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African Descent Women: Ethnicity and Condom Use

Yvonne O. Patterson
University of Connecticut - Storrs, pordow@yahoo.com

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Yvonne O. Patterson, Ph.D

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The impact of the HIV/AIDS epidemic among all African American/black women in the U.S necessitates a more in depth response and investigation into all the factors which may heighten women's risk for contracting HIV/AIDS. Although African American women's risk has been explored along several variables, there remains a gap in research knowledge around the effects of ethnicity on the rate of infection among African American/black women living in the U.S. Understanding the etiology of HIV/AIDS this diverse group is critical in developing effective prevention strategies. The term African-American/black was replaced with African descent within the main body of this dissertation to reflect a more appropriate representation of the ethnic diversity found within this racial category.

The goal of this study was to examine whether there are important cultural differences in the empowerment of African Jamaican and African American women that impact their condom use intentions. The theoretical framework included social identity theory, ethnic identity theory, empowerment theory, the theory of reasoned action. A cross-sectional survey design was utilized. The Ethnicity Power Condom Use Survey was administered to 102 African-American and African Jamaican women. Along with interviews, qualitative interviews were conducted with six African Jamaican women to develop a better understanding of their condom use experiences and beliefs. The phenomenological approach was used to guide the exploration of women's lived experiences. These qualitative interviews can help to fill the gap in the literature around African Jamaican women's condom use beliefs and patterns. Although the major

hypotheses posed in this study were not fully supported, qualitative results highlight the necessity of breaking the racial category African American/black. Results reveal that the more acculturated women become the lower their condom use intentions. Women's power in relationships was not related to their condom use self-efficacy nor their condom use intentions. Qualitative findings show that African Jamaican women's feelings of commitment in relationships were a major barrier to condom negotiation and desire. African Jamaican women also lacked important condom use negotiation strategies and critical knowledge around HIV testing protocol. Implications for social work education, research, practice, and for prevention among African Jamaican women are advanced.

African Descent Women: Ethnicity and Condom Use

By

Yvonne Opal Patterson, Ph.D

B.A., University of Connecticut, 2000

M.S.W., University of Connecticut, 2003

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African Descent Women and Condom Use

Presented by

Yvonne Opal Patterson, B.A., MSW

Major Advisor _____

Nancy A. Humphreys, DSW

Associate Advisor _____

Susan Witte, PhD

Associate Advisor _____

Catherine Medina, PhD

University of Connecticut

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As an African Jamaican women growing up in the Upper Albany neighborhood in the City of Hartford, I was confronted with the same adversity as my counterparts who were African American. There were virtually no differences in our social conditions though in our social outcomes. Like many I have lost family members and loved ones in what seem to be cruel and unnecessary conditions. However, the community I grew up in was filled with people who despite their struggles were caring and projected a sense of community. I want to acknowledge my community because without most of those that lived there, I would not be who or where I am today. I am privileged to have gotten to this place, I know; and likewise accept the responsibility of telling our story.

I would also like to thank the Community Renewal Team Inc. staff and administration for allowing me the space and hospitality in completing my study. If it were not for their encouragement, patience, and absolute kindness my work with the women may not have been so effective. Once a member of the CRT staff, I am well aware of the many hats that each person has to wear on a daily basis. Their ability to juggle their roles with absolute love and respect for community members was inspiring. I send a special thank you to all of the women who took time out of their busy lives to sit and engage in this study. These women opened up to share their very personal experiences, many in the hopes of helping their own communities.

Lastly, I would like to thank the many faculty, staff, students at the University of Connecticut School of Social Work for their love and support throughout this process. Every time I walked into the school I felt at home.

DEDICATION

This work is dedicated to my mother – Lolleta Pansy Patterson. Mummy if ah nevah fi yuh me nevah would reach yahso. You give me life and sacrifice uself without nuh expectation all deh time. Nobody honor yuh accomplishment dem but yuh go true dis world wid suh much grace and kindness. My hope is to one day find deh peace dat yuh have and be as gud to my children dem as yuh have been to all of we. Bless up me mada!

