

# Social Capital, Health and HIV Awareness of Girls in a Rural Caribbean Community

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## Abstract

*Girls and young women are bearing the heaviest burden of the rising HIV epidemic in the English-speaking Caribbean. Previous research has highlighted the importance of understanding geographical and sociocultural factors in the spread of HIV among this population. This paper reports an exploratory case study which assessed the role of social capital in health and HIV awareness among girls and young women in a rural, isolated community on Andros Island, Bahamas. We examined features of rural community life such as social networks, community engagement, safety and trust in relation to the health and HIV/AIDS awareness of school-aged girls living in this environment. Using focus group discussions and structured writing exercises, we collected information from 18 schoolgirls aged 9 to 16 years about community structure, friendship networks, participation in community life, and issues of safety and trust. We further explored concepts of health and perspectives on HIV/AIDS. Findings revealed a close-knit community in which girls were social as well as economic participants. Girls felt safe, trusted their elders and had an awareness of health and HIV related issues. These social capital elements can play an important role in HIV prevention for girls in the rural Caribbean.*

**Key Words:** social capital, health, HIV, girls, Caribbean

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## Introduction

**H**eterosexual transmission of HIV is a major contributor to morbidity and mortality among youth in the English-speaking Caribbean. Reports from the Caribbean Epidemiologic Center (CAREC) have revealed a dramatic and disturbing rise in prevalence among women younger than 15 years of age (CAREC, 1993). Indeed, young women account for about 7-10 % of reported AIDS cases, and this number is steadily increasing (UNAIDS, 2002). Biologically, female youth face greater vulnerability to HIV infection than their male counterparts. While this vulnerability is a direct result of unprotected sexual intercourse i.e., sex without condom use, other factors including limited access to vital prevention information, poverty, and gender inequality combine to produce profound effects on the health and quality of life of young Caribbean women.

As rural populations within this region transmigrate to urban centers for economic reasons, the geographic reach of the growing HIV epidemic is extending beyond traditional epicenters to once protected rural constituencies (Figueroa, 2003). Thus, girls residing in economically disadvantaged, rural communities face even greater vulnerability. Data from studies in Caribbean countries indicate that many girls experience early initiation of sexual activity (forced or consensual) that, coupled with failure to use protection, frequently results in unwanted or unplanned pregnancies. For example, studies conducted in Jamaica, the largest island of the English-speaking Caribbean, indicate that girls experience sexual intercourse as early as 11 years old, and 80-83% of births to teen girls are characterized as unintended or mis-timed (McFarlane, Friedman, 1999; Wyatt, Durvasula, Guthrie, 1999). Early initiators are more likely to be from rural, lower socioeconomic settings, less likely to use protection, and have less knowledge about sexually transmitted infections (STIs).

Rural schoolgirls from female-headed low-income households are often lured into “transactional sex” relationships with older men who contribute money to the household (Stuart, 2000). Research conducted by the Institute of Social and Economic Research (ISER) at the University of the West Indies (as cited in Howe and Cogley, 2000) indicated that schoolgirls are coerced to engage in transactional unprotected

sex with these men because it provides “material goods” such as books and pocket money for school, as well as clothes for recreational outings. This transactional sex may also result from a search for what constitutes a “father figure” or “Sugar Daddy” who can give them the material things they want (Kempadoo, 2004). Older men tend to have longer sexual histories and this often equates to longer exposure to STIs, including HIV. These conditions, coupled with social norms favoring male sexuality and lower status for women, compromise decision-making for condom use for pregnancy and STI prevention. In fact, condom use negotiation for self-protection in these circumstances is severely limited and, in some cases, virtually non-existent (Figueroa, 2003).

Increasingly, professionals involved in combating the spread of disease recognize the community social context as a viable resource and mediator of health and well being (Minkler and Wallerstein 1997; McKnight and Kretzman 1997). More specifically, social capital, which reflects the social processes, norms and trust among community members, is an important resource for community health promotion (WHO, 1998). Social capital contains elements such as social networks, community participation, information sharing, trust and reciprocity among community residents (Putnam, 1993, 1995, 1996). These elements are instrumental in buffering the effects of poverty on health and well being (Campbell, 2000; Campbell and Giles, 2001; Cattell, 2001; Kawachi, Kennedy and Glass, 1999). Thus socioeconomically disadvantaged communities or neighborhoods with high social capital are often able to shield children and youth from a range of negative health outcomes (Furstenburg and Hughes, 1995; Garmezy, 1991; Morrow, 2000; Runyan et al, 1998).

