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‘Some Men Just Don’t Want to Get Hurt’: Perspectives of U.S. Virgin Islands Men Toward Partner Violence and HIV Risks

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Abstract

Objectives—Global evidence suggests that individuals who experience intimate partner violence (IPV) can have accelerated risk for HIV transmission. The U.S. Virgin Islands (USVI) has high per capita rates of HIV and IPV that can have devastating effects on women’s health. Catalysts for these health disparities may be shaped by cultural and social definitions of conventional masculinity. Thus, understanding USVI men’s perceptions about HIV risks and IPV are a necessary component of developing strategies to improve women’s health. This study aimed to describe perceptions of HIV risks and IPV among USVI men.

Design—We conducted two focus groups with 14 men living on St. Thomas and St. Croix, USVI. The focus group interview guide was culturally relevant and developed using findings from research conducted about these issues on USVI. Thematic analysis was used to analyze focus group data. Transcripts were coded and categorized by four research team members and discrepancies were reconciled. Themes were developed based on the emerging data.

Results—Focus group participants were all US citizens born on the USVI, had a median age range of 20–25, 86% (12) were of African descent and 14% (2) were Hispanic. Themes emerging from the data were: (1) validating status, (2) deflecting responsibility, and (3) evoking fear and

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distrust. These ideas underscored the ways that attitudes and beliefs informed by gender and social norms influence IPV and sexual behavior between intimate partners.

Conclusion—USVI society could benefit from interventions that aim to transform norms, promote healthy relationships, and encourage health-seeking behavior to improve the health of women partners.

Keywords

intimate partner violence; HIV/AIDS; sexual health; masculinity

1. Introduction

Per capita rates of intimate partner violence (IPV) and HIV diagnoses are high among people living in the U.S. Virgin Islands (USVI) (SG et al. 2016). Emerging global research about these intersecting phenomena provide evidence that women and men experiencing or committing IPV potentiates risks for HIV acquisition (Heise and McGrory, 2015). Compared to the US mainland, this small group of islands—with a population of over 100,000—has the 3rd highest per capita rate of HIV infections (Centers for Disease Control and Prevention [CDC] 2015). While population-based surveys rarely capture the prevalence of IPV on USVI, according to the CDC's 2005 Behavioral Risk Factor Surveillance system, 22.5% of respondents reported a lifetime experience of IPV (ranging from 19.5% [Puerto Rico] to 35% [Nevada] (Breiding, Black, and Ryan 2008). A comparative case control study recently conducted on USVI among women attending family planning clinics found between 28-45% reporting a lifetime prevalence of IPV, inclusive of emotional abuse (Stockman et al. 2014). These rates are equal to or higher than the US mainland rates (Black et al. 2011).

The USVI are a cluster of islands acquired from Denmark by the U.S. government in 1917. It is an organized unincorporated territory of the US and includes three main islands: St. Thomas, St. John, and St. Croix (International Cartographic Association 2013). They are socially unique in that although a US territory, they have cultural practices specific to other Caribbean nations. For example, less than half (46.7 %) of the Virgin Islands population are native born; 34.7% were born in Latin America or on other Caribbean Islands, with 15.8% born in the United States. Less than 3% of the Virgin Islands population were born in Asia, Europe, and the Middle East.

The Caribbean has a rich cultural history influenced by high levels of migration, slavery, globalization, and indentured servitude (Plummer 2009). In fact, the USVI recognizes the centennial anniversary of the sale of Denmark to the United States. These social phenomena shape gendered socializations, interpersonal relationships, and subsequent health behaviors among Caribbean men and women (Case and Gordon 2016). As such, the contemporary impact of slave-holding colonialism warrant ongoing exploration and examination of marked health disparities. Seventy-six percent of the USVI's population is of African descent (U.S. Census Bureau 2016) and experience disparate outcomes in HIV similar to Black Americans residing on the US mainland (CDC 2015). Women of African descent in the US are disproportionately affected by both IPV and HIV (Black et al. 2014), yet there has been little

health disparities research conducted in the region, particularly concerning USVI men, sexuality, HIV/AIDS, sexually transmitted infection (STI) prevention, and IPV.

