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AIDS IN JAMAICA

The Grim Reality of HIV/AIDS in Rural Jamaica

BY DIANA J. FOX

farm work as laborers, shopkeepers, nurses and teachers. The town contains one dentist and three doctors, two of whom came to Frankfield from India to practice as part of their residency. One has stayed permanently.

Locally, Frankfield is known – in the words of one prominent minister – as “a mecca” since it is home to the Edwin Allen Regional High School and many small businesses that draw people from surrounding communities. It is also a center of market activity. There are two main streets which house all the town’s shops and where the outdoor market, built by the Government of Jamaica and the Inter-American Development Bank, attracts “higglers” (market women) who come down from the mountains from Thursday through Saturday to sell their produce and their wares. Residents’ lives are oriented around the agricultural calendar, the workweek, extended family and significant church obligations.

I will be traveling to Frankfield this June with four student anthropology majors who will each act as research assistants. Our days will be divided between interviews and participant-observation in areas of community life that will yield insights into the four dimensions of the project that I hope to fulfill. Students will rotate participant-observation sites that include the primary and high schools, the clinic, the doctors’ offices, restaurants, the town nightclub and church services and meetings. They will accompany ministers on their rounds to visit their parishioners.

The research begins with a guiding premise of cultural anthropology that behavior must be explained within its historical and cultural contexts. Medical anthropology shares this starting point in its approach to disease: disease itself is situated in a complex cultural matrix that influences peoples’ understanding of what constitutes health and illness, how they contract diseases, approaches to treating illnesses and how to live with diseases. While HIV is a virus that knows no

INTRODUCTION

This June I will return to the agricultural town of Frankfield, Jamaica for the sixth time since 1991. Thanks to a faculty/librarian research grant I recently received from Bridgewater State College I will embark on a new project. This project embraces certain aspects of my earlier research on the relationship between community economic development and shifting roles for women and men while addressing a topic that is becoming unavoidable in the Caribbean: the HIV/AIDS epidemic.

My attention turned to HIV/AIDS in Frankfield during my last trip in March 2000 when nurses at the town’s one clinic alerted me to the burgeoning threat of HIV infection, the slow response of the Government of Jamaica and how potential economic damage wrought by a full-blown HIV/AIDS crisis could stagger even slim prospects for community development. In my ensuing comments I will discuss what I have learned so far about HIV/AIDS, both from my preliminary findings and from the work of other researchers that have inspired me to pursue this line of research.

THE STUDY OF CONTEXT IN A GLOBALIZED WORLD

Since the project has yet to be implemented I want to explore some of the assumptions and frameworks that guide my approach to this study. First, I offer a brief ethnographic description of Frankfield.

Frankfield is home to approximately 6,000-8,000 residents, most whom are deeply religious Christians (biblical literalists) of over thirteen Protestant denominations. The town sits approximately 2,000 feet above sea level in the Rio Minho valley, surrounded by the cultivated mountains of Clarendon Parish. More than 80% of residents are citrus farmers, growing cash crops of oranges, cocoa and ginger mainly for Kingston markets. They also grow a variety of other crops including yams, cassava, plantains, bananas and various other vegetables. Many people, even those living in town, own small livestock including goats and chickens. Some own cattle and pigs. Farmers live in the hills above the town, and many homes do not have running water, so people walk down to the river to wash and children collect water from springs after school. Most hill residents are on the electric grid, as are residents living in town, where the community’s wealth is concentrated. People who do not



Three school girls in their uniforms.

borders, individuals carry belief systems and values that influence their actions and which increase or minimize their individual risks of contracting the virus. Individuals also exist in power relationships with other individuals that increase their risks of contraction. One of the prevailing beliefs about HIV infection that has international currency - found among many adult males throughout Asia, Africa and the Caribbean - is that having sexual intercourse with virgins will cure them of AIDS. In Frankfield and throughout rural Jamaica, young women are particularly vulnerable to the advances of older men seeking out virgins as sex partners. They regard older men as potential sources of income and gifts, as a way out of rural poverty. And due to their age and sex, these young women are physically vulnerable to pressure to engage in unprotected sex. This transnational belief of the "virgin cure" intersects with local patterns of relationship formation, resulting from economic need that in turn is shaped by women's financial dependence on men. There is a saying in Frankfield that young women use to express their draw to older men: "school boy have pocket money, but big man have salary." When young women in high school are acquiring some income

from older men, they no longer have to ride the overcrowded minibuses to school. They can ride in taxis instead. This is an important status symbol as it is regarded as a disgrace to travel in a minibus.

