

# **Attitude Towards Intimate Partner Violence Against Women and Risky Sexual Choices of Jamaican Males**

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## **ABSTRACT**

*For young Jamaican men, it is necessary to prove their virility to their peers and prove to their parents that they are of heterosexual orientation. These demands have produced a society in which men are sexually aggressive, even to the point of using violence to control the sexual choices of women. This paper examines whether Jamaican men who support intimate partner violence (IPV) against women are more likely to have unsafe sexual practices and social attitudes that could increase women's risk of contracting sexually transmitted infections. Men who responded 'yes' to violence against women are more likely themselves to have multiple sexual partners and less likely to use condoms consistently. They are also more likely to have forced a partner to have sex within the last year. Multivariate regression analysis shows that men who responded 'yes' to IPV are likely to be young, less educated and living in urban areas. Clearly, women in certain regions or subpopulations face an increased risk of contracting sexually transmitted infections due to the sexual choices of their partners. Intervention programmes to reduce sexually transmitted infections need to be developed with specific aspects of the cultural context of sexual relationships in mind. It seems especially important that male sexual choices and attitudes be directly addressed. Specific suggestions are made about an approach that has a proven record of success in reducing risky practices in high risk groups.*

# **Actitudes Hacia la Violencia Contra la Mujer por Parte de su Pareja Intima y las Elecciones Sexuales Riesgosas de Varones Jamaicanos**

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## **RESUMEN**

*Los hombres jamaicanos jóvenes necesitan probar su virilidad a sus iguales, así como probar su orientación heterosexual a sus padres. Estas demandas han producido una sociedad en la cual los hombres son sexualmente agresivos, hasta el punto de recurrir a la violencia para controlar las elecciones sexuales de las mujeres. Este trabajo se encamina a estudiar si los hombres jamaicanos que son partidarios de la violencia contra las mujeres por parte de la pareja íntima (VPI), presentan mayor probabilidad de prácticas sexuales inseguras y actitudes sociales que podrían representar para la mujer un aumento del riesgo de contraer enfermedades de transmisión sexual. Los hombres que respondieron "sí" a la violencia contra las mujeres tienden a tener ellos mismos múltiples parejas sexuales, y se inclinan menos a usar condones de forma consistente. También existe una mayor probabilidad de que hayan forzado a una pareja a tener relaciones sexuales en el último año. El análisis multivariado de regresión muestra que los hombres que han dicho "sí" a la VPI tienden a ser jóvenes, menos educados, y vivir en áreas urbanas. Claro está, las mujeres en ciertas regiones o subpoblaciones enfrentan un elevado riesgo de contraer enfermedades de transmisión sexual, debido a las elecciones sexuales de sus parejas. Los programas de intervención para reducir las infecciones por transmisión sexual, tienen que ser desarrollados teniendo en cuenta aspectos específicos del contexto cultural en el que se desenvuelven las relaciones sexuales. Parece especialmente importante que las elecciones sexuales y actitudes del varón sean abordadas directamente. Se dan sugerencias concretas en relación con un enfoque que ha alcanzado un éxito notable en reducir las prácticas de riesgo en los grupos de alto riesgo.*

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## INTRODUCTION

Like many other developing countries, Jamaica faces a growing Acquired Immune Deficiency Syndrome (AIDS) crisis. Cumulative AIDS prevalence ranges from 100 per 100 000 in rural areas to nearly 1000 per 100 000 in urban areas. However, the Ministry of Health (MOH) estimates that Human Immunodeficiency Virus (HIV) is far more prevalent within the population than is suggested by the official data because of the low rate of HIV testing in Jamaica. Data from the national survey of sexually transmitted diseases and sexual practices conducted in 2000 show that a mere 21% of adults report ever being tested for HIV. More than one-half of proven AIDS cases have been discovered among individuals between 20 and 39 years of age (1) and AIDS is the second leading cause of death among both men and women in the 30 to 34-year age-group. According to Norman (2), STIs ranked at number five among the leading causes of health centre visits in 1998.

