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Culture and its impact on the feminisation of HIV and AIDS risk among Caribbean women

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Abstract

The worldwide feminisation of HIV and AIDS has not left the Caribbean region unscathed. A decade ago, infection rates among West Indian women were 3-6 times higher than those of men. This paper addresses the crucial and inter-related roles of socio-cultural issues such as: patriarchy, commercialization of sex, men who have sex with men, violence and religious practices; all of which contribute to HIV and AIDS risk in the Caribbean. In so doing, the paper raises awareness of the stark reality of the lives of Caribbean women and the ways in which Caribbean culture disproportionately exposes them to the risk of contracting HIV and AIDS. The paper concludes and recommends that further research should be done to address the key sociocultural elements that negatively influence male-female relationships and their impact on HIV and AIDS risk in the Caribbean.

Keywords: HIV, AIDS, Caribbean, culture, women, sex

Introduction

The Caribbean region is suffering heavily from the HIV and AIDS pandemic. It is the leading cause of death among males and females between the ages of 20-59 (World Health Organisation, 2014). Women are currently contracting HIV at a disproportionate rate to men (UNWomen, 2015). These trends have led Caribbean regional and local health agencies and gender associations to unite in support of reversing the HIV epidemic. The main mode of HIV transmission in the Caribbean is that of unprotected sex between men and women. In many cases, it is a case of transactional sex (UNAIDS, 2012), where a person may have a sexual relationship with another in exchange for financial or material gains. These alarming statistics have inevitably led to HIV and AIDS being described as a feminised disease within the Caribbean basin. Many socio-cultural factors and realities of gender embedded in structural violence, described by Paul Farmer (as cited in Burtle, 2013, p. 1) as the "processes and forces [that] conspire to constrain individual agency," are directly related to the spread of HIV and AIDS, however, this phenomenon has been severely under-researched in the West Indies as a whole.

The most recent HIV and AIDS statistics (2007) show that women account for 51% of the total cases (Figure 1) (PAHO, 2002a). Women outnumber men and the figures are increasing as time passes (Table 1) (UNAIDS & WHO, 2008). Several socio-cultural factors make the HIV and AIDS danger quite pervasive among Caribbean females (Box 1). These socio-cultural factors directly influence gender relations (Table 2) (SIDA, 2006). Culture as it relates to structural inequalities and gender are therefore intertwined and can lead to vulnerability (Murray as cited in Barrow et al., 2009). Roberts et al. (2009, p. 11) add another dimension to this discussion when they have CARICOM on record as saying that "the behavioural dynamics that fuel the epidemic are linked to the socio-cultural contexts of sex and sexuality in the region." Whatever the dynamic, one's sexual perception is determined by social and cultural realities. Several interconnected, socio-cultural issues contribute to HIV risk in the Caribbean.

The everyday realities that will be examined include implications of patriarchy, transactional sex, men who have sex with men [MSM], violence and religion.