There is now emerging strong evidence that IPV increases risks for HIV transmission from men to women (Maman et al. 2000; Gielen et al. 2007; Phillips et al. 2014). Cultural and social explanations accelerate detrimental consequences to women's sexual health (Stockman et al. 2014). For example, sexual risk behaviors are more prevalent in relationships shaped by physical violence and forced sex by an intimate partner (Draughon et al. 2014). Males who engage in IPV are more likely to have multiple partners than men who do not use abusive tactics against their partners (Heise and Kotsadam 2015). Women reporting recent IPV are more likely to contract STIs, have a concurrent partner with STIs, or have a partner who also has concurrent partners. They are also more likely to experience psychological trauma and depression, decreasing their ability to negotiate condom use during vaginal or anal sex, which raises the risks for HIV transmission (Bergmann and Stockman 2015; Frye et al. 2011; Mittal, Senn, and Carey 2013). There are additional, more direct risks for HIV transmission such as sexual violence including sexual and reproductive coercion as well as forced vaginal or anal sex that contribute to women's risks. These behaviors can result in inflammation, immune activation and genital traumas that heighten biological risks for HIV transmission (Campbell et al. 2012; Heise and McGrory 2015).

In the Caribbean, IPV is shaped by values, roles, and behaviors that are normalized though imbalanced, often placing men in a dominant position over women (Kempadoo 2009). The higher positioning of men is thus determined by a set of attributes in society that have historical and generational significance. Rules, or norms, for masculine behavior play an important role in understanding relationships between Caribbean men and women (Jewkes et al. 2015). In this paper, we use the term 'norms' to describe often invisible attitudes that prescribe and proscribe what individuals should do and how they should feel in relationships with women (Pleck, Sonenstein, and Ku 1993).

Sexual behaviors occurring between Caribbean men and women have been investigated by social scientists over the last two decades to determine how representations of hyper-sexuality, the view that men want sex all the time (Pleck, Sonenstein, and Ku 1993), informed by slaveholding colonialism in the region continue to play out in today's societies (Case and Gordon 2016; Sharpe and Pinto 2006). Traditional masculine norms, including status or reputation and toughness, may provide insight into health-seeking or health risk taking behaviors (O'Neil 2015; Houle et al. 2015). For example, men who adhere to ideals about mental, physical, and emotional toughness are more likely to engage in risky behaviors such as substance use, including alcohol, marijuana, and other drugs (Griffith 2015; D M Gordon et al. 2013). These behaviors also have strong links to IPV victimization and perpetration (Cafferky et al. 2016). Violence against women and risky sexual behaviors such as multiple partnering and sexual-economic exchange are common themes discussed by authors examining sexual practices in this region of the world (Kempadoo 2009). Norms about the acceptability of men using violence towards females in relationships have been found to be associated with IPV in the USVI and globally (Stockman et al. 2014; Heise and Kotsadam 2015; Heise et al. 2016).

Adherence to masculinity norms and the negotiation of those norms by men living in the USVI can have grave implications for women's health. In the broader literature, scientific representations of Black heterosexual men emphasize gender expectations that heighten risks to sexual health (Santana et al. 2006). These expectations include engaging in sex with multiple sexual partners (Bowleg et al. 2011), pleasure-seeking (inconsistent condom use), anger, and an affinity for female subordination (perpetration of IPV). The significant role of gender norms is emphasized during childhood and continues to gain importance during adolescence (Plummer 2009). Thus, norms that guide men to demonstrate toughness and sexual prowess may be social forces driving the Caribbean HIV epidemic. Toughness has been associated with higher risk taking, including sexual behaviors, interpersonal violence, and substance use in Latino, African, and African-American populations (Siu, Wight, and Seeley 2014; Gordon et al. 2013).