There is the potential for morbidity and mortality from AIDS and STIs to have a ravaging effect on the working-age population. Such morbidity would be a serious problem for a small developing country that is reliant on a healthy labour force in order to sustain economic growth.

One of the MOH's concerns is the spread of HIV among women in general and young women in particular. According to the Ministry of Health, the rate of HIV infection in women is increasing more steadily than in men. Between 2003 and 2004, there was a 1.3% decrease in the number of AIDS cases reported among men. At the same time, the increase in AIDS cases among women was 10.9%. Furthermore, 13 of every 1000 pregnant women are infected with HIV. The MOH AIDS surveillance data show that girls aged 10 to 19 years are three times more vulnerable to HIV infection than boys in the same age group. The vulnerability of young women is related to two factors: 1) the tendency of younger females to have older male sex partners, which places these females at a negotiating disadvantage with respect to condom use during intercourse, and 2) the general control that men exercise over sexual choices (3). According to Norman, men decide when, where and how sex occurs (4). Clearly, male partners have a central role to play in reducing women's risk of contracting infections associated with sexual intercourse. The use of a condom during intercourse requires at least the co-operation of the male partner. Yet, in some social contexts, the interests of males are best served when a condom is not used and when the male is sexually active with multiple female partners. While some attention has been paid to the sexual choices and attitude of Jamaican males (2, 4–5), there is a paucity of work on the risks that these behaviours and attitudes pose for their female sex partners.

In Jamaica, a man's sexual reputation is derived from his ability to "perform". According to Norman (3) and Brown *et al* (6), performance is measured in two ways. One

measure of performance is the number of serial or concurrent female sexual partners the man has. The second measure of performance is the ability to father many children from many different women. Several authors (3, 7–8) suggest these are particularly important objectives for young men. In fact, there appears to be an incessant need for young males to prove their virility, both for the sake of their peers and to assure their parents that they are not homosexual (3).

Jamaica's culture of male domination is also complemented by a culture of violence. According to Harriot (9), Jamaica's homicide rate was 22.4 per 100 000 in 1990, four times the global average of 5.5. By 1996, the murder rate had risen to 37 per 100 000, twice the average for Latin America and the rest of the Caribbean. In 1996, Jamaica had the highest rate of violent crimes in the Caribbean, averaging 984.7 per 100 000. The rate of violent crimes is higher in urban areas. Several studies (10–12) conducted at two of the largest hospitals in Jamaica, the Kingston Public Hospital and the University Hospital of the West Indies, show that between forty and fifty per cent of patients admitted to emergency units for trauma were victims of interpersonal violence. Mansingh and Ramphal (12) reported that over eighty per cent of the victims of interpersonal violence suffered from injury inflicted by a relative (21.7%) or a friend or an acquaintance (62.3%). Furthermore, males committed 74.5% of the aggression against females.

Studies have established a link between intimate partner violence (IPV) and HIV risk (13–15). However, there has not been much focus on the risk behaviour specific to abusive or potentially abusive partners. This paper builds upon a small literature (16) that focus on male behaviour that put women at risk. One important question raised in this paper is whether men who support IPV also need to show their ability to perform and therefore make choices about sexual intercourse that could put their partners at risk for infections from diseases.

## SUBJECTS AND METHODS

The data for this study were collected in 2000 as part of the Ministry of Health's HIV/AIDS/STD Survey in Jamaica. The target population were persons aged 15 to 49 years. The sample was designed as a stratified multi-staged sample. The first stage is the selection of census Enumeration Districts (EDs). Enumeration districts are fully contained within each administrative region (parishes). The EDs are selected with probability proportional to their size (measured by the number of dwellings in each ED). The second stage is the selection of dwelling units within each ED. From each ED an equal number of dwellings were selected using systematic sampling with a random start. At the household level, respondents were selected from a random number grid using anyone drawn within the specific age range. The survey yielded a total sample of 1498 respondents of which 754 (50.3%) were males and 744 (49.7%) were females.