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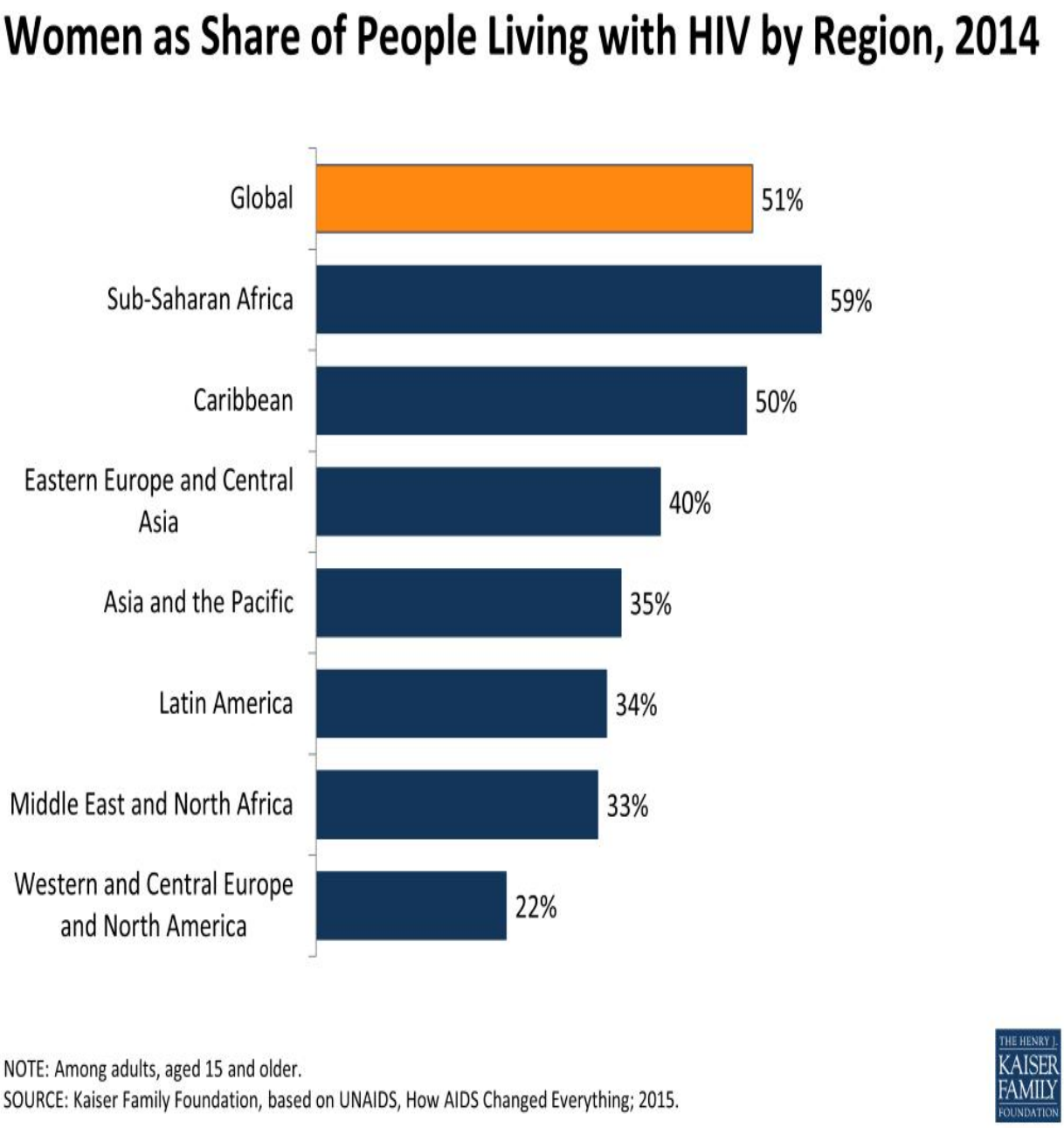
Figure 1. Women as share of people living with HIV by region, 2014



Source: Henry Kaiser Family Foundation, 2015b

Table 1. Estimated number of adults living with HIV, 2007 by country

Country	Male	Female	Total
Anguilla	Nd	Nd	Nd
Antigua and Barbuda	Nd	Nd	Nd
Bahamas	4,500	1,600	6,100
Barbados	1,200	<1,000	2,200
Belize	1,400	2,000	3,400
Bermuda	Nd	Nd	Nd
Brazil	476,000	240,000	710,000
British Virgin Islands	Nd	Nd	Nd
Cayman Islands	Nd	Nd	Nd
Costa Rica	6,900	2,700	9,600
Cuba	4,400	1,800	6,200
Dominica	Nd	Nd	Nd
Dominican Republic	Nd	30,000	59,000
French Guyana	Nd	Nd	Nd
Grenada	Nd	Nd	Nd
Guadeloupe	Nd	Nd	Nd
Guyana	29,000	7,100	12,000
Haiti	Nd	58,000	110,000
Jamaica	18,400	7,600	26,000
Martinique	Nd	Nd	Nd
Montserrat	Nd	Nd	Nd
Puerto Rico	Nd	Nd	Nd
St. Kitts and Nevis	Nd	Nd	Nd
St. Lucia	Nd	Nd	Nd
St, Martin	Nd	Nd	Nd
St. Vincent and the Grenadines	Nd	Nd	Nd
Suriname	Nd	Nd	Nd
Trinidad and Tobago	5,300	7,700	13,000
Turks and Caicos Islands	Nd	Nd	Nd
U.S. Virgin Islands	Nd	Nd	Nd