Norms are changing which inform new ideas about gender and aggression in interpersonal relationships among Caribbean and African-American men and women (Le Franc et al. 2008). For example, men who endorse the traditional norm of status or a man's need to achieve position or others' respect may have potential protective effects on health behaviors and outcomes (Griffith 2015; Gordon et al. 2013). This belief about masculinity may move men toward positive health behaviors in an effort to be good role models (Gordon et al. 2013). Male role norms can be incongruent with attitudes toward women. For example, in some cases, men may hold conservative or traditional views about male norms for behavior while holding more liberal views on women's behavior (Thompson and Pleck 1986).

There are limitations to the information we currently have about the ways violence and sexual risk behaviors shape Caribbean relationships. The populations of countries in the region are small; therefore, global studies tend to aggregate findings from several countries (Le Franc et al. 2008). This practice limits our understanding of the specific ethnic or cultural nuances that may drive sexual behaviors across the Caribbean and, specifically, in the USVI. Additionally, in-depth descriptions of attitudes and beliefs about sexual behavior and violence by men are underexplored in the literature (Stockman et al. 2013). While the current literature about HIV risks in the Caribbean is more focused on women, it demonstrates that gender norms are influential in the socialization of men and women, and influence behaviors that can create risks for both genders (Kempadoo 2009). The complex problems of sexual health and IPV are relational and cultural. The purpose of this paper is to describe gendered attitudes and beliefs about IPV and sexual risk among the USVI men who participated in focus groups conducted on the USVI of St. Croix and St. Thomas. By examining their attitudes and beliefs, we may better understand the risk for women living in the USVI and enhance the safety of families.

2. Methods

2.1. Setting and Sample

The present study is based on data collected from our parent project: Empowered Sisters Project (ESP). ESP is a larger randomized controlled trial in the USVI that aims to develop and test an IPV and sexual risk-reduction program for women attending public health clinics on St. Thomas and St. Croix. A series of focus groups were conducted by the study team

with stakeholders living in the USVI. These included two focus groups with adult women survivors of IPV, two focus groups with adult men, two focus groups with healthcare professionals (e.g. nurses, physicians, social workers), and two focus groups with other professionals (e.g. domestic violence advocates, community HIV/STDs prevention workers, and representatives of the judicial system with knowledge and experience working in the area of IPV and HIV). Focus group findings from the women's and professional groups will be analyzed and published elsewhere.

2.2. Procedures

We used purposive sampling techniques to recruit male participants who reported a current or past intimate relationship with a woman. Participants from St. Croix had completed court-appointed anger management training by the Men's Coalition of the Virgin Islands. Whereas, men participating from St. Thomas were recruited from the local university. Focus group methodology was chosen as the qualitative data collection method for this study because it provided the opportunity to collect descriptive data from persons that could provide a personal perspective about IPV and HIV risk behaviors (Davidson, Halcomb, and Gholizadeh 2013). The group environment provided participants an opportunity to interact and thus highlighted their perspectives on ways sexual risk and violence occur in their communities.

Prior to starting the focus groups, participants completed written informed consent that included the main purpose of the focus group discussions, to provide information supporting development and testing of an intervention designed to enhance abused women's use of personal and sexual safety strategies. The consent also included discussion of a dissemination plan for data collected during the focus group discussions. The focus group facilitator emphasized the confidential nature of the discussions and the study team's interest in creating a safe space for men to listen and learn from others about these sensitive topics from diverse perspectives. The focus group interview guide included open-ended questions and probes that emphasized domains of interest for IPV and HIV prevention. The focus groups lasted approximately 2 hours and were conducted in convenient locations and times determined by participants. Skilled study team members facilitated the discussions, while another team member, usually the project director, took notes throughout the focus group. To enhance confidentiality, participants used celebrity names as pseudonyms during the group. The institutional review board at the University of the Virgin Islands approved all study procedures. The interview guide included the following questions about men's perceptions of IPV: (1) What do you believe men in the USVI think about violence against women? (2) What role does self-control play during episodes of violence and aggression against a female partner? (3) How is violence and abuse of women or conflicts in intimate relationship seen in the USVI? (4) Some people think that yelling, cursing, pushing, shoving are not as bad as really beating someone up, especially if injuries were not bad enough to require a visit to the emergency department. What are your thoughts about this? Participants were also asked questions about HIV prevention including: (1) Can you think of any strategies that women should use to encourage men to use condoms, and (2) What do men think about condom use, and getting tested for STIs and HIV even if they don't have any symptoms?