The survey instrument included interviewer-administered questionnaires covering background information, including sex of respondent, date of birth, area of residence, educational attainment, religious affiliation and union status. Also, a wide range of behavioural data were collected, including drug use and alcohol consumption. One questionnaire asked respondent detailed questions on sexual history, including age at first intercourse, number of partners and condom use frequency. It was also ascertained whether the respondent had a history of sexually transmitted infections, their knowledge of STIs, HIV and AIDS, their attitude towards HIV and AIDS and their attitude towards persons living with AIDS, and whether they had been tested for the HIV.

## RESULTS

**Violence Attitude:** Each respondent (male and female) was asked whether a man was justified to use violence against a woman under three scenarios: 1) she was late cooking supper; 2) she refused to have sex with him and 3) he suspected that she has had sex with another man. Among males, the rate of positive response was 2.8% ( $n = 21$ ) for question -1, 3.2% ( $n = 24$ ) for question -2 and 24.4% ( $n = 184$ ) for question -3. The focus was placed entirely on question -3 since almost all of the males (except six) who responded “yes” to questions -1 and -2 also responded “yes” to the third question. Individuals who responded yes on question -3 are coded as supporting intimate partner violence. The remaining respondents are coded as not supporting intimate partner violence. Below, it is shown that difference in attitude towards violence against women is a significant predictor of sexual and other behaviour that increase women’s risk of contracting STIs.

**Union Status:** Respondents were classified into four groups based on union status. Those who are married or cohabiting were classified together. Individuals who had a partner who visited their household or whose household they visited were classified as “visiting”. Individuals who said they had a girlfriend whom they were dating were classified as “dating”. All remaining respondents were classified as “single”.

Chi-square and probit regression analysis were used to examine the data. Limdep was the statistical software used for the regression analysis, while the Stastical Package for the Social Sciences was used for the chi-square analysis.

Table 1 presents means or frequencies of the socio-demographic characteristics of the male respondents. Separate summary data are presented for those males who support IPV and for those males who do not. There are significant differences in the socio-demographic characteristics of males who support IPV and between males who do not. On average, men who support IPV were two years younger than men who do not. Men who support IPV are less likely to have a college education (2% vs. 6.5%) and less likely to be married (11% vs 20%). Supporters of IPV were less likely to have

Table 1: Socio-demographic characteristics of Subjects

Variable	Frequency (%) or Mean of X (Support IPV = Yes)	Frequency (%) or Mean of X (Support IPV = No)
Background		
Age	22.39	24.25
Secondary education (%)	76.08	78.42
College education (%)	2.17	6.49
Union status (%)		
Married	10.87	20.00
Visiting union	38.04	25.61
Dating	25.54	22.11
Single	25.54	32.28
Social behaviour and location (%)		
At least one alcoholic drink per week (Drinker)	50.6	32.1
No religious affiliation	45.11	35.44
Kingston Metro resident	40.22	34.56
HIV related variables		
HIV prevention knowledge	7.13	7.61
Not sexually active last three months(%)	12.50	21.40
AIDS prevalence <sup>1</sup>	313.48	325.50

<sup>1</sup>This variable was added to the data by the author. The values shown are AIDS prevalence per 100 000. AIDS prevalence was obtained from the Ministry of Health AIDS surveillance data. This variable was included to test the possibility that fear of contracting the HIV virus explains the violent attitude towards intimate partners suspected of cheating. The rank of the parish (in ascending order) was used in the regression rather than actual prevalence with the expectation that while an individual might not know actual prevalence data, he might have a clear idea of the relative spread of AIDS in different areas in Jamaica.

religious affiliation, more likely to be a resident of the Kingston metropolitan area and more likely to be sexually active in the last three months prior to the survey.

