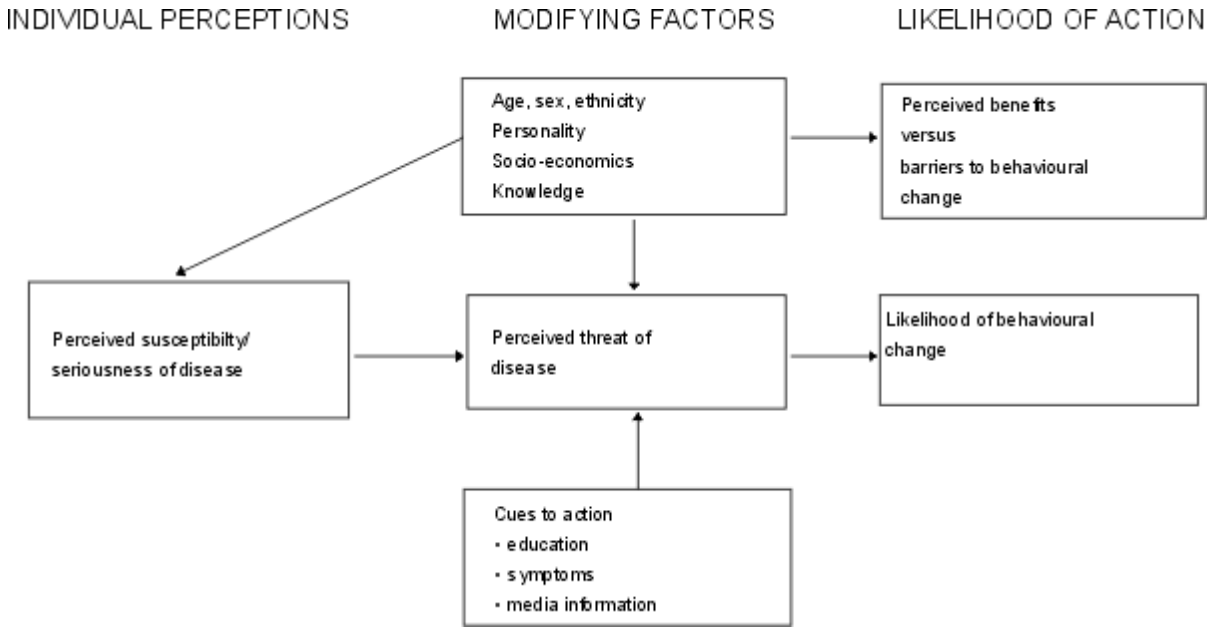
This chapter challenges this low emphasis on the influence of the social context on an individual's cognition. There are many impeding factors that contribute to the behaviour of engaging in sexual activity, and these can be classified under three main categories - the interpersonal, intrapersonal and the environment. With these three factors in mind, it is imperative that such things as peer pressure, societal expectations or perceptions, the individual's ability to negotiate safe sex, and environmental influences such as alcohol or drugs, are assessed.

The following presents a critical examination of the social cognition models, identifying the gaps within each theory. This chapter will provide a description and critique of the two main cognitive models: the Theory of Planned Behaviour and the Health Belief Model, highlighting definitions of major components. Following this, a discussion of attitudes toward condoms will be presented, showing the utility of each of these models in the domain of condom use. Finally, a critique of the strengths and limitations of each model will be given. This chapter will also describe the Stress-Appraisal-Coping model, which is relevant to later chapters.

2.2: The Health Belief Model:

The Health Belief Model (HBM) is often used due to its adaptability with many health issues. Often times, the HBM is applied as a "conceptual framework" for the interventions associated with health behaviours, as well as "to explain changes and maintenance of health behaviours" (Tedesco & Ivory, 2007, p. 584). This model has been widely used in various public health settings (Deshpande et al., 2009) as well as in studies related to "receiving immunisations, using preventative dental and health services, disease screenings, and diagnostics tests; assessing risk behaviours; and complying with medical advice" (Chew, Palmer, Slonska & Subbiah, 2002, p. 181). The key variables in the model are shown in Figure 2:

Fig 2: The HBM-Conceptual Model



Source: Glanz et al. (2002, p. 52)

The HBM was explained in four main constructs which characterised the individual's perceived level of threat and their perception o f benefits of a particular behaviour. The constructs outlined: were perceived susceptibility, perceived severity, perceived benefits and perceived barriers; these concepts were the precursor to a person's readiness to act. Glanz (2002, p.52) also suggested that another concept, 'cues to action' activates the readiness to act and stimulate overt behaviour.

There will now be a discussion of the three main categories provided in the model, and they will be broken down into the components that they comprise of.

Firstly, Individual Perceptions, will be looked at, followed by Modifying Factors and finally, Likelihood of Action. Individual perceptions speak directly at the knowledge and beliefs an individual has about his or her behaviours and the outcomes these behaviours can have. The idea of susceptibility in health looks at the risk a person has of contracting a particular disease or health outcome. Within the context of the HBM, perceived susceptibility examines the individual's opinions about how likely it is that their behaviours will to lead to negative health outcomes. For instance, individuals who smoke are known to have many complications such as lung cancer, bladder cancer, etc. If as a smoker, that individual does not feel a risk exist of developing any of these diseases, there will be reason in his mind to make change their behaviour.

Added to this, the HBM perceived severity component, focuses on just how serious the disease a person may be susceptible to, be. So, for example in the case of a smoker; lung cancer may be identified as one of the leading causes of death worldwide, a smoker may not understand how difficult lung cancer can be to detect and how difficult it can be to treat. They may also not know how painful and long lasting a disease can be later in life. The HBM seeks to raise awareness of how serious the outcomes of behaviours can be, in order increase the quality of one's life.

Having an understanding of individual perceptions it is also important to understand how modifying factors can affect someone's decision to change. Based on

the HBM, modifying factors outlines the features outside the body that influence how threatened a person feels by the outcome of continuing those behaviours, which puts them at risk. Shown by the arrows in the diagram above, perceived susceptibility and severity have their own impact on threat as well. Susceptibility, as stated before, showed how someone acknowledged that their behaviour could lead to a specific disease. Threat takes the idea one step further by examining just how likely it is that the disease could develop. Using lung cancer again as an example, someone who has been smoking for a year may not feel threatened by potential disease because they have not been smoking for very long and if they stop, their body can recover. On the other hand, a smoker who has been doing so for 25 years may feel very threatened by lung cancer if he/she has developed a heavy cough. The cough could be a symptom that increases his/her level of threat and triggers his/herdecision to quit.

Additionally, there are also environmental factors that can add to the threat of disease. An individual's demographic background, ethnicity and socioeconomic status can have an effect on their threat of disease.

Lastly, cues to action as seen in Figure 2 are regarded as the reasons why an individual realises he could be threatened by serious disease. Cues to action are anything that triggers a decision to change behaviour.

After becoming aware of the potential for developing a disease if behaviour does not change, it is important to weigh up the benefits and the barriers to taking action and determine if it is worth it. Therefore, the questions are asked: what are the benefits to change?; What are the reasons behaviour change cannot be achieved?

2.3: Criticisms of the Health Belief Model

There are two main criticisms of the Health Belief Model, firstly, the relationships between the variables have not been explicitly spelt out (Armitage & Conner, 2000) and no definitions have been constructed for the individual components, nor have clear rules of combination been formulated (Armitage & Conner 2000). It is assumed that the variables are not moderated by each other and have an additive effect (Stroebe, 1996). If, for example, perceived seriousness is high and susceptibility is low, it is still assumed that the likelihood of action will be high – intuitively, one might assume that the likelihood in this case would be lower than when both of the variables are high (Stroebe, 2000, Armitage & Conner, 2000).

The second major weakness of HBM is that important determinants of health behaviour, such as the positive regard of negative behaviours, (some people hold on to bad habits/behaviours because it yields them the opportunity to get a particular outcome; for example, an overweight person may use smoking as a means of achieving their desired body weight) and social influence, are not included (Stroebe, 2000,

Armitage & Conner, 2000). In addition, some behaviours, such as smoking, are based on habits rather than decisions (Rosenstock, 1990). Whilst the theory may predict adherence in some situations, it has not been found to do so for "risk reduction behaviours that are more linked to socially determined or unconscious motivations" (Blackwell, 1992, p.165).

Janz and Becker (1984) carried out a study using the HBM and found the best predictors of health behaviour to be perceived barriers and perceived susceptibility to illness. However, Becker and Rosenstock (1984), in a review of 19 studies using a meta-analysis that included measures of the HBM to predict compliance, it was calculated that the best predictors of compliance are the costs and benefits and the perceived seriousness. Therefore, there is lack of agreement over what really helps to predict health behaviour.

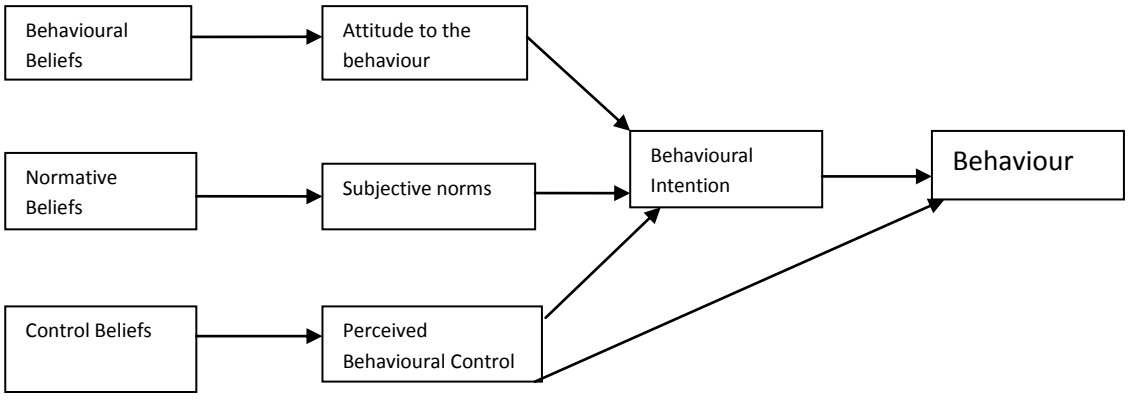
Additionally, the HBM has placed its emphasis on the individual, and has failed to take into consideration the role that the social, emotional and economic factors may play. There is also an absence of a role of emotional factors, such as denial and fear (Ogden, 2004). It has been suggested that alternative factors may predict health behaviour, such as outcome expectancy and self-efficacy (Seydel et al. 1990; Schwarzer, 1992). Schwarzer (1992) further criticised the HBM for its static approach to health

beliefs and suggests that, within the HBM, beliefs are described as occurring simultaneously with no room for change, development or process.

2.4: The Theory of Planned Behaviour

The theory of planned behaviour, which is a modification of the theory of reasoned action, is based on the assumption that human beings are usually rational and make systematic use of the information available to them (Ajzen & Fishbein, 1980). It has been to help in the understanding of various behaviours, including HIV/AIDS (e.g. Abraham, Sheeran & Johnston, 1998; Albarracin, Johnson, Fishbein & Muellerleile, 2001; Albarracin, Kumkale & Johnson 2004; Armitage & Conner, 2001; Bennett & Bozionelos, 2000; Hagger, Chatzisarantis & Biddle, 2002; Conner & Norman, 1996, 2005; Sheeran & Orbell, 1998; Sheeran & Taylor, 1999).

Fig 3: The Theory of Planned Behaviour Showing Linkages Between Components



Source: Azjen (1991, pp: 179-211)

2.5: Proposed linkages between components

Behavioural beliefs strongly influence an individual's attitude about the desirability of any specific behaviour; these beliefs although more general in nature, pre-condition an individual's attitude towards specific behaviours. For example, an individual who has a general belief that exercise is desirable and that individuals should "get as much exercise as possible" will tend to have a positive attitude towards enrolling at the gym or an aerobics class, for example.

Normative beliefs strongly influence the subjective norms that an individual establishes for him/ herself. For example, an individual who has a peer group that strongly endorses the idea that going to an aerobics class is both worth and achievable, will tend to set a personal, subjective norm of enrolling in a fitness programme themselves.

Perceived behavioural control affects both an individual's intent to perform a particular behavior and the actual use of that said behavior. Self-efficacy primarily explains the individual's own judgment of his/her ability to perform the desired behaviour; to carry it through to completion. An individual who has been successful in an undergraduate course, for example, may have high self-efficacy in terms of his/her assessment of their ability to complete graduate coursework. Control beliefs, on the

other hand, may decrease intention. For example, the same individual may know that he/she will have to work full time whilst completing graduate coursework to support a family. This individual may therefore evaluate the degree to which factors outside his/her control, such as not being able to take more than one or two courses per semester, or family demands on time, will prevent him/her from completing a graduate degree.

These theories are however not without their weaknesses. Sheppard et al. (1988, p.325) agree with the theory but make exceptions for certain situations when they say "a behavioural intention measure will predict the performance of any voluntary act, unless intent changes prior to performance or unless the intention measure does not correspond to the behavioural criterion in terms of action, target, context, time-frame and/or specificity." Therefore, if for instance, an individual decided to begin an exercise programme, but prior to that, he or she learnt that they have a medical condition; then this may affect their behavioural intention.

Sheppard et al. (1988) went further to say that there are two limiting conditions on 1) the use of attitudes and subjective norms to predict intentions and 2) the use of intentions to predict the performance of behaviour. They are:

1. **Goals Versus Behaviours**: Distinction between a goal intention (an ultimate accomplishment, such as losing 10 lbs) and a behavioural intention (taking a diet pill).

2. **The Choice among Alternatives**: the presence of choice may dramatically change the nature of the intention formation process and the role of intentions on the performance of behaviour.

The TPB has been criticised for providing an incomplete explanation of health-related behaviours (Conner & Armitage, 1998). A meta-analysis that assessed the application of TPB to various behaviours, including HIV/AIDS protective behaviours, indicated that the model accounted for only 27% and 39% of the variance in behaviour and intention, respectively (Armitage & Conner, 2001). Sutton (1997) also suggests that the TRA and TPB require more conceptualisation, definition and additional explanatory factors. Attitudes and intentions can also be influenced by a variety of factors. In more general terms,, the theory has been criticised for assumingthat behaviour is simply the product of intentions, which are, in turn, based on an explicit and conscious deliberation process (Conner and Armitage, 1998).

Conner and Armitage (1998) further discussed other socio-cognitive factors that the model overlooks. These include belief salience, past behaviour/habit, perceived behavioural control versus self-efficacy, moral norms, self-identity, and affective beliefs. In each instance, growing empirical evidence existed to support the inclusion of these additional variables in the TPB and some understanding of the processes by which these variables may be related to other TPB variables, intentions, and behaviour.

Hale et al. (2003) also account for certain exceptions to the theory when they state that the Theory of Reasoned Action focuses on explaining volitional behaviours. Its theoretical explanation does not cover a vast amount of behaviours, such as those that are involuntary, impulsive, spontaneous or habitual (Bentler & Speckart, 1979; Langer, 1989). These behaviours are usually excluded because they are probably performed by choice and may not involve a conscious decision on the part of the actor.

2.6: Applying these theories to Risky Sexual Behaviours

Risky sexual behaviour is defined as unhealthy behaviour through not using condoms when having sexual intercourse, having multiple sex partners, or engaging in casual sex. Healthy sexual behaviour on the other hand, refers to having protected sex. The theory of planned behaviour is one of the most frequently used models in explaining condom-use behaviour (Ajzen, 1991; Boer & Westhoff, 2006; Sheeran, Abraham, & Orbell, 1999).

Research conducted by Boer and Mashamba (2005) with adolescents in Tigray, Ethiopia, suggests that social cognitions based on the TPB are able to predict intended condom use in a non-western culture. The HBM has also been widely applied when trying to predict safer sexual behaviours (e.g. Armitage & Conner, 2000; Brewer et al., 2007; Conner & Norman, 1996, 2005; Eshrati et al., 2008; Gerrard, Gibbons & Bushman,

1996; Harrison et al., 1992; Leventhal, Kelly, & Leventhal, 1999; Munro, Simon & Volmink, 2007; Noar & Zimmerman, 2005; Rutter & Quine, 2002; Sheeran & Abraham, 1996; Sheeran et al., 1999; White, 2004; Zak- Place & Stern, 2004). Being that the HBM is of Western origin, most of these studies were conducted in Western countries, where perceptions of risk are considered to be highly individualistic.

There have however been instances when the HBM was applied in non-western societies, but, in the majority of these non-Western contexts, though the family, groups, and community played a greater role in decision-making process; the theories and models based on individualism continue to dominate communications strategies for HIV/AIDS prevention and care in such settings (Glanz et al., 2002).

In terms of HIV/AIDS, the HBM suggests that individuals are more likely to adopt safer sexual behaviours (e.g. abstinence, faithfulness or condom use) only if they recognise themselves as susceptible to HIV infection; believe the consequences of HIV infection are serious; believe something could be done to prevent it or moderate its severity; or if theybelieve they can successfully carry out the behaviour required to produce the desired outcomes and that the barriers to safer sex are comparatively low.

When applied to safe sex behaviours, the constructs of the HBM have been found to be significantly associated with these behaviours (Aspinwall et al., 1991; Bryan et al.,

1997; Hingson et al., 1990; Kalichman, 1998; Mattson, 1999; Wulfert & Wan, 1995). However, even though the model's constructs are individually significant in a majority of studies, the whole model appears to have low predictive power in terms of safe sex behaviours (Gerrard et al., 1996; Harrison et al., 1992; Iriyama, Nakahara, Jimba, Ichikawa & Wakai, 2006; King, 1999; Lin, Simoni & Zemon, 2005; Munro et al., 2007; Sheeran et al., 1999; Zak-Place & Stern, 2004). Considering the different components, perceived benefits and barriers, and perceived self-efficacy have been reported to have the strongest relationships with safer sexual behaviours (Bryan, 2002).

When applied to risky sexual practices the TPB theorises that attitude, subjective norm and perceived behavioural control are constructs related to intended condom use (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Godin & Kok, 1996). It is expected that the more positive the attitude towards condoms (sex-related attitude), the response-efficacy (health-related attitude and coping appraisal), and the subjective norm, and the greater the perceived behavioural control and the self-efficacy (coping appraisal) concerning using condoms, the stronger the individual`s intention to use condoms when having sexual intercourse (Ajzen, 1991; Rogers, 1975).

The TPB moreover declares that the intention to engage in a particular behaviour is a strong and proximal determinant of the actual behaviour; and thus intended

condom use is a good predictor of the actual use of condoms (Albarracin et al., 2001; Armitage & Connor, 2001).

In the application of TPB exclusively to condom use, a meta-analysis was conducted by Albarracin et al. (2001) to examine how well the theories of reasoned action and planned behaviour predict condom use. The authors synthesised 96 data sets (n = 22,594) containing associations between the models' key variables. As predicted by the theory of reasoned actions, condom use was related to intentions (weighted mean r. = .45); intentions were based on attitudes (r. =.58) as well as subjective norms (r. =.39) and attitudes were found to be associated with behavioural beliefs (r. = .56) and finally norms were linked with normative beliefs (r. = .46).

The Theory of Planned Behaviour's predictions shows consistency in saying that perceived behavioural control was related to condom use intentions (r. =.45) and condom use (r. = .25), but in contrast to the theory, it did not contribute significantly to condom use. The strength of these associations, however, was influenced by the consideration of past behaviour.

Albarracin et al. (2001) further found that studies that assessed behaviour retrospectively had higher intention – behaviour correlations (r = .57, p <.001) compared

to those that assessed it prospectively ($r = .45$, $p < .001$), suggesting that people base their intention to use condoms heavily on past sexual behaviours.

Earlier, it was noted that the socio-cognitive models have been criticised for their assumption that behaviour is primarily to be explained in terms of a conscious process of deliberation in which the individual weighs up the pros and cons of different courses of action. For example, within the TPB, the individual is seen as planning behaviour through the processing of a fixed or static set of cognitions (for example, attitudes, subjective norms, perceived behavioural control) which act as antecedents to behavioural intentions, which in turn predict behaviour (Flowers et al., 2002). It has often been pointed out that this assumption is particularly dubious when considering sexual behaviour (e.g., Ingham, Woodcock, & Stenner, 1992, Ingham & Van Zessen, 1997; Kippax & Crawford, 1993). They note that notions of reason, rationality or planning are at odds with wilder cultural understanding of sexual behaviour, often characterised as spontaneous, emotional, instinctual, or passionate. Safe sex also differs from other behaviours that have been successfully forecast by the TPB because of the increased importance of external factors (e.g. the availability of condoms) and the fact that it depends on interpersonal co-operation (Sheeran et al., 1999). More widely, it has been suggested that cognitive processes are not necessarily pre-requisites for behaviour (Bastard & Cardia-Voneche, 1997) and, significantly, this habit often precludes any deliberate action (Bloor, 1995; Rhodes, 1995).

Flowers (2002), then went on to state that the complicated characteristics in sexual behaviour and the frugality needed in defining and understanding social cognitive models such as the TPB, lends to the consideration of how capable these models are likely to be in capturing the authenticity, which is imminent in sexual decision making of a wide array of encounters in the midst of a vastly changing epidemic.

2.7: Other theories used in this paper (referred to in Chapter 8).

- Stress-appraisal coping model (Lazarus & Folkman, 1984)

When an individual is confronted with a stressful event, that person evaluates the event, and forms a judgment about the significance of the event as stressful or not stressful (primary appraisal). If the event is appraised as a threat, the person then assesses their coping resources and decides how to cope with the threat (secondary appraisal) (Cohen, 1984; Lazarus & Folkman, 1984). Coping responses have been categorised into problem-focused (trying to deal with the external situation) and emotion-focused (trying to deal with the negative emotions elicited by the threat).

2.8: HIV prevention behaviour compared to the prevention of STIs and pregnancy:

According to de Visser and Smith (1999) research based on individual rational decision-making models, such as the Health Belief Model and the Theory of Planned Behaviour, revealed that intentions to use condoms do predict condom use. the model components do predict intentions to use condoms (Baker et al., 1996; Boldero et al., 1992; Brien et al., 1994; Bryan et al., 1997; Galligan & Terry, 1993; Gallois et al., 1992; Gerrard et al., 1996; Schaalma et al., 1993), it was noted that the amount of variance in condom use explained by trait-like characteristics of the individual was not great (Fisher *et al.*, 1995; Schaalma *et al.*, 1993; van Landingham *et al.*, 1995). As a result of this variance, interventions based solely on these individual rational decision-making models - even if 100% successful - will not necessarily have a great impact on condom use behaviour, because knowledge and beliefs do not exert a strong influence on condom use behaviour.

They also alluded to the fact that, some of the past research has asseverate that among young heterosexual adults, condoms are utilised mainly for contraception, rather than for prevention of HIV/STDs, and that concerns about unplanned pregnancy are high, concerns about infection with HIV/STDs are low (Freimuth et al., 1992; Geringer et al., 1993; Kirkman et al., 1998; Maticka-Tyndale, 1991; Moore & Rosenthal, 1996; Pilkington et al., 1994; Shew et al., 1997.

Additionally, condoms use appeared to be influenced by the relationship between sexual partners. It was identified as a symbol that marks the depth of intimacy and strength of a relationship; as suggesting condom use to a regular partner was deemed as an accusation of infidelity, (Browne & Minichiello, 1994; Holland et al, 1991). deVisser and Smith (1999) also contributed that as a regular relationship develops and intercourse occurs more frequently, sexual partners are likely to change from condoms to other forms of birth control (Glor & Severy, 1990; Pilkington et al., 1994; Traeñ et al., 1992; Whitley, 1990). This suggests that relationship status is likely to serve as a proxy measure of the use of another form of contraception.

Ott et al. (2002) also looked at the tradeoff between hormonal contraceptives and condom use among sexually active adolescents. The results highlighted an inverse association between adolescents' condom use and hormonal contraceptive use that varies as a function of the type of sexual partner and the adolescents' perceptions of pregnancy and STD risk.

Sometimes the thought of not wanting to get pregnant is considered more significant than the threat of contracting HIV. In de Visser (2007, p. 305) it was noted that "young heterosexuals are more concerned about unplanned pregnancy than HIV/STIs, and condom use is unlikely if other contraception is used" (Cooper, Agocha, & Powers, 1999; de Visser & Smith, 2001; Kirkman, Rosenthal, & Smith, 1998).

2.9: How do issues of love and trust affect sexual behaviour and condom use?

At the very core of every intimate relationship is the human desire for affiliation and love. Fisher and Fisher (1997) cited that research on intimate relationships demonstrated that being a member of a couple functions as a buffer against stressful life experiences that contribute to physical and mental health problems. Other researchers also joined the research pool and were quoted by Fisher and Fisher (1997, p. 72), as saying, "stable and secure couples tend to be healthier, less anxious and depressed, and lived longer than people who are unattached'' (e.g., Goodwin,Hunt, Key, & Samet, 1987; House, Landis, &Umberson, 1988). These researches all pointed to the benefits of being in a relationship. It is therefore this propensity to identify with another human being on an intimate level, which pushes persons to seek out romantic, relationships sometimes at any cost.

Fisher and Fisher (1997) also alluded to the fact that relationships can also prove to be an undesirable characteristic in some instances. Accumulated evidence shows that the very same positive effects of relationships, such as trust and feelings of security, can also be counterproductive, as the associated desire to sustain these feelings also produces and perpetuates elevated levels of acquired immune deficiency syndrome (AIDS) risk behaviour in couples and actsas a repeatedly absolved source of risk for HIV and STIs.

HIV prevention programmes have throughout the years been concentrated on abstinence from sexual intercourse, condom use or the encouragement to enter into and maintain a monogamous relationship with a partner they is known well. Steady faithful relationships became regarded as an alternative to, and substitute for, other AIDS preventive behaviours. Moyo et al. (2008, p.435) stated, "that characteristics of sexual relationships are associated with condom use within those relationships; the older the male sexual partner in a heterosexual relationship, the lower the likelihood of condom use in that relationship." Ford et al. (2001) and Ku et al. (1994) suggest that the reason for this is primarily because gender power in heterosexual relationships in many societies, including the power to decide condom use, traditionally favours men, and women who are younger than their sexual partners may find it difficult to negotiate condom use with them.

Farrar (2012) examined the failure of the condoms as a means of HIV prevention in marital relationships in South Africa. Amid the HIV/AIDS epidemic, the widespread unwillingness to use condoms posed a critical challenge for HIV prevention campaigns.

This research employed the symbolic approach; twelve research databases were searched from 1980-2012, and the assessment included all peer-reviewed studies investigating condom use in marriage. Longitudinal studies were seen as particularly valuable as they assisted the understanding of potential behavioural changes over time.

Overall, 28 qualitative, three quantitative and 21 mixed methodology studies were included in Farrar's (2012) review.

The methodology revealed four key symbols about condoms that consistently limited male condom use: Condoms as preventing pregnancy; condoms as associated with HIV; condoms asserting lack of trust; and condoms conflicting with cultural values for female passivity (Farrar, 2012). It was generally understood in the Sub-Saharan African societies, that for married couples, it is culturally expected that they will be fruitful; therefore the prospect of having no children often conflicted with, and outweighed, the value of condoms for HIV prevention (Ulin, 1992: 60-61; Maharaj and Cleland, 2005: 331).

Additionally, HIV is a largely stigmatised illness throughout sub-Saharan Africa, and messages designed towards decreasing HIV transmission had been linked to condom use. Persons therefore, in committed relationships were unlikely to view a risk of HIV as being imminent, because all relationships are built on the premise of strong trust. As such the association of condoms with infidelity likewise emerged as a large impediment to male condom use in marriage; in every case, where the condom was linked to distrust, its use was avoided.

de Visser (2005) also contributed to the research on condom use as an STI preventative method among heterosexual young adults. He took a series of group discussions conducted with heterosexual young adults, who were residents of Melbourne, Australia. They wererecruited via advertisements placed on an urban

campus with a socio-economically diverse student population and via advertisements in a free youth-oriented newspaper.

The results showed that there were several avenues for interventions to raise awareness of the risk of STIs, providing information was not enough as there was no clear association between knowledge and condom use (supported by Sheeran et al. 1999). Moreover, respondents in this study were able to distance themselves from the likelihood of infection, believing that STI infection was something that happens to others. There were also some conflicting thoughts as theyrelated to the responsibility to bring condoms into the sexual exchange. it was suggested by both males and females that condom use would increase if more women requested it; many women felt unable to initiate discussions around it due to prevailing cultural and social expectations of women not taking the initiative in sexual matters.

Overall, de Visser (2005) has suggested, that interventions based on social cognitive models of health behaviour have been shown to produce significant changes in condom use for HIV prevention. However, interventions should not be based solely on social cognitive models without considering suggestions from participants, specifically their suggestions for how best to present health promotion messages.

Condom use in heterosexual relationships involves two people, which means that it is important to consider the relationship between the sexual partners, gendered

power relations and the way in which feelings of love and trust may affect their intentions to use condoms (Amaro, 1995; Willig, 1997; Holland et al., 1998; de Visser & Smith, 2004).

CHAPTER 3
NON-COGNITIVE FACTORS THAT MAY LEAD WOMEN TO ENGAGING IN RISKY SEXUAL BEHAVIOURS, AND THE CULTURAL INFLUENCES ON SEXUAL BEHAVIOUR IN ST.VINCENT AND THE GRENADINES

The previous chapter reviewed criticisms of the cognitive models of sexual risk-taking that assume that behaviour is the product of a rational process that weighs up the advantages and disadvantages of various courses of action before a decision is made. Sex takes place within a broader emotional, social and cultural context, and the cognitive models struggle to address this broader context.

Therefore, amore sophisticated framework needs to be developed to understand the sexual behaviour of individuals in the context of the risk of HIV, which should address social, lifestyle and cultural factors; behavioural and environmental factors (e.g. alcohol); personality and individual differences. Refer to chapter one, (section 1.4) for an understanding of the term "non-cognitive factors" as used in this paper.

This chapter reviews some of these non-cognitive influences on sexual behaviour. The literature in this area is very large, and so a comprehensive review of these factors was not attempted. Instead, the focus is on some of the factors that have attracted more research interest; and an illustrative, rather than a comprehensive,

sample of relevant evidence is presented. The factors that are reviewed in this chapter are emotional influences, alcohol, personality factors, and the cultural factors of stigma and gender roles. Additionally, consideration is given to the specific cultural context of SVG and its possible influences on sexual risk behaviour. The nature of the relationship between the two partners is another major factor, but research about this is reviewed in Chapter 6.

3.1: Risky Sexual Behaviour

The ability to abstain entirely from sexual activity is the ideal to guarantee the complete elimination of sexual risks. However, the reality remains that for most consenting adults, as well as many adolescents, abstinence is not seen as a reasonable goal or choice. Though most persons are well-educated about risky sexual behaviours, unsafe sexual practices are still occurring with sufficient frequency, therefore sexually transmitted diseases and unwanted pregnancies remain a significant public health concern in St.Vincent and the Grenadines.

In regards to this research thesis, risky sexual behaviour will be defined as having unprotected oral sex, vaginal and anal intercourse, with a steady or casual partner, and changing sexual partners frequently.

3.2: Emotional influences on behaviour

Given the nature of sexual activity, social and emotional factors may be at least as important as cognitive factors in understanding why people engage in unsafe sex. Outside the field of health behaviour, there are theories about behavioural choice that emphasise the role of emotions (e.g. Bechara, 2000), and it may be that these theories have a substantial role to play in explaining unsafe sexual behaviour.

This notion was examined in the HIV Counsellor Perspectives, (1997), in which it was stated that unsafe behaviours often result when a person's decision-making process is affected more strongly by emotion than logic or reason. For instance, emotions often take precedence when a person actively desires, pursues, or engages in sex or using alcohol or other drugs. In these situations, a person may be less able to see his or her choices and may rely on either past behaviour patterns or become more focused on immediate benefits, such as having the most pleasurable sex, than on long-term benefits such as remaining free of HIV infection.

A number of studies have examined emotional factors associated with risky sexual behaviour. Numerous studies have reported an association between negative affective states (such as anxiety and depression) and increased sexual risk behaviour in both adolescents and adults. This association has been seen across a wide range of populations, including adult men and women (Kelly et al., 1993), men who have sex

with men (Marks et al., 1998; Perdue et al., 2003), HIV-positive adults (Kelly et al., 1993; Parsons et al., 2003), women from marginalised social groups (Champion et al., 2002; Orr et al., 1994), opioid users (Camacho et al., 1996), young gay and bisexual men (Strathdee et al., 1998), and adolescents (Brooks et al., 2002). Post-traumatic stress disorder has also been found to be associated with increased sexual risk behaviour (Hutton et al., 2001; Ramrakha et al., 2000; Rogers et al., 2003).

To illustrate the nature of these connections in more detail, some of these studies can be considered in more detail. Seth et al. (2009) examined the relationship between psychological distress and STI/HIV-associated behaviours in African American youth. Logistic regression analyses revealed that adolescents with high psychological distress, relative to those with low psychological distress, were more likely to have an STI, use condoms inconsistently, not use condoms during their last casual sexual encounter, have sex high on alcohol or drugs, have male sexual partners with concurrent female sexual partners, have lower self-efficacy beliefs relating to condom use, partner sexual communication and refusal of sexual intercourse, and to be more fearful of communicating with their partners.