Source: UNAIDS/WHO Epidemiological Fact Sheets on HIV and AIDS, 2008 Update

Box 1. The Caribbean

Definitions of the territorial scope of the Caribbean vary. Probably the 'socio-cultural' definition of the 'wider' Caribbean is most relevant as it pertains to the HIV/AIDS epidemic within the region. The 'wider' Caribbean region includes the following:

1. Fourteen sovereign state members of the Caribbean Community (CARICOM), including both island nations (Antigua and Barbuda, The Bahamas, Barbados, Dominica, Grenada, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago) and the mainland countries of Belize in Central America, and Guyana and Suriname in South America.
2. Spanish-speaking Cuba and the Dominican Republic.
3. Two semi-autonomous states of the Kingdom of the Netherlands (Aruba and the Netherlands Antillean Island Territories of Bonaire, Curacao, St. Martin, Statia, and Saba).
4. Six British Overseas Territories of Anguilla, Bermuda*, British Virgin Islands, Cayman Islands, Montserrat**, and the Turks and Caicos Islands.
5. The U.S. commonwealth of Puerto Rico and territory of the U.S. Virgin Islands.
6. Four territories of the Republic of France consisting of French Guyana*, St. Martin, Guadeloupe, and Martinique.

*Bermuda and French Guyana are not usually classified as part of the Caribbean.

**Montserrat is also a member of CARICOM.

Source: Kelly & Bain, 2005

Table 2. Different types of gender relations of importance for HIV/AIDS

Type of relation	Expressions	HIV/AIDS-relevant examples
Area 1 **Primary relations, strong affection**	**"Private sphere inequalities"** • Pre-or extramarital "lasting love relations" • Marital relations (power, force, male violence)	• Rape in marriage • Male contraceptive control • Incest
Area 2 **Primary relations, weak or no affection**	**"Inter-personal power and dependence relations"** • Trafficking • Prostitution • Occasional sex • Rape • Certain community rituals, initiations and the like • Intergenerational sex • Paedophilia	• Infected men seek sex with virgin girls. • Religious leaders, teachers etc. misuse their position to get sex. • Resource-weak women accept transactional sex. • Orphaned children at increased risk.
Area 3 **Secondary contacts (mainly inter-personal)**	**"Public sphere inequalities"** • Male dominance in senior positions in governments, in international organisations and other agencies • Workplace relations • Services/discrimination • Community leadership	• Male perspectives dominate planning and priorities. • Women's voices suppressed. • "Men first" in e.g. bonuses, HAART to staff and promotions
Area 4 **Tertiary (no personal contact)**	**"An environment of inequality"** • Laws linked to gender inequality • (Poor) law enforcement • Macroeconomic priorities • Male morals (Some customary law and many religions)	• Male dominance slow down legal reform and/or law enforcement (World Bank, 2004) • Government budget reflects low priority to gender-relevant policies. • Inequality supported/ accepted by public authorities.

Source: HIV/AIDS Secretariat (SIDA), 2006

Patriarchy, gender and sex

Male-female power imbalances positively influence the spread of HIV and AIDS. Male sexuality and gratification are given prominence over female sexuality and gratification. According to Gupta (2002, p. 3), "Male pleasure supersedes female pleasure and men have greater control over their sexuality than women do." In Caribbean patriarchal culture, the needs of men are given priority because often, they are perceived to be the ones in charge. Their sexual behaviour may put women at risk since there is an unequal distribution of power in economic and social spheres (Gupta, 2002).