People contract diseases in specific places and under particular circumstances, yet human beings are mobile. The local context is inevitably embedded in larger regional, national and international processes. Due to a dearth of employment opportunities in Frankfield, and to the needs of an ever growing population (approximately 4,000 in 1991 and 6-8,000 in 2000), men and women migrate, traveling daily, seasonally or even for years at a time to find work throughout the island, in the United States, the United Kingdom and Canada. The channels transporting HIV to Frankfield, and from Frankfield to the outside world, are therefore related to employment situations, opportunities and constraints. And, as people move, so do ideas. Diffusion of beliefs and behaviors accompany the search to make a living.

As these examples illustrate, the cultural context of disease is layered and marked by dynamics of power and the global movement of capital. As George Marcus has expressed in his 1998 text, *Ethnography Through Thick and Thin*, ethnographers are seeking ways to embed ethnographic research "within

the context of a historic and contemporary world system of capitalist political economy." This does not negate the value of fieldwork. Rather, fieldwork is a beginning, necessitated by the constraints and directions of the methodology. Analysis begins locally gathering insights into the web of patterns that extend outward and which impact on the local setting. For instance, the factors and motivations that lead people to leave Frankfield and to return must be learned through direct interaction with migrants themselves. Data about the risk-increasing behavior of migrants when they are away from their families, and the behaviors of those that remain, can best be attained through sensitive inquiries after a long period of building rapport. Fieldwork is, of course, the means to acquire this information. The value of this approach lies in its capacity to integrate knowledge about individual behavior with - again quoting Marcus - "macro-theoretical literatures on the contemporary incorporation of peoples as working classes, or on the apparent reduction of local cultures by the macro-processes associated with capitalist political economy." This process of identification may permit generalizations about behavior that encompass other rural areas of Jamaica and, perhaps, beyond.

Effective social action is severely hampered without this effort to understand the convergences of the local and the global. As anthropological critics of some international development models have emphasized, social action designed without detailed knowledge of context is doomed to fail. The context, we are realizing, is plural. Moreover, surveys of the local cultural context of knowledge, and local attitudes and behaviors, are of limited utility if they are not placed in a framework of influential regional and global economic, political and social patterns. As Charles Bright and Michael Geyer conclude, we must understand events in a new light, as the "tense, ongoing interaction of forces promoting global integration and forces recreating local autonomy."

But the local cultural context is the place to begin, and since I am at the beginning, I must come to understand the cultural context of HIV/AIDS in Frankfield, Jamaica. At this preliminary stage in my investigation I can account for three categories of life in Frankfield that shape attitudes, beliefs and behaviors that increase individual risk of HIV contraction. These include 1) patterns of gender inequality, 2) religious values and beliefs and 3) economic conditions, opportunities and limitations.

THE POLITICAL ECONOMY OF GENDER INEQUALITY

As my earlier research demonstrates, and as feminist anthropologists have pointed out since Margaret Mead's pioneering work in the 1920s, the structures of societies and cultural processes are shaped by the dynamics of gender. HIV/AIDS is no exception. Increasingly, and especially in the developing world, HIV is being considered a "woman's disease." This idea suggests that gender inequality increases women's risks of contracting HIV. In order to understand some of the attributes of gender inequality in Frankfield, it is important to situate gender relationships within the economic climate that contributes to the shape of gender patterns.

As a poor country battling the combined legacies of colonialism and underdevelopment, Jamaica's position in the global economy is precarious at best. Its tourist industry on the north-west coast is the island's primary source of foreign exchange. Yet the industry has only minor impact on the island's interior – although, as I will point out later on, this minor impact may have major, unintended consequences. The economic burdens of Jamaica's colonial legacy also exacerbate the impact of epidemics and infectious diseases. This is generally because Jamaica is a resource-poor government tied to wealthy industrial nations through the debilitating regime of international loans. The Government spends little on health care, devoting resources instead

to servicing the interest on its debts. Although the first case of HIV in Jamaica was documented in 1982, it is just this past year that the health minister agreed to make a commitment toward funding HIV/AIDS prevention projects. This commitment has yet to be played out.