Recent research has demonstrated important relationships between elements of social capital and the health of girls residing in ethnic minority communities. For example, lower rates of teen pregnancy in predominantly poor Latino/Hispanic immigrant neighborhoods were linked with social capital elements such as commonly shared norms about appropriate teen behavior, peers and friends looking out for each other, shared adult responsibility in monitoring of teen behaviors, teen connectedness to adults, and adults’ positive attitude towards teenagers (Denner, Kirby, Coyle & Brindis, 2000).

Other research has provided evidence that social capital acts as a mediating factor in HIV prevention among youth, including girls, residing in rural, developing country settings. Campbell, Williams and Gilgen (2002) demonstrated this in a study with young people in rural South Africa. Young women living in a rural, poor Black township were less likely to be infected with HIV if they belonged to and participated in a community sports club or youth group. They were also less likely to participate in unprotected sex with casual partners. This social capital feature promoted sexual health and well-being and reduced the likelihood of HIV exposure and infection.

In this research brief, we present preliminary findings from an exploratory case study which examined key elements of social capital - social networks, engagement in community life, safety and trust - and assessed concepts of health and HIV awareness among schoolgirls in the rural English-speaking Caribbean. Our aim was to understand the social context of health, HIV awareness and its prevention among these girls. Specifically, we solicited the viewpoints of girls living in the rural Bahamas on social capital and their definitions of health and HIV/AIDS. We developed a working definition of social capital as a resource with features such as social roles, relationships and networks, information channels and trust among members of the community. Social capital, as a resource, enables individuals to actively engage with and benefit from community life. In this case study, social capital was operationalized as girls' social and economic participation in community life, friendship networks, and feelings of safety and trust in selected community members.

Previous research with girls in the English-speaking Caribbean has indicated that health and disease related knowledge and attitudes are mediated by geographical community environments, as well as access to and use of the social processes occurring in the community. For example, in assessing geographical variations in AIDS knowledge and attitudes among girls in Jamaica, Warren (1999) noted that girls in rural and remote areas were less likely to have heard of AIDS, less likely to have been exposed to multiple sources of information about the disease and less likely to perceive themselves at risk. These factors shape how girls view and experience health, and the extent to which they are shielded from HIV as a negative outcome of poverty and rural life.

However, limited data exists on social capital indicators of health and disease in schoolgirls in rural settings.

## Methods

The theoretical framework guiding the research was derived from Virginia Morrow (1999; 2000; 2001a) who argues that in developing a useful model of social capital, one must be aware that for children, "choice and freedom are constrained by everyday contexts, and a range of community, environmental, and socio-economic factors" (Morrow, 1999, p.761). Additionally, children and youth take a perspective on life that differs from the perspective of adult counterparts, and it is important to examine their perspectives in regard to health and quality of life. Therefore, any action taken to understand the context of children's lives and to intervene on behalf of their health and well being must consider their unique and powerful viewpoints.

In her work with school-aged children and health inequalities in the UK, Morrow juxtaposed conceptualizations of social capital by Putnam (1995) and those of Bourdieu (1986) (social capital as "social connections") to create a working definition of children's social capital. She proposes that social capital for children involves children's participation in the community and the extent to which they have freedom to make decisions and act in their own best interests. With the aid of qualitative research methods and structured activities, Morrow uncovered varying themes governing social capital, its meanings and access for young people and the impact it has on their lives. She demonstrated that elements of social capital relevant to the social life and well-being of youth can simultaneously possess positive and negative attributes. For example, a form of social capital known as "bonding capital" occurs through closely knit friendships and group membership, and promotes social cohesion among children. Bonding capital can be positive if it promotes a sense of belonging and safety for children within the larger community. However, bonding capital may be negative if it facilitates gang formation and youth violence. The direction and impact of social capital attributes as they relate to children's health and well being are therefore moderated by larger community processes, practices and resource availability (Morrow, 2001b). The direction is closely linked to

constraints around or freedom for youth participation in community processes and practices.