Audio-taped focus group responses were transcribed and checked for accuracy by the study team members and facilitators of the discussions. The data analysis team used descriptive thematic analysis within a constructivist epistemological tradition to derive coding categories and definitions within the two domains of interest: IPV and HIV (Braun and Clarke 2006). Transcripts were then reviewed by four research team members and coding categories were applied to sections of text. The same four research team members coded both transcripts; discrepancies were reconciled through group discussions. Themes were developed based on the participants' data that illustrated the coding categories (Denzin and Lincoln 2000). Self-reported demographic data were double data entered in SPSS (IBM Corp. 2013) and frequencies were used to describe the sample.

3. Results

The study included 14 men between 18 and 54 years of age, with a median age between 20 to 25 years. Two participants reported past IPV victimization and six reported past perpetration of IPV. Seven participants self-identified as Black/African-American, five as Black/African-Caribbean, and two as Hispanic.

Overall, masculinity norms for behavior were important drivers of responses to perceptions of sexual health and relationship violence. Three themes emerged from the statements of focus group participants: (1) Validating Status, (2) Deflecting Responsibility, and (3) Evoking Fear and Distrust. The authors recognize the findings as described reflect a subjective interpretation of the data.

3.1. Validating Status

The most prevalent masculine norm noted in discussions among the participants related to establishing and maintaining status. This theme described ways men perceived a social standing above women in their lives and how they applied these thoughts to interpretations of their own behaviors as well as to the behaviors of women in their community. Focus group participants discussed attitudes of women that illustrated a desire for power in their intimate relationships. Their rights as men included having control and responding to attention-seeking behaviors by their partners. This required a response that aligned with a status of dominance. For example, one participant said, 'I'm the man. I'm in control. You can't be bossing me around to do too much (St. Thomas)'. Another believed his status was bestowed upon him by virtue of being born male: 'I mean men from before time were like always in control for some reason. It's installed in our DNA (St. Thomas)'. Another participant analogized his position to that of a lion – king of the jungle, describing his status as a protector for his family, saying,

You know at the end of the day a man is supposed to be the lion of the household. If somebody coming to, a burglar come, whatever, somebody coming to endanger the house, a man going always be there on the front line. Ain't going be his woman for protection; for his cubs and for his woman. (St. Croix)

Relating to sexual health, focus group participants also certified their status as a guiding principle for behavior. One participant believed that all men are born with a certain set of

skills, saying, ‘You don’t have to learn to put on a condom...it’s like an instinct (St. Thomas).’

Behaviors that further increased risk for HIV transmission were discussed in the context of wanting to maintain a status compatible with hypermasculinity by seeking multiple partners and reporting this to friends. For example, one participant stated,

The more women they have the more manly they are because you see, you hear your friends talking. Oh yea I have so much girls’ numbers in my phone. Yea, I could text this girl, that girl, that girl, and that girl (St. Thomas).

Participants certified their status as men, carrying their masculinity like a badge of honor aimed at solidifying a higher position they felt they deserved. Their words provided a foundation for understanding attitudes towards women that may guide behavioral decisions and increasing their partner’s risks for victimization from IPV and undesirable sexually related outcomes.

3.2. Deflecting Responsibility

Beliefs about their masculine status complemented participants’ desires to avoid accountability for their roles in violent or sexual risk-taking behaviors. Several participants conjectured about motives for women’s actions, providing an opportunity to deflect responsibilities for their own behaviors. For example, one participant shared his perspective about why an argument could turn violent saying, ‘...she provokes him and provokes him till he does something he doesn’t want to do... But the women didn’t want to let him be in control and leave the situation (St. Thomas)’. A participant from St. Croix further re-stated the responsibilities women should own by implying men have little self-regulation for their own emotions: ‘So it’s like we try... [but] women provoke men to do a lot of stuff that they don’t want to do. (St. Croix).’ In these statements, the participants allude to the expectation that men lack control of their reactions to a partner during conflict. They further this argument and offer a suggested prevention strategy that places the responsibility for de-escalation squarely in the hands of the woman partner. This attitude provides a rationale for deflecting responsibility for emotional control and places it on his partner’s actions.