In another study of adolescents in Finland (Kosunen et al., 2003), self-reported depression had a positive correlation, with both numbers of sexual partners and occasions in which contraception was not used. Those participants who did not use contraception were found to have an almost doubled risk of depression than those who

engaged in safe sex, leading to the conclusion that having multiple partners was also associated with a risk of depression.

Lehrer et al. (2006) conducted a similar longitudinal study and found that depressive symptoms in males predicted nonuse of condoms at last sex and substance use at last sex. For females, the use of alcohol and drugs in their last sexual encounter was associated with moderate depression. Further analysis showed that depressive symptoms were found in those who had had over three sexual partners.

The link between affective difficulties and increased sexual risk may be that, similarly to self-harm and drug abuse, sexual activity and the positive affective states associated with it, may provide some relief from emotional distress. Cooper, Shapiro and Powers (1998) used questionnaire to assess the participant's self-reported reasons for having sex. They found that having sex as a means of coping with negative emotions was associated with greater increases in sexual risk behaviour (e.g., sex in exchange for drugs or money) up to two years. The association with depression is surprising, given that depression is often associated with decreased libido (DSM-3, American Psychiatric Association, 2000). However, the studies have included participants from the general population with low mood, rather than those who are clinically depressed, and it may be that the inhibiting effect of low mood at milder levels of depression is strong enough to outweigh other factors that lead the person to have sex.

Some have tried to incorporate emotions within the theory of planned behaviour by using the idea of anticipated emotional reactions. Conner and Armitage 's (1998) beliefs about likely emotional reactions are argued to be part of the decision-making process, whereby the potential advantages and disadvantages of various courses of action are weighed up before a decision is reached. Anticipated pleasure, for example, would be a reason to engage in risky sex; but anticipated shame would be a reason against it. However, other approaches consider that behaviour may not always be the product of this reasoning process, but may be a learnt response.

Bechara et al. (2000) have given a neuro-behavioural account of how emotional responses to a situation, learnt from previous experiences, can influence current behavioural responses. Within the framework of this hypothesis, emotional responses may act directly and subconsciously upon behaviour (and often not in the best interests of the individual), rather than feeding into a process of deliberation (Bechara et al., 2000). For example, people with depression may have learnt to engage in riskier sex because it allows them to escape from the painful feelings associated with depression – a feeling of being wanted within a sexual encounter may negatively reinforce risky sexual behaviour because it allows them to escape from feelings that they are unloved and unwanted.

3.3: Alcohol

Alcohol use has long been hypothesised as a cause of risky sex, and prevention and intervention campaigns were developed to warn against combining alcohol with sex. The Centre for Disease Control (CDC) even advised that raising taxes on alcohol would help to reduce the incidence of sexually transmitted diseases (CDC, 2000). However, is the belief that alcohol use leads to risky sex supported by the available evidence?

Numerous studies have indicated that individuals who drink more heavily are more likely to have multiple sexual partners and are less likely to use condoms consistently. For example, Leigh et al. (1994) found that heavier drinking patterns were associated with being sexually active and having more than one sexual partner, even when age, gender, and marital/relationship status were taken into account. A correlation has also been reported between the intensity of alcohol consumption (the quantity of alcohol consumed per sitting) and the incidence of unprotected sexual intercourse (Lauchli, 1996).

A recent study by Shisana et al. (2004) showed a strong link between sexual risk-taking behaviour and alcohol use. Respondents with multiple partners (16.2%) were significantly more likely to report consuming alcohol (2-3 times per week) than were mono-partners (8.3%), abstainers from sex in the last 12 months (5.0%) and virgins (0.5%). Condom use during the last sex act was negatively and significantly related to

frequency of alcohol use. Another study by Kalichman and Simbayi (2003) reported that having a history of engaging in an activity with higher risk for HIV infection was significantly associated with alcohol use. These researchers found that 54% of individuals who had been diagnosed with a sexually transmitted infection (STI) reported using alcohol, compared with 40% of persons who did not have an STI.

Again, the mechanisms whereby alcohol might have an impact on risky sexual behaviour are likely to be very complex (Thompson et al., 2004). The behavioural effects of alcohol are multi-factorial, including behavioural disinhibition and interference with judgment and decision making (Halpern-Felsher, 1996). It may be that alcohol interferes with the reasoning processes assumed by cognitive models, such as the theory of planned behaviour. It could also be that it interferes with the inhibitory effects of emotional learning on behaviour that are incorporated with emotional learning models such as that proposed by Bechara et al. (2000). An alternative explanation of the correlation between alcohol and risky sex may be that both represent manifestations of underlying risk-taking and/or sensation seeking tendencies (Leigh et al. 1994).

One body of evidence that is difficult to reconcile with these suggestions are the studies that have focused on the association between particular occasions of unsafe sex and particular episodes of drinking – i.e. whether unsafe sex is more often preceded by

alcohol consumption compared to no prior alcohol consumption (Leigh, 2002; de Visser & Smith, 1999). Leigh (2002) conducted a meta-analysis of these studies and concluded that the evidence about this was inconsistent. Leigh et al. (2008) also looked at this issue by using data from diaries kept by participants about alcohol use and sexual encounters. This information was collected over 8 weeks from college students and clients of a sexually transmitted disease clinic. The results showed no overall association between episodes of drinking and failure to use condoms. Others have reported similar findings (Fortenberry et al., 1997; Harvey & Beckman, 1986; Leigh, 1993). This raises the possibility that alcohol use is not a direct influence on condom use. Instead, the relationship may be explained by the possibility that both are the result of a tendency to take risks (Leigh, 2002).

3.4: Personality Factors

From as early as the 1970s, psychologists have been very interested in how personality traits relate to problematic sexual attitudes and behaviours (Eysenck, 1976). In Schmitt (2004, p.301), it was documented that "In the 1980s, increasing concerns over HIV/AIDS led to an interest in identifying the personality traits associated with marital infidelity and having promiscuous sex with multiple partners, both of which represent significant risk factors for contracting HIV (Hoyle, Fejfar, & Miller, 2000; Mashegoane, Moalusi, Ngoepe, & Peltzer, 2002; McCown, 1992)." So is there a specific personality trait which predisposes persons to engage in risky sex?

Sensation seeking was highlighted through previous research as, a personality disposition that is characterised by the propensity to seek optimal arousal and sensory-stimulating experiences; it is usually aligned with both alcohol use (Johnson & Cropsey, 2000) and sexual risk behaviour (Weinhardt & Carey, 2000). Based on this finding, it can be suggested that the Vincentian women investigated in the paper, were likely to have an embedded trait of sensation seeking; which they demonstrated during the carnival festivity which is the time characterised by excessive intoxication and reckless sexual activity.

Researchers such as Hoyle, Fejfar, & Miller, (2000); Kalichman et al., (1996); Logan, Cole, & Leukefeld (2002), presented meta-analyses that further showed that the personality trait of sensation seeking explains those individual features indicative risky sexual behaviours, inclusive, number of first-time sex partners, overall number of partners and the number of times, they would engage in unprotected sexual intercourse. Thus, sensation seeking is among the most reliable predictors of multiple health-compromising behaviours, including substance use and sexual risk behaviours.

Numerous authors have also found that individuals high on traits such as sensation seeking, impulsiveness and psychoticism are social nonconformists, display impulsive and compulsive sexual behaviours have more sex partners and extramarital

affairs, refuse to adopt sexual risk-reductions strategies, and abuse alcohol or illicit drugs (Kalichman & Rompa, 1995; Pinkerton & Abramson, 1995; Seal & Agostinellli, 1994; Sheer & Cline, 1995).

Zuckerman and Kuhlman (2000) looked at a variety of risky behaviours in 260 college students who were given self-report measures along with the Zuckerman-Kuhlman Personality Questionnaire (ZKPQ). An interesting question examined in this study was the effect of gender on personality and risk taking. In general, women tended to score higher than men on measures of neuroticism and sociability, men tended to score higher on measures of sensation seeking and aggression-hostility. The authors hypothesised that the relationship between personality and risk-taking might be mediated by gender.

3.5: Cultural factors (Stigma & Gender)

3.5.1: Stigma

According to the World Conference on Cultural Policies in Mexico (1982), and the UNESCO Universal Declaration on Cultural Diversity (2001), *culture* is a set of distinctive spiritual, material, intellectual and emotional features of a society or social groups, which encompasses, in addition to arts and literature, lifestyles, ways of living together, value systems, traditions and beliefs. There are many cultural features that

have been implicated in safe/unsafe sexual behaviour (e.g. religious beliefs, moral values, family systems), but this section focuses on stigma.

A more in-depth look at the relationship between violence, risky behaviour, and reproductive health, conducted by Heise and colleagues (1999) shows that individuals who have been sexually abused are more likely to engage in unprotected sex, and have multiple partners. This relationship was also apparent in the findings from a study conducted in Tanzania by Maman, Mbwambo and colleagues (2000), where some women who experienced violence were seen to be strong predictor of HIV. In that study, the women who sought services at the voluntary counselling and testing centre, who turned out to be HIV+ were 2.6 times more likely to have experienced violence in an intimate relationship than those who were negative.

One other significant cultural influence implicated in the practice of safe or unsafe sexual behaviour is stigma. Stigma is increasingly regarded as a key driver of the epidemic (Ogden & Nyblade, 2005). This is through the role it plays in undermining the ability of individuals, families and societies to protect themselves from HIV and to provide assistance to those affected by AIDS.

Stigma may make persons unwilling to find out or talk about the disease or even access counselling services, or get tested, which may lead those already infected to

unwittingly pass on the infection to others. According to the International Centre for Research on Women (2001-2005), persons living with HIV/AIDS are usually fearful of the anticipated stigma, seen if others around them become aware of their HIV status. This crippling fear has far reaching implications on the effectiveness of HIV/AIDS prevention, treatment and care programmes because infected persons are usually unwilling to access these services.

Further research data suggested that fewer people would seek HIV testing because they fear a positive test result, which in their minds is linked to the stigma they assume they would experience if tested HIV+.

The stigma attached to HIV/AIDS, as with other STIs, also causes persons to not seek information about the virus or even about their sexual health; their ignorance about how the disease is spread and what they can do to protect themselves also increases the risk of them engaging in unsafe sexual behaviour. Research has shown that stigma causes delays in STI testing-and treatment-seeking, and negatively impacts treatment adherence, which prolongs the risk of STI transmission to partners and potentially increases one's susceptibility to more serious infections and long-term complications, (Rusch et al, 2008; Heijnders et al, 2010).

Another significant way in which stigma contributes to the spread of HIV/AIDS relates to the reluctance to reveal HIV status to others, which may prevent people with HIV from taking steps to protect their sexual partners. Ogden and Nyblade (2005), cited, that stigma has the grave consequence of disabling people's ability and willingness to disclose their HIV+ status to others. From their research in Vietnam, one woman's case was highlighted, as being among those who continued to have sexual relations with her husband without condoms, which meant that the necessary measures were not put in place to prevent further transmission of the virus.

This act of refusing to disclose was also mirrored in studies done around the world. Stigma perpetuates feelings of guilt and embarrassment, as well as a fear of relationship breakdown or slander, which discourages infected persons from disclosing their infection to previous, current or future sex partners, (Lichtenstein, 2003; Lichtenstein & Bachman, 2005; Cunningham et al, 2002; Cunningham et al, 2009; Newton & McCabe, 2008; Gordon, 2007; Newton & McCabe, 2005). The expected response of the sex partner, being one of the primary determinants of disclosure, has been found to be influenced by the patient's own levels of anticipated and internalised stigma, (Bickford & Barton, 2007; Scrivener et.al, 2008; Newton & McCabe, 2005).

Whereas research on other health-related stigmas has more broadly considered the structural determinants of stigma, research on STI-associated stigma has

concentrated almost entirely on how individuals construct beliefs and attitudes towards STIs, sexual behaviour or identity, and how these beliefs and attitudes are communicated, (Earnshaw & Chandoir, 2007; Mahajan et al, 2008; Parker & Aggleton, 2003).

Addressing the culture of stigmatisation in St.Vincent and the Grenadines is vital in responding to the HIV/AIDS situation, because it is from an understanding of stigma, that other variables are noticed at play, for instance: A lack of disclosure; refusal of treatment; gender inequality; repeated pregnancy amongst HIV+ women; lack of condom use and risky sexual practices.

3.5.2: Gender

According to the Centre for Gender and Development Studies (CDGS), at the (University of the West Indies, 2004; Pargass 2005; Barrow 2006), various reviews of national and NGO HIV/AIDS programmes concluded that gender was an overlooked factor in many HIV prevention programmes. What appeared to be overlooked, was the persistence of gendered imbalances of power as well as the persistence of particular constructions of gender and sexuality, which together structurally locate girls, women, homosexuals and bisexuals in more vulnerable positions than the rest of the population, particularly heterosexual men.

It is useful that an understanding of the term gender be garnered, which will provide insight as it relates to its importance as a factor in the response to HIV. Very widely, it encapsulates the shared expectations and norms within a society that appropriates male and female behaviours, characteristics and roles. It is a differentiation between women and men, based on the social and cultural constructs of how both sexes are expected to relate to each other and function within society.

As a culturally-specific construct, each cultural context dictates what is acceptable behaviour for both males and females. There is, however, similarities in terms of the difference between the roles of women and men, be it in the family, community or work place; access to productive resources and decision-making authority. In many instances, the man was seen as ideally the one responsible for earning an income outside of the home, the woman's role was to be the caretaker of the home and children. (Sivard et al.1995; Buvinic 1995).

The unequal balance of power in heterosexual interactions is synonymous with the power imbalance in gender relations, which favours men. To this end, the pleasure of the males in a sexual relationship takes precedence over the pleasure of the females. Men had the responsibility and control over the decision to have sex, the place to have sex and how sex should be done.

According to Weiss & Rao Gupta, (1998); De Bruyn et al. (1995), Heise & Elias (1995), the imbalance of power existing between men and women in gender relations, has restricted the sexual free will of women, resulting in an increase in their risk and vulnerability amidst the HIV/AIDS pandemic. This viewpoint has been also supported by research carried out by the ICRW (International Centre for Women, 2005).

It was further noted by Carovano (1992) that in many societies, there is an element of silence about sexual activity. This therefore leads to the implication that women may possibly be naive and passive about sex and sexual interactions, making it a challenge for women to understand their role in reducing their risk to contracting sexually transmitted disease, as well as take confidence in their ability to negotiate safe sex practices.

Additionally, with the traditional norm for unmarried girl to remain virgins in many societies; there is an increase in the young women's risk because it is assumed that it will restrict their ability to seek information about sex, due to an embedded fear that in doing so, society will classify them as being sexually active. Further to this, being publicly candid about sexuality is not deemed as appropriate female behaviour in many cultures worldwide (Bassett & Mhloyi, 1991; De Bruyn, 1992; Hillier et al., 1998; Leary, 1995; Taylor, 1995; Weiss et al., 1996). Too much knowledge about sex leads to the assumption of a lack of sexual innocence and a shift from the naivety and passivity

often expected of women; this in turn limits the ability of these women to negotiate safe sex with their male partners.

Research has also shown that in cultures that place an extremely profound high value on virginity, young ladies maybe placed in a very precarious position. This is because in an effort to maintain their vaginal virginity, many may engage in anal sex unknowing of their increased risk of HIV (Weiss, Whelan and Rao Gupta 2000).

So it is seen that as a combination; the value placed on the maintenance of virginity and the normative of not publicly speaking about sex can be highly stigmatizing for both adolescent and adult women (Weiss, Whelan and Rao Gupta 2000; De Bruyn et al., 1995). Consequentially, they can also unwittingly infect other sexual partners. Like virginity, in many cultures, motherhood is considered to be a feminine ideal and as such, the use of barrier methods or non-penetrative sex as a option for safe sex presents a great challenges for women (Heise & Elias 1995; UNAIDS 1999).

The other considerations of gender that weighs heavily on the vulnerability of women to contract HIV relates to the economic dependency of women and violence against women. Research done by Heise & Elias, (1995); Mane, Rao Gupta & Weiss (1994); Weiss & Rao Gupta, (1998) has shown that women who are economically disadvantaged would be less likely to have success in condom negotiation within their

relationships; they are more likely to perform sexual acts for compensation and they are less likely to abandon a risky relationship if it provides economic stability.

Added to this Heise, Ellsberg & Gottemoeller (1999) highlighted that in population-based studies worldwide, over 50 percent of women report violent assaults by an intimate partner. This physical assault is often coupled with reports of sexual coercion, at least one third to one half of the times.

3.6: The cultural influences on sexual behaviour in St. Vincent and the Grenadines

In the following section, consideration is given to the aspects of Caribbean culture generally, and of SVG culture in particular, that may have an impact on the vulnerability of women to contracting HIV. Specifically, the role of religious and moral views; poor communication about sex; shame and stigma; close-knit community and family structures; gender roles; and the Carnival culture, are considered.

3.6.1: Religious and moral views

The Caribbean culture, and even more specifically the Vincentian culture, on which this study is based, has deep religious roots in Christianity. According to the St. Vincent and the Grenadines Population and Housing Census (2001), 51% males and 42% females identified themselves as Christians and regular church goers in the country; alluding to the importance placed on ascribing to some spiritual identity.

Christianity stresses sexual abstinence outside of marriage; and some Christian denominations have stressed sexual abstinence as the way forward in the fight against HIV. The Catholic Church has also in the past proscribed the use of condoms (Chua-Eoan, 2010)

Although sexual abstinence outside marriage, if put into practice, would have a protective effect against HIV, evidence about whether the churches' recommendations actually have any direct influence on people's sexual behaviour is unclear. As in the rest of the Western world, there has been an increasing divergence in the Caribbean between what the churches preach and the practice and behaviour of members of those churches (Lewis et al., 1997).

In St.Vincent and the Grenadines, churches share similar views on the notion and primacy of original sin. Their belief about the authority of the Bible on permissible sexual activity follows from interpretations of scripture that articulate certain sexual practices and activity outside of marriage as being sinful, and as such, carries after life consequences. This belief seemingly forces many followers to adhere to a lifestyle of chastity in public, and a sexually liberated lifestyle in private. But with a lack of existing research data, it is unclear to what extent the teaching of some churches against the use of condoms, and abstinence, has influenced the behaviour of their followers.

On the negative side, the failure to live up to the sexual ideal of chastity that is held up as something to aspire to by traditional religious and moral views, may make women vulnerable to contracting HIV for the reasons discussed earlier in this chapter. For example, the social norm of virginity may mean that families and communities do not provide relevant information to young women about protecting themselves, and, because of the shame associated with extra-marital sex, it may be difficult for women to actively access such information (ICRW, 2001-2005).

Although maintaining one's virginity to the point of marriage is something understood as being ideal in most Caribbean societies, there is a lack of empirical evidence about the relevance and impact religious beliefs and teachings have on maintaining such an ideal in these societies. Plummer (2009), highlighted that a KAP gap existed in the Caribbean as it related to HIV-related Knowledge, attitudes and practice in six eastern Caribbean states, in which SVG was examined.

Plummer (2009) alluded to evidence suggesting that religion contributed to the intensifying HIV risks existing in the Caribbean. He noted that with many religious voices delivering different messages when it comes to sexual safety, some being more pragmatic than others, persons are torn between ideas of what is best to preserve their spiritual identity.

There is a definite deficiency existing as it relates to Caribbean focused research, on the social factors, such as religion, which impacts the choices of persons to have sex; risky sex which contributes to the spread of HIV and other STIs. This points again to the timeliness of this research paper in not only highlighting the gaps but expanding the limited research pool related to the societal factors linked to the spread of HIV/AIDS in the Caribbean.

3.6.2: Lack of communication about sex

Various pieces of qualitative research in several Caribbean countries have shown that there is a lack of communication about matters of sexuality, between parents and children and between sexual partners. In particular, discussions about the use of condoms are rare (Allen, 2000; Kempadoo & Dunn, 2001; Bombereau, 2003; Mc Bride et al., 2005; Hutchinson et al., 2007; Barrow, 2007). According to Allen (2002), reporting on a study conducted in Tobago, suggested that sex was not something you talk about; it just happened. As mentioned in the previous section, it is likely that there is a connection between the lack of communication about sex and the social valorization of virginity. Guilt and shame may dissuade younger adolescents from acknowledging that they are sexually active, (Holschneider & Williams, 2003).

It must be noted that there is not a specific piece of research on St.Vincent and the Grenadines as it relates to the lack of communication about sex, the researcher being

a Vincentian could attest to the taboo, which exists when speaking openly about sexual relations, from a lived experience.

3.6.3: Shame and stigma

The discrepancy between the cultural ideal of chastity and extra-marital sex, together with the taboo surrounding sex, may mean that extra-marital sex is associated with shame and stigma. Shame and stigma may also surround the perceived consequences of extra-marital sex, such as HIV.

The consequences of the stigma is expected to be the same as those described earlier in the chapter, which includes preventing persons from talking about sex publicly, buying condoms, getting tested for STDs and getting treatments when infected.

3.6.4: Close-knit family and community structures

Being close-knit suggests being held together by social and cultural ties. The Caribbean is known for its close-knitted family structures, which may be so because of the community oriented villages, and the dense geographical layout which allows for the interaction of families within each community. This allows then for the parents,

extended families, and the wider communities to have a strong influence and expectations on how people behave, including their sexual behaviour.

By contrast, European and North American cultures have become increasingly individualistic, and social and family groupings have become looser and exercise less control over the behaviour and decisions of the individual (Basu Zharku, 2011). This leaves the choice of relationships and sexual behaviour solely up to the discretion of the individual, which eliminates the extremity of family and community expectations.

Although it is understood that Caribbean families are more tensed in terms of their expectations of especially the females, there is not any empirical evidence about this issue and its impact on sexual behaviour. To this end, there is a need to explore its possible impact on women's likelihood of engaging in unsafe sex.

3.6.5: Gender roles

Earlier, some of the global evidence was reviewed about how gender roles make women more vulnerable to sexual infections. The cultural ideals of virginity and chastity for women mean that societies expect them not to be sexually active outside marriage; not to ask or inform themselves about sex; and to be sexually passive within the relationships they have. Consequently, for those who do engage in extra-marital

sex, the activity is associated with shame, secrecy and stigma – which makes them vulnerable to infection for the reasons discussed before.

The expectation of sexual passivity may also make it difficult for them to negotiate in sexual encounters, which may, in turn, make them vulnerable to infection (for example, it make it difficult for them to insist on condom use). The economic dependence on men experienced by women in many societies may also put them at risk. It may be difficult for them to leave sexual relationships that are putting them at risk, and sexual favours may be exchanged for financial rewards.

In the Caribbean, these gendered norms for acceptable sexual behaviour are strongly evident. In Caribbean societies, young men are being encouraged by social norms to have sex from an early age outside of marriage and long-term partnerships, but women are being encouraged to maintain their virginity and chastity. Is this an ideal and realistic situation for these women? The researcher assumes that it may be unlikely that many young women will maintain the ideal, and so the problems outlined above that can be associated with this social ideal are more likely to be apparent.

3.6.6: Carnival

The Carnival festival is not exclusive to the culture of St. Vincent and the Grenadines. But it was chosen as a focus for this research because it is a period of time

in which all inhibitions are released and persons exercise limited sound judgment as it relates to sexual activity.

St Vincent Carnival or Vinci Mas, as it is commonly called, began as far back as the 1890s and was celebrated the Tuesday before Ash Wednesday. This was a time to throw away inhibitions and "free-up" before the commencement of Lent. Carnival is the most important festival in St. Vincent and the Grenadines. It is characterised by music, beauty pageants, displays of arts and crafts, costumes, alcohol drinking, and non-stop partying; it is a time of unadulterated fun in the sun, which lasts for a period of ten days.

The carnival is known to be associated with an increased incidence of unprotected casual sex (International AIDS Alliance, 2008). The cultural scripts of carnival actively encourage the loosening of sexual restraint and the pursuit of sexual pleasures. This pursuit is encouraged by the costumes, by the music and dancing, and by alcohol. Costumes are worn that emphasise sexual body parts; public nudity and semi-nudity are commonly accepted. The lyrics of 'soca' and 'dancehall' music, popular during Carnival, also encourage the unrestrained pursuit of sexual pleasure.

To illustrate this, Table 2 contains the lyrics of two songs by a well- known, internationally renowned soca artiste from St. Vincent, Jamesy P. The second song

contains references to 'whining' and 'daggering', terms which refer both to the movement of the male body during sexual intercourse and to movements made during the erotic dancing frequently seen during the carnival. In a study conducted amongst children and adolescents in Jamaica, Crawford (*The Gleaner*, 2008) reported that 10% of the boys and 3% of the girls identified dancehall music as the main trigger for their first sexual experiences. Alcohol is also heavily consumed during the carnival period. As discussed earlier in this chapter, alcohol use is a likely factor for placing people at risk of engaging in unsafe sex.

Table 2: Typical Lyrics from Soca Music in the Local Dialect of SVG, with the English Translations

NOOKIE	*VAGINA*
'Tonite I deh pon the huntin	*Tonight I will be hunting*
All over town I am searchin	*All over town I am searching*
Somehow I mus take home something	*Somehow I must take home something*
Good Lord,	*Tonight I must take a virginity*
Tonite I mus pick a pumpkin	*I'm looking for some vagina tonight*
I looking some Nookie tonite	*I want some vagina tonight*
(Wussy, Wussy)	
I want me some Nookie tonite	
(Wussy, Wussy)'	
SOCA DAGGERING	*Soca Rough Sex*
'We nah pamper nor pet	*We will not pamper or pet*
We nah gamble nor bet	*We don't gamble or bet*
Any girl wey we find, we ah go wuk her to death	*Any girl we find, we will 'sex' her to death*
Nah fret, and you nah hear nuttin yet	*Don't fret, you haven't heard anything yet*
I am the baddest whiner that she ever met	*I am the best sexual performer she has ever met*
Bend she over, and whine up whine up	*I will bend her over and 'whine up' (suggestive of a sexual position)*
Slap the bumpa... (whine)	*Slap her bottom*
*Kill her with the **daggering.***	*Kill her with the 'rough sex'*

Chapter 4

Methodological Issues

4.1: Introduction

This research paper utilised a mixed methods approach, using both qualitative and quantitative methods of data collection. It also made use of two different qualitative methods, namely thematic analysis and interpretative phenomenological analysis (IPA).

4.2: Rationale for using mixed methods

It has been argued that a mixed method approach is valuable because it capitalises on the respective strengths of each approach (Johnson & Onwuegbuzie, 2004). Pairing quantitative and qualitative components can help to corroborate the findings of the different studies and generate more complete data. The results from one method can enhance insights attained with the other method.

Qualitative approaches are particularly useful for the investigation of complex social processes, such as the sexual behaviour and relationships investigated in this study, because their focus on individual cases provides a more manageable method for focusing on how a complex system operates (Malterud, 2001). By contrast, in order to

allow the investigation of complex systems, quantitative methods must either recruit very large samples, or focus on a more narrow aspect of the system.

In this investigation, qualitative methods were used to explore the participants' experiences, with the aim of gaining some insight into those processes and factors that might contribute to unsafe sexual behaviour. Quantitative methods were then used to obtain corroborative evidence to support some of these insights.

It is recognised that not everyone accepts mixed method approaches; this is because of philosophical differences between typical quantitative and qualitative methods (Creswell & Clark, 2007). The quantitative approach has typically been based on positivist assumptions - that there is an objective reality that can be discovered using methods that prioritise the objectivity of the data collection and analysis. By contrast, qualitative approaches are typically based on constructionist assumptions – that 'realities' are socially constructed, that there are multiple realities which have equal validity, and that these can only be understood by the study of what participants say about their subjective experience. As these underlying assumptions are incompatible, mixed method approaches are controversial (Creswell, 2009). However, the association between the methodology and the underlying assumptions is historical, rather than logical. It is possible to use one method holding the assumptions typically associated with the other method, for example, to use qualitative methods whilst assuming a more

positivist position. There are also other philosophical positions that represent a compromise between the two more traditional philosophical positions, and which are compatible with either methodology. For example, critical realism, according to Collier (1994), holds that there is an objective reality, but that it is impossible to study this in a wholly objective way and our methodologies, theories and explanations are always influenced by subjective factors.

It is appreciated, then, that using quantitative methods to corroborate findings from qualitative research is a controversial issue. However, it is noted by the researcher that there is no compelling reason why this cannot be done.

4.3: Thematic Analysis

The first study carried out by the researcher was exploratory in nature as the main aim was to identify some processes and factors within the Vincentian social context that placed women at risk of HIV. Because the scope of this study was therefore fairly broad and exploratory, thematic analysis was chosen as the appropriate qualitative method. Thematic analysis (Braun & Clarke, 2006) is a method for identifying, analyzing, and reporting themes within data. It allows for a less interpretative and more descriptive account of the data than some of the other qualitative approaches, and thus can be more appropriate for preliminary investigations of an area where the scope may be fairly broad (Braun & Clarke, 2006).

4.4: Interpretative Phenomenological Analysis

One of the themes that stood out clearly from the initial exploratory study was the role of long term relationships in increasing the vulnerability of women to HIV. This phenomenon was then investigated further using IPA. IPA was chosen for this subsequent study because it prioritises the detailed analysis of each individual participant, and it provides scope for an interpretation of the data (Smith et al 1997). It was considered that, compared to the first qualitative study, a more detailed and interpretative analysis would be important to capture the complexity of long term relationships.

IPA helped the researcher to make sense of the experiences of the women being studied. The researcher was interested in their perceptions of their realities within their relationships: How they made sense of issues such as trust, HIV, infidelity; and more so how they experienced events within their relationship. Using IPA, The researcher was able to understand 'what it was like' for these women being in their relationships; how they processed and perceived external societal pressures and how they rationalised their sexual safety with their partners.

Being concerned more with the quality and texture of experiences, IPA afforded a rich sense of information which was reflexive in nature; thus the researcher was able to make sense of the participant's effort to make sense of their worlds. The

phenomenological approach generates deep insights because the data reflects on the perceptions held of the participant's experiences.

Additionally, through the interpretative aspect of IPA, the researcher was able to understand the line of thought of the participants, as well as better appreciate the choice of language used to translate their message. It involved a great sense of empathy; the ability to 'walk in their shoes' and as such, fully grasp their story.

From the information garnered from the IPA analysis, the researcherwas able in the subsequent quantitative study, to test some of the ideas that arose, such as the possible relationship between the trust and value placed in relationships and tolerance of infidelity. The researcher recognised that IPA is not typically used as the basis for generating hypotheses for quantitative testing; but there was no compelling reason not to do this.

4.5: Justification for using Thematic Analysis and Interpretative Phenomenological Analysis:

The researcher opted to use thematic analysis and interpretative phenomenological analysis (IPA) instead of a discourse analysis because the researcher in the first instance wanted the themes to emerge from the data in an inductive manner, avoiding any form of personal imposition. The focus was not on naturally occurring

text and talk, as the study was not interested in the thread of language or understanding social interactions. The study was primarily geared towards collecting information that spoke about the direct lived experiences and feelings of women in St. Vincent and the Grenadines, as it related to their vulnerability to HIV.

Grounded theory on the other hand, which is a qualitative approach, with an emphasis on developing a theory of how variables are related to one another, may have been a quite useful or better approach for this research, rather than doing IPA, and a subsequent quantitative study; however, grounded theory typically requires large numbers of participants, which made it difficult. The researcher did not have the resources needed to conduct so many interviews and also, based on the sensitive nature of the research topic and the difficulty experienced in getting persons to participate openly in the thematic analysis on much broader topics; the researcher opted to use IPA which would require less participants, but still garnered deep and rich data.

CHAPTER 5

AN INVESTIGATION OF THE NON-COGNITIVE FACTORS THAT LEAD WOMEN TO ENGAGE IN RISKY SEXUAL BEHAVIOURS IN ST.VINCENT AND THE GRENADINES, WITH SPECIFIC FOCUS ON THE CARNIVAL FESTIVAL

5.1: Introduction

In Chapter 3, evidence gathered from societies around the world about the role of non-cognitive factors that may make women vulnerable to engaging in unsafe sex, were reviewed. In Chapter 4, the evidence gathered from Caribbean societies about some of these factors, we're reviewed and there was a discussion aboutdiscussed some other potential socio-cultural factors. Generally, there is was a lack of evidence about the role of non-cognitive factors in a Caribbean context. The overall rationale for the present research was to address this lack of evidence and to explore the role of socio-cultural factors in the particular context of St Vincent and the Grenadines. It is particularly important to explore the role of socio-cultural factors within each culture, because cultures differ, and it is not certain whether a factor that is relevant to one culture will necessarily have any impact on another.

This chapter describes some qualitative research conducted with young women in St. Vincent. It was a preliminary investigation covering a wide range of socio-cultural

factors. The intention of using this broad approach was to follow it up with studies that focused more narrowly on a few factors identified as particularly relevant within this first study. This first study looked at young womens' perceptions of the socio-cultural influences that might make them susceptible to having unprotected and casual sex. There was a particular focus on potential influences associated with the carnival, which were discussed in Chapter 4. The study also addressed the assumption of the health belief models that sexual behaviour results from a rational process of weighing up the reasons for and against the behaviour, and sought the views of the participants on whether this was the case or not.

5.2: Method

Difficulties with recruitment were anticipated for a qualitative study about unprotected sex, because sexuality is not openly discussed in SVG society and because of concerns about confidentiality in such a close-knit community. To improve the chances of recruitment, participants were recruited through a public education project, managed by the National AIDS Secretariat's office in the Ministry of Health and the Environment, which involved community workers across the island disseminating information about HIV and sexually transmitted infections. Also with the aim of maximizing recruitment, a fairly wide age range (18-35 years old) was targeted. According to the national HIV/AIDS report for SVG (St. Vincent and the Grenadines

HIV and AIDS National Strategic Plan, 2009); the 18-35 age group is considered to be the group most at risk of HIV infection.