In applying this theoretical perspective to studying social capital and health awareness in children of the English-speaking Caribbean, the assumption is that school-aged children living in this region will view and experience their community, its social world and relationships in ways that differ from their adult counterparts. Their opinions and explanations about community life, social processes and participation help create a cultural model of social capital relevant for this population and setting, and a context for understanding health perceptions and related behaviors. Soliciting school-aged girls' viewpoints using this framework can facilitate discovery of complementary or contradictory themes that would be missed if studied from the Caribbean adult's perspective. With this in mind, to distinguish the mediators of girls' lives, the following factors were considered: the way community structures were described and interpreted; the types and extent of interactions girls had within it; the kinds of relationships they developed; and the way they understood and practiced health concepts.

### ***Research Setting***

Andros Island is the largest island in the Bahamian archipelago. The island is home to about 8,000 inhabitants, the great majority of whom (85%) are Black or of African descent. A small number of white Bahamians and expatriates also call this island home, permanently or seasonally. Andros is divided into the North, Central and South geopolitical divisions. This exploratory research was conducted during Summer 2003 in the community "settlement" of Red Bays, in North Andros. Red Bays is located on the western shore of North Andros, 20 miles inland from the nearest major road, Queen's Highway. It is home to about 300 inhabitants, of whom many have ancestors that can be traced back to Black Seminole Indians from the United States (Howard, 2002). Many residents of Andros Island, like those in other Out (Family) Islands in the Bahamas, transmigrate to Nassau for the procurement of goods, health services and employment. This fact presents a complex interaction that defies the strict rural/urban dichotomy.

Children and youth comprise approximately 81% of the population, most residing in households with up to four generations of relatives (Howard, 2002). Families are generally poor, with household

income derived from fishing, sponging and basket making (Howard, 2002). The settlement has four small family-owned shops that primarily stock dry and canned food items obtained from Nassau, the capital city located on New Providence Island. Public community infrastructure includes one primary school, Red Bays Primary, with approximately 76 children in attendance (49 are girls between 7 and 12 years old), the New Salem Baptist church, and an open field area that serves as the recreational spot for basketball, softball and community dances and festivals.

There is no high school in Red Bays. Prior to the construction of the main road in the late 1980's, parents would send their children to live with relatives in other Andros settlements or in Nassau so they could attend high school. Students are now transported daily by bus to North Andros High School located in Nicholls Town, some 30 minutes away (Howard, 2002). Prior to the late 1990's, no sex education was taught at Red Bays Primary (Reverend B. Newton, personal communication, July 29, 2003). Currently, students receive instruction in personal hygiene and wellness, sexual reproduction, basic information about HIV/AIDS, social responsibility and good citizenship through the Family Life and Health Education curriculum developed by the Ministry of Education. This curriculum is also taught at North Andros High School with additional emphasis on sexual responsibility (M. Bowleg, personal communication, June 17, 2005)

### ***Sampling and Recruitment***

The participants in the study were drawn from a purposive sample of schoolgirls aged 9-16 years old who resided in the community at the time of the study. Purposive sampling is useful in exploratory research and pilot studies, particularly in qualitative research with special populations or settings (Bernard, 2002). The girls included in the study were identified and recruited through a "household referral" strategy. The physical location of each household in Red Bays in which children were known to reside was identified from a community map constructed by our team of anthropology and community health field researchers. With the assistance of three schoolgirls who served as "social contacts" in the community, we generated a list of eligible schoolgirl participants and their parents/primary guardians in these households. We visited 15 households, that is, the households of all the

eligible schoolgirls on the list, to obtain permission for the study.

With the assistance of a young adult female community liaison, we orally presented and explained the study, its rationale and methods to both the parent/primary guardian and the eligible schoolgirl(s) in the household. Both oral and written consent were obtained from parents willing to have their child(ren) participate in the study. Parents were assured that permission/assent would also be sought from each eligible schoolgirl in the household. Parents were specifically discouraged from forcing their child/charge to participate. Parents and schoolgirls were assured that participation in the study was voluntary, confidentiality would be maintained, and no negative consequences would occur if they decided not to participate or to withdraw from the study at any point. In all, parents/guardians in 14 of the 15 households agreed to have their girl children participate in the study, and 23 girls assented to participate. All were of African descent. The study protocol underwent approval by an Institutional Review Board prior to the start of the study. Endorsement for the study was received from the Principal of the Red Bays Primary School and the spiritual leader/elder of the settlement.

#### ***Data Collection and Analysis***

Focus groups and structured writing were used in combination to explore schoolgirls' evaluation of their community, the nature of their social world, and their perceptions of health and its promotion in the community. Structured writing is helpful because it allows individual reflection and provides a non-threatening medium for expression of views. The structured writing exercise acted as an additional medium for expressing personal viewpoints and focused on "likes and dislikes" about community, and friendship definitions.