Caribbean culture dictates that gender norms are passed on in the upbringing of children. A 2000 PAHO adolescent health survey done in the Caribbean on 15,000 school students found that 78% boys and 40% girls were engaged in sexual activity before their teens (Allen et al., 2002). The median age for first sex is 13-15 years; the median age is less for boys than females (Gupta, 2002). Men are encouraged to be hypersexual, heterosexual beings, while women are supposed to be chaste. A virgin bride is far more valued than one who is not (Bombereau & Allen, 2008). Bombereau and Allen (2008, p. 13) suggest further that "there is an acceptance of sexual experimentation, even at an early age for boys, and valorisation of abstinence for girls." This is indicative of the sexual freedom that boys can have while girls are chastised for similar practices.

Females can be called by derogatory names such as 'jamettes' and whores. For males, "the sooner manhood is established, the better for a young male's self-image and the sooner parents can stop worrying about this aspect of their son's maturation" (Brown & Chevannes, as cited in Bombereau & Allen, 2008, p. 13). Boys are desirous to have their curiosity satisfied. Girls aspire to gain popularity. Peer pressure leads both sexes to engage in the early sexual orientation. Girls give in to sex with boys for fear that their boyfriends will look elsewhere (Hutchinson et al., 2007). Generally, men report sexual encounters at an earlier age than women. However, Bombereau and Allen (2008) warn that women under-reporting, and men over-reporting, could play a significant role on the validity of these results.

There is research that examines young girls' psyche and the meaning they attach to sexual activity. UNAIDS (2002) reports that HIV infection is brought about by the lethal combination of early sex and the regular exchange of partners. There is a mixing of ages between older men and younger women, which increases vulnerability because older men have been sexually active for a longer period and are more likely to have had multiple partners, placing them in a higher risk category (O'Leary & Jemmott, 1995). They may be less inclined to be tested so their HIV and AIDS status is unknown (PAHO, 2002b). This is evidenced by the fact that HIV rates are higher among young women than younger men in the same age category (Kelly & Bain, 2005). UNAIDS (2012) makes known that in the 15-24 age group, prevalence rates are 0.6% for young women while they are 0.3% for young men in the Caribbean. Furthermore, it is more difficult for young women to have the necessary skills to refuse sexual advances of mature men, especially in cases where the young women's economic needs drive their behaviour. Transactional sex is a means of acquiring material goods and additional presents from older men that younger men are incapable of providing (Kempadoo & Dunn, 2001). Issues around mental health also arise as young women are more likely to fall victim to low self-esteem and depression in their adult lives, which acts as a hindrance in negotiating safe sex practices with future partners (PAHO, 2002b).

Machismo and marianismo are important aspects of Caribbean culture. In the first instance, machismo calls on men to be acquainted with everything related to sex. It is ironic though that these men do not seek out information on sexual health, as a lack of knowledge might indicate inadequate sexual experience. Marianismo, on the flipside, necessitates that 'good' women are supposed to be less knowledgeable about sex, be submissive to their partners (Gupta 2002; PAHO, 2002b), and emulate the Virgin Mary always. Women accessing information about safe sex may be deemed promiscuous or adulterous (PAHO, 2002a). This inability to access information due to cultural constraints increases risk, evidenced by the fact that globally, only 38% of women obtain accurate safe sex facts (WHO, 2009c; UNAIDS, 2008). Women are therefore disempowered to negotiate and make informed safe sex decisions. As such, this 'good woman' status adds to HIV and AIDS susceptibility.

The machismo/marianismo dichotomy promotes differential gender norms when it pertains to fidelity and multiple-partnership. The feminine ideal requires that women be loyal and committed to satisfying male desires. The masculine ideal reflects a need for sexual gratification, in the form of several partners. According to Chevannes as cited by UNIFEM (2006, p. 10), "becoming an African Caribbean man privileges one to engage in all forms of sexual relations, from the promiscuous and casual to multiple partnerships. A man is not a real man unless he is sexually active." The social acceptance of these double standards would have started in adolescence (Gupta, 2002).