Some discussed their perceptions that a woman’s behaviors are rooted in a need for responsiveness from her partner. One participant said, ‘To have attention or she just wants to get beat up. I think it is mostly the attention part (St. Thomas).’ This statement implied that he believed some women have a desire to experience violence at the hands of their partner. To further this belief, several respondents rationalized violence as a response to women partners’ behaviors. For example, one participant stated,

Women just provoke us to do the things we don’t want to do. Like we control ourselves, but they just saying I want you to do this... Like why have self-control the first time... you [woman] do you want something to happen right? Some women out there that are so spiteful they would push a man to his limits. (St. Thomas).

This statement explains the perception of some participants that women partners are responsible for managing or preventing negative male behaviors towards partners. This

discussion prompted several participants to issue advice to women such as: ‘Don’t like do anything to make the man upset. Don’t push his buttons, don’t make him aggressive or anything... don’t do nothing wrong with the man.... Don’t do stuff that he doesn’t like. That’s the best way (St. Croix)’.

Regarding sexual behavior, participants’ comments gave insight to some direct pathways violence can lead to HIV/STI transmission through multiple partnering and engaging in sex without a condom. Most male participants did not accept responsibility for keeping themselves or their partners safe from infection. Prevention of HIV was the woman’s job. For example, condom use was universally unpalatable for the men participating in the focus groups. Several participants stated that women should be responsible for protecting themselves,

...Because if the girl really wants to protect herself, she would actually have it [condom] just in case the guy don’t have it. Because a lot of girls in the Virgin Islands and most in the states too, if they don’t have it, and they really want to have sex, they would actually do it. (St. Croix)

Another participant discussed the female condom as an option for protection that women should use, deflecting the responsibility for safe sex onto his partner. To this point, one participant said, ‘Instead of thinking of how to put a condom on him, she could put a condom on herself because there are women condoms’. (St. Thomas)

Continuing to deflect responsibility for engaging in sexually safe behaviors, another participant from St. Thomas discussed a reason men have multiple partners saying, ‘... women allow it’. This statement describes a pervasive attitude among the focus group participants that men are not responsible for their actions, specifically relating to maintaining control of their emotions during times of conflict with a partner or engaging in behaviors that put him or his female partner at risk for acquiring sexually related infections.

3.2. Evoking Fear and Distrust

This theme revealed the participants’ perceptions of the underlying catalyst for male behaviors when their actions are violent or sexually risky. Violence and risky sexual behaviors were used to cope with fear and distrust of sexual partners. Saving face and preserving masculinity were important to participants. For example, one participant described distrust when a partner discusses their relationship with someone else:

Like for instance, a girl would rather talk to her friend about what’s going on in their relationship more than to talk about it to their significant other and because of that, the word could get out and tell somebody else and then it gets back to the guy, then that brings on the rage. (St. Croix)

He believes that any action—in this case, discussing the relationship with an outside person—evokes fear about others having knowledge about personal business. He feels the relationship would be strengthened if she chose to discuss these issues with him as her partner. Thus, this statement implies he has fear of losing his place in the relationship, describing his reaction to that possibility.

Another participant drew on gender stereotypes when describing why he would have an angry response to a female partner during a public disagreement, saying, 'You going to make me look like a little girl in front of my friends (St. Thomas).' He goes on to describe how these situations can evoke fear and shame about his status. He shared the following: 'We do feel less manly. We do feel less. I mean, embarrassed. Yeah, embarrassed (St. Thomas).' The possibility of losing his superior male position or experiencing public shaming provided an opportunity for fear and distrust to shape interactions with female partners. As discussed by the participants, these feelings may drive violent responses and maladaptive conflict resolution.

