To my parents, Frank and Brenda Dolwick
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Gender, Transnational Migration, and HIV Risk Among the Garinagu of Honduras and New York City

By

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Chair: John Richard Stepp
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Major: Anthropology

The HIV epidemic is considered one of the most severe health crises of modern times. Gender inequality and migration have been shown to greatly influence HIV risk. This research considers gender, migration, and HIV risk among the Garinagu, a matrifocal Afro-Amerindian population by asking: 1) How do gender roles and male-female relations among Garifuna in New York City (NYC) compare to those among Garifuna in Honduras? and 2) How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras? Research was conducted in Trujillo, Honduras and NYC between July 2007 and May 2008 using participant observation, semi-structured interviews, and an anonymous survey.

Gender roles and male-female relations among the Garinagu of Trujillo, Honduras and NYC were considered through employment, households, partnerships, and children and childcare. It was observed that matrofocality remains, although it is adapted to the new lives of the Garinagu in NYC. Garifuna in NYC experience more distance from family, both in the U.S. and back home, and are more likely to legally marry their partners. As a result of these changes, two themes emerged – women become more independent, and greater equality between men and women develops.
These changes affect sexual relationships and behaviors. Although the discourse of sexuality would suggest otherwise, large deviations with respect to sexual behaviors were not observed between the two locations. However, differences are observed. Several serve to reduce the risk of HIV transmission including communication among sex partners, increased reporting of monogamy, and a decreased reporting of multiple sex partnerships. Others increase the risk of HIV infection, including a reduction in communication within families regarding sexual behaviors, low condom negotiation among married women, dishonesty of communication regarding HIV, and continued infidelity. Thus, a number of continuing and new challenges face the Garinagu of NYC directly, and the Garinagu of Honduras indirectly through transmigration. Recommendations include aiming to reduce HIV stigma among the Garinagu in NYC through the use of music and cultural pride to allow the issues of gender, migration, and HIV risk to be addressed.
CHAPTER 1
HIV/AIDS, MIGRATION, AND GENDER

Introduction

The HIV epidemic is one of the most severe health crises of our time. Despite remarkable advancements in our understanding of the virus and its effects on the body, HIV continues to spread and there have been few successes in the attempts to contain it. In areas most affected by HIV, life expectancy has been reduced greatly, economic growth has waned, and household poverty has deepened. Thus, in addition to being one of the most severe health crises of current times, the United Nations Development Programme (UNDP) cites HIV as being responsible for the greatest reversal in human development (UNPD, 2005). Currently, an estimated 33 million people globally are living with HIV, half of whom are women (Figures 1-1 and 1-2). In 2007, 2.7 million new infections occurred and 2 million people died of AIDS (UNAIDS, 2008b).

There are many ways in which exposure to HIV can be avoided or reduced. Methods for risk avoidance include abstinence, mutual fidelity to an unaffected partner, the use of condoms during intromissive intercourse, the reduction in the number of partners, and the treatment of other sexually transmitted infections (STIs) (Green, 2003; Cates, 2002). In the 1980s, male homosexuals in the United States (U.S.) and Europe responded to the AIDS epidemic by using condoms, and the result was a dramatic drop in the incidence of the disease. Since that time, condom use has commonly been thought to be the best solution to the HIV/AIDS pandemic (Green, 2003). However, the adoption of this Western technology has been limited in many locations and the effectiveness of condom use has been challenged (Green, 2003; Cates, 2002). Davis and Weller (1999) found that the level of protection condoms provide from HIV approximates 87%, with a range of 60% to 96% depending on consistency of use. In addition,
Mann, Stine, and Vessey (2002) argue that the number of exposures, or episodes of intercourse with an infected person, also impacts the range effectiveness of condoms. Condoms do, however, remain an important HIV prevention technology for people at high risk of exposure to HIV infection such as commercial sex workers and others who have multiple sex partners or who have sex with high-risk partners (Halperin et al., 2004; Green, 2003). Thus “messages [to encourage condom use] need to be carefully crafted so they can build on (and not substitute) the full complement of STI/HIV risk avoidance and risk reduction approaches necessary to optimize our prevention efforts” (Cates, 2002, p. 352).

In addition to condom use, primary behavior change (PBC) is commonly employed to reduce risk of HIV infection. PBC includes partner reduction, delay of sexual debut among youth, and abstinence for a specified period of time. Research suggests that PBC may be what most people choose for themselves regardless of what is promoted for HIV prevention (Green, 2003). Both condom use and PBC are methods of HIV risk avoidance and reduction that are controlled on an individual level.

During the 1980s, public health research on HIV/AIDS focused primarily on the physical characteristics of the virus and on the sexual behaviors of individuals that encouraged virus transmission. The Global Programme on AIDS, the World Health Organization’s (WHO) response to the epidemic, was medically and epidemiologically driven and was based on previous experience with other infectious disease outbreaks (Barnett & Whiteside, 2006). Prevention programs based on individual behavior change, including increased condom use and partner reduction, were thus soon developed (Parker 2001). These efforts were largely grounded in the results of knowledge, attitudes, and practice (KAP) surveys, which were used to provide local program managers with details of the local sexual culture. Using country specific data,
program managers could alter the general model provided by the Global Programme on AIDS to develop local programs to promote risk-reducing behavior (Barnett & Whiteside, 2006; Parker, 2001). These resulting programs were based on the underlying assumption that there is a direct link between knowledge and behavior and on two main theories: the Health Belief Model and the Theory of Reasoned Action and Planned Behavior (Hausmann-Muela, Muela Ribera, & Nyamongo, 2003; Barnett & Whiteside, 2006). However, this assumption has repeatedly failed to be supported, thus resulting in the so-called KAP-gap (Parker, 2001; Schoepf, 2001; Obermeyer, 2005). According to Obermeyer (2005, p. 3), “the correlations found [between knowledge and behavior] are tautological and not especially informative.” Auerbach, Auerbach, Wypijewska, and Brodie (1994, p. 87) argue that these models:

are limited in their ability to predict risk behavior for two main reasons. First, with respect to sexual behavior, the models are based on the assumption that sexual encounters are regulated by self-formulated plans of action, and that individuals are acting in an intentional and volitional manner when engaging in sexual activity. . . . Second, the dominant theoretical models of behavior do not easily accommodate contextual personal and sociocultural variables such as gender and racial/ethnic culture.

Since the 1990s, anthropologists have increasingly made clear the complexities of behavior choice situated in cultural settings. By focusing on the meaning of various risk behaviors, anthropologists have produced more nuanced understanding of the sexual transmission of HIV in diverse cultural settings. As a result of the contributions made by anthropologists, some researchers have developed ethnographically grounded education campaigns that are community based to promote change in individual behavior (Parker, 2001; Shedlin & Shulman, 2004; Chavez, 2003) and they have highlighted the need to address structural factors that limit or prevent access to various opportunities and/or services, including medical services (Chavez, 2003; Hirsch, 2003b). In 2008, the Joint United Nations Programme on HIV/AIDS (UNAIDS) blamed the continued expansion of the epidemic on social issues.
contributing to HIV risk and vulnerability, and specifically cited two social factors that they believe have not been adequately addressed: 1) gender inequality and 2) discrimination, stigma, and social marginalization (UNAIDS, 2008b).

This dissertation focuses on gender, migration, and HIV/AIDS among the Garinagu, an Afro-Amerindian population from Central America who have economically relied on migration since their ethnogenesis. The main questions in this research are: 1) How do gender roles and male-female relations among Garifuna in New York City (NYC) compare to those among Garifuna in Honduras? and 2) How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras? The Garinagu, research questions, methods, and results will be discussed at length in the following chapters after a literature review.

Gender and HIV/AIDS

In the 1970s and 1980s researchers recognized a “feminization of poverty,” a phrase used to denote the disproportionate number of women living in poverty. Currently, it has been said that there is a “feminization of HIV/AIDS” (Dworkin & Ehrhardt, 2007; Global Coalition on Women and AIDS, 2006). Women currently account for half of all HIV infections, up from 35% in 1985 (UNAIDS, 2008b; Dworkin & Ehrhardt, 2007).

The risk of HIV among women has not always been clear, as AIDS was first recognized in the United States in 1981 as a disease among homosexual males. As a result, males (generally homosexual) became the focus of HIV/AIDS research and clinical trials. The result was the formulation of a diagnostic definition by the Centers for Disease Control and Prevention (CDC) that was male-specific. This led to the exclusion of women in mainstream discussion and

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1 Garinagu refers to the population; Garifuna refers to an individual as well as the language, and is additionally used as an adjective (e.g. the Garifuna community or the Garifuna people).

2 Because the first cases of HIV/AIDS were recognized only in homosexual men, the disease was initially called Gay-Related Immune Deficiency Syndrome, or GRID (Barnett & Whiteside, 2006).
research of HIV/AIDS for years to come and resulted in misdiagnosis and underreporting of women with HIV/AIDS. Evidence suggests that early female cases of HIV/AIDS were not recognized despite seemingly obvious indications to the contrary:

Poor women were dying of AIDS in the United States long before their contributions to death statistics were officially recognized. In New York City and Washington D.C., higher unexplained rates of deaths among young women were reported as early as 1981, the same year that AIDS was first discovered among gay men in San Francisco. . . .Although retrospective analysis now suggests that excess mortality among these urban women was most likely AIDS-related, this was not appreciated during the first years of the epidemic. (Simmons, Farmer, & Schoepf, 1996, p. 58)

The first CDC report regarding AIDS and women actually surfaced in 1983, but the women were seen merely as partners of men with AIDS.

Globally, the shift from a male-only focus in HIV/AIDS literature and research was influenced by the illumination of local and regional epidemics outside of the U.S. and Western Europe. In Africa, for example, it was recognized that the virus was transmitted mostly from heterosexual activity, thus impacting and affecting both men and women. In many places, HIV-positive women outnumbered men among heterosexually transmitted HIV cases. The reasons for this were hypothesized to be a result of more men available to infect women and that women may be biologically more susceptible to the disease. More conclusive evidence of this last point surfaced in 1991. A decade after the initial discovery of AIDS, and as the result of growing evidence of heterosexual transmission and activist protests, the CDC revised the case definition of AIDS to include some common reproductive tract infections. This new case definition went into effect one year later, in 1992, leading to a tripling of AIDS cases recognized among women in the United States (Simmons et al., 1996). The invisibility of women early in the AIDS pandemic was largely due to three factors, according to Farmer (1999, p. 62):

the majority of women with AIDS had been robbed of their voices long before HIV appeared to further complicate their lives. In settings of entrenched elitism, they
have been poor. In settings of entrenched racism, they have been women of color. In settings of entrenched sexism, they have been, of course, women.

Today, HIV/AIDS is understood to increasingly affect women around the globe. Biological and social factors together increase HIV/AIDS risk among women globally.

**Biological Vulnerabilities of Women**

Biologically, women are more susceptible to the virus and research has suggested that HIV is up to 20 times more efficiently transferred from men to women during heterosexual vaginal intercourse. A number of biological factors increase susceptibility of women to HIV. HIV is more highly concentrated in seminal fluids than vaginal secretions, for example (Simmons et al., 1996). Younger women are especially vulnerable to HIV infection. This may be due to genital trauma resulting from first intercourse or intercourse before full biological development as the multiple cell layers and secretions that provide some protection in adult women develop gradually, and thus immature women do not fully have this protective layer. As a result, younger women are more likely to experience trauma and/or bleeding (Quinn & Overbaugh, 2005; Simmons, et al., 1996). In addition, women have more STIs than men, which enhance HIV transmission through two important ways. First, STIs may provide a break in the microbial barrier around the vaginal area. Second, STIs increase the presence of inflammatory cells, which are targets for the virus. Finally, hormones may play a role, although the influence of hormones on the risk of contracting HIV is not well understood. Some studies, for example, have found that women using hormonal contraceptives may be at increased risk for HIV infection (Sagar et al., 2004; Lavreys et al., 2004), although this issue is highly contested. Hormones (specifically progesterone) have been indicated, however, as a likely reason women are more susceptible to HIV in pregnancy (Quinn & Overbaugh, 2005). These examples provide some of the determinants that increase HIV infection among women. However, it is the social
factors that warrant most attention. Social factors are related to many of the biological factors increasing a woman’s risk (e.g., increased STIs) but also place women in a vulnerable position with increased risk of HIV contact independent of biological factors.

Social Vulnerabilities of Women

Rudolf Virchow, who has been considered the first to connect medicine and anthropology, recognized the importance of social factors on health and disease in the mid-19th century:

Virchow understood, as we his successors have not, that medicine, if it is to improve the health of the public, must attend at one and the same time to its biological and to its social underpinnings. It is paradoxical that, at the same very moment when the scientific progress of medicine has reached unprecedented heights, our neglect of the social roots Virchow so clearly identified cripples our effectiveness. (Eisenberg, 1984, p. 526)

Although the biological implications of HIV/AIDS are extremely important, HIV/AIDS is, at its core, a social issue. HIV/AIDS is socially constructed in the sense that it is shaped by social dimensions, social values, and social relationships. A second way that HIV/AIDS is a social disease is that it is spread through social behaviors. These behaviors include, of course, sexual contact and injection drug use. This leads researchers to conclude that HIV is easily preventable and leads to victim-blaming, as people with HIV/AIDS simply did not modify their behavior appropriately. However, the ability of individuals to adopt known HIV prevention strategies is to a large degree socially determined. The recognition of power differentials in interpersonal relations provides one, of many, examples. Finally, AIDS is a disease of society in the sense that the disease spreads along the fault lines of society. It is a disease that overwhelmingly affects the disposed and poor, and has become a “disease of social outcasts” (Singer & Baer, 1995, p. 226; Singer, 1994).
In 2004, as a result of the increase in HIV prevalence among women globally, the UNAIDS developed the Global Coalition on Women and AIDS to specifically address the needs of women and the prevalence of gender inequality in relation to HIV/AIDS. The development of this program is important because gender inequality has been shown to increase the vulnerability of women to HIV infection. Women frequently have restrictions to information, health services, and commodities (including access to condoms), and lack of power in sexual decision-making (UNAIDS, 2008b; Global Coalition of Women and AIDS, 2006; Kim & Watts, 2005; Cianelli, Ferrer, & McElmurry, 2008; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002).

In addition, researchers have recently posed that “sexual opportunity structures,” or structural factors that increase the chance of sexual interaction, occur at the intersection of gender, poverty, and migration (Dworkin & Ehrhardt, 2007). Although the majority of research in migration and HIV/AIDS has focused on male migrants who work as truck drivers, fishermen, servicemen, or traders, (e.g. Singh & Malaviya, 1994; Chirwa, 1997; Lacerda et al., 1997; Ramjee & Gouws, 2002) women are also moving in large numbers to industrial centers within and across countries (e.g. Houstoun, Kramer, & Barrett, 1984; Donato, 1993; Anthias & Lazaridis, 2000; Parrenas, 2001). Several factors increase the vulnerability of migrants, both male and female, to HIV, including separation from family, loneliness, poverty, and undocumented status (Haour-Knipe, 2004). Research suggests that immigrants reconstruct sexuality as they adapt to new political, economic, and cultural surroundings. Some evidence documents that immigrants tend to have more sexual partners than non-migrants, largely due to issues of exposure, changes in social settings, and decreased social monitoring (Buckley, 2005). Additionally, migrants are less likely to use health care services due to lack of knowledge of services, fear of deportation, or lack of medical insurance and ability to pay (Buckley, 2005;
Chavez, 2003). Women’s increased vulnerability to HIV/AIDS in general, combined with their heightened risks as immigrants, makes this group of particular concern. Thus, the continued research of women and HIV risk must include the consideration of women as migrants, intersecting with gender relations.

**Migration**

Currently, there are more than 200 million people living outside their country of origin (International Organization for Migration, 2008). These immigrants are diverse in scope and have vastly different migration experiences based on a number of factors, including where they are from and where they go, whether they are migrating by choice and/or whether they are legally allowed to enter the receiving country, their race and/or ethnicity, gender, age, and education level (Portes & Rumbaut, 2006). This section describes some of the theories that have driven and continue to propel migration research and will specifically look at immigration in the U.S., including health and healthcare among immigrants. Understanding these elements of migration is necessary to examine the role of migration in HIV transmission to both migrants and their non-migrant community members.

**Migration Theories**

Old views of international migration assumed that migrants either made a permanent break from their homeland or only temporarily moved to the host country for short-term economic gain. As a result of this, migrants were termed immigrants (who stayed in the host country permanently) or sojourners (who stayed in the host country only temporarily). The “classic” genre of migration theory, organized by Ravenstein (1885, 1889) in the late 19th century, conceptualized migration as a relocation of individuals across some space (national or international), and researchers following this conceptualization strove to develop models that would account for such movements (Zolberg, 1989). Currently, there is no single, coherent
theory of migration. The following review considers four theories: modernization/equilibrium, historical-structural approaches, the new economics of migration, and transnationalism.

(a) Modernization/equilibrium. Early migration research within anthropology was influenced by the modernization/equilibrium model (Brettell, 2000). Modernization/equilibrium theorists employ a push-pull model of migration. Under the modernization/equilibrium model, international migration occurs as the result of certain factors pushing the individual out of one country while being pulled into another based on the presence of economic opportunity. Push factors include job instability, high unemployment, and low wages. Pull factors, on the other hand, include the presence of jobs unfilled by the native population for various reasons (e.g. demographic or social) and higher wages (Bach & Schraml, 1982).

Based on this model, researchers believed that in time, as individuals earned money and took it back to their home country, resources would become more evenly distributed among the countries involved and thus, the sharp disparities leading to international migration would decline. This end result, however, has yet to occur (Miller, 1993). Research has instead shown that migrant savings and remittances are often spent on consumer items rather than for economic investment, and the skills migrants learn in their receiving location often cannot be applied back home (Brettell, 2002). Saskia Sassen (1990) discusses additional limitations to this model in The Mobility of Labor and Capital, arguing that the push-pull model does not explain, for example, why migration flows remain abundant even when economic development has occurred in large sending locations. Thus, while this theory of push and pull factors is not in itself incorrect, it is incomplete. Its focus is at the individual level, ignoring macrostructural factors (e.g. capitalistic market expansion and the structure of the global economy). These macrostructural factors help explain why international migrants are generally not from the most impoverished countries, or
even from the most impoverished regions of the sending country, as the push-pull theory would predict (Margolis, 1994).

(b) Historical-structural approaches. In opposition to the modernization/equilibrium proponents, the historical-structural paradigm rooted in Marxist political economy and world systems theory developed in the 1960s (Castles & Miller, 2003). Researchers sought to identify the above-mentioned macrostructural forces that created the conditions for migration in the first place. Historical-structural researchers focus on the links between the global expansion of capitalism and the resulting migration (Cheng & Bonacich, 1984; Miller, 1993). Proponents of this argument claim that as capitalism expands, it distorts the economies of less developed areas. The introduction of the capitalist market and mode of production displaces people from traditional economic arenas. The decline of the traditional economic arenas, however, occurs faster than industrial growth and as a result there are not enough jobs to absorb the people who have now become dislocated (Cheng & Bonacich, 1984). At the same time, growth in the capitalistic core increases demands for labor that cannot be satisfied by local populations alone, producing pressures that result in labor migration (Miller, 1993). Thus, historical-structuralism posits that individuals do not have free choice of migration, since they are constrained by structural forces (de Haas, 2007).

Unlike the modernization/equilibrium theorists, historical-structural theorists believe the economic gains associated with international migration remain in the host country (which is the capitalistic core). International migration is viewed as largely detrimental to the sending country because through international migration the country loses skilled members of society, thereby creating gaps in the labor force (Portes & Walton, 1981; Georges, 1990).
In direct contrast to the modernization/equilibrium theories, the research developed by historical-structuralists has been criticized for disregarding individuals. The migrant is portrayed as a passive reactor, or “pawn,” that is simply manipulated within the world capitalistic system (Brettell, 2000; de Haas, 2007). Additionally, recent history refutes some of the claims made by rigid historical-structuralists, as various formerly developing countries with high out-migration, including many southern European countries and some “Asian Tigers,” have achieved sustained economic growth (de Haas, 2007; Almeida, 1973; Papademetriou, 1985). Thus, opponents claim the researchers “developed good political economy but insufficient migration theory” (Bach & Schraml, 1982, p. 324).

While historical-structural research left much to be desired, many of the scholars using this approach, along with feminist scholars of the 1980s, were successful at bringing female migrants into view (e.g. Morokvasic, 1984). Previously, women were neglected in the literature, considered only as wives of male migrant workers. For instance, Lee wrote, in 1966 (p. 51), “indeed not all persons who migrate reach that decision themselves. Children are carried along by their parents, willy-nilly, and wives accompany their husbands though it tears them away from environments they love.” This androcentrism changed in the 1980s when women and migration became popular in the migration literature. Although the ensuing research strove to fill in gaps in the literature regarding women, it lacked attention to issues of gendered relations, and the “women only” approach failed to consider how gender as a social system contextualizes the migration processes (Hondagneu-Sotelo, 1999).

(c) New economics of migration. The new economics of migration developed in the 1980s and 1990s also in response to modernization/equilibrium models of migration (Massey et al., 2006), but this approach gradually developed into an alternative to the historical-structural
paradigm as well (de Haas, 2007). An important contribution of this approach is the recognition that migration decisions are not made by individuals alone, but by larger units of related people (Stark & Levhari, 1982; Hirschman, Kasinitz, & DeWind, 1999; Massey et al., 2006; de Haas, 2007).

Families and/or households collectively act to maximize income, through diversifying resources, in order to minimize income risks (Stark & Levhari, 1982; Hirschman et al., 1999; Massey et al., 2006; de Haas, 2007). Some family members may be assigned to work in the local economy, while others may be sent to work in foreign labor markets where wages are not strongly correlated with those in the local area. If activity in the local market fails to provide sufficiently for the household or family, migrant remittances are available for support (Hirschman et al., 1999; Massey et al., 2006). Thus, internal and international migration is perceived as income insurance for the household of origin (de Haas, 2007). In developed countries, minimal risks to household income exist as a result of private insurance or government programs. In developing countries, however, these institutional mechanisms of risk reduction are absent or inaccessible to poorer families, providing a need diversify risk through migration (Stark, 1980; Stark & Levhari, 1982; Massey et al., 2006).

Maintaining the level of household as the unit of analysis can be viewed as a compromise between individual actor and macrostructure approaches to migration studies. Understanding migration as a household livelihood strategy acknowledges that there is some room for agency (de Haas, 2007).

(d) Transnationalism. In the past decade, researchers have strived to improve on the insufficiencies of prior migration scholarship by considering local and macrostructure economical, political, social, and cultural influences for migration. This newer body of research
has been termed transnational migration research. The term transnationalism has been used by
many scholars from various fields to describe the complexities of migration activity and beliefs
in both sending and receiving countries. Although the term has been used in various ways,
Basch, Schiller, and Blanc (1994, p. 7) define it as:

processes by which immigrants forge and sustain multistranded social relations that
link together their societies of origin and settlement. . . . Transmigrants take actions,
make decisions, and develop subjectivities and identities embedded in networks of
relationships that connect them simultaneously to two or more nation-states.

There are four theoretical premises of transnationalism. First, transnational migration cannot be
unraveled from the changing conditions of global capitalism and must be considered within the
context of global capital and labor relations. Second, transnationalism is a process. Through
daily activities and social, economic, and political relations, migrants create and maintain social
networks that operate across national boundaries. These connections result in the movement of
both ideas and material objects. The focus, then, is on how migrants reconfigure space so that
they are actively a part of two or more nation-states. Third, the bounded social science concepts
of “ethnic group,” “race,” and “nation” can distort the perception of transnationalism and the
analysis of it. These culture constructs often seem fixed or primordial but instead must be viewed as dynamic processes undergoing constant reformulation. Finally, by living their lives simultaneously across borders, migrants become involved with the process of nation building in
two or more nation-states (Basch et al., 1994).

By expanding earlier models that were focused on migration based on wage differentials
and migrants as laborers, transnational studies have demonstrated that as transnational networks
operate, new ideas and practices are traded along with material resources (Basch et al., 1994;
Levitt, 2001; Hirsch, 2003a). For instance, transmigrants often return to their sending country
with new ideas that challenge fundamental notions and beliefs about class, gender, and power
within their country or culture (Basch et al., 1994; Levitt, 2001). Levitt (2001) calls the ideas and behaviors that flow from receiving to sending countries “social remittances.” For example, in her study in Miraflores, Dominican Republic, Levitt (2001) noticed gender roles were being questioned by returning migrant women. Additionally, many young women in Miraflores desired men who had migrated because these men were often more likely to tolerate deviations from the local norms regarding assigned gender roles. Transnational studies, thus, have provided evidence that migrants may feel and act like those people from both their home and receiving communities. These findings challenge earlier assumptions about identity and assimilation and highlight the connections migrants feel to both locations (Basch et al., 1994; Levitt, 2001). In the current research considering gender, migration, and HIV risk among the Garinagu of Honduras and New York City, transnationalism provides the guiding theoretical perspective.

Migration and Health

Concern for the spread of disease by immigrants has been a long-standing concern among public health officials, government members, and the public as a whole. In fact, immigrants in general have long been associated with disease and subgroups are sometimes associated with specific diseases (Markel & Stern, 2002). However, common health factors are actually related more to the nature of movement and mobility than to specific physical qualities of immigrants or populations themselves.

Gushulak and McPherson (2004) describe the relationship between health and mobility through two major processes: 1) movement and mobility and 2) disparity. The process of mobility has three components: the premovement phase, the journey itself, and the arrival phase. Gushulak and MacPherson (2004) argue, however, that it is the effects of disparity that are the most important factor determining the relationship between mobility and health. The most common movement of people is within their own country or within environments with similar
health practices and conditions. This movement, called neutral disparity movement, has little impact in terms of overall health. Conversely, travel between locations with disease disparities, referred to as prevalence gaps, and differing social and cultural understandings of disease and illness pose challenges for those involved in medicine and public health. Some of these challenges will be discussed in detail later in this section. Movement of populations across these prevalence gaps is bi-directional, and the migrants as well as stationary residents may be at increased risk for disease (Gushulak & MacPherson, 2004).

The association between immigrants and disease has shaped immigration policy and inadvertently reinforced negative stereotypes of immigrants as disease carriers. In the “old” migration (defined here as late 1800s and early 1900s), for example, Asians were seen as feeble and infested with hookworm, Mexicans as lousy, and eastern European Jews were thought to be vulnerable to trachoma and tuberculosis and possessed an overall “poor physique” (Markel & Stern, 2002). The oldest means of controlling immigration has been the inspection and exclusion of individual immigrants based on medical history, including mental health and behavior, and/or socioeconomic status (Fairchild & Tynan, 1994). Not surprisingly then, “anti-immigrant rhetoric and policy have often been framed by an explicitly medical language, one in which the line between perceived and actual threat is slippery and prone to hysteria and hyperbole” (Markel & Stern, 2002, p. 757).

In general, much has changed regarding immigration policy and our understanding of disease and health since the “old” migration. However, immigrants and disease remain linked in U.S. policy, research, and mass media in the “new” migration as well (defined here as 1965 to the present). A prime example is the association of Haitian immigrants and AIDS in the early 1980s (Farmer, 1992). Although AIDS was only first discovered in 1981, Haitian immigrants
were targeted by July 1982 as a risk group. Early in 1983 the CDC recommended that Haitian immigrants refrain from donating blood, which became policy soon thereafter by the U.S. Food and Drug Administration (FDA). Although Haitian immigrants were viewed in the same AIDS risk category as other perceived high risk groups such as homosexual males or intravenous drug users, known high risk categories based on epidemiological information, the CDC acknowledged that “very little is known about risk factors for Haitians with AIDS” (Fairchild & Tynan, 1994, p. 2014). Still, the association was fiercely etched into the minds of the government and public, resulting in harsher policies for Haitian asylum seekers and the detainment of more than 200 HIV-positive refugees in the overcrowded and unsanitary quarantine camp on Guantanamo Bay. The stereotyping of Haitian immigrants led to the reduction of tourism to Haiti and proved to be a long lasting blow for the Haitian economy (Fairchild & Tynan, 1994; Farmer, 1999). In 1989, a journalist for *Vanity Fair* wrote: “Haiti is to this hemisphere what black holes are to outer space” (Farmer, 1999, p. 100).

A more recent example of the continued association of migrants with disease are seen when considering swine flu (N1H1) (McNeil, 2009; Eviatar, 2009). The swine flu epidemic originated in Mexico in early 2009 and as a result numerous government officials called for the closing of the U.S.-Mexico border. Representative Eric Massa called for closing the border, stating in a press release: “I’m glad that the White House has issued a travel advisory and is conducting passive screening at the border, but I think we should consider stronger measures at the border” (Osborne, 2009). Although the first reported cases of swine flu in the U.S. occurred among schoolchildren who had traveled to Mexico during Spring Break, several popular conservative media hosts explicitly blamed the spread of the swine flu to the U.S. on undocumented Mexican immigrants (Eviatar, 2009). Thus, while knowledge of disease and
changes in immigration policy have occurred since the turn of the 20th century, the association of immigrants with disease remains strong and continues to shape immigration policy and public perception.

Currently, the CDC Division of Global Migration and Quarantine provides the Department of State (DOS) and the Bureau of Citizenship and Immigration Services (BCIS) with medical screening guidelines for all examining physicians in compliance with the Immigration and Nationality Act (INA) and the Public Health Service Act. A medical exam is mandatory for all refugees coming to the U.S. and all applicants applying for a U.S. immigration visa outside of the U.S. Approximately 400 physicians outside of the U.S. and approximately 3,000 physicians within the U.S. perform these required medical examinations. Visas or entry to the U.S. may be denied for various health related grounds, which are described in the INA. These grounds include individuals who have a communicable disease of public health significance, who fail to present documentation of having received vaccination against vaccine-preventable diseases, who have or have had a physical or mental disorder with associated harmful behavior, and who are drug abusers or addicts. The current list of communicable diseases includes the following: tuberculosis, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and leprosy (Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, 2003).

HIV was added to this list in 1987, although it was an issue of controversy. The main point of debate was one of economics, and Senator Don Nickles of Oklahoma adequately stated the fears of many regarding HIV and immigration in 1993:

If we change this policy we are going to have countless thousands of people who will want to emigrate to the United States, knowing we have quality health care and knowing we will take care of them. Uncle Sam will take care of them, the taxpayers will take care of them at enormous expense, . . .providing] health care for
countless thousands who do not have health insurance, countless people who are right now struggling to pay their health care bills. (Fairchild & Tynan, 1994, p. 2017)

This view, right or wrong, was been repeated continuously. Hundreds of thousands of people wrote letters to the CDC, the Justice Department, Health and Human Services, and Congress members in support of the ban for similar economic concerns (Fairchild & Tynan, 1994). Gilmore and Somerville (1994) describe an imaginary division between "them" and "us" as a way of creating a sense of security among the population supporting the anti-immigrant legislation. Although HIV was on the list of infectious diseases of significant public health importance and was used as a method of exclusion, a waiver could be granted for persons with any of the above health related problems, including HIV (Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, 2003).

In 2008, however, President George W. Bush signed into law a bill that removed the legal requirement that HIV-positive people be denied entry into the U.S. (HIV/AIDS and STD Updates, 2009). This law removed all legislative barriers to repealing the ban and allowed for the Department of Health and Human Services to remove HIV from the list of communicable diseases of public health significance (Crowley, 2009). The CDC proposed the removal as a revision to Code of Federal Regulations (CFR) 42, Part 34 (Medical Examination of Aliens) soon after (Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, 2009). President Barack Obama announced on October 30, 2009 that a final rule would be published in the Federal Register on November 2, 2009 and will take effect in January 2010 (Crowley, 2009). Under this new legislation, the of HIV as a communicable disease of public health significance will mean that HIV testing will no longer be required as part of the U.S. medical screening process and people who are HIV-positive will no longer require a waiver
for entry into the country (Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, 2009).

Although the U.S. government attempts to control disease spread at the borders, immigrants in the U.S. continue to face health related problems. U.S. policy regarding health and immigration cannot control individuals who come to the U.S. illegally or without an immigrant visa (e.g. individuals who overstay their tourist visa). Also, this method fails to control for the acquisition of disease within the U.S. borders. Concern of this kind, however, generally falls into one of dependency rather than public health of the nation. The most important legislation regarding these problems is the Personal Responsibility Act of 1996. This legislation barred immigrants from receiving cash assistance, Medicaid, Supplemental Security Income, food stamps, and other federal means-tested programs for five years after arrival. Undocumented immigrants were barred from everything short of emergency care or vaccination (Fairchild, 2004). The 1998 Health Care Reform Act emphasized the intolerance for undocumented immigrants in the health care system. This legislation again stated that undocumented persons are not eligible for health care except for emergency care. The guidelines put forth in this piece of legislation are strict and inflexible (Ruiz-Beltran & Kamau, 2001).

In spite of U.S. policy, or possibly because of it, the health of immigrants, in general, is better than their U.S.-born counterparts. Regardless of race or ethnicity, foreign-born persons in the U.S. generally fare better on a number of health outcomes compared to native U.S. citizens (Hummer et al., 1999; Singh & Yu, 1996; Pallotto, Collins, & David, 2000; Palloni & Arias, 2004; Acevedo-Garcia, Pan, Jun, Osypuk, & Emmons, 2005; Antecol & Bedard, 2006; Tolbert Kimbro, Bzostek, Goldman, & Rodriguez, 2008; Dominguez, Ficklin Strong, Krieger, Gillman, & Rich-Edwards, 2009). This is known as the “healthy immigrant effect” (Acevedo-Garcia et
al., 2005; Antecol & Bedard, 2006; Tolbert Kimbro et al., 2008; Parker Dominguez et al., 2009). This generality speaks to the fact that most immigrants are young and, contrary to popular belief, educated.

Additionally, HIV prevalence among immigrants appears to be similar to that of the native born population. However, this generality masks differences among subpopulations. In a survey of STI clinics, the overall HIV incidence was similar among foreign-born and native-born populations (1.6% and 1.8%, respectively) but differences were seen among various persons of different origins. Lower rates were seen in East Asians and Pacific Islanders (0.5%) and South and Southeast Asians (0.7%). Subpopulations from Mexico, Central America, and South America had an HIV incidence rate of 1.6%, the same as the foreign-born group as a whole. Higher incidences of HIV were witnessed in the subpopulations from the Caribbean and West Indies (2.9%), North Africa and the Middle East (3.3%), and Sub-Saharan Africa (2.2%) (Carlsten & Jackson, 2003). Farm workers, who are mostly from Mexico or Latin America, have an increased risk of HIV infection. An estimated 5% of farm workers are HIV-positive, which is nearly 10 times the U.S. national prevalence rate (0.6%). Studies have also found differences among subpopulations in Florida, California, South Carolina, and North Carolina, with seropositivity ranging from 2% to 13.5% among migrant farm workers (UNIDOS Network of Capacity Building Assistance Providers, 2004).

The connection of mobility and health has shaped both government policy and public perception of immigrants. The effect is still present today, as government policy continues to exclude immigrants based on health, although many aspects of this exclusion remain controversial. Exclusion of immigrants with disease may reduce the problem of dependency on U.S. public health, but it cannot address the issues of health among undocumented immigrants or
the health of immigrants once residing within the U.S. borders. Persons residing legally in the U.S. are entitled to health care and may not be discriminated against based on their race, color, or national origin as defined under Title VI of the Civil Rights Act of 1964 (U.S. Department of Health and Human Services, 2008).

Access to this care, however, may be limited due to a number of barriers, including those resulting from language confusion, lack of insurance, lack of money, lack of time, fear of deportation, or cultural insensitivity and in general, immigrants report low satisfaction with the health care system in the U.S. (National Coalition of La Raza, 2004; Kang, Rapkin, Springer, & Haejin Kim, 2003; Ruiz-Beltran & Kamau, 2001; Collins, Hall, & Neuhaus, 1999). Language barriers are commonly cited in general as an important barrier and cause of dissatisfaction to health care among immigrants in the U.S. One study, for instance, investigating health care of Latino immigrants in the Southern states (92% of which were foreign-born), found that the most commonly cited barrier to health care was language and communication issues (National Coalition of La Raza, 2004). In a survey of HIV-positive Asian and Pacific Island immigrants in NYC, Kang and colleagues (2003) found that informants emphasized that translations by medical interpreters were insufficient. Many felt that the assistance in understanding the medical system in general, and the services for HIV treatment in particular, were inadequate.

Other barriers mentioned frequently by Latinos in the Southern states were lack of insurance, lack of transportation, and discriminatory behavior by health care workers (National Coalition of La Raza, 2004). Ruiz-Beltran and Kamau (2001) also cite economic and emotional stress as barriers to health care. In another study, discrimination based on income, sex, or race was the most commonly cited reason for dissatisfaction with health care in the U.S. The survey, which did not specify the time the individual had lived in the U.S., found persons of Hispanic
origin blamed race and income as specific causes of discrimination (Collins, Hall, & Neuhaus, 1999).

Cultural insecurity manifested in perceptions of discrimination may pose a problem if immigrants feel confused or intimidated by the U.S. health care system and/or doctors. Unfortunately, this happens too often, and may lead to worsening conditions of health. Mexican women in Los Angeles, whose children were taken to the hospital for empacho (roughly translated as a combination of indigestion and constipation), did not return for follow-up visits when treated disrespectfully by the medical doctors. Empacho is not recognized as a disease in the biomedical categorization of diseases and thus the doctors may not have cared adequately for the children in the eyes of the mothers. This problem only became apparent after an unusual lead poisoning case was seen in the emergency room. Dissatisfied with the treatment of the biomedical doctor, the Mexican women bought a folk remedy from a local store, which had a high amount of lead tetroxide (PbO₄). Thus, cultural insensitivity led the women to avoid the hospitals and put the health of their children in danger (Trotter, 1998).

This discussion of migration and health is critical in understanding the actual and perceived risk of HIV transmission among Garinagu migrants and the community’s response to its HIV/AIDS epidemic. These issues will be described in detail later, and shall be discussed within the context of the political economy of the U.S. and the long held and harmful association of immigrants and disease.

**Summary**

The relationship between population movement and disease has long been recognized, as the history of association between immigrants and disease in immigration policy and public stereotypes suggests. The association between migration and the HIV/AIDS pandemic is no exception. Moving beyond early attempts to correlate knowledge and behavior, anthropologists
and other social scientists aim to highlight the social and cultural factors that allow HIV transmission to continue, including through population movement. Additionally, researchers have recently poised that “sexual opportunity structures,” or structural factors that increase the chance of sexual interaction, occur at the intersection of gender, poverty, and migration (Dworkin & Ehrhardt, 2007). This research hopes to add to this understanding by considering how migration among the Garinagu, an Afro-Amerindian population from Central America, affects gender roles and relations and ultimately HIV risk behaviors.

**Manuscript Organization**

The literature review discussed in this chapter documents the need to further examine the intersection of gender, migration, and HIV risk. This research aims to do just that by considering how migration may alter gender roles and relations and how those changes affect HIV risk among the Garinagu of Honduras. Chapter 2 will provide detailed information about this Afro-Amerindian population. I will begin by providing a general overview of the Garinagu, including their ethnogenesis, social and household structure, traditional gender roles, ethnomedical system, and HIV/AIDS epidemic.

Chapter 3 provides the research setting, beginning with the migration history of the Garinagu. Next, the Garinagu in modern day Honduras, and specifically Trujillo, Honduras, and the placement of Garinagu migrants in the U.S., specifically New York City, will be discussed. The selection of the Garinagu for this research was deliberate because the Garinagu have historically been reliant on migration and have one of the highest prevalence of HIV/AIDS outside of Sub-Saharan Africa. The threat to the survival of the Garinagu has been noted by many, and Jerry Castro, executive director of the Garifuna Coalition in NYC identifies
HIV/AIDS as one of four threats. Additionally, the Garinagu are matrifocal and women have relatively high social status. Much of the migration literature considering women and/or gender has focused on women moving from a traditional setting to a modern one via migration. In Latin America, this often has meant a consideration of women moving from locations with a strong *casa/calle* (house/street, or public/private) divide where women are limited to the household, or private sphere, to one in which the women occupy the public sphere alongside men. This is not the case among the Garinagu, as women are active both inside the home and in the community. As women’s participation in the economic arena continues to grow and the gender equality gaps lessen globally, understanding how migration affects women and male-female relationships in this context will better prepare social scientists and health professionals to improve the lives of migrants and combat the HIV/AIDS epidemic (International Labour Office, 2008).

The methods used to collect data for this research are described in Chapter 4. Research was conducted in Trujillo, Honduras and New York City using the same methodology. Both locations were considered because it is not possible to understand how migration affects gender roles and relations without an understanding of life in the sending community. The research design of this study is described in detail, including the methods of participant observation, interviews, and survey. The recruitment of participants is discussed and the demographic characteristics of both the interviewees and survey participants are provided. Analysis of both the interview text and survey results is described. Finally, the chapter concludes with a discussion of ethics in anthropological research in general, and HIV/AIDS research in particular. Anthropology as a discipline has always been oriented toward social policy and ethics, and the ramifications of the early associations of Haitians with HIV/AIDS (Farmer, 1992; Gray, Lyons, 3 The other threats considered most important by Jerry Castro were the illegal loss of land in Central America, language loss, and lack of uniting emblem/identity.
& Melton, 1995) and the myth of black hypersexuality (Staples, 2006; Abraham, 2002) demonstrate the necessity of maintaining these important ethical considerations in the forefront of all research endeavors dealing with the HIV/AIDS pandemic.

Chapter 5 provides the results of the first research question: How do gender roles and male-female relations among Garifuna in NYC compare to those among Garifuna in Honduras? This will be explored through consideration of the following categories in both Trujillo, Honduras and NYC: employment, households, partnerships, and children and childcare. Data from participant observation, interviews, and the survey are presented together to form a comprehensive picture of gender roles and relations among Garinagu in Trujillo, Honduras and NYC. The chapter concludes with a discussion on the similarities and differences observed between Trujillo and NYC, considering two main themes that emerged in NYC: independence of women and growing equality of men and women.

Chapter 6 explores the second research question: How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras? The sexual behaviors of Garifuna in Trujillo, Honduras and NYC are described, and differences are discussed. How these differences affect HIV are then considered.

Finally, Chapter 7 concludes the dissertation by providing a summary of the findings. Recommendations for combating the HIV epidemic among Garinagu in NYC are given and include the need to address the stigma that is associated with HIV. This stigma hampers the effectiveness of HIV education and awareness campaigns. Addressing the findings of this research therefore requires that stigma be addressed. Since the Garinagu are a transnational community, progress to reduce the HIV epidemic among the Garinagu in NYC will also help those in Honduras. Finally, the needs of future research are discussed.
Figure 1-1. HIV prevalence, 2007 (UNAIDS, 2008a)
Figure 1-2. Percent of HIV-positive adults (15 years and older) who are female, 1990-2007 (UNAIDS, 2008a)
CHAPTER 2
THE GARINAGU

Introduction

The bus terminal in Trujillo, Honduras is located at the edge of town, requiring the services of a taxi to take you through the hilly and curvy roads, some paved but many not. Visitors glimpse a mix of mestizo and African-descendant residents before climbing the steep hill to the city center, past the regional hospital and jail. Once in the city center, with the characteristic square park (el centro), the population becomes dominated by mestizos, and the African-descendent residents become sparse. The city center is located on a cliff overlooking the Caribbean Sea. Just over the hillside the African-descendant residents, the Garinagu, can be found once again in the Cristales and San Martin neighborhoods (barrios). This chapter explores the Garinagu by considering their ethnogenesis, social and household structure, traditional gender roles, ethnomedicine, and HIV/AIDS epidemic. Chapter 3 explores the importance of migration to the Garinagu and their presence specifically in Honduras and NYC.

Ethnogenesis and Early Life

Ethnogenesis is a process through which groups of people come to view themselves and be viewed by outsiders as ethnically distinct (Taylor, 1979; Rossens, 1989). Although this is most often thought to arise from ancient traditions and/or nationality, Roosens (1989) argues that a group’s ethnogenesis is also shaped, modified, and recreated in modern times. This section describes the early ethnogenesis and life of the Black Caribs, who gave rise to the Garinagu, while more recent modifications to the process of ethnogenesis are discussed later.

By 1503, the term “Caribe” was part of the Spanish vocabulary that referred to primitive, wild, or untamed groups of people who could be captured and sold as slaves. In the New World, the term was used to refer to native populations that lived in the interior. This term arose from
Spanish interactions with the Island Caribs, a group from the Lesser Antilles that developed as Carib-speaking people traveled from the Amazonian basin and merged with Arawakan speaking groups in the Caribbean Islands (González, 1988; Taylor, 1958; Conzemius, 1928). The group that emerged as Africans intermingled with the Caribs on the Caribbean island of St. Vincent became known as the Black Caribs, as the phenotype was greatly altered by the mixing of Africans with the Island Caribs. When the Black Caribs were deported to Central America, as described in detail below, the Black Caribs gave rise to the Garinagu as they intermingled with Africans and Creoles in their new environment. This section describes the development of the Black Caribs, their life on St. Vincent, and their deportation to Central America, where the Garinagu then emerged.