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INTRODUCTION/OVERVIEW

Background of Study

The HIV/AIDS incidence, prevalence, and mortality rates for African American women far outnumber the rates for all other racial groups of women in the United States (U.S) (Kaiser Family Foundation, 2013). Although African American women only represent 12% of the female population in the U.S, they accounted for 64% of all estimated female AIDS cases in 2010 (Kaiser Family Foundation, 2013). Incidence rates among African American/black women also surpass those of African American men (Morris, Kurth, Hamilton, Moody, and Wakefield, 2009). According to the Center for Disease Control and Prevention (CDC), in 2006, HIV/AIDS was the number one killer of African American women between the ages of 18-34 in the U.S. HIV/AIDS was also the third and fourth leading cause of death for African American women, 35-44 and 45-54 years old, respectively (CDC, 2008). Over three-fourths (87%) of all new infections among African American women in 2010, were attributed to high risk heterosexual contact (Kaiser Family Foundation, 2013). Heterosexual African American women are more likely to contract HIV from an infected steady sexual partner who they fail to use condoms with during sexual intercourse (El-Bassel, et al., 2009; Wyatt, Forge and Guthrie, 1998; Wyatt, Carmona, Loeb, Guthrie, Chin, and Gordon, 2000; Young, Washington, Jerman, and Tak, 2007).

Although male condoms are the most widely used and are reliable methods of protection from disease for both men and women during sexual intercourse; it is a socially gendered phenomenon, which leaves women at a disadvantage when negotiating condom use with a male sexual partner (Amaro, 1995; Gupta, 2000; 2002, Gutierrez, Oh and Gilmore, 2000). African American women's lack of power around pregnancy and condom use decision-making heightens their probability of contracting HIV/AIDS. Extensive research and scholarship has critically

examined the socio-structural, personal and interpersonal influences which impact African American women's HIV risk-taking behaviors (Airhihenbuwa et al., 2002; McNair and Prather, 2004; Sormanti, et al., 2004). However, most of the surveillance data, scholarship, research, and prevention strategies have lumped diverse ethnic groups of African American women into a single racial category (Ojikutu e al., 2013). As a result, while the incidence rates among African American women continue to rise, very little is known about differences that may exist in the HIV psycho social protective and risk factors between different ethnic groups of African American women (Hoffman et al., 2008).

The racial categories, African American and black, have been sanctioned through custom and are deeply embedded in the American discourse as well as in the academic literature (Agyemang, Bhopal and Bruijnzeels, 2005). The racial classification African American/black more appropriately applies to people of African ancestral origin and their offspring who were born in the U.S, the majority of who are descendants of people brought to the U.S as slaves (Agyemang, Bhopal and Bruijnzeels, 2005). Foreign-born African American populations do not fit this definition, since they were not born in the U.S, do not have a legacy of slavery in the U.S, and usually have important ethnic or cultural differences. This study sought to determine whether there are important cultural differences in the interpersonal and personal power of African Jamaican and African American women which impact their condom use intentions.

This researcher's professional experience in the field of HIV prevention underlines the importance of this study. As a manager working at the Community Renewal Team (CRT) for four years, my responsibilities included implementing three HIV group prevention interventions which were funded through the CDC. One was the Sisters Informing Sisters on the Topic of AIDS (S.I.S.T.A) intervention. Although, the intervention was developed within a cultural

framework that honored the experiences of African American women, it was targeted toward all women who were racially black. The S.I.S.T.A intervention included poems and other cultural materials which legitimized the cultural experiences of African American women.

Huge portions of the population who live in the North end neighborhoods of Hartford and are served by CRT are immigrants from the Caribbean. Despite being *racially* "African American/black" these women were ethnically or *culturally* different. The S.I.S.T.A intervention did not differentiate or honor the cultural experiences of these women. In most instances Caribbean women (mostly Jamaican) were visibly not engaged in the intervention. Not only did this impact group cohesion, but in many instances left this researcher wondering how appropriate the intervention was for this group of women. On many occasions this researcher had to find materials such as poems that were more closely aligned to the women's experiences. The researcher also spoke in patois much of the time to increase interest and develop a better understanding among the group.

During this five session intervention women were taught about the seriousness of HIV/AIDS, effective prevention methods (which included female condoms), and the importance of negotiating male condom use. Despite this critical information, women seemed unfulfilled. On many occasions women would ask, "how do I say this to my partner" or, "what do I do in this instance…", and this researcher had no answers for these questions; neither did the manual. Despite the obvious commitment to positive change, this researcher felt ill-equipped and incompetent on many days. These feelings stirred the passion for asking and finding answers to whether there are important differences between African American and African Jamaican women and what both groups of women could do to better protect themselves against HIV/AIDS infection. So in conducting this study, this researcher hoped to inform not only the research

literature but critical practice methods that could to help inform the social worker profession's knowledge base and their clients in the field of HIV prevention.