Using Morrow's theoretical framework of social capital, a topical guide for focus group discussions was created consisting of open-ended questions that captured roles and activities within the community (e.g., out-of-school activities girls typically participate in); friendship relationships; feelings of safety; and the community members who are trustworthy or the member a girl would turn to if she had a problem or health related issue. To capture perceptions and experiences of health, questions asked for definitions of health and types of health actions, the nature of AIDS, its cause, and the way HIV is transmitted and prevented (See Table 1).

The focus group discussion guide was refined based on cultural information derived from on-going anthropological work in the community (see Howard, 2002). It underwent pilot testing and final revision in The Bahamas with the assistance of local school teachers and community "social contacts". The format and standards were in accordance with the principles and procedures outlined by Morgan (1988) and by Ulin, Robinson, Tolley and McNeill (2002).

Focus groups were conducted during July and August 2003 with 18 of the 23 eligible schoolgirls. The 5 non-participants were not present in the settlement during the data collection period. The girls were separated into two age categories: 9-12 years (nine participants total) and 13-16 years (nine participants total), and two discussion sessions were held for each age category (four focus groups total). Each discussion group contained four or five participants. The discussions were held in a classroom at the Red Bays Primary School. Each discussion was limited to 45 minutes and was conducted by a trained moderator. A field research assistant took notes throughout the discussion. All discussions were audio taped and later transcribed for analysis. The structured writing exercise followed the focus group. The girls were provided with a colored binder with paper containing questions about community and friendship, and a No. 2 pencil or a pen. They were given 30-45 minutes to respond, and asked to limit responses to no more than two pages. Participants were later given photocopies of their writings with spelling and grammar corrections and suggestions for improvement. The girls were also given a small gift in appreciation for their participation.

An iterative content analysis method was used to discover and clarify concepts and themes related to the issues under study. Preliminary coding was generated first to identify the initial concepts and themes that emerged from the transcribed focus group discussions and writings by the girls. These concepts and themes under broadly defined elements of social capital and health were grouped and recoded for meanings and relationships between and within these areas. Findings were verified with representative girls and other individuals familiar with the community structure. Preliminary findings are presented in the following section.

**Table 1.** Questioning guide for focus group discussion and structure writing

<i>Techniques</i>	<i>Elements</i>	<i>Questions</i>
<i>Focus Group Discussion</i>	<i>Community Life and Social Networks</i>	<b>What is a girl's social life like? What does "friendship" mean? Who is a friend?</b>
	<i>Engagement, Safety and Trust</i>	<b>What activities do girls/young women do in the settlement? Do you girls feel safe in the settlement? If a girl had a problem, who would she go to? Talk to?</b>
	<i>Health/HIV Awareness</i>	<b>How do girls/young women define "health"? What does it mean to be healthy? What is AIDS? What is HIV? How could a girl get it? How does it affect health? How can girls/young women protect themselves from getting it?</b>
<i>Structured Writing</i>	<i>Community Life and Social Networks</i>	<b>What do I like about my community? What don't I like about my community? What is a friend?</b>

## Findings

### *Community Life and Social Networks*

Questions related to girls' likes and dislikes about their community produced responses that described the community as a "close place," one where everybody was related and everybody knew everybody living there. The settlement was peaceful most of the time, and there were very helpful people living in the community, described by some girls as "people that's always there when you need important stuff". Girls reported that they particularly liked the close proximity of a neighbor's house, and that a neighbor's home was always open and accessible to them. They did not, however, like the garbage that was on the sides of the streets and in the yards. The girls in the 9 to 12 year old group indicated they disliked boys who teased them a lot. The 13-16 year olds said they disliked neighbors who "talk about your business" and "tell lies on each other." Girls in both age groups referred to an ongoing jealousy between neighbors and some adult siblings in the settlement.

Social life consisted of friends, cousins, older women in the community and the "Rev," referring to Reverend Newton, the community elder and spiritual leader. Most identified a "friend" as someone with whom they could talk, share secrets, play softball and watch TV. A majority of the girls also identified siblings and cousins as part of their "friendship" network. A "friend" was also defined as someone who would love them and rescue them when they were in trouble; "friends are for when you get lonely, they will be right there for you"; "they do not tell lies on you" and "friends buy you things." Boys were not listed as part of this network.