Relating to sexual activity and risk, participants described fear about sexual performance, HIV testing, and sexual coercion. There were several discussions about women tampering with condoms to trap a man into pregnancy. One participant described his concerns about ruining potential future sexual partnerships through rumors after having sex with women:

Yeah, and at the same time you want to please this girl you have sex with right now because you know how word goes around. You wouldn't want to have a bad, like have sex with this girl bad and she ain't have nothing on sensation. This girl is just going to spread the word and she is going to be like that dude he gave the worse sex of my life. Destroy what other girl may want to go out with you after that. (St. Thomas)

This statement highlights the way reputation and prowess as a sexual partner are important markers of manhood. He describes a fear of losing this position and need to preserve a position as a good sexual partner in social circles to ensure future sexual relationship possibilities.

Thoughts about HIV prevention behavior extended this narrative of fear and distrust. One participant discussed ways that requesting a partner be tested for HIV could result in distrust between the man and his female partner, saying,

...nobody wants to get that test. I mean some people find it insulting, I mean let's say we go out and I thinking we getting close to the time where we going to have sexual intercourse. I can't tell you 'Hey let's go get an HIV test.' She going take it as an insult. She going to be saying 'Boy you thinking I have AIDS?' (St. Croix)

This participant's statement reveals that he wants to preserve the trusting bond that is developing between two partners advancing the least obtrusive pathway to sexual activity. In this way, requesting HIV testing from a partner could create distrust because it might imply the man believes the woman is infected. On the other hand, however, another participant implied that distrust already exists between USVI men and women when approaching condom use behaviors because there may be differential views around pregnancy intention between the partners. He said, 'never take a condom from a woman... Tampering, when they want to get pregnant, they does mess with the condoms... They also have something called turkey basting or something (St. Croix).' This view is important from the perspective of HIV prevention because differing intentions about timing or wantedness of pregnancy could influence decision-making about condoms.

Another prevalent fear discussed by participants was framed by societal homophobia. Some participants voiced concerns that USVI men would not disclose if they had engaged in same-sex behaviors, saying,

...black males have pride. They don't want to tell you, I catch the disease because I have sex with another man. That's just installed in their DNA that I'm not going to tell you that, I'm just going to tell you I have HIV. (St. Thomas)

This participant is candid about the stigma existing around behaviors of some USVI men that includes having sex with other men. These behaviors are shrouded by expectations for masculinity that are inflexible because they are part of the 'genetics' of being a man. Though his statement illuminates the silence around same-sex behaviors, he also reveals the possibility that if the man is HIV-infected, he may disclose this to a partner. This reveals his fear and distrust in his partner as well as in a society that stigmatizes sexual behaviors between men.

To further this discussion of masculine expectations, some participants discussed heterosexual behaviors that involved sexual activity with multiple women. According to the following participant from St. Croix, maintaining relationships with several women provided protection from emotional harm,

Some men just don't want to get hurt. Because in life the best feeling in the world is being in love, but the worse feeling in the world is getting your heart crush... So to protect myself... That's why they have multiple girls...

Multiple partnering is a key driver of HIV transmission and this statement describes an emotional protective measure that can lead to high-risk behaviors.

4. Discussion

This study explored attitudes and beliefs towards violence against women and sexual behaviors among USVI men participating in two focus groups. The manifestations of manhood, masculinity, sexual beliefs, and behaviors of African-descended men in the USVI are revealed in the men's narratives, highlighting the implications of intimate partner violence on USVI women's HIV risks.

The three themes that emerged from these data—Validating Status, Deflecting Responsibility, and Evoking Fear and Distrust—illustrate how language used by participants and attitudes towards a prescribed gender hierarchy could influence an environment in which IPV and HIV risk behaviors become accepted norms (Kempadoo 2009). This is important because masculine attitudes towards women influence pathways in which sexual violence can increase risks for HIV transmission (Raj et al. 2008; Santana et al. 2006).