Problem Statement

Currently, U.S federal standards for classification of data on race and ethnicity require a minimum of six categories for data on race (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander and Some Other Race), while requiring only two categories for data on ethnicity (OMB, 2010). Since the 2010 U.S Census, the federal standards have been broadened to include six categories of Hispanic/Latino ethnic groups [Not Hispanic, "Mexican", Mexican American", "Chicano", "Puerto Rican", "Cuban", and "Another Hispanic, Latino or Spanish Origin"] (Humes, Jones and Ramirez, 2011). Because groups are not commonly broken out, there is dearth of culturally specific HIV/AIDS data around the differences which may exist between different ethnic groups subsumed under the category African American/black. This lack of data negatively impacts the development of culturally specific prevention interventions. With the use of the broad racial category African American/black, equal HIV rates and risk behaviors are often assumed among the different ethnic groups (Kerani et al., 2008).

While racial categories bear significance in relation to class stratification, discrimination and privilege (House, 2001; Jackson and Cummings, 2008); they have very little relevance in describing cultural phenomena (Obasi, 2008). "Culture is the beliefs, systems of knowledge and patterns of behavior shared by a group of people" (Thompson-Robinson et al., 2007, p.157). Culture can affect a group's response to health and illnesses (Beckford-Jarret, O'Sullivan and Hoffman, 2009; Bent-Goodley, 2007; Bhui and Dinos, 2008). A basic necessity of group identity is the ability to identify oneself as a member of a particular group (Tajfel, 1982).

Ethnicity is often used as a proxy for culture (Phinney and Ong, 2007; Phinney, 1996). Ethnicity is a characterization used to group people who share common ancestry, history, traditions, and cultural traits (Cokley, 2007). People who identify with and are seen as having the same ethnicity, share language, beliefs, values, music, dress, and food (Cokley, 2007).

In a study that estimated and compared the HIV transmission rates by analyzing CDC surveillance data of black adults (those who identified as either black or African American) for whom foreign born status was available, Johnson, Hu and Dean (2010) found that among women, a higher percentage of foreign-born Blacks were diagnosed with HIV infection than native born blacks. These findings highlight the significance of looking at within-group differences.

Other studies that have comparatively examined foreign-born and U.S born African American populations on rates of HIV infection, substance use, and condom use as well as sexual behavior have noted many critical differences and the need for future research in these areas (Broman, Neighbors, Delva, Torres & Jackson, 2008; Hoffman et al., 2008; Kerani et al., 2008 Satcher-Johnson, Hu and Dean, 2010). For instance, Ojikutu, Nanji, Gona and Sithole-Berk (2013) administered a cross-sectional survey among 1,061 black individuals in Massachusetts to determine differences that may exist in the HIV testing behavior, risk patterns, barriers for testing. In this study, the mean barrier score for immigrants was much higher than those of who were born in the U.S. Clear differences have already been identified among different ethnic groups of African American women.

The Pan African diasporal community in the U.S is composed of multiple ethnic groups representing diverse cultures from around the world (Bent-Goodley, 2007; Beckford Jarret, O'Sullivan and Hoffman, 2009). The Pan African diaspora refers to the global distribution of

people of African descent outside of the African continent (Clarke, 1992). In Jamaica, 91% of cases with a known HIV transmission category are attributed to heterosexual intercourse. Among all reported adult AIDS cases for whom data about sexual practices are available, heterosexual practice is reported by almost 94% of persons. Not only is the prevalence high in Jamaica; once in the U.S., immigrants also encounter high rates of HIV/AIDS in states they are most likely to settle. In 2006, 30% of African descent people who migrated from the Caribbean region to the U.S came from Jamaica (Kent, 2007). In 2012, Connecticut ranked eighth (8^{th}) in regards to prevalence rates nationally. Connecticut is one of the top ten states where African Jamaican immigrants settle in the U.S (Kent, 2007).

HIV/AIDS reporting information among African American populations in Connecticut are not routinely broken out by ethnicity. The Connecticut Department of Public Health's [DPH] (2009) report on country of birth for those with HIV/AIDS stated that among the 19,216 HIV/AIDS cases reported from 1982 to 2008, only 68.8% were reported with a country of birth. In this report, Jamaica was the fourth leading country of birth for those with HIV/AIDS. DPH cautions, "Country of birth is incompletely reported for HIV/AIDS cases because it is not systematically recorded in medical records" . The DPH cautions readers in interpreting the results in the report due to the significant amount of cases for which country of birth was not reported (DPH, 2009).