Table 2 presents bivariate analysis of support for IPV and sexual practices and social attitudes of Jamaican males. There are some differences in the consistency of condom use of men who support IPV and men who do not. While 37% of men who do not support IPV say they use condoms consistently with their steady partners, only 29% of men who support IPV say they use condoms consistently. Males who support IPV are also significantly more likely to have multiple sex partners within the last three months and within the last twelve months. Whereas 63% of men who support IPV had multiple partners within the last twelve months, 48% of men who do not support IPV had multiple partners.

In terms of social behaviour and attitude, significant differences also exist. Forty-eight per cent of the men who support IPV against women believe it is acceptable for men to be unfaithful. Only 24% of men who do not support IPV believe it is acceptable for men to be unfaithful to their partners. In addition, men who support IPV against women are more likely to admit that they forced a partner to have sex within the last year (18.5% vs 8%).

Table 2: Support for intimate partner violence vs sexual risky behaviours and social attitudes

HIV Risk Behaviours and Attitudes	Support Intimate Partner Violence		<i>p</i> -value <sup>2</sup>
	Frequency (%)	Frequency (%)	
	Yes (n=184)	No (n = 553)	
Sexual Practices			
Always uses condoms during intercourse <sup>3</sup>	27.8	36.6	0.068483
Had multiple sex partners in last three months	41.3	32.3	0.054632
Had multiple sex partners in last twelve months	63.1	47.65	0.0008346
Social Behaviours and Attitude (% Yes)			
Forced partner(s) to have sex within last year	18.5	7.9	0.000136
Believes it is ok for men to be unfaithful	47.8	24.4	2.113E-09
Consumes at least one alcoholic drink per week	50.6	32.1	1.72E-05
HIV/AIDS knowledge and attitude (% Yes)			
Has above average knowledge on how to prevent HIV	48.8	55.6	0.124756
Would you care for someone who has AIDS	68.1	80.1	0.000
Should a nurse with HIV continue to work	16.8	29.7	0.022

<sup>2</sup>*p*-values are based on a chi-square test of independence with one degree of freedom.

<sup>3</sup>Since condom use is non-existent among married men, only unmarried men were included in the analysis.

Over 50% of supporters of IPV consume at least one drink per week. The proportion of weekly drinkers is significantly lower among non-supporters of IPV (32%). Alcohol consumption has been linked to high risk sexual practices in several other studies (17–18).

There are some differences in the level of knowledge of HIV prevention between supporters and non-supporters of IPV but the difference is not statistically significant. Finally, men who support IPV are more likely to have negative attitudes towards people who are HIV positive or have AIDS. They are less likely to be willing to care for an individual living with AIDS (68% vs 80%), although overall willingness is high, and less likely to agree that a nurse who is HIV positive should continue to work (17% vs 30%).

Table 3 presents multivariate regressions results for the regression of support for IPV against women on predictor variables. The dependent variable is equal to 'one' for men who support IPV against women who are suspected of being unfaithful, and 'zero' otherwise. The results shown are marginal effects based on probit regressions. Marginal effects show the per cent change (from the mean) in the probability of obtaining an affirmative response.

The individual's age and education level are both negatively associated with support for IPV against women. Males who have completed secondary education and college educated males are less likely to support IPV against women. Completion of secondary education reduces the support for IPV by 8%, while a college degree reduces the probability that males support IPV by 21%. Other variables that are negatively associated with support for aggression against women include knowledge of HIV prevention, if the individual was not sexually active in the last three months

Table 3: Probit marginal effects, support intimate partner violence (yes = 1, n = 754)