Jamaica's position in the global economy also shapes the economic options for men and women and, as I shall discuss, these economic options in turn influence the nature of gender relationships that put women at particular risk for contracting HIV. In Frankfield the unemployment rate lingers at a staggering 20%. Farmers earn meager livelihoods through sale of their cash crops to Kingston markets. Many men migrate seasonally to work as farm laborers in Florida and New England. Women migrate as well, but the conditions of their migration differ from men's. Unmarried and unattached women with children often leave their offspring in the temporary care of their own mothers. Others migrate with their children hoping to find permanent work in urban areas. Fathers migrate alone or with other men to seek seasonal farm labor. Jamaican women, unlike women from Mexico and other Latin American countries, do not participate in migrant farm labor. Farm work is considered men's work, although at home women may participate in some aspects of farm labor. Male migrants live in low cost, unsanitary housing conditions where they are subjected to underemployment, unemployment and poverty. Migration temporarily disrupts marital and family ties, leading to risky sexual behavior. In Jamaica, as in other parts of the world, when husbands return to their wives after a long absence – an outcome that is not guaranteed with migrant labor – many women, desiring to please their husbands and fearful of battering or abandonment if they do not, will not demand that their partner use condoms. Increasingly, anthropologists and others studying the gendered nature of HIV/AIDS are learning that for most women around the world the behavior that puts them at greatest risk

of infection with HIV is having sex with their husbands.

Other economic conditions shape patterns of sexual behavior. Rural, working class Jamaican families are typically matrifocal. That is, women serve as *de facto* heads of household in part due to the frequent long-term absence of men. Because so many men migrate to seek work, many rural Jamaicans live in common-law arrangements and do not marry formally until they are well into their forties when economic conditions may be more stable. When they do settle down with one partner, the household typically contains children who have been fathered by many different men. These marriage norms reflect a history of multiple sex partners for men and women, and continue to encourage the pattern. On my last trip in March 2000, I had a conversation with one woman, the mother of three children. She was in her early 40s and had just given birth to a new infant. She worked as a prep-cook in a restaurant while her 15 and 17-year-old daughters, who shared a father, cared for the infant. She had just gotten married to the father of her baby. She also had two sons, each of whom had a different father. When I asked her about the kind of work her new husband did, she told me that he had just left Frankfield to go to London to try to find work so that he could send back remittances to support his new family. I asked her how long he'd be gone. She smiled wanly and said, "two years." When a man is away for such long periods of time others may take his place, helping to care for children and provide for the household while women continue to bear children with their new baby-fathers. One method of HIV transmission is from mother to child during birth, or in the course of breastfeeding. It should also be noted that is difficult for women there to obtain birth control. The clinic dispenses shots of Depro-Provera, which many women claim makes them ill. The churches discourage use of birth control. Clinic nurses have shared with

me their disappointment when a woman finally agrees to use birth control, only to be dissuaded in Church on Sunday.

Other factors contribute to HIV risks for women. Unable to keep pace with rising costs of living, some people have begun to travel on crowded buses to the northwest coast to work in the tourist industry, Jamaica's fastest growing source of foreign exchange. Some women find positions in the commercial sex trade, thus increasing their vulnerability to HIV infection. There is also male prostitution in the form of "Rent-a-Rasta" or "Rent-A-Dread" sexual services frequented by white, European women, particularly Scandinavian tourists. Part of my efforts will be to explore the number of people from Frankfield who take up this line of work.

Another form of prostitution takes place locally in Frankfield but emerges from the wider economic conditions on the island, as well as from attitudes toward prostitutes. Frankfield houses one nightclub, which features regular striptease shows and post-show sexual engagements with the traveling strippers. One informant told me that because the stigma of prostitution is so high in the rural areas, prostitutes must either reside in the tourist areas or constantly remain on the move, performing throughout the country on the nightclub circuit. In this fashion they become known and develop a clientele, but they do not suffer the humiliation of living in a community that would subject them to constant ostracism. Women face enormous difficulties in negotiating safe sex practices with men that emerge out of power dynamics bound up in economic conditions. These include prostitution, the myth of the "virgin cure," economic conditions that produce migration, women's limited access to birth control and their inability to demand that their partners use condoms.

"SAVED" OR STIGMATIZED: THE INFLUENCE OF CHRISTIANITY

Another important factor to consider in addressing the cultural context of HIV/AIDS in Frankfield is attitudes toward homosexuality. These attitudes are crucial because they shape how residents understand the process of infection. In Frankfield AIDS is known as a "gay disease" as well as a disease of drug addicts and non-Christians. On one of the walls in the high school health education classroom is a poster that reads, "Protect Yourself Against AIDS." It features two drawings that divide the poster, one of a homosexual male couple and the other of an individual injecting himself in the arm with, presumably, heroin – a substance virtually unavailable in the rural areas, although it is common enough in Kingston and in the tourist regions. I saw this poster last March while sitting in on a health education class. The topic for the week was suicide, since for the past month the island had been plagued by a number of prominent suicides, the most recent being the death of a local detective who had shot himself after being diagnosed with cancer. I raise this topic because the manner in which it was discussed sheds light on the views of illness and death in rural Jamaica.