Hartford's diverse African descent population provides a unique opportunity to examine how ethnicity among African American and African Jamaican women may be a factor in women's psychosocial HIV risk factors, such as their inability to communicate and negotiate condom use with their male sexual partners. Wyatt, Williams, Gupta and Malebranche (2011) conducted a review of 166 HIV prevention and risk reduction interventions published from 1988

to 2010 to determine the extent to which U.S based interventions "address and include aspects of cultural beliefs in definitions, curricula, measures, and related theories that may contradict current safer sex messages" (p.362). Of the 166 literature reviewed, only 34 (20%) were identified. Those identified differed in cultural definitions and on the level of integration of cultural concepts (Wyatt, Williams, Gupta and Malebranche, 2011). More social scientists have not only emphasized the need for a disaggregation of data to reflect various ethnicities but also have called for more health disparities research on different ethnic groups of all races, including foreign and U.S born African Americans in the U. S.

Despite its common use in the literature, going forward in this study, the racial classification African American/black will be replaced with term African descent. Studies referenced in respect to African descent women in the literature review of this dissertation may or may not have included different groups of foreign-born African Americans such as African Jamaican women, unless otherwise stated. The term African descent disaggregates the racial category, African American/black, while more appropriately accounting for multiple ethnic groups (Gellespie-Johnson, 2008). The theoretical frameworks that guided this study include social identity theory, ethnic identity theory, empowerment theory, the theory of reasoned action (TRA), and the phenomenological approach.

Summary

This chapter introduced the importance of breaking out the African American/Black racial category in examining whether there are any cultural differences that may exist among African American and African Jamaican women that may impact their condom use intentions. Although African American/Black women's HIV/AIDS risk has been examined along many variables, there remains a gap in knowledge around whether culture may impact the condom use intentions

of the various sub ethnic group of women subsumed under the racial category African American/black. The results of this study can contribute to the development of more culturally appropriate prevention programs and interventions.

CHAPTER I

LITERATURE REVIEW

Theoretical Framework

This study utilized a theoretical framework informed by social identity, ethnic identity and empowerment theory the theory of reasoned action (TRA) as well as phenomenological approach. The phenomenological approach guides the development of the qualitative interviews and the analysis of the corresponding data in this study. This chapter presents a review of the literature in relation to these theories and their utility in explaining the major constructs in this study. The theoretical framework for this study is as follows.

Social Identity Theory

Tajfel (1981) defined social identity as an individual's "knowledge of his [her] membership [in] a social group" and "the value and emotional significance attached to that membership" (p.251). Ethnic group membership and loyalty is most salient where multiple ethnic groups are in contact with each other (Phinney, 1992; Worrell, Conyers, Mpofu and Vandiver, 2006; Tajfel, 1981). In small-scale societies, an individual's group loyalty is much less questioned than in more diverse societies (Tajfel, 1970). Tajfel made four major points which are relevant to this study.

First, self-identification is a basic necessity for group identity. Because an individual's ethnic identity is constructed over time, their ability to choose an identity is essential in understanding the meaning associated with being a part of a particular group. This meaning can then be used for make intergroup comparisons. Self-categorization is therefore essential in measuring ethnic identity.

Second, there are multiple social groups that individuals could claim membership at any given time and therefore multiple social identities from which they can choose (Tajfel, 1981). In the case of foreign-born African descent women, this may include a racial, ethnic, regional, and/or national identity. National and ethnic identities can be held concurrently or alternately at varying degrees of salience (Lui, Lawrence, Ward and Abraham, 2002). While ethnic identity denotes "an individual's sense of self in terms of membership within a particular ethnic group" (Phinney, Horencyzk, Liebkind and Vedder, 2001, p.496), national identity refers to "feelings of belonging to and attitudes toward the larger society" (Phinney, Horencyzk, Liebkind and Vedder, 2001, p. 497). Both national and ethnic identifications are related to a cultural experience (Tajfel, 1970). In this study, a woman's cultural group membership can include these labels: Jamaican, African Jamaican, American and African American.

Third, a woman's choice of identity is driven by the salience, value and meaning of each of the ethnic identities under evaluation within her social context (Tajfel, 1981). Accordingly, depending on the time, those present and the situation, different ethnic groups of African descent women may or may not be willing to self-identify as African American/black (Verkuyten, 2004). Researchers have noted that because race and racial identity may be socially constructed and viewed differently in predominantly African descent countries as opposed to the U.S, once in the U.S, African descent immigrants are able to move beyond the rigid white – black dichotomy and embrace a more cultural and/or national identity (Kusow, 2006; Waters, 1994).