### *Engagement in Community*

Overall, participants felt themselves to be an important part of the settlement and most had been raised there. However, one young woman said she "felt out of place" because she was sent off to school in the capital city, Nassau (which is on another island), but came home for long weekends, holidays and summers. This made her feel "left out from things going on daily" in the settlement. One older girl (16 years old) described the settlement as "boring" and

said that “the people are not progressing.” She preferred to stay to herself, and spent most of her time reading and expressing her thoughts in writing. She particularly enjoyed writing poems.

Girls were expected to help around the house with cooking and cleaning. They learned from their mothers, sisters and female cousins. They were also expected to do well in school. In addition, girls were involved in the economic life of the settlement. Many participated in hair braiding, by either assisting more experienced women with setting the styles, or getting their own hair done. Some participated in basket making with their mothers, grandmothers, aunts, sisters and uncles. A few accompanied family members, mostly fathers and uncles, when they went fishing. Girls did not participate in “sponging” as this was a “male” job. However, they were allowed to go down to the bay during “sponging” activities, to be by the water, watch the sunset and play.

Most girls in Red Bays were avid softball players. The settlement has its own women’s softball team that competes against other communities on the island. The team is typically organized and managed by older (above 20 years old) women (mothers, sisters, aunts and female cousins). Players range in age from 9 years to early 40’s. Men and boys do not play softball. The girls described men as “poor ball players” and only good for practice sessions. In fact, men were only allowed to participate in practice sessions with women just before an upcoming game with a Central, North, or South Andros Island team. Church and related activities were a major part of the girls’ lives. They said they enjoyed the lively Sunday services with charismatic preaching and gospel music, often accompanied by an acoustic guitar, electronic piano/organ and drums.

### ***Safety and Trust***

All the girls indicated that they felt very safe in Red Bays. In fact, many would sleep over at a neighbor’s home without their parents worrying about their whereabouts. A few, however, identified “dogs running wild” as a major concern and source of fear. They were fearful of being bitten by these dogs. Girls unanimously recognized the “Rev” as a major source of information for the community as well as a trusted confidant to young women. Girls could turn to “the Rev” for help if they were in trouble, e.g., became pregnant. Some indicated, “You can talk to the Rev ‘bout anything!” Friends (including cousins) were also a trusted

source of information and protection. “You can trust friends because they keep your secrets” was a commonly held perception among focus group participants. Additionally, teachers were seen as a source of support for health and for helping girls with family matters beyond the school setting. Older siblings were less frequently viewed as trustworthy.

### ***Health and HIV Awareness***

A young woman was perceived to be healthy if “she ate good food and did plenty, plenty physical activity.” Interestingly enough, girls described skinny or thin girls as “not healthy.” These were girls who were “poling” (skinny) and sickly. All the girls, even the youngest age cohort, were aware of AIDS and its ability to cause illness and death. They were also knowledgeable about its transmission by having sex. When probed about the origins of AIDS in their community, several said they knew about it because the disease was brought to the settlement by “men from Nassau.” Several of the girls indicated that they knew at least one person in the settlement with AIDS. Others said they knew about it from school and from older people in the community. Not all the girls appeared to understand the distinction between AIDS and HIV. However, several were aware that “using a condom” was a method used by persons who wanted to protect themselves from the infection. Several mentioned protection from the disease by not having any sex.

## **Discussion**

This paper provides a beginning exploration of the salient features of social capital and their relevance to health and HIV awareness among a population of children residing in a rural English-speaking Caribbean community. There are obvious limitations to this exploratory work, including the small number of focus groups (n=4) and participants (n=18), and the non-randomness of the sample. The findings can thus not be generalized to other populations of girls in English-speaking Caribbean island settings. Nonetheless, the perspectives of these girls offer valid, meaningful and insightful glimpses into the role of social capital in prevention of HIV spread. Our use of qualitative research methods previously normalized with children of similar age groups, and our cultural immersion in the community prior to the study provide assurance that high quality data were

collected. The girls' discussions and structured writings uncovered useful concepts, definitions and explanations which allow us to view social capital both as process and resource with a mediating role in health and HIV prevention among youth in rural, economically challenged Caribbean community settings.