The aim was to recruit between 5 and 10 participants. This is a relatively small number, but was consistent with the fact that the purpose of the study was to gather some initial ideas about the role of emotional, social and cultural factors, which would then be investigated in further detail in later studies, and the fact that the study was broadly phenomenological in its focus (i.e. it was primarily interested in the experience of the participants) and smaller numbers are considered appropriate for studies with such a focus (Smith, Flowers, and Osborn, (1997). In this event, 9 women were recruited.

The participants were drawn from various communities within St. Vincent and the Grenadines. The inclusion criteria were that they should be between the ages of 18 to 35; that they should have experience of sexual intercourse; and that they identified themselves as 'partygoers' who had taken part in the carnival. This criterion was of particular importance because they were considered to be the most likely target to have engaged in casual and unprotected sex during the carnival season. The interviews discussed specific instances in which the participants had unprotected and casual sex, exploring the participants' views of what led them to take part in this. The interviews covered social, lifestyle and cultural factors which focused on issues such as the participants' attitudes towards HIV/AIDS and their relationship with their partners,

friends and family. They also focused on the situation that led them to have unprotected sex (e.g. carnival in SVG).

The role of any rational decision-making processes, related to having safe or unsafe sex was also considered. The participants were also asked about instances in which they turned down an opportunity for casual sex, or insisted on condom use; the intent of this was to enable them to reflect on the reasons why on other occasions, they engaged in unprotected casual sex (i.e. what the difference was between the occasions when they had unsafe sex and those when they declined it).

To assist the researcher, a list of topics and possible questions was drawn up (Appendix 1). This was not used in a systematic way as an interview schedule; not every question was put to every participant, and not all questions put to participants appeared on the list. Rather, it was used as a memory aid for the interviewer to remind her about what general topics could be covered and what kind of questions might be used to encourage the participant to talk about the topic. It was anticipated that some participants might find it difficult to talk freely about sex because of the taboo surrounding it in SVG society, and so some more specific and open questions were included as a way of encouraging the participant to talk about these issues. It was hoped that this encouragement would then lead to more open conversation about the topics. Throughout, the researcher tried to encourage the participants to take the lead

in the conversation, and allowed them to take the conversation in the direction they wanted to.

5.3: Procedure

Prospective participants were identified and screened by the social worker of the National AIDS Secretariat, to determine if they were eligible and willing to volunteer for the study. The participants were identified from a list of persons that had an HIV test done at the Secretariat's office, within the last year. The Secretariat was chosen as an appropriate place to recruit persons; because of its central location, it was assumed that the persons seeking an HIV test would have been more willing to speak of any potential risk for HIV in their own lives. Once they agreed to participate, an appointment was arranged for the interviewee with the researcher.

A full explanation of the study was given by the social worker on the first contact with the participant, in the information leaflet and again when the participant turned up for the interview. A single question was used by the social worker and the interviewer to ensure that the participant understood what the study involved, (specifically: "Can you tell me what you will be asked to talk about in the interview?"). An informed consent form was completed by all participants. In this consent form, an outline of the research was given. Participants were asked to sign that they were willing

to take part in the study. (See Appendices 2 and 3 respectively for the participant information leaflet and informed consent form used in the study.).

Each interview lasted approximately 30-45minutes. After the interviews were completed, the researcher provided the participants with $10-15 Eastern Caribbean dollars, to cover their transportation cost to and from the interview site, as well as assisting with the costs of a small meal.

All methods and measures for the current study were reviewed and approved through the University of Birmingham's Ethical Review process (see Appendix 4 for approval letter from the Ethics Committee).

5.4: Participants' Description

The participants consisted of 10 women aged between 18 and 35 years. All of these women were self-reported partygoers (attended parties or carnivals fairly regularly). Five of the women were employed at the time of the interviews, whilst five were unemployed. Two of the participants were HIV infected. All of the participants had engaged in casual sex at some point, and were in a relationship at the time of the study.

5.5: Analytic Plan

The interviews were tape-recorded and then transcribed verbatim by the researcher. The responses are published exactly as they were stated by the participants in their local dialect, so as to capture the exact words of the participant. The local dialect is simply 'broken English'; which is English filled with slang words and idioms; it did not require translation or interpretation prior to the data analysis, because the researcher was also a native of St. Vincent and the Grenadines.

To ensure the accuracy of the transcription, the researcher asked the social worker, who was instrumental in the recruitment process of the participants, to also listen to the tapes and proofread the written transcripts to ensure that nothing was left out or misrepresented by the researcher. Additionally, each transcript was assigned a pseudonym by the social worker so that the researcher would have no be able to assign a face to the transcripts, hence eliminating any bias on the behalf of the researcher. To ensure confidentiality, each participant's name has been replaced by a pseudonym in the presentation of the findings.

The data were analysed using thematic analysis, as outlined by Braun and Clarke (2006). An overview was compiled that represented the participants' viewpoints about the factors that led to unprotected casual sex, and their views about whether unsafe sex was a result of a conscious decision-making process. Following the guidelines of Braun and Clarke (2006), five phases were undertaken. The first step requires the researcher to

become thoroughly familiar with the data. This involved repeatedly reading and re-reading the data in an active way, searching for meaning and patterns, and making notes of some initial ideas. The entire data set was read through several times in this way before beginning the coding process. The second step involved the generation of initial codes. At this stage, the researcher went through the transcripts, labelling the passages with codes (words used to describe what was said). As the researcher continued,through the transcripts, she checked and crosschecked the code labels to ensure that different labels were not duplicating the same idea.

In step three, the researcher refocused the analysis to look at formulating broader themes. She took all the different codes in each transcript and turned them into potential themes. Then, she took all the relevant coded extracts from across the transcripts within each identified theme. Following this, in step four, the researcher reviewed the themes, checking how well they fitted with the data and with other themes. A preliminary map of how the themes related to one another was drawn. Themes that seemed peripheral or less well supported by the data were removed. Finally, in the fifth step the themes were defined and named, and the thematic map was refined.

A number of steps were also taken to establish the credibility of the analysis. The information collected from the participants was summarised and presented to a

separate group of women identified at random from the Vincentian population by the researcher. This independent consultation group was chosen with the study's inclusion and exclusion criteria in mind, which were to be self-reported partygoers, sexually active and in a relationship at the time of the study. The women making up this group, unlike the sample group who were chosen from persons seeking an HIV test, were approached on the streets of the capital, at which point they were introduced to the study. Although this was a dubious method of recruitment, the researcher felt it provided a better opportunity to stir people's interest to take part. Once approached, the aims were discussed as well as their role as a member of the consultation group. Having agreed to be part of the group, they were told the time and venue to show up for the group consultation. Once having decided to take part, they were given an informed consent form to sign. It is likely that the women in the sample group and the consultation group differed, especially on issues of risk of HIV.

The main focus of the consultation was to gain feedback on the themes coming out of the research data and to ascertain whether the information from the participants was generally agreed upon or whether there are other issues to be considered. Considerable care was taken to ensure that no individuals were identified from this presentation, and consequently no direct quotations were used in the presentation.

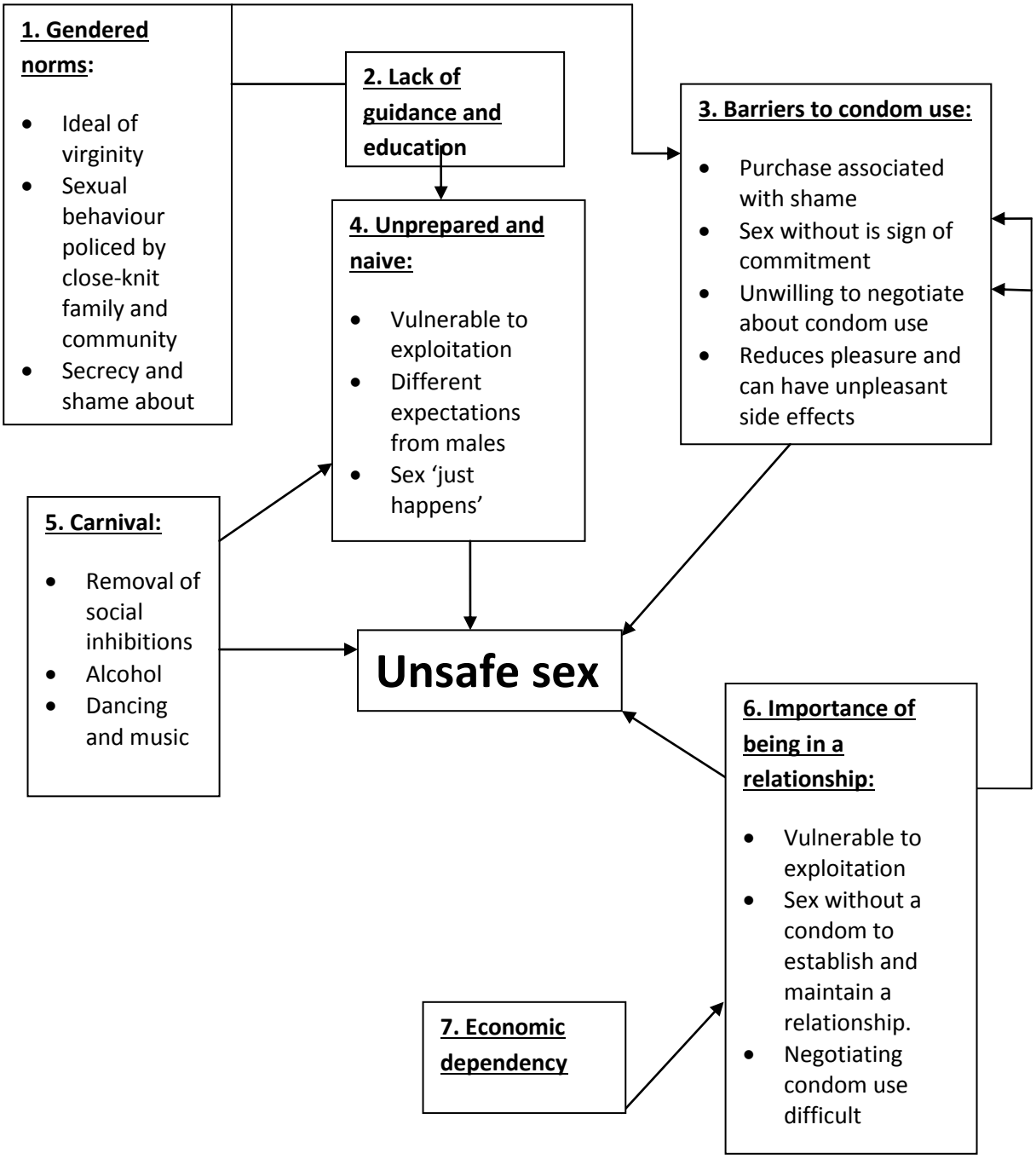
The consultation group was invited to the National AIDS secretariat's office for a meeting. They were asked to say the reason why they were there; a similar question to what was asked of the sample group. They were then asked the questions used in the interview with the sample participants and were told to write their responses on paper given by the researcher. Following this, the participants of this consultation group were shown the responses of the participants, as well as the themes that came out of the analysis from the participants. The process of obtaining the data from the consultant group and comparing the two sets of data was informal and less systematic.

When the comparisons were made between the data from the participants and the responses of the consultation group, agreement was reached on most of the information collected from the participants. It was noted that the differences existed on matters relating to what they were taught about sex as a young girl growing up. Most of the people in the consultation group were socialised differently and were not afraid to talk about sex in their households. In other respects, however, they were able to relate to the responses given by the participants.

Additionally, steps to enhance the credibility of the analysis were taken through supervision. The supervisor independently read all the transcripts, and then was involved in reviewing the themes; checking to see how well the data fitted with other themes and also working along with the researcher to review themes and consider how

the themes related to one another. Also, in the presentation of the results, care was taken to ensure that each point was supported by direct quotations from the participants.

Fig 4: A diagram showing a list of themes, gathered from the thematic analysis done on the data.



Before presenting the findings in great detail, a summary will be given of all the themes found in the data and seen in the model above in Figure 4.

5.6: Summary and linkages of themes

The data highlighted several emotional, social and cultural influences on unsafe sex. An important cultural influence is the **gendered norms** of Vincentian society. This is a close-knit family-centered community that polices the sexual behaviour of young women, promotes an ideal of women remaining virgins until they are married, and creates an atmosphere of secrecy and shame about sex.

Due to these cultural norms, there is a **lack of guidance and education** as it relates to safe and healthy sexual practices. Parents, schools and the wider society do not engage in open discussions about sex, nor offer clear guidance about how to practice safer sex. This has contributed to some women displaying a **level of unpreparedness and naivety,** as it relates to sex. Because of this, younger women are more vulnerable to sexual exploitation by older men who grooming them with gifts and talk of love before taking sexual advantage of them, and then discarding them. Naivety was also evident in relationships with male peers. Some participants found themselves, without expecting it, in situations with males where the male expected sex to occur. The lack of preparedness and naivety was also evident in the description of some of the participants of how sex 'just happened' without any prior planning or forethought.

Another important influence was **the importance placed on being in a relationship.** Participants would risk having unprotected sex with their partners because it was seen as a way of establishing and maintaining a relationship. This desire to be in a loving relationship is also likely to have contributed to the vulnerability of younger women to sexual exploitation by older men. The participants also reported an unwillingness to negotiate condom use within their relationships because the relationship was so important to them and they did not want to threaten it by upsetting their partners with talk of condom use. .To some extent, the importance the participants placed on their relationship was due to their **economic dependency** on their partner.

The gendered norms and the value placed on being in a relationship also created **barriers to condom use.** Participants alluded to the shame that comes from attempting to purchase condoms because of the culture of secrecy and shame surrounding sex. They also reported that sex without a condom was a means of establishing and maintaining a relationship, signaling to the man their love and commitment. Trying to negotiate about condom use within the relationship was seen as a threat to the relationship. Thus the importance placed on the relationship may mean that women are willing to override concerns about HIV in order to establish and maintain their relationships. Some participants also highlighted their unwillingness to use condoms

because of unpleasant side effects and a reduction in the pleasure of the sexual act in itself.

Another important element that came out of the thematic analysis was the impact of the carnival. During this period there is the removal of social inhibitions. Young people are given more freedom to behave without being policed by their parents or wider community. Amongst the partygoers, there is an understanding that sex is part of the carnival experience. This is emphasised by the sexually explicit music, dress code and dancing. The consumption of alcoholic beverages increases the likelihood of unsafe sex, as judgment is impaired.

5.7: Results

5.7.1. Gendered norms

5.7.1.1: Ideal of virginity

Participants noted that as females they are expected to maintain their virginity up to the point of marriage, or, for others, until they are in a committed relationship (which is a commonly regarded as a common-law marriage in the eyes of society). All participants reported that it was either directly communicated or just simply understood that a 'good' girl won't 'sleep around'.

> Indra: "Growing up I was thought to remain a virgin until marriage. You know you are not to associate yourself with too many men, cause

there was a stigma, which made you appear to be promiscuous, so basically growing up, it was just not to put yourself in situations, where sex would come into play, boyfriends were a NO NO!! So it was basically keep yourself pure until marriage. There is just one person for you."

Sushila: "Well my mother would have told me to have sex at a right age, don't go out there and look for nobody to love me because she and my daddy can love me the same way. There are a lot of other things I can be doing, I can be enjoying myself the same way, cause sex aint everything, it aint as good…. Or it aint going to run sparkles in your head or anything, it just a onetime thing and ***after*** that you aint special no more. Cause after your virginity gone, you aint special."

5.7.1.2: Sexual behaviour policed by parents and the community

It was noted in Chapter 3 that SVG retains a close-knit social organization, with families and the wider community exercising a strong influence on a person's behaviour. It was evident from the interviews that families and the wider community were active in policing the sexual behaviour of young women to ensure that they conform to the ideal of virginity.

I: What would be your mom's reaction if she found out you had casual sex, and it was unprotected?

Arifa: Well I know she will be shocked, furious, angry…She will be caught with so many emotions that day….I don't know exactly what she will say to me, but I know that if I am still in school at the moment she finds out, she might stop educating me or she might look to throw me out of the house, because she told me before that she isn't going to send any children to school and she know that she is spending her money and they are out there having sex…

I: "Does it really matter to you what your parents think about your sexual life?

Indra: Not really... probably my mother. I think it really does play a part. Yes it matters, they are my parents, and I seek their approval no matter how old I get so...."

Arifa:

(I: "Do you feel that the fear of your mom finding out that you are sexually active, that it places you in a position to have risky sex as you

are not willing to go and get a condom… you are solely dependent on your partner?)

"Well I would say so, I did try already to buy condoms in my uniform and there was a lady there, she don't know me and I don't know her, but she was like, oh why should you be buying a condom, school children are not suppose to be having sex… so since that I never tried again. I was ashamed and scared because I found her very inquisitive."

Agnes:

(I: "Do you feel that the fear of your mom finding out that you are sexually active, that it places you in a position to have risky sex as you are not willing to go and get a condom… you are solely dependent on your partner?)

"Well to go into a store and buy condoms, once I am not wearing my school clothes I am not afraid; but to go by the health centre I would be afraid because my mom doesn't know that I am sexually active as yet, and people within the area or the nurse can tell her, so I don't think it will be confidential around there."

5.7.2: Fear, secrecy and shame about sex

The strong presence of the virgin ideal, policed by the family and wider community, meant that sex before marriage (or outside a long term relationship) is associated with fear, secrecy and shame. The fear was not about engaging in the sexual act itself, but was rather attached to the likely consequences they would experience, from significant family members, if their sexual life is revealed.

> I: Does it matter to you how your mom feels about this?
>
> Arifa': Yea…I don't want to …or I wouldn't like to see the wrong side of her, so I prefer to keep it in, if she brings up the topic, when I was a virgin I would answer straight away… but now most of the times, when she ask me the question I sort of give an attitude towards the question, I would be like why are you asking me this and things like that …and then I might *stupes my teeth* [sign of irritation]…and she might think well I just don't want her to question me, so she will just leave it at that.
>
> I did try already to buy condoms in my uniform and there was a lady there, she don't know me and I don't know her, but she was like, oh why should you be buying a condom, school children are not suppose

to be having sex… so since that I never tried again. I was ashamed and scared because I found her very inquisitive."

I: What if a woman wanted to buy condoms, do you think it would be accepted?

Shennica: Maybe it will, but I for one not going to do that. Why? Because I will be ashamed, I would rather do without the sex, than have to go and buy.

I: Is this because you feel that people are judging you?

Shennica: Well yes, some of them do that, and Vincentians are so weird sometimes, if they see you have condoms, they will start to whisper that you going to have sex.

5.7.3: Lack of guidance and education

Most participants also highlighted that their education about sex was that of a scare tactic, where the adult figures in their lives highlighted the terrible consequences of sex before marriage; and there was little or no discussion of sex and no attempt to prepare them for the possibility of having sex before marriage.

I: "As a young lady what are some of the things taught?

Suzy: "If you go and have sex it will kill you. You are not suppose to have sex...I think a lot of the mothers still don't have the knowhow in terms of how to talk to their daughters about sex....in terms of what is expected if you find yourself in certain situations etc."

Interpretation of Data (5.7.1.1; 5.7.1.2; 5.7.2; 5.7.3):

The four prior listed sub-themes ('ideal of virginity', 'sexual behaviour policed by parents and community,' 'fear, secrecy and shame about sex,' and 'lack of guidance and education') all have some overlapping features and, as such, a comprehensive interpretation of the data will be provided for all four at once.

A strong self image is valued very highly within small Caribbean countries like St.Vincent and the Grenadines; which is a country known for high moral values, principles and religiosity (CAREC, 2007). Women are expected to remain chaste, as their virginity at marriage often has high social value. Social pressures encourage young women not to engage in sex before marriage but those that do are expected to do so in the confines of 'serious' and 'trusting' relationships. Sex outside marriage or long-term relationships is associated with secrecy, fear and shame for the participants. A lack of communication and education about sex can leave young girls and women feeling unprepared for dealing with it.

These findings echo the research reviewed in Chapters 3 about the problems caused by the gendered norms that expect virginity and chastity from young women in a society (ICRW, 2001-2005). These norms restrict their ability to access information about protecting their sexual health, and behaviour that protects them (e.g. purchasing condoms) becomes shameful and stigmatizing (Bassett & Mhloyi, 1991; de Bruyn, 1992; Hillier et al., 1998; Leary, 1995; Taylor, 1995; Weiss et al., 1996).

These quotes given by the participants made clear the link in the participant's mind between the virgin ideal, parental policing of that ideal, and the consequences of fear and lack of communication and guidance: Young women are not supposed to have sex, and their mothers instil fear in them to prevent it from happening. Additionally, it is evident there is a lack of confidentiality within the community health care system, making it a challenge for young ladies to safeguard themselves if they are having sex.

The fear of being perceived in a negative light by parents and the wider community contributed highly to the unwillingness of young ladies to access condoms from public places such as clinics or pharmacies, as they expect to be judged as being immoral or possibly promiscuous. Confidentiality in a small country where most persons know or are familiar with each other also proved to be a major issue.

Also, it appeared that young Vincentian women are at a disadvantage; based on their socialization in how prepared they are for the responsibility of sexual initiation and safety. This is evident in their inability to negotiate sexual safety; protecting themselves from illnesses such as HIV as well as protecting themselves emotionally from issues such as infidelity within their relationships.

5.7.4: Unprepared and naive

Possibly as a direct result of how these women were socialised about sex and the apparent lack of communication about matters relating to sex, most of these women appear to be unprepared for their first sexual encounter, and many described situations where sex was totally unplanned for on their side, but rather it just happened.

> I: Are you a person that would think a lot about your actions before you do them?
> Arifa: Well not really… I would act on the spur of the moment depending on who I am with at the time…
> I: As it relates to you having sex, do you think a lot about it or do you act on the spur of the moment?
> Arifa: I don't think about anything when it comes to that, I just go with the flow.

I: Since you have started having sex, would you have made any impulsive decisions to have sex?

Indra: Probably the first time I had casual sex. It was, you are at a club, you are having fun and then it came down to lets have sex... and without thinking, you go along with it.

Another consequence of the lack of guidance and preparation was an apparent naivety on the part of many of the participants, particularly the younger ones, about sexual matters.

I: Can you describe the situation in which you were that led to your first sexual encounter?

Sushila: Well he was older than me and I use to see him come around. I had like him but never really take him on, but then as I get older, I started to get to like him more, I want to see him every minute, want talk to him, I did want him to be mine and mine alone… He use to treat me like I was the only girl around, then as soon as we don't have sex, its like I ain't nothing…he use to treat me like I'm gold, then after he done have sex with me, he treat me like garbage…

I: How did that make you feel about yourself?

> Sushila: Well bad because after I did it, is like we did it twice, then it was just like he lose the feeling, he stop talk to me, he stop call me…and I use to cry a lot, cause I know I didn't do him anything wrong, I wanted to be with him alone, but it seems like he wanted someone else and he don't want me…

> Sushila: "Well I was looking for love, I didn't know exactly what love was, and I felt if somebody tell you that they love well then they love you… I didn't know that they only use the love talk to get sex…I thought that if they really care about you, they will say they love you and treat you the best way they could."

One area of naivety highlighted by a participant concerned the meaning and interpretation of behaviours and signals preparatory to a possible sexual encounter. One participant maintains that many open the door to sex either without realizing it, or because they assume they are in control of the situation, however, this is then proven to be incorrect.

> Suzy: "I think a lot of people pretend to be naive, they say "oh I don't want to have sex, I am not going to do this" - but even then we take the situation into the precarious moment where we go out, the person can drop you by your door, and you say goodnight, sometimes you see the intent but you take a bit further and you say you can come in

for a moment, and then you are in a situation, it is almost as if you given the right away...when you tell that person to come up, that is where you cross the bridge .... Some of us want to believe that even though he comes up, nothing is going to happen... I'm in total control but a lot of the time we are totally naive..."

I: Do you think that there is a difficulty in identifying when the bridge is being crossed?

Suzy: "I think you know when it is being crossed...you just think that you have control over the situation when you really don't...."

Interpretation of Data:

The descriptions of their unsafe sexual encounters given by the participants are at odds with the cognitive models of health behaviour that assume a conscious weighing up of the advantages and disadvantages of particular courses of action before a decision is made. The sexual encounter 'just happened' without much forethought or planning. This is consistent with critics of the limitations of these models who point out that most behaviour is not the product of a reasoning process (Bloor, 1995; Rhodes, 1995; Bastard & Cardia-Voneche, 1997) and that sexual behaviour in particular can be strongly influenced by emotional and social factors at the expense of good sense (Ingham & Van Zessen, 1997; Kippax & Crawford, 1993; Flowers et al. 2002).

Evidence about the sexual naivety of some of the participants should be considered in the context of some evidence suggesting that men and women generally differ in their interpretations of each other's nonverbal communicative behaviours. It has been suggested that adolescent females interpret nonverbal communicative behaviours (including clothing, posture, gaze, and so on) in a "less sexualised way" than do males (Zellman, Johnson, Giarrusso, & Goodchilds, 1979). Over three decades later, the research still suggests the same, as seen in work done by Jozkowski (2013), who states that the use of nonverbal cues to interpret consent to sexual intercourse could lead to miscommunication and, in some cases, could result in unwanted sexual advances and sexual assault. She found significant differences in how men and women communicated their consent to intercourse, with women using more verbal strategies and men using more non-verbal strategies. She found men also relied more on non-verbal indicators when interpreting their partner's consent and non-consent than women did.

In this present study also, it seems likely that because culturally there is a silence, lack of guidance and preparation as it relates to sex, the participants would have relatively little understanding of sexual matters. This may have been a major contributor to their sexual naivety, resulting in the stated experiences, that their sexual encounters often 'just happened'.

It should be acknowledged that it is not clear how accurate these reports are about thought processes that occurred at the time of the sexual encounter. They may have been distorted by memory inaccuracies or biases; or by an urge to provide a more acceptable explanation of what seemed, with hindsight, to be unacceptable behaviour that cast the participant in a more favorable light.

5.7.5: Carnival

Participants endorsed the idea that the carnival was a time for increased sexual activity. The carnival is viewed as a time when the normal social restrictions on behaviour, particularly sexual behaviour, are lifted and young people are given more freedom to behave without being policed by their parents and the wider community.

Roselle:

I: (Taking into consideration the whole carnival experience, what do you think accounts for the high rate of sexual activity during Carnival?)

"I think mostly it is the freedom. Some girls know that their mothers would not expect them to be at home, at a certain hour and they

would take the chance to just go and do what they wanted to do being out late."

Shennica:

I: (Taking into consideration the whole carnival experience, what do you think accounts for the high rate of sexual activity during carnival?)

"Yes, definitely, some of these young girls have no shame, they want to do it right there. This is what happens: when you jumping in a band, and dancing with a guy, he will have his hand all over you, feeling up their breast, and then because they have the alcohol, they allow them to do anything, and it leads to sex, because they have the alcohol and they want to sweat it out. Carnival is just the time when they get down to business, it is about who can behave the worse."

One of the major features of carnival is the excessive drinking of the patrons, male and female alike. All but one person pointed out that, at a party, they need the alcohol to loosen up and get in the groove of things. The alcohol was viewed as a way of releasing the inhibitions on behaviour, allowing the person to behave without thought and without restraint.

Sushila:

(I: Do you understand what alcohol does to the human body in terms of impairing judgment?)

"Well is like it give you this feeling to like be free… or do anything and don't care… When you drunk you talk out everything and anything some time you do things and then the next day I can't remember nothing I did…so is like somebody have to tell me. So is like it does confuse your mind and let you be free."

Arifa:

I: (Do you understand what alcohol does to the human body in terms of impairing judgment?)

"Well when you under the influence of alcohol, I think that it controls your body, mind everything, you are not sober, you are not focus, so you don't know what you are doing. It is just carefree, you just do it and you are not conscious of what you are doing, so it just happens…."

Being drunk was also seen as making women more vulnerable to the sexual advances of predatory males.

Shennica: "People take advantage of you, when you are intoxicated and have no ride to get home from a party"

Sushila: "Yea, especially if it is like a far away party like country...Georgetown, and you aint have a ride to come town, most likely you go scrunt [beg] at ride to come town…now if you stop a vehicle and is a guy driving, and you are intoxicated he might try certain things with you and force you to have sex with him, you might be fighting back for yourself, but you done freak out. He could do you things and drop you places, and when you catch yourself you wondering what you doing here or what happen to you."

These quotations also highlight a problem about public transport during the Carnival period. Most of the shows and parties end very late at night, long after the bus services have stopped. It was evident in the data collected that many women find themselves in very vulnerable positions as they try to acquire transportation to get home, being reliant on men to give them lifts home. In some cases, they were either forced or influenced to have sex, in order to obtain a ride home.

The music and dancing, in combination with alcohol, was another factor

highlighted as a reason for sexual activity.

Arifa:

(I: What is it about the music or the dance that may encourage you to have sex?)

"Well under the influence of alcohol, you partying and listening to this kind of music, it is like you have to go with the rhythm… they start being involved in vulgar activities with the dancing and…Well the dancing and the rubbing up is going to increase heat, pressure everything, something is going to rise/move so you start thinking within your mind, and then one thing leads to another."

Shennica:

(I: What is it about the music or the dance that may encourage you to have sex?)

"Yes, definitely, some of these young girls have no shame, they want to do it right there. This is what happens: when you jumping in a band, and dancing with a guy, he will have his hand all over you, feeling up their breast, and then because they have the alcohol, they

allow them to do anything, and it leads to sex, because they have the alcohol."

Paradoxically, though it is understood that carnival is the time to let loose of all inhibitions, a time in which it is understood that persons are going to have sex, the respondents noted that it is during this time that the scrutiny intensifies for women in particular when they try to access condoms. The season advertises fun at any cost, but there is still rigidity in terms of the ability of women to access condoms to be safe during the carnival period.

Indra:

(I: You said earlier that you were brought up in a strict Christian home, and even as it relates to condoms, that you wouldn't go to buy condoms as it causes you to be judged in the eyes of society, that she is having sex... during carnival do you think it is easier for people to access condoms?)

"Actually I think it is a time when people are looked at even harder, because now know it is the carnival season and they are looking like hawks to see who all comes to buy condoms, I think people access condoms if they want condoms, but people look at you even harder."

Interpretation of Data:

There is a paradox existing with the whole idea of carnival in that, it is a period of time in which people are expected to 'let go' and have fun but there is a major rigidity in terms of the ability of people to access condoms to be sexually safe during the carnival period.

The carnival is known to be associated with an increased incidence of unprotected casual sex (International AIDS Alliance, 2008). The accounts of the participants provide some of the reasons why this is the case – specifically, the lifting of normal social restraints on sexual behaviour, alcohol, the music and dancing, and, unexpectedly, the limitations of the public transport system. The link between alcohol and unsafe sex was discussed in Chapter 3. Most of the mechanisms suggested for the link are set within the framework of the cognitive models of health behaviour and are about the effects that alcohol has on judgment and decision-making (e.g. Halpern-Felsher, 1996). The present data suggests that the link also needs to be considered in terms of how alcohol interacts with social and other external factors – for example, one of the quotations suggests that alcohol interacted with the music to make sex more likely; and others suggested that alcohol made women vulnerable because it was interpreted by men as a sign that they were 'fair game'.

5.7.6: Relationships:

The sexual health of some of the participants appeared at times to be put at risk by their desire to be loved and in a relationship with a man. This happened in a number of ways. First, the desire for love (particularly in combination with the naivety described earlier) made some participants vulnerable to predatory men who used the language of love to obtain sex before moving on to other women (and who are therefore likely to have been high risk partners because of having multiple partners).

Sushila:

"Well I was looking for love, I didn't know exactly what love was, and I felt if somebody tell you that they love well then they love you… I didn't know that they only use the love talk to get sex…I thought that if they really care about you, they will say they love you and treat you the best way they could but then not everything is the same, I always getting throw away by love, I feel that if somebody tell me they love me. They actually mean it and that they want to spend the rest of their life with me, but then they have sex with you, and then they play hide and seek with you for woman, and when they done have sex with you, they say let me stop and cuss you off, and tell you things that you don't really like and you know just how they stand…but man always come in different ways to tell you them love you so you always end up and fall for it even though"

Sushila:

(I: "Can you describe the situation in which you were that lead to your first sexual encounter?)

"Well he was older than me and I use to see him come around. I had like him but never really take him on, but then as I get older, I started to get to like him more, I want to see him every minute, want talk to him, I did want him to be mine and mine alone… He use to treat me like I was the only girl around, then as soon as we done have sex, its like I ain't nothing…he use to treat me like I'm gold, then after he done have sex with me, he treat me like garbage…"

Another way in which the desire to be in a relationship potentially compromises the woman's sexual health is that sex without a condom is seen as a way of moving the relationship to the next level, and establishing it as a long-term relationship:

Suzy:

"For some guys having unprotected sex shows your level of commitment to the relationship and some women feel obliged to express that love. Once you are having sex all the time with a person, you relax your inhibitions, and you start thinking that you trust this person enough to remove the condoms from the equation."