Fourth, human beings strive to achieve a satisfactory concept and image of self (self-esteem). In choosing an identity a woman's ultimate goal is to acquire a social identity that would contribute positively to her image. The lower the objective status of the social group, the less it can contribute positively to an individual's self-esteem (Tajfel, 1970). Benson (2006) noted that African descent migrants have chosen not to identify as black/African American to

avoid the low status of African Americans in U.S, instead opting to identify culturally. A deeper understanding of African Jamaican and African American women's intentions to negotiate condom use can be attained through evaluating their ethnicity in conjunction with their race.

Ethnic Identity Theory

Rooted in social identity theory, Phinney's ideas on ethnic identity take into account that self-identification alone (although necessary) does not explain or predict behavior (Lam and Smith, 2009; Phinney, 1996). Phinney (1992) defined ethnic identity in terms of two dimensions – ethnic identity search and ethnic identity affirmation, belonging and achievement. Phinney (2004) notes both dimensions of ethnic identity could be influenced by the social context. Searching reflects the strength of one's connection to a particular ethnic group. Affirmation , belonging and commitment represents "ethnic pride, feeling good about one's background, and being happy with one's group membership, as well as feelings of belonging and attachment to the group" (Phinney, 1992, p.159). Women's choice of an ethnic label may differ on the strength of their connection and commitment to a particular group (Phinney, 1992). African Jamaican and African American women may differ on the strength and importance of their ethnic group membership

Phinney developed the Multigroup Ethnic Identity Measure (MEIM) to determine the strength of an individual's ethnic identification [ethnic identity score (EIS)] in relation to their self-identified group. In this study, women's EIS was used as a proxy variable to measure women's cultural experience. If African descent women strongly identify and date exclusively within their ethnic groups, their limited choice of partners may impact the size of their *sexual networks*. This in turn may increase their vulnerability to HIV/AIDS. Importantly, there is a gender/sex ratio imbalance among all African descent women and African descent men in the

U.S, where women outnumber men (Alleyne and Gaston, 2010; Newsome and Aurhihenbuwa, 2013). Many African descent men are unavailable for partnering with women. Compared to other racial groups this gender ratio imbalance is drastically lopsided [90.1 men to every 100 women] (Newsome and Airhihenbuwa 2013). The fact that African descent women are less likely to partner with men outside of their race (NASTAD, 2008; McNair and Prather, 2004; Wyatt, et al., 2000), has significant implications for African descent women who live in low income communities. The supply of marriageable African descent men is severely decreased due to high rates of incarceration, death by homicide and HIV/AIDS, as well as unemployment (Wilson, 1987; NASTAD, 2008; Alleyne and Gaston, 2010; Newsome and Aurhihenbuwa, 2013). Those who are available may be significantly impacted by the HIV/AIDS epidemic. Women's movement from an area of lower prevalence rate to one which is higher could increase their probability of partnering with someone infected with HIV/AIDS.

According to recent research, African descent women with limited choice in mate selection may opt to engage in unprotected sex instead of risking the loss of a mate (Wyatt, 1998; Newsome and Airhihenbuwa, 2013). The reduction of African descent women's dating choices, their segregation in low-income communities, and their tendency to date within their race increases their probability of contracting HV/AIDS. This reduction in the pool of men available limits their sexual networks, which indirectly allows for a more rapid spread of sexually transmitted diseases (Alleyne and Gaston, 2010; Newsome and Aurhihenbuwa, 2013). If African Jamaican and African American women identify with, and date exclusively within their own ethnic group, their choice of sexual partnership and ultimately their sexual networks will be limited even further. This decision may not only exacerbate their willingness to engage in

unprotected sex, but may also facilitates a more rapid spread of HIV/AIDS in an even smaller sexual network.

Hoffman et al. (2011) conducted a study of 20 men and 36 women who were born in the English-speaking Caribbean to gain insight into how migration may have shaped the groups sexual risk and protection. Although both men and women partnered with people who were not from the Caribbean, both group were more likely to have main and non-main partners who themselves were from the Caribbean -- women (72%) more so than men (54%). Similar findings were also reported by Marsicano, Lydie and Bajos (2013). Their study examined how racial boundaries shape the formation of sexual networks of immigrants from Sub-Saharan African countries living in Paris, France and surrounding areas. They found that women were more likely than men to partner with someone from their own country.

Gender and sexually normative expectations and roles can vary across ethnicity and impact women's ability to communicate and negotiate the use of male condoms differently. Although African Jamaican and African American women may both be embedded within patriarchal constructions of power, they may differ on the cultural norms surrounding their gender and sexuality. Women's culturally-based gender socialization may either constrain or enhance the negotiation of condom use (Soler et al., 2000). Culturally normative belief and attitudes provide the contextual guidelines for acceptable gender role conduct as well as a repertoire of acceptable sexual interactions and activities within a particular cultural group (Beckford Jarrett, O'Sullivan, and Hoffman 2009; Parker, 2009). The empowerment framework posits that women's lack of personal and interpersonal power in sexual relationships limits their ability to communicate and negotiate the use of a male controlled condom (Wingood and DiClemente, 2000; Wyatt et al, 2000), thereby making women more susceptible to HIV/AIDS.