The health behaviors of Caribbean men are influenced by complex dimensions of gender relations and expressions of masculinity (Case and Gordon 2016). Desires for power and control underpin IPV behaviors (Black et al. 2014). The rules for masculine norms of behavior were unwritten, however, participants shared values about the positioning of men, behavioral responsibilities of women, and emotional catalysts for decision-making. These

beliefs influenced their relationships with women. These findings are aligned with the literature examining cultural influences on sexual behavior of African Caribbean men that includes adherence to masculine norms as an accepted part of social life, highlighting the fragile relationship between IPV and risks for HIV (Kempadoo 2009; Stutterheim et al. 2013; Crowell et al. 2016; Santana et al. 2006; Case and Gordon 2016).

Participants in this sample overwhelmingly defined manhood as superior to womanhood and normalized sexual promiscuity. In recent literature, researchers suggest that men's sexual behaviors are influenced by three dimensions of masculine norms: (1) uncontrollable sex drive, (2) capacity to perform sexually, and (3) power over others (Fleming, DiClemente, and Barrington 2016; Kennedy et al. 2013). These dimensions can directly increase risky behaviors by men towards women. However, unlike our findings, Kennedy and colleagues also found that many men endorsed equality between the sexes and recognized that gender roles in relationships are fluid (Kennedy et al. 2013). Participant discussions regarding distrust provide insight into gender power relationships which may contribute to other consequences such as HIV and STIs disproportionately affecting women who experience IPV. For example, these data suggest that being distrustful of one's partner may mean that talking about condom use is avoided, and thus leads to unprotected sex.

Results from this study are aligned with theories of hegemonic masculinity (Connell 1987), masculine norms theory (Thompson and Pleck 1986), and gender role conflict (O'Neil 1981). As women are attaining higher levels of education and employment, a turn in roles and power differentials occurs. This change in gender norms is often perceived as threatening the current patriarchal society (Gabriel et al. 2016). Current evidence using these theories demonstrates that determinants of beliefs and attitudes of male superiority can be detrimental to the psychological and physical well-being of both men and women (Fields et al. 2015; O'Neil 2015; Morrell et al. 2013; Levant and Wimer 2014). These theories are defined by core elements that value heterosexuality, while simultaneously stigmatizing same-sex behavior, instilling fears associated with feminine presentations (O'Neil et al. 1986), and uplifting characteristics affiliated with masculinity such as status and toughness (Thompson and Pleck 1986). Similarly, gender roles are changing, particularly for women. These core elements are present throughout the USVI men's narratives and thus provide an organizing structure for reframing USVI participant responses using strength-based approaches (Englar-Carlson and Kiselica 2013).

For example, participants in this study discussed deeply held beliefs about the male's status as a protector for his family as well as his partner. While this position primarily described adherence to a role of 'physically' protecting their intimate partners and children from harm, we suggest approaching this attitude as an opportunity to extend the definition of 'protector' to one that could include shielding their sexual partners from violence and STIs/HIV. Thus, protection in this sense would mean healthy resolution of conflict without physical violence, using condoms to prevent transmission of infections, and getting tested for HIV at regular intervals. In this sense, protection goes beyond having to 'fight' somebody on behalf of one's significant other(s) or child(ren). We propose that building on already existing beliefs about masculinity could provide a viable pathway to creating interventions that reduce IPV and the risk of STIs/HIV transmission. Specifically, a focus on wellness and being a healthy

man could motivate HIV testing, promoting protection of self and his sexual partner that may build on perceptions of strength versus vulnerability. Reframing the responses of these Caribbean men provides a way to incorporate cultural standpoints and interpret behaviors within an operational context that differentiates ways that conventional masculinity promotes or challenges well-being (McNulty and Fincham 2012).

Transforming gender norms is a longer-term goal that can influence the outcomes of more proximal problems such as gender-based violence and HIV transmission behaviors. Many of the underlying factors of violence against women are a result of current beliefs of male superiority; therefore, it is perceived that women are in essence responsible for the violence they experience. Interventions that challenge gender and social norms are emerging strategies for behavioral change that are focused on decreasing IPV and HIV risks (Dworkin, Treves-Kagan, and Lippman 2013). Gender transformative research approaches aim to create opportunities for individuals to challenge gender norms, promote positions of social and political influence for women, and address power inequities among people of different genders (Viitanen and Colvin 2015).