Variable	b	se(b)	t	<i>p</i> -value
Constant	9.53E-03	0.119798	0.08	0.9366
Age	-6.15E-03	2.49E-03	-2.467	0.0136
Secondary education	-8.05E-02	4.19E-02	-1.92	0.0548
College education	-0.2100847	9.26E-02	-2.268	0.0234
Visiting union	0.1153847	5.19E-02	2.223	0.0262
Dating	0.1034829	5.83E-02	1.775	0.0759
Single	6.75E-02	5.71E-02	1.182	0.2372
Drinker	0.1264892	3.41E-02	3.705	0.0002
No religion	4.22E-02	3.25E-02	1.299	0.1938
Kingston Metro	9.10E-02	4.44E-02	2.051	0.0403
HIV Prev Score	-1.61E-02	8.10E-03	-1.989	0.0467
Abstain 3 months	-8.87E-02	4.56E-02	-1.946	0.0516
AIDS prevalence	-2.23E-02	1.04E-02	-2.145	0.032
Chi-square	72.25			
Significance	0.000			
Per cent of dependent variable correctly classified	76			

(approximately 9%) and the prevalence of AIDS in the individual's parish of residence. An important point to note here is that the hypothesis that fear of contracting HIV explains support for intimate partner violence is seemingly rejected by the data. Fear of contracting HIV could lead to a positive association between AIDS prevalence and support for intimate partner violence.

Males who are in visiting unions and males who are currently dating are more likely to support violence against women than married men (reference category). The probability that a man supports IPV against women increases by about 12% if he is in a visiting union and by about 10% if he

has a girlfriend. Men who describe their current status as single show some support for violence but the coefficient is statistically insignificant and smaller. Consuming at least one alcoholic drink per week raises the support for IPV against women by about 13%. Urban residence is also positively associated with support for IPV against women. The probability of support for IPV increases by roughly 9% if the individual resides in the Kingston Metropolitan area.

## CONCLUSION

This study reports several high risk behaviour patterns among Jamaican males. These high risk behaviours are consistent with the findings of other studies that focussed on the Jamaican population (2, 19).

Males in general have multiple sexual partners and less than a third use condoms on a consistent basis with their regular sex partners. However, males who support violence against intimate partners are significantly more likely to have multiple sex partners and less frequent condom use. In terms of social behaviour and attitude towards persons living with HIV/AIDS, persons who support IPV are clearly more likely to have negative attitudes, more antisocial behaviour and less favourable attitude towards HIV positive persons and persons living with AIDS.

Multivariate regression analysis shows that younger males and less educated men are more likely to support IPV against women who are suspected of being unfaithful. Relative to married men, males in visiting unions and males who currently have a girlfriend are more likely to support IPV. In addition, males who consume alcohol at least once weekly and males who live in Kingston support IPV.

Even though it could be argued that high risk and anti-social behaviours are prevalent in the male population in Jamaica, these behaviours and attitudes clearly occur at an increased frequency among males who have favourable attitudes towards intimate partner violence. These males constitute 25% of the male population overall, and an even higher proportion in the capital. Therefore, it is fair to argue that women who have sexual interactions with this subpopulation of males are at high risk of contracting STIs.

These results suggest that there is need to revisit the theoretical and philosophical underpinning of HIV/AIDS research and outreach programmes targeted to the Jamaican male populations. The sexual behaviour of these men cannot be viewed as separate from their social, cultural and economic context (20).

Even though one recognizes the need for solutions that can be implemented in the short run, truly effective solutions will require a long-term view that has cultural and attitudinal changes as the central points. For example, it is necessary that this subpopulation of Jamaican males come to view women as equals and not as a target for abuse or as instruments in achieving social glory. Prevention and outreach programmes have to acknowledge the important role that

men have to play in reducing the risk to females and help to teach men how to give up some of the power they now have over sexual choices.

There is an approach to AIDS prevention that has achieved success in other high risk groups that might serve as a model of how Jamaican males might be able to convince each other of the need for behavioural and attitudinal change. It is the grass-roots approach used by gay and bisexual men and the approach used to reach intravenous drug users. Gay and bisexual men have been able to persuade each other to develop a safe-sex social norm (21). Similarly, to target intravenous drug users, former drug users were enlisted as educators since they are better able to communicate with that group. On a similar vein, a safe-sex social norm has to be developed from within the high risk Jamaican male community with the help of members of that community who can communicate well with their own peers.