Empowerment Theory

Gutierrez (1999) defines empowerment as a "process of increasing personal, interpersonal or political power so that individuals can take action to improve their life situation" (Gutierrez, 1999, p.3). Power is the ability to influence one's own behavior and/or the behavior of others (Gutierrez, 1999). The HIV/AIDS epidemic among low-income African descent women in the U.S, is assumed to be directly related to the social and historical construction of oppression and powerlessness (Young, Washington, Jerman, and Tak, 2007). Empowerment theory has adopted a critical and feminist when analyzing women's behavior in relation to HIV/AIDS. The overall goal of empowerment is the reduction of inequality and increase in the individual's overall power. This reflects African descent women's ability to influence not only their behavior but also the behavior of their sexual partner (Gutierrez, 2000). Empowerment theory is a useful theoretical framework because it has integrated the two dimensions of power (personal and interpersonal power) vital to understanding condom negotiation patterns and behaviors (Gutierrez, Oh, and Gilmore, 2000).

Importantly, researchers have recently begun to challenge what is perceived to be a flawed conceptualization of women's risk for contracting HIV (Higgins, Hoffman, Dworkin, 2010; Edstrom, 2010; Gupta, Ogden and Warner, 2011). Many have theorized that an over-dependence on the *vulnerability model* not only distorts women's sexual agency, but also has romanticized women as victims in assuming all women wish to exercise self-protective behaviors while "othering" and stereotyping heterosexual men as disease carriers/perpetrators (Higgins, Hoffman, Dworkin, 2010; Edstrom, 2010; Gupta, Ogden and Warner, 2011).

Personal power. Personal power involves women experiencing themselves as competent and potent beings (Gutierrez, Oh and Gilmore, 2000). This denotes their knowledge,

understanding, and abilities to execute different skills, for keeping themselves safe when engaging in sexual intercourse with a male partner (Gutierrez, Oh and Gilmore, 2000). Women's perceptions, attitudes, self-efficacy and beliefs/values around condoms use has been recognized as important determinants of women's desire to have their partners wear condoms (Amaro Raj, 2000; Harvey et al., 2002). Personal power is similar to the concept of self-efficacy, one's ability to organize and execute actions required to achieve specific results (Gutierrez, Oh, and Gilmore, 2000). Along with women's knowledge and skills around HIV/AIDS, self-efficacy also has taken into account the process by which individuals cognitively appraise any given situation before making decisions. (Wulfret and Wan, 1993). Sobo (1993) found that even though unprotected sex may pose risk for African descent women, depending on the social situation in which the choice is made perceived benefits may outweigh the perceived risk. The perceived benefit of being in a sexual relationship may outweigh the risk associated with unprotected sex.

African descent women's cognitive appraisals rest not only on their knowledge and skills but also on "outcome expectancies, emotional states, social influences, and past experiences" (Wulfert and Wan, 1993, p.346), all of which are shaped within a cultural context. Women's perception of low risk in their relationship, their desire to become pregnant and hedonistic considerations may negatively impact any tendencies towards self-protective behaviors, such as condom negotiation and the overall desire for condom use (Wyatt et al., 2000).

Interpersonal power. Knowledge and skills as well as positive perceptions and beliefs for exercising condom negotiation do not necessarily guarantee that a male partner will wear a condom. While women may possess the knowledge and skills necessary to ideally negotiate the use of a male condom, wearing a male condom is an interdependent behavior which requires

cooperation from male partners (Amaro, 1995). Along with women's personal power, social scientists have stressed the necessity of examining women's power in relationships (interpersonal power). Interpersonal power in this instance is related to a woman's ability to influence condom decision-making in their relationship (Gutierrez, 2000). Research have suggested that African descent women's ability to communicate and negotiate the use of a "male-controlled" condom is positively related to their power and control in sexual relationships (Harris, Gant, Pitter, and Brodie, 2009; Puliwitzer, Amaro, De Jong, Gortmaker and Rudd, 2000). Harvey et al. (2002) conducted a study to examine the connection between relationship power and sexual/reproductive as well as condom use decision-making. They found a positive and significant relationship between women's participation in decision-making around condom use and their partner's use of condoms. Women who controlled or share in condom use decision making were more likely to have partners who had used condoms in the last three months. These women reported using them more often than women reporting that their partners controlled condom use decision-making (Wyatt et al., 2002).