Girls in the Red Bays settlement perceived their community as a cohesive, tightly knit, harmonious environment (with a few exceptions of course), in which they felt safe. Their social world consisted of "friends", defined as peers, close-in-age siblings and cousins; "friendships" offered a space for information sharing, social recreation and support. These friend characteristics and friendship roles have been linked to positive self-esteem and low prevalence of emotional disorders (Bukowski and Hoza, 1989). Further, these features of friendship have been shown to play an important role in deflecting sexual risk behaviors among adolescent females (Billy and Udry, 1985). This could well be the case in Red Bays in terms of HIV prevention among these girls. However, more research would be needed to test this assertion. Additionally, the girls are typically engaged with older women, their sisters, and female cousins in economic and social activities. This creates a model similar to the one found by Denner, Kirby, Coyle and Brindis (2001), in which girls continued connections to older adolescents and adults in the community shared and enjoyed monitoring the youth.

Proponents of social capital as an indicator of child development, welfare and health have pointed to the complexity of the linkages that exist between social capital and outcomes. Social capital may have differing meanings and associations depending on the geographical and cultural context. The relationships between social capital and child health may function one way in a developed country setting (Morrow, 1999; 2000), and in another in a developing country setting (Ferguson, 2004). This exploratory case study has yielded encouraging results for the latter case. The perspectives shared by the girls in this study indicate that young people lend important perspectives to a model of social capital. Social capital was defined in terms of physical and social closeness in the Red Bays community -- "closeness" of houses and "close" neighbor relations within the settlement. This closeness in part allowed girls to expand friendship networks beyond peer groups to include blood relatives and distant kin. The pastor, as community elder

and spiritual leader, was an important source of information and social support for health, as were parents and teachers. This feature is characteristic of communities that support girls' achievement and well being through intergenerational networks and it is a common feature among poor Latin American populations, whose cultural traditions emphasize familialism (Valenzuela and Dornbusch, 1994).

These girls' perceptions of health were largely framed around nutrition, physical activity and physical appearance, with excessive thinness viewed as negative and unhealthy. The majority of the girls were aware of AIDS; however, girls in the 13-16 year old cohort had more knowledge about HIV transmission and sexual risk behaviors, and acknowledged condom use as a viable means of protection. This study's findings suggest a niche for teachers and health educators who could exploit these features of social capital to more effectively introduce and strengthen HIV/AIDS education for early adolescent schoolgirls.

Virtually all girls had heard of and/or knew at least one person who was living with AIDS. This may not be unusual occurrence due to frequent transmigration to Nassau for work and pleasure. In a small, primarily homogeneous and socially cohesive community such as Red Bays, privacy is less likely to be maintained for persons with AIDS. The emphasis on "peers looking out for each other" and "making sure that friends don't get into trouble" highlights the strength of peer influence on behaviors. Peer education has been shown to be an effective social strategy developing safe sex awareness among young people in other Caribbean nations, such as Jamaica (Smith et al, 2003).

## Implications for HIV/AIDS Prevention

Much of what is known about the social contexts of youth, health and HIV prevention in the English-speaking Caribbean is derived primarily from studies in urban settings. This case study adds to the growing repertoire of research examining social and gendered contexts of prevention in rural settings. Conceptions of social capital that move beyond those advanced by earlier scholars are essential for accommodating the identities and practical everyday realities of rural Caribbean youth. This is especially critical for disease prevention and



health promotion efforts targeting girls and young women, who are now carrying a heavier burden of HIV infection. HIV/AIDS prevention programming designed to increase access to social capital could provide the leverage needed to override the HIV vulnerability imposed by poverty and sexual inequality.

School and community health educators working on HIV prevention for youth in poor, rural Caribbean settings should incorporate strategies to strengthen social capital in their outreach. Teachers can introduce friendship and trust building exercises among peers of girls in the classroom to facilitate open discussion and awareness about HIV and AIDS. Community health educators can collaborate with young women to organize after-school social opportunities such as girls' or "buddies" clubs which emphasize participation in dance, drama and poetry writing for building self-esteem, encouraging self-awareness and positive health behaviors. Finally, community health educators can collaborate with trusted community elders to facilitate parent-child discussion of sexuality and HIV/AIDS and encourage positive health attitudes. These approaches will certainly enhance the ability to respond in a meaningful way to this growing rural epidemic. As economic and social disparities continue to challenge AIDS prevention in this geographically vulnerable region, this kind of holistic approach could strengthen self- and community- efficacy for HIV infection avoidance and health promotion.

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