The students discussed the suicides mainly in terms of whether God would receive into his Kingdom those who had killed themselves. The teacher reminded the students that suicide is regarded as an abomination in the Bible and, as such, they would not go to Heaven no matter how these individuals suffered and no matter their good deeds on earth. She intended to teach the children the object lesson that the deeper your suffering the better off you will be if you open your heart to Jesus so that you can be healed. Since the well-respected detective had chosen suicide, he could not have chosen Jesus or have been "saved." Hence, his suicide was mourned all the more since he would not be "delivered into the arms of Jesus" in the afterlife.

Similarly, religious attitudes and beliefs shape perceptions of HIV/AIDS victims within the general populace. While clinic nurses have an understanding of how HIV is transmitted, it is still not clear to me whether their attitudes toward Christianity, homosexuality and poverty influence their beliefs about who is more likely to become infected. At this early stage it appears to me that even in the presence of education and exposure to the biology of HIV and AIDS, beliefs about goodness and salvation prosper as guides for identifying likely victims. One of my research assistants, an anthropology major at Mt. Holyoke College, recently told me of a conversation she had with a fellow student, a Jamaican woman from an upper-middle class family from the parish of Clarendon where Frankfield is located. The woman explained that as long as her sex partners were good Christians and well employed, they could not possibly be carriers of HIV. It is important to emphasize Paolo Friere's well-circulated idea that facts are not equivalent to "education." Education as a transformative process must deliver information in a package that is both meaningful and stirring enough to provoke challenges to received beliefs. In Frankfield, for example, biology teachers at the high school have told me that while they teach their students human evolution to prepare them for graduation tests, they don't believe a word of what they are teaching, and nor do their students. The education about HIV/AIDS offered to young people in Frankfield, as evidenced in the above-described poster, at best fosters an incomplete picture. At worst the picture is a most prejudicial one that, rather than provoke, reflects existing beliefs about homosexuality.

Homosexuality, like suicide, is abhorred throughout Jamaica. Homophobia is rampant and stigma is immense. It is not uncommon to hear young men say that they would "rather rape a woman than have sex with a gay man." A recent news article in the



Rastamen preparing their peanut porridge at their cookstand outside the center of town.

Jamaican Daily Gleaner described the violent murder of a prison inmate who accepted condoms from prison guards for protection against HIV infection. He was not gay, but the mere intimation that he might be was enough for blood lust to flow. Informants in Frankfield have described many other homophobic beliefs. One man, a local Rastafarian and hat maker, told me that he himself is not homophobic, but that if he were to befriend a self-identified gay man he would go out of business "within the week." He said that a few years ago a gay-pride march in Kingston, the first one scheduled to take place in Jamaica, was cancelled because of the violence that followed its announcement. People broke into hardware stores and armed themselves with shovels, axes and pitch forks, threatening to maim and kill the marchers. The police said that they would refuse to block the protesters and the march was cancelled.

In addition to the fear that homosexuals can contract HIV because homosexuality is un-Christian, other prejudices also exist. Young men who are unemployed and who are regarded as public nuisances are referred to as "rude boys" because they hang out on street corners smoking marijuana and drinking rum. These behaviors stigmatize them, leading good Christians to

distinguish them as potential carriers of HIV. On the other hand, these young men do not regard themselves as endangered. One young man, a barber, told me that "dem Sunday Christians are hypocrites" because they do not exhibit Christian forgiveness and charity toward those who need to hustle to get by. Individuals who do not regularly attend church, who have rejected the teachings of the church and who are therefore unable to be saved (there is adult baptism in Frankfield), are also deemed as threats. Each of these factors — homophobia, unemployment, rejection of Christianity, the dynamics of gender — shape ideas in this rural community about who are the "guilty," "deviant" and "dangerous others" perceived as likely HIV/AIDS victims.