**Ethnogenesis of the Black Carib**

Although African admixture occurred before this time (Wilson, 1993, 1997), the influx of Africans into St. Vincent as a result of wrecked slave vessels is credited as the most important factor leading to the birth of the modern day Garinagu¹ (Young, 1764; Gibbs, 1786; Edwards, 1799; Taylor, 1951; González, 1988; Miller, 1993; Coelho, 1995; England, 2006). In 1635, two Spanish slaving vessels sank off the coast of St. Vincent, allowing the surviving Africans to escape onto the island. This account posits that these Africans, who were ethnically heterogeneous, were taken in by the Island Caribs (DeFray, 2004; Roessingh, 2004; Crawford, 1997). Over time, this group continued to take in escaped slaves as well as some persons of

¹ One afternoon while attending the choir practice of a Garifuna singing group, I was told another version of this ethnogenesis. James Lovell, a Garifuna musician and community activist, shared this story as members of his choir nodded in the background. According to this account, Abubakari, an emperor of Mali, set sail in the Atlantic Ocean in 1311. During this exploration campaign, sea vessels arrived in the New World and shared the empire’s knowledge and technology. According to Lovell, it was these early arrivals to the New World that began to intermingle with the Carib and Arawak Indians. This account may be indicative of a desire among some Garifuna migrants in the U.S. to assert stronger African ties. While Garifuna in Central America locate and identify their roots in Africa as well, they often seek to assert their independence from African derived Creole populations who are generally viewed as inauthentic blacks that have assumed the culture of the European colonizers (Beaucage, 1989; Coehlo, 1955; Cosminsky & Scrimshaw, 1976; England & Anderson, 1998).
European descent. The African admixture was so great, however, that a dramatic change in phenotype emerged and a new distinct group, the Black Caribs, was present by 1700. Remaining Carib groups were differentiated from the Black Caribs and were referred to as Yellow or Red Caribs by the Europeans (González, 1988).

**Black Caribs on St. Vincent**

Although some slave trading and slave-raiding occurred between the Spanish and the native Island Caribs in the Lesser Antilles during the 15\textsuperscript{th}, 16\textsuperscript{th}, and 17\textsuperscript{th} centuries, the island of St. Vincent was less affected by this due to a 1659 agreement between the English and French that proclaimed St. Vincent Island Carib territory. The French slowly encroached on the island, but maintained friendly relations with the Caribs. In 1763, however, the island of St. Vincent was ceded to England in the Treaty of Paris after the Seven Years War between Great Britain and the Spanish-French coalition. The English were determined to establish sugar plantations on the island but had to contend with the presence of the Yellow and Black Caribs. Much of the land was purchased from these groups, but warfare also occurred. Eventually, the Carib groups were pushed into the northeast corner of the island, although some were able to lease land from the British in their newly acquired territory by professing allegiance to the British crown. Control of the island shifted powers once again, however, with the French forcefully taking control with the aid of the Black Caribs in 1779. The victory was short lived when in 1783 the island was once again formally restored to Great Britain (González, 1988).

During this time, the Black Carib were involved in agriculture and carried on a contraband trade with populations on other islands. Through this trade, they acquired the firearms and ammunition used in their forays against the British. Additionally, the British encouraged the Black Caribs to sell any surplus produce in the British marketplace. It has been suggested that the British were hoping to further increase the Black Caribs’ dependence on cash,
thereby reducing Black Carib hostilities and making more Black Carib available for working on
the island’s expanding sugar plantations (Miller, 1993). However, relations between the Caribs
-especially the Black Caribs) and the British remained strained and an alliance was formed with
the French mulatto revolutionary Victor Hugue. Hugue was an adversary to the British and was
critical of the slave dependent colonial system. Hugue, Yellow and Black Caribs, and remaining
Frenchmen fought against the British, calling themselves the Brigands, in the Carib War lasting
from 1795-1796. This war was unsuccessful for the Brigands, and the Yellow and Black Caribs
surrendered to the British on June 10, 1776. The British captured the Carib groups and took
them to the small island of Baliceaux near St. Vincent. At this time, there were approximately
5,000 Black Caribs. Most of these Black Caribs died as a result of this deportation due to
malnutrition, starvation, and/or disease. Eventually, the British allowed the Yellow Carib, who
had maintained more amicable relations with them, to return to St. Vincent. The remaining
Black Caribs, however, were deported in May of 1797 to the island of Roatan off the coast of
modern day Honduras (González, 1988).

The Garifuna in Central America

At the time of deportation, the English expected the Black Caribs to recreate their past
lives on the island of Roatan and even hoped that they would create military problems for the
Spanish, who had a strong foothold in the area (many of the Black Caribs were provided with
weapons for this purpose). However, the island was largely undesirable and the Black Caribs
were able to petition the Spanish to let them enter the mainland (Conzemius, 1928; González,
1988).

Spanish records indicate that there were approximately 1,700 Black Caribs at this time
that entered the mainland at Trujillo. Soon after arrival, however, the Black Caribs came to be
viewed as a threat to the Spanish, who believed the group was likely to align themselves with the native Miskito Indians who had sided with the British. Thus, the Black Caribs were encouraged to disperse and move inward along the various rivers (González, 1988).

By 1815, though, disputes among the European powers in the Central American territories were second to fear of colonial revolt. When Fernando VII gained power in Spain, he reinstated an old repressive constitution, resulting in increased revolutionary activities in Central America. The Black Caribs, alongside freed slaves, became mainstays in the Spanish Royalist army. The Central American provinces were declared independent from Spain in 1821, and the territory was annexed to Mexico in 1822. The first president of the Federation of Central American States was Manual Jose Arce, who gained the support of most of the Black Caribs by giving them money. When Arce was overthrown by Francisco Morazán in 1825, many Black Caribs fought with Arce in counterrevolutions. Morazán was eventually victorious and rebels, including many Black Caribs, were accused of treason. At this time, many Black Caribs fled the area, moving to British Honduras (now Belize) and Mosquitia (now part of Nicaragua) where they continue to live today.

In addition to political factors, the dispersal of Black Caribs during this time is also tied to the cholera epidemics pervasive in Honduras during the 1830s. The Black Caribs were thought to have introduced this disease, thus contributing to their social isolation. Many people believe it is during this time that the current settlement patterns of the Garinagu were established.

In Honduras, British Honduras, and Mosquitia, the Black Caribs continued to mix with Africans and Creoles, greatly contributing the African influence that is observed today among the group that became known as the Garinagu in Central America. The 19th century was a
formative period for the Garifuna and González (1988) has called the Garinagu a “neoteric\(^2\)” society. However, to label the Garinagu as a “neoteric” society discounts the Indian and African roots of the group. These roots speak to the history of the Garinagu and demonstrate the influence of the deportation event in the formation of the modern group. The influence of these roots is considered in the following subsection.

**Amerindian and African Roots of Modern Garifuna**

Genetic studies of modern Garifuna illustrate their tri-racial origin (Arawak, Carib, and African). Genetic analysis has demonstrated that 75.2% of the gene pool of modern Garifuna is of West African origin (believed to be of Yoruba, Ibo, and Ashanti descent), 22.4% is Amerindian, and 2.4% European (Crawford et al., 1981; Greene, 1998). Among the Amerindian component, the Arawak contributed genetically more than the Caribs (Crawford et al., 1981).

Amerindian and African roots are evident not only in the historical accounts of the group’s formation and genotype, but also in Garifuna culture and language. The Garifuna language is based on the language of the Island Carib, which was a mixture of Carib and Arawak languages. The Island Caribs largely formed as a result of Carib men capturing Arawak women. The Arawak women preserved their language and taught it to their daughters, while the men maintained their language and passed it on to their sons. The different languages used by men and women were often noted by European travelers (Conzemius, 1928). By the 17\(^{th}\) century, however, both men and women spoke a language with a typically Arawak structure that was no

\(^2\) In 1959 González (1970a) coined the term “neoteric” to refer to the Black Caribs. With this early usage, she meant that the society was not primitive and traditions were absent or shallow. Primitive societies are based upon traditions, whereas neoteric societies are new groups that develop in situations where people have broken ties with their traditional cultures. Through the course of her research, Gonzalez (1970a, p. 2) developed this term more completely and provided a list of characteristics that may identify neoteric groups: “varied ethnic or national origins, relative poverty and all this implies, ‘openness,’ secularity, reliance upon technicways, . . . face-to-face interpersonal relationships, . . .[often] characterized by the presence of consanguineal households, . . .and more commonly still, matrifocality . . .”
longer mutually intelligible with the languages of their Arawak neighbors living in other Caribbean islands (Kerns, 1997). Today, Garifuna retains Arawak structure as the dominant language structure, with 43% of the linguistic structure reflecting Arawak origin. Remnants of the different male/female languages remain evident:

for example, in women and men referring to themselves using different expression: of Arawak origin for women and of Carib origin for men. For instance, “I” is translated as *nuguya* in feminine Arawak and *au* in masculine Carib. Similarly, when it comes to sexual identity, a man calls a woman *würi* although she refers to herself as *hianru*. (Gargallo, 2005, p. 139)

Increasingly, however, men have begun using the feminine forms (Roessingh, 2004). In addition to the linguistic structure of Garifuna, the vocabulary also documents the historical connections to Caribs and Arawaks. Very few words of African origin have been identified in the Garifuna language, which developed on St. Vincent. This adds support to the greater influence of African mixture occurring later in Central America (González, 1988). Additionally, Garifuna also incorporates a large number of French, Spanish, English, and Miskito words:

[The Garifuna language] has . . .undergone some notable changes in the course of the last few centuries and has incorporated some Spanish, English, and particularly French words, in order to express the names of articles the natives did not possess before the arrival of the Europeans. They count in French, except for the first three numerals, for which they have native names (Conzemius, 1928, p. 185)

In addition to the linguistic ties, cultural elements of the modern day Garinagu also speak to their Carib, Arawak, and African ancestry. Domestic organization, division of labor, diet, religion, ancestral rituals, and music provide examples of this continuity. For example, although much of the Garifuna diet is of more recent origins, an important staple, cassava bread, remains. Similarities can still be seen between the Garinagu and Amerindians of South America in cassava bread making technique. The difference today is only that the Garinagu use

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3 The continuity of domestic organization and division of labor are considered in depth in subsequent sub-sections.
manufactured tools instead of making their own. Otherwise, the time consuming process of making cassava bread remains the same (Kerns, 1997; Conzemius, 1928).

Although most Garifuna are Protestant or Catholic, religious elements of their past remain evident. Roessingh (2004, p. 89) describes the religious system of the Garinagu as a “synthesis of various faiths. The most important of these are those of the Island Caribs, influences of African origin and Catholicism.” The religious system contends that there is one God, who is the Creator and who had a son named Jesus. However, Garifuna do not believe in the presence of a heaven and hell. Their afterworld is called Sairi and is believed to be a luxurious manioc (cassava) garden. Wrong doings are paid for while still alive and there is no equivalent to the Christian concept of hell. There are evil spirits, however, with Satan, called Uinani, being the dominant evil spirit. Other spirits in the pantheon include evil spirits of the Island Caribs as well as ancestral spirits who can harm and protect (Roessingh, 2004). Ancestor rituals are based on the Island Carib belief that “the departed relations [ancestors] were secret spectators of their [the Island Carib’s] conduct; that they still sympathized in their sufferings, and participated in their welfare” (Bryan Edwards, cited in Greene, 1998, p. 169). This belief is shared by many West African cultures as well. Ancestral spirits continue to be appeased by ancestor rituals, which show continuity in structure and song. This is evidenced by the dugu ritual. Many dugu songs refer to locations on St. Vincent and specific Carib tribes, for instance. It is said that these songs were carried over from St. Vincent and have been passed down through the generations. While the text largely reflects the Arawak structure of the language, the music’s distinct call and response pattern is largely evidence of African influence (Greene, 1998). Thus, continuity of their Amerindian and African ancestry can be observed in the modern day.
Matrifocality and Consanguineal Households

As previously stated, the continuity of their ancestry is also evident in the domestic organization of the modern Garinagu. It is important to explore this in depth as it is necessary to understand the effects of migration on gender roles and relations as related to family structure, sexual behavior, and childrearing. Specifically, the Garinagu have been described as a matrifocal group commonly typified by consanguineal household structural arrangements. The terms “matrifocal” and “matrifocality” have been applied to a range of people including the Javanese (Geertz, 1961), Nayar caste of South India (Kunstadter, 1963), Igbo of southeast Nigeria (Uchendu, 1965), urban black Americans (Stack, 1974), and the Muang of northeast Thailand (Davis, 1984). The term was first used by Raymond Thomas Smith (1956) to describe families in British Guiana (modern day Guyana) and has since been used in numerous ways in the literature:

Matrifocality may imply that women in a society have “rather good” status generally, or that they may have more control over income and expenditure; in another context it may refer to a situation where women are the primary earners in the household. Elsewhere, it may refer to those societies where male absenteeism leads to a predominance of households headed by women. (Mohammed, 1986, p. 191-172)

Tanner (1974) tried to provide a workable definition by applying three criteria: 1) the mother is central in family life, “structurally, culturally, and affectively,” 2) mother centrality is accepted, or “legitimate,” in the culture, and 3) the mother-child relationship is given priority over all other relationships. Today, the Dictionary of Anthropology simply defines matrifocal households as “structured around the mother and…the father is absent or plays a relatively limited role” (Barfield, 1997, p. 313).

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4 The continued inclusion of the “absent man” has been criticized by feminist scholars who argue that this definition suggests a deviation from the “norm,” which placed males as head of house. This was a popular idea during the 20th century, as will be described later in the section.
In a matrifocal household, relationships among family members tend to be centered on the original mother-child relationship, as Tanner (1974) acknowledged. Within the household structure, the mother-figure is least likely to have multiple or shifting allegiances to other families or households. Instead, this mother-figure is the focus around which all other members cluster. If extended family members are included in the household, these family members are most likely to be related to the unit through familial ties with the mother-figure. It follows that contact occurs more often with family members related through the mother-figure, and siblings sharing the same mother (uterine siblings) have stronger bonds than with those siblings sharing only a father. A person occupying the role of husband-father is less important, as he may or may not be present in the home.

Additionally, women are more able to make household and parenting decisions with or without the input of a male partner. This is not to mean all decisions are made by women, just that their independent input is at times utilized and respected. Matrifocality is not an either-or phenomenon, and so the degree to which this independence occurs may vary. It follows then, that in the eyes of the children, the maternal figures are more stable and the most dominant, providing both a nurturing presence as well as a disciplinarian.

González (1970) notes that it is possible to have matrifocal family organization without having matrifocal societal organization (i.e., women may still be rejected as political figures). However, among the Garinagu, matrifocality is seen in the social organization as well. Women commonly serve in organizations, on village councils, and may be healers (buyais), for example, although this varies by country and is more common in Belize. In all Garifuna communities, however, women play a vital role in ancestral rituals. When dealing with non-Garifuna groups, however, women are traditionally less involved (Kerns, 1997).
Although similar, consanguineal households are not the same as matrifocal households.

Consanguineal kin are those related by birth, and a consanguineal household can be defined as a co-residential kinship group which includes no regularly present male in the role of husband-father. Rather, the effective and enduring relationships within the group are those existing between consanguineal kin. . . .Conversely, a matrifocal family may quite well include a regularly present person in the role of husband-father...The crucial point in identifying the consanguineal household [is] the effective and enduring relationships are those existing between consanguineal kin. (González, 1970b, p. 236, italics in original)

Consanguineal groups, therefore, consist of a mother and her daughters and grandchildren, or a group of sisters and their children. Adult male member may at times be part of the household, but their residence is generally temporary. These men may be brothers or sons as well as the sexual and/or economic partners of the women (González, 1969). Although these arrangements seem similar, the consanguineal household may or may not be matrifocal, and a matrifocal society may or may not contain consanguineal households. Although the extent of consanguineal households varies by village, Garifuna households are commonly consanguineal. In 1956, for example, González (1988) found that 45% of the households fit the form of consanguineal household in Livingston, Guatemala. In 1990, Miller (1993) found consanguineal households to comprise 31.1% of the households in “Seaview,” Belize and more recently, England (2006) identified 40% of the households in Limón, Honduras as consanguineal.

The presence of matrifocality and consanguineal households is often seen among groups that have heavy male emigration, seasonal unemployment, or high degrees of male economic insecurity (Brogger & Gilmore, 1997). In the middle of the 20th century matrifocality was generally seen as a deviation from the norm, as described by Kunstadter in 1963 (p. 56): “the matrifocal family…is usually thought of as an extreme variant from the normal range of family types.” Accordingly, González (1969), conducting fieldwork in Livingston, Guatemala in the 1950s, argued that Garinagu matrifocality was an adaptation to the frequent absence of men from
the village due to labor migration. Although González (1969) found that 55% of households were based around an affinal, or married, couple, she noted that these households were unstable and frequently converted into the consanguineal type as unions dissolved. Like the dominant Latin American gender ideology, however, she argued that the Garinagu idealized the nuclear household and therefore the woman-headed household occurred only as a default (González, 1969).

Others, however, have argued that the gender ideology common in Latin America, with clear casa/calle (or house/street) gendered space, does not apply to Garifuna women in their home countries. Instead, like in West Indian and Carib societies, a different logic is seen. Here, women work in the fields and participate in community activities. Thus, in contrast to González (1969), Helms (1976) and Kerns (1997) argued that matrifocality among the Garinagu has deep cultural roots that are to be found among the Island Caribs in St. Vincent. Kerns (1997) found in her fieldwork in Belize that matrifocality does not only exist in consanguineal households, as González (1969) would suggest, but also in affinal households. Thus, it is not a default but rather a general orientation of the society. This general orientation developed, she argues, because of the male polygyny and female serial monogamy that existed in the Island Carib society (Helms, 1981; Kerns, 1997; England, 2006). Additionally, considering patriarchal societies in Latin America with heavy male emigration further negates matrifocality as a default. In many of these cases, women become only temporary heads of household but are not allowed to explore the public sphere, or calle, which is male gendered space and the dominant ideology of patriarchy remains (Georges, 1992; Mahler, 2001; England, 2006). Thus, Garinagu matrifocality and the presence of consanguineal households is best understood as developing from their cultural beginnings with the Island Caribs on St. Vincent.
Traditional Gender Roles

The way men and women are perceived and expected to behave is socially constructed and varies greatly from one culture to another, as Mead (1935) made clear in *Sex and Temperament*. This sub-section will consider the traditional gender roles through time among the Black Caribs on St. Vincent and the Garinagu in Central America.

**Gender Roles Among the Black Caribs on St. Vincent (pre-1779)**

The earliest accounts of life on St. Vincent come from 17th century European explorers and Jesuit priests. González (1988) notes, however, that few spent any significant time with the native populations. Early accounts describe the domestic organization of the Black Caribs as uxorilocal after marriage (González, 1988). Marriage occurred at an “early age,” and women were unable to choose a husband (George Davidson, quoted in Gullick, 1976, p. 13). Upon marriage, the husband provided his new bride with a furnished hut. Men would take several wives (four or five were common) and the man shared his time between them in different residences (Gullick, 1976). Additionally, men spent large amounts of time in a village men’s house. As Taylor (1951, p. 28) described: “such a socio-economic unit was divided, by its very nature, into an in-group consisting of the women together with their unmarried sons, and an out-group containing all the husbands.” A man could easily divorce a wife, but she could not divorce or establish another marriage until after her husband’s death. Information such as this led González to reject the idea posited by Helms (1976) and Kerns (1997) that matrifocality originated with the early Island and Black Caribs, as described in the previous sub-section. On this González (1988, p. 30) wrote: “There is simply no evidence for the Island Carib women having anything like the status and authority we see today among the Garifuna.”
When a child was born, the father engaged in the ritual behaviors of the couvade, although not much is known about the practice of the couvade on St. Vincent during this time\(^6\) (Gullick, 1976). At birth babies’ heads were boarded for two to three months to flatten their skulls. This practice is thought to have occurred to distinguish the Black Caribs from slaves (Gullick, 1976; González, 1988). Children were cared for completely by their mother for the first years of life. Around age two, men began to help care for their sons and eventually took complete control of them while the mothers remained responsible for the girls (Gullick, 1976).

Men and women had important roles in agriculture. Men cleared the land and then women planted and cared for the gardens. Men also hunted and fished while women cooked and kept domestic animals. Both the men and women performed some weavings together. Men commonly traded goods in nearby islands, often working with Europeans in this endeavor. There is no evidence of women working for wages at this time or working with the Europeans as domestics (Kerns, 1997; González, 1988). However, Black Carib women were not confined to their home; women were active in the local markets where they sold crops and cassava bread and bargained goods, including firearms and ammunition (Gullick, 1976; González, 1988; Kerns, 1997). A pattern of wage labor and production for exchange was therefore established on St. Vincent. Thus, both men and women were active in the public sphere. Methodist missionaries Mr. and Mrs. Baxter emphasized the lack of distinction in gender roles between Black Carib men and women in their following account about the Black Carib women: “Even their women put on a warlike appearance, and seem familiarized with the weapon of destruction. Cutlasses, and other accoutrements, are frequently in their hands; and knives are suspended by their naked sides” (quoted in González, 1988, p. 29).

\(^6\) More is known about the couvade of the Dominica Caribs around this time and there are likely great similarities. Taylor (1950) provides a review of this information.
Early Garifuna Gender Roles in Central America (1779-1900)

Little is known about the early life of the Garinagu\textsuperscript{7} in Central America, although within a few decades, they once again gained the attention of Europeans (Kerns, 1997). The accounts of their early days in Central America demonstrate a striking degree of continuity from their lives on St. Vincent. Nothing, however, is known about courtship and marriage, other than that the marriages were illegitimate by Christian standards. Records indicate that there were few men available to be wed by priests when they visited the Garifuna villages as most were away fishing or at work. Polygyny continued, with men taking three to four wives. Each wife maintained a separate house and the husband’s time was shared equally by all wives (Gullick, 1976).

Reports of pregnancy and couvade are missing from records during this time, but the couvade was probably still practiced as before on St. Vincent. Additionally, some Garifuna were converted to Christianity by the middle of the 19\textsuperscript{th} century and baptisms were performed on some babies (Gullick, 1976). Head deformation was eventually abandoned, as this was likely not necessary in Central America as a mark of group identity since Garifuna were easily distinguishable from their neighbors both by complexion and dress (Kerns, 1997). Additionally, little is known about children in their youth, other than that the mother was responsible for their well-being (Gullick, 1976).

In the household, men and women performed separate duties. Men were responsible for clearing land, planting, fishing, and building boats while women worked the fields, collected firewood, kept domestic animals, maintained the home, and bartered produce in the market (Gullick, 1976). Gargallo (2005) notes that the women’s role in agriculture facilitated the symbolic and economic importance of the female in Garifuna culture during this time (and

\textsuperscript{7} The deportation from St. Vincent and entry into Central America in 1979 generally denotes the name change from Black Carib to Garinagu/Garifuna.
through the 20\textsuperscript{th} century). Men did little in the home, leading visitors to their communities to comment on the apparent laziness of the men: “The lazy males are supported by their wives, who are much more muscular and stalwart of the two” (Charles, 1890, p. 114). Toward the end of the 19\textsuperscript{th} century women also began selling bananas for export, carrying the produce out to the large ships en route to New Orleans in canoes, and engaged in profane battles of words with the men purchasing the bananas: “Their tongues run like windmills; the purser of the steamer must be a sharp one to battle with them” (Charles, 1890, p. 119).

Unlike on St. Vincent, both men and women participated in wage labor, and in Central America the Garinagu quickly developed a reputation as good laborers. Men found different jobs in British Honduras, Guatemala, and Honduras. These included work as woodcutters, sailors, or plantation workers. Additionally, many enlisted in the military (England, 2006). Many of these jobs were seasonal (Miller, 1993). Independently, some carried contraband between the countries or sold deerskins, turtles, or fish in the markets. It is not known exactly when women began engaging in wage labor, but Kerns (1997) provides evidence that it may have been by the mid-19\textsuperscript{th} century. They were restricted, however, to low paying jobs in sugar and banana plantations, as laundresses, or as domestic servants (Kerns, 1997).

**Gender Roles Among the Garinagu in the 20\textsuperscript{th} Century**

Garifuna men in the 20\textsuperscript{th} century continued to have multiple wives, although often the wives lived in different villages (Gullick, 1976). The wives, in the eyes of the men but not always the community, enjoyed equal status and the man was expected to support each wife and their children (England, 2006). Although this is known to bring prestige among males, women in the second part of the 20\textsuperscript{th} century often complained to González (1969) that these relationships usually led to conflict among the women who fought for the man’s support. The concept of “illegitimate” child does not exist among the Garinagu, and children from these
unions considered themselves siblings (*hermanos por parte de papa*) (England, 2006). While these relationships were basically accepted, researchers in the middle of the century found that few men could support multiple partners. Coehlo (1995) found in 1955 that only 20-25% of men in Trujillo, Honduras had multiple wives and in Limon, Honduras in 1965, Beaucage (1970) reported only 14% of men had multiple wives.

Thus, at least by the middle of the 20th century, single unions prevailed. These unions could be legally sanctioned, usually in a Roman Catholic Church, or could be extralegal. Extralegal unions are widely accepted (and generally the norm) and the couple refers to each other as husband and wife. Kerns (1997) notes that in the Garifuna language there is no distinction made between legal and extralegal unions. While I was in Trujillo, Honduras and NYC, however, people usually were quick to tell me if their union was legal.

Married couples usually establish a home separate from their parents and traditionally the house was built by both the husband and wife (Kerns, 1997; Gullick, 1976). Kerns (1997) found that in the three villages she surveyed in the 1970s, 90% of couples lived in their own houses. Seven percent lived with the wife’s family and only 1% lived with the man’s family. However, marital unions were and are fragile, dissolved relatively easily, and are often overlapping and fluctuating (Kerns, 1997; González, 1984).

Among the Garinagu, sex is considered natural and healthy, and a person’s virginity is not highly valued. Although both men and women joke, discuss, and enjoy sexual relations, great differences are observed between men and women with respect to sexual behavior. Kerns (1997, p. 89) writes: “Men and women hold responsibility for their own sexual conduct, but a woman’s reputation depends on sexual restraint, while a man gains esteem for sexual initiative and prowess. A man known as a ‘breeder’ (the father of many children, especially by different
women) enjoys prestige among other men.” Largely, this is the result of the woman’s responsibility to other people, as sexual misconduct may put these individuals in harm. Engaging in sexual misconduct, for instance, may put a woman’s children at risk by jeopardizing the financial support received from the children’s father. Men’s desire for more than one sexual partner is considered natural, and in the past a man’s fidelity was often thought to be the result of sorcery. Although it is acknowledged that women experience great sexual urges as well, their sexual infidelities are not generally acceptable.

The type of union shared by a couple does not affect childbearing (Kerns, 1997); as previously mentioned, the Garinagu do not have “illegitimate” children. Until more recently, most women gave birth at home, often with the assistance of a midwife. During the birth, female family and friends may surround the woman, but the only man allowed in the room is the father. Traditionally, the midwife buried the afterbirth following delivery to prevent an enemy from taking the placenta and turning it upside down or putting salt on it, both of which are believed to prevent the woman from having any more children (Kerns, 1997). In the early 20th century, the couvade was widely practiced and occurred during pregnancy and after the birth of the baby (Coelho, 1949; Taylor, 1950; Kerns, 1997). Most accounts of the couvade come from Taylor (1950) and Coelho (1949) who documented restrictions placed on mothers and fathers around the birth of a child. These accounts describe restrictions on behavior for the father and on the diet for the mother. The reason for the couvade among the Garinagu is unclear, and has been interpreted in several different ways by Coelho (1949), Taylor (1951), González (1969), Munroe, Munroe, and Whiting (1973), and Foster (2005). The practice today, though, has largely degenerated (Foster, 2005), and instead a common method of offering protection to a baby is a small red bracelet around an infant’s arm designed to ward off evil.
Kerns (1997) describes the life stages of the Garinagu, placing childhood from approximately 1-12 years, adolescence from 12-16 years, early adulthood from 17-44 years, late adulthood from 45-70, and old age from 70 years. She notes, however, that in general chronological age is only loosely based on social age and females tend to enter these stages earlier than males. In childhood there is a slow development of general independence of the child from the mother through weaning, toilet training, and schooling. Puberty marks the transition into adolescence and usually sexual activity begins during this stage. Traditionally, women did not leave the house during their menstrual cycles as the scent of menstrual blood was thought to attract the evil spirits wináni and mafia. The Garifuna word for menstruate, anúra múnada, literally means to “sit at home.” Kerns (1997) found, in her research conducted in the 1970s, that women tended to stay at home during menstruation only during adolescence at the insistence of their mothers, although at all ages menstruating women did not participate in the dugu since this was offensive to the ancestors. Early adulthood is denoted by the acquisition of employment or the birth of a child. For most Garifuna, this occurs by 20 years of age (Kerns, 1997).

In the early 20\textsuperscript{th} century, the division of labor among men and women was similar to those of the 18\textsuperscript{th} and 19\textsuperscript{th} centuries: men hunted and fished, made traveling baskets, made boats, and did carpentry while women burned land, planted, weeded, and harvested crops, aided in house building, sold goods in the market, and cooked (Gullick, 1976). Additionally, both men and women participated in wage labor. Again, many of the jobs conducted by the men were seasonal, requiring long absences from the village. Partly as a result, horticulture declined rapidly in the 1930s and 1940s (Miller, 1993). By the late 1940s, Taylor (1951) found that less than half of the households in one Garifuna village maintained horticultural plots.
Thus, the Garinagu became increasingly dependent on the cash economy by the mid-20th century. Taylor (1951) found in the 1940s that most adult men and nearly half of the women worked away from the village for up to six months a year. Men continued to find work on banana plantations, logging camps, or in large cities (Beaucage, 1970; England, 2006). Taylor (1951, p. 74) noted in regard to women, “if the father be away, the mother will not hesitate to accept employment a long way from home. She will shut up house, leave her children with her own mother or with a married sister, and go her way.” Women often found work in the citrus cannery in Belize, the banana plantations in Honduras, or as street vendors or domestics in large cities (Miller, 1993; McCommon, 1982; Khan, 1987). Migration to the U.S. began to occur more frequently among Garifuna men in the 1940s and in the 1960s for women, as will be discussed in detail later.

Aging among the Garinagu is often defined by a reduction in sexual activity, reproduction, and ability to work. Women in Central America often have difficulty finding employment over the age of 50, unlike men, and thus aging is experienced differently by men and women (Kerns, 1997). Men, in contrast, could find work in the past until physically unable, although this is changing in many locations, including Trujillo, Honduras, where jobs are scarce. Thus, as opposed to women whose aging process is defined by inability to find employment, Kerns (1997) noted that decline in sexual relations more commonly defines aging in men. During this time, women often involve themselves in ritual activity and/or take an increased interest in health and sickness, offering advice to young mothers about the care of their children. Upon death, men and women go to “the other side” but continue to be involved in their descendants’ lives (Kerns, 1997, p. 102). Through ritual, they are cared for by the living and maintain influence over their family.
Ethnomedicine

The ethnomedical system of the Garinagu is both personalistic and naturalistic. A personalistic system is one in which “illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or a god), a nonhuman being (such as a ghost, ancestor, or evil spirit), or by a human being (a witch or sorcerer)” (Foster & Anderson, 1978, p. 53). Specifically, Taylor (1951) found four causes of illness and disease among Garifuna in Belize: 1) neglect of deceased ancestors, 2) angering of the spirits, 3) sorcery or poisoning, and 4) purely natural causes. These disease categories will be considered here. The healing modes and ritual healers will also be described.

Illness can be ancestor related if the deceased ancestor feels neglected or becomes angered. After the death of a family member, different rituals must occur at specific times. Additionally, an ancestor may request rituals by appearing in a dream. These rituals are outlined in Table 2-1, and each must occur to meet the needs of the dead.

The Garinagu believe that ancestral spirits have two powers: gubida and the ahari. The gubida is a negative spirit, bound to the earth, and is dangerous and demanding. This spirit requires conformation through the requirement of ritual acts among his living kin. Alternatively, the ahari is a positive power, who protects living relatives (Roessingh, 2004). Ignoring the demands of an ancestor can result in illness or other misfortune. A deceased relative is implicated as the source of an illness under the following circumstances: 1) the illness is serious, possibly even life threatening, 2) the illness does not respond to normal therapeutic procedures, 3) the illness is related to a visit in a dream by a deceased relative, and 4) a healer, called a buyai, confirms an ancestor’s involvement. Cohen (1984, p. 19) provides an example of this type of incident, in which an injury occurred:
One informant . . . described a leg injury he had sustained . . . a result of a bamboo roller striking his calf as he was beaching his canoe. He recalled feeling a “sharp slap” followed by a surge of pain. The next morning he was unable to walk. A few nights later he saw his great grandmother in a dream. She asked for food, a sign that the injury was spirit related. As his condition was not improving, the family summoned a [buyai]. . . . A consultation with the ritual healer confirmed ancestral involvement. The cure was that he host the sacred [dugu].

In this example the ancestor ritual was a curative measure for the injured man. However, ancestral rituals can also be preventative. For example, if an ancestor comes to an individual in a dream and makes a request, the individual can perform the required duties in order to prevent illness or misfortune that may result if the ancestor is ignored (Cohen, 1984; Kerns, 1997).

In addition to ancestral spirits, other spirits may inflict harm as well. One example is Agayuma, the river spirit. This spirit presents itself as a woman and seduces men. Once seduced, the man must contact a buyai for help or his dreams will reveal to him his oncoming death. Like the ancestral spirits, these spirits can also inflict harm in non-health related ways as well (Roessingh, 2004).

Sorcery is a third major etiologic category among the Garinagu. Kerns (1997, p. 79-80) notes that: “In some respects sorcery is a matter of everyday concern. People often speak of it, and some take daily ‘precautions’ to protect themselves… even men and women who profess not to believe in many other supernatural phenomena consider sorcery a real and dangerous threat.” Old quarrels are often rekindled when a person suffers some misfortune, especially a wasting illness. In the case of sorcery, sorcerers (obeahmen) may use magic (obeah) to inflict harm or the layperson may use poison. Men who die suddenly and unexpectedly, for example, are often thought to have consumed poison. Sorcery is covert, and few readily admit to the use of sorcery although the threat of its use is common. Kerns (1997, p. 79) recorded a threat she witnessed while in Belize:
A woman whose prize rooster disappeared one night confronted the man she believed had taken it and demanded payment. When he denied her charge and refused to compensate her loss, she swore to see a ‘wise man’ (a diviner, assumed to be a sorcerer as well) in the district town. A few days later the man sent her partial payment, which the woman said was not entirely satisfactory but certainly better than nothing.

Finally, disease can also be attributed to natural causes. There exist a number of culturally defined conditions that have no biomedical counterparts. These conditions must be treated by a doctor moreno (a doctor of color, or a Garifuna healer). One example is caída de paletilla. The paletilla is described as a cartridge-like body part that surrounds the heart. If a person moves abruptly or carries a heavy load, the paletilla may drop, causing pain that is often accompanied by coughing blood. Massage therapy must lift the paletilla back into place, using the technique of cupping. A small candle is placed over the chest and covered with a glass jar to create a vacuum. The pressure created from this vacuum draws the skin, and paletilla underneath it, up (Cohen, 1984).

As described above, the Garinagu have four main etiologic categories to explain illness and disease. When ill, most Garifuna will seek biomedical care after home remedies of herbal medicines are tried without success. A doctor moreno is consulted when natural illnesses unique to Garifuna, such as caída de paletilla, are suspected. The healing repertoire of the doctor moreno includes massage, as mentioned above, and herbal therapy. If these treatments or treatments provided by biomedical health workers are successful, the illness is attributed to natural causes.

If a cure is not forthcoming or the patient suffers a relapse, a buyai is consulted (Jenkins, 1983). Buyai status is ascribed. Being born with placenta matter over the head is generally thought to be a sign of future divination. This gift is generally identified, however, by the visitation of spirits when the child is around nine years old during a stubborn bout of illness.
This begins the process of becoming a buyai, which is long and arduous (González, 1988). One buyai described this to me:

We have our ancestors choose us. Many of us are chosen, few are called. Many would want to be buyais but are not. There are many buyais who did not want to be buyais. Yes. I began when I was 15 or 16 years old, denying myself, because I did not want this for myself. But one is not what one wants to be, but what the ancestors mandate, because we have the capacity, fortunately or unfortunately, of communicating with them, that is how we are. . . So I began when I was 15 or 16, I received when I was about 23, later after suffering a lot, because they mandate and we have to follow. I practice buyaisrism not for personal gain. No. For me buyaisrism is not a business. For me, buyaisrism is a necessity.

Knowledge is learned over time through visions and dreams (González, 1988). The buyai’s diagnostic procedures include asking questions to special ancestral spirits called hiuruhas and candle divination (Jenkins, 1983). If ancestral involvement is implicated, the buyai consults with the hiuruha(s) to determine the demands of the patient’s ancestor. These demands are then met with private rituals (i.e., food and drink offered in the home) or large rituals (i.e., the dugu) (Roessingh, 2004). If the buyai determines that ancestral spirits are not involved, prayers, medicines, or baths may be prescribed or referrals may be made to other healers (Jenkins, 1983). In the case of sorcery, an obeahman or obeahwoman may be summoned, as obeah is not a skill of the buyai. The sorcerer, then, is able to diagnose, identify wrongdoers, and heal the patient. Unlike buyais, sorcery can be learned and sorcerers do not necessarily have to be Garifuna (Roessingh, 2004).

In addition to the traditional healers already described, Garifuna villages may also contain midwives (parteras), massagers (sovadores), and snakebite doctors. Midwives are part-time practitioners who conduct prenatal exams, assist in delivery, and provide postnatal care for the mother and infant. Massagers, as the name implies, provide therapeutic massages. Although these massages can also be performed by a doctor moreno, some people specialize in this specific treatment. Finally, a snakebite doctor provides treatment in case of contact with
poisonous snakes. In treating the snakebite, the snakebite doctor makes two perpendicular incisions over the snakebite, uses a razor to scrape the area, and then applies a salve containing onion, garlic, and other unidentified ingredients (Cohen, 1984).

The ethnomedical system of the Garifuna reveals both a disease theory and health care system. The disease theory contains four main causes of disease, of which three are personalistic. If an illness is serious, not resolved by treatments for natural diseases, and/or the illness is stubborn or long, a *buyai* is contacted to confirm or discredit suspicions of personalistic disease origins. Additionally, review of the ethnomedical system reveals the health care system, which defines the organization of health care. Among the Garinagu, some healers achieve their status by divine intervention, while other categories of healers are laypersons who have been trained.

As previously mentioned, the ethnomedical system of the Garinagu is partly naturalistic, and the ethnomedicine of the Garinagu is not mutually exclusive from biomedicine. González (1963) reported that many Garifuna were eager to have better biomedical services in their communities. Indeed, it is common for groups to maintain belief in both their ethnomedical system and biomedicine, and to use these systems for different reasons. Kleinman (1976, p. 663) refers to this practice as “pragmatic strategies” and Pillsbury (1978, p. 6) speaks of “eclectic resort.” An example of this was presented while I was in Trujillo. A young man was repeatedly having seizures but the biomedical doctors in Trujillo could not determine their cause. The family took the young man to the hospital in La Ceiba for further evaluation. Again, the doctors could not determine what was causing the seizures. Only after repeated contact with biomedical doctors proved unsuccessful, the family consulted with a *buyai*. The *buyai* informed the family

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8 Biomedicine is recognized as an ethnomedicine of Western culture (Brown, Barrett, & Padilla, 1998).
that the young man was not honoring an ancestor who had reached out to him in a dream. The cure, therefore, was to perform an ancestral ritual in this person’s honor.9

HIV/AIDS provides an example of an illness that the Garinagu believe to be solely naturalistic. Although buyais and local healers may be consulted to treat symptoms, the buyais I talked to all insisted that they encouraged HIV-positive people to utilize the services of biomedicine and would not work with individuals who refused to acknowledge their HIV status. More on HIV/AIDS among the Garinagu is provided in the following sub-section.

**HIV/AIDS among the Garinagu**

The Garinagu appear to be disproportionately affected by the HIV/AIDS epidemic in Central America. Little data are available specific to the Garinagu as country data generally do not distinguish ethnic groups, although the World Health Organization (2005b) estimate that 8 to 14% of the Honduran Garinagu are HIV-positive (see Table 2-2). More recently, however, Paz-Bailey and colleagues (2009) found an estimated population prevalence of 5% based on their sample of approximately 800 Garifuna in Honduras.10 The HIV prevalence of Belize is 2.4%, the highest in Central America. Again, the Garinagu population has higher prevalence rates, with the 2001 estimate at 8% (UNAIDS, 2004a). Very little information from Belize is available, but reported AIDS cases show the second highest concentration of cases in the country occur in the Stann Creek District, where 53.9% of the population is Garifuna (Palacio, 2005).

Even less information is available for Garifuna in Guatemala, and USAID (2008) simply states: “The Garifuna population…is more at risk than the general population.” Nicaragua has the lowest prevalence of HIV in Central America at 0.2%, and no information is available on the

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9 To my knowledge, the seizures ceased to occur after this event.

10 The overall adult prevalence of HIV/AIDS in Honduras in is 0.7% (UNAIDS, 2008c).
prevalence of HIV among the Garinagu there (World Health Organization, 2005c). Although Garifuna from Belize, Honduras, and Guatemala are considered a high risk group for HIV/AIDS, Honduras has the longest-standing rate of HIV/AIDS infections, and thus most research on HIV/AIDS among the Garinagu has been conducted here.

The early movement of HIV in Honduras is often blamed on the presence of U.S. military troops along the north coast and central region during their activities against Nicaragua’s revolutionaries in the 1980s (Gargallo, 2005). The HIV epidemic became visible, particularly in the north coast among the Garinagu, in the early 1990s. Mirtha Colon, the president of Hondurans Against AIDS in NYC, traveled to Honduras during this time to meet with members of the Department of the Minister of Health:

Honduras didn’t want to face it. Honduras didn’t know how to face it; they don’t know how to deal with an epidemic like that. At the same time we were informed in Tegucigalpa dengue...was going on. I believe they told us they had put some money to HIV/AIDS education and prevention but because of dengue they had to take that money, and we talking about the government, they had to take that money and put it to dengue because they feel dengue killed from one day to the other instead of HIV [with which] people can live longer, even though life expectation at that time in Honduras was six months to a year.

The high rate of HIV among the Garinagu has often been blamed on their “promiscuity,” to which Mirtha Colon responds:

Even though the [Garifuna] community is being severely affected by the epidemic [so is] San Pedro Sula [Honduras], and San Pedro Sula is not a Garifuna community. Ok, so why was San Pedro Sula so severely affected and what do you call that if you call our community...promiscuous, what do you call there?

The HIV epidemic among the Garinagu is largely a result of heterosexual transmission although few studies have been conducted to learn about transmission of HIV in Garifuna communities. Instead, focus has been placed on prevention campaigns. Research on behaviors that facilitate HIV transmission cite low condom use (García, Salavarría, Valentín, Ramirez, & Sierra, 2000; Stansbury & Sierra, 2004; Sabin, Luber, Sabin, & Monterroso, 2008; Paz-Bailey et
Multiple concurrent sexual partners may be very important in the spread of HIV among the Garinagu, and this is associated with low condom use. MCPs are those in which partners overlap such that one or both persons in a sexual relationship also has one or more other sexual partners at that same time (Adimora et al., 2002). MCPs have been implicated in the transmission of a number of STIs including chlamydia (Potterat et al., 1999), gonorrhea (Castor, Jolly, & Furlonge, 2002), and syphilis (Koumans et al., 2001). García et al. (2000) found 28% of Garifuna men and 3% of Garifuna women had more than one sexual partner, although in 2008 Paz-Bailey and colleagues (2009) found MCPs much higher among women. Their research included 817 Garifuna from eight Honduran communities, among which they found 36% of men and 29% of women had MCPs. In both studies, condom use with a stable partner was much lower than with casual partners (4% and 12% among men, respectively, and 5% and 10% among women, respectively). In Belize, Buszin et al. (2009) found 59% of men and 33% of women reporting MCPs but only half (50%) reporting consistent condom use with occasional partners and 12% with any partner.

The response to the HIV epidemic among the Garinagu in Honduras was relatively rapid, and multiple local and international organizations, more recently in collaboration with the Honduran government, developed campaigns to educate and prevent HIV spread. Local organizations involved in education and prevention campaigns include the Organization of Ethnic Community Development (ODECO)\(^{11}\), the Central American Black Association (CABO, ...
or ONECA), and the Garifuna IEC Committee. Additionally, Honduran organizations including El Buen Pastor and Foro Nacional de SIDA, often in collaboration with international agencies, conduct HIV campaigns along the north coast.

These campaigns have been varied in content and method, and have utilized the media to promote preventative attitudes and behaviors. Health Communication Partnerships, in collaboration with the Garifuna IEC Committee, for example, developed a radio drama called “Los Ancestros no Mueren” (The Ancestors Never Die) in both Garifuna and Spanish. One social worker credited the campaign with increasing the demand for antiretroviral therapy (ARVs) by HIV-positive persons and educating the public of the need to seek help at a hospital or biomedical clinic. Additionally, a KAP survey conducted by El Buen Pastor in Honduras in 2000 demonstrated that these campaigns have largely succeeded in educating Garifuna about HIV/AIDS. They found that knowledge about sexual risk factors for transmission of HIV was high (90%) (García et al., 2000). Evidence of the risk factors discussed, including MCPs and low condom use, however, support the presence of a KAP-gap among the Garinagu of Honduras.

Less consideration has been given by scholars to Garifuna in Central America outside of Honduras. Belize has conducted several HIV/AIDS prevention campaigns, including one by the National Aids Prevention and Control Program, which used the motto “If you wa mek love, wear a Glove” (Roessingh, 2004). The first project specifically addressing the epidemic in the Garifuna population occurred in 2003 and was produced by the Dangriga HIV/AIDS Society and Proyecto Acción SIDA de Centroamérica. Called Powa Fu Women, this project aims to

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and land issues. While I was in Trujillo, however, a local chapter opened and board members had plans to work on HIV prevention.