Adverse socio-structural factors such as a low socio-economic status (SES) a serious sex ratio imbalance, and women's experiences of gender inequalities have been found to negatively influence the condom use decision making for African Jamaican and African American women (Amaro and Raj, 2000; Harvey et al., 2003; Wingood and DiClemente, 2000; Wyatt, Forge, and Gothrie, 1999; Wyatt et al., 2000). Gender inequalities are shaped within a cultural context. These include the presence of traditional male dominated gender and sexual roles, women's financial/emotional dependence on male partners, women's increased exposure to sexual abuse and intimate partner violence (IPV), as well as an their early initiation of sexual intercourse (Wingood and DiClemente, 2000).

Female subordination and vulnerability are embedded in Jamaican cultural norms, (Gupta, 2002). These traditional conceptualizations around male/female roles and sexual interactions have helped to foster gender inequalities, such as sexual assault and intimate partner violence (Gupta, 2002). In Jamaica, sexual and physical violence against girls and women, though under-reported, is pervasive (Henry-Lee and Branche, 2003; Muturi, 2009; UNDP, 1999). Women's exposure to physical and sexual violence has been found to limit their ability to initiate a conversation around or negotiate condom use with their sexual partners (Amaro, 1995; Pulewitzer, 2000). The Jamaica Reproductive Health Survey (JRHS,2008), measured women's conceptualization of gender role (USAID, 2010). Overall, Jamaican women from rural areas, lower wealth and fewer years of education reported more traditional attitudes toward gender roles and norms. For instance, 68.6% of women agreed with the statement that "a good wife obeys her husband even if she disagrees". Approximately, 35% of women reported IPV by a partner over their lifetime. Women's gender socialization could influence not only their gender norms and sexual scripts, but also their desire and intentions to negotiate condom use.

Theory of Reasoned Action

The theory of reasoned action (TRA) posits that individuals' behavior is primarily determined by their intentions to engage in that behavior (such as condom use) (Ajzen, 1991). Behavior intentions are, in turn, influenced by behavioral beliefs and attitudes as well as subjective norms (Azjen and Fisbein, 1980). Behavioral beliefs and attitudes reflect the individual's positive or negative evaluation of the behavior in question, while subjective norms correspond with the individual's perception of whether significant others approve or disapprove in their engagement in the target behavior (Hutchison et al, 2007). African Jamaican and African American women's behavioral beliefs and attitudes around condom use may be culturally specific. For example,

Hutchinson et al. (2007) found that cultural factors negatively impact Jamaican adolescent sexual beliefs and behaviors on individual, family and societal levels. The findings from this study can add to the literature in understanding whether or not culture is a significant predictor of women's condom use intentions.

Phenomenological Approach

The phenomenological approach is one of many types of qualitative research methods that allow researchers to gain insights into and deeper meanings of lived experiences (Rubin and Babbie, 2014). Rooted in the seminal work of three philosophers (Edmund Husserl, Rene Descartes and Emmanuel Kant), phenomenology is defined as "knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one's immediate awareness and experience" (Iwamoto, Creswell and Caldwell , 2007). The phenomenological approach can allow the researcher to explore an individual's subjective experiences (Bevan, 2014). Accordingly, the researcher attempts to condense lived experiences around a particular phenomenon through exploring, elucidating and describing the complex underlining meanings of any given phenomenon (Creswell, Hanson, Clark-Plano and Morales, 2007; Iwamoto, Creswell and Caldwell, 2007). Following this particular process, the researcher collects data from individuals who experienced the phenomenon, reflect on essential themes that emerge, and engage in an interpretive of in describing the relevance and meaning of the group's lived experiences. An interview is the most popular method for data collection in this approach to research (Bevon, 2014). A phenomenological approach was deemed appropriate for use, since understanding the lived experiences of African Jamaican women around their condom use desires and negotiation patterns was one of the goals of this study,. Six African Jamaican women were interviewed in achieving this goal. This researcher developed the Condom Use

Intentions Conceptual Model below, which depicts the proposed relationships between each variable used in this study. This conceptual model guided the test of the five hypotheses as well as the development of important themes during the analysis of the qualitative data.