Plummer, McLean and Simpson (2008) argue that men are forced into conforming to what they observe as normative, risk-taking, male conduct. According to Mane and Aggleton (2001, p. 27) "cultural and societal expectations and norms create an environment where risk is acceptable, even encouraged for 'real' men." It is within this socio-cultural context that women are hindered from openly discussing issues of extramarital relations (UNIFEM, 2002).

Economic inequality between men and women drives the HIV and AIDS epidemic in the Caribbean. The power a man has over the woman influences the decisions she makes regarding condom use, safety of sexual contact and access to health services, as well as communication on multiple partners (PAHO, 2002b). Although times have been changing, women are still not accessing job opportunities as easily as men. In many cases, their earnings are significantly less than their male partners. As such, many women are reliant on men for their own livelihood and that of their families.

Women who are unemployed are at risk as they may engage in social prostitution in exchange for material gains (O'Leary & Jemmott, 1995). PAHO (2002b) states that research conducted in the Caribbean demonstrates that vulnerable women will remain in relationships without questioning their partners' behaviours, lest they be abandoned without a means of survival. It is their hope that submission to high-risk situations with one man, or multiple men, or several 'baby-fathers' will ensure financial stability. The fear of poverty is so powerful that many women are willing to sacrifice their own emotional and sexual well-being, by sharing a man (Bombereau & Allen, 2008). Although in Caribbean countries, free medical testing for HIV is offered, women may not be able to afford health insurance or have money to pay for STI testing that is not free, thus increasing their HIV and AIDS risk.

The issue of migration arises where women and men leave their respective countries of origin in search of work that better allows them to take care of their families back home. Their children, often termed 'barrel children,' succumb to 'Western Union syndrome,' and depend solely on remittances from their foreign-based parents for their livelihood. The mentality that develops from this dependency results in sexual risk as unsupervised children may accept gifts from older men and/or women in return for sex. These kids may also become victims of sexual abuse by adults. Their own peers might also be attracted by their material possessions which leads to sexual relations (Bombereau & Allen, 2008).

Violence and sexual abuse

The Caribbean region has faced a high incidence of violence and abuse against its female population. Gendered violence could be in the form of rape, domestic violence or coerced sex (PAHO, 2002a). Momsen (2004) is of the view that wherever there are inequalities in communities, there is a proportionate amount of violence. It is reassuring though that within recent years, there has been a minor decrease in such cases (Momsen, 2004). Social norms of gendered violence and abuse continue to fuel HIV and AIDS because vulnerable populations are either unwilling or unable to report or speak about injustices being met out to them. It is a primary course of disempowerment that, according to Blanc (as cited in PAHO, 2002b, p.12), "leads to women's increased susceptibility to HIV infection by limiting their physical and mental freedom."

From as early as adolescence, girls are subjected to sexual abuse globally. A 2002 WHO study (Bombereau & Allen, 2008) says that 30% of adolescent girls reported forced sex with men. According to a Caribbean Youth Health Survey held in 2003, 38% of the youths claimed that they were compelled into having their first sexual encounter (Table 3) (Halcon et al. as cited in Bombereau & Allen, 2008). Vulnerability, coupled with sexual assault of young girls, must be addressed within the context of human rights and parental protection before the situation escalates into a regional disaster. Evidence is showing that forced, early, sexual experiences lead to psychological trauma resulting in more high-risk behaviours in adulthood. Victims of such abuse are more likely to maintain a cycle of intergenerational violence, which certainly will intensify the epidemic in the Caribbean (Bombereau & Allen, 2008).

Among adult women in the Caribbean, gender inequalities may lead to physical, sexual and psychological abuse by their sexual partners (PAHO, 2002a). Smith-Fawzi et al. (as cited in Bombereau & Allen, 2008) suggest that economic necessities are responsible for women being subjected to, and putting up with, violent atrocities. The 2005 WHO report on domestic violence (as cited in Bombereau & Allen, 2008) confirms that interpersonal violence, aggression and the HIV epidemic are directly linked. Because of the machismo construct mentioned earlier, women are not allowed to refuse sex with their partners. Women who do so might run the risk of violent acts being perpetrated against them.