12 The first four episodes can be accessed at http://www.m-mc.org/spotlight/honduras_ancestors/index.php
empower Garifuna women to take control of their lives and health and protect themselves from HIV through day-long retreats (Efunyema, 2003).

As previously mentioned, among the Garinagu HIV/AIDS is viewed solely as naturalistic in etiology and thus the biomedical resources, including ARVs, are promoted and utilized. *Buyais* do have a role in the HIV epidemic in Garifuna communities, however. In Trujillo, three *buyais* informed me that they saw most of the HIV-positive persons in Trujillo but only to relieve symptoms of opportunistic infections:

Through the ancestors we have achieved medicines that hinder the infection but do not cure. One must be very cautious with that. We accompany them [to biomedical appointments] and make them feel that they matter as people and that HIV does not mean death. Here in Honduras we have antiretrovirals. We make the people see that if they go to a health center, they can extend their lives; we cannot extend anyone’s life. We have medication for the opportunistic infections not for HIV.

Additionally, according to the *buyais* I talked with, they will not provide services to HIV-positive people who deny their status:

There are people who know they have the virus but they will not accept it. So even if they come seeking our services, if they do not accept their situation, we do not help them. What we work on are things that are transparent, we do not hide anything. If you hide your situation we won’t be the ones who will put it in full view.

I was told that earlier HIV campaigns included *buyais* to educate them about HIV/AIDS and encourage them to send HIV-positive patients to the biomedical hospital or clinics, although I was unable to obtain detailed information about these. Thus, the *buyais* in Trujillo, at least, are providing aid to the HIV epidemic in the community by working alongside biomedical public health specialists and doctors.¹³

¹³ Sabin et al. (2008), conducting a rapid ethnographic assessment in six locations in Honduras in 2004, report that they heard of *buyais* telling Garifuna that they were cured of AIDS and giving inaccurate information on HIV/AIDS. *Buyais* in Trujillo, while important, do not have as much social power as those in the smaller villages, possibly contributing to the differences observed. Additionally, as the capital of the department, Trujillo has a large
Data about the HIV prevalence among the Garinagu is limited and claims have been made that race has contributed to the focus on the Garinagu as a population of high risk for HIV/AIDS in Latin America (Gargallo, 2005); however, the importance of the epidemic in their community cannot be ignored. As previously mentioned, Jerry Castro, executive director of the Garifuna Coalition, labels the epidemic as one of the four threats to the survival of the Garinagu.

Summary

In 2001, the United Nations Educational, Scientific and Cultural Organization (UNESCO) proclaimed the language, music, and dance of the Garinagu a masterpiece of the oral and intangible heritage of humanity (UNESCO, 2001). The Garinagu, whose survival has been threatened by a number of issues including language loss, population dispersement, and HIV/AIDS, have attracted scholars for centuries to their various cultural traditions. Palacio (2005) notes, however, that less attention has been given to the social and community problems of the Garinagu. Many of these issues have arisen directly or indirectly as a result of international migration. Research on Garifuna migration to the U.S. has been long standing though, as demonstrated by the research of Nancie González (1979, 1988). More recently, research on Garifuna migration to the U.S. has been conducted in Los Angeles on patterns of migration (Miller, 1993) and migration and identity (DeFray, 2004), and in NYC on migration, transnational politics and racialized space (England, 2006) and migration and religion (Johnson, 2007). The current research likewise considers migration by the Garifuna, aiming to also consider how the HIV epidemic is affected among Garifuna in NYC. The long history of migration among the Garinagu is the focus of the Chapter 3. Additionally, Garifuna in Honduras biomedical hospital, and thus biomedical services are more easily accessible than in more isolated Garifuna towns and villages.
and New York City will be discussed in depth, as these locations provide the setting for the current research.
Table 2-1. Sequence of death rites among the Garinagu (Adapted from Kerns, 1997, p. 151)

<table>
<thead>
<tr>
<th>Name</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wake and burial, <em>beluria</em> and <em>abunahani</em></td>
<td>Obligatory, within 48 hours of death</td>
</tr>
<tr>
<td>Novena and ninth-night wake, <em>arisaruni</em> and <em>beluria</em></td>
<td>Obligatory, usually within 2-3 weeks after death</td>
</tr>
<tr>
<td>End-of-mourning ceremony, <em>tagurun ludu</em></td>
<td>Obligatory, 6 months to one year after death of a spouse or parent</td>
</tr>
<tr>
<td>Bathing the spirit, <em>amuidahani</em></td>
<td>Obligatory if requested, usually within a year of death, sometimes after several years</td>
</tr>
<tr>
<td>Requim Mass and feasting, <em>helemeserun hilana</em> and <em>efeduhani laugi lemesi</em></td>
<td>Obligatory if requested, usually a year or two after death</td>
</tr>
<tr>
<td>Feeding the dead, <em>chugu</em></td>
<td>Obligatory if requested, rarely less than 10 years or more than 50 years after death</td>
</tr>
<tr>
<td>Feasting of the dead, <em>dugu</em></td>
<td>Obligatory if requested, rarely less than 10 years or more than 50 years after death</td>
</tr>
</tbody>
</table>

Table 2-2. Reports of HIV prevalence among the Garinagu of Central America

<table>
<thead>
<tr>
<th>Location</th>
<th>Year</th>
<th>Sample</th>
<th>HIV prevalence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>2001</td>
<td>N/A</td>
<td>8.0%</td>
<td>UNAIDS, 2004a</td>
</tr>
<tr>
<td>Honduras</td>
<td>1998</td>
<td>General (N=310)</td>
<td>8.0%</td>
<td>Sierra et al., 1999</td>
</tr>
<tr>
<td>Honduras</td>
<td>1998</td>
<td>Men</td>
<td>8.5%</td>
<td>Sierra et al., 1999</td>
</tr>
<tr>
<td>Honduras</td>
<td>1998</td>
<td>Women</td>
<td>8.2%</td>
<td>Sierra et al., 1999</td>
</tr>
<tr>
<td>Honduras</td>
<td>1998</td>
<td>16-20 year olds</td>
<td>16.0%</td>
<td>Sierra et al., 1999</td>
</tr>
<tr>
<td>Honduras</td>
<td>2005</td>
<td>N/A</td>
<td>8.0-14.0%</td>
<td>WHO, 2005b</td>
</tr>
<tr>
<td>Honduras</td>
<td>2006</td>
<td>General (N =817 )</td>
<td>4.5%</td>
<td>Paz-Bailey et al., 2009</td>
</tr>
<tr>
<td>Honduras</td>
<td>2006</td>
<td>Men (N = 418)</td>
<td>3.8%</td>
<td>Paz-Bailey et al., 2009</td>
</tr>
<tr>
<td>Honduras</td>
<td>2006</td>
<td>Women (N = 399)</td>
<td>5.1%</td>
<td>Paz-Bailey et al., 2009</td>
</tr>
</tbody>
</table>

*a National HIV prevalence for each country is as follows: Belize 2.4% (UNAIDS, 2004a), Guatemala 1.0% (World Health Organization, 2005a), Honduras 0.7% (UNAIDS, 2008c) and Nicaragua 0.2% (World Health Organization, 2005c).
CHAPTER 3
GARIFUNA ON THE MOVE: THE GARINAGU IN HONDURAS AND ABROAD

Introduction

This chapter provides the setting for the current research on migration, gender, and HIV risk among the Garinagu. Although the Garinagu currently deem Belize, Guatemala, Honduras, and Nicaragua home, only Garinagu from Honduras are considered for this research. Therefore, an overview of Honduras and the presence of Garinagu in that country will be provided. Additionally, the Garinagu have expanded their presence globally and now reside in various locations within the U.S., Europe, and Asia. This research considers the Garinagu in NYC and thus only NYC as a migration hub and the positioning of Garinagu within it will be explored in depth here. Considering the environment of NYC, specifically in regard to its history with immigration, it is important to understand the environment many Garifuna migrants come to call home in order to avoid what Rollwagen (1975) called the “city as constant” argument. By excluding the context of the host location, researchers risk assuming that the life of immigrant groups are exactly the same, regardless of the city in which they reside. NYC has a long history with respect to immigration, and it is this that will be discussed. First, however, the role of migration among the Garinagu both currently and in the past will be presented.

Garifuna Migration

The Garinagu have a long history of migration; the Island Carib males were known to travel far distances for extensive periods of time to trade with other groups. The initial contact of Caribs and Arawak, in fact, is thought to have resulted from Carib men traveling to the island to act as the middleman in trading between the Arawaks in the islands and Amerindian groups in

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1 Spain is a popular location in Europe due to the common use of the Spanish language. Additionally, I met and/or heard of Garifuna living in Germany, Belgium, and Italy.

2 A community member in Trujillo had a sister living in Japan.
South America. As previously discussed, Island Caribs, and later Black Caribs, began trading with the Europeans and acting as middlemen for the Europeans and other indigenous groups when contact with Europeans was made. From these interactions with the Europeans and their manufactured goods, wage labor intensified. Evidence suggests that after deportation in 1797, dependence on these foreign goods led to the intensification of migratory practices, as men (and eventually women) looked for wage labor opportunities. Thus, migration has been an important part of life for the Garinagu and their ancestors.

In more recent times, men and women migrated to work in the mahogany fields of Belize or banana plantations in Belize, Guatemala, and Honduras. Economic motivations led to the formation of these migratory patterns. In their home countries of Belize, Guatemala, Honduras, and Nicaragua, the Garinagu are a minority population that lives predominately in isolated communities. Unlike many other immigrant groups from Central America, however, Garifuna migration has not been based on political turmoil. Although the land of Honduran Garinagu is currently imposed upon by outsiders involved in the tourist industry, Garifuna have not had to migrate due to lack of land. Instead, migration allowed Garifuna to earn additional money to buy goods and improve their economic standing (England, 2006). More recently, however, social and economic problems have increasingly influenced migration as many villages experience social isolation and reduced economic opportunities, and urban areas have increasingly becoming plagued with social ills, including drug and criminal activity (Miller, 1993; Roessingh, 2004; Palacio, 2005; England, 2006).

Until the 1940s, migration was largely national or regional. International migration did not become common until World War II, when Caribbean and Central Americans were recruited to serve in manufacturing jobs and for sectors such as the Merchant Marines (González, 1988;
Johnson, 2007). Many Garifuna men helped man the Merchant Marine fleets, which provided services and materials to the U.S. marines engaged in the war (González, 1988). Working for the Merchant Marines required men to be absent from their villages and families for longer periods of time, but offered the men much for their service. For instance, the companies could send the men’s family part of their paycheck directly and when the men retired, the companies provided retirement checks, which allowed the men to have ample funds in older age (England, 2006). Additionally, as a result of their service, the National Maritime Union helped Merchant Marine servicemen acquire United States citizenship and gave them retirement benefits that helped them establish households in the U.S. (González, 1988). The National Maritime Union was headquartered in NYC, which was at that time the center of the shipping industry. When Garifuna men joined this union they were required to go to NYC to fill out documents when changing companies. As a result, many men established a resident base in NYC (England, 2006). These migrants became the seed migrants who were able to start the process of chain migration.

Migration to the U.S. among women became more common in the 1960s and 1970s as a result of U.S. immigration reform under the Immigration and Nationality Act Amendments of 1965 (the Hart-Celler Act) that changed the preexisting migrant quota system and allowed for family reunification (England, 2006; Johnson, 2007). A third influx of Garifuna migrants to the U.S. occurred during the late 1980s and 1990s economic boom (Johnson, 2007), which followed an economic recession in Honduras (Vinelli, 1986).

Today, the number of Garifuna in the United States is unknown, but in the 1980s, González (1988), who has long worked with Garifuna in Central America and more recently in New York City, believed there were 75,000 to 100,000 Garifuna living in the U.S. More recent
estimates are between 100,000 to 500,000 (Cantor, 2005) and DeFray (2004) estimates that half of the world’s Garifuna population resides in the U.S. These immigrants live in Los Angeles, Chicago, New Orleans, and New York City. Since many of these migrants came as a result of employment with the Merchant Marines or the resulting family unification program, an estimated 60-80% of Garifuna migrants are in the U.S. legally (Cantor, 2005).

Without a doubt, migration for economic improvement continues to be a major force within the Garifuna community at large. Both Miller (1993) and England (2006) noted that economic motivations were the primary reasons given by respondents regarding their own migrations. While extremely important, economic motivation does not fully explain the large percent of Garifuna who travel overseas to live and work. The idea of migration has become engrained in the Garifuna culture, forming a true “culture of migration” (Miller, 1993; Johnson, 2007; Cohen, 2004). Additionally, this has been called a “migration mentality” whereby migration is viewed as the only way to achieve anything in life (Rubinstein, 1983, p. 298). Migration to the United States is so common in Garifuna communities that it creates little stir. This is observed in the remarks told to Miller (1993, p. 186) in “Seaview,” Belize:

In the ‘40s the first set of Garifuna people to leave Belize and migrate, maybe they go three, four, five years, and then suddenly they make a trip home. You’d find that relatives would be flockin’ that buildin’ [the bus station] lookin’ for this newcomer, and everybody want to see this lady from America, this gentleman from America, because America was such a big word in our little community . . . but nowadays, when they come if they don’t get on the street and go look for people, they can forget it. People don’t bother lookin’ for them no more... When they come they come ordinary, like, you know, that they just home from Belize City.

Miller (1993) describes what she calls a States orientation in “Seaview.” Ideas of the U.S. and migration to the U.S. are visible in just about every aspect of life, and the introduction to the U.S. occurs at an early age. Miller (1993), for instance, writes of a three year old who was proud that his new ball cap was from the United States. His family, in fact, often played games in which
the boy was “goin’ to States.” The game involved a pretend airplane ride and a return with a bag stuffed with goods for all of the family. This demonstrates the early age at which Garifuna learn about the U.S. and mentally begin planning for their future there (Miller, 1993).

Miller (1993), found, however, the States orientation was most visible among the young adults. These young adults listen to American rap music, wear clothing with the logos of U.S. sports teams, and prefer clothes designed by Nike and Tommy Hilfiger (Miller, 1993; Anderson, 2005). González (1988) attributes marijuana smoking to this States orientation, as younger men (and some women) turn to drugs to ease the boredom while they wait to go abroad or try to be “cool” like the kids they hear about in New York City. Additionally, popular music often focuses on migration. One example is the song “The Amnesties are in Town” which was popular in Belize in the 1980s. This song was written about the Immigration Reform and Control Act of 1986, which provided amnesty to approximately three million undocumented persons in the U.S. The lyrics to the song describe the flood of amnesties returning home to visit, causing congestion at the parties.

In addition to popular clothes, activities, and music, the States orientation has noticeable effects on the educational systems. Several education officials told Miller (1993) that an estimated 80% of their students intended to migrate to the U.S. someday. This belief among the students resulted in disruptive behavior and a lack of motivation. Many students with parents in the U.S., for instance, acted out at school in hopes that their parents would send for them. Others failed to do their work or put in much effort as they were “simply biding their time while they wait to migrate to the United States” (Miller, 1993, p. 188). This is a problem in Trujillo, Honduras as well. One community leader explained:

> The majority [of children left by migrants] become delinquents . . . they don’t have anyone to keep an eye on them. They come in and out whenever they like. They
don’t want to study because they see everything as being easy. They just wait for the end of the month for their check to come in to go out drinking, smoking, to do drugs and all because of that monthly check that comes in. So then, they don’t worry about studying or working or about doing anything. They in and out, in and out, wasting time, waiting for the chance to leave as well.

Similar problems have been discussed in other areas where a States orientation prevails (e.g., Levitt, 2001).

The idea of migration in general and to the U.S. in particular, however, is more deeply engrained than a simple look at pop culture can suggest. Even traditional aspects of Garifuna culture have been modified to incorporate migration themes. *Abaimahani*, or songs of remembrance sung by women at various occasions such as ancestral rituals, often make reference to migrants and their experiences (Kerns, 1997; Miller, 1993). One song Miller (1993) heard often during her research described a migrant’s amazement upon first seeing the lights of Los Angeles through the plane window. At the ninth-day wakes (*belurias*) a folktale is often told about a fisherman and his passport:

[The story is of] a fisherman who loses his passport while out in his boat during Hurricane Hattie. Fifteen years later, while fishing from a pier, the man hooks a huge “jewfish” and discovers that in the fish’s mouth is his long lost passport - - with a newly issued U.S. visa. The man’s long struggle to land the fish and retrieve the passport rivals that of the Hemingway character in *The Old Man and the Sea*. (Miller, 1993, p. 187)

Miller (1993) also found that *buyais* had incorporated elements of migration into their roles as spirit mediums and healers. She found that local *buyais* would “fix” the passports of persons hoping to migrate. Once the passport has been fixed, the potential migrant keeps the passport shut and delivers it to the consulate offices where a visa is sure to be issued. Alternatively, Miller (1993) noted that the *buyai* is visited by soon-to-be migrants to ensure their safe passage across the border. This visit occurs most often when the migrants are entering the U.S. illegally.
The previous examples demonstrate that while migration ultimately stems from economic motivations, the States orientation is visible in multiple arenas of Garifuna culture. Although most migrants recognize that their migration effort is tied to a desire for economic advancement, many also view migration as a family obligation, a way to improve oneself, and an opportunity to have an adventure (Palacio, 2002; England, 2006).

The Garinagu in Honduras

Honduras is located in Central America, surrounded by Guatemala, El Salvador, Nicaragua, and the Caribbean Sea. The country, home of approximately 7.2 million mestizos, Amerindians, Garifunas, creoles, and whites, is mostly mountainous with coastal valleys. The Garifuna population, situated along the northern coast, is estimated to be between 100,000 and 200,000 (Cantor, 2005).

Honduras is one of the poorest countries in the Western Hemisphere and is the second poorest country in Central America. Income distribution is extremely unequal and unemployment is high. The country relies on exports, largely to the U.S (Central Intelligence Agency, 2009). No other Central American country, in fact, has been as historically dependent on U.S. capital and political policy. This dependent and submissive position developed largely as a result of U.S. land ownership in Honduras, whereby U.S. fruit companies have owned the majority of its productive land since the early 1800s (Latin America Bureau, 1985). By 1918, U.S. owned fruit companies accounted for 75% of all the banana lands in Honduras, and the largest companies, Standard Fruit and United Fruit, continued buying land from local owners until almost all of the land in northern Honduras was in their control (Euraque, 1996). These lands in the “banana republic” aided in the country’s dependence on the export of bananas, or “green gold” (Latin America Bureau, 1985).
Unlike other countries in Central America, Honduras did not become a major exporter of coffee until the 1940s (Latin America Bureau, 1985). Therefore, Honduras never developed a coffee growing elite. The absence of this powerful group led to a political structure based on regional landowners and the U.S. owned fruit companies and throughout most of the 20th century the fruit companies had a virtual monopoly over the political and economic sectors in Honduras. Thus, where coffee production facilitated national development in other Central American countries, banana production diminished independent development in Honduras, and the country has instead been dependency-oriented (Latin America Bureau, 1985; Schmalzbauer, 2005). Schmalzbauer (2005) provides, as an example of this dependency, the fact that a national currency and bank was not established in Honduras until 1950.

Today, the largest exports continue to be bananas and coffee, making the country extremely vulnerable to natural disasters and changes in the commodities’ prices. The country is also heavily reliant on migrant remittances, which account for a quarter of the country’s gross domestic product (GDP). Remittances are only slightly less important to the GDP than exports, as they are equivalent to three-quarters of exports (Central Intelligence Agency, 2009). In 2002, it is estimated that transnational migrants provided US$770 million into Honduras’ US$6.5 billion economy. An estimated US$100 million of these remittances were provided to Garifuna communities. Overall, approximately 16% of Honduran households receive remittances, although when considering the northern coast, where the Garifuna communities exist, this estimate increases to 42% (Cantor, 2005).

Honduras has one of the highest incidences of poverty in the Western Hemisphere. The Honduran government, with the aid of international agencies, embarked on a Poverty Reduction Strategy (PRS) after Hurricane Mitch took the lives of almost 6,000 people, caused damage to an
estimated 1.5 million people’s property, and caused major loses of infrastructure and food crops (World Bank, 2009; Morris et al., 2002). Following Mitch, poverty estimates increased from 69.4% to 74.6% (Morris et al., 2002). As part of the PRS, the government aimed to reduce by half the incidence of extreme poverty by the year 2015. Currently, 59% of the population lives below the poverty line and 36.2% live below the extreme poverty line (World Bank, 2009).

Additionally, as part of the PRS, there has been increased spending on health and education (World Bank, 2009). Per capita total expenditure on health in 2006 was US$241. The government expenditure on health, as a percent of total expenditure on health, was 47%. The population growth rate was 2%. The most recent maternal mortality rate per 100,000 live births is from 2000 and was 110. Infant mortality rate per 1000 live births, in 2006, was 23 (World Health Organization, 2009). Vaccination programs have been extensive, and have reached almost the entire population (World Bank, 2009).

Honduras has the highest number of HIV/AIDS cases in Central America with an adult prevalence of 0.7% 3 (UNAIDS, 2008c). The WHO estimated that in 2005, 63,000 (range 35,000-99,000) people in Honduras were living with HIV/AIDS (World Health Organization, 2009). However, it is estimated that more than two-thirds of Hondurans are unaware of their HIV status (UNAIDS, 2003). The majority of cases are in the economically productive population, aged 15-49 years. Additionally, the epidemic is concentrated within several groups in Honduras, including men who have sex with men (16%), sex workers (up to 16% in some areas), prisoners (7%), and the Garinagu (4.5%-14%) (UNAIDS, 2004b; World Health Organization, 2005b; Sierra et al., 1999; Paz-Bailey et al., 2009). In 2005, an estimated 4,500 HIV-positive persons were receiving antiretroviral therapy (World Health Organization, 2009).

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3 The high rates of HIV/AIDS in Honduras compared to other Central American countries may be partly due to better surveillance (UNAIDS, 2004b).
Over US$14 million was spent in 2006 on HIV/AIDS research, prevention, care, and treatment, with domestic public expenditure providing approximately 29% of the cost. International agencies and donors provided US$10 million (UNAIDS, 2008c).

(a) Trujillo, Honduras. Trujillo, capital of the department of Colón, lies on the northern coast of Honduras, resting between mountains to the south and the Caribbean Sea to the north. Trujillo was the first location of entry onto the Central American mainland by the Garinagu in 1797 (González, 1988). In 2005, the population of Trujillo was approximately 8,500, roughly 2,000 of which were Garifuna (23.8% of the total population) (Griffin, 2005). Although the Garifuna population is spread out within Trujillo, the predominant Garifuna areas, or barrios, are Rio Negro, Cristales, and San Martin.

Trujillo was selected for this research based on a number of considerations. First, most recent anthropological research of the Garifuna is focused on the western part of the north coast of Honduras where numerous Garifuna communities exist (exceptions are Sarah England’s research on politics and transnational migration in Limón to the east of Trujillo, Wendy Griffin’s research on various topics including land rights all along the northern coast, and the inclusion of Trujillo in a multisite rapid ethnographic assessment considering issues of HIV by Sabin and colleagues). Thus, Trujillo was largely unexplored territory for recent anthropological research on both migration and HIV/AIDS. Additionally, Trujillo and its surrounding Garifuna villages of Santa Fe and San Antonio send a large number of Garifuna migrants to the United States and are greatly influenced by the transnational networks that have arisen. HIV/AIDS is recognized as a problem in Trujillo (as in most Garifuna towns and villages) and many Garifuna in Trujillo attribute this problem to migration, both locally and internationally.
Migration statistics for Trujillo are not available, but when I asked local Garifunas about the population of Trujillo, the most common answer was that it is impossible to know because of all the Garifunas leaving for the large Honduran cities of San Pedro Sula or Tegucigalpa or for the United States. Over half of the participants in my research had lived outside of Trujillo, mostly for work.\(^4\) Men and women reported living in La Ceiba, San Pedro Sula, and Tegucigalpa, Honduras, as well as in Mexico, Belize, and Guatemala; 13.8% of men and 2.7% of women had previously lived in the U.S. While in Trujillo I heard many stories of attempted border crossings from young men; almost every young man I met had tried to cross or was planning to soon if they could not be sponsored legally. Many older men who had lived in the U.S. enjoyed practicing their English with me, proudly showing me their U.S. documents. A few still carried them around in their wallets. Migrant houses were obvious; most were large concrete homes surrounded by fences\(^5\) and topped with satellites for TV reception. The majority were still under construction, as migrants sent money to slowly build their new homes. A few of the homes even had large, expensive trucks parked outside. Indeed, almost everyone I talked to had some connection to the U.S. Cantor (2005) found that 85% of households in Cristales received remittances from migrants. Only 65 of the 345 households did not have a household member who intended to migrate or had already migrated.

HIV and AIDS records for Trujillo are kept by national employees as well as by a local epidemiologist. Between 2002 and 2006, 117 new cases of HIV were diagnosed (Region Sanitaria Departamental de Salud No. 2, personal communication, October 10, 2007). Information on the distribution of these incident cases is not known. Additionally, as mentioned

\(^{4}\) Employment both in Trujillo and New York City will be discussed at length in Chapter 5.

\(^{5}\) Most homes in Trujillo do not have fences. It was explained to me that the use of the fence was for privacy purposes - something migrants discovered while living in the U.S.
previously, UNAIDS estimates that two-thirds of Hondurans are unaware of their HIV status (UNAIDS, 2003).

**Garinagu in New York City**

New York City has often been called an immigrant city (Foner, 2001). According to U.S. Census estimates for 2008, 8.2 million people live in NYC. Of these, 35.9% are foreign born (U.S. Census Bureau, n.d.). The foreign born population of NYC has grown rapidly since 1970. Between 1970 and 1980 this population grew 16%; between 1980 and 1990 it grew 25%, and between 1990 and 1999 it grew 27%. Additionally, immigrant records of intended destination provide an indicator that NYC houses a much more diverse immigrant population than do other common receiving cities (such as Los Angeles) and the U.S. in general (Kraly & Miyares, 2001).

Immigrants arriving in NYC enter a changing environment, in part because of other immigrants. The manufacturing sector, a common mode of employment for many immigrants in NYC, began declining around 1970 as production factors, including labor access and transportation, became less important. The processes of globalization that were reducing traditional employment such as manufacturing in NYC, however, were the same ones that reinforced NYC as a global financial center. This produced many high end jobs in finance, law, and business, while also generating more need for low end jobs in service. The economy of NYC has thus been in flux, but since 1965 employment opportunities as a whole have not increased as they have elsewhere in the country. Ethnic niches have developed, however, since the 1960s and 1970s as natives, mostly white, retired or left the city as the economy shifted. Immigrant networks provided recent immigrants with employment in these niches as jobs became available. Thus, although NYC has not experienced economic growth since the 1970s, immigrants have continued to pour into NYC and obtain employment largely as a result of the declining native white population (Wright & Ellis, 2001).
(a) The Bronx, New York City. Immigrants reside in all five of NYC’s boroughs; however, they are not distributed evenly (Kraly & Miyares, 2001). In 2000, Queens had the largest proportion of immigrants (46.1% of the total population), followed by Brooklyn (37.8%), Manhattan (29.4%), the Bronx (29%), and Staten Island (16.4%) (U.S. Census Bureau, n.d.). Although Garifuna live in all five boroughs, the Garinagu from Honduras largely reside in the Bronx. While there are not any Garifuna “communities” in the sense that Garifuna are congregated in small areas, many Garifuna live in the South Bronx. Particularly, many live in the Hunts Point-Mott Haven neighborhoods, although I also met people from other areas, including Riverdale, High Bridge, Morrisana, Tremont, West Farms, and Morris Park.

Approximately 1.3 million people live in the Bronx. Of these, 42.7% self-identify as black and 51% classify themselves as Spanish, Hispanic, or Latino. The number of Garifuna in NYC in general and the Bronx in particular is unknown, but the Garifuna Coalition, a nonprofit group headquartered in NYC that serves as a resource and advocate for issues in the Garifuna community, is encouraging Garifuna in NYC to participate in the 2010 census. The hope, according to Jerry Castro, executive director of the Garifuna Coalition, is to get enough people to specify Black Honduran, Black Guatemalan, Black Belizean, or Black Nicaraguan on the census. Then, those individuals who live within districts known to have high Garifuna populations can be assumed to be Garifuna. If enough people do this, it is hoped that the organization can work with NYC Congressmen to get a category for Garifuna on the subsequent census.6

Although the number of Garifuna in the Bronx in particular, and NYC in general, is unknown, the presence of Garifuna is visible. A large part of the South Bronx, including parts of Hunts Point, Mott Haven, and Morissana is called Garifuna Village. Dawson Street, in the South

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6 This is being promoted in other cities with high numbers of Garifuna as well.
Bronx, is a popular hangout for Garifuna and many Garifuna owned businesses are seen, including a beauty shop and private club. A building on this street is partly shaped like a “V” and is referred to as “the boat.” Garifuna use this as a meeting place, often calling out “meet me at the boat.” This street is so closely tied to the Garifuna community that action is underway to change the name of Dawson Street to Chief Joseph Chatoyer Way in honor of the St. Vincent hero. Additionally, Garifuna can be seen congregating in different parts of the Bronx, including parks that have been informally renamed based on the heavy presence of Honduran townspeople, including “Trujillo Park.”

The effects of the HIV/AIDS epidemic on this population are also largely unknown. Data collected by health care providers do not specify Garifuna ethnicity and therefore data is only available in aggregated form. It is estimated that 2% of the Bronx population is living with HIV/AIDS. Although the residents of the Bronx make up only 17% of the population of NYC, they comprise 25% of incident HIV cases. In 2004, the incidence rate of HIV in the Bronx was 67.6 per 100,000 residents. In the High Bridge-Morrisana neighborhoods the incident rate was 105.4 per 100,000 and in Hunts Point-Mott Haven it was 105.0 per 100,000 persons. HIV/AIDS prevalence is also highest in these areas and is 2.4% and 2.3%, respectively. Forty percent of these new cases occur in women. In NYC overall, only 32% of new HIV cases in 2004 occurred in women, and thus women in the Bronx are more affected than elsewhere in NYC. Seventy-five percent of these infections in the Bronx among women resulted from heterosexual contact. Among men, homosexual contact was the most common method of HIV transmission, but heterosexual transmission occurred in 27% of incident cases. Fifty-three percent of new HIV cases occurred in blacks and 42% among Hispanics. Additionally, 21% of all new HIV diagnoses were among people born outside of the U.S. The median age at diagnosis was 38 and
the median age of death was 48. In the Bronx, HIV/AIDS largely affects residents in their 30s and 40s (New York City Department of Health and Mental Hygiene, 2006).

The HIV epidemic became visible within the NYC Garifuna community in the early 1990s. Two community members, Maria Marin and Mirtha Colon, noticed Garifuna coming in and testing positive for HIV while working in a medical clinic. According to Colon, “at first, you know, one or two affected persons, but we didn’t pay much attention until, I think, there were…8 or 10 people who [were positive in about a 6 month period] and then we became very very concerned.” Marin and Colon became active in the community’s action to prevent HIV, eventually forming a group that later became known as Hondurans Against AIDS. The group was initially provided space by the Segundo Ruiz Belvis clinic in the Bronx to provide workshops and today, with Colon as President, the organization continues to provide community forums on various topics,
7, conducts an AIDS conference, provides HIV testing at various cultural events, and sponsors a mass for World AIDS Day.

The Garinagu as a Transnational Community

As previously described, transnationalism is a process that allows individuals and communities to be connected simultaneously to two or more nation-states. The Garinagu are indeed a transnational community, as community members in Trujillo, Honduras and New York City were often intimately linked with the other. In both locations, these connections are experienced at a community-wide level as well as at an individual level. This section describes some of these connections, and highlights the role of transnationalism in the HIV epidemic.

On the streets of the South Bronx, Honduras maintains a visible presence through the placement of the Honduran flag on restaurant signs and in cars, dangling off rearview mirrors.

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7 The group provides workshops on a number of issues in addition to HIV/AIDS, including human rights and gender.
These symbols of home are only an exterior reflection of the importance of Honduras to the Garifuna migrants. Many of these migrants are still actively involved in the lives of family members in Honduras and in the development of their communities. Family members discuss immediate healthcare decisions of loved ones on the phone and then supply money for the chosen health seeking behavior; video of parties or events in Honduras are viewed in NYC shortly after they are recorded; hometown associations meet to discuss their contributions to their Honduran hometown community projects; a Honduran doctor comes to tell the Garifuna community about a new Garifuna hospital opening in Honduras’ north coast; and every September, Garifuna community members in NYC gather for the annual Honduran and Central America Day Parade and the Honduran Food and Music Festival that follows.

In Trujillo, many community members are also involved in both nations simultaneously. For example, at the bottom of the hill in barrio Cristales there is a small green building bearing pictures of the Honduran and U.S. flags. This building houses the Asociación de Jubilados Honduro-Americanos (Association of Retired Honduran-Americans). This newly formed organization consists of approximately 55 retired Garifuna men and women who are American citizens. The members mostly consist of retired return migrants receiving pensions from their employment in the U.S., although there are members representing all of the larger U.S. cities that house Garifuna migrants. The goal of the organization is to provide community support through various projects; the current projects are focused on providing health services to the area for a minimal charge. Another example of a community project undertaken by migrants and return migrants in Trujillo, Honduras is right outside the Asociación building; the paved street is one of the few paved roads in the barrio. This construction was completed through the use of collective remittances through the organization Patronato (Cantor, 2005). Although most remittances enter
the community through individual contributions made to the level of the household (Cantor, 2005), the influence of migrants in the U.S. is visible at the community level.

Remittances made by migrants to community development as well as to the household and the “culture of migration” aid in keeping Garifuna in Honduras physically and emotionally tied to the U.S. However, as previously discussed, transnational communities are also involved in the transfer of ideas. This is seen with respect to gender relations. Nonmigrants witness changes among many of the return migrants, as described by one woman:

The only thing is that people that are over there, people that come back from the United States tend to pick up some Anglo-Saxon behaviors. [For example], the very idea of sharing salaries and of splitting household expenses between the two, that type of thing. . . .I’ve had the opportunity to speak to many of the men that have lived in the United States and the way women are treated is different. It’s like…like with more respect, being more considerate of the person you are with. Because, normally a Garifuna man, Honduran, Trujillano, or wherever he’s from, from the ones I’ve heard from with friends and ones I’ve been with, very few have…[well], the woman herself is of little concern to them. But, for the man that has lived in the United States, he is more concerned with and even makes sure that his woman is okay, that she looks good, and all those other things that here, normally, a man could not care less for.

Anderson (2005) discusses another type of transfer he witnessed in Sambo Creek, where boys and young men have adopted a style referred to as “bad boys.” Many Garifuna have assumed the ideas and images of African-Americans in the U.S., who are commonly perceived as violent criminal. This racial geography, called “Black America,” provides Garifuna men with a style of dressing that includes baggy pants, Nike sneakers, and large Tommy Hilfiger shirts as well as street language and handshakes. Migration aids this “bad boy” response by supplying not only the materials but the ideas needed to assume this position as well (Anderson, 2005).

The theoretical framework of transnationalism is important in the understanding of the HIV/AIDS epidemic among the Garinagu, as community members closely associate HIV with migration. One community leader who works with HIV in Trujillo told me:
Here it is believed that HIV came to Trujillo due to migration. The men here would leave to the United States. It is believed the men would return infected and would infect their partners due to the machismo promiscuity. Because inside migration exists machismo because they believe that their woman has to sleep with them without protection. No matter with how many women he has slept with over there, the machismo does not allow him to care for the person he has at home. . . . We believe that migration is something to that has to be dealt with here because quite simply, the persons who return from the United States come back to initiate their old relationships. They go away a long time in the journey to the United States, suffering, doing what they must, everything is sacrificed, and the reward is almost always the disease of HIV.

Another community leader reiterated this belief, saying that few community members that have not left Trujillo become infected; people infected with HIV in Trujillo, she claimed, are ones who have returned from working elsewhere.

Beliefs about the role of migration in HIV transmission in Trujillo deal not only with return migrants who move back to Honduras, but also who come to visit. Evita, a woman I interviewed in NYC, had a cousin named Alfred who was visiting Honduras when we met. Her cousin was HIV-positive, but was not open about his status and did not know that some of his family members, including Evita, knew. Evita said she knew he was sexually involved with women when he returned for his visits but did not disclose his HIV status and was not careful about protection. Another woman in NYC told me of a friend in Honduras who was infected in this way:

This guy knew for sure that he was infected and went back to Honduras for vacation and was sleeping around with different women and he infected not only one but different women in different communities. . . . he went to a party, he know somebody, you know, he decide he go around corner, it’s dark, there’s not a lot of light and you can have, you know, a one night stand. And he has infected a lot of people. He died in a car accident a couple of years ago but can you imagine? My friend was one of those women that he slept with, so maybe he’s been sleeping a lot of women over there. And they got infected. They were with this man for one night while he was on vacation and then [they think] he come to the United States and, you know, that he gonna send you money, he gonna be my boyfriend, blah blah blah.
Most of these stories involve a HIV-positive man who returns to visit Honduras and infects numerous women in the process, although a few people told me of others who were instead infected while visiting Honduras. Regardless of how this transmission actually occurs, it is clear that transmigration is critically important to the perpetuation of the epidemic, and is identified as such by Garifuna in Trujillo, Honduras and NYC.

**Summary**

The current transnational movement by the Garinagu in general has been influenced by a history of dependence on wage labor and migration, and within Honduras has been influenced by the intimate neo-colonial relationship between Honduras and the U.S. While most Garifuna cite economics as the main motivation for migration, a culture of migration can be seen whereby cultural stories and songs have incorporated tales of migration, producing a migration mentality. Garifuna from Central America have spread across the globe, and within the U.S. now populate many major cities. This chapter focused only on Garifuna in Honduras and New York City, as these are locations where the current research was conducted. In conducting research on transnational communities, multiple locations must be considered “because any individual’s position is multiple vis-à-vis different locations and contexts” (England, 1998, p. 142). How information was collected and analyzed in Trujillo, Honduras and NYC is the focus of Chapter 4.
CHAPTER 4
RESEARCH DESIGN AND METHODS

Introduction

The objective of this research was to better understand the relationship between migration, gender roles, and risk of HIV infection among the Garinagu. This research was conducted with Garifuna in Trujillo, Honduras and in New York, New York. I went to Trujillo first to get a better understanding of life at “home,” as most transmigrants continue to use the term even when they have fully settled in their receiving country (Basch et al., 1994). “Home,” however, is not a static concept but is also changed by the transnational community and so this was kept in mind. Then, I went to NYC to learn how migration from the homeland has affected gender roles, sexual behavior, and risk of HIV/AIDS. The first section of this chapter describes the research design, methods used to collect data, and the strengths and limitations of the research. The chapter concludes by discussing ethical considerations in anthropology in general and in this research in particular.

Research Design

Approval for this project was received from the University of Florida Institutional Review Board (IRB) in July 2007. Data collection occurred in Trujillo, Honduras during July, September, and October 2007 and in NYC between December 2007 and May 2008. This exploratory research utilized both qualitative and quantitative ethnographic methods to address the following questions:

1) How do gender roles and male-female relations among Garifuna in New York City (NYC) compare to those among Garifuna in Honduras?

2) How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras?
Entry into the Community

(a) Trujillo, Honduras. In July 2007, I went to Trujillo to identify an organization to collaborate with and met Maribel Miranda from Foro Nacional de Sida (Fonasida), one of 12 national chapters of an organization that promotes HIV prevention. Maribel, a nurse who is the President of this chapter of Fonasida, runs Fonasa along with a young man named Diego. Diego, in his mid-20s, had no formal health training but had several family members who were HIV-positive. Although the office consisted of only three small rooms, I was able to provide privacy to those who agreed to be interviewed since homes are rarely empty and are often filled with people coming in and out throughout the day. I would, however, visit homes when asked to conduct interviews and distribute surveys.

(b) New York City. To gain entry into the community, I contacted several community leaders, attended a Garifuna church in the Mott Haven neighborhood, and befriended the friend of Marcos, a young man I met in Trujillo. From these initial contacts, I met many Garifuna who then continued to introduce me to others. Participants were much more interested in talking to me and participating in the research after learning that I had been to Honduras and several Garifuna communities (including Trujillo). Many were excited to reminisce about their home, and to ask what I saw and did. As a result of the Garifuna community being spread out in the city, and in the Bronx specifically, it was difficult to find base locations from which to operate. Instead, all surveys and interviews were conducted in participants’ apartments, at local businesses near the participants’ home or work, or at community events.

Participant Observation

Participant observation, which is a fundamental method of cultural anthropologists regardless of the research topic, involves immersion into a community such that the community members become comfortable with your presence and as a result act natural in your presence and
accept you into their lives (Bernard, 2005). Dewalt and Dewalt (2002) argue that this method improves the quality of data collection and interpretation in fieldwork situations. Additionally, this method is useful in the case of the current research because data collection on sensitive subjects, including sexual behavior, is fraught with a variety of reporting biases (Gribble, Miller, Rogers, & Turner, 1999). However, self-disclosure research has demonstrated that research participants are more willing to respond honestly and in more detail to people with whom they feel emotionally comfortable (Catania, Binson, Canchola, Pollack, & Hauck, 1996).

In Trujillo I lived with two families, although one only briefly. When I first went to Trujillo to arrange for my research with the local community leaders I lived with a woman named Patricia. Patricia lived in a small two-bedroom house with her two daughters, ages 11 and 16, and a cousin, age 18. The house, in barrio Rio Negro, consisted of concrete walls and floor with a thin tin roof. Patricia was a single mother who earned money by cooking for family members whose main caregivers were in the U.S. Patricia herself had never been to the U.S., but had many family members living there and although Patricia’s house was small and her income was meager, the house had a washing machine bought by a migrant relative. In fact, the room I stayed in was crammed with belongings of various migrant relatives, including winter coats, sweaters, medicine bottles from a hospital in the Bronx, and various gadgets all stuffed in bags from NYC stores.

When I returned to Trujillo in September, I moved in with a young family in barrio Buenas Aires, a new area just up the hill from Cristales. The house was run by Maria, a 34 year old mother of three. Her current partner and father of two of her children, Franco, lived in the house as well. Only the couple’s two children lived permanently in the house. These were a 4
year old boy named Luis and a 1 year old girl, Layla; Maria’s oldest daughter, Johana, age 9, lived with her maternal grandparents although she stayed at the house from time to time.

Maria worked several jobs and independently supported the household, as Franco was unemployed. Maria worked full time for the local government but supplemented her income by cooking food for various organizational meetings or workshops and selling soft drinks and beer from the house (the yard became an impromptu bar on several occasions with a dozen men or so drinking until the late hours). Franco had previously worked in construction and on fishing boats in Nicaragua and Columbia. Although he wanted to work, Franco was currently unable to find local employment. He had tried to enter the U.S. illegally but was unsuccessful, and hoped at some point to get papers to enter legally from distant relatives living in the U.S. The family received no remittances.

Their house, a large two-story home with concrete floors, walls, and ceilings, was owned by a couple living in NYC. By local standards, the house was extremely large and nice, with a large yard and big wooden privacy fence. Maria and her family rented the bottom floor and the second floor was reserved for the owners when they came to Trujillo to visit. Like many homes owned by migrants, construction on the house was not yet complete. Although a nice bathroom was installed, plumbing had not yet been added.

In addition to living with two Trujillo families, I also engaged in the community through participant observation. My first week in Trujillo my presence was announced and I was greeted on the local radio station by the popular local disc jockey known as “El chico con la voz sensual” (the kid with the sensual voice). I spent many days in the Fonasida office, in the center of Cristales, talking to many community members as they passed by on their way to the store or to the beach. I also spent much of this time talking with some of the older men who congregated...
across the road from Fonasida outside a woman’s home. This woman sold shots of a locally produced grain alcohol called aguardiente and many men spent the day sitting on her stoop purchasing shot after shot. Many of these men were return migrants who were excited at the opportunity to speak English. I also met many people by sitting in the town center (el centro).

In NYC I did not live with a Garifuna family, but participated in many community events, including workshops arranged by Hondurans Against AIDS, went to local restaurants and bars, and to personal events when invited by Garifuna community members. These included household gatherings and parties. Most of the time was spent in the Bronx, although I did conduct two interviews in Brooklyn and attended one party in Brooklyn.

Community Interviews

In a study examining interviewer sex, respondent sex, and item wording effects on responses to questions regarding sexuality, Catania et al. (1996) found that same-sex interviewers reduced bias on several aspects of sexual questions as compared to opposite-sex interviewers and recommend that in research on sexuality, interviewers should be matched with the interviewee on sex. I decided not to hire a male interview assistant due to two main concerns: 1) time constraints, specifically in Trujillo, that limited my ability to find a qualified assistant and/or train an assistant and 2) perceived or real confidentiality concerns by participants if hiring a community member in Trujillo. Thus, the semi-structured interviews focusing on gender, migration, sexual behaviors, and HIV/AIDS occurred among Garifuna women only.