## REFERENCES

1. Summary of AIDS cases in Jamaica, 1982–1999. Ministry of Health, Kingston, Jamaica 2003.
2. Norman L. Sexually transmitted disease symptoms. A comparative analysis of male and female youth in Jamaica. *West Indian Med J* 2001; **50**: 203–8.
3. Norman L. The construction of masculinity and femininity within the Caribbean context: Relations to Family, Gender and HIV/AIDS. Department of Sociology, Psychology and Social Work, University of the West Indies; 2003.
4. Norman L, Uche C. Prevalence and determinants of sexually transmitted diseases: An analysis of young Jamaican males. *Sexually Transm Dis* 2002; **29**: 126–32.
5. Eggleston E, Jackson J, Hardee K. Sexual attitudes and behaviour among young adolescents in Jamaica. *Intern Fam Plan Persp* 1999; **25**: 78–84.
6. Brown J, Chevannes B. Why man stay so: An examination of gender socialization in the Caribbean. Kingston: University of the West Indies 1998.
7. Dann G. The Barbadian male: Sexual attitudes and practice. Hong Kong: MacMillan Publishers, 1987.
8. Freilich M. Sex, secrets and systems in the Caribbean. In: Gerber, S. (ed.) *The Family in the Caribbean*. Puerto Rico: Institute of Caribbean Studies; 1969: 47–62.
9. Harriott A. Police and Crime Control in Jamaica: Problems of Reforming Ex-colonial constabularies Barbados: The University of the West Indies Press; 2000.
10. Crandon I, Carpenter R, McDonald A. Admissions for trauma at the University Hospital of the West Indies. A prospective study. *West Indian Med J* 1994; **43**: 117–20.
11. McDonald A, Duncan ND, Mitchell DIG, Fletcher PR. Trauma aetiology and cost in the accident and emergency unit of the University Hospital of the West Indies. *West Indian Med J* 1999; **48**: 141–2.
12. Mansingh A, Ramphal P. The nature of interpersonal violence in Jamaica and its strain on the national health system. *West Indian Med J* 1993; **42**: 53–6.
13. Amaro H, Raj A. On the margin: power and women's HIV risk reduction strategies. *Sex Roles* 2000; **42**: 723–49.
14. Lichtenstein B. Domestic violence, sexual ownership, and HIV risk in women in the American deep south. *Soc Sci Med* 2005; **60**: 701–14.
15. Fonck K, Els L, Kidula N, Ndinya-Achola J, Temmerman M. Increased risk of HIV in women experiencing physical partner violence in Nairobi, Kenya. *AIDS Behav* 2005; **9**: 335–9.
16. Raj A, Silverman JG, Amaro H. Abused women report greater male partner risk and gender-based risk for HIV: findings from a community-based study with Hispanic women. *AIDS Care* 2004; **16**: 519–29.

17. Sly DF, Riehman KS. Substance use, multiple substance use, sexual risk taking and condom use among low income women. *Pop Res and Policy Review* 1999; **18**: 1–22.
18. VanLandingham MJ, Suprasert S, Sittitrai W, Vaddhanaphuti C, Grandjean N. Sexual activity among never-married men in Northern Thailand. *Demography* 1993; **30**: 297–313.
19. Figueroa J, Brathwaite A, Wedderburn M, Ward E, Lewis-Bell K, Amon JJ et al. Is HIV/STD control in Jamaica making a difference? *AIDS* 1998; **12 Suppl 2**: S89–98.
20. Amaro H. Love, sex, and power: considering women's realities in HIV prevention. *Am Psychol* 1995; **50**: 437–47.
21. Browser BP. Black men and AIDS: Prevention and black sexuality. In: Majors RG, Gordon JU, ed. *The American Black Male: His present status and his future*. Chicago: Nelson Hall; 1994; 115–126.