Men who subscribe to machismo feel as though they ought not to be questioned by, or made demands of, by women. If questions and/or demands from women do occur, men who subscribe to machismo believe that they have the right to 'put the woman in her place' by carrying out physical or emotional assault on her. This, in turn, affects the woman's mental well-being as well as her reproductive health (PAHO, 2002a). Bombereau and Allen (2008) have found that abusive males tend to be at higher risk of HIV infection as they engage in sexual intercourse without condoms. Finally, violent acts may also be a cause and a result of the actual HIV infection. Many womenfolk do not request an HIV test of their partners or disclose the results of their own testing. This leads to the occurrence of another avenue of violent situations (International Women's Health Coalition, 2008).

Table 3. Sexual behaviour of Caribbean adolescents

	Female	Male	Total
Ever had sexual intercourse	**22.2**	**51.9**	**34.1**
First intercourse was forced (yes or somewhat)	**47.6**	**31.9**	**38.3**
Age of first intercourse			
<10	**23.5**	**54.8**	**42.8**
11-12	**16.8**	**54.8**	**42.8**
13-15	**44.7**	**19.3**	**28.9**
16 and over	**15.3**	**2.7**	**7.6**
Used a condom at most recent intercourse	**59.8**	**49.6**	**53.3**

Source: Halcon et al., 2003 as cited in Bombereau & Allen, 2008

Commercialisation of sex

Harsh economic realities are so powerful that some women feel that the only opening is local or regional sex work (PAHO, 2002b). The pattern of poverty and migration based on the demands of the tourism sector is contributing to the spread of the HIV and AIDS epidemic in the Caribbean region (PAHO, 2002b). Caribbean women in the sex industry have become the caricature carriers of disease (Roberts et al., 2009). Some Caribbean research (Deschamps et al., 2013; Figueroa, 2008) reveals that the social climate of risk factors and high-risk behaviours made commercial sex workers [CSW] particularly vulnerable to HIV infections (Table 4) (Bombereau & Allen, 2008). If prostitutes were attached to brothels as opposed to the streets, they would have been more inclined to use condoms. It is interesting though that HIV seroprevalence was at about 46% for both groups of workers (Bombereau & Allen, 2008). It has been suggested that, among sex workers, there was a perception that customers who might be married, good looking, or frequent clients, were low risk. A lapse in judgement caused them not to use condoms with these clients (Bombereau & Allen, 2008). It must be recognised that the issue of the Caribbean as a thriving commercial sex tourism hotspot has directly impacted the spread of the regional epidemic (Roberts et al., 2009). Legal and illegal inter-island migration occurs as the sex tourism blossoms. Sexual contact with people from various Caribbean countries and other geographical regions of the world is also augmenting levels of risk (Bombereau & Allen, 2008).

Sex work, prohibited by law in Caribbean territories, poses a serious problem to the health of individuals as they are impotent in obtaining health insurance, preventative and secondary health care, and accessing police and social services. In cases of abuse from clients, or sex work establishment owners, help in unavailable. Caribbean legislation does not provide protection from discriminatory and abuse practices perpetrated against sex workers. Those of illegal migration status live in fear of deportation if they file any official complaints. Consequently, under these circumstances, they are left to fend for themselves (PAHO, 2002b; Bombereau & Allen, 2008).