In Trujillo, 11 women between the ages of 19 and 46 years who had never migrated to the U.S. were asked about their beliefs regarding migration, male-female relations, gender roles, sexuality, sexual behavior, and beliefs pertaining to HIV/AIDS. Interviews took place in the offices of Fonasida, lasted approximately 30-45 minutes, and were conducted in Spanish. Interviews were not offered in Garifuna because in Trujillo Spanish is the primary language.
outside of the household (and sometimes within the household) and all women of reproductive age are fluent in Spanish. At the completion of the interview, each woman was given 50 lempira (L) (approximately US$2.65). In NYC, 24 Honduran Garifuna women between the ages of 19 and 52 years were interviewed about migration, male-female relations, gender roles, sexuality, sexual relations, and beliefs pertaining to HIV/AIDS. These interviews were similar to those conducted in Trujillo, except additional questions were asked about their migration experience. Interviews were conducted in apartments or in restaurants and lasted approximately 60-90 minutes. Participants choose to complete interviews either in English or Spanish. Each woman was given a US$24 New York City transit MetroCard for her participation.

(a) Sampling. The Garifuna can be considered a hidden population in New York City. The term “hidden population” is most often used for the severely disadvantaged and disenfranchised, such as the homeless, prostitutes, gang members, or other “street people,” although migrant and refugee populations also constitute hidden populations (Lambert & Wiebel, 1990; Spring et al., 2003). The Garifuna may also be considered a hidden population for two reasons. First, among hidden populations, the size and boundaries of the population is unknown (Heckathorn, 1997). As previously discussed, the size of the Garifuna population in NYC is unknown and estimated population ranges are large. The Garifuna are not counted in the Census or on standard surveys and are not uniquely identifiable based on phenotype. Additionally, while most Honduran Garifuna reside in the South Bronx, Garifuna immigrants can be found in various locations in New York City, including all five boroughs.

Second, hidden populations experience issues with privacy concerns because their status may be stigmatized or because their membership may signal illegal activity, or in the case of immigrant populations they may be undocumented, have expired visas, or reside in apartments
with excessive numbers of people (Heckathorn, 1997; Spring et al., 2003). This often leads
members to refuse to participate in research or to give false information (Heckathorn, 1997).
While many Garifuna are in the United States legally, countless are not. Ethnographic fieldwork
also demonstrated a large amount of distrust of others among the Garifuna immigrants,
especially among the most recent immigrants. Hidden populations are difficult to reach for
research endeavors and random sampling, although ideal, is not realistic.

Research on hidden populations is most commonly performed using three sampling
techniques: snowball sampling (or other types of chain referral sampling), key informant
sampling, and targeted sampling (Heckathorn, 1997). This research used two of these three
nonprobability sampling techniques: 1) snowball sampling, which will be described here, and 2)
key informant sampling, which will be described in more depth under the subsection Community
Leader Interviews.

While snowball sampling allows access to an otherwise hidden population, it has several
limitations. Unlike random sampling designs that are grounded in probabilistic theory, using the
law of chance to estimate bias parameters, nonrandom sampling designs, such as snowball
sampling, are not (Faugier & Sargeant, 1997). Thus, several biases may exist. First, these
samples tend to be biased towards more cooperative people in the population. Since privacy is a
concern, the participants recruited may protect certain friends by not recruiting them. In the
current research, this “masking” could have occurred by participants not recruiting friends who
are in the U.S. illegally for fear of legal sanction. Additionally, referrals rely on personal
networks and so those participants with larger social networks may be oversampled and persons
in very small social networks may be excluded from the study altogether (Erikson, 1979). As a
result of these limitations, snowball samples are generally considered convenience samples and therefore lack claim to unbiased samples (Heckathorn, 1997).

Despite these limitations, the usefulness of using snowball sampling on hidden populations has been stated extensively. For example, Biernacki and Waldorf (1981, cited in Faugier & Sargeant 1997, p. 796) write: “The method is well suited for a number of research purposes and is particularly applicable when the focus of research is on a sensitive issue, possibly concerning a relatively private matter, and thus requires the knowledge of insiders to locate people for the study.”

(b) Recruitment. Most of the women interviewed were recruited by social contacts through the snowball technique. Initial contacts were found through active participation in the community and several initial contacts were utilized. In Trujillo, many of these initial contacts were made simply by my being outside of Fonasida and curiosity about my presence. In NYC, initial contacts were made through several methods. I was introduced to individuals in the community by family members of people I befriended in Honduras and met other community members independently at community events and parties. Each person who participated was asked for contact information for others who would be willing to participate. Most often, the initial contact called their contacts first, and then provided me with the names and contact information after getting permission from their references.

In addition, flyers advertising the research were posted in Trujillo and in areas of NYC where Garifuna were known to reside. The flyers were posted in Spanish and English (in NYC only) and stated that the interview was anonymous. In Trujillo, people who were interested were directed to Fonasida. In NYC my telephone number was given as a contact. In Trujillo, I

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8 Although it once flourished, tourism in Trujillo is rare and most gringos there are working for various government or nongovernment agencies.
walked through town with a community member who knew most of the local homeowners and storeowners. We asked permission to hang flyers at businesses (mostly small convenient stores or bars). Additionally, since there are not many businesses outside of el centro, flyers were posted with permission on the walls of homes on prominent streets in Trujillo. In New York City, I initially posted flyers in store windows in areas of the Bronx where I knew Garifuna lived, such as Mott Haven and Hunts Point. As I met more community members and went to their homes, I asked if many Garifuna lived in the area and if so I then posted additional flyers in that area as well. Additionally, I left stacks of flyers at Garifuna owned businesses after discussing the project with them. Although a large number of flyers were posted in various locales in NYC, no contacts were made through this method of recruitment. Instead, all participants in NYC were recruited through social networks.

(c) Analysis. All interviews were transcribed and when conducted in Spanish, were translated into English. Analysis of the interviews identified and considered themes, specifically through the techniques of repetition and cutting and sorting (Ryan & Bernard, 2003). Text analysis was conducted on NVivo software (version 8, 2008, QSR International, Cambridge, MA).

Community Leader Interviews

Semi-structured interviews with community and organizational leaders were conducted focusing on migration and HIV/AIDS. In Honduras, five community leaders, who may or may not be involved in HIV/AIDS campaigns, were asked about important cultural, economical, and political circumstances affecting HIV risk factors. Additionally, inquiries were made as to the availability of services for health care, including HIV education and testing. Both male and female community leaders were interviewed. Three buyais were also interviewed about their activities related to migration and HIV/AIDS. All interviews lasted approximately 45-60
minutes and were conducted in Spanish. These interviews were voluntary and compensation was not provided. Five interviews with community leaders and HIV/AIDS activist were also conducted in NYC regarding the most important issues pertaining to migration and HIV/AIDS in the transnational Garifuna community. Male and female community leaders were interviewed. Interviews lasted approximately 60-90 minutes and were conducted in English. Participation was voluntary and compensation was not provided.

(a) Sampling. The second common sampling method used for hidden populations employed in this research was key informant sampling, which were community leaders and HIV/AIDS activists. Key informants were interviewed in both Trujillo and NYC. Key informants are distinct from the general population as a result of their position in the research group or culture. Generally, these individuals have access to knowledge not obtainable by all members of the group. As a result of their skills or position in the group, key informants may provide more information about the issue at hand. Tremblay (1989) calls these persons natural observers, as they are generally interested in what is occurring around them and they observe changes in their culture and make inferences about them. Five characteristics of key informants are highlighted by Tremblay (1989):

- The formal position or role of the key informant should provide the individual with information of interest to the researcher
- The key informant must have absorbed this information in a meaningful way
- The individual must also have a willingness to share this information
- The key informant must be able to effectively convey this information to the researcher
- The key informant should present the information objectively and without bias

An advantage of this technique is that a large amount of quality information can be obtained quickly. However, key informants, as a result of their position, may not represent the view of the
general population (Marshall, 1996). For this study, key informants were defined as any Garifuna community leader or activist or any member of the Garifuna community who worked with migrants and/or HIV/AIDS within the community.

(c) Recruitment. Community leaders were identified through my involvement in the community. In Trujillo I interviewed five individuals: a Garifuna social worker at Hospital Salvador Paredes who works with HIV/AIDS patients, the president of Fonasida, a Garifuna doctor serving as the director of the Centro de Atención Integral (Center for Integrative Services), a government program providing various services relating to HIV/AIDS, the president of Nuevo Amanacer (New Dawn), the local Garifuna HIV-positive support group, and a director for the Asociación de Jubilados Honduro-Americanos (Association of Retired Honduran-Americans). In NYC, five community leaders were also interviewed: the president of Hondureños Contra el SIDA (Hondurans Against AIDS), the executive director of the Garifuna Coalition, Inc., two Garifuna social workers at different Bronx clinics who work with HIV/AIDS patients, and the president of Mujeres Garinagu en Marcha (Garifuna Women on the March).

Data Collection: Survey

A structured survey was used in addition to the interviews. Data collection on sexual topics cannot be validated in the field, and thus the qualitative data can be supplemented by anonymous quantitative data to see if the emerging picture is consistent and credible (Green, 2003). The survey further investigated the issues of migration, male-female relations, gender roles, sexual activity, and knowledge, beliefs, and behaviors related to HIV/AIDS (Appendices C and E). The survey included the HIV-Knowledge Questionnaire (HIV-K-Q) developed and validated by Carey, Morrison-Beedy, and Johnson (1998). The HIV-K-Q, which measures knowledge about transmission, prevention, and consequences of HIV infection, provided an assessment of the respondent’s knowledge of HIV. The HIV-K-Q is comprised of 45 true/false
questions. All 45 questions were included and any concerns about cultural appropriateness of the questions were addressed in the analysis. The survey was open to all Garifuna community members between the ages of 18 and 55 who were or ever had been sexually active. The same survey was used in both Trujillo and NYC, except questions regarding migration were changed for the survey in NYC.

In Trujillo, the majority (74.2%) of surveys were distributed at the offices of Fonasida. Additionally, 25.8% were completed in homes by individuals who could not come to the office. Surveys were available only in Spanish. The survey was not provided in Garifuna because of the predominate use of Spanish among the target demographic in Trujillo. Upon completion, participants were given L30 (approximately US$1.60). In NYC, surveys were completed at various locations including in homes (33.3%), soccer matches (11.8%), church (8.6%), streets or Trujillo Park (5.4%), restaurants and bars (4.3%), at work (3.2%), or through friends in unknown locations (33.3%). Surveys were available in English and Spanish. Upon completion, participants were given a US$6 MetroCard. The survey took an average of 30.23 minutes to complete (range = 11-64 minutes).

(a) Sampling. Due to a lack of a sampling frame in NYC, in both locations a nonrandom sample was used for the survey as well. Any Garifuna man or woman meeting the selection criteria was allowed to complete a survey. Surveys completed by individuals who did not meet the criteria were excluded from analysis. In Trujillo, 66 surveys were included in analysis (29 by men and 37 by women). Survey participants in Trujillo ranged in age from 18 to 54 years, with a mean age of 30.8 years. In NYC, 93 surveys by Honduran Garifuna were included in analysis (44 by men and 49 by women). Respondent age ranged from 18 to 53 years, with a mean age of
The age of survey participants did not significantly differ between locations. Demographic information for the survey participants is provided in Table 4-1.

**Recruitment.** Recruitment for the survey occurred in the same manner as recruitment for the interviews. Flyers were posted in various locations in Trujillo and NYC providing details about the survey, compensation, and my contact information. Additionally, social networking was used to inform community members about the survey and encourage participation.

**Analysis.** Analyses of the survey responses were performed to provide a description of each variable, to test relationships between variables, and to make predictions based on the data. Univariate, bivariate, and multivariate analyses were performed. Univariate descriptive statistics were computed for each variable. These are compared for the following using \( t \) tests for continuous variables and \( \chi^2 \) tests for categorical variables: Trujillo vs. NYC, males vs. females, Trujillo males vs. Trujillo females, NYC males vs. NYC females, Trujillo males vs. NYC males, Trujillo females vs. NYC females, and younger respondents (defined by the mean age of survey respondents) vs. older respondents. Bivariate analyses included correlations of various variables. The following correlations were performed: Pearson’s correlation for continuous variables, point biserial correlation for dichotomous and continuous variables, Phi correlation for dichotomous variables, and Spearman’s correlation for ordinal variables and/or ordinal and continuous variables. Separate multivariate regression and unconditional logistic regression models were fit to explore positive correlations between variables. Each multivariate model included age, sex, and years lived in the U.S. The variable “years lived in the U.S.” was used as a proxy for acculturation, while being mindful that unidimensional measures of acculturation are fraught with problems (Cabassa, 2003; Thomson & Hoffman-Goetz, 2009).
For all analyses, a p-value of 0.05 was used as the cutoff for declaring a result statistically significant. All statistical analyses were performed using SPSS (version 14.0, 2005, SPSS Inc., Chicago, IL).

**Research Assistant**

In NYC I hired an assistant to who initially came with me to all interviews and events and then later worked independently when I could no longer be in NYC due to my impending childbirth. My assistant, Jaughna Nielson-Bobbit, was a graduate student at New York University’s Steinhardt School of Culture, Education, and Human Development and was identified through a solicitation to the school’s office. Due to concerns of stigma surrounding HIV among the Garinagu of NYC, I chose to employ a non-Garifuna assistant. In addition to studying public health, Jaughna’s family is from the U.S. Virgin Islands. Jaughna’s experiences living in the United States mixed with travel back home helped her gain rapport with the study participants. Jaughna and I worked together from December 2007 to March 2008, and then Jaughna independently finished with the interviews and surveys during April and May 2008.

**Research Strengths and Limitations**

Investigations into sexual behavior date to the 18th century and have become crucial in the understanding of STI transmission. Over time a number of approaches have been employed by both biological and behavioral scientists. Academic inquiry into sexual behavior, however, is hampered by the fact that it is largely a private matter subject to varying degrees of cultural constraint (Fenton, Johnson, McManus, & Erens, 2001). Indeed, bias in sampling and responses are found to be more prevalent in sexuality research than other behavioral study (Bradburn & Sudman, 1979; Catania, McDermott, & Pollack, 1986). Additionally, challenges to research with immigrant populations also present problems, as these groups are often hidden populations with unknown population parameters (Heckathorn, 1997; Spring et al., 2003). A number of
considerations were made to reduce the challenges presented by the subject and population researched; however, issues remain. This section discusses the limitations of the research and the methods devised to counter them.

First, due to the absence of a sampling frame and the impracticality of devising one for the current research, this study used a nonrandom volunteer sample. General limitations of nonprobability sampling were provided earlier in the chapter. A number of studies have reported that volunteers in studies regarding sexual behavior tend to be more sexually experienced, experience less sexual guilt, and have more relaxed sexual attitudes and behaviors than those recruited from the general population (Strassberg & Lowe, 1995; Fenton et al., 2001). However, participation in research on sexual behaviors is more problematic if the topics are considered intrusive, sensitive, or of no relevance (Fenton et al., 2001). The interview and survey asked only general questions about non-taboo sexual behaviors in the Garinagu community and all participants were told they could skip questions or terminate their participation at any time. No question in the survey was left unanswered any more than another and no one chose to skip questions during the interview.

To counter the issues of the nonrandom study and the increase risk of bias due to the research subject, a number of considerations were made. First, employing an ethnographic component provides many advantages over using survey methods alone and can highlight issues in the survey that may result from participation bias. Ethnographic and qualitative research has in fact greatly aided in the understanding of the HIV epidemic, and was key to understanding the early AIDS epidemic in the U.S. (McKusick, Horstman, & Coates, 1985; Parker & Carballo, 1990). Ethnographic research in studies of sexuality and sexual behavior has allowed for exploration of concepts within communities (Spencer, Falkner, & Keegan, 1988; Elam, Fenton,
& Johnson, 1999; Stansbury & Sierra, 2004), identified factors of interest or concern specific to communities (Stansbury & Sierra, 2004; Brunnell et al., 2005; Sabin et al., 2008), has informed the development and design of quantitative survey instruments (Mitchell, Wellings, & Elam, 1998; NIH Collaborative HIV/STD Prevention Trial Group, 2007), and has played an important role in developing prevention strategies. Thus, the ethnographic component aids in the interpretation of the survey and the understanding of the epidemic overall. In this research it is unknown if the participants differ from the general Garinagu population, but involvement in the community leads me to believe that the interview participants were more educated and were not in fact any more sexually experienced than their peers.

A second consideration in the attempt to increase participation and reduce bias involves interview characteristics. First, being a female researcher may have aided in this area, as several studies have found that participants tend to report more sexual information to female interviewers (DeLamater, 1974; Johnson & DeLamater, 1976; James, Bignell, & Gillies, 1991; Catania et al., 1996). For this reason, a female assistant was used. Among the Garinagu, Sabin and colleagues (2008) found that alignment with community leaders was important in community participation. In Trujillo, Honduras I worked within the offices of Fonasaída, a national HIV/AIDS organization that was located in Cristales, the largest Garifuna neighborhood, and was operated by Garifuna community members. In NYC, I discussed my intentions with community leaders before entering the field. Many people asked if I knew specific leaders in the community and seemed comforted that I did.

Another factor that has been shown to influence participation in sexuality studies is the perceived importance of the topic. In Trujillo, Honduras, HIV/AIDS is openly an important topic in the community. Almost all of the people I talked with, both as part of the interview,
survey, or casually, knew someone with HIV or AIDS. Many had an HIV-positive family member. In NYC, however, this was less common largely as a result of the stigma that continues to surround HIV/AIDS. Few people knew someone with HIV or AIDS. Although most considered HIV/AIDS to be an important topic, it was less discussed than in Honduras.

To improve responses in the survey, the survey was completed by respondents while in my presence. This allowed me to directly explain the rationale and format of the survey. This has shown to have a motivating effect on the survey participant by allowing them to ask for definitions or clarifications. Additionally, the interviews also allowed for this, as well as probing for ambiguous responses and clarifying ambiguous responses (Gribble et al., 1999). Questions in both the survey and interviews began neutrally, asking for demographic characteristics and information on topics not relating to sexual behavior. Spencer and colleagues (1988) found this to be advantageous. Formal terminology was used in the survey and in the interview, unless the interviewee felt more comfortable using colloquial or street language. This has generally been demonstrated to be the preference of interview participants (Spencer et al., 1988; Fenton et al., 2001). The use of a structured self-completion survey in addition to face-to-face interviews was designed to increase participation. The use of a self-completed survey reduces the need for respondents to disclose information to a researcher, and thus often provides more valid reports (Catania, Binson, van der Straten, & Stone, 1995).

The use of a nonrandom volunteer sample is not ideal; however, the lack of a sampling frame in NYC and the impracticality of devising one for this research prevented the use of a random sample. Additionally, research considering sexual behavior has been shown to recruit participants that differ from the general population in several ways, creating participation bias. However, the use of participant observation served to illuminate issues on participation bias and
considerations were made to both the survey and interview to reduce the sensitivity of the material, which may have increased the willingness to participate.

Finally, two additional limitations warrant mention. First, the exclusion of men in the in-depth interviews reduces the understanding of some of the issues uncovered. Although the literature suggests that interviewer sex is important in collecting data on sexual behaviors through interviews, this literature is largely based on samples in the U.S. and Western Europe (e.g. Hutchinson, Marsiglio, & Cohan, 2002; Catania et al., 1996; DeLamater, 1974; Schofield, 1965). It is unclear if these findings are true for ethnographic research as well. However, after conducting this research I believe that among the Garinagu I could have interviewed men myself and received reliable answers. Second, the current research also did not include individual measures of gender identity or acculturation. While the number of years lived in the U.S. was included in all multivariate analyses of the NYC sub-sample, this proxy measure is limited in its usefulness. When using this measure to approximate acculturation, it is assumed that the process of acculturation occurs along a single continuum, ranging from unacculturated to acculturated, and is a zero-sum phenomenon. Although often used, proxy measures such as the one used here do not capture the complexity of acculturation and provide only an incomplete understanding of the acculturation process (Cabassa, 2003).

**Ethics in Anthropological Research**

From the beginnings of anthropology’s existence as a distinct discipline, anthropology has been oriented toward ethics and social policy. However, as Fluehr-Lobban (2003, p. 1) notes, “ethics in anthropology is like race in America: dialogue takes place during times of crisis.” Claims of anthropological involvement in clandestine activities surfaced during times of political unrest, specifically during the Cold War and the Vietnam War, causing turmoil in the profession of anthropology in general and the American Anthropological Association (AAA) in
particular. The Committee on Ethics, appointed in 1968, prepared a draft that called for a standing Committee on Ethics and a draft Code of Ethics for AAA. In 1970, a standing committee was finally elected and the draft code was revised, published, and shortly after adopted by the members of AAA. Not surprisingly, based on the events leading to the formation of the document, the first principle of the 1971 Code of Ethics, or PPR, stated: “In research the anthropologist’s paramount responsibility is to those he studies. When there is a conflict of interest, these individuals must come first.” This document was concerned with the many professional relationships encountered by the anthropologist: responsibility to those studied (the host community), responsibility to the profession of anthropology, responsibility to the public, responsibility to one’s students, responsibility to one’s sponsors (funders), and responsibility to one’s own government and to the host government. This Code of Ethics has subsequently been debated and revised two times, first in 1984 and again in 1998. Important changes in the 1998 revision include that the code address ethical issues faced in the four-field definition of American anthropology and that the code include language on informed consent for the first time (Fluehr-Lobban, 2003).

The current research was developed and executed with great ethical concern. This section first describes ethical concerns related to the topic of HIV/AIDS research and then outlines the measures taken to ensure the protection of the Garifuna community in general and the research participants specifically.

**Research Ethics and HIV/AIDS**

Issues of ethics in HIV/AIDS research is generally not specific to HIV/AIDS research, but hold true for research in general. However, the complexity of HIV/AIDS research and the seriousness of potential research outcomes (including death) warrant ethical debates regarding HIV/AIDS research. Two important points relevant to behavioral research regarding HIV/AIDS...
will be discussed here: 1) the investigation of a highly personal and sensitive subject and 2) the enhanced potential for exploitation of research participants.

By the very nature of the topic, HIV/AIDS research inherently forces the researcher and participants to discuss highly personal and sensitive topics. Researchers must be extremely explicit regarding the nature of their work, what information they will be collecting, and why. Issues of confidentiality should be fully explained (Gray et al., 1995). The Lambda Legal Defense and Education Fund (1984, as cited in Gray et al., 1995, p. 48-49) provides eight measure to protect confidentiality:

- Researchers should not collect identifying information if it is not necessary
- If there is a need for identifying information, participants should be informed beforehand as to what identifying information may or may not be treated confidentially
- Researchers should enter into an agreement clearly specifying that the information will not be released to third parties without participants’ written consent and that the information will be used only by those working on that particular project
- Researchers should guarantee that if they receive a subpoena or similar order, they will notify participants of same and will make every effort to resist such orders
- Researchers who are given permissions to disseminate identifying information to third parties should be required to bind those third parties to the same strict standards of confidentiality to which the researchers are held
- Any possible risk associated with the disclosure of identifying information should be explained to the subject prior to participation in the research program
- To avoid the inadvertent release of identifying information, internal procedures and safeguards should be developed to separate identifying information from non-identifying information so that the former is disclosed only in connection with essential uses in research
- All researchers, researchers’ assistants and all others connected with the project should provide these guarantees

In addition to the protection of confidentiality, participants who are hesitant to participate should not be coerced, even if nonparticipation is nonsystematic and results may become biased. These
issues only highlight the ethical considerations when conducting research. The above precautions and ethical concerns hold true for any research endeavor involving human subjects. The seriousness of potential consequences of HIV/AIDS research, however, makes their thorough consideration of even greater importance (Gray et al., 1995).

In addition to the protection of individuals, the impact of the research project on the study population must also be considered. Although HIV/AIDS is associated with behavior and not group membership, the public can easily confuse the two. The early association of AIDS with Haitians, previously mentioned, provides a clear example. Early in the epidemic, a number of Haitians residing in the U.S. fell ill to opportunistic infections. Unlike native U.S. citizens, the ill Haitians denied any homosexual activity, creating a stir among researchers. “In 1982, U.S. public health officials inferred that Haitians per se were in some way at risk for AIDS, and suggested that unraveling ‘the Haiti connection’ would lead researchers to the culprit” (Farmer, 1992, p. 2). Less than one year later, the CDC referred to four “high risk groups” for the first time. These high risk groups became known as “the Four-H” club, because the groups listed by the CDC were homosexuals, Haitians, hemophiliacs, and heroin-users. The reference to Haitians was associated with hypersexuality, voodoo, and blood letting rituals, causing speculation that the disease actually came to the U.S. from Haiti. This belief was maintained in spite of epidemiological data that suggested HIV was introduced into Haiti by tourists from the U.S. The assigning of blame to Haitians had severe consequences, even though the CDC removed the term “Haitian” as a risk group designation in 1985. Originally, for instance, the FDA refused blood donations from any Haitian who entered the U.S. after 1977. In 1990, five years after being removed as a high risk group, the agency issued a ruling prohibiting all Haitians from donating blood. Although this ban was removed shortly thereafter, the stigma attached to Haitians has
endured (Farmer, 1992). In talking about my research, I still have people comment to me that HIV came to the U.S. from Haiti, where people have no (or reduced) morals regarding sexual practices.

Second, ethical care and continued debate must increase the prevention of exploitation of persons in developing countries. HIV/AIDS threatens those in developing countries much more, although researchers are largely from developed countries.

In such circumstances, the conflicts inherent in human research become particularly profound because of the powerlessness that people who may be ‘subjected’ to research already experience. Their use by researchers on behalf of society in such a context makes the possibilities of harm to, or exploitation of, participants especially worrisome. (Gray et al., 1995, p. 6)

This increased potential for exploitation is related to numerous factors, including the increased power of the Western researcher and the limited resources and minimal regulatory systems present in most developing countries. Additionally, some African countries appear to be especially attractive for vaccine trials because of the high attack rates that allow researchers to acquire more information in less time. The ease at which exploitation can occur becomes evident in the following example. Between November 1994 and October 1998, a randomized-control trial was conducted in Uganda to examine the relationship between serum viral load, concurrent sexually transmitted diseases, and other known and putative HIV risk factors such as male circumcision and several sociodemographic and behavioral factors. Researchers screened 15,127 individuals, of which 415 were HIV-positive with a HIV-negative partner. These HIV-positive individuals were not offered treatment and were not encouraged to inform their partners, since the relationship between serum viral load and seroconversion was a primary research question. The research was later published in the *New England Journal of Medicine*, leading one magazine writer to ask, for example, “Excuse please, but why isn’t this like the *New England Journal of Medicine*] supporting the Tuskegee experiments?” (cited in Farmer, 2005, p. 198).
HIV/AIDS researchers (and all researchers) working in developing countries must be extremely conscious of the power differentials and factors providing ease of exploitation. The Belmont Report, created by the U.S. Department of Health and Human Services, refers to this in the case of research in the U.S., stating:

The selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. (The National Commission for the Protection Of Human Subjects of Biomedical and Behavioral Research, 1979)

This ethical foundation must not be removed when researchers conduct research on persons who are not U.S. citizens. Finally, the researcher must consider the subsequent allocations of benefits. Too often, research regarding HIV/AIDS that takes place in developing counties supplies information for Western citizens. Lack of infrastructure in developing countries should not make simply ignoring this fact okay. The allocation of benefits gained from research should be considered during the stage of research development.

Ethics, of course, should be required and should be maintained in all research endeavors, regardless of the subject at hand. However, HIV/AIDS research involves the investigation of a highly personal and sensitive subject and the enhanced potential for exploitation of research participants.

**Ethical Considerations in the Current Research**

Prior to entering the field I confirmed with local community leaders that the issue was of importance to the community and that my research would be welcomed. Once in the field I informed each person I met about my research and was open to all inquiry about my intent and purpose. Since the topics of migration and HIV/AIDS are particularly sensitive, I often reiterated that anything people told me was anonymous and that I would gladly exclude any
information from my reports if desired. Prior to participation in the interview, I went over the informed consent with each woman and explained that she could end the interview at any time without penalty. I also informed the women that any question could be skipped. All interviews and surveys were administered under a unique participant identification number and all computer files were kept password protected. As I felt that the information did not enhance the quality of the current research, I did not ask participants their HIV status or, in the case of the Garifuna in NYC, their legal migration status. If this information was provided, it was done voluntarily at the participant’s discretion. In this report, all of the names of participants and community members have been changed to protect the identity of those involved. The names of community leaders have not been changed, as permission was granted by each community leader to use his or her real name.

Summary

In an effort to investigate migration, gender, and HIV/AIDS among a hidden population, quantitative and qualitative methods were employed. In this research, in which the sensitive subjects of HIV/AIDS and migration are discussed, the qualitative data can thus be supplemented by anonymous quantitative data to see if the emerging picture is consistent and credible (Green, 2003). Semi-structured interviews allowed participants to describe the topics in their own words. The survey allowed participants to anonymously provide details about their knowledge, behaviors, and beliefs about these topics. Similar research strategies were employed in Honduras and in NYC, although more emphasis was placed on data collection in NYC since the focus of the research is how migration affects gender roles and risk of HIV. At all stages of the research, caution was taken to provide for the anonymity of the research participants, and ethical considerations were maintained in accordance with the American Anthropological Association’s Code of Ethics (1998).
Table 4-1. Demographic information of survey participants in Trujillo, Honduras and New York City

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trujillo, Honduras</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>30.03 (18-46)</td>
<td>31.41 (18-54)</td>
<td>30.80 (18-54)</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trujillo, Honduras</td>
<td>22 (75.9%)</td>
<td>23 (62.2%)</td>
<td>45 (68.2%)</td>
</tr>
<tr>
<td>Honduras, other</td>
<td>7 (24.1%)</td>
<td>13 (35.1%)</td>
<td>20 (30.3%)</td>
</tr>
<tr>
<td>Missing</td>
<td>0 (0.0%)</td>
<td>1 (2.7%)</td>
<td>1 (1.5%)</td>
</tr>
<tr>
<td>Lived outside of Trujillo previously</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20 (69.0%)</td>
<td>18 (48.6%)</td>
<td>38 (57.6%)</td>
</tr>
<tr>
<td>No</td>
<td>9 (31.0%)</td>
<td>18 (48.6%)</td>
<td>27 (40.9%)</td>
</tr>
<tr>
<td>Missing</td>
<td>0 (0.0%)</td>
<td>1 (2.7%)</td>
<td>1 (1.5%)</td>
</tr>
<tr>
<td>Lived in the U.S. previously</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (13.8%)</td>
<td>2 (2.7%)</td>
<td>6 (9.1%)</td>
</tr>
<tr>
<td>No</td>
<td>25 (86.2%)</td>
<td>35 (94.6%)</td>
<td>60 (90.1%)</td>
</tr>
<tr>
<td><strong>New York City</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>34.34 (18-53)</td>
<td>33.57 (18-53)</td>
<td>33.94 (18-53)</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York City</td>
<td>5 (11.4%)</td>
<td>6 (12.2%)</td>
<td>11 (11.8%)</td>
</tr>
<tr>
<td>Trujillo, Honduras</td>
<td>12 (27.3%)</td>
<td>9 (18.4%)</td>
<td>21 (22.6%)</td>
</tr>
<tr>
<td>Honduras</td>
<td>27 (61.4%)</td>
<td>34 (69.4%)</td>
<td>61 (65.6%)</td>
</tr>
<tr>
<td>Lived in the U.S. previously</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (20.5%)</td>
<td>5 (10.2%)</td>
<td>14 (15.1%)</td>
</tr>
<tr>
<td>No</td>
<td>28 (63.6%)</td>
<td>37 (75.5%)</td>
<td>65 (69.9%)</td>
</tr>
<tr>
<td>Missing</td>
<td>7 (15.9%)</td>
<td>7 (14.3%)</td>
<td>14 (15.1%)</td>
</tr>
<tr>
<td>Years lived in the U.S.</td>
<td>13.31 (1-38)</td>
<td>14.48 (0.75-32)</td>
<td>13.89 (0.75-38)</td>
</tr>
<tr>
<td>Years lived in Honduras</td>
<td>19.0 (0-51)</td>
<td>18.13 (0-43)</td>
<td>18.54 (0-51)</td>
</tr>
</tbody>
</table>

\(^{a}\) Participants could list multiple locations; locations provided were Mexico (1.5%), Belize (1.5%), Guatemala (4.5%), Puerto Cortes, Honduras (4.5%), Tegucigalpa, Honduras (9.1%), La Ceiba, Honduras (12.1%), San Pedro Sula, Honduras (22.7%), and Honduras, other (7.6%).

\(^{b}\) Mean participant age in Trujillo and New York City did not significantly differ.

\(^{c}\) Many respondents wrote Honduras as place of birth and did not provide a city. Thus, some of these respondents could have been born in Trujillo as well.
CHAPTER 5
GENDER ROLES AMONG THE GARINAGU IN TRUJILLO, HONDURAS AND NEW YORK CITY

Introduction

To consider the challenges that place migrants at increased risk for HIV in their “sexual opportunity structures,” it is necessary to understand gender and gender relations as these social norms, albeit changing, shape the behaviors that ultimately place persons at risk for sexually transmitted HIV. For the Garinagu, gender roles in their homeland differ from much of Latin America. Unlike many groups in Mexico, Central, and South America, the Garinagu are matrifocal and do not have a strong *casa/calle* gender divide (González, 1965; González, 1988; Radcliffe & Westwood, 1996; Kerns, 1997; Abbassi & Lutjens, 2002; Hirsch, 2003a). Still, their behaviors are motivated by their traditional roles and influenced by others as migrants adapt to new environments and witness new ways of life.

This chapter, then, addresses my first research question: How do gender roles and male-female relations among Garifuna in NYC compare to those among Garifuna in Honduras? Although attempts were made to include the male perspective through the survey, more was learned about women due to the fact that interviews occurred only with them. Thus, this chapter will be heavily weighted to their perspective, and I begin by presenting what they believe is most important about being a Garifuna woman. This will help clarify later discussions of gender roles. The nature of gender relations is not easy to grasp in its complexity, which arises partly due to the fact that gender relations, like all social relations, are both material and ideological (Gerson & Peiss, 1985; Moore, 1994; Agarwal, 1997). However, an attempt is made to explore gender roles and male-female relations here by consideration of the following: employment, households, partnerships, and children and childcare. The survey data discussed in this chapter are available in Tables 5.1-5.4. Chapter 6 will then consider how the adaptations related to
gender roles and relations made by the Garinagu in NYC influence sexual behavior and risk of HIV infection.

**Being a Garifuna woman**

One woman in NYC told me, “A Garifuna woman must be proud of being a Garifuna woman. To raise her head high and shout it to the world that I am of the Garifuna race so nobody forgets.” Overwhelmingly, the women interviewed in both Trujillo and NYC believed that they, as women, were connected to their culture and responsible for its continuity. Included in this, the women often mentioned the Garifuna language, their traditional dance, and their traditional food when asked what was important about being a Garifuna woman (Table 5-5).

Almost as many women in NYC, however, connected being a Garifuna woman with the maintenance of the house and family. One woman in NYC said, for example, “We make the house run… I don’t think men would be able to survive, ‘cause I tried letting my husband run the house at one point when he was [here], and they don’t know how to run the house… [Women] make the house run, we make the house run…” Family unity is crucial, and extends beyond the immediate family unit. Garifuna family unity is highlighted in the following Garifuna woman’s statement:

The way we deal with our family lineage and how we interact with each other… We have a very expansive family where cousins that are first cousins, second cousins, third cousins all count the same. And I think that’s part of what’s important to us, because...we have cousins that are my mother’s cousins that in this country would be considered twice removed and for us in Honduras, Garifunas, we say ‘well, that’s my cousin!’ and you don’t know if it’s a first cousin or a fifth cousin...it’s still a cousin!

When asked what is most important about being a Garifuna woman, more women in NYC stated family than in Trujillo (p = 0.03). While family is important to the women in Trujillo, the women in NYC may be more focused on this aspect, as many are in NYC to provide for their family in Honduras. The majority of women interviewed (84.2%) sent money to family
members in Honduras regularly or when needed, mostly to their maternal family. Additionally, one only recently stopped sending money to Honduras as a result of her mother’s death. The importance of family is described more in depth in the section on children and childcare.

Although the women in NYC often characterized themselves as independent, and many attributed their independence to migration, only one woman connected this idea with her belief of what it means to be a Garifuna woman. Instead, the women largely viewed this independence as a result of overcoming difficulties with migration (or in the case of children of migrants, learned of this through their migrant parents) and thus saw independence as connected to migration and not necessarily to their role as a Garifuna woman. This idea will be explored later in the chapter, as it constitutes a major theme among the women in NYC.

**Employment**

When considering gender and gender roles, employment is a fundamental component, as employment outside of the home demands a greater presence in the public sphere and provides an increased awareness of personal autonomy, individual rights, and gender relations. In much of Latin America, women’s involvement in the employment sphere increased dramatically post World War II during a period of rapid economic growth, with a threefold increase in labor participation by women occurring between 1950 and 1980 (Safà, 1996). Garifuna women, however, became engaged in public employment much earlier and, according to Taylor (1951), almost all Garifuna women had some experience with wage labor by the 1940s. Increased desire and need to find employment is a major motivating factor for migration among both men and women, and employment in the host city or country provides the migrant with new experiences that may challenge the migrant’s belief system. Thus, this section considers employment among Garifuna in Trujillo and NYC.
Employment in Trujillo

Primary sector employment opportunities in Trujillo most often focus on fishing or construction among men and teaching or government work for females. These opportunities, however, are limited. Azucena Alvarez, a social worker at the Hospital Salvader Paredes, commented that “the persons that sometimes emigrate from here to there, more than anything the Garifuna does so to look for work because they can’t find any here. Living here in Trujillo, there aren’t any factories, not a single factory; there is nowhere to work.” Franco, with whom I lived in Trujillo, was unemployed and complained to me often that there was no work available in Trujillo. He hoped an opportunity in construction would become available, but during the time I was in Trujillo no job materialized for him.

This difficulty in employment is evident in the survey results. Among the respondents, only 62.1% of men and 34.3% of women were employed (p = 0.03). Among those employed, 66.7% of men and 88.9% of women had full-time positions. When considering employment by age group, only 40% of those between the ages of 18 and 32 years had any type of steady employment. This figure is slightly higher for those respondents age 33 to 55, at 58.3%. Few respondents provided information on their wages, but for the 16 responses provided the average monthly income for full-time workers was US$201.79 for men and US$182.16 for women. It is probable that few persons responded to this question as a result of varying monthly income due to the nature of their employment in particular and because of the instability of employment in general.

The low number of Garifuna in Trujillo who are employed as indicated in the survey is partly deceptive as this is likely a reflection only of work in the primary sector. Many Garifuna, however, find income generating opportunities in the secondary market. Among the women interviewed, 27.3% were employed in the primary sector and 18.2% had informal employment.
One woman worked in a restaurant kitchen, two worked for local organizations, one woman did housekeeping, and one did laundry for other community members.

The importance of generating income in the secondary sector is also evident when considering the multitude of ways Garifuna men and women generate income. Maria, for example, was employed full-time in a government office, but also cooked meals for organizational meetings and sold beverages from her home. On several occasions, her front yard became an impromptu bar filling with men buying and drinking beer. In addition to selling beer, she also made snacks for men to purchase on these occasions. Maria, who did not receive any remittances, said that incomes were so low that people had to find additional ways to supplement their income.

This strategy of income generation is one of “occupational multiplicity” which is common in areas with low wages and few available jobs in the formal sector (Comitas, 1973; Georges, 1990; Sikkink, 2008). For men, this strategy often involves migration between various jobs, including fishing in the Atlantic or Pacific Oceans and banana harvesting in plantations in Honduras or Belize. Franco had previously worked on boats in Colombia and Nicaragua, and Alejandro, a friend’s cousin, had worked in nearby Tocoa on a short term government contract. For women, this “occupational multiplicity” often involves engaging in a wide range of activities simultaneously, as demonstrated by Maria. Patricia was not formally employed but cooked meals for family members whose primary caregivers were in the U.S. and did laundry for her neighbors for a fee.¹

Another example of income producing opportunities is seen by Bertha, a young woman who managed her migrant brother’s business in Trujillo. In addition to helping her brother,

¹ Patricia had a washing machine that was purchased for her by a migrant relative.
Bertha used her migrant brother’s truck to travel to La Ceiba on a monthly basis to buy undergarments. She then sold these items on the streets of Trujillo for a small profit. Other opportunities include selling snacks and other small items out of the house, selling homemade breads, including *pan dulce* (sweet bread) or *pan de yucca* (manioc bread), on the streets, or selling lottery tickets. These income generating activities are often not considered jobs and thus would not be reported on the survey. For instance, Pia, a woman interviewed in NYC, told me that in Honduras she did not have a job. However, “I had a room of groceries [where I] sold everything. I would go to San Pedro, buy from the small markets, bakeries…things like that…and I would sell guinea, bananas, oil, flour…everything.” Thus, for Garifuna in Trujillo, formal employment is limited and unstable, leading men and women to engage in income generating strategies outside the primary employment sector.

**Employment in New York City**

Overwhelmingly, Garifuna migrants come to the U.S. to find employment or are brought to the U.S. as children by family seeking work. Legal status affects the ability of a migrant to find employment and influences the type of employment gained. According to one community leader, male migrants in the U.S. without documentation are increasingly having a difficult time securing employment. This is a result of increased U.S. government regulation as well as a lack of trained skills on the part of the Garifuna male migrant. Undocumented migrants often find “Mickey Mouse” documents (fake documentation) as needed, however. Thus, despite these problems, the majority of survey respondents in NYC were employed. Eighty-six percent of men and 85.4% of women were employed. Almost all of these jobs were full-time positions (92.9% for men and 72.2% for women) (*p* = 0.04). Considering age, employment was also similar, as

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2 Documentation status of the survey respondents is unknown
among those between 18 and 32 years, 86.4% were employed and among those 33 to 55 years, 85.1% held jobs. Thus, employment was common for all survey respondents. The mean monthly income for full-time employed men was US$1810.63 and for women US$1930.90.

The majority of the women interviewed (79.2%) were also employed. Overwhelming, the women were employed in health fields. Almost half of those women working were home attendants, nurses, medical assistants, or medical billing specialists. Another common employment field was childcare. In addition, several women were involved in house cleaning. All of the working women worked full-time, unless also attending school. Only four women were not employed. One woman did not work so that she could excel in school, which was paid for by her family in NYC. Another chose not to work because any household income beyond her husband’s would render them ineligible for many government assistance programs but they would not yet be able to independently afford all they needed. The other two women did not work because one just had a baby and the other was on disability leave. Unlike the women in Trujillo, the Garifuna women in NYC did not have multiple ways to generate income. Most of the working women made enough money with their one job, or in the rare case with two part-time jobs, such as was the case of Pia, a 46 year old. Lucia also worked two jobs in an effort to save money for a down payment on a house, thus using the income from her second job not to supplement the family’s income but to save solely for future use.

Garifuna men in NYC also found niches of employment. Many of the women interviewed had husbands who worked with the Merchant Marines or with the Navy. Others had husbands who worked in maintenance, often as an apartment superintendent. Finally, construction was also a popular means of employment, and Garifuna men were often found on Dawson Street in the South Bronx working for a day labor construction company. However,
according to Jerry Castro of the Garifuna Coalition, men have a harder time finding work than females. Although many men are skilled in construction or carpentry, they are unable to find jobs. The day labor positions offered on Dawson Street, for example, are provided on a first come first serve basis and are dependent on demand in the area. Thus, the work is unstable and unpredictable. Overall, however, Garifuna men and women in NYC have been able to find employment and, like many immigrant groups, have found niches in employment.

**Households**

In considering migration, the household is often considered as a group that pools and controls resources, and makes joint decisions regarding resource allocation. Ethnographic studies, however, demonstrate that the Western models of household structure and function do not often apply to households in Africa, the Afro-Caribbean, and among blacks in the U.S. where household members often have demanding obligations beyond the household (Whitehead, 1978; Cross, 1979; Sudarkasa, 1998). The analysis of the Garinagu household as a bound economic unit pulling resources and making joint decisions is largely historically inadequate, as traditionally men and women retain incredible autonomy, and bonds between lineal kin remain the strongest, regardless of residence.

Below, Garinagu households are considered more as residential units than as economic units, although the women interviewed did provide information on their household economic situation at times. How partners, when present, contribute to the household will be considered in the next section. The household is considered here using two types of classifications that have previously been used to describe Garinagu households. The first follows González (1969), Roessingh (2004), and England (2006) in describing the household as consanguineal, which refers to kinship that is assumed to be biologically based, and affinal, which refers to kinship
created by law (Sudarkasa, 1998). The second follows Kerns’ (1997) classification of households described in Table 5-6.

**Households in Trujillo**

The households of the women interviewed in Trujillo averaged 4.8 members (range: 2-8). The average number of adults permanently living in these households was 2.7. Of these, an average of 1.9 (70.3%) were female. The women interviewed in Trujillo overwhelmingly lived in consanguineal households. Of the 11 women interviewed, only two (18.2%) lived with a partner in affinal households. Neither of these partnerships were legally sanctioned. Another woman, Nancy, lived in an affinal household, but not her own. After leaving an unfaithful partner, Nancy moved in with her brother and his wife. The other eight (72.7%) women lived with various consanguineal kin.

Only one of the affinal households was a simple nuclear household described by Kerns (1997). Rosa, a 23-year-old pregnant woman, lived with her spouse and their son. Occasionally, however, her sister stays with them. Isebei, the only other woman to live with a spouse, has an extended modified nuclear household. Along with her husband and their two children, her husband’s daughter from a different relationship also resides with the family. Like Rosa and most of the other women, Isebei’s household occasionally has additional members as well. Isebei’s sister and cousin, who are 33 and 26 years old, respectively, live with Isebei’s family when they return from working in La Ceiba.