Our findings add to the emerging literature on the utility of gender transformative work because, to our knowledge, the qualitative perceptions of Caribbean men have not been analyzed. The current tenets of gender transformative work reframe perceptions that adhere to rigid notions of masculine power. Gender transformative researchers have introduced a more fluid concept encompassing multiple masculinities as a more sustainable approach to displaying masculine behaviors while simultaneously being true to social and cultural norms associated with expectations for gender presentation (Dworkin, Treves-Kagan, and Lippman 2013). Furthermore, feminist Caribbean scholarship has advanced the notion that while gender and sexuality often intersect, there is space to examine them semi-independent of one another as forces for understanding the distinct cultural and social relations of Caribbean life (Kempadoo 2009). Current intervention approaches also suggest that impact can be maximized if implemented during adolescence when young people are negotiating gender identities and navigating sexualities (Morrell et al. 2002; Jewkes, Wood, and Duvvury 2010).

Findings from this paper are reflective of the larger global phenomena of intersecting violence and HIV risks occurring among men and women across the global south (Maman et al. 2000; Stockman, Lucea, and Campbell 2013; Hirsch et al. 2009). While experiences of individuals living in the USVI are often excluded, this pandemic has consequences of illness, suffering, and premature death that affects the health and well-being of men and women around the world. Furthermore, research examining the unique cultural contexts of risk burdens occurring among members of the USVI community require innovative community-based approaches to eradicate inevitable morbidities affecting its citizens.

5. Limitations

Findings from this study should be considered within the context of several limitations. Men participating in the focus groups were diverse in their ages and experiences but the perceptions of men who had experienced or committed IPV were over-represented because the intervention was focused on advancing safety profiles for women currently experiencing

abuse. Additionally, while focus group methodology is a useful tool for data collection, given the sensitivity of the topics of this study, we recognize that social desirability may have had a role in influencing participant responses. To decrease the effects of potential bias, a mixed methods approach that incorporated survey data and individual interviews may have been useful to triangulate and decipher individual beliefs.

6. Conclusion

The high per capita rates of HIV and IPV in the USVI warrant close examination of social and cultural phenomena that influence perceptions and behaviors of men and women in sexual relationships. The role of gendered norms for behavior, specifically masculinity, have likely associations with some health outcomes that cause grave disability and early death for women in the USVI. The risky behaviors associated with masculinity norms could also have detrimental impacts on USVI men's health because it accelerates the fragility of interpersonal gender relations that can influence mental well-being and the stability of families. While gender transformative research and praxis may play a pivotal future role in changing risky behaviors, there are some positive aspects of masculinity narratives that researchers and practitioners can build upon to enhance safety in intimate relationships. Male participants discussed desires to prevent early pregnancy and to protect their families from harm, providing a potential starting point to cultivate an environment for healthy relationships to thrive and eliminate disparities that persist among this small cluster of Caribbean islands. While cultural shifts around gender often progress slowly, ethnically informed interventions should be considered during early adolescent years of development when intimate relationships are being formed. Additionally, due to the unique nature of many Black men's lives, interventions addressing the intersection of HIV and IPV risks could be informed by the systemic discriminatory practices that shape their interactions with women in society.

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Key Messages

1. The aim of this study was to investigate the attitudes and beliefs about intimate partner violence and sexual behaviors among African-Caribbean men participating in two focus groups
2. Men participant narratives revealed beliefs aligned with conventional masculinity ideologies that often hindered healthy relationship pathways.
3. Men described a need to protect themselves from emotional harm, precipitating engagement in HIV risk behaviors such as having concurrent and multiple partners.
4. We suggest reframing attitudes and beliefs subscribing to conventional masculinity to highlight existing culturally-specific strengths and protective factors to advance implementation of interventions focused on combating disproportionate rates of HIV and intimate partner violence in the USVI.