Table 4. HIV seroprevalence estimates from surveys with female commercial sex workers

Country	*Year*	*Characteristics of sex workers*	*Percentage found to be HIV positive*	*95% confidence interval*	Source
Guyana	1993	Females in Georgetown recruited in sex work locations including streets, commercial sex establishments (brothels), hotels, bars and the port	25%	17 to 33%	Carter et al, 1997
Guyana	1997	Females in Georgetown recruited on the streets and in commercial sex establishments	46%	Not reported	Persaud et al, 1999
Guyana	2000	Females in Georgetown recruited in sex work locations including streets, commercial sex establishments, hotels, discos, bars and the port	31%	25 to 36%	Allen et al, 2006
Jamaica	1995	Females in Montego Bay	25%	18 to 33%	Douglas et al, 1997
Suriname	1996	Females working on the streets	22%	Not reported	Suriname National AIDS Programme, 1996
Suriname	2005	Male and female	24%	19 to 30%	Maxilinder foundation, 2004

Source: Bombereau & Allen, 2008

Homosexuality and men on the down low

Stigmatisation of homosexuality in the Caribbean has contributed to another group being vulnerable to HIV and AIDS. Studies that account for HIV prevalence among homosexual populations within the region range between 7-26% (USAIDS, 2012). There have been reports of low condom use among homosexual and bisexual men. Because of stigma, MSM or bisexual men seldom self-identify. As such, the statistics might not be a true reflection of the Caribbean reality (Tabet et al.; Carceres as cited in Bombereau & Allen, 2008).

Hypersexuality among Caribbean men to prove their heterosexuality also boosts the risk as they set out to have numerous partnersto avoid stigmatization (Plummer, 2013). According to De Groulard et al., (as cited in Bombereau & Allen, 2008), "There is a stronger sense of identity and communication among younger and more educated MSM." Their educational background could also be an indication that the sexual practices among this group are guided by safer choices given.

MSM in the Caribbean not as well researched so data collection is problematic for accurately analysing risk among this population. In member countries of the Organisation of Eastern Caribbean States [OECS], such as Grenada, a lack of confidentiality and social anonymity hinder eliciting information from MSM. Further, they also hinder MSM from accessing condoms, HIV and AIDS counselling and testing (Bombereau & Ogunnaike-Cooke, 2007). Generally, homosexual or bisexual men keep their sexual preferences to themselves, and it may or may not remain among the gay communities. There are psychological effects associated with this secret lifestyle: men live in self-denial and possess low esteem, which makes them even more vulnerable to unsafe sex with comforting partners. As is the case with male sex workers, access to health care services is limited for fear of being found out. Research is also showing a preference for private physicians, preferably homosexual, and hospitals and/or health care overseas (Bombereau & Allen, 2008).

In terms of multiple partnering among homosexuals, there is a trend that leans toward serial monogamous relationships and concurrent partnering for short periods. This is evidenced by the fact that there is a tremendous level of distrust among individuals, so they move from partner to partner (Allen et al., 2002). Unlike CSWs, MSM have higher condom usage rates, perhaps as a response to the lack of trust among that community. Like the US, Caribbean heterosexual married men called 'men on the downlow' engage in extramarital sex with other men. This is an attempt to steer away from accusations of homosexuality; and to affirm their false sense of masculinity as a means of avoiding public humiliation (Bombereau & Allen 2008). The phenomenon has a 'bridging effect:' the passing on of disease from this group of men to unassuming women (SIDA, 2006). Again, this population has been under-researched so any concrete pronouncements on social, behavioural and biological data cannot be made (Bombereau & Allen, 2008).

Religious beliefs and practices

Religious values and beliefs are at the heart of Caribbean culture. They play a considerable role in how people relate one to the other and the behaviours that govern these interactions. Religion is sometimes seen as a purposive extension of patriarchy: a means of maintaining social control. Soares (2005, p. 67) elucidates, "This ideology of male dominance, which underlies society's discrimination against and oppression of women, is propagated by social and cultural institutions such as the church." Socio-cultural norms as they relate to religious cosmology are therefore linked to gender inequality. This is integral to the feminisation of HIV and AIDS. All persons are not entitled to what Soares (2005, p. 67) calls "gender justice" where "the same rights, freedoms, opportunities, recognition, and respect for all women and men regardless of their position in society, race and colour identity, religious persuasion, ethnic origin, and sexual orientation [are given]." Ideally, everyone should be awarded equal opportunities, especially those who have been traditionally dispossessed and disadvantaged by their life's circumstances.