ETHICAL DILEMMAS: CONCLUSIONS

I enter into the project aware that the fatality rates in the rural areas of Jamaica due to AIDS are likely to increase for numerous reasons. These include late diagnosis of HIV, lack of policies to protect and prevent infection, limited skills and resources to prevent mother to child transmission and lack of accessibility of anti-retroviral therapies because of their high cost. There is some hope that this last limitation might change, given the emerging political climate that may pressure

pharmaceutical companies both to sell their therapies to governments at significantly reduced rates and to ease restrictions on their patents. Still, a study published by the University of West Indies, Mona Campus, Kingston Jamaica shows the projected macroeconomic impact of HIV/AIDS between 1997-2005, based on a low case scenario. The Gross National Product (GNP) will decline by 6.4%; savings will decline by 23.5%; investments will decline by 17.4%; employment in agriculture, the mainstay of the rural areas, will decline by 5.2%; manufacturing will decline by 4.1%; the service sector will decline by 8.2%; the labor force will decline by 7.3% and the cost of HIV/AIDS will increase by 35.4%. The impact of these macroeconomic factors on households is also grim considering subsequent declines in household income and family members, as well as increases in the cost of health care, medications and funeral and burial costs.

Given these numbers and the real life situations they imply, I am challenged to think about my research in ways that call into question the paradigm of relativist thought. Challenges to relativism have been levied by many well-known anthropologists including Sydney Mintz, Eric Wolf, John Cole. These challenges have stirred the waters. Still, they have not yet led to a full-fledged reexamination of the ethical dilemmas raised by relativist thinking that has permeated the discipline. I was trained to embrace cultural relativism. Throughout graduate school there was little if any critical reflection on that concept. In fact, the postmodern position that infused the field in the late 1980s and early 1990s encouraged not only cultural, but moral relativism as well through its focus on the absence of Truth with a capital "T" and the existence instead of multiple, mutually exclusive truths based on human perceptions. But as I increasingly contemplate those human behaviors that cause physical and emotional harm to others, I find myself turning away from the accepted wisdom of relativism and



School children in their fifth year classroom.

instead contemplating its poverty as a guiding philosophy of the discipline. Feminist anthropologists have also been struggling with relativism for some time now, especially those persons involved in the international human rights movement, advocating against traditional practices that are harmful to women. But there is still very much a hesitancy to denounce relativism, as if doing so would lead to the assumption that we embrace thoughtless, scathing judgment. Instead, I think that it is time for cultural relativism to metamorphize into something new, a sort of methodological relativism, as David Maybury-Lewis has suggested, that asks researchers to consider the logic of a viewpoint or practice to understand it as cultural “insiders” do, but not as an excuse not to form an opinion that one keeps hidden from one’s research subjects, especially when those practices violate international human rights norms. If one of anthropology’s missions is indeed to collaborate rather than simply to portray, represent and analyze “the other,” then cross-cultural moral dialogues where both parties are free to engage in cultural criticisms should be part and

parcel of the process of collaborative engagement. In this way, culture is only one component in the process of arriving at appropriate human conduct. It is not the final arbiter.

I make these statements thinking about the educational program I plan to design in conjunction with a Kingston-based non-governmental organization, the Jamaican AIDS Support Group (JAS). How should I express my deep concern with the rampant homophobia and the dangers of these beliefs for Jamaicans? How should I discuss the effects of Christian fundamentalism on stigma? Should the avoidance of offense be my priority, or should I consider that disagreements inevitably offend - at least temporarily? What responsibility should the anthropologist take in participating in and even initiating a dialogue that will have unknown effects, effects that may lead to violence or even to being rejected by the community? Even though one of my closest informants has become a family friend who came to my wedding in the U.S. and who calls me her “American daughter,” I am still ultimately an outsider. To what extent will people accept provocations to the mainstream view from an outsider, that

HIV/AIDS is a disease of the marginalized, and, hence, a valuable measure of dominant moral standards? I have only tentative answers to these questions.

First, it has been important for me to be reminded that since its inception, anthropology has grappled with ethical dilemmas, and that my concerns are not new or novel. While this is not the space to explore the range of those concerns, it is important to point out that in 1999 the Anthropological Declaration of Human Rights was adopted by the American Anthropological Association supporting the principles in Universal Declaration of Human Rights. It thereby underscored anthropology’s commitment to international human rights norms. My proposals for education will be organized with these rights in mind, in conjunction with the members of the Jamaican AIDS Support group who travel around the country organizing workshops, street theatre and other venues to educate people about HIV/AIDS. They seek slowly to dismantle homophobia and to encourage attitudes that promote gender equality. The existence of this group indicates that there are multiple moral views within Jamaican society as there are in any society, and that by aligning myself with this group I am demonstrating that I share values that they hold. Culture exists at organizational levels as well as societal ones, and by joining this organization I become a cultural insider at that level. Second, anthropologists will take new risks when publicly aligning themselves with those who share their values, thereby distinguishing themselves from those whose values differ. We must be willing both to risk rejection and to have our own views analyzed and challenged, just as we may challenge the views of others.

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