Even within the context of more casual relationships between women and men, sexual intercourse was viewed by some participants as a way of turning the relationship into something more fulfilling and meaningful:

Suzy:

"What would you say then was the underlying factor that pushed you towards having casual sex? I guess that I was seeking some sort of connection, I would also say that I don't have full control of my urges, and the know how that I don't need to always give into them, because once there is a likely candidate I would give in, that is why I guess sometimes it is about companionship... any type of relationship whether it is steady or not, when you with somebody even on a superficial level, you develop that expectation after for sex."

In terms of negotiating condom use within a relationship, the participants reflected on several reasons why this might not happen. First, it was felt that those who were economically dependent on their partners had little choice but to go along with what the man wanted.

Indra:

"Yea, I think it is difficult for most persons who are not exactly uneducated but are from the lower socio-economic strata... because they may need the man to help them in the home and so there is no way she can say to him you have to use a condom, cause in his mind if she is his woman then she should do what he wants, as he is maintaining the house. But when you think of more educated women I'm not sure if it such an issue."

(I: Generally, in your mind how easy do you think it is for women to negotiate safe sex with their partners?)

Indra:

"... the ladies in the lower socio-economic strata, they truly have no other choice, in their minds, they are struggling financially, and if they are with a partner that is willing to take care of them, and their children"

One participant suggested that women's behaviour in this respect is driven primarily by their feelings for the man, often at the expense of being sensible:

Indra:

(I: Generally, in your mind how easy do you think it is for women to negotiate safe sex with their partners?)

"I really don't think it is easy, especially for those ...because, I have found that women of all ages are very emotional and they tend to link their sexual practices to how they feel about their particular partners, so even though they may want to say, I'm not comfortable not using a condom, they are still not going to use it, because they figure, they feel this way about this person, I feel that I trust him, even though when the look at their situation, they know their partner cannot be totally trusted, it is just about pleasing their partners..."

For those within a relationship, some felt that they had to comply with the man's wishes as it related to sex in an effort to ensure he doesn't leave the relationship. This links in with the great importance of the relationship to many women, which was described earlier.

Shennica:

(I: On a general scale, do you think women in SVG are able to negotiate condom use with their partners?)

"No. Why? Because some of them so into the man, that they will do anything, so as not to lose the man."

(I: What will happen in a situation, if he decides he wants to have unprotected sex, will you?)

"Well I would think about a minute or two then I think I will just go with it, because I think I will be influenced by his decision to not use condoms.

Interpretation of Data:

Relationships are very important. It is a basic human instinct to connect with another human being. Research on the benefits of relationships has shown that they are of paramount importance in that couples in stable long lasting relationships are most times healthier and happier and have more longevity than persons who are single and not in a committed relationship.

Due to the importance of relationships, it was observed that the participants in this study appeared willing to run risks with their own health by having sex without a condom in order to establish or maintain a relationship. It is evident that the quest for love brings into consideration, a discussion of how these women viewed themselves in relation to their partners and within their relationships.

Foreman (2003) cited the work of Cummings, Battle, Barker, and Krasnovsky (1999), where, after interviewing 142 African American women, they found that sexual

risk-taking was associated with a variety of factors; such as being a major source of self-validation and esteem for women, as well as assisting women in maintaining their beliefs that their partners are faithful. Could the same be said for the women in this study? Is it that they placed more value on their relationships and partners than they did their own lives?

A discussion of the literature relating to the role of relationships in increasing women's vulnerability to infection will be taken up at greater length in the next chapter. However, here it is important to briefly take note of (gendered) relationship characteristics such as love, trust and economic dependence, which influences the vulnerability of these women towards engaging in unsafe sex.

Gender roles and norms have an indelible impact on heterosexual relationship dynamic. Gender inequity and differential power relations, according to O'Leary (2000) play a role in the lack of condom use within steady relationships. In most instances women give over their right as it relates to the decision to practice safe sex, to their partners. The theory of gender and power has looked at the norms governing social and sexual relations and was found to be a useful heuristic in understanding non-condom use (Wingwood & DiClemente, 1995). It is suggested that the lack of condom use in relationships is coerced by socio-economic constraints, power differences in the relationship and socialised gendered cultural norms.

Added to this, there is evidence showing that women are less likely to practice safe sex within the context of steady relationships as opposed to casual partnerships. This is owing to the perception that the insistence of using condoms in a steady relationship, introduces mistrust and the threat of infidelity. Sobo (1995), explained, "because of the trust and closeness that it connotes, unsafe sex signals the perfect union."

5.7.7: Barriers to condom use:

Previously, it has been revealed that there are several major barriers to women using condoms. Accessing condoms posed problems to some of the women in the study, as there exists some level of social stigma associated with women acquiring and carrying condoms, within the Vincentian society. It was also stated by some participants that sex without a condom is a way of expressing commitment to a relationship and turning it into a long-term relationship, which many of the participants were so keen to achieve. The desire to establish and maintain a relationship (which was a necessity for those women who were economically dependent on their partners) also meant that participants were generally unwilling to negotiate about condom use and simply went along with what the man wanted. Some participants even appeared not to see this aspect of the relationship as their responsibility:

Shennica: I think it is the guy's job to get the condoms.

Some further barriers to condom use were apparent from the interviews. Condoms were perceived to reduce the pleasure from sex, and to be associated with unpleasant side effects:

I: Do you think sex is better with or without condoms?

Suzy: “Definitely without; “

I: why is that?

Suzy: “With me personally when I have sex, depending on the type of condoms, they tend to dry out easily and it makes the sex uncomfortable, so I think if it is with somebody that I am possibly not in a relationship but may be having sex regularly for a , then I would take the risk of having unprotected sex.”

I: “Do you think sex is better with or without condoms?

Paula: “For me it is without...condoms takes away from it...I only buy two types of condoms: bareback and roughrider, they are more lubricated than the others. I think it is better without condoms, but I won’t risk having unprotected sex with someone I don’t know.”

I: Do you think sex is better with or without condoms?

Roselle: “Without;

I: why?

Roselle: “Because the condom gets in the way of the whole feeling…”

I: “Do you think sex is better with or without condoms?

Indra: “Without.”

I: Is that part of the reason why you decided to have unprotected sex?

Indra: “No, at that time I was having some medical problems, and at first I wanted to see what was contributing to it, so that was just the choice then to try without it, but then in the end it just continued that way.”

I: Do you think sex is better with or without a condom?

Shennica: “For me without….

I: Why is that?

Shennica: “When I use the condoms I get some rash, I don’t know if it is an allergic reaction but around the area, I get bruised and so...”

I: “Why don’t you use condoms all the time?

Agnes: “Sometimes the scent makes me nauseous, and it rubs hard at times…”

Interpretation of Data:

The responses gained in this study were also supported in other studies. Studies done by (Maman et al., 2000; Jewkes et al., 2003) have likewise found that suggesting condom use can introduce distrust into relationships or will signify that the relationship is not a serious one. Others too have reported the stigma attached to the purchase of condoms by women (Joseph, 1999; Jewkes et al., 2003). Young girls felt that having or seeking a condom indicated to society that they were sexually active, and this consequently caused them to avoid the use of condoms for fear of appearing too experienced. For older females, seeking, discussing and/or negotiating condoms were regarded as signs of promiscuity. These studies also mention the barriers to condom purchase and use posed by the lack of confidentiality among health care workers (Joseph, 1999; Allen, 2000) and the perception that purchasing condoms is a male's responsibility (Allen, 2002).

Another profound reason why persons are reluctant to use condoms during sex is accounted for by the perception that it subtracts from the sexual pleasure normally experienced, more so by men during sex. According to Grady et al. (1999, p.10) "the issue of perceived sexual pleasure is central to the use of condoms regardless of whether the purpose of use is to protect against STIs, prevent conception, or both." It was further been reported by Skidmore & Hayter (2000), Flood (2003), Crosby et al. (2005), that males placed greater value than women on sexual pleasure, with men asserting that condom use interferes with sexual pleasure and intimacy. To this end,

men display much greater resistance to condom use on the basis of the pleasure principle as seen in de Visser (2004).

5.7: Conclusion

In this study, we investigated the socio-cultural factors that influence Vincentian women to engage in risky sexual behaviour. The data suggested the importance of gendered norms and the ideal of virginity. This was enforced by mothers and the wider community, and failure to live up to this ideal (i.e. sex outside marriage or a long-term relationship) was associated with shame and secrecy. The assumption that young girls should not have sex also contributed to a lack of communication and education about sex. This, in turn, led to young women being unprepared and naive, and liable to exploitation by predatory men or to ending up unwittingly in situations where the males expected sex. The carnival was viewed as a time when unsafe sex was more likely to happen – because of the removal of social constraints on sexual behaviour, alcohol, music and dancing, and transport problems. Wanting to be loved and in a long-term relationship was another factor. This led some to them to be exploited by predatory men who used the language of love to obtain sex. Sex without a condom was seen as a way of moving a relationship to the next level, and establishing it as a long-term relationship. Negotiating condom use within a relationship was uncommon. Those who were economically dependent on their partner were obliged to go along with what the man wanted. The importance of establishing or maintaining the

relationship also meant that some women were unwilling to go against the man's wishes or to threaten the relationship by raising the issue of condom use.

Another aim of this study was to investigate the extent to which participants engaged in the process of rational consideration about the advantages and disadvantages of different courses of action assumed by the cognitive models of health behaviour. Amongst the participants, there was little evidence of this. When asked directly about why they engaged in unsafe sex, many participants felt that sex 'just happened'. For example, Arifa stated "I don't think about anything when it comes to that (sex), I just go with the flow." There was no evidence here that Arifa engaged in some process of consciously deliberating about the options in the situation itself.

This was felt to be particularly true in the carnival, where sex was seen as almost the natural consequence of the removal of behavioural inhibitions, the alcohol, music and the dancing. One participant felt that rational considerations about sexual health were often overridden by the woman's emotional response to the man and her desire to please him. These data are consistent with the criticisms of the cognitive models' approach to sexual health, and the calls for sexual behaviour to be understood within a broader framework that considers emotional, interpersonal and situational variables (Campbell, 1997; Campbell & Williams, 1998; Ingham & Van Zessen, 1997; Kippax & Crawford, 1993; Ingham, Woodcock, & Stenner, 1992; Joffe, 1996).

5.8: Limitations of this study:

Due to the sensitive nature of the research interest and the culture of shame and secrecy surrounding sex, it was a challenge to get participants to speak freely about issues around HIV risk, their relationships and sexual activities. Also because of the anticipated challenge of this research topic couple with the research pool being so saturated in SVG, a pilot interview was not done on a sample of the population prior to the actual data collection.

Some of the questions used in the interview were too closed and restrictive. This could have been construed as leading the participants. The questions were then followed on with additional probes for information. This is not usual in qualitative research, and there may have been some distortion of the participants' representation of their experiences as a result (Denzin & Lincoln, 2005). However, throughout the interviews, the researcher tried to encourage the participants to take the lead in the conversation, and allowed the participants to take the conversation in the direction they wanted to.

The cultural taboos around sex, and particularly sex outside marriage, may have caused the participants to provide biased responses that they assumed the researcher wanted to hear and/or responses that may have presented them in the best light. Also, the reports of the participants' past sexual experiences were reliant on their recall of

their thought processes (Willig, 2001). This may have introduced inaccuracy and bias in their accounts of the events.

As with all qualitative studies, the results are a product of the researcher's choice of interview questions and the researcher's interpretation of the data, and so personal biases of the researcher may have influenced the results. These biases were monitored closely by the researcher; the participants' responses were summarised and repeated back to each participant by the researcher, to make sure the words of the participants were represented as they meant it to be presented.

This research also failed to give consideration to the economic dependence of the participants on their partners, which could have also affected their intention to achieve sexual safety within their relationships.

Finally, one of the main limitations of qualitative studies is that it is difficult to know how representative the participants are of the group that is of interest. Therefore, it is difficult to say whether or not it is possible to generalise the findings.

CHAPTER 6

STEADY LONG TERM RELATIONSHIPS AND THEIR IMPACT ON UNPROTECTED SEXUAL BEHAVIOUR

The previous chapter reported on a number of social and cultural issues that may be relevant to a consideration of the vulnerability of women in SVG to HIV infection through unsafe sexual practices. One of the main issues highlighted was the role played by male-female romantic relationships:

- The desire for love made more naive women vulnerable to sexually-predatory men, who are likely to have multiple partners.
- Not using condoms was seen as a way of moving a relationship to the next level and establishing it as a long-term relationship.
- The economic dependency of some women on their male partners meant that they felt obliged to go along with the wishes of their partners, even if this meant not using a condom.
- Not wanting to risk the man leaving the relationship also meant a willingness to go along with the wishes of their partner, in this respect.
- Talking about the need to use condoms was difficult within relationships because of the implications of a lack of trust and infidelity.

- The woman's trust and love for her male partner may override more rational considerations about the need to use condoms, and so condoms might not be considered even if the woman knows not using them is putting her at risk.

The rest of this thesis reports in more detail on research that has explored the role of romantic relationships in making women vulnerable to infection. Chapters 7, 8 and 9 will report on three studies that have looked at this issue, before going on to describe this research. The present chapter reviews some of the previous research on the role of romantic relationships.

6.1: Do long-term intimate relationships constitute a risk factor for HIV?

Monogamy is of course only an effective strategy if both partners are infection-free at the beginning and remain faithful throughout the relationship. Clearly, this is not always the case. Research indicates that despite declarations of monogamy, many individuals lie about their fidelity (Cochran & Mays, 1989; Conley & Rabinowitz, 2004). Furthermore, many individuals are simply unaware of their sexual health status (contracting HIV/STI prior to the relationship) and may unknowingly carry these infections (Cochran & Mays, 1989; Conley & Rabinowitz, 2004).

According to Newmann (2000) evidence from around the world shows that sexual intercourse within marriage or with a long-term partner puts many women at

risk of HIV infection, most commonly from their husbands' or partners' extramarital liaisons. From as early as the 90's, evidence began to accumulate that some of the positive consequences of being in a relationship, such as feelings of security and trust, and the associated desire to maintain these feelings, produce and perpetuate elevated levels of Acquired Immune Deficiency Syndrome (AIDS) risk behaviour in couples, and serve as a frequently overlooked source of risk of Human Immunodeficiency Virus (HIV) infection (Misovich et al., 1997).

A recent article by (UNAIDS, 2009) highlighted that an estimated 50 million women in Asia are at risk of becoming infected with HIV from their intimate partners. Evidence from many Asian countries indicates that these women are either married or in long-term relationships with men who engage in high-risk sexual behaviours. It is estimated that more than 90% of the 1.7 million women living with HIV in Asia became infected from their husbands or partners in long-term relationships. In Cambodia, India and Thailand, the largest number of new HIV infections occurs amongst married women.

6.2. How are women put at risk within long-term relationships?

There appear to be two main ways in which long-term relationships increase the risk of women. Both involve the risk of being infected by a male partner who has contracted the disease through sexual relationships outside the marriage or long-term

relationship. First, women may remain in such a relationship even when they know or suspect that their partner has been unfaithful. Second, condom use within long-term relationships may be low, and so the protective advantage of condoms against infection is lost. Most previous research has concentrated on this second mechanism, but there is still some evidence relating to the former.

Primarily, those who would have researched the former, concentrated on why persons who have been hurt (victim), forgive their (transgressors). According to the work done by Finkel, Rusbult, Kumashiro, & Hannon, (2002); Paleari, Regalia, & Fincham, (2005), the main aim of seeking forgiveness is for the restoration of harmony in relationships, where persons would have been wronged; people are more inclined towards forgiveness if they value and are committed to their relationships.

When dealing with the issue of infidelity in relationships, it was identified by Shackelford, Buss, and Bennett (2002) that a difference existed between men and women in how they react to sexual infidelity. They noted that men found sexual infidelity more difficult to forgive than women and were more likely to believe that they would end a relationship with a partner who committed this transgression, whilst women on the other hand were more likely to forgive and remain.

6.2.1: Why do women stay in a relationship when their partner is unfaithful?

Before discussing why women stay in relationships when their partners have been unfaithful, it is important to understand what is meant by the term infidelity. Drigotas and Barta (2001, p.177), infidelity is defined as "a partner's violation of norms regulating the level of emotional or physical intimacy with people outside the relationship." It can take the form of being either sexual or emotional, or in some instances both. For the purpose of this research, we will focus primarily on sexual infidelity and will pay attention to behaviour involving sexual contact, such as kissing, intimate touching, oral sex, or sexual intercourse.

It is important to consider how people react in a situation, in which a partner has cheated on them, i.e., would they stay in the relationship or leave? In a study conducted by Knox et al. (2000), whose data were drawn from 620 never married undergraduates from five first year level sociology courses at East Carolina University, it was found that two-thirds of the students surveyed cited that they would end a relationship with someone who had cheated on them. The students voluntarily completed an anonymous questionnaire which was designed to assess the respondent's attitudes and behaviour toward infidelity.

The question still remains as to why women would remain in a relationship after finding that their partners were unfaithful. Evolutionary theory, (Harris 1996), contributed a significant amount of research on the differences in emotional reactions to

a partner's infidelity from the different genders. They hold the premise that men and women put different emotional weight on the different forms of infidelity and as such, the outcome/decision to remain in a relationship may vary.

In a study conducted by Harris (2003), in which sex differences in emotional responses to infidelity were examined, which involved a meta-analysis of 32 independent samples using the forced-choice hypothetical method, revealed an effect size of 1.00 (log-odds ratio), typically interpreted as moderate effect size. Males were generally likely to report more distress with sexual infidelity than emotional infidelity, whilst women were more likely to report that emotional infidelity would distress them more than sexual infidelity. Could it then be assumed that women who are willing to remain in their relationships even after their partners were sexually unfaithful; would be those who rationalised the act to be just sex without any emotional attachment to the other woman? According to Harris and Christenfeld (1996), most women would think that men are capable of having "meaningless sex" without emotional attachment, and as such a man's emotional infidelity is more hurtful because it implies that he is not only sexually involved but emotionally involved as well.

There are however other prevailing factors that would bear some significance when a woman decides to leave or remain in an unfaithful relationship. According to Drigotas, Safstrom, and Gentilia (1999), the justification provided for infidelity is a

significant factor in deciding to end a romantic relationship. There are five basic categories of justifications given for betrayal: sexuality, emotional satisfaction, social context, attitudes- norms, and revenge-hostility. Sexuality motives include the desire for variety and dissatisfaction with the primary sexual relationship. Emotional satisfaction might imply relationship dissatisfaction, padding or cushioning one's ego so that they feel better about themselves, and/or emotional attachment to the other person. Social contextual factors refer to opportunity and absence of the primary partner. Attitude-norms include sexually permissive attitudes and norms. Revenge-hostility applies to infidelity that occurs in retaliation for some perceived wrong by the partner.

The most important of these categories is attitude-norms. The research of Drigotas et al. (1999) took the form of two separate studies designed to test the effectiveness of the investment model in predicting physical and emotional infidelity in dating relationships. The first was a longitudinal study of participants in dating relationships at a private university in the south-eastern United States, whereby measures of investment model constructs at the beginning of the semester were used to predict infidelity over the course of a semester. From this study it was revealed that commitment level at the beginning of the semester successfully predicted later emotional and physical infidelity.

Other commentaries suggest that women who stay with unfaithful partners themselves face judgment from other people who cannot understand why anyone would give an unfaithful man a second chance. Although there are a variety of complex factors that make each situation unique, there are general reasons why many women decide to continue fighting their relationship: whether children are in the equation; if the couple has children together, then the idea of breaking apart a relationship does not just two persons, but it also impacts the lives of their children. Many women would choose to stay with unfaithful partners because they would rather try to make the relationship work than risk hurting their children, whether emotionally or by cutting down on their resources.

Additionally, discovering infidelity is usually enough to unsettle an individual's sense of stability and confidence, but separating may be even more challenging as one of the benefits of being in a long-term relationship is the sense of overall security and having a general sense of how your future looks. Infidelity distorts this vision and presents questions about the relationship, but for some women, the idea of also ending the relationship is an even bigger loss of stability and peace of mind.

Although economic dependency was not directly measured in this study, finances can be an unavoidable part of the equation when women decide to stay with cheating partners or not. Being unemployed, due to child-rearing or other reasons, can

make it extremely daunting to face the idea of losing their partner's income and having to find work.

Considerations are also given to the direct psychological impact, having to leave one's relationship may have on the individual. Women with certain personality types may view leaving the relationship as an admission of failure. They see surviving the infidelity as a challenge to overcome hardships and prove to the other women that they cannot affect their relationship. All this is intensified by the fear of not finding another relationship; the thought of wanting their unfaithful partners to change and last but by no means least, the feeling that they invested time loving their partners and that treasuring memories a happy relationship in the past, and knowing that your relationship can get better with hard work, are the best ways to overcome the wounds of cheating.

The second study used earlier investment model measures to predict the physical and emotional intimacy of opposite-sex interactions (as measured using a diary method) over the course of the 1-week school break during the spring semester at the same university.

6.2.2: Condom use within long-term relationships:

This review will focus on condom use within long-term relationships. It is understood that condom use is vital in reducing the transmission of sexually

transmitted infections, but in order to be fully effective, condoms must be used consistently and correctly, especially in situations where the risk of STI or HIV transmission is high.

It is very useful to examine whether there exists a non-use of condoms amongst women who are in long term relationships. Cassell et al., (2006), explored the changing pattern of condom use from 1990 to 2000 in Britain. The aim being to identify socio-demographic and behavioural factors associated with condom use; and the reasons for condom use in the year 2000. They administered large probability sample surveys amongst residents in Britain, between the age range 16–44;(n = 13 765 in 1990, n = 11 161 in 2000), as well as conducted face to face interviews with self completion components to collect sociodemographic, behavioural, and attitudinal data. Cassell et al., (2006), found that amongst sexually active men aged 16-24years, there was an increase from 61.0% in 1990 to 82.1% in 2000. Among the women of the same age, there was an increase from 42.0% to 63.2%, with smaller increases among older age groups. The data concluded that there was a substantial increase in the rates of condom use from the period 1990-2000, specifically among young people. However, there was noticeably inconsistent condom use by persons showing high rates of partner acquisition.

De Visser et al. (2003) also examined safe sex and condom use among a representative sample of adults in Australia. They sought to provide reliable estimates

of the frequency of condom use among Australian adults, using computer-assisted telephone interviews with a sample of 10,173 men and 9,134 women between the age range 16-59years – the response rate was 73.1% (69.4% men, 77.6% women). It was found that just as in other studies, that condom use was strongly associated with partner type and use of other contraception (de Visser et al., 2003).

There is also great deal of evidence from many different cultures that women are much less likely to use a condom within marriages and long-term sexual relationships than they are in more casual sexual encounters (Bazargan, et al., 2000; Friedman et al., 2002; Macaluso, et al., 2000; Riehman, et al., 2006) and if their partners are unfaithful, this increases their risk of infection.

Research has illustrated that young adults are more likely to use condoms with casual encounters, such as 'one night stands' (Catania, Stone, Binson & Dolcini, 1995; Harrison et al., 1991; Misovich et al., 1997). Within steady relationships, condoms are often replaced by other measures, namely, oral contraceptives (Civic, 2000; Critelli & Suire, 1998; Manlove, Ryan & Franzetta, 2007; Misovich et al., 1997).

Misovich et al. (1997) reviewed research on AIDS preventive behaviour which indicated that minority and nonminority heterosexual adolescents and adults, gay men, injection drug users, and commercial sex workers were all less likely to practice safer

sex with close relationship partners, compared with partners they perceive to be "casual" sexual partners.

This present study also highlights the fact that many women in close relationships are engaging in HIV risk behaviour over extended periods of time and are unaware of their actual HIV status. Likewise for their partners, practicing unprotected sexual intercourse with a committed relationship partner, who is HIV-positive but not tested for HIV, is a major and unrecognised source of HIV risk.

6.3: Why are condoms used less?

One obvious reason why condoms might be used less in long-term relationships compared to casual relationships is that the intention to get pregnant is more likely within a long-term relationship. Another reason is that condoms are used for contraception as well as HIV/STIs prevention, and condom use is less likely if other contraception is already being used within a long-term relationship (Bryan et al., 1997; Critelli & Suire, 1998; de Visser & Smith, 1999; Rosenthal et al., 1997; Wendt & Solomon, 1995). However, this review concentrates on relationship factors that may explain the reduced use.

6.3.1 Difficulties of negotiating condom use

Sexual decision-making, an essential factor in the causal profile of HIV infection, is largely controlled by men, not just because of gender dynamics affecting when and

how sex occurs, but also because it is men who choose to wear or not to wear condoms (Zierler, 1997). Thus, in many societies and many relationships, condom use is not the result of a discussion and a decision made by equal partners; instead, it is dependent on whether the man chooses to use them and on whether the woman is able to negotiate about their use.

These results from previous research suggest that in SVG, negotiating about condom use was not easy for many of the participants: Not wanting to risk the man leaving the relationship meant a willingness to go along with the wishes of their partner about whether condoms are used. This is consistent with other research that suggests that women believe that actively addressing the potential for HIV risk within their relationship would pose an unwarranted threat to relationship stability and maintenance (e.g., Bowen & Michal-Johnson, 1989; Wingood, Hunter-Gamble, & DiClemente, 1993). The current researcher believes that for most of these women, the mere discussion with their partners about the threat of HIV in their relationship would mean that either an accusation was being made that their partners' are being unfaithful, or it may cause their partners to become suspicious of their actions, which may have led to a threat of HIV.

The research reported in the previous chapter also suggested that a woman's economic dependency on the man also made them more likely to go along with the man. Others too have reported that women who are economically dependent on their

husbands or lovers are unlikely to negotiate condom use or inquire about their partners' extramarital liaisons (Baylies, 2000).

6.3.2 Women not wanting to use condoms within the relationship.

The last section dealt with reasons why it might be difficult for women to negotiate condom use even when they want to use them. It is also the case that condom use may be less within a long-term relationship because women do not want to use them in the relationship.

In the previous chapter, it was noted that some of the participants saw sex without a condom as a way of moving the relationship onto the next level and turning it into a long-term committed relationship. Others have also noted that some women may use sex as a bonding mechanism in creating or maintaining relationships and in feeling connected to others, and some women use casual or unprotected sex as a strategy to "catch love." (Rosenthal et al., 1998). Rosenthal's sample was recruited at discos and bars in Melbourne Australia: 112 respondents were asked to narrate their experiences of sex, love, romance and safety, with particular emphasis on casual sexual encounters. The results of this qualitative research showed that casual sex was viewed as an essential strategy in the search for love and sexual safety practices were related more to their anticipated impact on finding love than on an assessment of the potential of sexually transmitted disease transmission. This view was consistent with cultural

notions of femininity in sex as the relinquishment of control for the sake of love. The findings of this study suggested that the current HIV/AIDS prevention messages may be disregarded by individuals, especially unmarried women, who view condom use as an obstacle in their quest for love.

Within established relationships, the transition from condom use to oral contraceptives can be a symbolic event. It results in greater feelings of commitment to the relationship (Conley & Rabinowitz, 2004; East et al., 2007). It is often perceived as a progressive step in a favourable direction, signifying stability. For many it creates a new 'identity' for their relationship, graduating to the quintessential monogamous couple. Whereas unprotected sex is affiliated with these positive developmental milestones, condoms come to symbolise an external object that will contaminate the intimacy within a loving partnership (East et al., 2007). This romanticist view of unprotected sex is not gender discrepant. Young males' also associate the transition from condoms to oral contraception with developmental milestones within relationships. Similar to young women, males also associate unprotected sex with monogamy, trust and intimacy (Flood, 2003). Condoms are perceived as a barrier against these milestones, as the physical barrier becomes representative of emotional roadblocks, preventing the relationship from escalating to the next level (East et al., 2007; Flood, 2003). Consistent condom use throughout the relationship begins to become affiliated with infidelity (Flood, 2003).

Other research has highlighted the symbolic meanings of condom use within a relationship that act as barriers to their use within a committed long-term relationship. Adults typically perceive condom use as a precaution to be taken within casual sexual relationships,rather than loving relationships (Baylies, 2001; East et al., 2007). Many young adults associate condoms with adverse meaning to the relationship. Condoms are symbolic of disease, infidelity, lack of trust, and less commitment (East et al., 2007; Kirkman, Rosenthal & Smith, 1998). There is also the message to one's partner that they do not trust them to remain faithful to them (Conley & Rabinowitz, 2004). Within relationships, once the transition occurs to oral contraceptives alone, it may be more difficult to transition back to condom use, as it would carry all of these negative connotations (Conley & Rabinowitz, 2004; Pilkington et al., 1994). To transition back to using condoms is often believed to be representative of problems within the relationship (Conley & Rabinowitz, 2004). These findings are consistent with the results of the study reported in the previous chapter: some participants noted that raising the issue of condom use was difficult within a relationship because it implied a lack of trust and a suspicion of infidelity.

Another major reason why women may not want to use condoms within a long-term relationship concerns the trust they develop in their partner. Trust in one's partner plays an instrumental role in the decision to discontinue condom use (Civic, 2000; Masaro et al., 2008; Misovich et al., 1997; Winfield & Whaley, 2005). Women in

close, longer-term relationships may assume their partners are monogamous and that partners do not have sex outside of the relationship. (Bazargan et al., 2000; Friedman et al., 2002; Macaluso et al., 2000; Misovich et al., 1997). Instinctively, individuals characteristically believe that it is extremely unlikely that a trusted relationship partner would have engaged in behaviours that could infect them with HIV (e.g. Kline, Kline, & Oken, 1992; O'Donnell, San Doval, Vornfett, & Dejong, 1994). For many, it is inconceivable to imagine contracting a sexually transmitted infection from a loving partner (East et al., 2007; Goldmeier & Richardson, 2005; Misovich et al., 1997; Pilkington, Kern & Indest, 1994). Thinking about condom use and their own sexual health also contradicts their perceptions of their partner and relationship as being healthy and loving (Conley & Rabinowitz, 2004). Trusting the partner can also mean that the transition from condoms to oral contraceptives may be seen as a means of guaranteeing their partner's faithfulness. As the partner loves her, he would not put her at risk by being unfaithful and having unprotected sex with her (Conley & Rabinowitz, 2004).

This has some parallels with the data from the study described in the previous chapter in which some participants felt that the woman's trust and love for her male partner may override more rational considerations about the need to use condoms, and so condoms might not be considered even if the woman knows not using them is putting herself at risk within that relationship.

Other research evidence points to how long-term relationships may undermine the sense of vulnerability to infection, which is largely based on the trust that women have in their partners. Persons who engage in casual sex with different partners rate their level of sexual risk to be significantly higher than those within relationships (Britton et al., 1998; Misovich et al., 1997). Individuals typically perceive engaging in casual sex as risky behaviour (Corbin & Fromme, 2002; Manlove et al., 2007). As such, the fear of HIV acts as a motivating factor to use condoms with casual partners (Britton et al., 1998). Whereas in monogamous dating relationships, persons feel less risk and will therefore use condoms less often, inconsistently, or not at all (Cooper & Orcutt, 2000; Corbin & Fromme, 2002; Manlove et al., 2007; Misovich et al., 1997).

There is a perception of low probability of contracting HIV within a monogamous relationship (Ishii-Kunzt, Whitbeck & Simons, 1990; Misovich et al., 1997). It is the tendency that persons often believe themselves to be impervious to HIV. They recognise that whilst others may be affected by HIV, they maintain the belief that it won't happen to them (East et al., 2007; Misovich et al., 1997; Redston-Iselin, 2001). Many are driven to maintain the perception that their sexual partner is safe, to avoid feelings of instability, or that the partner poses a threat (Misovich et al., 1997).

Generally in monogamous relationships, adults typically base their opinions of sexual safety subjectively. They consider their partner's appearance, trust, personality

characteristics and they make assumptions (i.e. 'just knowing') (Civic, 2000; East et al., 2007; Skidmore & Hayter, 2000). For many, there is the implicit assumption that someone they have an emotional connection with and trust, would not have a risky sexual history, or be a risk to their health (East et al., 2007; Misovich et al., 1997; Skidmore & Hayter, 2000). During this stage, many individuals become protective of their relationship. Due to the often negative connotations associated with safer sex practices, many adults will forgo engaging in these actions to protect their relationship (Misovich et al., 1997). Feeling a sense of security and protection within a monogamous relationship contributes to the decision to discontinue condom use (Corbin & Fromme, 2002).

Researchers examining monogamy as a risk-reduction strategy have recently begun to focus on the meanings attached to individuals' perceptions of monogamy. Hearn et al. (2005) conducted in-depth interviews with women having methadone treatment in Columbia, New York and explored how women value monogamy in their relationships, and how this was related to their ability to protect themselves. In this study, a sample of 38 ethnically diverse women was interviewed, to explore the meanings of monogamy and concurrent sexual partnerships in the relationships of women in methadone treatment with a history of physical abuse. Additionally, the ways in which having a history of intimate partner violence influences women's desire and ability to insist on monogamy was addressed. The results indicated that the

majority valued monogamy and reported practicing it; but many of the women were indifferent to this ideal or were unable to challenge their non-monogamous partners for fear of severe reprisals.

Britton and colleagues also found that women define monogamy in different ways, which may lead to a false sense of security associated with being in a serious committed relationship, and these varying interpretations may lead to greater HIV risk (Britton et al., 1998).