The majority of the women live in extended modified nuclear households. Eight (72.7%) of the women, including Isebei, reported this type of family household unit. All households had a focal woman but one. Nany lived in an extended modified nuclear household with her father as

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3 Adult members include any permanent resident age 18 years or older. Those under the age of 18 will be described in the section on children and childcare.
the household head. The house also contained Nany’s brothers and sisters and three nieces. Her mother lives in La Ceiba and one of her brothers, who lives with the family occasionally, lives in New Orleans. In the other cases, the households had the interviewee, the interviewee’s mother, or the interviewee’s maternal grandmother as the focal woman and contained additional consanguineal relatives including aunts, cousins, and nieces. Lauru’s household provides an example of this arrangement. Lauru’s mother is in Florida and her father lives in Maryland. She lives with her maternal grandmother in an extended household that also contains her brothers, an aunt, and a cousin. Her mother stays in the household when she returns from the U.S., as does a male cousin who lives in NYC.

The remaining two households were a modified nuclear and an extended non-nuclear. In the first case, Crystal lives only with her brother. Her household is expanded at times, however, to include their mother, who lives in the U.S. and their two brothers, who work in larger cities in Honduras. Only one woman lived in a non-nuclear house, but this household followed the female-centered mold; Sulma lived with her grandmother and aunt.

As these examples demonstrate, most of the women had family members moving in and out of the household. Eight (72.7%) of the households had members that reside elsewhere for parts of the year. These were equally likely to be women and men. Of the 15 temporary members provided, eight (53.3%) were women and included mothers, sisters, cousins, and nieces. The remaining seven male members (46.7%) were brothers, sons and, in one case, a brother-in-law. None of the women reported a spouse or father living in the household part-time.

**Households in New York City**

The households of the Garifuna women interviewed in NYC were smaller than their Honduran counterparts’, averaging 3.4 members (range: 1-6) (p = 0.01). Like in Trujillo, however, households were made up largely of women kin. In NYC, households averaged 2.5
adults, of which 1.8 (72%) were women. Almost half (45.8%) lived in consanguineal households. Compared to their Honduran counterparts, however, a higher percentage (45.8%) resided in an affinal household. Additionally, 8.3% of the households consisted of single women, something unseen in Trujillo. Both of these women found themselves alone after their affinal household dissolved.

Households in NYC were also less likely to include extended family than in Trujillo. Seven households (29.2%) were simple nuclear and nine (37.5%) were modified nuclear. These modified nuclear families included Aina, who lived only with siblings, and Ara, who lived alone with her two children. Only six households (25%) contained extended family members. Juana and Reina are two examples of this type of household. Juanita and her baby lived with her mother, and Reina lived with her husband, their son, and her sister’s adult son. Only Marisol’s household was an extended non-nuclear household. She lives with her paternal grandmother and her oldest brother.

In Trujillo, three of the households (27.3%) included spouses, two (18.2%) of which included the interviewed woman. In NYC, however, almost half of the households (45.8%) included partners, and nine (37.5%) of these were the partners of the woman interviewed. Six (66.7%) of these partnerships were legal marriages. Thus, although the households are similar to those in Trujillo, the households of the women interviewed in NYC were more likely to be smaller, to include only immediate family members, and to include the presence of male partners. Additionally, only three women (12.5%) reported having persons live in their households temporarily. One woman had a son who lived elsewhere in the U.S. but came to stay with her often, another woman had a brother stay with her frequently, and in a third household
the couple had the husband’s children from a previous relationship live in the house part time. Thus, the households in NYC are more permanent in structure and size than those in Trujillo.

**Partnerships**

Traditionally, the Garinagu recognize three types of partnerships. The highest status relationship is a legal union involving the church. Many couples forgo marriage until later in life once they are sure the union will last because divorce is a complicated and expensive process. Consensual unions are less prestigious but are common and often preferred because of the ease of dissolution. In these relationships, the couples refer to each other as spouses but quickly explain that they are not legally married when asked. Secondary unions are the least common and involve an individual maintaining an outside partner (and possibly children) with a person of the opposite sex in addition to his or her primary spouse. Men are most frequently the individuals maintaining an outside partnership (Kerns, 1997). Like most of the Afro-Caribbean, Garifuna have traditionally had transitory relationships, changing partners at least once in their lives (Barrow, 1986; Miller, 1993; Kempadoo, 2004). This section considers the conjugal relationships in Trujillo and NYC, considering legal marriage, co-residence, and multiple partnerships, and discusses the roles of the partners in the household.

**Partnerships in Trujillo**

Among the survey participants, only 15% were legally married. Respondents over the age of 33 years were more likely to be married than were younger respondents (25% v. 7.1%, respectively) (p = 0.04). Overwhelmingly, participants were most likely to be in a long-term relationship, but not legally married. Excluding those who were legally married, 52.2% of men and 41.4% of women were part of a long-term union. Younger participants were more likely

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4 The survey did not specify if the partners lived together or were considered spouses in a consensual union.
than their older counterparts to be in this type of a relationship (50% v. 35.7%), although this difference was not statistically significant. Just under half (45.5%) of the women interviewed were in a relationship, but none were legally married, and only two (18.2%) lived with their partner. Two women (18.2%) were in a relationship with men living in the U.S.

Most of the women interviewed believed having a male partner was important all or some of the time; only 20% said it was not important because they could work and get ahead on their own. Forty percent of the women interviewed believed it was always important to have a male partner. The women who said it was important to have a partner felt having a partner prevented a woman from being lonely, was needed to start a family, provided companionship, and taught a woman about herself. Another 40% said that it was important to have a partner in certain situations. For several of the women, it was important to have a partner if children were present. For example, one woman said: “Well, right now I can say it is important to have a partner because I have my children. But, for a woman without children today, it’s not that important to have a partner.” Sulma, however, provided another situation in which having a partner is important: “Sometimes because…having a partner is good company, right? Because sometimes family members move far away and you’re left alone. So then, it’s important to have a partner.”

The women interviewed provided several qualities that they desired in a male partner (Table 5-7). Women wanted a man who could be faithful and a man who was a good communicator, with whom they could discuss their day and problems. Raquel, who was not in a relationship, believed that the most important quality in a man was: “being very faithful. Having trust is very necessary, and…how can I tell you what’s most important? Eh…trust is most important. Trust because without trust the reality is that there’s nothing you can do.” Sulma desired communication: “How do I describe a good partner…that which is based on good
communication above all. Because I think that to be a couple…whether there’s some distance or if they’re close by, the fundamental basis [of a good relationship] is communication.” After these qualities, honesty and respect were the second most common qualities stated by the women. One woman described the importance of these two qualities: “Well, I describe a good partner based on the mutual respect each person deserves. Communication, trust …and above all, respect. If there is respect, everything else is there.”

Regardless of whether or not a woman has a partner, women do the majority of the housework and are largely responsible for taking care of the children. Emeri, for example, described her typical day as follows: “I get up in the morning, I bathe [the children], they go to school, I go to work, get back home to make their dinner for when they get back from school.” The women, however, also provided examples of how partners helped in the house (Table 5-8). Over half of the women stated that their partners helped financially by working: “Well, when I had a partner, he helped around the house plenty, worked, and we both paid so that we could . . . have a better life as a couple. Yes, we helped each other out a lot.” Several women also mentioned that their partners helped take care of the children, helped around the house, and talked with them to help solve problems.

One third of the women interviewed stated that their partners helped around the house. This was consistent with the findings from the survey, where 34.5% of women agreed that it was socially acceptable for Garifuna men in Trujillo to perform housework. Sixty-eight percent of men, however, responded that it was socially acceptable for Garifuna men in Honduras to perform housework (p = 0.01). A possible reason for this disconnect could be in how women and men define “help.” While living with Maria and Franco, Franco did perform some household duties. He often dressed and bathed the children, would occasionally wash clothes,
and swept the floor. Although Franco was unemployed and spent most of his time in the home, Maria paid a young neighbor to tend to the children and house while she worked. Thus, while Franco did indeed help around the house, it was not sufficient for its maintenance. Younger respondents were more likely to believe it was not socially acceptable for Garifuna men to perform housework in Honduras, as only 43.2% answered yes compared to 64.7% of those respondents age 33 and older. Conversely, the majority of respondents answered that it was socially acceptable for Garifuna women in Honduras to do housework; 95.2% of males and 90.9% of females agreed this was so.

**Partnerships in New York City**

Among the survey respondents in NYC, 37.4% were legally married. Respondents in NYC were three times as likely to be married than their Honduran counterparts (OR = 3.4, 95% CI: 1.48-7.72). Older respondents were more likely to be married than younger respondents (55.6% v. 19.6%) (p < 0.001). Of those not legally married, 50% were in a long-term relationship. Older respondents were slightly more likely to be in a long-term relationship than younger respondents (60% v. 44.4% respectively), although this difference was not statistically significant. Among the women interviewed, 62.5% were in a relationship, and 33.3% were legally married (although two of these women were separated).

Four of the women interviewed migrated to the U.S. leaving a partner in Honduras, and two women came after their husband. In both of the latter cases, their husbands lived in NYC for several years and then returned to Honduras to marry the women. Through immigration sponsorship the men then brought over their wives. Of the six women in a partnership at the time of their migration, none migrated with their partner.

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5 The survey did not specify if the partners lived together or were considered spouses in a consensual union.
Elsy came to the U.S. by herself with plans to meet her partner, David, in NYC later. When she arrived, she lived with David’s family members in the Bronx. Shortly after arriving, Elsy found out she was pregnant and David quickly came to help her in the U.S. The two lived together in the same apartment. Elsy and David got married in NYC shortly before the birth of their child, but three weeks later David was killed in a fire. Elsy had their baby and eventually met and married another Garifuna man, who she is still married to today.

Lucia and Santo had a common law marriage in Honduras and had a six month old baby when Lucia was granted sponsorship to the U.S. through her mother. Lucia wanted to come to NYC but Santo did not. Lucia decided to come on her own, leaving Santo and their son: “He didn’t want to come, he wanted to stay there. [But] I had a life to lead.” Santo and Lucia tried to keep their relationship going, but after a year each found new partners. Lucia met another man in the U.S. and had another son by him:

I [tried to keep the relationship with Santo], but he didn’t want to come over and I really wanted to bring my son here and the only way I could bring [him] over was to have someone help me. I needed to have a certain amount of money in the bank and my [second] son’s father, he was able to help me with that.

Nine years later, Santo came to NYC and Lucia left her second partner to be with him. The two legally wed and had another child together. Currently, the couple lives in their own apartment in the Bronx, but Lucia is working two jobs and saving money for a house. Although Santo wants to return to Honduras, Lucia does not, and Santo acknowledges that he may never return since he wants to stay with Lucia and their children.

Elsy and Lucia both migrated to the U.S. in the 1980s. Nita immigrated four years ago, leaving her partner Adulio and their three children in Honduras:

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6 In 1990 a social club in the south Bronx called Happy Land burned down. Eighty-seven people were killed, many who were Garifuna.
[I was with Adulio] nine years, but due to circumstances where he was cheating on me, and aside from that, the economy for three children was not enough, I said to him one day, “cross over to the U.S., I’ll stay here working because the children are growing and need more every day.” He said, “I am not leaving my country.” So then the following year I said to him, “I am leaving.” He did not believe me. He said, “You are not going anywhere.” So I told my mother, “Mommy, I want you to take my children because I am going to the other side.” She could not believe me. I stayed waiting for my mother and she did not come. An uncle, my mom’s brother, came and asked, “Nita what happened?” And I said to him, “I am leaving because I can no longer stand the situation.” So, he left with the children and the father was not there because he was working. When he got home I was not there. I know he suffered but I was doing this for my children.

Nita arrived in the U.S. without documentation after working in Belize and Guatemala. She met Pancho, moved in with him, and found herself pregnant. Pancho quickly became abusive and often threatened to call the authorities on Nita if she did not cooperate with him. She left Pancho, taking their daughter with her, and now lives in a shelter for women.

Pia came to the U.S. 11 years ago as a 36 year old woman. She left two children and her partner of ten years in Honduras. “At first, I lived there, very peacefully in my country, very happy with life with my partner but, I had to come here…to work and struggle for my family.” Once in the U.S. Pia began a new relationship, as did her partner in Honduras. Four years later Pia had the opportunity to bring her children and her former partner to the U.S. Like Lucia, Pia left her new partner in the U.S. to reunite with her partner from Honduras when he arrived in the NYC, but the relationship quickly dissolved: “It turned out that when he got here, everything changed. I had to separate from him and continue fighting [on my own].” Pia and her partner lost trust in each other as a result of migration and their separation, and the relationship did not continue peacefully. Pia left her partner and has not found a new one; she is satisfied being on her own and helping her daughter raise her grandchild.

The stories of Elsy, Lucia, Nita, and Pia demonstrate the independence of Garifuna women. While Garifuna women in Honduras are independent as well, many credit migration to
the U.S. as increasing this independence, and among the women interviewed, just over half (52.2%) did not believe that having a partner was important. Naomi said that a partner was not important:

because I went to school. My mother always put that, she always put that on; she always taught us that you don't need a man to be happy. Go to school, do what you have to do, you can defend yourself, you don't have to put up with crap from a man. So, that’s what’s going to defend you, your education. So no, I don’t need a partner. I don’t feel like it’s necessary.

Aina also did not feel a partner was important, proclaiming: “I’m very independent. I do things on my own. I mean, if I have one, fine! I have someone to talk to, maybe if I have a problem I could just tell that person and we just solve it together, but then again I can solve my problems by myself. I’m a very independent person.” Naomi and Aina, however, both immigrated to the U.S. as children and spent their formative years with their family in the U.S. Reina, who came to NYC as a 34 year old, felt a partner was very important:

There’s too much space in this country. You get here and there’s a family that welcomes you when you emigrate. But after one month, two months, three months . . .after a year, you’re no longer welcome in that house. I don’t know if it’s because of the pressure they get from this country, but no one tolerates problems if they’re not their own. You will only tolerate your own problems and those of your children. That’s the difference with our countries. In our country, my cousin can come, my brother can come and we’ll all be in the same home, all living together without any problems.

Reina felt it was actually more important to have a partner in the U.S. because of the lack of family. Several women, however, simply stated that they felt a partner was important because the love a partner provides is different from that of family members, and that love was important.

Half of the women interviewed were attracted to a man that was respectful and treated them well. Evita provides one example of this: “first of all respect. They have to respect me. Now I have my kids, they don’t have to father my kids, they have to respect my kids, okay? To help me every way, taking care of the house, the income, that’s respect from him.” Additionally,
just under half (45%) desired a man who worked and earned a good living: “I want a professional boyfriend or man, whatever you want to call it. I don’t want to use the word bum but, I don’t want those who don’t think of education as the biggest part of your life. I just don’t find them attractive.” Like their Honduran counterparts, many women also stated that they wanted a man who was honest and a good communicator. Only one woman (5%) explicitly stated that fidelity was important.

The women in NYC largely reported that male partners contribute to the household by working and bringing home money. Several women added that men specifically aided in paying rent and bills. Half of the women also reported that male partners helped around the house. Overall, though, the women discussed their relationships as a partnership, with each person responsible for themselves but working with the other. Leyla, for instance, told me: “Really, right now, uhm, the rent, the lights, everything. The bills my husband is in charge. I am in charge of the little stuff, you know, that I will do it. And if, you know, I do a chore it’s not just because, ok, you have to do it, no. It’s not like that. We’ve got into an agreement together.”

Isabel, a 47 year old who migrated to the U.S. when she was 23, described her situation, in which her husband did not participate in the household, as abnormal:

It’s like macho guys before, like his father, like used to be like that too...he learned from his father, how he, you know, used to do it. And he found a woman that like to do it for him, do stuff and he found me and now I say “you found a stupid woman!” [laughs] Because no women in the world come over here working together, you know, everything is fifty-fifty in this country but for him, me is 100%! . . .When I come home from work, I come home from work on the weekdays actually, I have to go take my clothes off and start cooking, maybe because I started like that. If I, you know, teach him another way to do maybe it was going to be different but then he used to be like that and I’m not going to change him now. It’s already, like, late for him. I think it’s late. But he’s very caring when I’m sick and stuff . . .he tell me not to do nothing. And sometimes I do because I want to get rest, I say I don’t feel good!
As with the women interviewed, 50% of the women answering the survey believed that it is socially acceptable for Garifuna men in the U.S. to do housework. Men answered yes more often, with 65% saying it is socially acceptable for Garifuna men in the U.S. to do housework. Conversely, almost all believed that it was socially acceptable for women to do housework; 94.4% of males and 97% of females answered that this was possible. There was no difference in response for both men and women’s ability to perform housework in different age groups.

**Children and Childcare**

Kern (1997, p. 1) wrote that the “links with and between women as mothers provide the stable framework of social life. The mother-child bond –and particularly that between mothers and daughters– is the most enduring and strongly reciprocal of all relationships.” Additionally, England (2006) noted that the social value of Garifuna women is based on their role as mother, not as wife. The importance of family in general, and children in particular, is obvious among the Garinagu as was observed in the way the women themselves discussed the importance of being a Garifuna woman. This section considers the role of both men and women in the family with respect to children and childcare.

**Children and Childcare in Trujillo**

Among the women interviewed, 54.5% had children. These women had one to three children each, with an average of 1.8. All of the women, however, expressed the importance of having children and those without them planned to have children in the future. The majority of the participants in the survey also had children. Just over half of the male respondents in Trujillo had children (55.2%). The male respondents with children averaged 2.06 children. Among the female survey respondents, 62.2% had children and averaged 2.5 children. Almost all of the respondents 33 years and older had children (87.5%) while less than a half (42.9%) of respondents 18 to 32 years had children.
As previously mentioned, all of the women interviewed believed having children was important for Garifuna women. Many shared the sentiments expressed by Crystal, that “to be a mother, it is special...children fill you with joy and form a family.” These two ideas, providing happiness and forming or maintaining a family, were the most common reason cited for having children in Honduras (Table 5-9).

All of the women interviewed lived with their children, although Seru had one adult son in the U.S. Among the survey respondents, females in Trujillo were more likely to live with some or all of their children (91.3%) compared to the men (68.8%), although this difference was only moderately significant (p = 0.057). When considering only those respondents age 33 and older, women were significantly more likely to live with children (82.9%) compared to men (53.6%) (p = 0.03). Although women of all ages report living with the children more than men, women were less likely to report ever financially helping their children (23.6%) as compared to men (57.2%), although this difference was not statistically significant. Additionally, only 5.9% of women reported that they always contributed financially to their children whereas 28.6% of men reported doing so. Conversely, 76.5% of women and 42.9% of men never contributed financially for their children. Respondents age 33 years and older were more likely to report that they never provided financially for their children (70.6%) than those 18 to 32 years (50%). This is partly due to the fact that some of the older respondent’s children are able to care for themselves.

Male respondents overwhelmingly felt that they were able to raise children (70.8%), although the women strongly disagreed. Only 34.5% of females said this was true (p = 0.01). Younger persons in Trujillo were more likely to believe that Garifuna men in Honduras were able to raise children (52.8%) than those 33 or older (47.1%), although this difference was not
statistically significant. Conversely, both males and females in Trujillo agreed that women were able to provide this role (100%).

Although the women interviewed believed having children was important, many stressed the difficulties of being a mother, particularly in Trujillo. Seru cried as she discussed her children, saying:

I am both mother and father to them. . . .Since the age of twelve, I’ve had to work for myself and for my children. And, my children . . . I have serious problems with my son. He wants to take to the streets . . . I don’t know what to do. I give him everything, I tell him to use his siblings as examples because they’re at least trying to be someone . . . and why not him, right?

Another of Seru’s sons lived in the U.S. She worried about him: “He’s in the States but it’s not going very well for him because he is an illegal. . . . He sometimes calls me crying because he doesn’t have anything. I suffer a lot. There are times when he tells me he has nothing to eat . . . [he only finds] works two or three days.” Seru blamed many of the issues with her two sons on her inability to provide fully for her family. Like many women, Seru had little formal training and has not been able to find steady work. Instead, she finds odd jobs when available. At the time of the interview, Seru had no source of income, although she had previously been washing clothes for other families.

Many of the women interviewed felt the difficulty in employment in Trujillo, and the insecurity of income limited women from having as many children as in the past. Nany, a 19 year old currently without children told me: “Well, people in the past used to have many children. My mother, for example, had 13 children. We are 13 siblings. And she says that today she would not have had that many children because life in Honduras is too expensive.” Nancy, a single mother, also believed that having many children was no longer desirable: “[We] live in deep poverty and to bring [many] children to this world to suffer, it is better not to.”
Children and Childcare in New York City

Like in Honduras, the majority of the women interviewed (62.5%) had children. These women each had between one and four children, with an average of 1.9. Additionally, one woman, Naomi, was pregnant with her first child. The majority of men (68.2%) and women (69.4%) who completed the survey also had children. Males had an average of 3.18 children while females had an average of 2.48 children. Almost half of the respondents 18 to 32 years of age had children (43.5%) while almost all of those 33 and older had children (93.6%).

Nineteen of the 22 women (86.4%) asked about children believed having children was important for Garifuna women. Like their counterparts in Trujillo, the women cited the creation and maintenance of family as a major reason, with 35% providing this response. Nina, for example, said: “We have the chance to create family . . . basically we are here for that, [to] have a family.” Several women stressed the role of the children in care giving later in life, including Nita: “When a mother is older she wants somebody to take care of her, to take her to the doctor and help with her medicines. She thinks that just like when you were a baby and she was after you, in the same way you’ll be after her when she is older.” The continuation of the culture, however, was the most common reason provided for the importance of Garifuna women having children: “[If] we don’t have no kids we not going to continue, you know?” Several women discussed the importance of teaching their children Garifuna, exposing them to the food and rituals, and sharing their history, although this was recognized as difficult for those children raised in the U.S. Moluin, who has one son, said: “A lot of the kids are really Americanized . . . they’re not into the rituals and praying. And it [is] really hard, but at least they know it. They know it’s there, they know what it is.”

The majority of women (79.2%) lived with all or some of their children, both young and fully grown. Only three women (12.5%) had children living elsewhere in the U.S. Two of these
women had grown children living on their own and one, Moulin, had a son living with his father. Moulin, however, was in the process of trying to get him to NYC with her. A victim of domestic abuse, Moulin had to flee her husband and was not able to take her son. The other two (8.3%) women who did not live with their children had young children in Honduras, as did Nita, who additionally had a child while living in the U.S. All of the children living in Honduras resided with maternal family members.

Among the survey respondents, males lived with one or more of their children in 48.3% of the cases, with an additional 3.4% reporting that they lived with one or more children some of the time. Women reported living with one or more of their children in 78.8% of the cases. Parents 33 years and older were slightly more likely to live with a child (66.7%) than those 18 to 32 years (60%) although this difference was not significant. One hundred percent of the male respondents reported always providing money for their children while only 56% of females report the same (p = 0.01). The majority of those 33 years and older and those between the ages of 18 and 32 reported that they always provide financially for their children (74.1% and 72.2%, respectively), although 18.5% of respondents 33 years and older reported never providing financially for their children.

Garifuna men in NYC were more likely than their Honduran counterparts to feel they could raise children (86.4% v. 70.8%, respectively), although this difference is not statistically significant. While fewer women (61.8%) agreed with this sentiment, Garifuna women in NYC felt the men in NYC were able to raise children more so than the men in Honduras. Although women in NYC unanimously agreed that women in Honduras could raise children, only 94.3% agreed that this was true for their peers in NYC. Ninety percent of males also believed this was so.
Like in Trujillo, the women interviewed acknowledged that having and raising children was difficult. Their reasons, however, differed. Although the high cost of living was discussed by several women, the most common difficulty discussed regarding raising children in the U.S. was lack of family support: “Back home we have somebody who can always [help with the kids] . . .we have babysitters, free babysitters . . .family members. Over here you have to pay.” Pia added:

In Honduras, you do not need to pay for a daycare because you take care of your own child at home. And here, the first six months you can be with your baby, but you are separating yourself from the outside so you can take care of your child. In second place, you have to give it all the attention of the world. So to me, it is different. Over there, everyone helps you take care of your child because all of them do not have jobs and they are always there.

The women acknowledge the hardship of raising children without the help they would receive from family in Honduras, but take pride in being able to provide for their children:

Now it’s hard, everything is hard. Even though I like to work, I like to, I like to do myself. And [American] people, women over here they have kids and they don’t think about going back to school or to work. They just stay home. And I’m like, what is the reason to have kids, to stay home, just so somebody else, you know, raise that kid. . . .I feel bad when I see woman healthy and not doing nothing because then I’m like whose paying for those kids? It’s me because I work hard.

The women provided differing opinions regarding Garifuna immigrants having children once in the U.S. Several women reported knowing undocumented Garifuna women in the U.S. who had children in order to gain access to government services. Nita, however, who migrated to the U.S. without documentation, disagreed: “When they are here, many women do not want to have children because they come to fight. We come to do what we come to do. Many women let ourselves be misled by a man, we are not careful and there comes a baby, and there is no other way but to have it.” This is in fact what happened to Nita, who left her partner and three children in Honduras and did not intend to have children in the U.S. Overwhelmingly, however, most of the women did not feel Garifuna women had more or less children than their Honduran
counterparts. Most believed overall that childbearing was similar for Garifuna women in NYC as it was in Honduras, although several believed that greater access to education encouraged women to have children at an older age. Naomi believed this, saying: “[In Honduras] their education is not, uh, there’s education but let’s just say it stops. . . .But you have more schooling here, and over here the more schooling you have the more you make so it keeps you from having kids. Over there you don’t have as much schooling, so I guess they start making babies.” Overall, however, the survey data revealed no difference in women having children, regardless of their age.⁷

Additionally, two women interviewed discussed the increased abilities for a woman to have children in the U.S. because of the greater access to advanced medical procedures. Reina, for example, came to the U.S. in hopes of receiving medical treatment:

In our native country what we need a little more of has to do with health because there are things that we can’t accomplish there and we do accomplish them here. I had fertility problems. I managed to get pregnant with my son here in this country because of how advanced medicine [is]. I lived [in Honduras] with infertility . . .you have to acknowledge this country in that sense—medicine is just more advanced.

Leonor also hoped the access to advanced biomedical procedures would help her have children. After separating from a 13 year partnership which left her childless, Leonor planned to use artificial insemination if she did not meet another partner soon. At 38 years old, Leonor acknowledged that her time to be a mother was running out and she was not willing to be without a child.

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⁷ Education level was not obtained.
Differences in Gender Roles and Relations

In both Trujillo and NYC, women are seen as the keeper of culture and family. Although the women in NYC were more likely to respond that caring for family is the most important thing about being a Garifuna woman, women in both locations were charged with keeping the house running and caring for the family. Women in NYC, however, had the extra burden of providing for family in Honduras as well as in NYC.

Unlike in many other populations studied regarding gender and migration, the Garinagu do not distinguish between calle and casa, or public and private gendered space. Both men and women are readily visible on the streets, and women who can find work often will do so to help support their family. In addition to working outside the home, women are active in the community and are often leaders of community organizations. Likewise, in NYC, women continue to seek employment outside the home in order to maintain their household, even when a husband or male partner is present and employed. The women, however, often found this work to be much more difficult than in Honduras, where women were often viewed as unemployed, with larger amounts of free time. The women in NYC often talked of their Honduran counterparts enjoying lazy days, spent lounging in the house. Nina, for example, said that in Honduras “there’s some women that they do work but basically most of them have someone here and they just help them, you know, send them some money and…they just waiting for people to help them.” This was seen also in the survey, as only 51.5% of respondents in NYC thought a Garifuna in Honduras could have a job. This sentiment demonstrates the higher value placed on employment in the formal market, as many of the Garifuna women in Honduras are actually busy generating income in the secondary market.

The hard work that the Garifuna women in NYC endured, however, was largely done to benefit their family in Honduras. Many of the women interviewed supported children, mothers,
aunts, or cousins and one woman, Fe, even supported one of her former school teachers. Most of the women believed this entry into the formal market, largely as a result of higher education, and the stable income it provided for them and their families in the U.S. as well as in Honduras, allowed Garifuna women in NYC to be more independent:

Here I tend to think the women are more independent because they have to work, so they are more outspoken. They’re a lot more outspoken than in Honduras. I think here, where women in Honduras might never separate or divorce from their partner, here they’ll do it because economically they can afford it and if not there’s other ways you can feed your family without having a man. . . .I think here a lot of women think about other factors like educating themselves and trying to, you know, change what’s considered the stereotypical careers of women in Honduras, in Garifuna women. And they tend to be more outgoing here. Their self-esteem is higher here too.

The idea of greater independence in Garifuna women as a result of increased formal employment (and education) was heard again and again among the women interviewed. Only one woman, Reina, strongly disagreed:

Suddenly, we came to this country searching for a better future. But, we get to live in the reality of it when we are here. . . .There are thousands of women here, right, that get up very early to work so that they can support their families and, what we end up getting in this country is the disintegration of our families. They leave their children, they leave their mothers, they leave their parents . . . in exchange for nothing. Because, sometimes we say that there isn’t any work in our countries but what happens? That those that came, they don’t talk to us about the realities of living in this country. They don’t tell us about the realities of this country . . . because it’s not easy. A single woman here, it's a lie that she can make it because working to pay the rent, to pay the “biles” [bills], what we call them. If we want to get a little ahead here, it will be when there’s a husband working right by our side. It’s the only way in which we can get ahead.

Reina, however, was one of only four women not employed and spent many months alone in NYC while her husband worked as a Merchant Marine. She came to this country to have access to improved medical technology in hopes of having a child. Thus, Reina’s situation is vastly different from those women who conversely view Garifuna women in the U.S. as more independent from family and men.
This focus on increased independence by the women in NYC is also evident through consideration of differences observed between Trujillo and NYC in other areas as well. Changes in household structure, for example, led to greater separation from consanguineal kin in NYC as many Garifuna migrants move into smaller, more stable, affinal households. Many women commented that the hardest part of moving from Honduras to NYC is the absence of family, even when they had family in NYC:

There was a lot of poverty in our countries but there’s the richness of having a family, what is ours, which is what we miss living in this country. Here, there may be a lot of wealth in other areas but there’s a lack of wealth when it comes to family. Because, you could be my sister but have no time for me. You could be my cousin but not have time for me. You have to go out and work to take care of your children. So then, what one suffers . . . what one misses in this country is the family. It’s the family. There can be work, there can be money, but there’s no family.

Several women complained that they only saw their mothers and sisters on the weekends or a few times a month even when they lived nearby. They blamed the long work hours and the fast paced lifestyle. This separation from family, compared to the situation in Honduras, also encourages women to be independent by dealing with their struggles alone.

Women, however, also shared their struggles with their partners, many more of whom were legal spouses in NYC. Marriage is much more common in NYC than Honduras (p = 0.001). The U.S. government places greater emphasis on the nuclear family and this influences immigration sponsorship. A lawful permanent resident, for instance, may only sponsor immigration for their unmarried sons or daughters and their legal spouse (U.S. Citizenship and Immigration Services, 2009). The U.S. government’s emphasis on the nuclear family also affects other government and private programs. Elsy, for example, said:

You know what, sometimes [marriage is] just for convenience because sometimes the men is illegal, woman is legal and so the only way is to get married. And like I told you, we learn things here. In Honduras . . . you can live with your man if you’re not married but here [there are] so many that things you can’t do if you’re
not married. You can’t do it with the men. So that’s why we got married here. Like if he die and you not married you can’t collect. Like I said to do some things living with men, you have to be married. Because everything involves paperwork here. So I think that’s why people get married. Like me, when my husband died [in the Happy Land fire], my first husband, I married him March 6 and he died March 25. And we have our daughter already, but . . . if we were not married I couldn’t do nothing.

None of the women saw their marriage as a business transaction though, as each did love her partner.

Even in marriage, however, the women maintained their independence. In addition to being physically separated from their consanguineal kin, many were also separated from their partners for long periods of time due to work. Some of the women had spouses in the Merchant Marines who would be gone for two month periods, and others simply claimed that conflicting work schedules kept them from seeing their husbands often. For Lucia this was a choice and not a necessity. As previously mentioned, she worked two full-time jobs to save money to buy a house, although her husband wanted to retire in Honduras. Lucia was happy in NYC and had no intention of going back to Honduras regardless of what Santo did. She loved Santo dearly, but just as she left him in Honduras years ago because he did not want to come to the U.S., she was willing to separate again if their desires in life were not the same.

In addition to greater independence, a second theme that surfaced was that of equality of men and women. Women complained often of the machismo that existed in Honduras even though the women there are relatively independent and have many freedoms not observed in societies that have a strong casa/calle distinction.

I don’t want to stereotype but a lot of Garifuna men are macho. Yeah. They’re like macho. They have the mentality that the female has to cook, the female has to clean, the female has to do everything and you know. Mostly the ones over there. The ones over here don’t have that mentality as much as the ones over there. I don’t know. . . . Maybe because the females out here, the ones that are here see that the female out here are more independent and don’t have to rely on them as much as the ones over there [in Honduras]. They rely on their money more.
As discussed earlier, many of the women in NYC described their partnerships as equal, with both men and women participating in the maintenance of the household and the care of the children. Only Isabel described her relationship as one sided, with her doing all the household work. She acknowledged this as unusual for relationships in the U.S. and even jokingly called herself a “stupid woman.” This idea was expressed by the survey respondents as well, as the men and women in NYC largely did not believe it was socially acceptable for Garifuna men in Honduras to do housework. Only 44.4% of males and 30.6% of females answered that this was possible. Even Reina, largely unhappy with her recent move to the U.S. noted this distinction: “in Honduras, the men don’t help as much, they go out, there’s much more machismo; and here her husband helps to cook, helps clean, goes to the supermarket, works [to] help pay the rent . . .it’s much more equal status here [than] in Honduras.”

The increase of independence among women and equality between men and women are largely a result of migration, but also of age. In Trujillo, the ideas expressed by the younger respondents were more similar to those heard in NYC. The younger population of Trujillo is the first to live with female migration to the U.S., which became common after U.S. migration reform in the 1960s. Thus, they have been the first exposed to the changes of gender roles and male-female relations as a result of transnational migration. Their perceptions are somewhat unrealistic, however, as their beliefs regarding the increased equality of Garifuna men and women in the U.S. and increased sexual freedoms of Garifuna women in the U.S. were greatly exaggerated. Still, the influence of these changes occurring among their migrating friends and family can be observed in Trujillo in the reduced acceptance of infidelity and the heightened
importance of fidelity\(^8\) in general and the reduced age of sexual debut among the younger females.

**Summary**

This chapter attempted to explore how transnational migration has influenced gender roles and male-female relations among the Garinagu of Trujillo, Honduras and NYC through consideration of employment, households, partnerships, and children and childcare. It was largely observed that matrofocality remains, although is transformed and adapted to the new lives of the Garinagu in NYC. Women still define themselves through their culture and family, largely remain in consanguineal homes (although they are smaller and more stable), and place emphasis on childrearing. However, Garifuna in NYC experience more distance from family, both in the U.S. (largely as a result of long work hours) and back home (a result of distance) and are more likely to legally marry their partners. As a result, two themes emerged – women become more independent in general, and greater equality between men and women develops. These interconnected themes affect sexual relationships and behaviors. Chapter 6 considers these sexual relationships and behaviors in more depth, and addresses how the differences observed among the Garifuna migrants in NYC affect HIV risk behaviors.

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\(^8\) As will be discussed in the following chapter, this is in contrast to the result of independence and equality among Garifuna women in the U.S. where instead a man’s “natural” inability to be monogamous is exaggerated and younger women’s infidelity appears to be more common.
Table 5-1. Survey data provided among participants in Trujillo, Honduras\textsuperscript{a}

<table>
<thead>
<tr>
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<th>Women</th>
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<th>p-value</th>
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<td></td>
</tr>
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<td></td>
<td></td>
</tr>
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<td>0.22</td>
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<td></td>
</tr>
<tr>
<td>Full-time employment (US$)\textsuperscript{c}</td>
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<td>182.16</td>
<td>0.25</td>
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<td></td>
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<tr>
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<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>Long-term relationship\textsuperscript{d}</td>
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<td></td>
</tr>
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<td>Have children</td>
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<td></td>
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<td></td>
</tr>
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<td>Always</td>
<td>4 (28.6%)</td>
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<td>1 (4.3%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{a} Numbers and percentages may differ as a result of incomplete responses.

\textsuperscript{b} For categorical variables Pearson’s chi-square test was used and the provided statistic is the Pearson $\chi^2$. Independent groups t-test was used to compare means and the t test statistic is provided.

\textsuperscript{c} Conversion rate used from Honduran lempira to US dollars was 18.90 limpera to 1 US dollar.

\textsuperscript{d} Excludes married men and women.
Table 5-2. Survey data provided among participants in New York City\(^a\)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Test for difference(^b)</th>
<th>p-value</th>
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<tr>
<td>Employed for wages</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>37 (86.0%)</td>
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<td></td>
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<tr>
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<td></td>
<td>1810.63</td>
<td>1930.90</td>
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<td><strong>Relationship Status</strong></td>
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<tr>
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<td></td>
<td>0.04</td>
<td>0.85</td>
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</table>

\(^a\) Numbers and percentages may differ as a result of incomplete responses.

\(^b\) For categorical variables Pearson’s chi-square test was used and the provided statistic is the Pearson $\chi^2$. Independent groups t-test was used to compare means and the t test statistic is provided.

\(^c\) Excludes married men and women.
<table>
<thead>
<tr>
<th>Table 5-3. Survey data provided among male participants in Trujillo, Honduras and New York City&lt;sup&gt;a&lt;/sup&gt;</th>
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</thead>
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<td>Employed for wages</td>
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<tr>
<td>No</td>
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<td>Employment type</td>
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<tr>
<td>Part-time</td>
</tr>
<tr>
<td>Full-time</td>
</tr>
<tr>
<td>Monthly income (mean)</td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Long-term relationship&lt;sup&gt;d&lt;/sup&gt;</td>
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<td><strong>Children and Childcare</strong></td>
</tr>
<tr>
<td>Have children</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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<tr>
<td>Number of children (mean)</td>
</tr>
<tr>
<td>Financial support of children</td>
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<tr>
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<tr>
<td>Rarely</td>
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<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>Live with children</td>
</tr>
<tr>
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</tr>
<tr>
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<tr>
<td>Sometimes</td>
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</tbody>
</table>

<sup>a</sup> Numbers and percentages may differ as a result of incomplete responses.

<sup>b</sup> For categorical variables Pearson’s chi-square test was used and the provided statistic is the Pearson $\chi^2$. Independent groups t-test was used to compare means and the t test statistic is provided.

<sup>c</sup> Conversion rate used from Honduran lempira to US dollars was 18.90 limpera to 1 US dollar.

<sup>d</sup> Excludes married men and women.
Table 5-4. Survey data provided among female participants in Trujillo, Honduras and New York City<sup>a</sup>

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<td>1.08</td>
<td>0.30</td>
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<td>26 (72.2%)</td>
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<tr>
<td>Monthly income (mean)</td>
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<td></td>
</tr>
<tr>
<td>Full-time employment (US$)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>182.16</td>
<td>1930.90</td>
<td>-8.96</td>
<td>&lt; 0.001</td>
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<tr>
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<tr>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (41.4%)</td>
<td>16 (55.2%)</td>
<td>1.11</td>
<td>0.29</td>
</tr>
<tr>
<td>No</td>
<td>17 (58.6%)</td>
<td>13 (44.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children and Childcare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23 (62.2%)</td>
<td>34 (69.4%)</td>
<td>0.49</td>
<td>0.48</td>
</tr>
<tr>
<td>No</td>
<td>14 (37.8%)</td>
<td>15 (30.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children (mean)</td>
<td>2.50</td>
<td>2.48</td>
<td>0.04</td>
<td>0.97</td>
</tr>
<tr>
<td>Financial support of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>13 (76.5%)</td>
<td>8 (32.0%)</td>
<td>12.59</td>
<td>0.01</td>
</tr>
<tr>
<td>Rarely</td>
<td>1 (5.9%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>2 (11.8%)</td>
<td>3 (12.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>1 (5.9%)</td>
<td>14 (56.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live with children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21 (91.3%)</td>
<td>26 (78.8%)</td>
<td>4.39</td>
<td>0.11</td>
</tr>
<tr>
<td>No</td>
<td>1 (4.3%)</td>
<td>7 (21.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>1 (4.3%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Numbers and percentages may differ as a result of incomplete responses.

<sup>b</sup> For categorical variables Pearson’s chi-square test was used and the provided statistic is the Pearson $\chi^2$. Independent groups t-test was used to compare means and the t test statistic is provided.

<sup>c</sup> Conversion rate used from Honduran lempira to US dollars was 18.90 limpera to 1 US dollar.

<sup>d</sup> Excludes married men and women.
<table>
<thead>
<tr>
<th>Table 5-5. Important features of being a Garifuna woman in Trujillo, Honduras (n=11) and New York City (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trujillo</strong></td>
</tr>
<tr>
<td>Culture</td>
</tr>
<tr>
<td>Family / House*</td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Food</td>
</tr>
<tr>
<td>History</td>
</tr>
<tr>
<td>Work</td>
</tr>
<tr>
<td>Strong / Strong-minded</td>
</tr>
<tr>
<td>Dance</td>
</tr>
<tr>
<td>Independence</td>
</tr>
<tr>
<td>Responsible</td>
</tr>
<tr>
<td>Self identification</td>
</tr>
<tr>
<td>Confidence</td>
</tr>
<tr>
<td>Community unity</td>
</tr>
</tbody>
</table>

Women could provide several responses and some provided none. Thus, the columns do not add up to the number of interviewees.

* p = 0.03

<table>
<thead>
<tr>
<th>Table 5-6. Household typologies of the Garinagu (Adapted from Kerns, 1997)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household type</strong></td>
</tr>
<tr>
<td>Nuclear family household</td>
</tr>
<tr>
<td>Simple nuclear</td>
</tr>
<tr>
<td>Modified nuclear</td>
</tr>
<tr>
<td>Extended family households</td>
</tr>
<tr>
<td>Extended simple nuclear</td>
</tr>
<tr>
<td>Extended modified nuclear</td>
</tr>
<tr>
<td>Extended non-nuclear</td>
</tr>
</tbody>
</table>
### Table 5-7. Qualities in a man desired by women in Trujillo, Honduras (n=11) and New York City (n=20)\(^a\)

<table>
<thead>
<tr>
<th>Quality</th>
<th>Trujillo</th>
<th>New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring / Affectionate /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding</td>
<td>2 (18.2%)</td>
<td>7 (35.0%)</td>
</tr>
<tr>
<td>Unselfish</td>
<td>0 (0.0%)</td>
<td>1 (5.0%)</td>
</tr>
<tr>
<td>Responsible</td>
<td>1 (9.1%)</td>
<td>6 (30.0%)</td>
</tr>
<tr>
<td>Works / Earns a good living*</td>
<td>1 (9.1%)</td>
<td>9 (45.0%)</td>
</tr>
<tr>
<td>Takes care of self / Drug-free</td>
<td>0 (0.0%)</td>
<td>2 (10.0%)</td>
</tr>
<tr>
<td>Honest</td>
<td>3 (27.3%)</td>
<td>6 (30.0%)</td>
</tr>
<tr>
<td>Faithful**</td>
<td>4 (36.4%)</td>
<td>1 (5.0%)</td>
</tr>
<tr>
<td>Loves my children</td>
<td>0 (0.0%)</td>
<td>2 (10.0%)</td>
</tr>
<tr>
<td>Handsome</td>
<td>1 (9.1%)</td>
<td>4 (20.0%)</td>
</tr>
<tr>
<td>Good communicator</td>
<td>4 (36.4%)</td>
<td>7 (35.0%)</td>
</tr>
<tr>
<td>Similar values</td>
<td>0 (0.0%)</td>
<td>3 (15.0%)</td>
</tr>
<tr>
<td>Takes care of family</td>
<td>0 (0.0%)</td>
<td>5 (25.0%)</td>
</tr>
<tr>
<td>Intelligent</td>
<td>1 (9.1%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Treats me well / Respectful</td>
<td>3 (27.3%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Good personality</td>
<td>0 (0.0%)</td>
<td>2 (10.0%)</td>
</tr>
</tbody>
</table>

\(^a\) Women could provide several responses and some provided none. Thus, the columns do not add up to the number of interviewees.

* \(p = 0.06\), ** \(p = 0.02\)

### Table 5-8. Ways male partners help women in Trujillo, Honduras (n=9) and New York City (n=20)\(^a\)

<table>
<thead>
<tr>
<th>Help</th>
<th>Trujillo</th>
<th>New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work / Make money</td>
<td>5 (55.6%)</td>
<td>11 (55.0%)</td>
</tr>
<tr>
<td>Pay rent</td>
<td>0 (0.0%)</td>
<td>4 (20.0%)</td>
</tr>
<tr>
<td>Pay bills*</td>
<td>0 (0.0%)</td>
<td>6 (30.0%)</td>
</tr>
<tr>
<td>Take care of kids</td>
<td>3 (33.3%)</td>
<td>4 (20.0%)</td>
</tr>
<tr>
<td>Take care of the family</td>
<td>0 (0.0%)</td>
<td>1 (5.0%)</td>
</tr>
<tr>
<td>Help around the house</td>
<td>3 (33.3%)</td>
<td>10 (50.0%)</td>
</tr>
<tr>
<td>Cooking</td>
<td>0 (0.0%)</td>
<td>3 (15.0%)</td>
</tr>
<tr>
<td>Talk about and/or help solve problems</td>
<td>3 (33.3%)</td>
<td>3 (15.0%)</td>
</tr>
<tr>
<td>Help accomplish dreams</td>
<td>0 (0.0%)</td>
<td>1 (5.0%)</td>
</tr>
<tr>
<td>Nothing</td>
<td>0 (0.0%)</td>
<td>3 (15.0%)</td>
</tr>
</tbody>
</table>

\(^a\) Women could provide several responses and some provided none. Thus, the columns do not add up to the number of interviewees.