Religions practised in the Caribbean such as Christianity, Hinduism and Islam, all have perspectives on the socio-cultural issues raised in this review. Since Christianity is the most practised religion, for the purpose of this discussion, allusion will be made primarily to the Christian faith and how it adds to the complexity of the problem involving HIV and AIDS and women. The Bible, in Isaiah 61:1, preaches that people should live their lives following the example of Jesus Christ whose coming was "to proclaim liberty to the captives and to heal the broken-hearted." Soares (2005) interprets this to mean that 'captives' and 'the broken-hearted' refer to the oppressed in society like women, homosexuals and the poor, all of whom are at high risk of HIV. It seems logical, therefore, that as Christian followers, they should devote themselves to the eradication of injustices meted out to these groups. Isaiah presents God's message, "I love justice and hate oppression," while another prophet warns that "injustice is unrighteous and sinful" (Soares, 2005, p. 68). On this premise religious leaders should cry out against abhorrent acts of inequalities and discrimination against the disenfranchised communities. The God that is served is the epitome of love and would therefore want justice for all. Therein lies the conflict, which is quite difficult to reconcile, between what the Bible says and what the church preaches.

Christianity teaches that man is the head of the household and the wife must submit to him. According to 1 Corinthians 11:3: "Christ is supreme over every man; the husband is supreme over his wife." Everyday living of 'good' Christians often reflects this philosophy of male superiority over the woman as part of the divine design. In cases of infidelity and domestic violence in marriage, couples are encouraged to work through their differences. Many couples therefore end up staying together although their relationships can potentially lead to the detriment of their health and well-being.

Overall, gender norms are seldom challenged by all religions. Despite society's religiosity, which supposedly promotes monogamy, it seems more tolerant of promiscuous males than females. That said, monogamy is considered the solution for HIV and AIDS prevention (Roberts et al., 2009). Some hold the religious belief that chastity until marriage is an increased guarantee of not contracting the disease (Voelker, 2001). For Catholics, if people engage in sexual intercourse, even within the sanctity of marriage, all contraceptive methods are prohibited. Inevitably, for those who heed this instruction, their HIV risk is intensified. Some followers of the Muslim religion practise polygamy. However, only the first wife is recognised by the law, and the others are regarded as common-law wives. The non-criminalisation of this polygamous practice contributes to the spread of HIV as there is no guarantee as to whether the husband and his wives will be faithful.

Finally, religious groups have consensus on the prohibition of prostitution and homosexuality. In a Grenadian study on the beliefs of the Grenadian Faith-based Community on HIV and AIDS, Gomez and Alexis-Thomas (2010, p. 359) found that church members do not alienate these groups but offer advice and counselling in the hope that they change their 'illegal,' 'wrong' and 'sinful' lifestyle.

Conclusion

This paper has passionately captured the socio-cultural issues that contribute to the HIV risk in the Caribbean. The unfortunate reality of the Caribbean is that in a machismo culture, the norm is for women to give in, reluctantly, to male betrayal entitlement, while sacrificing their own desires to roam. Society applauds women for sacrifice but ignores men's philandering. As much as reciprocal faithfulness is expressed as part of the nuptial vows, men have been the ones more inclined to break this contractual agreement. Male virility leads men into dangerous adulterous liaisons. As conveyed by Plummer (2013/2011), risky behaviours and emotional detachment are important to male identity formation. The repercussions for women are quite different. By and large women are held accountable for disloyalty; they are treated like social outcasts. Brown and Chevannes (2001) claimed that there are divergent expectations for infidelity for men and women, in which a male's multiple partners are justified through cultural norms, and a woman's infidelity is often punished. Finally, in a patriarchal culture, the implications for male-female relationships and their potential impact on women's overall well-being are yet to be fully explored and understood. This investigation, therefore, sets some of the groundwork for future research into interrelated notions of education, gender and health that can be pursued as the saga continues to unfold.

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