CHAPTER 7

WOMEN IN LONG TERM RELATIONSHIPS AND THEIR RISK OF HIV

7.1: Introduction:

The second part of the study was done in an effort to support the findings of the first qualitative study, which suggested relationships as a possible risk factor for HIV in St.Vincent and the Grenadines. Added to the data revealed in the first qualitative study, the literature review in Chapter 6 further indicated that in other cultural contexts, established long-term relationships have been highlighted as a major risk factor for HIV and STIs. Resulting from these, it was considered pertinent that this study be done, assessing the degree to which long-term relationships might be a risk factor in the context of St.Vincent and the Grenadines. The study was in the form of a survey asking women diagnosed as HIV-positive how they contracted the disease. The particular point of interest was to investigate the percentage that believed that they contracted the disease from a long-term partner. The study thus aimed to establish how important a factor long-term relationship might be in the transmission of HIV in this cultural context.

An important point to note, as background information for the study, is that in St. Vincent and the Grenadines, heterosexual transmission has been identified as the

main transmission route for HIV since the start of the epidemic, (CAREC...Behavioural Surveillance Surveys, 2005-2006). With 71% of the infected persons acquiring HIV from heterosexual contact, it is important to distinguish the type of relationship in which this transmission happened, as it has major risk implications, and should be considered when formulating prevention programmes.

7.2: Method

7.2.1: Data Collection Site:

This study was carried out at the Infectious Disease Unit in St.Vincent and the Grenadines. This unit is located in the Milton Cato Memorial Hospital, which is the main hospital in the country, located in the country's capital Kingstown. The main purpose of this unit is to provide care and treatment to persons living with HIV/AIDS in St.Vincent and the Grenadines. It serves a population of 319 clients, inclusive of children, (159) males and (160) females. At present, there is only one primary public clinic that caters to the needs of persons living with HIV/AIDS in St. Vincent and the Grenadines.

7.2.2: Recruitment Process:

These participants were recruited at the Infectious Disease Unit, by the counselor assigned to the Unit. Participants were approached and told about the study, and they

were then asked whether or not they would like to take part in the study. On deciding to do so, they were given a participant information sheet, were given time to consider whether they wanted to be involved, and then asked to sign an informed consent form, showing that they agreed to be a part of the study (see Appendices 5a, 5b & 5c for copies of the participants' information sheet, consent form and counselor's information sheet respectively).

7.2.3: Participants:

The inclusion criterion for participation in this study was being an HIV+ woman attending the infectious disease clinic. The counselor would have engaged **only** the women attending the clinic during the data collection period, which was over a month, starting in April 2010 to May 2010. Seventy-five participants were recruited in this study, which marks 41% of the total number of HIV+ women attending clinic who had existing clinic appointments at the time of data collection. None of the women approached about this study declined to take part.

The participants were between the age ranges of 18-40yrs. Of the 75 participants, 33 (44%) of the women were between the ages 20-30yrs, 19 (25%) were between the ages 30-40yrs, 16 (21%) were over 40 years of age and 7 (9%) were under the age of 20. These 75 participants reflected the overall client population at the Infectious Disease Unit, because they were reminiscent of the socioeconomic background, family type and educational background of all the female patients at the Infectious Disease clinic; most

of the participants (44%) came from 20-30 age group, which overlapped with the age range of 18-25, considered to be the most at-risk group for contracting HIV in SVG (CAREC, 2005-2006).

7.2.4 Survey questions

The survey was designed to find out, the participants' age, whether these women knew how they contracted HIV; whether they knew who they contracted it from; if it was contracted through sex or by other means; and what type of relationship they were involved in with their sexual partner at the time of transmission (see Appendix 6 for a copy of the survey).

The participants were given response choices to each question. The whole survey and results will be illustrated in the results section of this chapter. For question 3, which asked the participants about the type of relationship they had with the person who they caught the disease from, two of the response options included terms such as 'common-law relationship' and 'friends with benefits'. For clarity these will be explained now: 'Common-law' relationships are categorised as living arrangements, where couples live together, invest in their relationship, whether financially or otherwise, very similar and reflective of a traditional marriage arrangement; but they have not been legally married. 'Friends with benefits' is a relationship that describes a hetero-sexual friendship in which there isn't a define commitment towards developing a long term relationship,

but they will engage in sexual exploration and gratification with each other without the pressure of a commitment.

7.2.5: Data Collection & Analysis:

The surveys were filled out in the counseling room used by the Infectious Disease Unit. The process was kept confidential and anonymous. Participants were told not to write their names or leave any identifying marks on the questionnaires. On completion of the survey, the participants were asked to place the completed questionnaire in a plain empty envelope and return to the counselor. The counselor would then return the envelopes to the researcher unopened. Each questionnaire took approximately 5-10minutes to be completed by the participants. The data were coded and entered on SPSS software, and were subjected to some descriptive analyses.

7.2.6: Results

Table 3: The Survey Questions And The Responses Of The Participants In Percentage:

Survey Questions	Results (%)
Q1: How old are you?	
Under 20	9.3%
20-30	44.0%
30-40	25.3%
Over 40	21.3%
Q2: Do you know how you caught HIV?	
Yes	100%
No	
(b) If you answered yes, how did you catch it?	
Sex with a man	100%
Sex with a woman	
Blood transfusion	
Injecting drugs	
Born with it because mother had HIV	
Tattoo/body piercing	
Other	
Q3: ***If you caught HIV through sex***: At the time you caught the disease, what kind of a relationship did you have with the person you caught the disease from?	
Living together in a marriage or common- law relationship	40.0%
Going steady but not living together	56.0%
Friend / friend with benefits / acquaintance	1.3%
Didn't know them that well / stranger	1.3%
Other	1.3%

All participants responded and there were no missing data. The results of major significance showed that 96% of the women surveyed thought they contracted the disease in the context of a long-term relationship. At the time of the survey, they were either living with their partners, in a marriage or common law relationship or going steady with their partners but not living together. This allowed for the inference that these women were in relationships where they trusted their partners to be faithful to them and to protect them from sexually transmitted infections, hence the reasons they may have been willing to engage in unprotected sex with them.

Additionally, a total of 58.7 % of the participants indicated "Other" as the reason for taking an HIV test. These participants were unable to use the options provided as the reason for taking the HIV test; the researcher then probed to find out their personal reasons for taking the test and it was revealed that they found out their status as a result of being pregnant and having to do routine screens at the ante-natal clinics.

7.3: Discussion

The aim of the present study was to investigate how important long-term relationships might be in the transmission of HIV to women in SVG. Ninety-six percent of the sample reported that they had contracted it from their steady sexual partner; whereas only 4% reported contracting it from a more casual sexual relationship. This

provides evidence for long-term relationships being a major factor in the spread of HIV amongst women in SVG: Women appear to be at high risk from infected male long-term partners, who have either come into the relationship already infected, or who have been unfaithful in the relationship.

These results do need to be treated with some caution. A major limitation of this study was the reliance on what the participants reported as the truth. Another major limitation was that it is not clear how accurate their beliefs about how they contracted the disease are.

Despite the limitations to the study, the data however do suggest that unprotected sex within steady relationships is a major factor in the spread of HIV in SVG. The following two chapters report on further research into how these relationships may put women at risk. The next chapter reports on a qualitative study that explored the role of steady relationships in more detail than the initial qualitative study.

CHAPTER 8

AN EXAMINATION OF STEADY LONG TERM RELATIONSHIPS AND ITS IMPLICATIONS FOR HIV TRANSMISSION AMONGST VINCENTIAN WOMEN

8.1: Background and Rationale

Coming out of the initial qualitative study (Chapter 5), investigating the non-cognitive factors that led women to engage in risky sexual behaviours in St. Vincent and the Grenadines, it was revealed that the cognitive models of health were limited in their usefulness in understanding risk behaviours of a sexual nature.

It was also identified from the initial qualitative study that there were many socio-cultural contributors to the sexual decision process of many Vincentian young women. One very significant factor was the very intense need to be in a relationship. The need to be loved and accepted by the opposite sex appeared to be so strong that many would be willing to do whatever it took sexually to satisfy the needs of their mates, to the extent that they would put themselves at risk of contracting STIs and HIV. Some of the participants were vulnerable to sexual exploitation by older men who took advantage of their desire to be loved. Sex without a condom was also viewed as a way of moving the relationship to a more serious level.

The importance of relationship issues in considering the spread of HIV was also highlighted by the review of previous research on this topic (Chapter 6) and by the survey study (Chapter 7), which indicated that 96% of the women who took part in the study believed that they had contracted the disease from a partner with whom they were in a long-term relationship.

As a follow on to these studies and the literature review, it became imperative that an examination be done on the complexities of the issues Vincentian women faces in order to have intimate, sexual relationships in the context of HIV/AIDS. The rationale was to achieve a more in-depth look into the lives of Vincentian women and their relationships, to ascertain whether these long term relationships acted as a risk factor for HIV transmission in SVG; as found to be the case in other cultures, suggested by the literature reviewed in the earlier chapters. As it cannot be assumed that this fact was universal to all cultures, it was worth to investigate.

The study reported in this chapter was a further qualitative study that explored in more depth the role of issues associated with long-term relationships that may make Vincentian women more likely to engage in unsafe sexual practices, and thereby more vulnerable to HIV infection.

8.1.0: Methods

8.1.1: Recruitment Strategy:

The recruitment of the participants was done with the assistance of an independent consultant that worked with the Peer Communication Program at the National AIDS Secretariat, instead of the social worker, as in the previous study. The consultant assisted in identifying potential persons from the general population to be a part of the study. The peer communication programme is one in which persons would visit various communities in the country to disseminate information about HIV/AIDS etc. The target population for this programme are persons who are sexually active, engaging in risky sexual practices and persons who are generally interested in learning about their sexual safety. This programme allows from an anthropological type of methodology where the communicators will fit into the communities and hang around on the various 'blocks' and develop a rapport with the people, to gain trust amongst the population, allowing them the chance to communicate the right information about HIV/AIDS related issues.

Having gained the trust amongst the persons in the varying communities, the communicator was able to advertise the study and solicit the participation of persons. When persons came forward expressing their willingness to take part in the study, the study was then explained to the potential participants and they were given an information leaflet, (see Appendix 7 for the participant's information leaflet used in this

study). After a minimum of 24 hours, they were contacted again, by the consultant, to see whether they were interested in taking part in the study.

On the information leaflet, there was contact information for the consultant and the researcher, so that the participants could make contact if they desired to participate, or if they had any questions about the study.

No pressure was placed on the persons to take part in the study. It was strictly voluntary. Also no direct approach was made by the researcher to any potential participant.

(a) Consent:

A full explanation of the study was given by the consultant on the first contact with the participant, in the information leaflet and again when the participant turned up for the interview. A single question was used by the consultant and the interviewer to ensure that the participant understood what the study involved and why they were there, (specifically: "Can you tell me what you will be asked to talk about in the interview?"). An informed consent form was completed by all participants. In this consent form, an outline of the research was given. The participants were asked to sign that they were willing to take part in the study. (See Appendix 8 for consent form used in this study).

(b) Withdrawal:

Along with the informed consent, participants were briefed about their right to withdraw from the study at anytime during the interview process and within a week of doing the interview. If the participant decided to withdraw, they were also asked to sign a withdrawal statement (see Appendix 9 for withdrawal statement).

8.1.2: Inclusion/exclusion criteria:

Inclusion criteria:

The participants were required to be female, between the ages of 18 and 35, in a steady relationship that was of at least six months duration, and to be sexually active within that relationship.

Exclusion criteria:

Participants were excluded if they were married to their partner. Married women were exempt from participating because it was felt that being married had a different type of relationship dynamic and carried a different degree of obligation to remain in the relationship when compared to persons who have newly committed to a relationship or those going steady and living together.

8.1.2b: Description of participants:

The participants were women between the age range of 18-35 years, who were presently in a steady long-term relationship. The relationship must have been a minimum of 6 months old, with a cut-off maximum of 3 years in the relationship. They were drawn from various communities within St. Vincent and the Grenadines, taken from amongst persons within either the middle or low socio-economic bracket. All participants had a high school education.

8.1.2c: Definitions:

For the purpose of this study, the following terms were defined as follows:

Long-term relationship: A relationship with one person lasting for longer than 3 months and not exceeding more than 3 years. It did not include married partners. (The terms long-term relationship and steady relationship were used interchangeably.)

Risky sexual behaviours: Engaging in any sexual behaviour that has the potential to be harmful either immediately after the act or in the long term. Examples include having sex without a condom when there is no guarantee that both parties are HIV-free, and having sex with a partner who is suspected of being unfaithful.

8.1.2d: Participants:

There were 9 participants in this study. Each participant was given a pseudonym as an identifier to safeguard their anonymity. Below is a brief description of each participant:

Roxy

Roxy had been in a long distance relationship with her present partner for a period of 8 years. Her partner resided on one of the Grenadines islands where he worked. She was self-employed as a farmer and vendor.

Ren

Ren had been in a long- distance relationship with her present partner for a period of 8 months. Her partner resided on one of the Grenadines islands where he worked. She juggled two jobs to meet her financial needs.

Monique:

Monique had been in a long distance relationship with her present partner, who currently resides in the United States, for approximately 10 months. She is a teacher by profession.

Stacey:

Stacey had been in a common law relationship with her present partner for 3 years. She works as a cashier.

Tracey:

Tracey had been in a common law relationship with her partner for 4 yrs. She works with the Government as an administrative clerk.

Raj:

Raj had been in an on-and-off relationship for close to 8 years. She did not live in the same house with her partner, but in very close proximity in the community. She was unemployed at the time of data collection.

Sophie:

Sophie had been in a relationship on-and-off for 13 years, the longest period of living together being 4 years. She is presently living with her partner. She is unemployed and highly dependent on her partner and family.

Denise:

Denise had been in a relationship with her partner for 6 months. She is employed as a secretary and is living with her parents.

Louise:

Louise had been in a relationship for 2 years. She is employed [redacted]. She lives with her parents.

There was some heterogeneity in the sample. The participants varied in terms of whether or not they lived with their partner and in terms of the length of the relationship. Homogeneity within the sample is more usual in IPA studies (Smith et al., 2009). However, IPA is based on the analysis of each individual case, and so it provides the opportunity to consider whether any heterogeneity within the sample was relevant to their experience of the phenomena in question. The potential influence of whether

living together and the length of the relationship on their experience were borne in the mind of the researcher when carrying out the analysis.

8.1.3: Ethical Approval

As a result of Study 1, this second was developed. Instead of having to re-apply for ethics approval as a completely new study, the researcher made a request to the University's Ethics Committee for amendments to the first study, as they are all inter-related. The amendments included changes to:

- The analysis: - To analyse the data, Interpretative Phenomenological Analysis was used, which is aimed at developing an account of how a given a person, in a given context, makes sense of a phenomenon. Usually these phenomena relate to experiences of some personal significance- such as a major life event or the development of an important relationship.
- The participants: - The targeted population as well as the sample size changed.
- Recruitment: - The person used to recruit the participants changed but the process remained the same as the first study.
- The Interview schedule also changed from what was used in Study 1.
- Within the application, ethical approval was also requested for the survey study reported in Chapter 7.

Ethical approval was given within 3 weeks of submission (see Appendix 10 for letter of approval the ethics committee).

8.1.4: Interview Schedule

The interview schedule used in this study incorporated questions about:

- General aspects of the relationship
- The importance of being in a steady relationship
- Safe sex issues within the relationship

See Appendix (11) for a copy of the interview schedule

Transcription:

Each interview was tape-recorded. Immediately following the interview session, the tapes were played repeatedly by the researcher, to ensure clarity and to get 'a feel' of what was stated by the participants. The transcripts were then scribed verbatim, along with the interview questions. It was imperative to do these transcripts immediately after the interview because IPA is concerned with documentation far beyond the words spoken. In IPA, the false starts or long pauses, when the participants used sounds such as 'hmmm' or 'sighed' or even 'laughed' are all relevant to the participants' story.

8.1.5: Method of Analysis

The analytic process used in this study was that of Interpretative Phenomenological Analysis (IPA), as outlined by Reid, Flowers and Larkin (2005). IPA

is concerned with trying to understand the lived experiences of participants and how participants themselves make sense of their own lived experiences.

The phenomenological aspect of IPA involves exploring the individual's personal experience of the topic. The focus is on their experience, rather than on any objective record of events. The interpretative aspect is based on the recognition that the researcher's attempts to represent that experience is coloured by what the researcher brings to the process. This indicates the need for this to be recognised and acknowledged. However, IPA also embraces this in a positive way and interpretation of the data by the researcher is viewed as an integral part of the process, allowing a deeper level of understanding of the participants' experiences and allowing those experiences to be related to the wider body of existing research

thematic analysis was used in the first qualitative study, the researcher opted to use IPA in this second study. In the first study, the focus was on gaining a general idea of what non-cognitive factors may be relevant to understanding engagement in unsafe sex by Vincentian women. This second qualitative study was concerned to gain a deeper understanding of one particular aspect of this (i.e. the role of intimate relationships) and so a methodology and analysis that allows more in-depth exploration and interpretation was required.

8.1.5a: Analysis of Data

Step one:

An idiographic approach was used which started the analysis with particular examples before moving on to a more generalised categorisation of claims. The initial step involved the researcher becoming very familiar with the data. The interviews were transcribed verbatim in an effort to capture the full essence of what the participants were saying and experiencing. Margins were placed on the actual interview scripts on both sides, as they were being read. On the left hand, it was annotated what was considered significant about what the participant said (refer to Appendix 12 for an example, of a coded transcript).

On the transcripts, there were those that had richer content than others and as such, warranted more commentary. Some of the comments documented by the researcher were basic summaries and paraphrases of sections of the data; some were associations. The researcher's preliminary interpretations were also placed in the margins. There were also comments made on the use of language, such as slogans, and pauses in the responses.

In the right hand column, emergent themes were noted from the notes taken, by looking for similarities and differences across all the interview transcripts. At this point initial notes were transformed into concise phrases aimed towards acknowledging the intricate value of what was found in the text. After the transcripts were completed, they

were read and re-read several times, so that the researcher could get a clearer view of the participants' experiences.

The aim of this first step was to produce a comprehensive and detailed set of notes and comments on the data. With this said, caution was taken not to read too much into the data, placing words into the mouths of the participants. The focus was on capturing what aspects of their experience seemed important for each participant.

Step Two:

In this next step, the themes emerging from step one were all listed on a separate piece of paper and the connections between them were identified. The list of themes was then moved from a chronological order (based on how they emerged in the transcript) to a more analytical ordering. As connections were made, themes were clustered together, at which point some super-ordinate concepts emerged. Connections were made based on similarity of content, whether two or more participants alluded to particular issues, such as trust or communication (refer to Appendix 13, for a list showing emerging themes).

In a table (see appendix 14) the researcher placed the super-ordinate themes, and then under each there was a list of emerging themes that could have been explained by the super-ordinate themes. There was also a list of page numbers from the transcripts,

(see appendix 15), where the supporting data could be found to support each emerging theme as well as the super-ordinate themes. It also helped to identify any responses by the participants, which were totally different to the other participants in the group. It was basically about looking for patterns across the cases, identifying how a theme in one case may help to illuminate a different case, for example which themes were more prominent etc.

Step 3:

Finally, in this last step, the researcher was concerned with moving from the final themes to the written report outlining the meanings inherent in the participant's experience. Having looked for recurrent themes, the researcher then tried to work out the best way to report on the themes in the data, fully capturing the participant's lived experiences, which is the crux of the work in doing an IPA analysis.

8.1.6: Steps taken to establish credibility of the interpretation

Establishing credibility is of vital importance in any research but more so for qualitative research. Due to the subjective nature of qualitative work, it is imperative that some level of credibility be maintained as there is the risk of imposing oneself on the data, and placing your own 'twist' and interpretation to the data which may not be reflective of what the participants experienced or shared during their interviews. Direct quotations were used throughout to support my account of the participants' views and feelings.

As a means of a credibility check for this study, three transcripts (of course these transcripts were already given pseudonyms to safeguard the participants and guarantee anonymity and confidentiality), were chosen, and they were given to a colleague of the researcher who has also done some work using IPA. She followed the same process by adding initial notes to the transcripts, emerging themes and the super-ordinate themes and finally interpreting what was in the data.

The researcher and her colleague both then compared their analyses. Although there were many similarities, quite a few differences were also noted. There were a few instances where it was felt that the researcher read more into the data than was actually there, and as such, was interpreting and placing words into the mouths of the participants instead of merely identifying the themes that emerged. For instance, in interview 5, where Tracey mentioned not having any control over whether her partner forms an emotional attachment with someone else, the researcher extended my interpretation to say that Tracey was fearful of losing her partner emotionally, when this may not be the case. This flawed interpretation was then removed.

As another means of ensuring credibility, the researcher also had to make sure that the data collected were exactly what was communicated in the interviews. During the interviews themselves, I sought clarity from the participants on statements that were unclear; and it was ensured that she transcribed the data in the local dialect, which

was used by the participants, so that the true emotion of the participants could be captured.

8.1.6a: Reflexivity

It was important that the researcher monitored her thoughts and feeling about the information given during data collection. To make sure that she did not distort her account of what was told to her by the participants, she tried to place myself in the mental position to understand each participant's situation completely and objectively. She challenged myself to not only accept and reproduce the information given in a verbatim manner, but to apply thought stopping in instances where her mind caused her to wonder why the women may have accepted certain things within their relationships. That is, she had to make a conscious effort to stop myself from imposing judgmental thoughts on the participants who stated that they were willing to accept infidelity.

It was also very necessary and pertinent to be self aware because some of the information gathered had a direct impact on me, especially when speaking about the issue of infidelity. At the time of the data collection, the researcher's marriage was affected by infidelity and she had to decide whether it was something she was willing to accept, just as most of these women would have done in their relationships. It was only at that point that she was able to fully understand just how easy it is to turn a 'blind eye' to the knowledge of infidelity from your partners out of fear of losing the life you had become accustomed to.

To fully monitor her thoughts and feelings about what was happening personally, the researcher kept a journal, in which she wrote things down (see appendix 16 for a copy of a journal entry). This process of journaling helped her tremendously in isolating her feelings from the data being assessed from the participants.

8.1.6b: Supervision:

All of the transcripts were read by the researcher's supervisor, Dr. Gerard Riley. The researcher's account of the data gathered was also considered by Dr. Gerard Riley, and very useful and relevant feedback was given. Modifications were made on the basis of the feedback given. These modifications included a change in the number of themes presented in the results. Initially, there was a list of 9 themes, as seen in Table 4 below:

Table 4: List Of Nine Initial Themes

Main Themes	**Text**
1. Issues of Trust in the relationship	• Trust relating to one's partner (what is said) • Worrying when partner is not around • Not allowed to go out without her partner • Keeping tabs on each other in the relationship (frequent calling and texts) • Trust as it relates to being responsible for feelings • Trust as it relates to partner having sex with other people
2. Communication within the relationship	• Conversation depends on the possible expected reaction • Good open communication is vital • Ability to talk about anything • Apprehension when discussing issues about feelings • Vague discussions about HIV/STI risk within the relationship
3. Conflict in the relationship	• Managing Finances • Dealing with partner's outside responsibilities (step-children) • Responses to conflict in the relationship
4. Perception of ideal relationship	• Marriage • Role of Christianity • Trust • Ability to reason/ have fun together
5. HIV Testing	• Acts as a safety net for having unprotected sex (if partner is safe then so am I) • Offers comfort by alleviating the stress of the unknown
6. Significance of a steady relationship	• Happiness; peace of mind • Lessens the stress and complexity of having multiple partners • Protection of the heart • Stability • Companionship • Marriage
7. Unfaithfulness in the Relationship	• Acceptance/forgiveness • Self-blame • Repeated instances of cheating • Cheating (protected vs. unprotected) • Sense of denial • Link to HIV • HIV Testing offers reassurance to remain in the relationship
8. Attitude towards condom use in the relationship	• Negative physical reactions (itching; rash) • Sex is better without condoms • Going bare is an expectation of a steady relationship • Condoms are only to prevent **pregnancy** in the relationship ❖ Pregnancy is more of a concern than HIV • Linking unprotected sex with intimacy • Deciding on condom use in the relationship
9. Type of Relationship	• Long-distance • Casual partners turned steady partners • Work colleagues turned romance

These themes were sifted through to see if the relevant and supporting quotes existed to match each theme. From this, some themes were merged together and renamed, and some were deleted due to a lack of supporting quotes. In the end 6 themes were reported on.

8.2: Presentation of Findings

Using the IPA described by Smith et al. (2009) the analysis detailed a number of recurrent themes. Below there is a presentation of these themes, which relate to the participants overall view of being in a steady relationship and how these views place them in the position of being at risk for HIV or other STIs. Table 5 displays the overarching themes identified:

Table 5: Overarching Themes: Second Qualitative study

❖ Importance of long-term relationship:	▪ Benefits ▪ Social pressure
❖ Keeping the relationship going at all costs	
❖ Trust:	▪ High level of stated trust ▪ But behaviour suggests some lack of trust ▪ Reasons given for placing trust in partner (often naïve)
❖ Infidelity:	▪ Experienced by high number of participants ▪ Tolerated by many ▪ Reasons given for toleration, but there are limits

These themes provide an in-depth look at what women value and the lengths they will go to safeguard these relationships with their partners. These themes will be further developed and illustrated by the use of a model in chapter 9, which aimed to link some of the themes.

8.2.1: The importance of long-term relationships:

This theme addresses the significance placed on being in a steady relationship by the women in this study. This theme is broken down into two sub-themes: the benefits of being in a long term relationship, as stated by the participants; and the social pressures to be in a long term relationship.

Benefits: Most of the participants expressed great value and pride in being in a long-term steady relationship, as they see it as being linked to their happiness, stability and security as a woman, and the ultimate goal of marriage. Just knowing that there is someone that they can call on and rely on as a companion is of vital importance to these women, and it also reduces the stress of having multiple partners.

> Roxy: It's very important; when you have your partner and you feel happy, ah just love it. (Int.1: 107-108)

Interpretation:

For Roxy, happiness is very important; but how reliant is her personal happiness on her partner?

> Tracey: The comfort of being with one person all the time; You know that person is there, you know what that person likes, and he knows what you like. It is very interesting getting to know somebody, the companionship can be beautiful, at any time, knowing the person is there, even if you don't live together is kind of comforting. (Int. 5: 160-165)

Interpretation:

For Tracey comforts comes from companionship. The ability to engage each other, learning their likes and dislikes….. Of particular importance is her choice of words, "the comfort of being with ONE person all the time"- the shows that for Tracey a long term faithful relationship is very important to her. Zoning in on the word 'one', Tracey is more likely a faithful partner and someone who values commitment.

> Sophie: Well you can become husband and wife and he can help out with the bills and thing cause right now, I not working. If I tell him to do this for me he will do it and so on. (Int. 6: 144-146)

Interpretation:

For Sophie the idea of a good relationship is one that culminates in marriage. She sees the man as being the breadwinner; one who would take care of her needs. This is a typical response for most women in the Caribbean as a whole who has been socialised

to believe a man takes care of his wife and home. She sees her partner as being someone she should be able to count on.

Sophie's experience is one in which she is unemployed and at the time of the interview was very reliant on her partner to take care of her.

> Denise: To me it is very important, because personally I do not like the idea of having more than one relationship. I believe it is very complicated and I believe that it leads to lots of problems in the end, so I believe in a steady relationship and if you are in a steady relationship with somebody that you should let others know about it and let your friends and whoever they are respect your relationship, so you will not be able to go into a relationship when you are already in one. (Int.8:166-174)

Interpretation:

A relationship for Denise is not something to be taken for granted. She appreciates monogamy and would do what she believes is in her power to safeguard against being in a multiple partner relationship. So she finds it necessary that her family and friends know about her partner…..maybe not only as a form of accountability on her part but also as a means of keeping tabs. For instance the line saying "if you are in a steady relationship with somebody that you should let others know about it and let your friends and whoever they are respect your relationship, so you will not be able to go into a relationship when you are already in one"……..this suggests that she expects when this knowledge is share, maybe (1) If her partner deviates, she expects her family

and friends will help to keep him in check by either informing her or possibly warning other females to stay away or (2) it provides some level of accountability for herself as well to remain focused and committed in her relationship.

From the responses given above, when asked about the importance of being in a steady relationship, it must be noted that these women attribute their happiness to their companionship with a man. They expressly value having this 'go-to' person in their lives, on which they can depend. It alleviates their stress of having to juggle between numerous partners as they anticipate the relationship culminating in marriage, which is the ultimate goal of any steady relationship. For others it is seen as a means by which they can guarantee a reduction in their sexual risk, as well as limiting the propensity towards promiscuity.

> Monique:" Very important, because if I am not in a steady relationship, I get frustrated because you will have a number of suitors and you might get tempted to sleep around just to appease that sexual you know….." (Int. 3: 198-201)

Interpretation:

A relationship acts as a buffer for sexual temptations for Monique. Relief of frustration, and gives her clearer focus.

> Raj: Well it is very important to me you know because AIDS ah go round (is going around) and sometimes you can get infected so being in a relationship with one person is very good.
>
> I: Why is it good?

> Raj: Because sometimes, when you have more than one relationship, you can ketch [catch] disease and errm [pause for thought], if you have one partner, you can reduce that. (Int.6: 162-168)

Both Monique and Raj have linked having one steady partner to the avoidance of being placed in a vulnerable position sexually, where they can likely contract HIV or STIs from having more than one sexual partner.

8.2.2: Social pressure to be in a relationship:

The need that exists within these women to be in a steady relationship appears to be something that has been engraved in their minds through socialization and the expressed expectations of the significant persons in their lives. The majority of the women in this study stated that the support of family and friends was relevant to their decision to be in a steady relationship with their partners.

> Stacey: "So after we come friends and is so we use to be talking and talking for about three months before we get into the relationship. Well he introduce me to he [his] mother and we met and we talk and I introduce he to my mother, well he and my mother talk, I don't know what dem [them/they] say but dem [them/they] talk and that was another month like going four months or so we

start getting closer and I start go by he and sleep and he came by me. (Int 4: 23-30)

Interpretation:

Of major significance to the development of any relationship is the introduction to the mothers. Following this introduction and dependent on the outcome of the initial meeting, the relationship can progress speedily to sex, if it didn't do so previously. Stacey appeared quite happy about meeting her partner's mom, and vice versa.

The introduction to the family, primarily the parents of the family is one of the first things that would have to take place, as a means of cementing or sealing the seriousness of a relationship. Additionally, for these women there is the belief that it is socially expected of an 'adult woman' to either be in a steady stable relationship or have a child, as either of these will show some level of stability in their lives. It also appears that for many of these women a subliminal pressure exists so much so, these women will become driven to either start a relationship or maintain their current one at any cost.

I: So is there any pressure from family or friends for you to be in a steady relationship?

Tracey*:* Noooooo.....when I am out of a relationship, they may throw little jokes on me about not going to get married, (laughs) but no real pressure...No. (Int.5: 185-187)

Although Tracey expressed that there is no pressure for her to be in a relationship, her response was not convincing. If one were to examine the laughter in her response, it can be deduced that there was a lack of seriousness on her part or the possibility that she was trying to hide how affected she is normally by statements like those. Another participant with a similar story was Raj-

I: What would your family or friends think if you weren't in a committed relationship?

Raj: My friends... [Laughs] will start throwing words at me saying like 'No man nah war you' [No man wants to be with you] and things like that.

I: And would that bother you?

Raj: No.

I: Do you feel the need to be in a relationship to avoid hearing these things from your friends?

Raj: No.

I: Okay, what are some of the things your friend will say specifically?

Raj: That me old, no man nah wah me [No man wants to be with you].... me cyaar [can't] keep ah man and things like that.

I: So let's say you heard that your partner was planning on ending the relationship, what would you be willing to do to keep it?

Raj: Anything he wants...anything he wants me to do, I will. Anything at all it doesn't matter. (Int. 6:178-195)

Based on Raj's responses it is evident to me that she feels somewhat pressured to be in a relationship, though she would have responded NO. This conclusion is based on her response to the last question stating her willingness to do whatever it takes to keep her relationship safe. This determination can be linked to a possible fear that she may have about her family and friends finding out that she is single, as they would infer that she is unable to keep a man.

For other participants it was seen where the mothers of these women would have formed bonds with their partners, to the extent that they would be emotionally affected if the relationship between their daughters and these guys were to end.

I: What would be the reaction of your family and friends if you were not in this relationship?

Monique*:* Well my mother will be disappointed. I: Why is that?

Monique: Because one she has gotten pretty close to him, they live together yea for about a good six months now, so even If I don't know him that way I have second hand information that he is a good person. She lived with him for six months, so she will be disappointed on that note that she got so close to him and on the other hand she will feel bad for me knowing that I invested in another relationship and it didn't work out you know?

I: Do you think it is important to your mom that you are in a relationship?

Monique: Well she wants me happy… which is ok, you have all the academics and other accomplishments, it's now as a woman you should have kids, a house, you know from her perspective, so I think she wants that. I: Do you share your mom's views on this? Monique: yea, I have done all that needs to be done and that part of life seems to be like the last bit to round it all up. (Int.3: 281-302)

Similarly, another participant cited that she expected the same type of response from her mother if the relationship was to come to an end.