* \(p = 0.06\)
Table 5-9. Reasons provided for why having children are important in Trujillo, Honduras (n=9) and New York City (n=20)\textsuperscript{a}

<table>
<thead>
<tr>
<th>Reason</th>
<th>Trujillo</th>
<th>New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue culture/race</td>
<td>3 (33.3%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Makes you a woman</td>
<td>1 (11.1%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Creation or maintenance of family / Future support</td>
<td>5 (55.6%)</td>
<td>7 (35%)</td>
</tr>
<tr>
<td>Unique love</td>
<td>1 (11.1%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Learn from children</td>
<td>1 (11.1%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Provides happiness / Prevents loneliness*</td>
<td>6 (66.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Please men</td>
<td>0 (0.0%)</td>
<td>2 (10.0%)</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Women could provide several responses and some provided none. Thus, the columns do not add up to the number of interviewees.

\* p < 0.001
CHAPTER 6
GENDER ROLES AND HIV/AIDS RISK AMONG GARIFUNA IN NEW YORK CITY

Introduction

Chapter 5 explored how migration to NYC has affected gender roles and male-female relationships through consideration of employment, households, partnerships, and children and childcare. It was observed that although matrifocality remains, women tend to live in smaller and more stable households. Garifuna women in NYC experience distancing from their consanguineal family both physically as well as emotionally, as many commented on the difficulties of seeing family members living nearby due to the busy lifestyle in NYC. Consequently, women become more independent from their family. Their household instead is more likely to include a male partner, who they often legally wed. Men’s role as provider increases, with all of the men surveyed providing financially for their children. Men were largely able to do this as a result of the increased employment opportunities available to both men and women in NYC. In addition to greater opportunities in employment, women felt that migration allowed them to have greater opportunities in education as well. The independence gained and confidence instilled through education and employment developed into a greater equality with their male partners, and many women described their relationships as true partnerships where decisions and actions were completed jointly.

These transformations of gender roles in NYC have varying affects on sexual behaviors and risk for HIV. In this chapter these interconnected themes of independence and equality are explored by considering the second research question: How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras? Based on the discourse of sexuality, great differences in the sexual behaviors of Garifuna in Honduras and
NYC were expected. In Trujillo, people spoke of the sexual freedoms enjoyed by their migrant peers:

Over there, there’s more—I think there’s more chaos. Over there, there’s more debauchery. Here they’re a bit more cautious because it’s such a small place and everyone knows your business. [Not] in the United States, which is large. [People could live] in the same building and not know each other. So then, I think there’s like much more liberty to do things. . . Being unfaithful, for example, there are many places they could go into and not be seen by anyone. Here in Trujillo, you go into a hotel and the whole world knows about it and sees it. They leave a hotel and the whole world checks it out. [That doesn't happen] over there. They have more freedom over there to do their thing.

Men and women in the U.S. also talked about the sexual freedoms found in the U.S. and told stories of men and women “going crazy” with members of the opposite sex upon arrival to the States. Despite these stories, the reported behaviors did not differ substantially.

Although large differences in sexual behavior were not found, differences do exist, and they are important with respect to HIV risk. Many of the changes serve to reduce the risk of HIV infection for Garifuna men and women living in NYC, although a few increase this risk. Some of the changes in risk were directly observed, and some can be extracted from the literature based on similarities in other populations, requiring further investigation of these issues among the Garinagu. The perceived and reported behaviors and resulting changes in risk for HIV among the Garinagu in NYC, both positive and negative, are discussed at length below.

**Sexual Behaviors**

Conducting fieldwork in Belize in the 1970s, Kerns (1997) noted that some adolescents (ages 12-15) become sexually active soon after puberty. In the case of young girls, most relations are hidden, as a girl’s mother may face criticism for allowing this to occur. Conversely, “a fifteen-year-old boy who had an infant son was considered exceptionally precocious and virile. Men and women often pointed him out, remarking with a smile how strange it was that ‘such a small boy is really a man.’” (Kerns, 1997, p. 98). While in Trujillo, I was told boys are
never really just friends with girls; they are always looking for more. However, while a man is often celebrated for his successes in sexual relations, and sexual relations are considered natural and necessary, women face harsher social control over their sexuality, as sexual misconduct can be viewed as dangerous for the well being of the woman’s family, particularly her children (Kerns, 1997).

In Belize, Roessingh (2004) was told by male consultants that female homosexuality does not exist among the Garinagu, although Sabin and colleagues (2008) report otherwise. I never heard female homosexuality discussed, although I did not specifically inquire about it. Male homosexuality is more common, although mostly on “the down low” (Martinez & Hosek, 2005; Millett, Malebranche, Mason, & Spikes, 2005), and at least one community leader believed this was an important component of the HIV/AIDS epidemic in the NYC Garinagu community. While the role of homosexuality and/or bisexuality is important for discussions of HIV/AIDS, the current research only considered heterosexual encounters as this is thought to be the most important means of HIV transmission among the Garinagu. Thus, the current section considers various elements of sexual behavior, including sexual debut, number of partners, fidelity, and condom use.

**Sexual Behaviors in Trujillo**

When I first arrived in Honduras, I was picked up from the La Ceiba airport by Alejandro, a 24 year old, and two of his male friends. Alejandro was the cousin of Lester, a Garifuna migrant I met online. Lester arranged for his cousin to pick me up using the truck he bought for his family to share in Trujillo. Alejandro’s friends were both in their mid-20s as well, and while driving around La Ceiba the three proceeded to whistle, holler, and motion to young females, often yelling for their telephone numbers, motioning for the girls to call them, or telling the girls that they were sexy. During the three hour drive to Trujillo we listened to several music
CDs, including one by Akon as well as others by famous reggaeton and punta rock artists. Akon’s lyrics were very sexually suggestive, and included explicit references to sexual activities and female anatomy. The songs by Akon were in English, and I asked the three men if they understood them since none of them spoke English. They all laughed and said they did not understand every line, but they understood the essence of the song well. Later, I heard an 11 year old girl singing one of the songs while eating lunch at a table, using all of the English sexual terminology. The men were not uncomfortable joking about women in front of me and the little girl’s mother was not uncomfortable listening to her young daughter sing slang sexual terms, as sexuality is a natural component of life.

(a) Sexual debut and partnerships. The average age of sexual debut among the men who participated in the survey was 14.89 and among women was 18.43 years of age (p < 0.001) (Table 6-1). In addition to engaging in sex at a younger age, the men also had more lifetime partners than the women. The men averaged 8.47 sexual partners while the women averaged 3.74 partners (p = 0.01). When considering partners in the past year, men averaged 2.5 partners while women averaged 1.11 partners (p = 0.01). People often mentioned the double standard regarding sexual activity, where men are applauded for their multiple partners but women with many partners are viewed negatively, and this social idea is demonstrated in the reporting of sexual partnerships.

In Trujillo, females were more likely than males to believe that males could have many sexual partners (73.9% and 54.5%, respectively) (Table 6-2). Age did not influence this belief, as 63.6% of young respondents in Trujillo and 66.7% of older respondents answered that this was acceptable. Far fewer respondents believed Garifuna women in Honduras could have many

---

9 This number is probably low as many men wrote in “many” or “don’t remember.”
sexual partners. Among males, 35.3% believed this was possible, compared to only 11.5% of the females, a difference that was moderately significant (p = 0.06). However, younger respondents in Trujillo were more likely than those 33 years or older to believe this was possible (26.7% and 7.7%, respectively), although this difference was not statistically significant.

(b) Monogamy and fidelity. Just over half of the men and women (51.7% and 58.1%, respectively) were married or in a long-term relationship, but 86.2% of men and 63.9% of women reported having a regular sex partner (p = 0.04) (Table 6-3). Additionally, 37.5% of men and 21.7% of women reported having more than one regular sex partner at the time of the survey. Although secondary unions were traditionally accepted, they occur less often today. While living in Trujillo I knew of only one older woman who openly maintained two relationships, although this type of union was more common among men in the past. Among the survey participants, only 54.5% of men believed Garifuna males in Honduras could have many sex partners, and 60% believed they could have sex while in a relationship with someone other than their partner. Slightly more females (69.2%) agreed. Younger respondents in Trujillo were more likely to believe this to be true than older respondents (71.9% and 50%, respectively), although this difference was not statistically significant. Fewer respondents answered that Garifuna women could have sex with someone else while involved in a relationship. Among men, 46.7% answered that this was possible while only 17.9% of women agreed (p = 0.05). Younger respondents in Trujillo were more likely to answer that this was possible than older respondents (36.7% and 7.7%, respectively) (p = 0.05). Few respondents, male or female, reported that they were in a mutually monogamous relationship. Only 24% of men and 39.1% of women reported that they were faithful and were confident their partner was as well.
Conversely, 36% of men and 26.1% of women reported that they were not in a mutually monogamous relationship.

Although the majority of women stated that it was socially acceptable for men to have multiple sex partners and sex outside of their relationship with different women, the women revealed to me during the interviews and casual conversation that they did not like this, and many cited this as the reason HIV was such a big problem in their community. Six of the women interviewed (54.5%) had been cheated on by a partner and one (9.1%) was not sure of her partner’s fidelity. Dora left her unfaithful partner, explaining:

I was with him all this time . . . like [5 or ] 6 years, and, well, we got along well. He simply did not want to have a baby, he also had his [relationships] with other friends outside [of our relationship] and succeeded in getting another girl pregnant. So then . . . that provoked the change. That is, because of that interruption from that . . . from that girl, this and that of the baby, and it was an endless list of things that as a woman did not sit well with me. And I just saw that he no longer respected me as a woman nor the home we lived in because we lived together. So then, I made the decision to leave. I came back home, with my mom, where I live today. But before that, that is, apparently we were doing well because we behaved very well. Before I left to live in his home, I would get to my house, we’d go out together, and we’d have lots of fun and then [he cheated on me].

All of the women except Seru, however, reported that they had always been faithful to their partners, past and present. Seru had been unfaithful with her last partner, who also engaged in sex outside their relationship. She said she realized the danger in this type of relationship: “it scared me that I might get some illness…and it would be shameful to have someone tell my children, ‘Our mother has the virus.’ So, one has to take care of oneself.”

(c) Condoms. Seru stated that she always used condoms during her infidelities. Most women, in fact, claimed to always use condoms, although several women changed their answer after further inquiry:

Suzanne: Do you always use [condoms]?
Lauru: Yes.
Suzanne: Yes?
Lauru: Uhm, not a lot. [laughs]
Suzanne: It’s ok.
Lauru: Not often.

Among the survey respondents, 48.3% of the men and 34.3% of the women answered that they always used condoms (Table 6-3). Only 3.4% of men reported never using condoms compared to 22.9% of women. The remaining respondents used condoms rarely, sometimes, or often.

Among men, reported condom use was positively correlated with the number of lifetime partners (rho = 0.46, p = 0.05) (Table 6-4). This correlation was not observed for women; however, when considering only the number of sex partners in the previous year, women with a higher number of partners reported higher condom use (rho = 0.4, p = 0.02) (Table 6-5). Slightly more than two thirds of men (69%) and women (67.6%) reported using a condom at last sexual intercourse.

Condom use at last sexual intercourse was not significantly associated to that interaction being with a regular sex partner; 33.3% of men and 36.4% of women who reported not using a condom during their last sexual encounter had that encounter with a person who they did not consider a regular partner.

The majority of men (95.8%) and women (88.9%) felt that it was socially acceptable for Garifuna men in Honduras to buy or get condoms, and 74.9% of men reported they always felt comfortable doing so. Only 3.8% of men reported that they never felt comfortable obtaining condoms. Fewer felt that it was socially acceptable for Garifuna women in Honduras to purchase or obtain condoms; only 60% of men and 41.4% of women agreed that this was acceptable. Half of the women surveyed though reported always feeling comfortable buying or obtaining condoms but 16.7% reported never feeling comfortable. No association was observed between reported condom use and comfort buying or obtaining condoms for men or women.
All of the women interviewed who used condoms stated that they were comfortable getting condoms, carrying condoms, and asking their partner to use a condom. Nany, for instance, told me:

I understand that even if I love my partner, I do not have to have sex with him without protection. Because if he has AIDS, who will protect me? The use of the condom is important. They say it’s safe. [I can carry a condom] because if I am going to have sex with my boyfriend, and maybe he does not have any, I do. I think in life you must be sure of what kind of person you will be with. Sometimes a man tends to ask a woman, “give it to me without a condom.” But as a woman, one must be smarter and use condoms.

After claiming that they were comfortable carrying condoms, two of the women, however, quickly added that if they carried condoms they would be carrying them to give out to friends or kids on the street. It is unclear if requests for condom use are successful.

Sexual Behaviors in New York City

The women in NYC often referred to Garifuna men as “fresh”: “Sometimes when I’m on the street and I’m dressed the way I normally dress, nice, tight, sexy and whatever, drivers, cab drivers talking . . . man, they just stare, you know? . . . It’s like, you know, they fresh!” Like in Honduras, sexuality is natural and normal, and an important part of the lives of Garifuna men and women.

(a) Sexual debut and partnerships. Men engaged in sex for the first time at an average age of 15.46 years, several years younger than women whose average age at sexual debut was 18.21 years (p < 0.001) (Table 6-6). Men had more sexual partners during their lifetime than women, averaging 10.1\(^{10}\) partners compared to 3.38 partners for women. In the year prior to the survey, men averaged 2.64 sex partners and women averaged 0.91 sex partners (p = 0.01).

\(^{10}\) This number is probably low as many men wrote in “many” or “don’t remember.”
In the U.S. it was agreed that Garifuna men could have many sex partners by 57.1% of the male respondents and 79.4% of the female respondents in NYC (Table 6-7). Additionally, younger respondents in NYC believed this to be true more so than older respondents (75.8% and 63.6%, respectively), although this was not statistically significant. Few believed that Garifuna women in the U.S. could have many sex partners. Only 26.3% of men and 26.5% of women agreed that this was acceptable. Those respondents between the ages of 18 and 32 were more likely to agree, with 33.3% answering yes, compared to only 15% of respondents aged 33 and older.

(b) Monogamy and fidelity. The majority of men (72.7%) and women (75.5%) reported having a regular sexual partner (Table 6-8). Over half of men (59.4%) and women (59.5%) were confident that their relationship was mutually monogamous. Only 19.4% of men and 5.6% of women had more than one regular sexual partner. Seventy percent of males in NYC believed that it was socially acceptable for Garifuna men in the U.S. to have sex with someone other than their partner while in a relationship (Table 6-7). Among women, 84.8% agreed that this was true. Younger respondents were more likely to believe Garifuna men in the U.S. could have sexual relations outside a partnership, with 83.9% answering yes compared to 72.7% of older respondents. Far fewer believed that Garifuna women in the U.S. could have sex with someone other than their partner while in a relationship. Only 33.3% of men and 41.2% of women agreed with this statement. Again, however, the younger respondents were more accepting of this possibility, with 46.9% answering yes compared to only 25% of older respondents.

Men and women were more likely to report that they were in a mutually monogamous relationship, although infidelity remains an important issue among the Garinagu living in NYC. Twenty-five percent of men reported that their relationship was not mutually monogamous and
15.6% were not sure. Among the female survey respondents, 10.8% reported that their relationship was not mutually monogamous and 29.7% were not sure. One story of infidelity was shared by Moluin, a 25 year old mother of one. Moulin was separated from her husband when I met her, fleeing an abusive relationship. The abuse began, she said, after her husband found out she had been unfaithful. Moluin tried to fix the relationship after her infidelity but was unable to:

It really sometimes was an issue. It was, towards the end of our marriage really. He would bring up me cheating on him. “Oh you can do it with him but you can’t do it with me?” Unfortunately but that was the way he made it seem. It was a problem. I would even tell him a lot of the times it would feel like he was raping me. I would tell him that! But to him, “[With me it] was rape, but the other guy wasn’t rape?” So it was really uncomfortable.

Including Moluin, seven (33.3%) of the women interviewed had cheated on a partner. The majority of women (63.6%) reported that at least one partner had cheated on them and 13.6% were not sure. Thus, although infidelity seems to be reduced in NYC among the Garinagu, it remains an important issue and will be explored further in depth later in the chapter.

(c) Condoms. Just under half (43.6%) of the men surveyed reported using condoms at every sex act; 15.4% never wore condoms (Table 6-8). Women reported less condom use, with only 29.8% reporting use at every sexual encounter and 25.5% reporting that they never used condoms. Reported condom use was not correlated with the total number of lifetime sex partners or the number of sex partners in the previous year for men or women (Table 6-9 and Table 6-10). Men reported using a condom at their last sexual encounter significantly more than women (69.8% and 38.8%, respectively) (p = 0.01); 78.6% of men and 87.8% of women reported that this encounter was with a regular partner. For the male respondents, using a condom during the last sexual encounter, however, was not significantly associated with that encounter being with a
regular partner; 33.3% of the men who reported not using a condom engaged in sex with someone they did not consider a regular sexual partner.

Male respondents in NYC largely believed it was socially acceptable for men to buy or obtain condoms with 85% agreeing with this statement (Table 6-7). Women saw no social issues with this, and 100% responded that this was socially acceptable. Men believed it was less acceptable for Garifuna women to purchase or obtain condoms as only 61.1% responded that this was socially acceptable in the U.S. Three-quarters of the women (75.8%), however, did not believe this was a problem. Younger respondents were more accepting of Garifuna women in the U.S. buying or obtaining condoms than older respondents (78.1% v. 57.9%, respectively). Although the majority of men and women surveyed believed it was socially acceptable for Garifuna men and women to obtain condoms, only 44.7% of men and 39.1% of women reported they always felt comfortable doing so themselves. Additionally, 28.9% of men and 37% of women reported never feeling comfortable doing so. Only two of the women interviewed told me they would not buy condoms, and several answered that they would buy condoms but were embarrassed doing so: “I feel weird, like, I’m going in there buying condoms down at the corner. You know, they going to look at me like ‘Oh my God she’s going to go have sex,’ you know? But, maybe I don’t care anymore. I’m just like I’m going to protect myself!” Many of the women, however, felt fine buying condoms as they recognized that they would protect them from pregnancy and STIs. One woman exclaimed: “I think it’s the best thing that ever happened!”

The majority of survey respondents and women interviewed also believed it was acceptable for Garifuna men and women in the U.S. to carry condoms. Eighty-five percent of men and 88.6% of women found it acceptable for men to carry condoms, and 55.6% of men and
62.9% of women found it acceptable for women to carry condoms. The women interviewed also were largely alright with this, and 78.6% said they were comfortable carrying condoms themselves.

**Differences In Sexual Discourse**

The descriptions of reported sexual behaviors in Trujillo, Honduras and NYC demonstrate little difference (Tables 6-11, 6-12, and 6-13). Among women, however, those in Trujillo felt their counterparts in NYC had more sexual freedom while those in NYC felt their counterparts in Honduras were subject to more control. Especially during arrival in the U.S., men and women were said to enjoy the new diversity of people surrounding them and “go crazy” with the opposite sex. Length of time in the U.S., however, is not significantly associated with the number of lifetime sexual partners or sexual partners in the previous year (Table 6-14) nor do the average reported sexual partners in the previous year differ significantly between migrants in the U.S. less than five year and those in the U.S. more than five years. Thus, contrary to the ideas expressed about the sexual freedoms of migrants and particularly recent migrants, the lack of difference in reported behavior suggests that little has changed in the sex lives of Garifuna men and women in NYC. Busy lifestyles, responsibility to family in NYC and back home in Honduras, as well as community surveillance among women (Kerns, 1992) may influence this observation.

Ethnographic research, however, illuminated shifts in behavior that may affect the risk of HIV infection in both positive and negative ways. First, communication about sexuality within Garifuna families remains closed, unlike in Trujillo where young women told me they were comfortable discussing sex with their family. Many older women told different stories from when they were young in Honduras, and so the open dialog in Trujillo appears to be of recent origin. The HIV epidemic is likely a driving force in this new open communication, as the
community has actively been fighting the HIV/AIDS epidemic through education and treatment campaigns. In NYC, HIV remains heavily stigmatized, likely affecting dialog among community members, including with family and partners. An important outcome of this is the dishonesty in conversations about HIV between partners. Second, the social geography of infidelity appears to have shifted among the Garinagu in NYC. While multiple regular partnerships were less frequent in NYC, many partnerships still show overlap and many involve sexual contact outside of the partnership of short duration. Additionally, the increased equality of men and women has led to an apparent increase in female infidelities among young women. These differences are the focus of this sub-section. Their affect on HIV risk will be discussed subsequently.

Communication About Sexual Behaviors and HIV

Although the reported sexual behaviors of Garifuna men and women in NYC did not differ greatly from their counterparts in Trujillo, communication about HIV did. This is important in discussion of sexual behavior and HIV risk as communication about sexuality is shown to greatly impact sexual behavior. This sub-section considers stigma of HIV/AIDS and communication about sexuality among the Garinagu of NYC, specifically within the community and between family member and sexual partners.

(a) Stigma and communication. In Honduras, although stigma associated with HIV occurred, it was not as present as in NYC. The president of Nuevo Amanacer (New Dawn), an HIV/AIDS support group, for instance, told me: “I don’t really feel any discrimination. I think we’ve already crossed that bridge.” This sentiment was heard over and over. The reasons for the reduction in stigma and discrimination in Trujillo are multifaceted, and are related to the presence of a public hospital, the availability of free ARV therapy, education programs including a radio drama aired in Spanish and Garifuna, collaboration with buyais, and an active people
living with HIV/AIDS (PLWHA) group. Instead of fearing those with HIV, people discussed
the availability of ARVs in the hospital and the long lives PLWHA now lived. Almost everyone
surveyed (98.5%) knew someone with HIV or AIDS; 59.1% of survey participants reported
having at least one HIV-positive family member and 74.2% reported having at least one HIV-
positive friend. In the hospital, a volunteer is often seen talking with HIV patients to act as an
advocate if needed and to ensure proper care is being provided in a timely manner.

Although stigma and discrimination have largely been reduced in Trujillo, and many of
the factors contributing to a reduction of stigma in Trujillo also exist in NYC, stigma associated
with HIV is clearly evident among Garifuna in NYC. Fe, who hides her HIV status from her
family for fear of discrimination, shared the following story:

I have a cousin [who] passed away. She just died 2 years ago. She had AIDS since
she was 15. [The family] went in her bag and when they were rummaging they
found she had medications so everyone was on her business. She passed away
within a couple of years because she had no family support. The ignorance! I’m
sayin’ . . . her own mother put her in a residence for individuals for special care
that’s owned by [a] hospital in the Bronx. She had it very bad, you know, she
needed special care and nobody wanted to give it to her. And I couldn’t offer it to
her here because I don’t have enough room to help her. They were so eager for her
to pass that she died on Thanksgiving Day and by Sunday she was already shown.
In the Honduran community we don’t do it like that! Like they had already prepaid
the funeral! That’s really bad. And she was 22. Very young, beautiful, young
woman!

Fearing a similar negative reaction from her friends and family, Fe has not told anyone of her
HIV-positive status except her husband who infected her, from whom she is currently separated:

“Instead of helping they put fault at you, like ‘Why you let it happen?’ No, I don’t have too
much family support.”

Respondents in NYC were more likely to be misinformed about non-sexual transmission,
and were more likely to believe you could get AIDS from a toilet seat (p = 0.03) or a mosquito
bite (p < 0.001). Respondents in NYC were also less likely to know that medicine was available
to treat AIDS than their peers in Honduras (p < 0.001). Not surprisingly, survey respondents in NYC were significantly less likely to know someone with HIV than those in Trujillo (p = 0.006), and knew less people who had HIV or AIDS (p < 0.001). Most of the people known with HIV or AIDS lived in Honduras and not NYC.

Everyone I talked to about HIV/AIDS, however, acknowledged that HIV was an issue in the Garifuna community in NYC, and many stated that they felt the risk for infection was the same for Garifuna in NYC as in Honduras, but many also discussed problems with learning about HIV within the community. Several women told me of people purposely walking by meetings about HIV to see who was inside. Those people, I was told, surely had HIV. Despite the name Hondurans Against AIDS, the organization actually focuses on issues other than HIV/AIDS, most of the time as a result of this stigma. Due to low attendance of the meeting, the organization began focusing on land issues in Honduras in the 1990s. According to president Mirtha Colon:

that called a lot of attention, of people attending the meetings. Then during the meetings, once in awhile we would do, like, a workshop on AIDS or a conference on AIDS. Then they would attend. But it was kind of mixed with the other [issues] so we were not focused only on HIV/AIDS. So we continue doing it that way today. We still [operate] that way because . . . that has worked.

Stigma associated with HIV often leads to a fear of HIV testing, although this was not found among the Garinagu in NYC. The majority of men (87.8%) and women (82.6%) in NYC reported having been tested for HIV at least one time. Additionally, 55.9% of men and 50% of women reported that they were tested regularly. Survey respondents ages 18-32 reported regular testing more than those ages 33 and older, although this difference was not significantly significant. Respondents in NYC were significantly less likely to report that they felt scared or nervous getting tested than the survey participants in Trujillo (p = 0.004 and p = 0.03, respectively). This acceptance of HIV testing is thus a positive finding, although if a person
tests, positive steps must be taken to prevent transmission to others. The high social stigma of HIV reduces the likelihood of the latter from happening.

(b) Communication with family and friends. Many mothers I talked to claimed to discuss sex with their children, both male and female. Isabel even put out a bowl of condoms for her children to take with them as needed:

I bring condoms over here and I put them in this [clear bowl] so they can see. The little one has a bunch in her thing, in her little pocket[book]! And I tell her whenever you think just let me know so I can know what you’re up to so I can help you because no friend’s going to help them. Only me. If they get pregnant it’s up to me!

While Isabel claimed that she and her daughters were comfortable discussing their sex lives, most of the younger women stated this was not so. Nina described a recent situation with her mother while laughing:

She saw me with [birth control pills] and she said “Why you taking it?” to see what I would say. And I say “Cause I don’t want to have no kids!” [laughs] She was like, looking at me like “Oh yeah?” [laughs] Just looking at me . . . her expression on her face! I said “No, you know I’m having problems with my period so my doctor prescribed them” and she was just like “Ok.” She knows [I’m sexually active] but she acts like she don’t know. . . . She won’t say anything about it. She won’t ask me anything about it.

Talking about sex and pregnancy with Juana’s mother, Marisol, I was told that the two had an open dialog regarding sex and pregnancy. Later, when I was alone with Juana, who had a newborn baby, she told me this was not the case and that she was uncomfortable discussing these issues with her mother despite her recent childbirth.

More often, the younger Garifuna women in NYC claimed to be able to discuss these issues with their friends, but only on a superficial level: “[I talk about sex with some of my friends] but it’s not like we have a big conversation about it!” Instead, most young women claimed to learn about sex and STIs in school, and one talked about TV movies on the Lifetime channel that dealt with issues of sex, teen pregnancy, and STIs, including HIV.
The reduced communication with family about sexual matters in general and HIV in particular are influenced by the decreased direct role of consanguineal kin due to the physical and emotional distance experienced from family. Additionally, discussion about sexual behaviors and HIV were also not as open in NYC as Trujillo, partly due to increased independence, busy lifestyles, reduced community unity, and increased stigma around HIV. It does appear, however, that communication regarding sexual behavior was improving in the NYC Garifuna community, as several older women stated that nowadays discussions about sex in general were more open:

Yes, the new generation [talks about sex]. But the older people do not do it, it embarrasses them. But the new generation, yes, they do. They discuss about sexuality and HIV also. The new generation nowadays talks about everything. Before, when I was small, you could not talk about anything. But now . . . they are open to talk on any subject.

While this suggests a positive trend, this observation exaggerates the openness of the younger generation similar to what occurred when talking to the mothers based on subsequent talks with younger women. Discussion of sexuality between young women with their family, therefore, remains strained.

(b) Communication with sexual partners. Communication about sexual matters among sexual partners was more common. Most men (60.5%) and women (79.5%) surveyed answered that they always felt comfortable talking about condom use with their sexual partners. Seventy-five percent of those between the ages of 18 and 33 years always felt comfortable with this discussion, as did 63.6% of respondents age 33 years and older. Among men, comfort talking about condoms was positively associated with reported condom use (rho = 0.49, p = 0.003), and those who reported always being able to discuss condom use were nine times more likely to report that they always used a condom than those who were sometimes or never comfortable discussing condom use (OR = 9.3, 95% CI: 1.9-45.6). Similarly, among women, comfort talking
about condoms was positively associated with reported condom use (\(\rho = 0.48, p = 0.002\)). None of the women who were only sometimes or never comfortable talking about condom use with their partners reported that they always used condoms.

Overwhelmingly, however, Garifuna women in NYC reported comfort in discussing condom use with their partner. All of the women who were not legally wed felt comfortable refusing sexual advances if a request to use a condom was ignored. It appears, therefore, that the increased equality between men and women in NYC may be positively influencing condom negotiation by unmarried women.

Several of the married women interviewed, however, discussed the issues of condom use with their husbands. Leyla felt comfortable asking her husband to use a condom, but said if she made this request he would say no and she would have to have sexual relations with him anyway: “[He will tell] me ‘Oh I don’t want to use condoms… you’re my wife and I don’t want to use condoms.’ [If he refuses] I would just have to do it because at one point, you know, he will get tired of using condoms with his wife.” Angel also stated this, saying: “My husband with me would not use a condom. He would think it absurd!” Other studies among the Garinagu in Honduras report low condom negotiation by women with their partners (Tercero, Arana, & Miranda, 2002; Sabin et al., 2008). Within marriages in the U.S. the continued inability of women to successfully engage in condom negotiation (if desired) presents a problem since it has been determined that infidelity is still common within these newer legally sanctioned unions.

Respondents who were comfortable with discussing condoms were 2.5 times as likely to report that they were comfortable discussing HIV with their sexual partners (OR = 2.5, 95% CI: 1.3–4.8). In fact, the majority of survey respondents were comfortable discussing their HIV status with sex partners, although women were much more comfortable with this than men (p =
51.4% of men and 79.5% of women always felt comfortable with this conversation. Comfort with discussing HIV with sexual partners was not significantly associated with overall reported condom use for males. Women who were always comfortable discussing HIV with their partners were less likely to have used a condom at last intercourse (p = 0.01).

Among the women interviewed, 89.5% said they could talk to their partners about HIV. Although the women interviewed were largely comfortable discussing HIV with their partners, many cautioned that men were not always honest in these conversations. Many told stories of men lying to their partners about being tested and/or their status if HIV-positive. Evita, for example, told me: “I heard of [people who are HIV-positive] going to go and make a copy from their doctor to cover the positive part and put negative and they going to show people that they are okay.” Johana shared a story that happened to her when discussing HIV status with a new sexual partner:

[I asked him if he had been tested] and he said “Oh I got tested.” But I [tricked] him. I was like “Oh what is the color that they give you? Was it blue, green, or white?” He was like “Oh, it’s green.” I say “No you lying to me! That means you didn’t get tested!” He’s like, “I, please, I got tested.” I was, like “Hm mm, you didn’t get tested!” and he’s just like “Ok, I’m going to have an appointment some time so . . .” So then, it was just like I leave it at that but I already knew that he was lying to me so it was always in my mind that I always had to use protection.

The dishonesty that can surround discussions of HIV occurred not only with new partners but with spouses. Fe tried to talk about HIV with her husband, but only found out her husband was HIV-positive when he got sick one time:

He was in the hospital for three days and when they gave me some paperwork I read between the lines, you know, the social work notes...[His diagnosis was] six years before me and him met each other. . . .He didn’t tell me. I have to find paperwork and things just to find out!

The examples of Evita and Fe demonstrate that although many men and women claim they are comfortable discussing HIV, the honesty of these conversations may be questionable.
Infidelity: Traditional Men and Americanized Young Women

Men and women in NYC were more likely to be confident that their relationship was mutually monogamous than their counterparts in Honduras, and women in NYC were more likely to report that their last sexual encounter was with a regular partner. However, ethnographic and interview data suggest that infidelity remains an important issue within the Garifuna community in NYC. An important difference with respect to infidelity observed in NYC is the apparent increase in infidelity among young women. Indeed, having relations outside of a partnership is not uncommon among the Garinagu historically, and among men it has been considered natural. Previous anthropologists commented that this was a common reason for separation. Presently in Trujillo, however, women discussed men who were unfaithful to their partners as stupid or selfish and most said that they believed fidelity was the key to reducing HIV in their community.11 In NYC, however, although women wanted a faithful partner, Garifuna women continued to discuss Garifuna men’s inability to be faithful to one partner as natural. Some women stopped dating Garifuna men because of this, some continued with the serial monogamy relationship pattern as historically observed among the Garinagu in Central America, some accepted their unfaithful spouse, and some became unfaithful themselves. A woman being unfaithful to her partner is not new among the Garinagu; however, among the younger women, differences are observed between Honduras and NYC.

Leyla, telling me a story of her infidelity, said: “Well, after I found out that [my partner] was cheating on me, you know, I wanted to break up with him, I wanted to leave, whatever. I said ok. He did it, I’m going to do it.” She continued to explain: “I think if they would be faithful maybe women would be faithful also, you know?” Cheating on a partner as an act of

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11 This is a more recent development likely stemming from HIV education and awareness.
revenge was not reported in Honduras and many of the women in NYC stated that this would not happen there. Infidelity among the women interviewed in NYC was more common than those in Trujillo, and although a woman’s infidelity in NYC was often viewed as a response to their partner’s indiscretions, most of the affairs described by the women interviewed were not. A third of the women interviewed had cheated on a partner, and only Leyla said this occurred in response to her partner’s infidelity. The other indiscretions were the result of other emotional and physical motivations, and many blamed these affairs on the women becoming “Americanized”:

They become more unfaithful, I can tell you that. . . . If the man goes out and they know they unfaithful, they do the same thing too. Back home they won’t do that. I mean nowadays they might do it but [not] back then when I was living there. [Now] . . . they pick up the bad things that the American girls do. But they do that, they go with two or three boys at the same time. I don’t know. [They’re] more independent.

Another woman simply said: “Over here they become more unfaithful, I can tell you that. No offense, but they pick up the bad things that the American girls do!”

The interviews shed light on the issues surrounding fidelity among the Garinagu of NYC. Both men and women survey participants were more likely to report that they were in mutually monogamous relationships than their counterparts in Trujillo, but the survey results also highlight the continued problem of infidelity. Among those in a long-term relationship, 37.5% of men were unsure if they were in a mutually monogamous relationship, and half of the women either knew their relationship was not mutually monogamous (6.3%) or were unsure (43.8%). Fidelity among those in a long-term relationship and those who were married did not differ significantly for men or women. Over a third of married men (37.5%) reported that their relationship was not monogamous. Among married women, 12.5% claimed to not be in a monogamous marriage and 18.8% were unsure. Additionally, being married was not a significant
predator of fidelity by itself or when controlling for age, sex, or years lived in the U.S. (Table 6-15). Being married was also not significantly associated with the number of sexual partners in the past year nor a significant predictor of the number of reported sexual partners during the previous year by itself or when controlling for age, sex, and years lived in the U.S. (Table 6-16). Thus, infidelity remains an issue even for married couples. That more long-term couples were unsure of the mutual monogamy status than their married counterparts, however, may further signal an increased communication among married couples.

Not surprising, based on the history of fluctuating relationships among the Garinagu and the independence of women, most of the women interviewed left their relationship after learning of their partner’s indiscretions. Only Barana chose to stay with her partner, stating: “Faithfulness . . . I used to believe in that word a lot. I am faithful myself, but right now, I doubt and I am not sure of a man’s faithfulness. I’m not 100% believer in a man’s faithfulness.” Although the women in NYC reported that women in Honduras were more likely to stay with an unfaithful partner, this was not observed. All of the women interviewed in Honduras left their partners when they learned of their infidelity. Although the Garifuna women in NYC largely did not remain with unfaithful partners, many commented that they knew older Garifuna women who did, who stayed in their marriage and ignored their partner’s indiscretions:

Some women they know, but they pretend to play the part, like the status of the girl. They are married or whatever, they prefer to pretend that everything is okay, that there is no problem even though they know that their husband is participating in these extramarital relations… I think it is just to keep the status of [wife]. I could say “Oh he has his adventure or whatever with someone else, but I don’t care because I’m the wife and he’s always going to come back to me.” [If he comes back home] they can prove that they’re the number one.

Although Evita did eventually reunite with her unfaithful partner, who she says is still probably unfaithful, and several women reported briefly continuing sexual relationships with their unfaithful partner after their infidelities.
It is possible that this occurs with older women, as the women interviewed tended to be younger. These older women who remain with unfaithful partners may do so because they were accustomed to seeing men in Honduras have multiple partners; however, this needs to be explored further. I only met two older couples where I knew the men had been unfaithful. In one case the woman claimed she would leave her husband if she ever learned that he cheated on her. I truly believe she did not know of her husband’s affairs. In the second case, the woman knew of her husband’s infidelity, as he contracted HIV during their marriage and brought it back to their home. I did not know this couple well, as they spent most of their time in their apartment, and did not have a conversation with her about her decision to stay with her unfaithful husband.

The continued infidelities evidenced in the survey responses and discussed by the women interviewed suggest that the growing equality between men and women is influencing this behavior. Specifically, the younger women interviewed in NYC were more likely to have cheated on a partner. As men and women experience greater equality within partnerships, specifically marriages, the social geography of infidelity changes. Although there is evidence that open multiple partners in Trujillo are on the decline, men and women were more likely to report having multiple regular sex partners than their counterparts in NYC. Data from the survey and interviews, however, highlight that multiple partnerships are in fact occurring in NYC although these may not take the form of multiple regular partners. Among men in a long-term relationship, men reported having between 0 and 20 sex partners in the past year (Figure 6-1). For married men, this range was 0-10. Women in a long-term relationship reported between 0 and 3 sex partners in the past year, and for married women 0-2 (Figure 6-2). The wide range of
reported numbers, particularly among men, demonstrates that affairs are occurring. They are just occurring differently.

Several women did experience infidelity from a partner that involved the overlapping of women as partners, and thus the men were maintaining multiple regular partnerships for a period of time. Naomi, for instance, became pregnant while her partner, Antonio, was transitioning back to Elda, the mother of his first child after years of separation:

He’s a DJ and I find that she was always at one of his parties. She was flirting with him, carrying on with him and I can’t live like that, you know? You making show, not respecting me. You should put a stop to her. She feels like just because she’s your baby’s mother she can do as she pleases and that’s not the case. So I let him go. That’s the reason why we split. That’s the reason why he moved. So he moved out. We was trying, while we were in a relationship [to have a baby]. We was together for four years. We trying for two and a half years, I couldn’t conceive. [Then] we split…It just so happened he came back…in December and boom I’m pregnant. [But] he still over there with her and their child. She’s expecting also.

Naomi and Elda’s concurrent pregnancies by Antonio demonstrate the increased risk of HIV transmission from concurrent sexual partners – Antonio did not use a condom with either woman, as both were regular partners. Several similar stories were shared by the women interviewed.

Many of these infidelities, by both men and women, however, involved sexual encounters with partners who would not be considered regular. Some affairs occur one time or for a very short duration, such as Moluin’s brief affair with a male friend. These may be with people just met at a bar, club, or party, with commercial sex workers (CSW), or with friends. Although prostitution is not common within the Garifuna community itself, Hunts Point is considered a red light district in NYC, and its large commercial sex industry was filmed in the 1990s in the documentary “Hookers at the Point.” Based on reports from the women interviewed, many Garifuna men frequented the Hunts Point prostitutes during the previous decade. The presence
of CSW is not as common in the area as it was in the previous decade as a result of former
Mayor Rudy Giuliani’s campaign to clean up the city in the 1990s, but I did hear about Garifuna
men having occasional relations with CSW. These one-time or short-term partners provide
different risk with respect to HIV.

(a) Condom use in partnerships and infidelity. Reported condom use at last sexual
encounter with a regular partner among the survey respondents was actually high; 69.7% of men
and 39.5% of women reported that they used a condom during their last sexual encounter with a
regular partner. However, 8.3% of men and 20% of women responding that their relationship
was not mutually monogamous or were unsure of their partner’s fidelity reported that they never
used condoms (Figure 6-3). Although half of these men reported using a condom during every
sex act, only 20% of these women reported the same. Reported condom use among married men
and women was lower than among their counterparts in long-term relationships, although this
difference was not statistically significant.

The Risk of HIV

Although reported sexual behaviors did not differ greatly between Garifuna in Trujillo
and NYC, important differences were observed with respect to communication of sexual issues
and fidelity among couples. These differences have important consequences with respect to HIV
risk. Stigma surrounding HIV/AIDS in NYC discourages open discussion about sexual
behaviors and risk of HIV in general. Additionally, growing independence of women from their
families has negatively impacted communication within families regarding sexual behavior. The
increased role of male partnerships, however, encourages open communication about sexuality
among partners. Finally, the continued infidelity and altered social geography of infidelity
continues to place Garifuna men and women at risk.
Communication and HIV Risk

Communication about sexuality in general, and HIV in particular, occur within the context of what the community considers normal and acceptable. Thus, the stigma surrounding HIV influences how the community portrays the issue of HIV and how individuals discuss their sexual behaviors with family, friends, and partners. Modern conceptions of social stigma are based largely on the work of the sociologist Erving Goffman (1963), who described stigma as a response to a negative attribute that devalued a person socially. Stigma has historically been associated with various diseases, including leprosy (Gussow & Tracy, 1970), tuberculosis (Macq, Solis, Martinez, Martiny, & Dujardin, 2005; Sengupta et al., 2006), and epilepsy (MacLeod & Austin, 2003). Since the discovery of HIV, stigma of PLWHA has been reported globally, and in 2002 UNAIDS declared that stigma associated with HIV was one of the greatest barriers to preventing infection and reducing the impact of the disease (UNAIDS, 2002a, 2008b).

Stigma associated with HIV is so widespread that it is now recognized that there are three phases to a HIV epidemic in any community: 1) the epidemic of HIV infection where the virus enters the community unnoticed, 2) the epidemic of AIDS which appears when HIV causes life-threatening complications, and 3) the epidemic of social, cultural, economic, and political responses to AIDS, which is characterized by stigma, discrimination, blame, and collective denial (Parker & Aggleton, 2003). The epidemic of stigma and discrimination hinder the ability to combat the epidemics of HIV and AIDS by creating fear of HIV testing and treatment because of the possible negative reactions of others. Those at risk of infection and many who are already infected are discouraged from protecting themselves and others because of the belief that doing so may raise suspicion about their HIV status. Additionally, stigma and discrimination cause PLWHA to be viewed as a problem when in fact they must be part of the solution (UNAIDS, 2002a).
Communication among the Garinagu of NYC is strained in general because of the stigma present. When considering communication at the family level this communication remained strained. Research shows that communication within families regarding sexuality is an important determinant in sexual behavior, and a lack of communication among parents and their children regarding sexuality has been shown to negatively impact the child’s wellbeing with respect to HIV risk. Early parent and child communication has, for example, been associated with delayed sexual debut (Hutchinson, 2002; Babalola, Tambashe, & Vondrasek, 2005), sexual abstinence after sexual debut (Babalola et al., 2005), reduced sexual partnerships (Holtzman & Rubinson, 1995; Babalola et al., 2005), increased communication with sexual partners (Hutchinson & Cooney, 1998), increased condom use (Holtzman & Rubinson, 1995; Miller, Levin, Whitaker, & Xu, 1998; Hutchinson & Cooney, 1998; Hutchinson, 2002; Hutchinson, Jemmott, Sweet Jemmott, Braverman, & Fong, 2003), and reduced risk of STIs (Hutchinson, 2002). DiClemente and colleagues (2001) found that among sexually active African American females, infrequent communication with parents about sex was associated with decreased use of contraceptives, decreased use of condoms, and less communication with their sexual partners.

The potential lack of communication with family regarding sexual behaviors also can be damaging in other ways. Research suggests that when there is not open dialog about sexual behaviors with family, individuals may be more influenced by their peer’s behaviors (Whitaker & Miller, 2000). At least among younger adolescents, perceptions of peer sexual activities greatly influence sexual behaviors, including condom use (Stanton et al., 2002; Holtzman & Rubinson, 1995), and those who discussed sex only with peers were more likely to have multiple partners (Holtzman & Rubinson, 1995). As most of the women interviewed were older, I did not systematically collect information on parent-adolescent communication about sex. Thus, further
research on the dialog between Garifuna mothers and daughters and between peers is warranted to better understand the role of open (or closed) communication on the sexual behaviors of young Garifuna men and women.

The open communication only with partners instead of with family may be a reflection of the increased importance of partners when in a relationship as the result of the decreased presence of consanguineal kin. The unease expressed by women regarding honesty in discussions of HIV, however, is of particular concern because it is related to the HIV stigma present in the community. Research among other groups has demonstrated that not disclosing HIV status to sex partners is related to HIV stigma and social support and is associated with risk factors that increase HIV transmission (Kalichman & Nachimson, 1999; Simbayi et al., 2007; Steward et al., 2008; Wong et al., 2009). Thus, although men and women feel comfortable discussing issues of sexuality, including condom use negotiation among those not married, the perception of dishonesty surrounding HIV discussions may jeopardize the health of individuals and needs to be addressed.

**Infidelity and HIV Risk**

Fidelity in relationships, especially marital unions, has been an important topic in HIV/AIDS research and campaigning, as evidence from around the world suggests that a woman’s greatest risk of contracting HIV is from her husband, largely a result of the husband’s extramarital relations (Trask et al., 2002; Clark, 2004; Clark, Bruce, & Dude, 2006; Hirsch, Higgins, Bentley, & Nathanson, 2002; Wardlow, 2007; Smith, 2007; Parikh, 2007; Painter, Diaby, Matia, Lin, & Sibailly, 2007; Dunkle et al., 2008; Phinney, 2008). Given the fact that male infidelity is responsible for much of women’s HIV, and that around the world men, both single and married, report higher rates of partner change and extramarital relations than women (Jenkins & the National Sex and Reproduction Research Team, 1995; Mercer, Khanam, Gurley,
& Azim, 2007; Opio et al., 2008), it is not surprising that research regarding extramarital relations has focused largely on men. Indeed, much research has been conducted on men’s extramarital activities in general (e.g. Broude, 1980; Jankowiak, Nell, & Buckmaster, 2002; Winking, Kaplan, Gurven, & Rucas, 2007; Jankowiak & Hardgrave, 2007) and the association of these affairs with HIV risk, in particular (e.g. Hirsch et al., 2007; Wardlow, 2007; Smith, 2007; Parikh, 2007; Phinney, 2008). Conversely, less has been written on women’s extramarital relations and those that have generally view women as pursuing relationships for economic survival (an exception is Tawfik & Watkins, 2007).

Transmission of HIV in discordant couples results largely from the reduction of condom use with regular partners, married or not (Mgalla & Pool, 1997; Macaluso, Demand, Artz, & Hook, 2000; Outwater et al., 2000; van Rossem, Meekers, & Akinyemi, 2001; Norman, 2003; Clark, 2004; Maharaj & Cleland, 2005; Westercamp et al., 2008). As a result, multiple regular partnerships have been demonstrated to greatly increase the risk of HIV transmission. Morris and Kretzschmar (1997), for example, used mathematical modeling to compare a population with high concurrent partnerships and a population with serial monogamy. Keeping the total number of sexual partnerships similar, HIV transmission occurred much more rapidly within the population with high prevalence of concurrent partnerships. The resulting epidemic in this population was in fact ten times greater. The model kept the infectivity of HIV constant and thus measured the impact of sexual networking alone. The increased risk of STIs in general, and HIV in particular, with concurrent partnerships has been found based on epidemiological data as well (Rosenberg, Gurvey, Adler, Dunlop, & Ellen, 1999; Koumans et al., 2001; Manhart, Aral, Holmes, & Foxman, 2002; Kelley, Borawski, Flocke, & Keen, 2003; Adimora et al., 2004; Halperin & Epstein, 2004).
Although concurrent sexual partnerships have been the focus of much recent research on HIV transmission, short duration sexual encounters also are important in HIV risk. Particularly, the increased risk of HIV transmission from CSW is extensively documented (e.g. Celentano et al., 1994; Thuy, Nhung, Thuc, Lien, & Khiem, 1998; Kilmarx et al., 1999; Pando et al., 2006; Hagan & Dulmaa, 2007; Wang et al., 2007; Uuskula et al., 2008). The extent to which CSW are visited is unknown, and based on the stories heard it is likely that most extramarital sexual encounters are not with a CSW. While the reduction in regular concurrent partners is a positive change in behavior with respect to HIV risk, overlapping of sexual partnerships and one-time or short-term extramarital relations place individuals at risk of HIV infection as a result of decreased condom use in regular partnerships.

Summary

In exploring how sexual behavior and the risk of HIV infection differs between Trujillo, Honduras and NYC, it was found that although the perception of sexuality among Garinagu in NYC was thought to be freer than among their counterparts in Honduras, large deviations in sexual behaviors compared to their counterparts in Honduras were not observed. Instead, the differences between the sexual behaviors of men and women in NYC differed only subtly from their counterparts in Honduras. This likely results from a combination of changing relationships in NYC and a lack of time to engage in many sexual encounters. For women, the influence of community surveillance is also important in maintaining constraint on their sexuality as it is in Honduras (Kerns, 1992). Second, women exaggerate the cultural notion of the male’s natural inability to be monogamous, resulting in four outcomes: they refuse to have a Garifuna male partner, they simply leave their partners if they find out of infidelities, they ignore their partner’s infidelities to maintain an illusion of family, or devalue their own fidelity and engage in extramarital relations themselves (acting “American”). Those who are most likely to become
involved in extramarital affairs themselves generally do not have children, and thus these affairs prevent them from directly harming their consanguineal kin.

These changes in sexual behavior have varying consequences with regard to HIV risk. Several observed behaviors serve to reduce the risk of HIV transmission:

- Communication among sex partners was high, positively affecting condom use
- Men and women were more likely to report being in a mutually monogamous relationship
- Men and women were less likely to report they had multiple regular sex partners

However, some observed behaviors increase the risk of HIV infection:

- HIV remains highly stigmatized, negatively influencing communication, education, and prevention efforts
- Communication among consanguineal kin regarding sexuality and sexual behaviors was limited
- Condom negotiation among married women remains low
- Dishonesty of communication between partners regarding HIV is common and is related to the stigma surrounding HIV
- Infidelity remains an issue among couples, married or not
- Young women were more likely to be involved in extramarital relations

Thus, a number of continuing and new challenges with respect to HIV face the Garinagu of NYC directly, and the Garinagu of Honduras indirectly through transnational migration. Chapter 7 provides a summary of the research, gives recommendations for action to combat the HIV epidemic among the Garinagu, and describes future research needs.
Table 6-1. Sexual debut and partnerships reported by survey participants in Trujillo, Honduras

<table>
<thead>
<tr>
<th></th>
<th>Men Mean (Range)</th>
<th>Women Mean (Range)</th>
<th>t</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at sexual debut</td>
<td>14.89 (9-22)</td>
<td>18.43 (13-26)</td>
<td>-4.65</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of lifetime sex partners</td>
<td>8.47 (2-20)</td>
<td>3.74 (1-20)</td>
<td>2.93</td>
<td>0.01</td>
</tr>
<tr>
<td>Number of sex partners in previous year</td>
<td>2.50 (0-10)</td>
<td>1.11 (0-5)</td>
<td>2.85</td>
<td>0.01</td>
</tr>
<tr>
<td>Number of sex partners in previous month</td>
<td>1.38 (0-8)</td>
<td>0.37 (0-3)</td>
<td>2.58</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Table 6-2. Socially acceptable behavior by Garifuna men and women in Honduras as reported by survey respondents in Trujillo, Honduras

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>Pearson $\chi^2$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men can have many sex partners</td>
<td>12 (54.5%)</td>
<td>17 (73.9%)</td>
<td>1.84</td>
<td>0.18</td>
</tr>
<tr>
<td>Women can have many sex partners</td>
<td>6 (35.3%)</td>
<td>3 (11.5%)</td>
<td>3.51</td>
<td>0.06</td>
</tr>
<tr>
<td>Men can have sex outside of a relationship</td>
<td>12 (60.0%)</td>
<td>18 (69.2%)</td>
<td>0.43</td>
<td>0.52</td>
</tr>
<tr>
<td>Women can have sex outside of a relationship</td>
<td>7 (46.7%)</td>
<td>5 (17.9%)</td>
<td>4.03</td>
<td>0.05</td>
</tr>
<tr>
<td>Men can buy or obtain condoms</td>
<td>23 (95.8%)</td>
<td>24 (88.9%)</td>
<td>0.85</td>
<td>0.36</td>
</tr>
<tr>
<td>Women can buy or obtain condoms</td>
<td>12 (60.0%)</td>
<td>12 (41.4%)</td>
<td>1.64</td>
<td>0.20</td>
</tr>
<tr>
<td>Men can carry condoms</td>
<td>23 (92.0%)</td>
<td>23 (85.2%)</td>
<td>0.59</td>
<td>0.44</td>
</tr>
<tr>
<td>Women can carry condoms</td>
<td>11 (55.0%)</td>
<td>16 (55.2%)</td>
<td>0.00</td>
<td>0.99</td>
</tr>
</tbody>
</table>

*a Percentages may diff based on incomplete responses.
Table 6-3. Reported sexual partnerships and condom use by survey respondents in Trujillo, Honduras

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>Pearson χ²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regular sex partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25 (86.2%)</td>
<td>23 (63.9%)</td>
<td>4.14</td>
<td>0.04</td>
</tr>
<tr>
<td>No</td>
<td>4 (13.8%)</td>
<td>13 (36.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multiple regular sex partners</strong></td>
<td></td>
<td></td>
<td>1.40</td>
<td>0.24</td>
</tr>
<tr>
<td>Yes</td>
<td>9 (37.5%)</td>
<td>5 (21.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>15 (62.5%)</td>
<td>18 (78.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mutually monogamous relationship</strong></td>
<td></td>
<td></td>
<td>1.34</td>
<td>0.51</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (24.0%)</td>
<td>9 (39.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>9 (36.0%)</td>
<td>6 (26.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>10 (40.0%)</td>
<td>8 (34.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have sex with non-Garifuna</strong></td>
<td></td>
<td></td>
<td>10.14</td>
<td>0.04</td>
</tr>
<tr>
<td>Never</td>
<td>14 (48.3%)</td>
<td>31 (83.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>3 (10.3%)</td>
<td>2 (5.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>9 (31.0%)</td>
<td>3 (8.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>1 (3.4%)</td>
<td>0 (0.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>2 (6.9%)</td>
<td>1 (2.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Condom use</strong></td>
<td></td>
<td></td>
<td>6.12</td>
<td>0.19</td>
</tr>
<tr>
<td>Never</td>
<td>1 (3.4%)</td>
<td>8 (22.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>2 (6.9%)</td>
<td>2 (5.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>7 (24.1%)</td>
<td>10 (28.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>5 (17.2%)</td>
<td>3 (8.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>14 (48.3%)</td>
<td>12 (34.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Condom use at last sexual intercourse</strong></td>
<td></td>
<td></td>
<td>2.09</td>
<td>0.35</td>
</tr>
<tr>
<td>Yes</td>
<td>20 (69.0%)</td>
<td>25 (67.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (20.7%)</td>
<td>11 (29.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>3 (10.3%)</td>
<td>1 (2.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Last sexual intercourse with a regular partner</strong></td>
<td></td>
<td></td>
<td>1.34</td>
<td>0.51</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (72.4%)</td>
<td>23 (65.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (20.7%)</td>
<td>11 (31.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>2 (6.9%)</td>
<td>1 (2.9%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6-4. Correlation matrix of reported condom use and sexual partnerships among male survey participants in Trujillo, Honduras

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Condom use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age of sexual debut</td>
<td>-.27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Lifetime sex partners</td>
<td>.46*</td>
<td>-.44</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sex partners in previous year</td>
<td>.21</td>
<td>-.27</td>
<td>.60**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sex partners in previous month</td>
<td>.27</td>
<td>-.33</td>
<td>.70**</td>
<td>.77**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Comfortable talking about condoms with partner</td>
<td>.70**</td>
<td>.05</td>
<td>.16</td>
<td>-.16</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Comfortable buying/obtaining condoms</td>
<td>.37</td>
<td>-.14</td>
<td>.25</td>
<td>.27</td>
<td>.51*</td>
<td>.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Comfortable talking about HIV with partner</td>
<td>.03</td>
<td>-.07</td>
<td>-.33</td>
<td>-.09</td>
<td>.09</td>
<td>-.23</td>
<td>-.12</td>
<td></td>
</tr>
</tbody>
</table>

* p ≤ 0.05, ** p ≤ 0.01
Table 6-5. Correlation matrix of reported condom use and sexual partnerships among female survey participants in Trujillo, Honduras

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Condom use</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age of sexual</td>
<td></td>
<td>.46**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>debut</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Lifetime sex</td>
<td>.12</td>
<td></td>
<td>.43**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sex partners in</td>
<td>.40*</td>
<td>.61**</td>
<td>.56**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>previous year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sex partners in</td>
<td>.11</td>
<td>.34*</td>
<td>.36*</td>
<td>.28</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>previous month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Comfortable</td>
<td>.57**</td>
<td></td>
<td>.01</td>
<td>.14</td>
<td>.15</td>
<td>.07</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>talking about</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>condoms with partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Comfortable</td>
<td>.52**</td>
<td>.13</td>
<td>.35</td>
<td>.18</td>
<td>-.00</td>
<td>.36</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>buying/obtaining</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>condoms</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Comfortable</td>
<td>-.01</td>
<td>.38</td>
<td>.27</td>
<td>-.16</td>
<td>-.02</td>
<td>.41</td>
<td>-.13</td>
<td>-</td>
</tr>
<tr>
<td>talking about HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p ≤ 0.05, ** p ≤ 0.01
Table 6-6. Sexual debut and partnerships reported by survey participants in New York City

<table>
<thead>
<tr>
<th></th>
<th>Men Mean (Range)</th>
<th>Women Mean (Range)</th>
<th>t</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at sexual debut</td>
<td>15.46 (10-30)</td>
<td>18.21 (9-25)</td>
<td>-3.71</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of lifetime sex partners</td>
<td>10.10 (1-100)</td>
<td>3.38 (1-9)</td>
<td>1.82</td>
<td>0.08</td>
</tr>
<tr>
<td>Number of sex partners in previous year</td>
<td>2.64 (0-20)</td>
<td>0.91 (0-3)</td>
<td>2.85</td>
<td>0.01</td>
</tr>
<tr>
<td>Number of sex partners in previous month</td>
<td>0.54 (0-3)</td>
<td>0.11 (0-2)</td>
<td>3.13</td>
<td>0.003</td>
</tr>
</tbody>
</table>

Table 6-7. Socially acceptable behavior by Garifuna men and women in New York City as reported by survey respondents in New York Citya

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>Pearson $\chi^2$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men can have many sex partners</td>
<td>12 (57.1%)</td>
<td>27 (79.4%)</td>
<td>3.12</td>
<td>0.08</td>
</tr>
<tr>
<td>Women can have many sex partners</td>
<td>5 (26.3%)</td>
<td>9 (26.5%)</td>
<td>0.00</td>
<td>0.99</td>
</tr>
<tr>
<td>Men can have sex outside of a relationship</td>
<td>14 (70.0%)</td>
<td>28 (84.8%)</td>
<td>1.67</td>
<td>0.20</td>
</tr>
<tr>
<td>Women can have sex outside of a relationship</td>
<td>6 (33.3%)</td>
<td>14 (41.2%)</td>
<td>0.31</td>
<td>0.58</td>
</tr>
<tr>
<td>Men can buy or obtain condoms</td>
<td>17 (85.0%)</td>
<td>34 (100%)</td>
<td>5.40</td>
<td>0.02</td>
</tr>
<tr>
<td>Women can buy or obtain condoms</td>
<td>11 (61.1%)</td>
<td>25 (75.8%)</td>
<td>1.20</td>
<td>0.27</td>
</tr>
<tr>
<td>Men can carry condoms</td>
<td>17 (85.0%)</td>
<td>31 (88.6%)</td>
<td>0.15</td>
<td>0.70</td>
</tr>
<tr>
<td>Women can carry condoms</td>
<td>10 (55.6%)</td>
<td>22 (62.9%)</td>
<td>0.27</td>
<td>0.61</td>
</tr>
</tbody>
</table>

a Percentages may diff based on incomplete responses.
Table 6-8. Reported sexual partnerships and condom use by survey respondents in New York City

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>Pearson $\chi^2$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular sex partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32 (72.7%)</td>
<td>37 (75.5%)</td>
<td>0.09</td>
<td>0.76</td>
</tr>
<tr>
<td>No</td>
<td>12 (27.3%)</td>
<td>12 (24.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple regular sex partners</td>
<td></td>
<td></td>
<td>3.02</td>
<td>0.08</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (19.4%)</td>
<td>2 (5.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>25 (80.6%)</td>
<td>34 (94.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutually monogamous relationship</td>
<td></td>
<td></td>
<td>3.46</td>
<td>0.17</td>
</tr>
<tr>
<td>Yes</td>
<td>19 (59.4%)</td>
<td>22 (59.5%)</td>
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</tr>
<tr>
<td>No</td>
<td>8 (25.0%)</td>
<td>4 (10.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>5 (15.6%)</td>
<td>11 (29.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have sex with non-Garifuna</td>
<td></td>
<td></td>
<td>9.30</td>
<td>0.05</td>
</tr>
<tr>
<td>Never</td>
<td>18 (45.0%)</td>
<td>28 (63.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>6 (15.0%)</td>
<td>7 (15.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>14 (35.0%)</td>
<td>4 (9.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>0 (0.0%)</td>
<td>1 (2.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>2 (5.0%)</td>
<td>4 (9.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
<td>6.83</td>
<td>0.15</td>
</tr>
<tr>
<td>Never</td>
<td>6 (15.4%)</td>
<td>12 (25.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>4 (10.3%)</td>
<td>3 (6.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>5 (12.8%)</td>
<td>14 (29.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>7 (17.9%)</td>
<td>4 (8.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>17 (43.6%)</td>
<td>14 (29.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last sexual intercourse</td>
<td></td>
<td></td>
<td>9.69</td>
<td>0.01</td>
</tr>
<tr>
<td>Yes</td>
<td>30 (69.8%)</td>
<td>19 (38.8%)</td>
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<tr>
<td>No</td>
<td>12 (27.9%)</td>
<td>12 (27.9%)</td>
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<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>1 (2.3%)</td>
<td>6 (12.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last sexual intercourse with a regular partner</td>
<td></td>
<td></td>
<td>1.79</td>
<td>0.41</td>
</tr>
<tr>
<td>Yes</td>
<td>33 (78.6%)</td>
<td>43 (87.8%)</td>
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<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (14.3%)</td>
<td>3 (6.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>3 (7.1%)</td>
<td>3 (6.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>1. Condom use</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age of sexual debut</td>
<td>-.05</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Lifetime sex partners</td>
<td>-.08</td>
<td>-.27</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>4. Sex partners in previous year</td>
<td>.21</td>
<td>-.18</td>
<td>.67**</td>
<td>-</td>
</tr>
<tr>
<td>5. Sex partners in previous month</td>
<td>-.02</td>
<td>-.11</td>
<td>.43*</td>
<td>.41*</td>
</tr>
<tr>
<td>6. Comfortable talking about condoms with partner</td>
<td>.49**</td>
<td>-.36*</td>
<td>.29</td>
<td>.30</td>
</tr>
<tr>
<td>7. Comfortable buying/obtaining condoms</td>
<td>.45**</td>
<td>-.25</td>
<td>-.13</td>
<td>-.04</td>
</tr>
<tr>
<td>8. Comfortable talking about HIV with partner</td>
<td>-.18</td>
<td>-.02</td>
<td>.14</td>
<td>.18</td>
</tr>
</tbody>
</table>

* p ≤ 0.05, ** p ≤ 0.01
Table 6-10. Correlation matrix of reported condom use and sexual partnerships among female survey participants in New York City

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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</thead>
<tbody>
<tr>
<td>1. Condom use</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Age of sexual debut</td>
<td>-.14</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Lifetime sex partners</td>
<td>.14</td>
<td>-.58**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sex partners in previous year</td>
<td>.12</td>
<td>-.45**</td>
<td>.39**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sex partners in previous month</td>
<td>-.22</td>
<td>-.36*</td>
<td>.27</td>
<td>.21</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Comfortable talking about condoms with partner</td>
<td>.48**</td>
<td>.13</td>
<td>-.20</td>
<td>-.03</td>
<td>-.36*</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Comfortable buying/obtaining condoms</td>
<td>.57**</td>
<td>-.11</td>
<td>.08</td>
<td>-.04</td>
<td>-.20</td>
<td>.58**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>8. Comfortable talking about HIV with partner</td>
<td>.33*</td>
<td>.22</td>
<td>.05</td>
<td>.02</td>
<td>-.35*</td>
<td>.66**</td>
<td>.41*</td>
<td>-</td>
</tr>
</tbody>
</table>

* p ≤ 0.05, ** p ≤ 0.01
<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th></th>
<th></th>
<th>Women</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trujillo</td>
<td>NYC</td>
<td>t</td>
<td>Trujillo</td>
<td>NYC</td>
<td>t</td>
</tr>
<tr>
<td>Mean age at sexual debut</td>
<td>14.89</td>
<td>15.46</td>
<td>-0.63</td>
<td>0.53</td>
<td>18.43</td>
<td>18.21</td>
</tr>
<tr>
<td>Mean number of lifetime sex partners</td>
<td>8.47</td>
<td>10.10</td>
<td>-0.35</td>
<td>0.73</td>
<td>3.74</td>
<td>3.38</td>
</tr>
<tr>
<td>Mean number of sex partners in</td>
<td>2.5</td>
<td>2.64</td>
<td>-0.17</td>
<td>0.86</td>
<td>1.11</td>
<td>0.91</td>
</tr>
<tr>
<td>previous year</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Mean number of new sex partners in</td>
<td>1.38</td>
<td>0.54</td>
<td>2.13</td>
<td>0.04</td>
<td>0.37</td>
<td>0.11</td>
</tr>
<tr>
<td>previous month</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Table 6-12. Reported sexual behaviors among Garifuna males in Trujillo, Honduras and New York City

<table>
<thead>
<tr>
<th></th>
<th>Trujillo (%)</th>
<th>NYC (%)</th>
<th>Pearson $\chi^2$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular sex partner</td>
<td></td>
<td></td>
<td>1.86</td>
<td>0.17</td>
</tr>
<tr>
<td>Yes</td>
<td>25 (86.2%)</td>
<td>32 (72.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4 (13.8%)</td>
<td>12 (27.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple regular sex partners</td>
<td></td>
<td></td>
<td>2.25</td>
<td>0.13</td>
</tr>
<tr>
<td>Yes</td>
<td>9 (37.5%)</td>
<td>6 (19.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>15 (62.5%)</td>
<td>25 (80.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutually monogamous relationship</td>
<td></td>
<td></td>
<td>7.74</td>
<td>0.02</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (24.0%)</td>
<td>19 (59.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>9 (36.0%)</td>
<td>8 (25.0%)</td>
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</tr>
<tr>
<td>Unsure</td>
<td>10 (40.0%)</td>
<td>5 (15.6%)</td>
<td></td>
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</tr>
<tr>
<td>Have sex with non-Garifuna</td>
<td></td>
<td></td>
<td>1.88</td>
<td>0.76</td>
</tr>
<tr>
<td>Never</td>
<td>14 (48.3%)</td>
<td>18 (45.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>3 (10.3%)</td>
<td>6 (15.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>9 (31.0%)</td>
<td>14 (35.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>1 (3.4%)</td>
<td>0 (0.0%)</td>
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</tr>
<tr>
<td>Always</td>
<td>2 (6.9%)</td>
<td>2 (5.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
<td>3.81</td>
<td>0.43</td>
</tr>
<tr>
<td>Never</td>
<td>1 (3.4%)</td>
<td>6 (15.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>2 (6.9%)</td>
<td>4 (10.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>7 (24.1%)</td>
<td>5 (12.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>5 (17.2%)</td>
<td>7 (17.9%)</td>
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<td></td>
</tr>
<tr>
<td>Always</td>
<td>14 (48.3%)</td>
<td>17 (43.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last sexual intercourse</td>
<td></td>
<td></td>
<td>2.37</td>
<td>0.31</td>
</tr>
<tr>
<td>Yes</td>
<td>20 (69.0%)</td>
<td>30 (69.8%)</td>
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</tr>
<tr>
<td>No</td>
<td>6 (20.7%)</td>
<td>12 (27.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>3 (10.3%)</td>
<td>1 (2.3%)</td>
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</tr>
<tr>
<td>Last sexual intercourse with a regular partner</td>
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<td></td>
<td>0.50</td>
<td>0.78</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (72.4%)</td>
<td>33 (78.6%)</td>
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<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (20.7%)</td>
<td>6 (14.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>2 (6.9%)</td>
<td>3 (7.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table 6-13. Reported sexual behaviors among Garifuna females in Trujillo, Honduras and New York City</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Regular sex partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23 (63.9%)</td>
<td>37 (7505%)</td>
<td>1.35</td>
<td>0.25</td>
</tr>
<tr>
<td>No</td>
<td>13 (36.1%)</td>
<td>12 (24.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple regular sex partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (21.7%)</td>
<td>2 (5.6%)</td>
<td>3.52</td>
<td>0.06</td>
</tr>
<tr>
<td>No</td>
<td>18 (78.3%)</td>
<td>34 (94.4%)</td>
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</tr>
<tr>
<td>Mutually monogamous relationship</td>
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</tr>
<tr>
<td>Yes</td>
<td>9 (39.1%)</td>
<td>22 (59.5%)</td>
<td>3.24</td>
<td>0.20</td>
</tr>
<tr>
<td>No</td>
<td>6 (26.1%)</td>
<td>4 (10.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>8 (34.8%)</td>
<td>11 (29.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have sex with non-Garifuna</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>31 (83.8%)</td>
<td>28 (63.6%)</td>
<td>5.31</td>
<td>0.26</td>
</tr>
<tr>
<td>Rarely</td>
<td>2 (5.4%)</td>
<td>7 (15.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>3 (8.1%)</td>
<td>4 (9.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>0 (0.0%)</td>
<td>1 (2.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>1 (2.7%)</td>
<td>4 (9.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>8 (22.9%)</td>
<td>12 (25.5%)</td>
<td>0.21</td>
<td>0.99</td>
</tr>
<tr>
<td>Rarely</td>
<td>2 (5.7%)</td>
<td>3 (6.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>10 (28.6%)</td>
<td>14 (29.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>3 (8.6%)</td>
<td>4 (8.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>12 (34.3%)</td>
<td>14 (29.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last sexual intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25 (69.0%)</td>
<td>19 (38.8%)</td>
<td>7.69</td>
<td>0.02</td>
</tr>
<tr>
<td>No</td>
<td>11 (29.7%)</td>
<td>12 (27.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>1 (2.7%)</td>
<td>6 (12.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last sexual intercourse with a regular partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23 (65.7%)</td>
<td>43 (87.8%)</td>
<td>9.56</td>
<td>0.01</td>
</tr>
<tr>
<td>No</td>
<td>11 (31.4%)</td>
<td>3 (6.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td>1 (2.9%)</td>
<td>3 (6.1%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

199
Table 6-14. Regression of reported number of lifetime sex partners and sexual partners in the previous year on age, sex, relationship status, and years lived in the United States among Garifuna survey participants in New York City; standardized regression coefficients

<table>
<thead>
<tr>
<th>Variables</th>
<th>Lifetime sex partners</th>
<th>Sex partners in previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.01</td>
<td>.14</td>
</tr>
<tr>
<td>Sex</td>
<td>-2.30*</td>
<td>-3.05**</td>
</tr>
<tr>
<td>Relationship status</td>
<td>0.24</td>
<td>.11</td>
</tr>
<tr>
<td>Years lived in the U.S.</td>
<td>1.24</td>
<td>.08</td>
</tr>
</tbody>
</table>

Adjusted $R^2$ 0.09 0.11

* $p \leq 0.05$, ** $p \leq 0.01$

Table 6-15. Regression of reported fidelity\(^a\) on marital status, age, sex, and years lived in the United States among Garifuna survey participants; odds ratio

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td>.553</td>
<td>.687</td>
<td>.497</td>
</tr>
<tr>
<td>Age</td>
<td>1.019</td>
<td>.994</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>.483</td>
<td>.344</td>
<td></td>
</tr>
<tr>
<td>Years lived in the U.S.</td>
<td></td>
<td></td>
<td>1.086</td>
</tr>
</tbody>
</table>

\(^a\) Reported fidelity was classified as 1: mutually monogamous, or 2: not mutually monogamous or unsure.
Table 6-16. Regression of reported number of sex partners in the previous year on marital status, age, sex, and years lived in the United States among Garifuna survey participants; standardized regression coefficients

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td>.148</td>
<td>.196</td>
<td>.197</td>
</tr>
<tr>
<td>Age</td>
<td>.099</td>
<td>.102</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>-.340*</td>
<td>-.339*</td>
<td></td>
</tr>
<tr>
<td>Years lived in the U.S.</td>
<td></td>
<td>-.008</td>
<td></td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>.009</td>
<td>.114</td>
<td>.103</td>
</tr>
</tbody>
</table>

* $p = 0.002$

Figure 6-1. Number of reported sex partners in the previous year by Garifuna men in New York City by relationship status
Figure 6-2. Number of reported sex partners in the previous year by Garifuna women in New York City by relationship status.

Figure 6-3. Reported condom use among survey participants in New York City not in a mutually monogamous relationship or unsure of their partner’s fidelity.
CHAPTER 7
RECOMMENDATIONS AND CONCLUSIONS

Introduction

This research aimed to explore the intersection of gender roles, transnational migration, and HIV risk among the Garinagu of Honduras and NYC through the following research questions: 1) How do gender roles and male-female relations among Garifuna in NYC compare to those among Garifuna in Honduras? and 2) How do sexual behavior and HIV risk among Garifuna in NYC compare to those among Garifuna in Honduras? Data collection occurred in Trujillo, Honduras between July and October 2007 and in NYC between December 2007 and May 2008. The exploratory research utilized the following qualitative and quantitative methods: participant observation, semi-structured interviews with female community members, semi-structured interviews with community leaders, and an anonymous survey given to men and women. Specific findings for each question were provided in Chapters 5 and 6, respectively. This concluding chapter provides a summary of the results, recommendations for reducing HIV risk among the Garinagu in NYC, and needs of future research.

Summary of Findings

To determine how transnational migration has influenced gender roles and male-female relations among the Garinagu of NYC, the following domains were considered: employment, households, partnerships, and children and childcare. Adult men and women largely migrate to the U.S. for economic reasons, and most are able to find employment. Men often work with the Merchant Marines, in construction, or in maintenance. Women largely find employment in the health sector, as nurses, home aids, or medical billing specialists. Few women were unemployed, and this was generally by choice. Overall, men and women were equally likely to be employed, and among those employed full-time there was no significant difference in
reported monthly incomes. It was largely observed that matrofocality remains, although it is transformed and adapted to the new lives of the Garinagu in NYC. Households predominately consist of female kin (although they tend to be smaller and more stable), all of the women interviewed sent remittances to family members in Honduras (these family members were largely maternal kin), and maternal kin in Honduras were most commonly charged with caring for the children of migrants left at home. Additionally, Garifuna women in NYC still define themselves through their culture and family and place emphasis on child rearing. However, Garifuna in NYC experience more distance from family, both in the U.S. (largely as a result of long work hours) and back home (a result of distance) and are more likely to legally marry their partners. These relationships were described as a partnership, with each person participating in household tasks and decision-making. As a result of these changes, two themes emerged – women become more independent in general, and greater equality between men and women develops.

These interconnected themes affect sexual relationships and behaviors and therefore HIV risk. First, it was found that the perception of sexuality among Garinagu in NYC was exaggerated by community members in both Honduras and NYC. Although Garifuna in both locations thought greater sexual freedom existed among Garifuna women in NYC, large deviations with respect to sexual behaviors were not observed between the two locations. Instead, the differences between the sexual behaviors of men and women in NYC differed only subtly from their counterparts in Honduras. This likely results from a combination of changing relationships in NYC and a lack of time to engage in many sexual encounters. For women, the influence of community surveillance is also important in maintaining constraint on their sexuality. Second, women exaggerate the cultural notion of the male’s natural inability to be
monogamous, resulting in four outcomes: they refuse to have a Garifuna male partner, they simply leave their partners if they find out of infidelities, they ignore their partner’s infidelities to maintain an illusion of family, or devalue their own fidelity and engage in extramarital relations themselves (thereby acting “American”). Those who are most likely to become involved in extramarital affairs themselves generally do not have children, and thus these affairs prevent them from directly harming their consanguineal kin.

These changes in sexual behavior have varying consequences with regard to HIV risk. Several observed behaviors serve to reduce the risk of HIV transmission. These include communication among sex partners, which positively affected condom use, increased reporting of mutually monogamous relationships, and a decreased reporting of multiple regular sex partnerships. However, some observed behaviors increase the risk of HIV infection. These included a reduction in communication among consanguineal kin regarding sexuality and sexual behaviors, low condom negotiation among married women, dishonesty of communication between partners regarding HIV, continued infidelity in general, including among married couples, and increased involvement in extramarital relations by young women. Thus, a number of continuing and new challenges with respect to HIV face the Garinagu of NYC directly, and the Garinagu of Honduras indirectly through transmigration.

Recommendations

Several recommendations can be devised from the conclusions presented in Chapters 5 and 6. First, unlike in Trujillo, Honduras, where very little stigma surrounded HIV, much of the problems regarding HIV risk in NYC are related to, or exasperated by, the stigma present with respect to HIV. Stigma associated with HIV undermines public health efforts, and thus the need to reduce stigma associated with HIV and discrimination of HIV-positive persons is of utmost importance (Malcolm et al., 1998; UNAIDS, 2000; UNAIDS, 2002a; UNAIDS, 2002b).
However, issues of stigma and discrimination have been poorly understood and often marginalized within programs to combat HIV/AIDS (Parker & Aggleton, 2003).

Two recommendations are provided here for addressing this stigma. First, the perpetuation of stigma and discrimination that serves to strengthen and reproduce inequalities of class, race, and nationality must be addressed in the U.S., through reexamination of government policy and mass media accountability. Second, stigma can be confronted within the Garifuna community itself. Due to the importance of music among the Garinagu and the leadership positions of many Garifuna musicians in NYC, musicians can incorporate HIV education into songs of cultural pride, challenging the community to engage in open discussion and take responsibility for their epidemic. The use of entertainment-education has been documented in numerous locations and has been found to be very successful in promoting changes in attitudes and behaviors, including in Trujillo (Goldstein et al., 2000; Panford, Nyaney, Amoah, & Aidoo, 2001; Meekers & van Rossem, 2004; Sood, Singhal, & Law, 1997; Poindexter, 2004; Vaughan, Rogers, Singhal, & Swalehe, 2000; Singal & Rogers, 1999; Watts, 1998).

It is vital, however, that sexual behaviors that increase HIV risk not become associated with immorality. Recent research on extramarital relationships has shown that the association of infidelity with immorality leads to a focus on secrecy and not protection (Hirsh et al., 2007; Parikh, 2007; Smith, 2007). These recommendations and considerations are discussed at length in this sub-section.

**Reduction of Stigma Surrounding HIV/AIDS**

The differences observed with respect to HIV stigma may be partially influenced by the timing of migration, whereby most migrants arrived in the U.S. before changes occurred in Trujillo, as well as by migrants from other parts of Honduras where stigma associated with HIV has not been successfully reduced. Additionally, once in the U.S., stigma may continue as a
result of competing minority status markers. Bryce-Laporte (1972), one of the earliest social scientists to consider the unique experience of black immigrants, argued that black immigrants experienced more competing pressures, affiliations, and inequalities than native blacks and Caucasian immigrants. He described their national presence as one of double invisibility – first as blacks and second as foreigners. For the Garinagu in NYC, they are 1) black, 2) migrants, 3) Hispanic, and 4) Garifuna; all of these place the individual and group within multiple minority categories that are often discriminated against. In a context in which immigrants are already associated with disease, adding HIV to this list may be too much to bear, creating an environment susceptible to HIV stigma and denial. Thus, combating the stigma associated with HIV is necessary at two levels. First, harmful associations of immigrants and disease must be challenged in U.S., and second, the stigma specific to the Garifuna community must be addressed by the community directly to promote reduction of HIV risk behaviors.

(a) Awareness of discourse associating migrants with disease and its role in producing stigma. U.S. government regulations and mass media discussions regarding immigration and disease are important in the continuation of stigma surrounding HIV/AIDS in general and within migrant communities, including the Garifuna community. Stigma has long been recognized as a hindrance to combating HIV epidemics worldwide and the need to fight it has been stated by HIV researchers for decades (Mann, 1987; Piot, 2000; UNAIDS, 2002a; Parker & Aggleton, 2003).

Parker and Aggleton (2003) argue that part of the difficulty of effectively dealing with stigma results from the lack of theoretical and methodological tools to do so. Researchers often treat stigma as a static attribute instead of a malleable social process (that is often resisted). Additionally, research is generally individualistic, considering the perceptions of individuals and
the consequences that perception of stigma have on the life of the individual. Less consideration has been provided to the structural conditions that create or perpetuate stigma surrounding HIV. Parker and Aggleton (2003) believe it is vitally important that stigma be understood as a process that arises and takes shape within contexts of culture and power. Therefore, it is necessary to examine how individuals, communities, and the state create and reproduce social inequality. Considering stigma in this manner requires a focus on the political economy of stigmatization and its connections to social exclusion (Parker & Aggleton, 2003).

Under this conceptualization, stigma, according to Parker and Aggleton (2003, p. 18), is “deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality.” Using the notions of symbolic violence (Bourdieu, 1991; Bourdieu & Wacquant, 1992; Bourdieu & Passeron, 1990) and hegemony (Lears, 1985; Gill & Law, 1989), dominant meanings and values occur in such a way that structures of social inequality are legitimized, even to those who are the objects of domination (Parker & Aggleton, 2003).

The removal of HIV from the list of communicable diseases of public health significance is one important step in fighting stigma around migrants and HIV in the U.S. Dr. Martin Cetron, director of the CDC’s Division of Global Migration and Quarantine, said: “We’re trying to end the stigma and the discriminatory practice for a disease that doesn’t warrant exclusion for coming into this country. We have to appreciate this is not a threat we face from abroad” (Aleccia, 2009). Likewise, Secretary of Health and Human Services Kathleen Sebelius (2009) stated in the press release about the repeal of the HIV entry ban: “Though the United States has been a leader worldwide when it comes to ending the stigma of HIV/AIDS, we’ve been one of only 12 countries who, by their policies, still enable the myth that HIV/AIDS is a threat. Lifting
the HIV ‘entry ban’ represents [a] blow against stigma.” Thus, the removal of HIV from the list of diseases of public health significant is extremely important in fighting the harmful association of migrants and disease.

Although progress is being made to reduce negative associations of immigrants and disease at the level of U.S. policy at least with respect to HIV, popular media continues to perpetuate this association, often with overstated claims of causality. Although rarely used, one of the more effective methods of intervention is the mobilization of those groups and/or communities facing stigmatization (Altman, 1994; Daniel & Parker, 1993; Stoller, 1998; Parker & Aggleton, 2003). Mobilization of people in general, and affected populations in particular, may be beneficial in several ways.

Mobilization of groups to demand responsible and accurate reporting may greatly impact the perceptions of viewers maintaining an “us’ versus “them” position, reducing hostilities towards immigrants in general and exaggerated associations of migrants and disease in particular that produce and reproduce stigma and inequality.

(b) Utilization of music and cultural pride. While stigma must be understood and challenged at the larger societal level, it can also be confronted within the community itself. Most Garifuna I met in NYC were proud to be Garifuna and were generally excited to talk to me about the culture. Attaching HIV education and prevention to this community pride, specifically through music, could encourage individuals to take action against the epidemic in the community. Musicians could greatly influence this movement. While discussing various issues in the Garifuna community with community leaders, I was told that musicians are currently leading the community in terms of cultural preservation. I was fortunate to meet several of the musicians named, and learn of their work in the community. Additionally, many of the
community members I talked to discussed their love of music, particularly the punta rock and reggaeton performed by their own community members. While I was in NYC, Andy Palacio, the creator of punta rock and a cultural icon, died suddenly. Emails were quickly passed around the community and websites were immediately spreading the sad information. A tribute was organized to honor Palacio and was attended by hundreds of community members who watched performances by local Garifuna musicians and dancers, saw scenes of the burial procession in Belize, and joined in the singing of Palacio’s music. This event further demonstrated the important role of music in the community as a symbol of Garifuna culture and pride.

The use of music to educate community members about HIV/AIDS, encourage open and honest communication, address the role of infidelity, and challenge the stigma associated with HIV may be of great benefit. Many examples of the use of entertainment to combat social problems, often utilizing folk media, demonstrate the effectiveness of this approach, including one in Honduras. The strategy, called entertainment-education, is the process of designing and implementing entertaining programs to educate community members about certain topics, influence attitudes, and change overt behaviors (Vaughan, Rogers, Singhal, & Swalehe, 2000). Examples have been documented in various locations, including South Africa (Goldstein et al., 2000), Ghana (Panford et al., 2001), Zambia (Meekers & van Rossem, 2004), India (Sood et al., 1997), Costa Rica (Poindexter, 2004), St. Lucia (Vaughan, Regis, & St. Catherine, 2000), Mexico (Singhal & Rogers, 1999), and Japan (Watts, 1998). Many of these examples are radio or television dramas, much like the radio drama “Los Ancestros no Mueren” (The Ancestors Never Die) that was described in Chapter 2 and was aired in Honduras in Spanish and Garifuna. However, any medium that exists in a community to convey messages in a culturally appropriate manner can be used. Music is and historically has been used among the Garinagu to discuss
various topics including religion, history, and migration, and the use of the Garifuna language in songs is currently one way the language is being taught to younger community members. Using music to educate about HIV and motivate community and personal responsibility, while attaching these issues to pride in the culture, is an appropriate action that is relatively cheap and time efficient compared to alternative forms of entertainment-education.

Due to the importance of music in the community, ample opportunities are available for the use of music aimed to promote HIV awareness and prevention. Music is performed in clubs, at parties, and at the numerous cultural events that occur throughout the year, including the annual Garifuna Community Forum and Independence Parade. Youth ensembles, young adult bands, adult choirs, and dancers can be utilized in various ways and at various events to provide entertainment as well as information in a fun, non-threatening manner.

**Preventing the Association of HIV and Immorality**

As previously discussed, infidelity is an important factor in the HIV epidemic among the Garinagu. Indeed, many people identified this as the most important issue with respect to HIV and saw the promotion of fidelity among couples as the solution to the HIV problem in the community. Additionally, for many individuals, fidelity was associated with the Christian church. Laughing, one woman said that for a Garifuna couple to be mutually monogamous, “I think that both of them have to go to church!” While the promotion of fidelity is only one component of HIV prevention, it is crucial that HIV prevention campaigns avoid the association of HIV risk behaviors and immorality, which sometimes results from HIV prevention campaigns.

Recent ethnographic research on extramarital relationships demonstrate that notions of sexual immorality do not necessarily cause people to cease their relationships outside of their marriage, but instead change the social landscape of these affairs (Hirsch et al., 2007; Parikh, 2007; Smith, 2007). In an effort to avoid public scorn and domestic conflict, the adulterer’s
primary concern is secrecy and not protection (Parikh, 2007). Hirsch and colleagues (2007) note that “safe sex” becomes defined not in terms of condom use but instead in terms of discretion. For Garifuna men and women, secrecy could allow the continuation of their partnership in an environment where consanguineal family is not as abundant and household transition is more difficult. Additionally, for women, secrecy could reduce the threat of community gossip, intimate partner violence, and dissolution of their partnership and financial support. More research is warranted about this occurrence; however, the importance placed on infidelity in the Garinagu HIV epidemic and the common association in the community of fidelity and the Christian church necessitates the warning of associating fidelity and morality based on the recent literature.

**Future Research Needs**

Several areas of investigation among the Garinagu with respect to HIV/AIDS that require research presented themselves during the course of the current work. First, as previously discussed, the current research did not include gender identity or acculturation measures. Although years lived in the U.S. was used as a proxy measure for acculturation, there are limitations to this as discussed. Thus, research is warranted that considers these individualized experiences and their influence on gender roles and sexual behaviors. For example, when discussing the role of men and women within households, women often referred to the reduction of machismo among Garifuna men in the U.S. The use of a gender identity scale can illuminate the role of machismo-like attitudes and behaviors and consider these in association with sexual behaviors among Garifuna men in the U.S. Additionally, many women referred to young women who cheated on their partner as “Americanized.” Using a multidimensional scale of acculturation could aid in the understanding of women’s infidelity.
Since infidelity was found to be an important topic among the Garinagu in Honduras as well as NYC, further research is warranted on the topic, especially since it plays a key role in the continuation of HIV transmission in the community. Ethnographic research on extramarital relationships in general is scarce as infidelity tends to be highly morally charged and generally occurs in private settings (Smith, 2008). However, recent anthropological inquiry demonstrates the important information to be gained from ethnographic research concerning infidelity with regard to HIV risk (Hirsch et al., 2007; Parikh, 2007; Smith, 2007). Although women also participate in sexual relationships outside of their primary relationship, the majority of infidelities occur by men. Thus, a more nuanced understanding of these relationships would greatly aid in the understanding of HIV risk among the Garinagu, both in Central America and the U.S. By conducting research on infidelities by Garifuna men, prevention campaigns designed to reduce the risk of HIV infections during these encounters will be better informed.

In addition to the numerous stories of women and men becoming infected with HIV as a result of unfaithful partners, numerous stories were also told of community members becoming infected during migrant travel to Honduras. In Honduras, these stories involved a migrant male visiting the town and engaging in sexual relationships with numerous women, infecting many of them. In NYC, the stories sometimes told of an HIV infected man returning to Honduras and infecting the women there, and sometimes told of a migrant returning home only to become infected while there. Although migrants return so frequently that there is little excitement generated by their return, migrants are seen as having greater access to wealth and often draw the attention of women hoping for immediate or long-term financial gain. Some people claimed romances with return migrants occurred in the hopes of receiving remittance money, while others simply wanted to be taken out to eat at one of the nicer restaurants on the beach. While in
Honduras I befriended a migrant who was in town on vacation. He told me of his frustrations with his return migration status, claiming that many of his male friends were jealous of him because of his financial success overseas and his ability to “get any Garifuna woman” in Honduras. The role of return migrants in perpetuating the epidemic is without doubt important; however, it warrants better understanding to facilitate education campaigns and possibly development campaigns if structural factors are in fact the motivating factor for these unsafe sexual relationships.