Roxy: Hmmm, well my mother does say me can't leave him, cause she will vex with me, she really love him. Because my boyfriend is cool and humble, he is one of a kind, the real fact is you won't find a man who will take a woman with a child and accept the child as his, and that's a real plus. [shakes head, and laughs] (Int.5 : 133-138)

Knowing how her mother feels about her partner seemingly warms her heart and gives her the encouragement within the relationship. Additionally it is worth noting the manner in which Roxy glorifies her partner, for taking on her child as if it were his own, which takes us to the next issue of how these women will perceive their partners as well as themselves in these relationships.

Analysis:

There is a 'reality' in the Caribbean that women very often seek intimacy with men because they are defined by having a man (Neeley-Smith 2003). The cohesion of this new union is very important, since it also measures a woman's ability to "keep her man." She is expected to do everything in her power to maintain the union. The subliminal pressure that exists in the Caribbean for people to be in and maintain long-term relationships is embedded in the strong religious background of the countries, but it is an area that has not been thoroughly researched at the moment.

Many women as seen in this study will amplify the benefits of being in a steady relationship, because many view it as their ultimate goal in life; having achieved everything else in life such as education, employment, house, car etc.

Overall there is great support in literature about the benefits of being in steady stable romantic relationships for both males and females. Research consistently shows that married people report less psychological distress than those who have never married, those who are divorced, and those who are widowed (Barrett 2000; Marks &

Lambert 1998; Menaghan & Lieberman 1986; Waite & Gallagher 2001). Individuals seek companionship, help, affection, intimacy and emotional security (Demir, 2007)... In a study by Montgomery (2005) subjects mentioned that romantic involvement led to self-growth and understanding. They also mentioned that involvement led them to feeling better about themselves (Montgomery, 2005).

As mentioned by the participants in this study, being in a romantic relationship can create a safety net. Couples who share a household generally gain in economic terms, because with two incomes couples enjoy higher standard of living (Stack & Eshleman, 1998). They can afford better housing, food, and other services.

8.2.3: Trust in the relationship:

In this study most of the participants alluded to the fact that they trust their partners significantly.

I: You are living apart at the moment, how much do you trust your partner?

Monique: 100% (smiles) (Int.3:80-82)

I: How much trust do you have in your partner?

Roxy: A hundred percent...

I: (Repeat with emphasis) 100%?

Roxy: Yea

I: So do you ever worry about what he gets up to when you are not together?

Roxy: No, fo wah [for what]

I: So you have total confidence in your partner?

Roxy: Yea, 100% (Int.1:78-86)

Denise: I would say I trust him a lot as in if he tell me that he is somewhere I believe that he is at that place and if he told me he didn't do something, I would believe him as I have a lot of trust in him. (Int.8:92-95)

Ren: Sometimes I tell him gwaan [go on] lime with his friends (have fun with his friends), because I trust him, same way he can trust me to go out with my friends. (Int.2:34-36)

For other participants a distinction was made in terms of how trust is defined. One participant was clever in her distinction, and looked at trust as being applied either to feelings or sex. For Tracey, this distinction helped her to qualify her stance on why she trusted her partner or why she didn't. In her mind, she couldn't control whether her partner fell in love or became emotionally attached to another woman, but she felt more confident in trusting that her partner may not cheat, because he is sexually satisfied at home. With that said however, it was quite interesting to note that Tracey mentioned not being willing to contemplate that her partner may be unfaithful, for her it is much simpler to remain in a state of denial about his faithfulness.

Tracey*:* ..... It depends... I look at trust from two different angles. There is the deep trust that involves being responsible for my feelings and then there is the sexual trust. In terms of whether he is having sex with other people, I don't think about it. (Int.5: 76-80)

Tracey: ..... I also believe that if he is satisfied sexually at home, he won't go outside, and I believe that if I get him tired enough he can't get up to go anywhere. (Laughs)

I: So do you believe that sex is a way of keeping him quiet?

Tracey: No....not in terms of emotional attachment with somebody else, because it may not stop him from falling in love with somebody else, but in terms of seeking out that physical attachment.... it is not that men won't have the urge to see what's different but when they are satisfied at home, it is harder to think about what is out there. (Int.5: 108-118)

Throughout the scripts from each participant, it was seen where they used very simplistic reasoning to rationalise their trust in their partners. One thing that stood out most is the fact that it is natural for each partner to keep 'tabs' on each other. It was important to maintain contact with each other whilst being absent from each other's presence, as well knowing exactly where each person will be at a given time.

I: Do you ever worry when you are not around your present partner?

Raj: Yea...sometimes

I: Sometimes? Why sometimes and not all the time?

Raj: Because, you know we does get contact sometimes, but when I am not around, me always dey [will be] thinking about things like that, all the negatives.

I: So are you more relaxed when you know exactly where he is?

Raj: Yea, like when he at work, when he finish like he does call and say he is on his way, so then I does start to time him. (Laughs)

I: What time is he normally at home after work?

Raj: Around like six

I: So let's say it becomes 7 or 8'oclock and he is not at home?

Raj: (Laughs loudly) well I will be real upset, when he gets in he will have to tell me where he went, where was he at (x) time why he got home so late. (Continues laughing) (Int.6: 125-143)

This tab-keeping appears to be an understood element in Raj's relationship between her and her partner.

I: And do you think he trust you as a partner?

Raj: Well yea, I will say that.

I: Would he also call to find out where you are when you leave the house as well?

Raj: Yea, he does do that too

I: Is that something that is understood, that you will both call each other, to know each other's whereabouts?

Raj: Yea, I go say so.

Denise, another participant, also cited that she had to be in constant communication with her partner, even though she also stated that she trust her partner. The trust appears to be contingent on the ability to prove that her partner is where he said he would be at any given time; failure to do this, results in anxiety and worry on Denise's part.

Denise: I would say that I have a lot of trust in him because of the type of relationship we have together because when we are together we...okay...we talk to each other a lot in the day; if he going somewhere he would call me first and tell me like, 'I want to go somewhere' or 'I'm going somewhere.' So he will tell me where he will be. I remember more than one occasions when he went somewhere and somebody will come and say, 'You know I saw your boyfriend there,' and I would be like 'yea I know'...so I would say I trust him a lot.

I: Okay, can he say the same for you?

Denise: I believe he would

I: So do you at anytime worry about what he is up to when he is not around you?

Denise: Sometimes you know

I: Can you describe the circumstances that have led you to worry?

Denise: Errm [pause for thought]...it wasn't exactly a situation per se.... You see sometimes he will go away with his friends, which I know...they normally do sometimes or at least once in a or something like that but sometimes I does be calling and sometimes I have to call about 2/3 times before he actually answers right. And when he comes, he go say he didn't hear the phone or something like that but sometimes...well it is very rare for me to worry.

Throughout the scripts from each participant, it was seen where they used very simplistic reasoning to rationalise their trust in their partners. Another reason put forward for trusting their partners was the fact that he was a 'nice 'person. This form of reasoning appeared to be somewhat vague and superficial, but it appeared to be the reason most of these women held on to, as an explanation for trust. Additionally one participant highlighted that she trusted her partner based on his ideals.

I: Why do you trust your partner so much?

Roxy: Because he is a very nice person and I think he deserves the 100% trust.

(Int. 1: 223-225)

Monique: Because….hmmm…I would say his ideals. And based on his ideals there are things I know he will not do, not just because he shouldn't do these things but because he believes in some things even more than I do, you know… Okay, when it comes to things like cheating…he wouldn't not cheat because it would hurt necessarily but because to him, he thinks it is disrespectful, he thinks that if he does it he is putting our relationship in jeopardy, not just because I would get hurt but rather what benefit will it be to him to do that, he would say it isn't worth it to cheat. So I think because of those ideals, I can trust him. In terms of judgment, he may sometimes think when he have female friends, because he is now moved back to New York, he is getting in touch with them, some female friends that he had before, he will be a little naïve of their intentions, you know by chatting and so on… (Int.3:84-99)

8.2.4: Dealing with infidelity in the relationship:

Infidelity was undoubtedly one of the most profound themes emerging from this study. For these women, there appeared to be no clear-cut way in which infidelity would be dealt with. For many of the women, there was the acceptance that infidelity happens and that human beings are sexual beings and there was the general acceptance that these things do happen.

Monique: Unforgivable? Hmmm, cheating is not necessarily unforgivable you know but cheating unprotected and having a child, now that's unforgivable.

I: So if your partner cheats and uses a condom, you will be ok with that?

Monique: I won't be ok but I may be able to forgive him and take him back.

I: Why is that?

Monique: Because I am sexual and I know how difficult it is to be apart from your partner and have desires, and sometimes you have a close friend and then something like this happens, I am not excusing it but things happen and I can forgive. (Int.3:241-253)

Sophie: Well me does always say me nah mind if yo [you] want to go out and do yo [your] thing, as long as yo [you] use a condom. (Int.7: 221-222)

I: Ok, let's say you found out that he had another woman that he slept with, how will you respond?

Stacey: Well to be honest eh [okay] if he tell me before well ah go keep a little noise but yo [you] know sometimes, you know you just can't tell ah man wey [a man what] to do. (Int.4: 110-114)

These women have proven to be quite understanding of the indiscretion of their partners. It is almost to the extent that they are rationalising that infidelity is a common practice that cannot be avoided, and it is simply better if as a woman you accept it and put rules in place whereby you demand that he uses a condom, or he be the one to admit his indiscretion to you.

The fact that these women would emphasise the use of condoms, would suggest that they are mindful of the risk involved in having unprotected sex, with multiple partners. Additionally, it points to the fact that they are aware of how intimate an act of unprotected sex, whether vaginal, oral or anal can be; and as such, are not totally comfortable when their partners would have engaged in these acts without taking the proper precautions to protect themselves. The whole issue of having unprotected sex with persons outside of the relationship also goes against any respect that this man should have had for them as steady partners.

I: Do you believe unprotected sex demonstrates more intimacy?

Monique: Yes it does because if you could put yourself at risk with this other person, you must have some sort of, well that's my view that you must have some sort of idea or feeling enough for this person that you are willing to put yourself at risk with them, I think that is what makes it more intimate than you using a condom with that person to me, that also goes for oral sex… its very intimate.

I: So basically you are saying that if your partner has unprotected sex with someone or even oral sex that you would not consider taking them back?

Monique: Nope … (Shakes head vigorously) (Int.3:254-267)

Stacey: No, we don't really like…Well I does tell he like if he going out nuh [ok], well if you have a friend and you feel like if you could do something make sure get yo [your] condom, and mek sure use yo [your] condom and ting cause AIDS dey bout [AIDS is around] and yo [you] don't know who is who and yo [you] don't know who have it, cause yo [you] might look nice but yo [you] don't know if the body have it so yo cyar [you can't] be trustful, so if yo [you] know yo go wah [you would want] something, yo [you] go walk wid yo [carry your] condom and so….and he does tell me the same thing and so, like if me go out and me have a friend, cause yo [you] could like have a friend and don't go into relationship with the friend, you and the body could be friend with different personality. (Int.4: 93-104)

Another issue relating to infidelity that is worth noting is the frequency of these acts of infidelity that these women allow themselves to be tolerant of. However, the question is: how many times can one be forgiving of such acts of indiscretion?

Louise: Well as I said earlier right errm (pause for thought)...in terms of staying in the relationship if he wants in or out...now given the amount of relationships that he had in the past and I have forgiven over and over and moved on and tried...I don't think I will forgive him for another and I have expressed that verbally to him so he knows, that is he wants to jeopardise the relationship and have another relationship outside I don't have a problem but I would not be around for that definitely?

I: Is this because you have forgiven him for all the other instances?

Louise: It is just something I would not tolerate in a relationship because the same way a man will want to entertain other people in the relationship is the same way the woman could want to do the same and entertain other relationship, and the fact that as the woman you keep a stable mind and you could be responsible not to entertain other parties, I think the man could as well and I think it is a lack of respect if they decide to travel that path and you will forgive and then they do it again, so it is definitely a lack of respect. And it is not going to stop to change the price of eggs as they may put it but maybe later on something may come up but maybe if it is the first it is happening I will forgive but a repeated offence definitely not.

Louise who would have accepted infidelity on numerous occasions whilst being with her partner, is now saying that it is enough and she wouldn't be willing to tolerate

anymore, but is it because she is now approaching marriage with this man that the dynamics have now changed? Or is that she has now come to the realization as she stated that the act shows a lack of respect for her as a partner?

A lot of times, human beings try their very best to come to grips with things when they occur in life; we question ourselves, we question others, all in an effort to understand why the particular phenomena would have occurred. The sad thing is when it applies to issues of infidelity, most women always tend to feel it can possibly be their fault, and it is probably something they did or didn't do that would have caused their partner to be 'have eyes for another'. It was seen that most of the women in this study that may have experienced infidelity in their relationships, felt that it was probably due to something that they may have done, and would have taken some blame for the act of their partners.

I: Both of you were at fault in this relationship?

Louise: Well I was pregnant and I wasn't really the pleasant you know person errm [pause for thought]...so I would say I created some of the issues where he you know had to you now create another relationship...and he could ah do without those relationships. But up at that point I was unclear as to if I wanted to stay in a relationship with him, so even if I had told him plain and straight I didn't, with the few frustrations and hiccups that we had, I think at that point he

was considering moving on you know. I think yea...when you listen to him and you get his side of the story you decide to leave the issues aside and keep the trust there. So that didn't really break it down too much, I think from here on if anything else go wrong it will be difficult to trust the individual again 100%.

I: Do you blame yourself for him having these other relationships?

Louise: Not entirely but I would say I had a few you know; I created some of the issues we had because as I said I wasn't a pleasant person during pregnancy. I was more anti-social and even though we had started on a rocky footing where he was in a relationship and that kind ah thing, errm [pause for thought]...I wasn't sure if I wanted that relationship, so I told him it was okay if you wanted to move on, I encouraged him actually to move on and I was trying to move on and in light of that he tried to move on but I guess he still had hope that we would have had a relationship at some point. (Int.9:71-98)

I: So are you saying that it was your fault why he was unfaithful early in the relationship?

Ren: Yea because, every time he come around, I just had some excuse why I couldn't go with him, not that I didn't want to go you know, but I had to safe-guard myself. I didn't want to rush things, so I hold back. So I blame myself for a lot of the things that happen. (Int.2:182-184)

8.2.5: Threat of HIV in the relationship (Condom use; HIV; Pregnancy):

In order to negotiate sexual safety, it is vital that there is some perception that safety is an issue firstly and secondly that it is something that is attainable within the relationship. All of the participants in this study cited that they do not feel at risk of contracting HIV from their partners, even though they may be concerned of their partner's faithfulness. Their greatest concern appears to be pregnancy instead of HIV; reasons being some would have had children already whilst others weren't in the position to support a child at the present moment.

> Monique: Yea, we will incorporate it, because I guess to prevent pregnancy outside of this will be to go on the pill but I think we will do some condom use in there, to prevent pregnancy you know
>
> I: Is pregnancy your major concern right now with your partner?
>
> Monique: With him, I think I do trust that there will be no contracting of disease, we will be married soon and I do believe I don't need to be so cautious about my husband, because if I had to be so about my husband then it is might as well I don't have a husband at all, yea so pregnancy because you know the timing may not be right to have kids right now. (Int.3: 362-374)
>
> Denise: Once I know that...because sometimes you want to do it unprotected, and then after you get pregnant you have big confusion in the relationship. (Int. 8: 246-249)

I: What is your major concern of having unprotected sex...is it pregnancy...HIV what is it?

Denise: My major concern,...well knowing what he does and the tests that he has to do every six months and stuff like that...well maybe I can say that at the moment, my concern is pregnancy because I am not working and he is working...but I always say I do not want to have a child without being able to take care of that child properly and I don't want to have a child unless I can do it properly.

I: So pregnancy is the main thing?

Denise: Yes

I: So have you ever had unprotected sex with him?

Raj: Yea..

I: And was that the time you got pregnant?

Raj: Yea

I: So outside of that time you had unprotected sex with him?

Raj: yea

I: Why is that? Are you afraid of pregnancy or something else?

Raj: The main thing is pregnancy really (Int.6: 202)

When asked further about HIV, many will allude to the fact that they feel safe with their partners, and if their partner cheats, they will become fearful of HIV based on who their partner was unfaithful with. They will take a keen look at the physical appearance of the young lady, and who judge whether or not in their opinion the person is safe of HIV.

> I: If your partner were to sleep with someone else, would you still consider having unprotected sex with him, if the relationship continues?
> Roxy*:* No, because I don't know if the other lady had anything she giving way, so why should I (rolls eyes) you think it is easy to get AIDS? (Int.1:188-193).

> I: If it is the first offence, would you have been able to forgive the fact that he had unprotected sex with someone else?
> Louise: Depends on who it was...if the character definitely looks unhealthy then you know, but sometimes you can give and take why...and do a couple test and thing. (Int.9: 279-284).

HIV testing was found to be of great significance to these participants as it their way of alleviating the stress within themselves that they are free of HIV. For some of these participants they would vow on the negative status of their partners and use it as their own security. Although they would attest that they do not take an HIV test as

regularly as they should, each of the participants would have indicated that it is necessary procedure and it is something they needed to be committed to doing.

I: So have you had unprotected sex with him?

Sophie: Yea, that is why I does do my test, because I want to make sure. (Int.7:185-187)

Roxy: Well the both of us had an HIV test, and we were ok, so then I said why should I use them. (Int.1: 203-204).

I: Do you get tested?

Tracey: I do it, maybe not as often. He doesn't know necessarily, but I take comfort in the fact that what I don't have, he don't have either. It may not be necessarily so but I take comfort in that fact. (Int.5: 209-213)

Denise**:** Well my partner is... the line of work that he does he has to be taking test every couple of months...for the line of work that he is in, and once he safe I know I safe to. Yea, he does that and early this year I did one. But it didn't have anything to do with the relationship. A friend of mine wanted to go and do one and she was scared, so I was confident in myself and ...so I did one with her to help her feel more comfortable. (Int.8: 208-215)

Whilst as mentioned earlier it was evident that persons saw taking an HIV test as important, it was also quite noticeable that there is little or no concern about HIV as a threat in their lives. Whether it was due to the fact they can possibly be afraid to think of the risk of HIV in their relationship, it mostly appeared as though it passed the minds of these women as a fleeting thought, rather than being a case for focused consideration or assessment of risk in the relationship.

> I: At what point did HIV/STI become a concern/consideration?
>
> Denise: Well I can't say I did consider that (Int.8: 327-328)

One participant that considered contracting HIV from her partner, took comfort in the fact that he is a kidney patient, stating that he cannot afford to become immune-compromised in his present health condition. To this end, she finds comfort in believing that whist he is safeguarding himself from HIV, he is also protecting her as she does not have another partner outside of him.

> Monique**:** I think that whole thing with Trust and there is a comfort for me because he is on meds, he needs to stay safe, not just for me but for himself because he is a kidney transplant patient, so he can't compromise his immune system as he is on immune-suppressant drugs and so he can't afford to compromise his immune system. So it's almost like a safety net in a sense that he will behave because it's not just for us but for him and his own health.

Monique has clearly given over her right to sexual safety to the hands of her partner, trusting that he will safeguard himself and hence the protection will trickle down to her. She is however cognizant of the fact that is she is found to be HIV positive it will her own fault as she realises she had the choice to protect herself by demanding condom usage but didn't.

> I: Okay, Let's say that even though as you know him to be on immune-suppressant drugs and how important it is for him to be safe, he still went against all that and placed himself at risk for HIV, and not only that he contracted HIV and it was passed on to you, how would you react to all that?
> Monique: Well I guess I will be angry like anybody else, I mean you will be pretty angry to know you put your trust in somebody and they hurt you, but at the end of the day I always believe the decision was mine. I don't think you blame people in that situation because you decided to take part in unprotected sex, I will be angry, I mean to murder, but there is still a big responsibility where I decided to put myself at risk.

Just like Monique, there were others within the study who also felt that an HIV negative result basically opened the door to having regular unprotected sex with their partners. A lot of these women took absolutely no time to consider the 'window period'

in HIV testing, that even though the test may reveal at the time that their partner's are HIV negative they can still be HIV positive and not know it as yet.

Raj: Once he can prove that he doesn't have HIV, and then I will go along with it. (Int.6: 253-254)

I: Do you test regularly?

Ren*:* Well the Last time I test was last year, and everything was ok

I: And what about your partner?

Ren*:* Everything is ok with he (him) too.

I: Do you understand what it means to have unprotected sex in light of HIV?

Ren: Yea, it easy to get AIDS.

I*:* Do you feel threatened in anyway, as it relates to contracting HIV?

Ren: I don't feel threatened but sometimes like my mind does run on it, and it will take me a to come around again. (Int.2: 250-262)

Owing their decision of having unprotected sex to the fact that their partners appears to be HIV negative, it is no wonder that the majority of the women interviewed highlighted having unprotected sex. Condom usage appears to be a negative issue as it is cited as being uncomfortable and it has had adverse effects in the past, such as causing rashes and itching in some of the relationships.

I: Can you tell me what caused the change from using condoms?

Ren: I don't even know, the thing is when I use condoms, depending on what type I use, I does be going to the doctor, with like infection and stuff so… (Int.2: 230-234)

Louise: Well I didn't like them, used to feel a little irritated, it took away from the sex because at the end of the day it was like having sex with the rubber. (Int.9:211-213)

I: Have you ever used condoms?

Roxy: Well we tried to, but he says it irritates him, so we don't. (Int.1: 156-158)

For those who did not have a negative reaction towards using condoms, there was a consensus between them and their partners to 'do away' with the condoms, as it was a means by which they can show intimacy. It is believed that the risk of having unprotected sex was a clear indication of the seriousness of the commitment and the closeness between partners.

I: Do you think sex is without condoms shows how two people feel about each other?

Ren: Yea, I guess.

I: In the first few months when you were using condoms, do you think that you are now closer as a couple than you were a few months ago?

Ren: "Yeah, definitely, it's just like there is more appreciation, not really for the sex alone but for the person he is and with all he has done for me." (Int.2: 320-328)

I: Do you believe unprotected sex demonstrates more intimacy?
Monique: Yes it does because if you could put yourself at risk with this other person, you must have some sort of, well that's my view that you must have some sort of idea or feeling enough for this person that you are willing to put yourself at risk with them, I think that is what makes it more intimate than you using a condom with that person to me, that also goes for oral sex… its very intimate. (Int.3: 254-262)

Stacey: Well when we get in deeper and deeper, he stop use the condoms.
I: Why did you stop?
Stacey: Well me as a person, I go say I'm not a run around person, well man don't trust woman like that, cause it have some man wey [that] does use condom with dem [their] woman, but with me I am a person that you don't need to have no fright over. Cause I is a person when you dey [in a relationship] with somebody is one. And me personal don't love up the condom." (Int.4: 72-73)

When considering the very loose, and even possibly naive manner in which these women decided to have unprotected sex, it reveals that there must be a great level of trust between these partners, but can this trust really override the possible risk that exist within these relationships?

Analysis:

As in this present study, the ability to negotiate safe sex with a partner is a vital step in guaranteeing safety within the relationship, but both partners must however realise the need for sexual safety, as well as assess whether they are at risk for HIV within their union. It is not enough to do an HIV test, but rather to follow through in health behaviours that will support the maintenance of an HIB negative status. It is evident that once a relationship is considered to be stable and long-term that the threat of HIV seemingly becomes secondary to the thought of pregnancy; of whether it is the right time, or more importantly, whether or not they want to get pregnant.

Intimate relationships are a definite overlooked source of risk for HIV. It is very important that couples are able to openly discuss issues relating to HIV, a lot of the times relationships in which condoms are not used, are normally the same ones in which a discussion about condom usage and safe sex has been avoided.

8.2.6: Communication in the relationship:

The ability to speak openly within a relationship was identified by all the participants as being vital. With the exception of two persons, every other person cited that they had experienced open and easy communication with their partners; giving them the ability to discuss any range of things such as financial issues, health issues, cheating, condom usage etc.

> I: So what is the communication like in the relationship?
> Stacey: Yea, if something affecting me whether it be wid [with] he or something else, I will talk to him. (Int.4: 152-153)

> Louise: I would say very good, we could sit down have a conversation and reason out different things, debate on a couple topics and come to an agreeable you know solution at the end. (Int.9: 19-21)

> Monique: We are very open, we can talk about anything, and there is comfort, nothing to fear...if you have a thought about something, whether it be sexual or otherwise and you mention it to your partner, he isn't someone who would say…oh that's childish or you're weird. Trust me it is not like that, there is nothing I can say to surprise and there is nothing he can say to surprise me, so we can talk about everything, and have differences of opinion on certain topics but we can openly argue and have a discussion on practically everything. (Int. 3: 20-29)

For these women, being able to comfortably approach their partners places them in a very good position to be able to work out their sexual safety in the relationship. They should be empowered enough to discuss the issue of cheating in the relationship, presenting a clear stance as it relates to being cheated on, especially as it relates to the implications of contracting HIV. This seemingly however is not the case, though persons would identify that they can talk about anything, they are not willing to 'rock the boat', so to speak, in challenging any view that their partners may hold that is contrary to their own, even if it is detrimental to them to do this.

8.2.7: Willingness to go to great lengths to maintain their relationship:

In the game of love, being an understanding partner is a necessary trait but how far will these ladies be willing to go to protect their relationships and to remain with their partners? The assumption can hereby be made from this study, that this 'willingness to do anything' extends not only to sexual activities including not using condoms but also with forgiving multiple instances of infidelity.

This issue of safeguarding the relationship is of great importance, because it discusses the lengths at which these women will go, to show their friends and families that they can keep their man. When asked about what they will be willing to do to safeguard their relationships, the majority of the women stated that they would be willing to do anything their partner wants, if it will guarantee the survival of the relationship.

I: So let's say you heard that your partner was planning on ending the relationship, what would you be willing to do to keep it?

Raj: Anything he wants...anything he wants me to do, I will. Anything at all it doesn't matter. (Int.6:191-195)

Roxy: I will go very far, I will try my best not to make that happen. So I will do whatever he wants and listen to what he says. (Int.1: 147-149)

Others would have phrased their response differently, stating that they would be willing to make changes within themselves if it meant saving the relationship and making their partners happy. However, they would not be willing to fight for their partners if he wanted to leave to be with another woman.

Tracey: Well it will depend on his reason for leaving, if it is because some interest in other women, I will let him go, but if it is about our compatibility and the way we relate to each other, I would try as much as possible and go as far as I need to, without losing completely who I am to compromise and make the relationship work, but once it has to do with another woman I will just let it go. (Int.5:192-198)

Monique: I think I will try my best to rectify whatever the issue is. If it is something that I have done or something that I am doing, I will try my best to

> change that thing, put my all into changing that thing to preserve the relationship. If it is something that he has done that I can forgive, I will try my best to forgive it to maintain the relationship. But if it is something that is……[rolls eyes] hmmm (Int.3: 232-238).

Analysis:

Evident from the responses is the fact that many of these women employ some defensive strategies to explain their feelings about infidelity. They would explain infidelity in ways that do not threaten the relationship; such as blaming themselves for the indiscretions of their partners, or even making it appear that infidelity is normal. They may tolerate the infidelity in order to preserve the relationship; but to deal with their feelings towards their partner in relation to the infidelity, they may find ways of explaining the infidelity that avoids blaming their partner and excuses their behaviour.

Accepting infidelity may appear to be a 'small' sacrifice, in light of the bigger picture, which may mean holding on to the man that is taking care of them and their children, but it comes with an even more enormous possible consequence; the probability of contracting HIV or an STI. Therefore, it is important to examine how these participants perceived their risk of contracting HIV within their relationship.

8.3: Discussion

Overall, from the findings of this study, it is clear that whilst the participants were mindful of the presence of HIV, they all however did not believe that they themselves were at risk for contracting HIV. This was primarily due to the fact that they were in steady long-term relationships and as such, expressed a deep-rooted level trust in their partners, despite instances of infidelity within their relationships on the part of their partners.

Individual differences were noted amongst the participants, highlighting that not all the participants cited having 100% trust in their partners, tolerated infidelity, or saw themselves as having no sense of risk from HIV in their relationships. Some participants quite firmly stated they would not tolerate infidelity; they were concerned about their HIV status and insisted on using condoms within their relationship. However, the fact that the majority cited that they do not use condoms with their partners, suggests that they had an increased risk status for HIV, and needed some intervention, geared towards addressing risky sexual behaviours amongst persons within committed relationships.

Specific to this study was the cultural context in which this study was done. The stated and unstated expectations of women in the Vincentian society placed them in a vulnerable position, due to their desire to be in a relationship. Not for a lack of information or HIV education or the ability to communicate openly about HIV and

condom use, but rather for 'love', women place themselves in situations where they can easily contract HIV, from a partner whom they suspect may be unfaithful whilst in a relationship with them.

In order for persons within committed relationships to understand the risk involved in having unprotected sex with their partners, if their partners are unfaithful, HIV education and intervention has to be geared towards a dyadic approach rather than an individualistic approach.

Many of the theoretical underpinnings for intervention programmes come from individual determinants of sexual risk behaviour, such as the Health Belief Model (Becker 1974), and Theory of Planned Behaviour (Ajzen et al., 2007), which were referenced as the theoretical basis for this research study.

These approaches focused on the role of cognitive and motivational processes that operate at the level of the individual, such as self-efficacy, personal beliefs and intentions, and perceived norms toward condoms (Albarracin et al., 2005), whilst negating the impact of the interpersonal dynamics between partners has been overlooked in HIV prevention models. Therefore examining the broader literature on partner influences in health behaviour demonstrates that partners and accompanying relationship factors need to be included in how health behaviour change is

conceptualised (House et al. 1988; Lewis et al. 2006). Further support was given by Riehman et al. (2006) who suggested that incorporating heterosexual couples intervention is crucial in addressing the mounting evidence, showing that not only do men bring HIV risks into their partnerships, but women also transmit HIV acquired from a previous relationship, or by having multiple and concurrent sex partners.

In countries such as SVG, where there is more of an individualistic approach to the HIV prevention programmes; is suggested suggest that a couple-based approach would work better. There is much strength in a couple-based approach in dealing with the vulnerabilities and susceptibility to HIV transmission in intimate relationships. Based on the information gathered from this research; firstly it may be useful to add to the existing counseling and testing program offered in the country, a prevention intervention focused on Couple Voluntary Counseling and Testing (CVCT), where couples would come forward voluntarily to be counseled and tested for HIV. The CVCT has been used in Africa and in numerous studies, and it was noted to have the ability to possibly avert more than two thirds of new HIV infections among urban men and women (Allen et al., 1992; Farquhar et al., 2004; Padian, O'Brien, Chang, Glass, & Francis, 1993). Added to that it has been "found to increase condom use and reduce sexual risk taking" (Kamenga et al., 1991; Allen et al., 1992, 2003; Dunkle et al., 2008; Roth et al., 2008).

Coupled with CVCT, further discussions with couples on topics such as safe sex practices and prevention of HIV and other STIs, as well as the importance of HIV testing, was found to be useful in reducing HIV risk amongst intimate relationship partners. Particular attention was placed on communication, negotiation and problem-solving skills in relationships, which would help to reframe safer sex not, as an act of the individual but rather as an act of love, trust, loyalty and commitment, and as a means of protecting and preserving the relationship and the community.

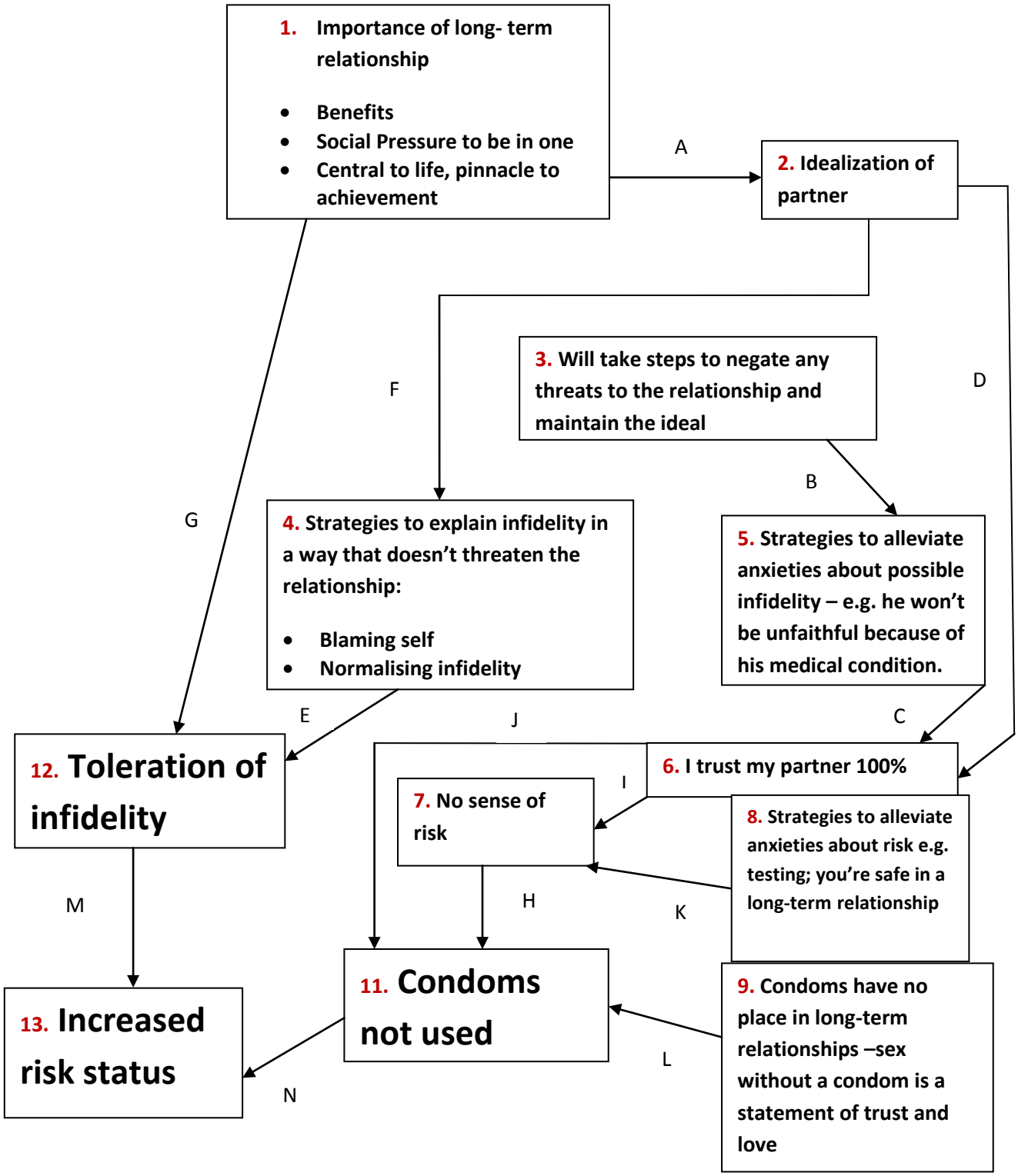
8.4: Linking the themes identified in this study

This study explored some of the ways in which long-term relationships may increase the HIV risk status of Vincentian women. These included the toleration of infidelity, and a low rate of condom use within the relationship. The participants differed in these respects – some were less willing to tolerate infidelity and were more likely to use condoms. The themes generated from the qualitative study brought to light some factors that could possible explain why these differences existed

This aim of this section is to use psychological theories and some plausible suggestions to try to link the themes and to develop a model of how being in a long-term relationship may increase a woman's risk status in this cultural context. Following this, Chapter 9 will then report on a quantitative study that tested some of the main features of this model.