Finally, although the current research did not aim to identify Garifuna in NYC with or without documentation, most of the participants were in the U.S. as legal residents or citizens. The challenges faced by migrants without documentation are unique and often place the migrant in situations that increase the risk for HIV infection. Most Garifuna in the U.S. have legal documentation, and no research specifically regarding Garifuna migrants without documentation has been conducted.

**Conclusion**

The HIV epidemic is often called the most severe health crisis of modern times. Anthropological research has greatly added to the early prevention efforts that were largely medically and epidemiologically driven by fostering the development of ethnographically grounded education campaigns that are community based and highlighting structural factors that drive the epidemic (Farmer, 1992; Parker, 2001; Shedlin & Shulman, 2004; Chavez, 2003; Hirsch, 2003b). The importance of gender inequality in the continued expansion of the epidemic has been noted (UNAIDS, 2008b). In addition, researchers have recently poised that “sexual opportunity structures,” or structural factors that increase the chance of sexual interaction, occur at the intersection of gender, poverty, and migration (Dworkin & Ehrhardt, 2007).
For the Garinagu, a matrifocal Afro-Amerindian population from Central America, the HIV/AIDS epidemic is tied to the survival of the culture. Largely as a result of migration, projections were once made the culture would not survive through the beginning of 21st century. Today, the Garifuna language is considered endangered and new threats to the culture have developed. One of these threats is the HIV/AIDS epidemic, which has disproportionately affected the Garinagu in Central America. Migration plays an important role in both the dispersion of the community members and the threat of HIV/AIDS, but ironically is currently believed to be economically necessary for the survival of the Garifuna communities in Central America. Thus, the need to understand the epidemic and curtail HIV transmission is of immediate concern.
**APPENDIX A**

**HOUSEHOLD COMPOSITION FORM**

### Adults living in household

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Comments</th>
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### Children living in household

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Father (and mother if not own children)</th>
<th>Comments</th>
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</table>

Total number of people living in the household ____________

Are there any other people who live here from time to time?
APPENDIX B
INTERVIEW GUIDE: HONDURAS

How are you?

Tell me a little about yourself. (Fill out household form here).

Prompt Questions: Have you ever lived in the United States?

Describe a typical day for you.

Prompt Questions: What are your responsibilities? Do you work outside the home? If so, what do you do? Have you ever worked outside your village? Have you ever worked in the United States?

In your opinion, what are the most important parts of being a Garifuna woman?

Do you think it is important for a Garifuna woman to have children? How do you feel about a Garifuna woman NOT having children?

Prompt Questions: How many children should a Garifuna woman have? Why do you think having children is/is not important? How have you prevented pregnancy in the past? How do you prevent pregnancy now?

What makes a good partner?

Prompt Questions: What qualities do you like in a man? Is it important for your family to get along with your partner? When you have a male partner, what do they do to help you? Does your partner need to be from your same town? Does migration affect the ability of a man to be a good partner?

Is it important to have a partner? Why or why not?

Prompt Questions: Does your typical routine change when you have a partner compared to when you don’t? Does having a partner or not having a partner affect your children in any way?

How many relationships have you had?

Prompt Questions: How old were you when you first had a male partner? How long have these relationships lasted? Do all partnerships involve a sexual relationship? Where you legally married to any of them? Why did the relationships end? During your partnerships were you faithful to him? Was he faithful to you?

Could you tell me about your first male partner and your relationship with him?
Prompt Questions: How old were you when you started this relationship? How long did the relationship last? Did it involve a sexual relationship? Where you legally married? Why did the relationships end? During your partnership were you faithful to him? Was he faithful to you?

Do you have a partner now? Can you tell me about your current/last partner and your relationship with him?

Prompt Questions: How long have you been with this partner? Does it involve a sexual relationship? Are you legally married? Are you faithful to him? Is he faithful to you? Are you happy in this relationship? How much time do you spend together? Does your partner live here or in another town/village/city?

Do you talk openly with your current/last partner about your feelings? Are there any topics you cannot discuss with your partner?

Prompt Questions: Can you openly discuss sexual matters? Is there anything you would not be comfortable discussing with your partners? If your partner wanted to have sex and you did not, would you be comfortable saying no? If you wanted to use a condom during sex would any of your partners refuse? Why or why not? What would you do if they refused? What if you wanted to talk to your partner about HIV/AIDS? Do you know anyone who has been physically hurt by their male partners? Do you think this type of violence happens in your community? Why or why not?

How do you feel about men being faithful to their female partners? How do you feel about your partner being faithful to you?

Prompt Questions: Are most men faithful when they migrate? Why or why not? Are women faithful?

Have you seen or heard many educational programs about HIV/AIDS? What were they like?


Do people openly discuss issues of sexuality and/or HIV/AIDS?

Prompt Questions: What do they talk about? Are any topics not discussed? Where and when is it discussed? Will men and women talk about these issues with each other?

Are you comfortable discussing issues of sexuality and HIV/AIDS with others? Family? Friends? Midwives, doctors or other health care workers?
Since learning about HIV/AIDS, do you think people’s behaviors have changed? How? Have you changed your behavior in any way?

Prompt Questions: How has your behavior changed? What do you do (or what don’t you do) now?

What are local ideas about condom use? How do you feel about condom use?

Prompt Questions: Do you know where to buy condoms? Can a woman buy condoms? Are you comfortable buying condoms? Are you comfortable carrying condoms? Are you comfortable asking men (or your partner) to wear a condom? Will a man ever refuse to wear a condom if asked? Why? What will the woman (or you) do in this situation?

Do you think you could ever get HIV/AIDS? Why or why not?


If you were going to develop a way to teach your community about HIV/AIDS, what would you do and say?

Prompt Questions: Who would you want to teach these classes – a man, woman, a Garifuna or foreigner? Who would you want to come to these classes? Who needs to learn or hear about HIV/AIDS most – men, women, kids, or just everyone? How would you make people comfortable about talking about these issues?

Is there anything else you would like to add about sexual relationships or HIV/AIDS?
Background Information

Age_________________

Sex:       Male             Female

Are you Garifuna?      Yes      No

If not, what is your ethnicity________________________________________

Where were you born?___________________________________________________

Have you ever lived in the United States?      Yes      No

Have you ever lived outside your hometown?      Yes      No

Where? _____________________________________________________________

Are you legally married?      Yes      No

Are you in a long-term relationship (but not legally married)?      Yes      No

Are you employed for wages?      Yes      No

Is so, is this:       Part time       Full time

If so, how much money do you make per month? ___________________

Do you have any children?      Yes      No

If so, how many? ___________________

Do you help pay for the care of these children?

    Never      Rarely      Sometimes      Always

Do these children live with you?      Yes      No      Sometimes      Other___________
Gender Roles

1. Who can do the following (check all that apply):

<table>
<thead>
<tr>
<th></th>
<th>Garifuna in your home country</th>
<th>Garifuna in the United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Raise children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do housework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have many sex partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have sex with someone else while in a relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buy condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carry condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate sex with a new partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get tested for HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss HIV/AIDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sexual Activities

1. What do you consider to be sex? (Check all that apply)

   ___ oral sex           ___ anal intercourse   ___ touching

   ___ vaginal intercourse ___ kissing

   other__________________________

2. How old were you the first time you had sex?______________

3. How many sex partners have you had in your life?______________

   3a. How many of these were in the last year?______________

   3b. How many NEW sex partners have you had in the last month?______________

4. Do you currently have a regular sexual partner?  Yes  No

   4a. Are you and your partner faithful to each other?  Yes  No  Don’t Know

   4b. Do you have more than one regular sexual partner?  Yes  No
5. Do you have sexual relations with people outside your ethnic group?
   
   Never    Rarely    Sometimes    Often    Always

6. How often do you use a condom when you have sex?
   
   Never    Rarely    Sometimes    Often    Always

6a. Did you use a condom the last time you had sex?  Yes  No  Don’t remember

6b. Was this last sexual act with a regular partner?  Yes  No  Don’t remember

6c. Do you use condoms when giving/receiving oral sex (blowjobs)?
   
   Never    Rarely    Sometimes    Often    Always

6d. Are you comfortable getting/buying condoms?
   
   Never    Rarely    Sometimes    Often    Always

7. Are you comfortable talking with sexual partners about the following:
   
   Their sexual history?     Never       Sometimes        Always
   Their HIV status?          Never       Sometimes        Always
   Wearing a condom?       Never       Sometimes        Always

8. If you are female, do you use any other form of birth control?  Yes  No

8a. If so, what?____________________________

HIV/AIDS Knowledge

For each statement, please circle true (T), false (F) or I don’t know (DK). If you do not know, please do not guess; instead circle DK.

1. HIV and AIDS are the same thing   T    F    DK
2. There is a cure for AIDS         T    F    DK
3. A person can get AIDS from a toilet seat  T    F    DK
4. Coughing and sneezing DO NOT spread HIV  T    F    DK
5. HIV can be spread by mosquitoes  T    F    DK
6. AIDS is the cause of HIV         T    F    DK

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7. A person can get HIV by sharing a glass of water with someone who has HIV T F DK
8. HIV is killed by bleach T F DK
9. It is possible to get HIV when a person gets a tattoo T F DK
10. A pregnant woman with HIV can give the virus to her unborn baby T F DK
11. Pulling out the penis before a man climaxes or cums keeps a woman from getting HIV during sex T F DK
12. A woman can get HIV if she has anal sex with a man T F DK
13. Showering, or washing one’s genitals or private parts, after sex keeps a person from getting HIV T F DK
14. Eating healthy foods can keep a person from getting HIV T F DK
15. All pregnant women infected with HIV will have babies born with AIDS T F DK
16. Using a latex condom or rubber can lower a person’s chance of getting HIV T F DK
17. A person with HIV can look and feel healthy T F DK
18. People who have been infected with HIV quickly show serious symptoms or signs of being infected T F DK
19. A person can be infected with HIV for 5 years or more without getting AIDS T F DK
20. There is a vaccine that can stop adults from getting HIV T F DK
21. Some drugs have been made for the treatment of AIDS T F DK
22. Women are always tested for HIV during their Pap smears T F DK
23. A person cannot get HIV by having oral sex, mouth-to-penis, with a man who has HIV T F DK
24. A person can get HIV even if she or he has sex with another person only one time T F DK
25. Using a lambskin condom or rubber is the best protection against HIV T F DK
26. People are likely to get HIV by deep kissing, putting their tongue in their partner’s mouth, if their partner has HIV T F DK
27. A person can get HIV by giving blood T F DK
28. A woman can get HIV if she has sex during her period T F DK
29. You can usually tell if someone has HIV by looking at them T F DK
30. There is a female condom that can decrease a woman’s chance of getting HIV T F DK
31. A natural skin condom works better against HIV than does a latex condom T F DK
32. A person will NOT get HIV if she or he is taking antibiotics T F DK
33. Having sex with more than one partner can increase a person’s chance of being infected with HIV T F DK
34. Taking a test for HIV one week after having sex will tell a person if she or he has HIV T F DK
35. A person can get HIV by sitting in a hot tub or swimming pool with a person who has HIV T F DK
36. A person can get HIV through contact with saliva, tears, sweat or urine T F DK
37. A person can get HIV from the wetness from a woman’s vagina T F DK
38. A person can get HIV if having oral sex, mouth-on-vagina, with a woman T F DK
39. If a person tests positive for HIV, then the test site will have to tell all of his or her partners T F DK
40. Using Vaseline or baby oil with condoms lowers the chance of getting HIV T F DK
41. Washing drug use equipment with cold water kills HIV T F DK
42. A person can get HIV if she has vaginal sex with a man who has HIV T F DK
43. Athletes who share needles when using steroids can get HIV from the needles T F DK
44. Douching (washing the vagina) after sex will keep a woman from getting HIV T F DK
45. Taking vitamins keeps a person from getting HIV T F DK

HIV/AIDS

1. Have you ever known someone with HIV/AIDS? Yes No Unsure
   1a. How many people have you known with HIV/AIDS?
      ___ 1 ___ 2-5 ___ 5-10 ___ more than 10
   1b. What were their relationship(s) to you? Check all that apply
      ___ family member
      ___ friend
      ___ boyfriend / girlfriend / spouse
      ___ coworker
      ___ other ______________________________

2. Do you know where to go to get tested for HIV? Yes No Unsure
3. Have you ever been tested for HIV?  
   Yes      No      Don’t know
3a. If so, are you tested regularly?  
   Yes      No      Don’t know
3b. How many times have you been tested?  
   __1-5   __ 6-10    __ 10 or more
4. How do you feel about getting tested for HIV/AIDS? (Check all that apply)  
   ___ fine / OK  
   ___ scared  
   ___ nervous or anxious  
   ___ I don’t need to be tested  
   ___ my partners get tested  
   ___ it costs too much money  
   ___ I don’t have time to get tested  
   ___ other  ______________________________
5. Since learning about HIV/AIDS, have you changed your sexual behavior in anyway?  
   Yes      No      Don’t know
5a. If so, how? (Check all that apply)  
   ___ I use condoms regularly now  
   ___ I don’t have sex with as many people  
   ___ I don’t have sex  
   ___ I am faithful to my partner  
   ___ I get tested for HIV/AIDS  
   ___ I don’t have sex with people who look sick  
   ___ I only have sex with people I know well  
   ___ I take vitamins or medicine to prevent getting HIV  
   ___ I talk about HIV/AIDS with friends and family  
   ___ I talk to sex partners about HIV/AIDS  
   ___ I avoid people who look sick  
   ___ Other  ______________________________
APPENDIX D
INTERVIEW GUIDE: NEW YORK CITY

How are you?

Tell me a little about yourself. (Fill out household form here).

Describe a typical day for you.

  Prompt Questions: What are your responsibilities? Do you work outside the home? If so, what do you do?

Tell me about your family here in NYC.

  Prompt Questions: Did you migrate together?

Tell me about your family in Honduras.

  Prompt Questions: Do family members ever come to visit you here in NYC? Do you have children in Honduras? If so, who takes care of them?

How often do you go back to Honduras?

  Prompt Questions: For what reasons do you return to Honduras? How long do you go back to Honduras for? Do you like returning? Is it difficult to return? Why or why not?

What do you like about living in NYC?

What do you dislike about living in NYC?

In your opinion, what are the most important parts of being a Garifuna woman?

Are Garifuna women in NYC any different than Garifuna women back in Honduras? Is so, how?

Do you think it is important for a Garifuna woman to have children? How do you feel about a Garifuna woman NOT having children?

  Prompt Questions: How many children should a Garifuna woman have? Why do you think having children is/is not important?

Does migration affect a woman’s decision to have children? If so, how?

  Prompt Questions: How does a woman control pregnancy? Does it affect the number of children desired?
Has migration affected Garifuna male and female relationships in any way? Has migration affected your interactions with men in any way?

What has been the hardest part about your migration experience?

Do you see any health care workers here in NYC?

Prompt Question? If not, how come? What type of health care provider(s) do you see? Why do you seek health care? How do these experiences differ from those in Honduras? Do you see health care providers back in Honduras? What about your children?

Do you have any type of health insurance here in the U.S.?

Prompt Questions: Is this provided by work? Do you receive any government assistance? What about your children?

Is there anything you would like to add about your migration experience or about being a Garifuna migrant?

What makes a good partner?

Prompt Questions: What qualities do you like in a man? Is it important for your family to get along with your partner? When you have a male partner, what do they do to help you? Does your partner need to be from your same town? Does migration affect the ability of a man to be a good partner?

Is it important to have a partner? Why or why not?

Prompt Questions: Does your typical routine change when you have a partner compared to when you don’t? Does having a partner or not having a partner affect your children in any way?

How many relationships have you had?

Prompt Questions: How old were you when you first had a male partner? How long have these relationships lasted? Do all partnerships involve a sexual relationship? Where you legally married to any of them? Why did the relationships end? During your partnerships were you faithful to him? Was he faithful to you?

Could you tell me about your first male partner and your relationship with him?

Prompt Questions: How old were you when you? How long did the relationship last? Did it involve a sexual relationship? Where you legally married? Why did the relationships end? During your partnership were you faithful to him? Was he faithful to you?
Can you tell me about your current/last partner and your relationship with him?

Prompt Questions: How long have you been with this partner? Does it involve a sexual relationship? Are you legally married? Are you faithful to him? Is he faithful to you? Are you happy in this relationship? How much time do you spend together?

Do you talk openly with your current/last partner about your feelings? Are there any topics you cannot discuss with your partner?

Prompt Questions: Can you openly discuss sexual matters? Is there anything you would not be comfortable discussing with your partners? If your partner wanted to have sex and you did not, would you be comfortable saying no? If you wanted to use a condom during sex would any of your partners refuse? Why or why not? What would you do if they refused? What if you wanted to talk to your partner about HIV/AIDS? Do you know anyone who has been physically hurt by their male partners? Do you think this type of violence happens in your community? Why or why not?

How do you feel about men being faithful to their female partners? How do you feel about your partner being faithful to you?

Prompt Questions: How do you feel about men being faithful to their female partners? Are most men faithful when they migrate? Why or why not?

Have you seen or heard many educational programs about HIV/AIDS in New York City? What were they like?

Prompt Questions: Are many educational programs directed specifically at Garifuna or are they to a general audience? What did they tell you? Were you comfortable discussing HIV/AIDS in this setting? Did you learn anything? Do you know how and where to get tested for HIV/AIDS? Have you ever been tested for HIV/AIDS? Why or why not? Do you think people should get tested for HIV/AIDS regularly? Why or why don’t people get tested?

Have you seen or heard many educational programs about HIV/AIDS in Honduras?

Prompt Questions: How did these compare to the one here in NYC? What did you like or dislike about these in comparison to the ones you have seen in NYC?

Do people openly discuss issues of sexuality and/or HIV/AIDS?

Prompt Questions: What do they talk about? Are any topics not discussed? In what context is it discussed? Will men and women talk about these issues with each other?

Are you comfortable discussing issues of sexuality and HIV/AIDS with others? Family? Friends? Midwives, doctors or other health care workers?
Since learning about HIV/AIDS, do you think people’s behaviors have changed? How? Have you changed your behavior in any way?

Prompt Questions: How has your behavior changed? What do you do (or what don’t you do) now?

What are local ideas about condom use? How do you feel about condom use?

Prompt Questions: Do you know where to buy condoms? Can a woman buy condoms? Are you comfortable buying condoms? Are you comfortable carrying condoms? Are you comfortable asking men (or your partner) to wear a condom? Will a man ever refuse to wear a condom if asked? Why? What will the woman (or you) do in this situation?

Do you think you could ever get HIV/AIDS? Why or why not?


Do you think living in NYC affects your risk for getting HIV/AIDS? Why or why not?

Prompt Questions: What about for other people? What is different about NYC that may improve or reduce your risk for getting HIV/AIDS?

If you were going to develop a way to teach your community about HIV/AIDS, what would you do and say?

Prompt Questions: Who would you want to teach these classes – a man, woman, a Garifuna or foreigner? Who would you want to come to these classes? Who needs to learn or hear about HIV/AIDS most – men, women, kids, or just everyone? How would you make people comfortable about talking about these issues? Would you change parts of your program depending on if you were in NYC or Honduras?

Is there anything else you would like to add about sexual relationships or HIV/AIDS?
APPENDIX E
SURVEY: NEW YORK CITY

Background Information

Age____________________

Sex    Male          Female

Are you Garifuna?       Yes          No

   If not, what is your ethnicity________________________________________

Where were you born?___________________________________________________

How long have you lived in the United States (this time)________________________

Have you ever lived in the United States before?________________________________

How long did you live in your home country?_________________________________

Are you legally married?     Yes      No

Are you in a long-term relationship (but not legally married)?    Yes    No

Are you employed for wages?    Yes   No

   Is so, is this:   Part time     Full time

   If so, how much money do you make per month? ___________________

Do you have any children?   Yes   No

   If so, how many? ______________

   Do you help pay for the care of these children?

          Never       Rarely       Sometimes       Always

   Do these children live with you? Yes   No   Sometimes   Other___________

NOTE: The remainder of the survey used in New York City is the same as shown in Appendix C.
APPENDIX F
GUÍA DE LA ENTREVISTA: HONDURAS

¿Cómo está?

Háblame sobre usted. (Planilla de composición familiar aquí).

Preguntas conductoras: ¿Ha vivido usted en los Estados Unidos? ¿Ha trabajado usted fuera su villa? ¿Ha trabajado usted en los Estados Unidos?

Describame un día típico en su vida.

Preguntas conductoras: ¿Cuáles son sus responsabilidades? ¿Trabaja fuera de su casa? ¿Qué hace?

En su opinión, ¿qué es lo más importante de ser una mujer Garífuna?

¿Es importante para la mujer Garífuna tener hijos? ¿Qué piensa sobre las mujeres Garifunas que no tienen hijos?

Preguntas conductoras: ¿Cuántos hijos debería tener una mujer Garífuna? ¿Por qué piensa que es/no es importante tener hijos? En el pasado, ¿cómo evitó embarazarse? Ahora, ¿cómo evita embarazarse?

¿Cómo describe a una buena pareja/compañero?

Preguntas conductoras: ¿Qué cualidades te gustan en un hombre? ¿Es importante que su familia se lleve bien con su pareja? ¿Cuando tiene pareja, que hace para ayudarle? ¿Su pareja tiene que ser del mismo pueblo? La migración, ¿afecta la habilidad del hombre para ser un buen compañero?

¿Es importante tener pareja/compañero? ¿Por qué?

Preguntas conductoras: ¿Cambias su rutina cuando tiene pareja/compañero? El tener o no tener una pareja, ¿afecta a sus hijos?

¿Cuántas parejas/compañeros ha tenido?


¿Me puede hablar sobre su primera pareja y su relación con él?
Preguntas conductoras: ¿Cuántos años tenía cuando empezó esta relación? ¿Cuánto duró esta relación? ¿Hubo relación sexual? ¿Fue usted fiel durante esta relación? ¿Fue fiel su pareja?

¿Tiene pareja ahora? Me puede hablar sobre su pareja actual/última pareja y su relación con él?


¿Hablan ustedes abiertamente sobre sus sentimientos con sus pareja(s)? ¿Hay algún(os) tema(s) que no pueda hablar con él/ellas?

Preguntas conductoras: ¿Puede hablar abiertamente sobre temas sexuales? ¿Hay algún tema que no se sienta cómoda hablando con su pareja? Si su pareja quisiera tener relaciones sexuales y usted no quisiera, ¿se sentiría cómoda diciendo que no? Si usted quisiera usar condón/preservativo durante el sexo ¿alguno de sus parejas diría que no? ¿Por qué? ¿Qué haría usted si se rechazaron a usarlo? ¿Y si usted quisiera hablar con su pareja sobre el VIH/sida, podría? ¿Conoce a alguien que ha sido maltratada físicamente por su pareja? ¿Piensa usted que este tipo de violencia pasa en su comunidad? ¿Por qué?

¿Qué piensa sobre la fidelidad del hombre? ¿Qué piensa sobre la fidelidad de su pareja?

¿Ha tenido o visto programas educacionales sobre VIH/sida? ¿Cómo han sido esos programas?

¿Piensa usted que las personas hablan abiertamente sobre temas de sexualidad y VIH/sida?

Preguntas conductoras: ¿De que hablan? ¿Algún tema que no se hable? ¿Dónde y cuándo se discuten estos temas? ¿Hablan los hombres con las mujeres sobre estos temas?

¿Se siente usted cómoda hablando sobre la sexualidad y el VIH/sida con otros? ¿Familia? ¿Amistades? ¿Parteras o matronas? ¿Doctores y algún otro trabajador de la salud?

Desde que se aprendió sobre la existencia del VIH/sida ¿piensa usted que ha cambiado el comportamiento de las personas? ¿En qué sentido? ¿Ha cambiado su comportamiento?

Preguntas conductoras: ¿Cómo ha cambiado su comportamiento? ¿Qué hace o no hace ahora?
¿Cuáles son las ideas locales sobre el uso del condón/preservativos? ¿Qué opina usted sobre el uso del condón?

Preguntas conductoras: ¿Sabe usted donde comprar condones/preservativos? ¿Puede una mujer comprar condones/preservativos? ¿Se siente usted cómoda comprando condones/preservativos? ¿Se siente cómoda llevando condones/preservativos con usted? ¿Se siente usted cómoda pidiéndole a un hombre/su pareja que use condón/preservativo? ¿Se negaría un hombre a usar condón/preservativo? ¿Por qué? ¿Qué haría la mujer en esta situación?

¿Piensa usted que podría quedar infectado o contraer el VIH/sida? ¿Por qué?

Preguntas conductoras: ¿Cuáles son las maneras que se puede contraer el VIH/sida? ¿Ha conocido a alguien infectado con el VIH/sida? ¿Qué pasa en su comunidad cuando alguien se contagia del VIH/sida? ¿Qué pasa si alguien muere de sida?

Si usted pusiera desarrollar una manera de enseñarle a su comunidad sobre el VIH/sida, ¿que haría y diría?

Preguntas conductoras: ¿Quién enseñaría esas clases – un hombre, una mujer, una Garífuna o un extranjero? ¿Quién quiere que asista a estas clases? ¿Quién necesita aprender o escuchar sobre el VIH/sida – hombres, mujeres, niños o todo el mundo? ¿Cómo haría que las personas se sientan cómodas hablando sobre este tema?

¿Hay alguna otra cosa que quisiera agregar sobre las relaciones sexuales o el VIH/sida?
Información General

Edad________________________ 

Género:  Masculino   Femenino

¿Es usted Garífuna?   Si     No

    Si no es Garífuna, ¿cuál es su grupo étnico? ________________________________

¿Donde nació?______________________________________________________________

¿Ha vivido en los Estados Unidos?  Si     No

¿Ha vivido fuera de su villa?  Si  No

     ¿Donde?______________________________________________________________

¿Está legalmente casada?  Si    No

¿Está en una relación de largo plazo (pero no legalmente casada)?   Si     No

¿Tiene un trabajo en el cual le pagan?   Si     No

     Tipo de trabajo:  Medio tiempo   Tiempo completo

     ¿Cuánto gana al mes?_______________________

¿Tiene hijos?   Si    No

¿Cuántos?________________________

¿Ayuda a pagar por el cuidado de su(s) hijo(s)?

     Nunca     Casi nunca     A veces     Siempre

¿Vive(n) su(s) hijo(s) con usted?  Si  No  A veces  Otro__________________
Roles de los Hombres y las Mujeres

1. ¿Quién hace las siguientes labores (marque todas las que apliquen):

<table>
<thead>
<tr>
<th>Los Garífunas en su país de origen</th>
<th>Los Garífunas en los Estados Unidos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hombres</td>
<td>Mujeres</td>
</tr>
<tr>
<td>Hombres</td>
<td>Mujeres</td>
</tr>
<tr>
<td>Criar a los hijos</td>
<td></td>
</tr>
<tr>
<td>Tener un trabajo</td>
<td></td>
</tr>
<tr>
<td>Hacer las labores en casa</td>
<td></td>
</tr>
<tr>
<td>Tener muchos parejas sexuales</td>
<td></td>
</tr>
<tr>
<td>Tener relaciones sexuales con otra persona mientras está con una pareja</td>
<td></td>
</tr>
<tr>
<td>Comprar condones</td>
<td></td>
</tr>
<tr>
<td>Llevar condones</td>
<td></td>
</tr>
<tr>
<td>Iniciar las relaciones sexuales con una nueva pareja</td>
<td></td>
</tr>
<tr>
<td>Hacerse la prueba del VIH</td>
<td></td>
</tr>
<tr>
<td>Hablar sobre el VIH/Sida</td>
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</tbody>
</table>

Actividades Sexuales

1. ¿Cómo define las relaciones sexuales? (Marque todas que apliquen)
   ____  sexo oral                     ____ penetración anal                   ____ acariciarse
   ____ penetración vaginal     ____ besarse        otro_____________________

2. ¿Cuántos años tenía cuando tuvo su primera relación sexual? ____________

3. ¿Cuántas parejas sexuales ha tenido en su vida?__________________
   3a. ¿Cuántas parejas sexuales tuvo el año pasado? ____________
   3b. ¿Cuántas parejas NUEVAS ha tenido en el último mes? ____________

4. ¿Tiene una pareja sexual regular?   Si       No
4a. ¿Son usted y su pareja fieles?  
   Si  No  No sé

4b. ¿Tiene más de una pareja sexual regular?  
   Si  No

5. ¿Tiene relaciones sexuales con personas de otros grupos étnicos?
   Nunca  Casi nunca  A veces  Frecuentemente  Siempre

6. ¿Con qué frecuencia usa condón?
   Nunca  Casi nunca  A veces  Frecuentemente  Siempre

6a. ¿Usa un condón la última vez que tuvo relaciones sexuales?
   Si  No  No recuerda

6b. ¿La última relación sexual fue con una pareja regular?
   Si  No  No recuerda

6c. ¿Usa condones cuando da/recibe sexo oral (a un hombre)
   Nunca  Casi nunca  A veces  Frecuentemente  Siempre

6d. ¿Se siente cómoda consiguiendo/comprando condones?
   Nunca  Casi nunca  A veces  Frecuentemente  Siempre

7. ¿Se siente cómoda hablando con sus parejas sexuales sobre:
   ¿Sus historias sexuales?  Nunca  A veces  Siempre
   ¿Su condición de VIH?  Nunca  A veces  Siempre
   ¿Usar condón?  Nunca  A veces  Siempre

8. Si es mujer, ¿usa alguna forma de planificación familiar?  
   Si  No  No soy mujer

8a. Si usa, ¿cuál?____________________________
Conocimiento sobre VIH/Sida

Por cada frase, por favor circule Verdadero (V), Falso (F) o No sé (NS). Si no sabe, por favor no trate de adivinar, marque NS.

1. VIH y sida son la misma cosa  V  F  NS
2. Hay cura para el sida  V  F  NS
3. Una persona puede contraer el sida del servicio sanitario  V  F  NS
4. El toser y estornudar NO son modos de contagio del VIH  V  F  NS
5. VIH puede ser transmitido por los mosquitos  V  F  NS
6. Sida es causado por el VIH  V  F  NS
7. Una persona puede contraer el VIH al compartir un vaso de agua con alguien que tiene VIH  V  F  NS
8. VIH es destruido con lejía (cloro)  V  F  NS
9. Es posible contraer VIH cuando una persona se hace un tatuaje  V  F  NS
10. Una mujer embarazada con VIH puede darle el virus a su bebé no nacido  V  F  NS
11. Sacar el pene antes de que el hombre llegue al orgasmo o eyacule previene que la mujer contraiga el VIH durante el sexo  V  F  NS
12. Una mujer puede contraer el VIH si tiene sexo anal con un hombre  V  F  NS
13. Bañarse o lavarse sus partes genitales o privadas después del sexo previene que la persona se infecte del VIH  V  F  NS
14. Comer comida saludable previene que una persona se infecte del VIH  V  F  NS
15. Todas las mujeres embarazadas con VIH tendrán bebes con sida  V  F  NS
16. Usar condones de látex reduce los chances de una persona de contraer el VIH  V  F  NS
17. Una persona con VIH puede verse y sentirse saludable  V  F  NS
18. Las personas que han sido infectadas por el VIH muestran rápidamente los síntomas o signos serios de la infección  V  F  NS
19. Una persona puede estar infectado del VIH por 5 o más años sin tener sida  V  F  NS
20. Existe una vacuna que previene que las adultos contraigan el VIH  V  F  NS
21. Existen algunas medicinas para el tratamiento del sida  V  F  NS
22. Las mujeres siempre se les hace la prueba del VIH durante su examen ginecológico (citología o prueba del cáncer cervical)  V  F  NS
23. Una persona no puede contraer el VIH al tener sexo oral, boca y pene, con un hombre que tiene VIH  V  F  NS
24. Una persona puede contraer el VIH aunque ella o él solo hayan tenido relaciones sexuales con la otra persona una vez
25. Usar un condón de piel de cordero es la mejor protección contra el VIH
26. Las personas pueden contraer el VIH al tener un beso profundo, poner su lengua en la boca de su pareja, si su pareja tiene VIH
27. Una persona puede contraer VIH al donar sangre
28. Una mujer puede contraer VIH si tiene relaciones sexuales durante su periodo menstrual
29. Puede saber si alguien tiene VIH al solo verlos
30. Existe un condón femenino que reduce los chances de una mujer de contraer el VIH
31. Un condón de piel natural trabaja mejor contra el VIH que un condón de látex
32. Una persona no puede contraer el VIH si él o ella están tomando antibióticos
33. Tener relaciones sexuales con más de una pareja, aumenta los chances de una persona de ser infectada con el VIH
34. Hacerse una prueba del VIH una semana después de tener relaciones sexuales, le dirá a la persona si tiene VIH
35. Una persona puede contraer el VIH al sentarse en un Jacuzii o piscina con una persona que tiene VIH
36. Una persona puede contraer el VIH por el contacto con saliva, lágrimas, sudor o orina
37. Una persona puede contraer el VIH de la humedad de la vagina de la mujer
38. Una persona puede contraer el VIH si tiene sexo oral, boca y vagina, con una mujer
39. Si una persona resulta positiva con el VIH, entonces el centro de prueba le dirá a todos/todas sus parejas
40. Usar Vaselina o aceite de bebé con los condones reduce los chances de contraer VIH
41. Lavar los instrumentos o objetos (jeringas, etc.) que se usan para consumir drogas con agua fría destruye el VIH
42. Una mujer puede contraer el VIH al tener penetración vaginal con un hombre que tiene VIH
43. Los atletas que comparten jeringas cuando usan esteroides pueden infectarse de VIH de las jeringas
44. Lavarse la vagina después de tener relaciones sexuales previene que la mujer se infecte de VIH
45. Tomar vitaminas previene que una persona se infecte de VIH
VIH/Sida

1. ¿Ha conocido a alguien con VIH/sida?  
   Si  No  No estoy seguro/a

1a. ¿Cuántas personas ha conocido con VIH/sida?  
   ___ 1   ___ 2-5  ___ 5-10   ___ más de 10

1b. ¿Cuál era la relación con usted? Marque todas que apliquen:  
   ___ familiar  
   ___ amigo/a  
   ___ novio/novia/esposo/esposa  
   ___ compañero/a de trabajo  
   ___ otro  ________________

2. ¿Sabe adonde ir para hacerse la prueba del VIH?  
   Si  No  No estoy seguro/a

3. ¿Se ha hecho la prueba del VIH?  
   Si  No  No sé  

3a. Si su respuesta fue sí, ¿con regularidad se hace la prueba?  
   Si  No  No sé

3b. ¿Cuántas veces se ha hecho la prueba?  
   ___ 1-5  ___ 6-10  ___ 10 o más

4. ¿Cómo se siente acerca de hacerse la prueba del VIH/sida? (Marque todas los que apliquen):  
   ___ Bien / OK  
   ___ Asustado/a  
   ___ Nervioso/a o ansioso/a  
   ___ No necesito la prueba  
   ___ Mis parejas se hacen la prueba  
   ___ Cuesta mucho dinero  
   ___ No tengo tiempo  
   ___ Otro  ________________
5. Desde que aprendió sobre el VIH/sida, ¿cambiado su comportamiento sexual de alguna manera?  Si  No  No sé

5a. Si ha cambiado, ¿cómo ha cambiado? (Marque todas los que apliquen):
   ___ Usa condones regularmente ahora
   ___ No tengo relaciones sexuales con tantas personas
   ___ No tengo relaciones sexuales
   ___ Soy fiel a mi pareja
   ___ Me hago la prueba del VIH/sida
   ___ No tengo relaciones sexuales con personas que se vean enfermas
   ___ Solo tengo relaciones sexuales con personas que conozco bien
   ___ Tomo vitaminas o medicinas para prevenir contraer el VIH
   ___ Hablo con mis amigos y familiares sobre el VIH/sida
   ___ Hablo sobre el VIH/sida con mis parejas
   ___ Evito a las personas que se ven enfermos
   ___ Otro __________________________________________
¿Cómo está?

Háblame sobre usted. (Planilla de composición familiar aquí).

Decríbame un día típico en su vida.

Preguntas conductoras: ¿Cuáles son sus responsabilidades? ¿Trabaja fuera de su casa? ¿Qué hace?

Hableme de su familia aquí en Nueva York.

Preguntas conductoras: ¿Emigraron juntos?

Hableme de su familia en Honduras.

Preguntas conductoras: ¿Su familia la viene a visitar a Nueva York? ¿Tiene hijos en Honduras? ¿Quién los cuida?

¿Cada cuánto tiempo viaja a Honduras?

Preguntas conductoras: ¿Por qué razones regresa a Honduras? ¿Por cuánto tiempo va a Honduras? ¿Le gusta regresar? ¿Es difícil regresar? ¿Por qué?

¿Que le gusta de vivir en Nueva York?

¿Que no le gusta de vivir en Nueva York?

En su opinión, ¿qué es lo más importante de ser una mujer Garifuna?

¿Son diferentes las mujeres Garífunas en Nueva York que las mujeres Garífunas de Honduras? ¿Cómo?

¿Es importante para la mujer Garífruna tener hijos? ¿Qué piensa sobre las mujeres Garífunas que no tienen hijos?

Preguntas conductoras: ¿Cuántos hijos debería tener una mujer Garífruna? ¿Por qué piensa que es/no es importante tener hijos? En el pasado, ¿cómo evitó embarazarse? Ahora, ¿cómo evita embarazarse?

La emigración, ¿afecta la decisión de la mujer de tener hijos?

Preguntas conductoras: ¿Cómo controla quedar embarazada? ¿Afecta el número de hijos que desea tener?
¿Ha afectado la migración la relación entre los hombres y las mujeres Garifuna? ¿Ha afectado la migración su relación con los hombres Garifuna?

¿Qué ha sido la más difícil de emigrar?

¿Visita centros de salud en Nueva York?

Preguntas conductoras: ¿Por que no? ¿Qué tipo de centros de salud visita? ¿Por que va? ¿Cuáles son las diferencias entre los centros de Honduras y los de Nueva York? ¿Veía a un doctor en Honduras? ¿Llevada a sus hijos?

¿Tiene algún tipo de seguro médico en los Estados Unidos?

Preguntas conductoras: ¿Se lo da su trabajo? ¿Recibe ayuda del gobierno? ¿Y sus hijos?

¿Quiere añadir algo más sobre su experiencia migratoria o sobre ser una mujer Garifuna que ha migrado?

¿Cómo describes a una buena pareja/compañero?

Preguntas conductoras: ¿Qué cualidades te gustan en un hombre? ¿Es importante que su familia se lleve bien con su pareja? ¿Cuando tiene pareja, que hace para ayudarle? ¿Su pareja tiene que ser del mismo pueblo? La migración, ¿afecta la habilidad del hombre para ser un buen compañero?

¿Es importante tener pareja/compañero? ¿Por qué?

Preguntas conductoras: ¿Cambias su rutina cuando tiene pareja/compañero? El tener o no tener una pareja, ¿afecta a sus hijos?

¿Cuántas parejas/compañeros ha tenido?


¿Me puede hablar sobre su primer pareja y su relación con él?

Preguntas conductoras: ¿Cuántos años tenía cuando empezó esta relación? ¿Cuánto duró esta relación? ¿Hubo relación sexual? ¿Fue usted fiel durante esta relación? ¿Fue fiel su pareja?

¿Me puede hablar sobre su pareja actual/pasado y su relación con él?

¿Hablan ustedes abiertamente sobre sus sentimientos con su(s) pareja(s)? ¿Hay algun(os) tema(s) que no pueda hablar con él/ellas?

Preguntas conductoras: ¿Puede hablar abiertamente sobre temas sexuales? ¿Hay algún tema que no se sienta cómoda hablando con su pareja? Si su pareja quisiera tener relaciones sexuales y usted no quisiera, ¿se sentiría cómoda diciendo que no? Si usted quisiera usar condón/preservativo durante el sexo ¿alguno de sus parejas diría que no? ¿Por qué? ¿Qué haría usted si se reusaran a usarlo? ¿Y si usted quisiera hablar con su pareja sobre el VIH/sida, podría? ¿Conoce a alguien que ha sido maltratada física o moralmente por su pareja? ¿Piensa usted que este tipo de violencia pasa en su comunidad? ¿Por qué?

¿Qué piensa sobre la fidelidad del hombre? ¿Qué piensa sobre la fidelidad de su pareja?

Preguntas conductoras: ¿Son fieles los hombres cuando emigran? ¿Por qué? ¿Son fieles las mujeres? ¿Por qué?

¿Ha visto o escuchado sobre programas educacionales sobre el VIH/sida en Nueva York? ¿Cómo son esos programas?

Preguntas conductoras: ¿Hay muchos programas dirigidos específicamente a la Garifuna o son la población general? ¿Qué le dijeron en estos programas? ¿Se sintió cómoda hablando sobre el VIH/sida en este lugar? ¿Aprendió algo en estos programas? ¿Sabe cómo y donde hacerse la prueba del VIH/sida? ¿Se ha hecho la prueba alguna vez? ¿Por qué? ¿Piensa que los personas deberían de hacerse la prueba del VIH/sida? ¿Por qué?

¿Ha visto o escuchado sobre programas educacionales sobre el VIH/sida en Honduras?

Preguntas conductoras: Se parecen o no parecen a los de Nueva York? ¿Qué le gusta o no le gusta de los programas de Honduras? ¿Y de los de Nueva York?

¿Las personas hablan abiertamente sobre sexualidad y VIH/sida?

Preguntas conductoras: ¿Sobre qué hablan? ¿Qué temas no discuten? ¿En que contexto se discuten? ¿Hablan los hombres y las mujeres sobre estos temas mutuamente?

¿Se siente usted cómoda hablando sobre la sexualidad y el VIH/sida con otros? ¿Familia? ¿Amistades? ¿Parteras o matronas? ¿Doctores y algún otro trabajador de la salud?

Desde que se aprendió sobre la existencia del VIH/sida ¿piensa usted que ha cambiado el comportamiento de las personas? ¿En qué sentido? ¿Ha cambiado su comportamiento?

Preguntas conductoras: ¿Cómo ha cambiado su comportamiento? ¿Qué hace o no hace ahora?
¿Cuáles son las ideas locales sobre el uso del condón/preservativos? ¿Qué opina usted sobre el uso del condón?

Preguntas conductoras: ¿Sabe usted donde comprar condones/preservativos? ¿Puede una mujer comprar condones/preservativos? ¿Se siente usted cómoda comprando condones/preservativos? ¿Se siente cómoda llevando condones/preservativos con usted? ¿Se siente usted cómoda pidiéndole a un hombre/su pareja que use condón/preservativo? ¿Se negaría un hombre a usar condón/preservativo? ¿Por qué? ¿Qué haría la mujer en esta situación?

¿Piensa usted que podría quedar infectado o contraer el VIH/sida? ¿Por qué?

Preguntas conductoras: ¿Cuáles son las maneras que se puede contraer el VIH/sida? ¿Ha conocido a alguien infectado con el VIH/sida? ¿Qué pasa en su comunidad cuando alguien se contraje del VIH/sida? ¿Qué pasa si alguien muere se sida?

¿Piensa que el vivir en Nueva York afecta su riesgo de contraer VIH/sida? ¿Por qué?

Preguntas conductoras: ¿Y para otras personas? ¿Que hace que aumente o disminuya el riesgo de contraer VIH/sida en Nueva York?

Si usted pudiera desarrollar una manera de enseñarle a su comunidad sobre el VIH/sida, ¿qué haría y diría?

Preguntas conductoras: ¿Quién enseñaría esas clases – un hombre, una mujer, una Garífuna o un extranjero? ¿Quién quiere que asista a estas clases? ¿Quién necesita aprender o escuchar sobre el VIH/sida – hombres, mujeres, niños o todo el mundo? ¿Cómo haría que las personas se sientan cómodos hablando sobre este tema? ¿Cambiaría partes de este programa si estuviera en Nueva York o Honduras?

¿Hay alguna otra cosa que quisiera agregar sobre las relaciones sexuales o el VIH/sida?
APPENDIX I
CUESTIONARIO: NEW YORK CITY

Información General

Edad_________________

Género: Masculino  Femenino

¿Es usted Garifuna?   Si     No

Si no es Garifuna, ¿cuál es su grupo étnico?______________________________

¿Donde nació?___________________________________________________________

¿Cuánto tiempo ha vivido en los Estados Unidos? (esta vez)_______________________

¿Ha vivido antes en los Estados Unidos? Si     No

¿Por cuánto tiempo vivió en su país de origen?_________________________________

¿Qué es su país de origen?___________________________________________

¿Está legalmente casada?   Si     No

¿Está en una relación de largo plazo (pero no legalmente casada)?  Si     No

¿Tiene un trabajo en el cual le pagan?    Si    No

    Tipo de trabajo: Medio tiempo  Tiempo completo

¿Cuánto gana al mes?_______________________

¿Tiene hijos?  Si     No

¿Cuántos?______________________

¿Ayuda a pagar por el cuidado de su(s) hijo(s)?

    Nunca    Casi nunca    A veces    Siempre

¿Vive(n) su(s) hijo(s) con usted?  Si    No    A veces    Otro__________

NOTE: The remainder of the Spanish survey used in New York City is the same as shown in Appendix G.
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BIOGRAPHICAL SKETCH

Suzanne Dolwick Grieb earned a Bachelor of Arts in anthropology from the University of Florida in 1999 and a Master of Science in Public Health from the University of South Florida in 2002 with a concentration in Tropical Public Health and Communicable Disease. After graduating with her master’s degree, she worked at the American Cancer Society in the Department of Epidemiology and Surveillance Research as an epidemiologist in International Tobacco Surveillance before continuing her graduate studies.