It must be made clear that model development is not a part of IPA, so this is something separate from the traditional qualitative IPA report. The aim of this was to generate, on the basis of the qualitative study, hypotheses (about why women tolerate infidelity and do not use condoms within a relationship) that were about relationship issues and that could be quantitatively tested. It was also to test those hypotheses derived from the traditional cognitive models that were linked with the relationship-based hypotheses (through the tendency of some women to have an exaggerated trust in their partner) in order to see how well they compared with the relationship-based ones.

5: Summary of themes identified in chapter 8 showing proposed linkages between themes:



8.4a: Explaining the model

The model aims to explain an increased risk status for women in long-term relationships. The model focuses on unidirectional relationships between the variables to avoid over-complication. However, it is acknowledged that many of the relationships are likely to be bi-directional. For example, the model suggests a reduced sense of risk may reduce the probability of condom use, but failing to use condoms within a relationship may, in turn, lead to an increase in the person's sense of risk. It is also acknowledged that some of the links made are speculative and there are no prior studies to support the claim (e.g. link D).

Some of the proposals are based on the stress-appraisal-coping model of Lazarus and Folkman (1984) and the coping research that developed on the basis of this. According to this model, situations are appraised in terms of whether or not they pose a threat (part of the "primary appraisal"). If a situation is evaluated as threatening, the person then considers the coping resources at his or her disposal and decides how to deal with the threat (the "secondary appraisal"). The subsequent coping literature looked at different types of coping strategies that people use (Carver et al., 1989). One of these coping strategies is cognitive re-appraisal – i.e. changing the way that we think about things so that they are no longer threatening (Folkman, 2009).

Links M and N

As discussed in the previous chapter, tolerance of infidelity within a relationship and not using condoms are likely to increase the risk of contracting HIV from one's partner.

Links A B C and D

Based on the great importance placed by many Vincentian women on the relationship, we can suggest that they are sensitive to any threats to their relationships – such as infidelity or the man leaving them for someone else. Therefore, on the basis of the stress-appraisal-coping research, it can be suggested that some women may respond to these threats with cognitive reappraisal strategies to alleviate their (often unspoken) anxieties. These cognitive reappraisals do not need to be rational or accurate. Their function is to alleviate anxiety. Some of the themes detected in the qualitative study could be interpreted as such coping strategies. Idealisation of the partner and the relationship could help to alleviate the anxieties: thinking that the man and their relationship are very good, may help reduce their worries of being cheated on or abandoned. So those for whom the relationship is more important may be more likely to idealise their partner and relationship (link A).

The qualitative research also suggested that another strategy used by some women to alleviate their anxieties was to come up with explanations of why their partner would not be unfaithful (link B). This would have the effect of reassuring

themselves that the man is faithful (link C). On the basis of this, they may be more trusting of the man. On the assumption that those who feel the relationship is more important, are more likely to engage in strategies to alleviate any anxieties about it, and those who feel the relationship is more important are hypothesised to be likely to be more trusting of their partner. It is also suggested that those who idealise their partner and the relationship are more likely to trust their partner, since the idealisation may include an idealisation of their likely faithfulness (link D).

Link E and F

The qualitative study suggested that some women explained their partner's infidelity in ways that exonerated the man from blame – by, for example, blaming themselves, or by seeing infidelity as a natural and inescapable part of being a man. Such women may be more likely to tolerate infidelity when it occurs (link E). Evidence in the qualitative study also suggested that some women are prone to idealising their partner and their relationship. It seems reasonable to suggest that those who idealise their partner more are more likely to use the explanations of infidelity that do not involve blaming the man, and so are more likely to be tolerant of infidelity (link F).

Link G

This is a common-sense suggestion: if you have a lot to lose if a relationship ends, then you may be more prepared to tolerate infidelity in order to preserve the

relationship; but if the relationship is less important, a person may be less prepared to put up with unacceptable behaviour in order to keep it going.

Links H I and J

The background to these is the health belief model (Armitage & Conner, 2000) and the idea that people who perceive themselves to be at risk of infection will take steps to protect themselves, and conversely, that those who do not perceive themselves to be at risk will not take steps to protect themselves (link H). Trusting one's partner to be faithful seems a very likely contributor to someone feeling that they are safe (link I); there may also be a direct effect between trust and condom use (link J).

Link K

In the model, it is suggested that some alleviated their anxieties about their risk status by cognitively reappraising their situation in a less threatening way – for example, by reassuring themselves that regular testing and being in a long-term relationship protects them from the disease.

Link L

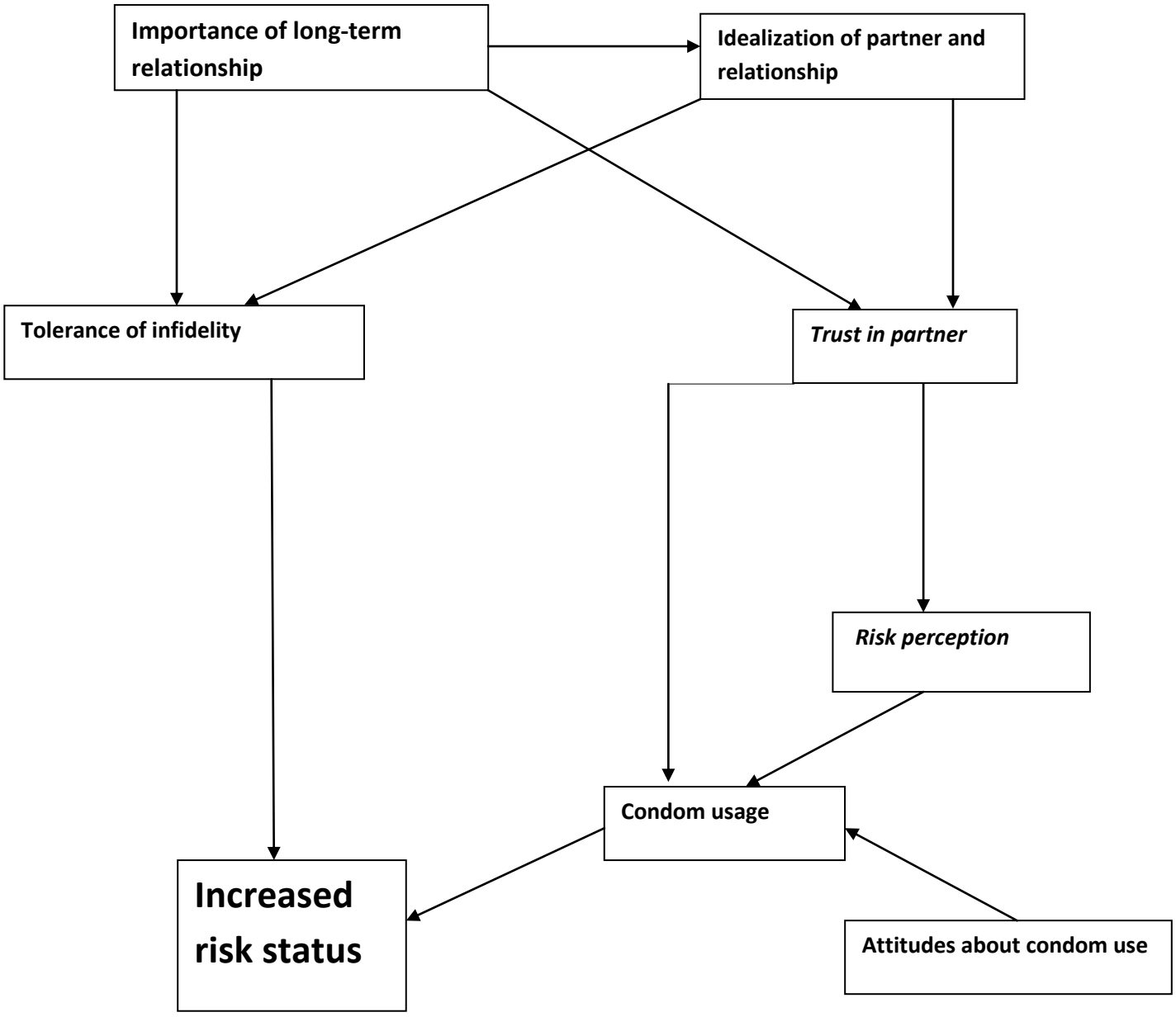
As reviewed in Chapter 2, attitudes towards condom use are viewed within the cognitive models as being influences on condom use. Many of the participants in the study had a negative attitude towards the use of condoms within a long-term relationship, and this may have decreased the likelihood of their use.

8.6: Next step

Following the qualitative study discussed above, a quantitative study was done to test some of the predictions arising from the model. It was not possible to measure all the variables in the model, as it would have been over-complicated; too demanding on the participants; and it would have been very difficult to measure some of the variables (e.g. the tendency to use strategies to alleviate anxiety about the trustworthiness of one's partner, or anxiety about one's HIV risk status).

Due to the complexity of the model and because of the difficulties of measuring some of the variables contained in it, the quantitative study tested only some of the links. These are shown in Figure 6.

Figure 6: A Simplified Version of Original Model, Showing the Associations Tested in the Final Quantitative Study:



The following were the hypotheses measured quantitatively and which will be discussed in chapter 9:

1. Women who tolerate infidelity more will be:
    i. Likely to perceive the relationship to be more important
    ii. More likely to idealise their partner
2. Women who trust their partners more will be:
    i. Likely to perceive the relationship to be more important
    ii. More likely to idealise their partner
3. More condom use within the relationship will be associated with:
    i. Less trust in their partner
    ii. A reduced perception of risk
    iii. Fewer negative attitudes about condom use

CHAPTER 9

WHEN LOVE BECOMES DANGEROUS: ACCEPTING INFIDELITY, DENYING THE USE OF CONDOMS AMIDST THE PRESENCE OF HIV

9.1: INTRODUCTION

In the first qualitative study (Chapter 5), relationships were highlighted as one of the issues relevant to a consideration of non-cognitive factors that may put women at risk. Their desire to be in a relationship meant that some women were at risk of exploitation by men, who played on that desire to obtain sex; Some women also saw sex without a condom as a way of moving a relationship onto the next level and establishing it as a steady relationship. A concern not to do anything to upset the relationship made it difficult for some women to negotiate the use of condoms within the relationship, and they simply went along with what the man wanted.

The concept of non-cognitive factors or socio-cultural factors, were discussed in chapter one. These factors include things such as music, personality traits, relationships, emotions, alcohol, stigma, trust, peer pressure, gender inequality, and tolerance to infidelity.

For many of the women in this study, there is awareness that these concepts exist, but there is not much time or effort placed in understanding how these concepts shape their decision making ability. To this end, in this study the concepts such as trust, relationship idealisation and risk perception, will be also noted as non-cognitive factors/socio-cultural factors.

The literature review of research on the role of relationships in women's vulnerability (Chapter 6), confirmed the relevance of relationship issues in understanding why women may not use condoms within a steady relationship. It also highlighted that another way in which steady relationships may put women at risk is when women are prepared to remain in a relationship (and have sex within that relationship) with a man that they know or suspect to have been unfaithful. The second qualitative study (Chapter 8) suggested a number of possibilities about the reasons why these two mechanisms of risk within a steady relationship (not using condoms and tolerating infidelity) may operate. Central to both mechanisms may be the importance of being in a steady relationship. Due to its importance, some of the participants seemed to put a lot of effort into protecting it from threat, and maintaining it in the face of threat. This may make them prepared to tolerate infidelity in order to maintain the relationship. Cognitive appraisals also appeared to be used as coping strategies to diminish any threats to the relationship and eliminate any concerns about threats to their own sexual health. These strategies included the idealisation of their partner; blaming themselves for infidelity or normalising the infidelity; and coming up with

reasons why the partner would not be unfaithful and with reasons to alleviate their anxieties about their risk status. It was suggested that the use of these strategies may result in some women having an unrealistic level of trust in their partner, and an unrealistic sense of the HIV-risk, that sex with their partner was placing them under. It was suggested that these unrealistic appraisals of trust and risk, together with negative attitudes towards the use of condoms, may partly explain the lack of condom use within the relationships.

The quantitative study reported in this chapter attempted to test some of these ideas. Questionnaires were used to measure the importance that the participant placed on their long-term relationship; the extent to which they idealised their partner; their willingness to tolerate any infidelity of their partner; their level of trust in their partner's faithfulness; their sense of risk within the relationship; their attitudes towards using condoms (both generally and within a long-term relationship; and their actual use of condoms within the relationship. The following hypotheses were tested:

1. Women who tolerate infidelity more will be:
    - Likely to perceive the relationship to be more important
    - More likely to idealise their partner
2. Women who trust their partners more will be:
    - Likely to perceive the relationship to be more important

- More likely to idealise their partner

3. More condom use within the relationship will be associated with:

    - Less trust in their partner
    - A reduced perception of risk
    - Fewer negative attitudes about condom use

9.2: Method:

9.2a: Sampling and Sample Size:

For the purpose of this quantitative study, a non-random convenience sampling method was employed to select participants. The reason for this was a lack of time and resources needed to obtain a random sample. Specific criteria had to be met to be able to participate in this study. The criteria included women between the ages of 18-35 years old and involved in intimate relationships for a minimum of three months minimum at the time of data collection, which were similar to those criteria needed to be a part of the previous qualitative studies.

A power calculation was carried out using the G-Power software (Faul, Erdfelder, Lang, & Buchner, 2007). The main analyses conducted were tests of the

significance of correlations. As the study was about complex social phenomena, it was expected that the population correlations would only be of a moderate size. With the power set at the conventional level of 0.8 and alpha set at 0.05 (two-tailed), G-Power indicated that a sample of **82** would be required to detect a moderate correlation (r=.30). This sample was however not achieved in this study, and only 60 were recruited. Limitations on time and resources meant that the recruitment of participants could only be carried out at one place, and that recruitment could not be continued until the target of 82 was reached. A post-hoc analysis using G-Power, a sample of 60 and otherwise the same parameters, indicated that the achieved power was 65%.

9.2b: Participant Characteristics:

The participants were required to be Vincentian women between the ages of 18 – 35yrs who were involved in an intimate sexual relationship with a man for a minimum of 3 months, at the actual time of data collection. Persons excluded from participating in this study were those who could not read and as such would not have been able to complete the questionnaire.

The participants came forward voluntarily in response to an advert for research participants placed at the National AIDS Secretariat, The Ministry of Health, Wellness and the Environment and the Infectious Disease Clinic. These are all located in

Kingstown, the capital of St. Vincent and the Grenadines (see Appendix 17 for a copy of the advert used).

The sample was thus a self-selected one that may not be representative of the population meeting the inclusion/exclusion criteria. Of the 70 that came forward, 60 women qualified to take part in the survey. Eight of the 10 women who did not qualify for inclusion, were not in a relationship for a period of 3 months at the time of the data collection and the other two women became apprehensive and changed their mind about answering questions about their relationships.

Table 6: Breakdown of Demographic Data:

Demographic Variables	Frequency	Percentage (%)
How old are you?		
18-22yrs	15	25
23-27yrs	24	40
28-32yrs	13	21.7
33 & older	8	13.3
Relationship type with current partner		
Getting acquainted	6	10
Dating	26	43.3
Common-law	12	20
Married	16	26.7
Living with partner		
Yes	25	41.7
No	35	58.3
Length of time in relationship		
3-6months	11	18.3
6-12 months	14	23.3
1-3years	12	20
3years & older	23	38.3
Educational background		
Primary	5	8.3
Secondary	19	31.7
Tertiary/University	36	60
Current Occupation		
Student	9	15
Housewife	6	10
Employed	36	60
Unemployed	9	15

9:2c: Data Collection measure:

Participants completed a 95-item self-report measure; comprising 8 sections (see Appendix 18). Some of these sections presented previously-published questionnaires in their original format; some presented previously-published questionnaires that were supplemented by additional items drawn from the qualitative data provided by the studies described in earlier chapters; some presented abbreviated versions of previously-published questionnaires; and some presented items that were drawn from a range of existing questionnaires or devised for the purposes of the present study.

(a)The Marital Aggrandizement Scale:

The Marital Aggrandizement Scale measures the extent to which the participant conveys an excessively positive portrayal of their partner and their relationship. It was developed by Norm O' Rourke and Phillipe Cappeliez (2002). The MAGS was studied with a sample of 610 adults over the age of 49 who had been married for at least 20 years. In O'Rourke & Cappeliez's study, the MAGS had good internal consistency, with an alpha of .85. It also has excellent stability with a reported test-retest coefficient of .80 over an average interval of 15months.

The scale had good construct validity, which was demonstrated by the lack of correlations, as predicted, with several other measures including measures of psychological well being, and moderate positive correlation with measures of marital satisfaction.

Scoring: Responses are on a seven-point Likert scale ranging from 'not true' (=1) to 'very true' (=7). Higher scores indicated a greater tendency towards idealization of their partner and relationship.

(b)The Marital Alternatives Scale:

The Marital Alternatives Scale (MAS) measures how much better or worse off persons thought they would be without their current partner. It provides a measure of how much emotional and practical investment the participant has in their current relationship. It was developed by Udry (1981).

In a study involving nearly 400 couples, Udry (1981) reported only modest internal consistency (split-half reliability = 0.7). He reported good concurrent and predictive validity; the measure significantly predicted disruption (divorce or separation).

The MAS, which originally is an 11-item scale, was modified for the purpose of this study, with the addition of 6 items provided from the qualitative studies carried out by the researcher. These additional questions were coined from the data collected in study three where women alluded to the cultural expectation and social pressure that existed to maintain a relationship; for example study three revealed that women were pressured by their families and friends to remain in a relationship, and as such, a question was added which reflected this: "Family and friends would look down on you

because you couldn't keep your man...." Options: Impossible; Possible but unlikely; Maybe; Certain.

It was also important for there to be culturally sensitive questions, because a measure validated in the Western Cultural context may not wholly be valid in the Vincentian culture. Using qualitative data gathered from the relevant cultural context may enhance the validity of the measure.

Scoring: Seven items on this scale were reversed scored; item responses ranged from 1(impossible) to 4 (certain) and were scored by simply summing across items; the maximum possible score was 68, whilst the minimum possible score was 17. To aid in the interpretation of the results, total scores were reversed so that higher scores indicated that the relationship was more important to the participant.

(c) Attitude towards Cheating Scale:

The purpose of the attitude towards cheating scale was to gain a better understanding of what people would do in the face of infidelity, as well as to understand their willingness to stay or leave the relationship.

This scale was developed using the questions derived from a questionnaire by Whately ("Attitudes towards Infidelity Scale"; Whately, 2006) as a guide. Items from Whately's scale were reworded and restructured. In addition to this, questions were

also formulated using information gathered from the two previous qualitative studies conducted. These questions measured not only the tolerance towards infidelity but ,the willingness to confront their partner's infidelity and to continue in the relationship despite their partner's infidelity.

There were two main questions asked in the scale: (1) suppose you had reasons to suspect that your partner might be having sex with someone. What would you do? (2) Suppose your partner admitted having sex with someone else. What would you do? An example of the response options were "Do nothing and carry on as normal".

The highest value for each item response was (5), whilst the lowest was one. A high score on the entire scale meant that there was a greater tolerance for infidelity.

(D) Trust in Partner scale:

The Trust in Partner scale was developed to assess their beliefs about whether their partner might be unfaithful and might put them at risk of catching HIV.

The scale was developed using information gathered from the two previous qualitative studies conducted. This scale had one main question, which asked: "How likely is it that your current partner, he is in a relationship with you, would do the following?"…with possibilities ranging from "Have sex with someone else" to "Tell

you if he was infected with HIV or other STI". Options included: Definitely do this; probably do this; not sure; probably wouldn't do this; definitely wouldn't do this.

The highest value for each item response was (5) whilst the lowest was one. A high score on the scale meant that there was great trust in one's partner.

(E) Condom Use scale:

This scale was devised for the current study, using some items from other measures of condom use scales such as Riley and Baah-Odoom (2010) and the Counselling and Testing for HIV protocol booklet (JHPIEGO, 2004).

A total of seven questions were developed to assess whether the participants used condoms in their current relationships. Questions were asked to solicit a yes or no response. For example: "Have you ever used condoms in your current relationship?"…Yes or No. A response in the affirmative was given a score of (1). A maximum score of (7) represented high condom usage in the relationship.

(F) Attitudes towards Condom Use Scale:

To assess general attitudes towards condom use, 12 items were taken from the questionnaire developed by Riley and Baah-Odoom (2010). An additional five items were added to assess potential obstacles for future use of condoms in relationships where they were not currently being used. An example is: If I asked to use a condom in

the future, my partner would think I'd been sleeping around. These items were based on findings from the two qualitative studies. Questions were answered on a five-point scale ranging from 'strongly agree' to 'strongly disagree'. Higher scores indicated more positive attitudes towards condom use.

(G) Risk Perception Scale:

In this section of the questionnaire, most of the questions were taken from the instrument used by Riley and Baah-Odoom (2010). Additional questions were added about how vulnerable they felt within their current relationship. It thus measured the person's views on their general level of susceptibility to contracting HIV, and their susceptibility within their current relationship. In Riley and Baah-Odoom's study the internal consistency value was 0.63.

This scale had possible responses ranging from: (1) strongly agree to (5) strongly disagree... They were asked to respond to how strongly they agreed to statements such as: "It's possible I could catch HIV from my current partner." The minimum possible score was 13, the maximum possible score was 65. Higher scores indicated greater perceived risk.

9:3: Ethics Approval:

Ethics approval for the study was granted by the Ethics Committee at the University of Birmingham (see appendix 19 for a copy of the approval letter).

9:4: Procedure:

The adverts requesting women to participate in this study (Appendix 11) were placed at three locations: the Ministry of Health, Wellness and the Environment, the Infectious Disease Clinic and the National AIDS Secretariat. The adverts were displayed two weeks before the commencement of data collection, on the walls of these buildings and on the public bulletin boards, accessible to the general population of persons seeking medical care or general health information and HIV testing.

The adverts gave information about the approximate length of time needed to complete the questionnaire, the inclusion and exclusion criteria, and the type of information that would be solicited from the participants, as well as the contact information of the researcher. The adverts also indicated that there was a bonus prize to be won for taking part in the study.

When a potential participant attended one of the sites at the set times, they were initially met by a research assistant, who established whether or not they satisfied the inclusion/exclusion criteria.

Those who met the criteria were given the participant's information sheet (Appendix 20) to read by the researcher assistants, who answered any questions they had about participating in the research. Those who were willing to continue were given a date to return (one week later) to complete the questionnaire.

When they returned at the appointed date, the research assistants assisted with the distribution of the consent forms (Appendix 21) and provided the potential participants with another participant information leaflet so that they could remind themselves about the purpose of the study. The researcher was on hand to answer any questions participants had about the study. Once they had signed the consent form, they were given the questionnaire by the researcher and placed in a quiet room by themselves to complete the questionnaire. The questionnaires took approximately 45-60 minutes to complete.

When finished, the participants were given a plain empty envelope, in which they were asked to place the completed questionnaire, which they sealed and handed over to the researcher. Using this method offered the participants a sense of comfort in knowing that their responses were held in the strictest confidence and would not be traced back to any one person, as no names or identifiers were placed on the questionnaires by the participants. Participants were given their codes, and would be required to present their codes if they were successful at the prize draw. Additionally, if they wanted to withdraw from the study, they were given a two-week period from the point of completing the questionnaire to contact the researcher and ask that their questionnaire code be withdrawn from the study.

9.5: RESULTS

9:5.1: Preparation of the data for analysis:

The data were first entered on SPSS. The file was searched for missing data. A number of options have been proposed for dealing with missing data (Acock, 2005; Marlin, Roweis, & Zemel, 2005). One option is to simply omit any subscale score that has missing data from the analysis. This option had disadvantages in the present case. Simply omitting the data can bias the outcome in the case that the data are not missing at random, but are related to some observed or unobserved variable (Hamer & Simpson, 2009); and the option can also cause problems when the sample size is small or moderate, because of the impact this has on the power of the statistical tests. As an alternative, it was decided to pro-rate the subscales score when any data were missing unless the participant had missed a large number of items. It was considered that, because the amount of missing data was relatively small, this would not have any great impact on the outcome of the analysis – or at least would have less of an impact than omitting subscale scores when any data were missing. Accordingly, participant SW06 was removed from the file because she had a lot of missing data and was scoring at the extremes on the items she did complete. Otherwise, only 6 other participants had missed items; 4 of these missed only one item, 1 missed three and 1 missed four items.

The distribution of each subscale variable was then inspected for normality, using the explore function under the 'descriptive statistic' feature on SPSS. Each

subscale total was also examined for skewness and kurtosis by dividing the statistic by its standard error. A result that was greater than 2.58 was taken as evidence of significant skewness or kurtosis (Tabachnik & Fidell, 2001). The data were also inspected for the presence of univariate outliers. At this point, it was revealed that the Marital Aggrandizement Scale total using the recoded scores showed significant skewness and kurtosis. This may have been attributed to the outlier present with one participant scoring 16 out of a maximum total of 18 on the scale. To address this, the recommendation by Tabachnik and Fidell (2001) was adopted, whereby the outlier was given a raw score that was one unit smaller than the next most extreme score in the distribution. Having done this, the outlier disappeared and the scores were normally distributed. All the other variables were normally distributed using the criterion described above. Accordingly, the data were subjected to parametric analysis such as the Pearson's correlation.

Scatter-plots of the variable pairs involved in the hypotheses were also inspected for the presence of bivariate outliers. Once the univariate outlier on the Marital Aggrandizement Scale was adjusted, no bivariate outlier was detected.

9:5.2: Descriptive Statistics:

Table 9 provides the mean, standard deviation, possible and obtained ranges, and internal consistency (Cronbach's alpha) for all the subscale scores. Except for the Attitudes towards Cheating Scale, all internal consistencies were above 0.7, which is

usually considered the benchmark for acceptable internal consistency (Bland & Altman, 1997). Scores on all the variables showed a good spread across the possible range of scores. The Attitudes towards Condom Use Scale caused some difficulties. Five of the items were to be answered only in the event that condoms were not currently being used within the relationship. However, all participants answered these items, suggesting there had been some confusion about them. So these items were excluded from the total. Also excluded from the total were two items that asked about the benefits of condom use (protection against pregnancy and against infection). All participants agree with these items. As a result, their correlation with the total was low. Table 7 provides statistics for this scale with these seven items excluded.

Table 7: Descriptive Statistics

Variables	Mean	St. Dev	Cronbach's Alpha	Possible range of scores	Minimum Actual Score	Maximum Actual Score
Marital Aggrandizement Scale	64.61	13.61	.775	18-126	25.0	108
Marital Alternative Scale	48.65	8.57	.885	17-68	25.0	63.0
Attitudes towards Cheating	39.35	5.27	.680	11-55	29.0	50.0
Trust partner	20.05	4.11	.714	6—30	11.0	30.0
Risk perception for HIV	41.56	7.42	.798	13-65	30.0	60.0
Actual condom use	4.01	2.04	.768	0-7	0.0	7.0
Attitude toward condom use	31.95	8.66	.864	10-50	18.0	47.0

9:5.3: Participants' scores on subscales:

It is worth noting that the scores gathered on the subscale Actual Condom Use. Only 65% used condoms on the first occasion of having sex within the relationship, and only 30% used a condom on the last occasion – even though nearly 60% reported that they or their partner kept a supply of condoms at home. This suggests a relatively low usage of condoms within these relationships.

Table 8: Correlations Between Subscales In The Hypotheses

Attitude towards cheating (Tolerates infidelity)	Marital Alternative Scale (relationship being more important) (. 417**) Marital Aggrandizement Scale (Idealise partner) (.246)
Trust in Partner	Marital Alternative Scale (relationship being more important) (-.064) Marital Aggrandizement Scale (Idealize partner) (-.079)
Condom Use	Less trust in Partner (-.298*) A reduced perception of risk (-.110) Fewer negative attitudes towards condom use (.240)

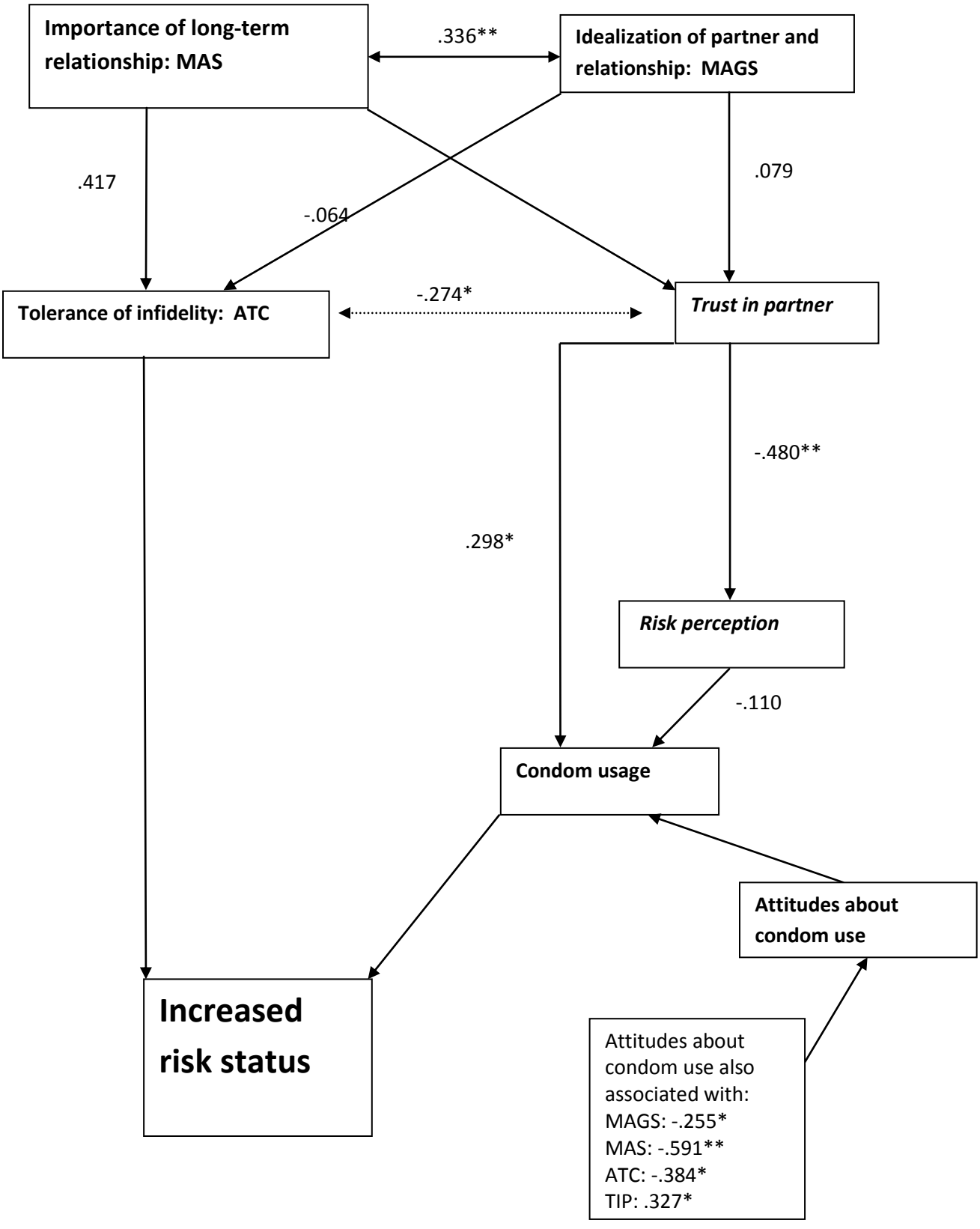
Table 8 showed the relationships existing between the subscales on the questionnaire. The original hypotheses were revisited, and this will be discussed below will with an indication of whether they were supported by the results. Firstly it was expected that women who tolerated infidelity would be more likely to perceive their relationship as more important (measured by the MAS); this claim was supported (.417**), whilst the claim that women who tolerated infidelity were more likely to idealise their partner was not supported, (.246).

Secondly, it was hypothesised that women who trusted their partners would be likely to perceive their relationship as being more important than it is, and would idealise their partners; these claims were not supported, with correlation coefficients (-.064 & -.079) respectively.

Thirdly, it was hypothesised that more condom use in the relationship would be associated with less trust in their partner, but contrary to this expectation, more condom use was significantly associated with greater trust in the partner, (-.298*). Additionally, it was found that more condom use within the relationship was not associated with a reduced perception of risk (-.110) nor fewer negative attitudes about condom use by these women, (.240).

Figure 6, which is a simplified version of the original model, shows the parts of the model that were tested, and demonstrates whether the hypotheses were supported or not. The figures show Pearson's correlation. Asterisks show the significant findings.

Figure 7: Diagram showing correlations relevant to hypotheses



From the diagram, there is evidence to support the idea that those who have a lot invested in the relationship tend to idealise that relationship. There is also evidence to support the idea that having a lot invested and idealising the relationship will result in a greater tolerance of infidelity. However, there was nothing to support the idea that these two factors would result in more trust in the partner. Also, although more trust in the partner was associated, as hypothesised, with a perception of being at less risk, feeling less at risk did not produce less condom use and was, in fact, non-significantly associated with more condom use. Moreover, more trust in the partner was, contrary to the hypothesis, significantly associated with *greater* condom use (.298*).

It must also be highlighted that favourable attitudes towards the use of condoms did not significantly predict actual condom use. In addition to this, it was noted that Attitude Towards Cheating was negatively correlated with Trust in Partner (-.274*) – which might be due to the fact that those who do not trust their partner, and who are intolerant of infidelity, would be less likely to be still in a relationship – so the sample may contain a biased number of those who do not trust their partner, but who are tolerant of infidelity.

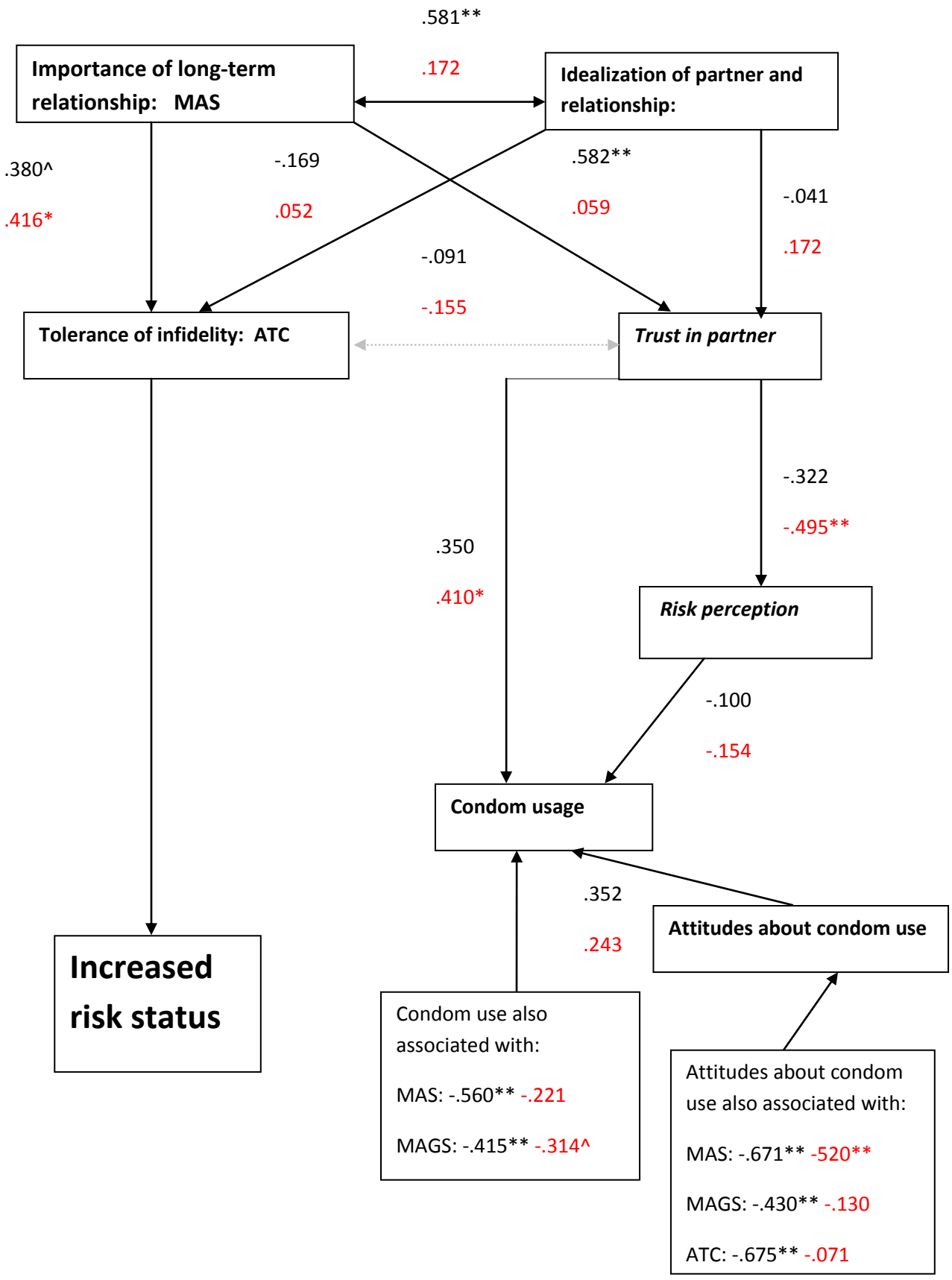
9:5.4: Demographic Analyses:

This section reports on how the demographic variables related to the subscale scores on the questionnaire. The analyses revealed that the youngest age group and the student group (which were, unsurprisingly, significantly associated with each other)

had more positive attitudes towards condom use, but they were not using condoms more frequently. There were no significant differences in relationship type (married, common-law etc.). Those living with their partner had significantly higher scores on the MAS, which probably reflects their greater economic dependence, and as such, the ending of the relationship would have a greater impact etc. Condom use was significantly higher in the group of women who had been in their relationships for the least amount of time (3-6 months), reflecting the finding from the qualitative study that condom use tended to become less frequent as the relationship developed and that, once it had stopped, condom use was unlikely to start up again.

For levels of education, an analysis was carried out based on dividing the sample into two – those who had received tertiary education and those who had not – in order to avoid too small samples in the individual demographic categories. Results of the analysis are shown in Figure 6. Figures in black show results for those with no tertiary education, and figures in red show results for those with tertiary education. Lower levels of education were significantly associated with greater tolerance of infidelity (i.e. higher ATC scores); less trust in the partner; and less favorable attitudes towards condom use (though not less frequent condom use). This may help explain the unexpected significant negative correlation between the ATC and Trust in Partner scores – i.e. the connection is due to the fact that both are connected with level of education.

Fig 8: Model showing Correlations with Education Status



9:6: Discussion:

This study followed up on the earlier quantitative study (which suggested the importance of long-term partners in the spread of HIV) and the earlier qualitative study (which suggested some possible factors that might make women in long-term relationships vulnerable to contracting the disease). Specifically, the study investigated two factors within long-term relationships that may make women vulnerable – the tolerance of infidelity within the relationship, and failure to use condoms. The model proposed on the basis of the qualitative study, suggested a number of factors that might influence these two outcomes. The present study tested aspects of that model.

9.6.1: Tolerating infidelity

The results supported the proposal of the model that those who had more invested in the relationship and for whom the consequences of ending the relationship were more serious (as measured by the MAS), were more likely to tolerate infidelity in the relationship. This is not a very surprising finding: If a person has a lot to lose when a relationship ends, then they may be more prepared to tolerate infidelity in order to preserve the relationship; but if the relationship is less important, they may be less prepared to put up with unacceptable behaviour in order to keep it going. Nevertheless, the finding may be of importance in considering how women are put at risk for HIV infection in SVG. The results of the qualitative studies and of this study

indicate that the social and cultural consequences of not being in a steady relationship are considerable issues for Vincentian women, as seen in study one and study three. Additionally in the quantitative study, on the MAS for instance, only 14% of the sample were certain that they could support themselves at their present standard of living if the relationship ended and 78% thought this was very unlikely or impossible, which speaks of the economic disparity between the women in this study and the men they were involved with, as it appeared that these women were quite economically dependent on these men for survival. Thirty six percent of the women were certain (and another 18% thought it likely) that they would feel ashamed if they had to tell others that the relationship was over. Given this degree of pressure on Vincentian women to obtain and sustain a long-term relationship, it may be that many of them are willing to tolerate levels of infidelity in a relationship that would be unacceptable in other societies. That willingness to tolerate infidelity within the relationship then, in turn, puts them at increased risk of HIV infection.

Another aspect of the model was supported for those with less education: Placing greater importance on the relationship was associated with a tendency to idealise the relationship and the partner; and this idealisation, in turn, was associated with a greater tolerance of infidelity. The explanation for this is not clear. In Chapter 8, it was suggested that idealisation may be a cognitive reappraisal strategy that helps the person cope with anxieties about threats to the relationship. Possibly, this is a coping strategy, which those with less education are more likely to use. Also in Chapter 8, it

was suggested that the link between idealisation and the willingness to tolerate infidelity is that those who idealise their partner and the relationship may be more likely to explain infidelities in terms of factors such as their own failings or the normality of male infidelity, rather than in terms of the failings of the man; and that those who explain the infidelity in this way are more likely to be tolerant of it. Again, it may be that those with less education are more likely to blame themselves or to normalise infidelity rather than to blame the man. Consistent with this explanation; those with less education were significantly more tolerant of infidelity than those with more education.

9.6.2: Trusting partner

In Chapter 8, it was suggested that another coping strategy that some women used for dealing with anxieties about the relationship and about HIV risk was to come up with explanations of why their partner would not be unfaithful. This led to the suggestion that the more important the relationship was, the more likely the person was to have addressed these anxieties in this way and therefore the more likely the woman was to trust their partner. It was also suggested that those who idealised their partner and the relationship would be more likely to trust them, since the idealisation may include an idealisation of their likely faithfulness. The results of the present study provided no support for either of these two suggestions. One possible explanation of this is that there are much more powerful influences on trust, and that therefore any

effect of these two weaker factors was unlikely to be detected. For example, the man's actual behaviour is likely to be the most important predictor of trust.

9.6.3: Use of condoms

Another factor that puts women at risk within long-term relationships is not using condoms. The results of the study suggested that failure to use condoms in steady relationships may be a major issue in increasing HIV risk for Vincentian women: Only 65% of the current sample used condoms on the first occasion of having sex within the relationship, and only 30% used a condom on the last occasion. The findings of this study are consistent with other research that has suggested low rates of condom use in steady relationships (e.g. Riehman et al., 2006; Bazargan et al., 2000; Friedman et al., 2002). As stated by Macaluso et al. (2000), in Riehman et al. (2006, p.667); "HIV risk may be higher among persons, who report being in monogamous relationships as a result of lower condom use in longer, more committed partnerships."

The model proposed two reasons for reduced condom use: firstly that those who trust the man less may feel more at risk of HIV and therefore are more likely to use a condom; and that negative attitudes towards the use of condoms would be associated with reduced use.

9.6.4: Role of Trust and risk perception

The results did not support the prediction. Although those who trusted their partner less, felt significantly more vulnerable to HIV, feeling vulnerable to HIV

was not associated with more condom use. Also, contrary to the predictions of the model, those who trusted their partner more were significantly more likely to use condoms within the relationship.

There are a number of possible explanations of why feeling vulnerable to HIV was not associated with more condom use. First, it was clear from the first qualitative study (Chapter 5) that many participants did not take any responsibility for condom use and simply left the decision to the man. Therefore, concerns about their risk status may not have been associated with actual condom use, because few women make the decision to use condoms within the relationship. Secondly, the association between risk perceptions and condom use appears to be a complicated one (Riley & Baah-Odoom, 2010). The findings also alluded to some studies which have supported the idea that perceiving more risk leads to greater condom use (e.g. Adih & Alexander, 1999), but others have reported the opposite (e.g. Akwara, Madise, & Hinde, 2003). One possible explanation of this inconsistency is that perceived risk may be influenced by the individual's actual use of condoms – that those who have actually put themselves at more risk by not using condoms may accurately perceive themselves to be at higher risk (Burkholder, Harlow, & Washkwich, 1999). The link between higher risk perception and condom use may therefore only be likely to occur for intended condom use, rather than actual condom use (Riley & Baah-Odoom, 2010). As the present study measured actual condom use, it may have been unlikely that the expected link would occur.

An unexpected finding was that contrary to the predictions of the model, those who trusted their partner more were significantly more likely to use condoms in the relationship: the explanation of this is not clear. It may be that the man's willingness to use condoms in the relationship made the woman feel more confident that he would use condoms outside the relationship, and therefore that she was at less risk of being infected by him. It may be that the man's willingness to use condoms also made her feel that he took his responsibilities about protecting their sexual health seriously, and that he was therefore less likely to be unfaithful.

9.6.5: Attitudes towards condom use

In this current study, attitudes towards condom use did not significantly predict actual condom use. This is surprising because attitudes towards condom use have generally been found to be reliable predictors of condom use. In a large meta-analysis of the predictors of condom use, Sheeran et al., (1999) reported that across 38 studies, the mean correlation between the two was 0.32, and thus, statistically reliable. Attitudes towards condoms also appear as factors in applications to condom use of the cognitive models of health behaviour, such as the theory of planned behaviour. However, many of these studies involved male participants and were conducted in affluent societies. As noted previously, this present research has found that many Vincentian women do not contribute to decisions about condom use within the relationship; as seen in study one, section 5.7.7, page 123. This may explain of why their attitudes towards condom use did not significantly predict actual condom use.

9.6.6: Condom use predicted by the MAS and the MAGS

For the group that has received less education, condom use was predicted by the importance of the relationship (MAS) and the idealisation of the relationship (MAGS). Those who had more invested in the relationship and idealised it more were less likely to use condoms. This connection was not explained by the route predicted by the model (i.e. via trust in partner). So what might explain it? Some of the questions about attitudes towards condom use asked about the use of condoms in the context of long-term relationships. It was clear that many participants felt their use can be damaging to the relationship. For example, 38% agreed that 'asking to use a condom causes bad feelings in a relationship'. Those who have invested more in the relationship and who idealise it more may be more concerned about avoiding causing potential damage to the relationship by insisting on condom use – so they may be more likely not to insist on their use. This would be another example of the importance of being in a relationship overriding other considerations. This suggestion may also help explain why the MAS and the MAGS also predicted the attitudes to condom use variable for the whole sample.

CHAPTER 10

GENERAL DISCUSSION OF STUDIES

10.1: Summary of results

- Study One:

Based on a review of the literature that raised questions about the sufficiency of the cognitive models of health behaviour (Chapter 2) and that implicated non-cognitive factors such as cultural and social issues (Chapter 3), the first study was a qualitative study exploring the contribution of cognitive and socio-cultural factors to unsafe sexual behaviours, with a particular emphasis on the role of the Carnival. The study involved ten Vincentian women aged between 18 and 35years. All of these women were self-reported partygoers (attended parties or carnivals fairly regularly).

The data suggested the importance of gendered norms and the ideal of virginity in contributing to a lack of communication and education about sex and to shame and secrecy when the ideal and the norms were breached (ICRW, 2001-2005). These, in turn, led to young women being unprepared and naive, and liable to exploitation by predatory men, or to ending up unwittingly in situations where the males expected sex. The carnival was viewed as a time when unsafe sex was more likely to happen (International AIDS Alliance, 2008). This was because of the removal of social constraints on sexual behaviour, alcohol, music and dancing, and transport problems.

Wanting to be loved, and in a long-term relationship, appeared to be another factor associated with unsafe sex. This led some women to be exploited by predatory men who used the language of love to obtain sex. Sex without a condom was seen as a way of moving a relationship on to the next level, and establishing it as a long-term relationship. Negotiating condom use within a relationship was uncommon (CAREC, 2007). Those who were economically dependent on their partner were obliged to go along with what the man wanted. The importance of establishing or maintaining the relationship also meant that some women were unwilling to go against the man's wishes, or to threaten the relationship by raising the issue of condom use.

Another aim of this study was to investigate the extent to which participants engaged in the process of rational consideration about the advantages and disadvantages of different courses of action assumed by the cognitive models of health behaviour. There was little evidence of this. Perhaps due to their being unprepared and naive, many participants felt that sex 'just happened'. This was felt to be particularly true in the Carnival, where sex was seen as almost the natural consequence of the removal of behavioural inhibitions, the alcohol, the music and the dancing. One participant felt that rational considerations about sexual health were often overridden by the woman's emotional response to the man and her desire to please him (Bloor, 1995; Rhodes, 1995; Bastard & Cardia-Voneche, 1997).

The first study highlighted a potentially important role for long-term relationships in increasing the likelihood of women engaging in unsafe sexual

behaviour. Wanting to be loved and in a long-term relationship led some to be exploited by predatory men who used the language of love to obtain sex. Sex without a condom was also seen as a way of moving a relationship to the next level, and establishing it as a long-term relationship. The importance of establishing and maintaining the relationship also meant that some women were unwilling to go against the man's wishes over condom use, or to threaten the relationship by raising the issue of condom use.

Although both qualitative studies suggested that there were barriers to condom use amongst Vincentian women, such as embarrassment about their purchase and beliefs that their use might undermine a relationship, the role of beliefs and attitudes in influencing condom use is well established in previous research (e.g. Albarracin et al., 2001). It was therefore decided not to measure attitudes to condom purchase and use in the second quantitative study but, instead, to focus on other factors that have been less well studied, which were more directly related to some of the themes from the qualitative studies that were more specific to Vincentian women (such as the importance placed on intimate relationships and the tendency to idealise the partner and relationship).

- Study Two:

The second study was a survey study to investigate the role of long-term relationships in HIV infection, in a more direct manner. Seventy-five women attending

a HIV clinic were asked how they thought they had contracted the infection. The overwhelming majority (96%) believed that they had contracted it within a long-term relationship – either from a husband or common-law partner (40%) or from a steady partner whom they were not living with at the time of the infection (56%).

❖ Study three:

The third study was a qualitative study involving nine participants that explored these issues in more detail. The participants were women between the ages of 18-35 years, who were currently in a steady long-term relationship for minimum a period of six months and a maximum period of three years.

Several themes about long-term relationships were generated from this study. For many of the participants, long-term relationships were seen as highly important because of the benefits they brought (e.g. economic security) and because of social pressures to be in such a relationship. The importance of the relationship meant that women were willing to make a lot of effort to secure and maintain a relationship. Infidelity within such relationships had been experienced by many of the participants. Many were willing to tolerate it, and gave various reasons for this. Some of these reasons involved explaining the infidelity in terms that exonerated the man from blame (e.g. blaming themselves for not being able to keep their man happy). Most of the participants also stated that they had a high level of trust in their partners, although the behaviours of some of them suggested that there was a gap between stated and actual

trust. Various reasons were given for having this trust in their partners. Perception of HIV-risk within the relationship varied. Some denied being at risk, but others were worried about it. Some participants used various strategies to reassure themselves about their risk. Condoms were not often used in the relationships. Various reasons for this were given; some of which suggested that the decision about condom use was left to the man and the woman went along with whatever he wanted.

- Study Four:

On the basis of the last qualitative study, Chapter 9 developed a model of how long-term relationships might put women at risk in terms of the factors that might increase their willingness to tolerate infidelity in the relationship, and that might decrease their use of condoms. The final quantitative study was designed to test this model. Sixty women completed questionnaires that measured the importance of the long-term relationship to them; their tendency to idealise their partner and their relationship; their level of trust in their partner; their willingness to tolerate infidelity; their perception of their risk status within the relationship; their attitudes towards condom use; and their actual condom use.

This study investigated two factors within long-term relationships that may have made women vulnerable – the tolerance of infidelity within the relationship, and failure to use condoms. The model proposed on the basis of the qualitative study suggested a number of factors that might influence these two outcomes, and the present study

tested aspects of that model. The following is an itemised summary of the overall findings of this study:

- Women were more likely to tolerate infidelity if they had invested more in the relationship, and if they deemed the consequences of ending the relationship more serious.

- Looking at the link between the tendency to idealise relationship and a tolerance towards infidelity; although the explanation is not clear, it was consistent those with less education were significantly more tolerant of infidelity than those with more education.

- The results suggested that the failure to use condoms within steady relationships might be a major issue in increasing HIV risk for Vincentian women. The findings of this study are consistent with other research that has suggested low rates of condom use within steady relationships.

- There was no support for suggesting that the more important the relationship, the more likely the woman was to trust her partner.

- The results did not support the prediction that those who trusted their partners less would feel more at risk in their relationship. Although those who trusted their partner less felt significantly more vulnerable to HIV, feeling vulnerable to HIV was not associated with more condom use. Also, contrary to the predictions

of the model, those who trusted their partner more were significantly more likely to use condoms within the relationship.

- Finally, attitudes towards condom use did not significantly predict actual condom use. For the group that had received less education, condom use was predicted by the importance of the relationship (MAS) and the idealisation of the relationship (MAGS). Those who had invested more in the relationship and idealised it more, were less likely to use condoms. This connection was not explained by the route predicted by the model (i.e. via trust in partner).

10.2: General conclusions

Taken together, the four studies underline the importance of social and cultural factors in understanding why women in SVG put themselves at risk of HIV infection. Social norms and ideals about how women should behave mean that sex outside long-term relationships can be surrounded by shame and secrecy, leaving many young women vulnerable to exploitation and to sexual encounters, for which they are unprepared. The carnival is a time when unsafe sex seems particularly likely, because of the withdrawal of the usual social constraints on behaviour and the prevalence of sexual stimuli such as the dress, the music and the dancing. Long-term relationships also appear to be a significant risk factor, as evidenced by the high rate of HIV infections that appear to have happened within such relationships. The desire to establish and maintain such a relationship appears to be an important factor in raising

risk, in several ways. It makes naive young women vulnerable to sexual exploitation by men who use the language of love to obtain sex. Sex without a condom is used as a way of moving a relationship onto the next level and turning it into a long-term relationship. Condom use within long-term relationships appears to be relatively infrequent, and not using a condom is seen as an expression of the intimacy and depth of the relationship. The importance of avoiding anything that might threaten the relationship means that some women simply go along with the man's wishes in terms of condom use, and that some are willing to tolerate infidelity within the relationship.

By contrast, the explanations offered by the cognitive models of health behaviour fared less well. In the first qualitative study, participants did not view their sexual behaviour as the product of a rational assessment of the pros and cons of unsafe sexual behaviour. Instead, sexual encounters were viewed as something that 'just happened', and which women were often unprepared for; or they were viewed as being the result of emotions and not reasoning. In the last quantitative study, contrary to the predictions of the cognitive models, attitudes towards condom use and perceived risk were not significant predictors of condom use. This was not necessarily surprising, if it was the man who made the decisions about condom use in the relationships.

10.3: Practical Implications

The results of the first qualitative study suggest the need for more open communication about pre-marital sex in Vincentian society, particularly between

mothers and their daughters. Young women need to be better prepared for sexual encounters so that they can make more rational decisions about their sexual health, rather than finding themselves in sexual situations for which they are unprepared or in which they are exploited by predatory men. The naivety of some young women about sexual matters needs to be tackled through better education in schools and a greater willingness of parents to talk to their children about these matters. Several studies (Kirby, 2001a, 2005b; Alfred, 2003a, 2008b; Santelli et al., 2006) have shown that very effective sex education and HIV prevention programmes have result in person delaying sexual initiation, reducing the frequency of sex, and number of sexual partners. These programmes also contribute to a decrease in incidence of unprotected sex, and an increase in the use of condoms, and other contraceptives.

Additionally, social attitudes towards female sexuality need to change, both in terms of the expectation that women should save themselves for marriage, and in terms of the pressures that women feel when they are not in a long-term relationship. Pre-marital sex in Vincentian society is widespread. Strong social disapproval will not alter this. Instead, it just promotes the secrecy and shame that means there is little open discussion of the issue, and therefore, young women are naive and unprepared. Similarly, it is not helpful when women who are not in long-term relationships are made to feel incomplete and inadequate. This is a factor in increasing their risk status. One way of tackling these issues would be to raise awareness of the damaging effects of these social attitudes on women through discussions in the media.

The increase in unsafe sex associated with the carnival also needs to be addressed. There is a great need for the Government, primarily the Ministry of Health and those organisations involved in addressing HIV/AIDS to amplify their prevention programmes specifically during the carnival period,. Information about safe sex and condoms need to be made freely available during this period.

Performers and producers of the various shows and carnival events need to be made more aware of, and take more responsibility for, the impact that the lyrics, dances and general atmosphere during the carnival can have on the behaviour of impressionable and vulnerable youngsters. One very practical step that could be taken is to address the gap in the public transport system. It was clear from some of the participants in the first qualitative study that the absence of any public transport after the end of carnival events left young women vulnerable; rides home were often available only at the cost of sex, at the end of the ride.

Another practical step would be to make it easier for young women to access condoms. In the first qualitative study, it was clear that buying condoms in the usual outlets was associated with shame, embarrassment and the fear of parental discovery. Consideration needs to be given to how women can access condoms without having to go through this threat of humiliation.

Gender and social inequalities need to be tackled. Some of the participants were economically dependent on their male partners, and this is why the relationship was so

important for them and, accounted for them putting up with infidelity and avoiding conflict over condom use. Priority given to men in making the decisions over condom use probably reflects wider gender inequalities in society.

Through family discussions, education and public health campaigns, women should be encouraged to take more responsibility for their own sexual health. Too often in these studies, participants seemed to be passive and accepting in the face of threats to their sexual health – whether in the form of an unfaithful partner, or a partner who is unwilling to use condoms. Women need to be more proactive and take more control over these situations. This may require programmes to help them develop the necessary skills for dealing with such situations.

Finally, education and public health programmes also need to tackle some of the unhelpful attitudes, beliefs and myths, evident in these studies that increase women's risk status. These include the ideas that women are safe in a long-term relationship from infection; that sex without a condom indicates the seriousness of the relationship, and is a way of taking it to the next level; that condoms are not acceptable in a long-term relationship; and that men are not to blame for infidelity (because it is just in their nature, or because it is the woman's fault for not keeping them sexually satisfied).

10.4: Limitations of the studies

- Qualitative Studies (studies 1 & 3):

Due to the sensitive nature of the research interest and taboos around discussing sex in culture, it was a challenge to get participants to speak freely about issues around HIV risk; their relationships and sexual activities. To attempt to address this, sometimes the questions were more specific and closed than is typically the case in qualitative research. This is acknowledged as a potential weakness that may have created some bias in the data. The responses were recorded immediately by the researcher; this may have been unnerving and may have caused the women being studied to provide biased responses that they assumed the researcher wanted to hear, as well as the responses that may have presented them in the best light.

As with all qualitative studies, the results are a product of the researcher's choice of interview questions and the researcher's interpretation of the data, and so personal biases of the researcher may have influenced the results (Yardley, 2007). However, to address this, the researcher's supervisor was also involved in the process of analysis, ensuring that each theme was supported by data and assessing the plausibility of the interpretations. Efforts were made to ensure that major points were always supported by direct excerpts from the transcripts. After the first qualitative study, an overview of the results was also presented and discussed with a consultation group composed of women from a similar background to the participants, to determine whether they endorsed the findings.

Another limitation of qualitative studies is that it is difficult to know how representative the participants were of the general population of women in SVG. So it is difficult to say whether it is possible to generalize the findings.

Quantitative Studies (Studies 2 & 4):

Measures:

Some subscales of the questionnaire used in the second quantitative study were modified specifically for this study from previously published questionnaires, and so there is no evidence of their validity and, there is also limited evidence about their reliability. Although other subscales were unchanged versions of previously published questionnaires, with some evidence about their reliability and validity, they have not been used previously in this cultural context and so evidence for their validity and reliability is again limited.

Most of the subscales achieved a Cronbach's alpha above the benchmark of 0.7, although the attitudes towards cheating subscale fell just short. One issue about the validity of the questionnaire as a whole, and about the survey used in the first quantitative study, is that not all participants may have told the truth about such sensitive and personal issues. It should also be noted that the survey study was, of course, asking the participants about their beliefs about where they had contracted HIV; and their beliefs about this may not be accurate.

Additionally, in the second quantitative study, the measure for condom use could have included a better measure of recent condom use for the participants. Also, using a measure of past behaviour as the dependent variable in the study raises problems of causation, which could have been reduced by changing the dependent variable to a measure of intentions.

Sampling:

For both the quantitative studies, the samples were self-selected and so it was unclear how representative the sample was of the population. Demographic information about the populations was not available to make such comparisons.

Although educational level of the participants was not used as an exclusion criterion for the second quantitative study, the majority of the participants' educational background showed that they had attained secondary and tertiary education, with the minority only having attained primary level education. This may have limited the generalisability of the findings to less educated women in St. Vincent and the Grenadines. It may be possible that women from the lower educational and economic strata may have a different outlook to the whole issue of accepting infidelity within their relationships.

The sample size was relatively small in the second quantitative study (Study 4). As mentioned in chapter 9, the G-Power calculation indicated that a sample of 82 participants was required to detect moderate effects. However, limitations of time and

resources meant that a sample of only 60 was recruited. Failure to achieve adequate power meant an increased possibility of Type II errors (i.e. of the statistical tests failing to show a significant association, even though such an association exists in the population). The relatively small size of the sample also meant that only a basic correlational analysis was appropriate. A more detailed regression analysis of the interaction of demographic factors with the subscale scores was not appropriate because of this. Also, the model tested in this study proposed some mediated relationships between variables, but it was not appropriate to test these because it is suggested that structural equation modelling (of which mediation analysis is a type) requires at least 200 participants for a reliable analysis (Tabachnik & Fidell, 2001).

10.5: Contribution to knowledge pool and directions for future research

Only parts of the model were tested in the second quantitative study. One possible direction for future research would be to investigate other aspects. In particular, there is potential for investigating the suggestions made about the role in increasing the risk status of coping strategies to alleviate anxieties about threats to the relationship (such as infidelity) and about one's risk status. Another possible direction that could be explored in more detail is the possible role of age and education in explaining differences in the pattern of results for different demographic groups.

The current research focused exclusively on women. It would be useful to obtain male perspectives on some of the issues raised, such as how decisions are made within

the relationship about the use of condoms, and how they respond to the woman's anxieties about threats to the relationship. The current studies underline the importance of the relationship as a risk factor. To fully understand its role, we need to understand how the couple interact and, it is not possible to obtain a full picture through considering one viewpoint only.

More generally, the results of the current studies are consistent with the criticisms of the cognitive models' approach to sexual health, and the calls for sexual behaviour to be understood within a broader framework that considers emotional, interpersonal, situational and cultural variables (Campbell, 1997; Campbell & Williams, 1998; Ingham & Van Zessen, 1997; Kippax & Crawford, 1993; Ingham, Woodcock, & Stenner, 1992; Joffe, 1996).

This paper was definitely a ground-breaking piece of research for St. Vincent and the Grenadines. It lends insight to the sexual vulnerability of Vincentian women, owing not only to power and financial inequity in relationships, but also on the imposed cultural value and importance placed on being in long-term relationships. This paper highlighted some socio-cultural factors that may play a role in enhancing the vulnerability of some women to HIV infection. These cultural factors include the pervasive silence surrounding sex: the idea that a woman's ability to maintain her romantic relationship defines her; the carnival period which is characterised by the loss of inhibitions; and an overall contribution by factors such as as music, personality traits,

relationships, emotions, alcohol, stigma, trust, peer pressure, gender inequality, and tolerance to infidelity on choices made, which then has clear health implications.

The research particularly highlighted the importance attached to committed heterosexual relationships by some women for a range of emotional, social and economic reasons. The weight attached to relationships, in turn, may have implications for women's risk status. Sex without a condom was viewed by some as a means of establishing such a relationship in the first place, and within the relationship, condom use was viewed by some as a mark of a lack of trust. Some women were prepared to tolerate infidelity to maintain the relationship. The research indicated the need for raising awareness of these issues within SVG society, and tackling them through open discussion – both within society generally and within heterosexual partnerships.

This paper has also provided the needed empirical evidence to support an HIV targeted intervention, specific for Vincentian women and young girls. This intervention would be designed to improve the awareness of safe sex practices through HIV education and prevention programmes, which includes public discussions about infidelity, serial monogamy and sexual responsibility of sexually active persons, regardless of gender or age, as well as targeted childhood sex education, specifically targeting young girls before sexual initiation.

This research was also instrumental in suggesting that the practiced ABCs of prevention method by the National HIV program in St. Vincent and the Grenadines, be complemented with an approach that takes into the consideration the duality and

dynamics of heterosexual relationships. It is expected that this research will be fed into the country's very limited research pool.

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