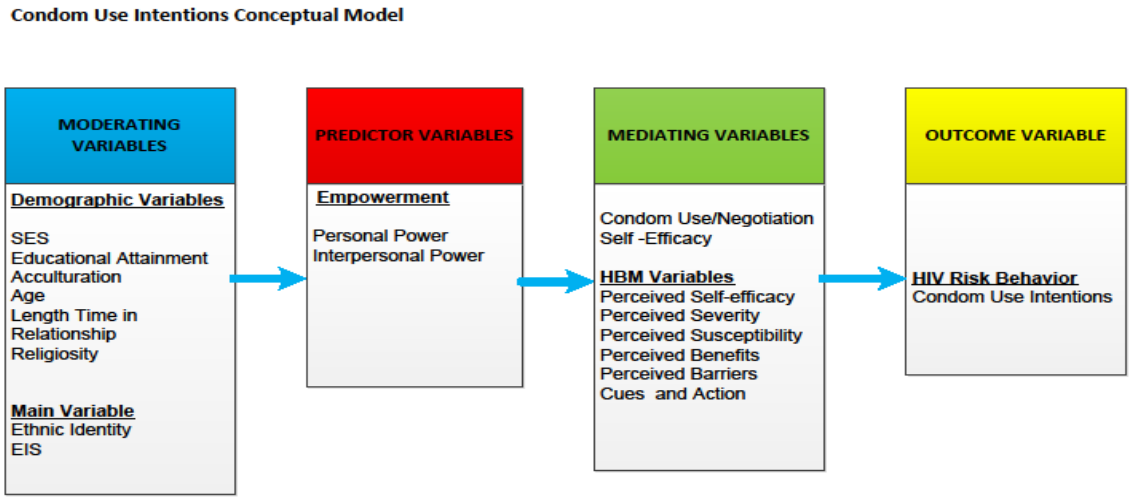

Figure 1.1: Condom Use Intentions Conceptual Model

Research Questions and Related Hypotheses

This study examined three questions. Is there an association between African descent women's ethnic identity score (EIS) and women's perceived sense of power? Is there a difference in the personal and interpersonal power of African Jamaican and African American? If there is a difference, does it impact there condom use intentions? The study examined the following hypotheses:

1. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower perceived *personal power* compared to women who self-identify as African American.
2. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower perceived *interpersonal power* compared to women who self-identify as African American.

3. Women with lower personal power will have lower condom use intentions.
4. Women with lower interpersonal power will have lower condom use intentions.
5. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower perceived *condom use intentions* compared to women who self-identify as African American.

Summary

African Jamaican and African American women are examined in this study. The goal of the study is to determine whether cultural differences around empowerment and condom use intentions exist between these two ethnic groups of women. Underlying theories which support this study are social identity theory, ethnic identity theory, empowerment theory and the theory of reasoned action. The phenomenological approach helped to guide the development of qualitative questions asked in this study. This conceptual framework was chosen because of its utility in examining the role of that culture plays in influencing women's empowerment and intentions for condom use in relationships.

CHAPTER II

METHODOLOGY

Design and Rationale

The study utilized a cross-sectional survey research design. The Ethnicity Power Condom Use Scale (EPCUS) was administered by the researcher to all study participants during face-to –face encounters. Use of the interview survey method was especially advantageous because of the low literacy rate in the various communities from which the sample was drawn. In this way, it assured a higher response rate and reduced the rate of missing data (Rubin and Babbie, 2014). This method also allowed the researcher to observe respondents and field out needs for clarifications (Rubin and Babbie, 2014).

Along with surveys, semi-structured interviews were conducted to gain further insight into African Jamaican women's perceptions and experiences around condom use. The use of a qualitative phenomenological approach was essential in understanding African Jamaican women's experiences. The development of the qualitative questions used in the semi-structured interviews was guided by the Health Belief Model (HBM; Rosenstock et al., 1994). In her major dissertation work, Gillespie (2005) conducted a qualitative study which examined the lived experiences of Jamaican women around HIV/AIDS preventative behavior. Her work was also used to inform the development of the questions and probes. The addition of these qualitative interviews helped to support the interpretation of quantitative findings. Information gained through the semi-structured interviews can help to fill the existing gap in the literature regarding African Jamaican women's condom use negotiation beliefs and patterns.

Sampling

subjects. The sample of 102 women (52 African American and 50 African Jamaican) was recruited from programs operated by the Community Renewal Team (CRT), a non-profit agency, which provides social and health services to Hartford neighborhoods. Hartford is an ideal location for this study. According to the City of Hartford's One City, One Plan Demographics Report (2010), over 18% of Hartford's population is foreign born. Jamaica is the leading country of origin for immigrants that settle in the City of Hartford. The highest concentrations of Jamaican immigrants can be found in the Upper Albany, Blue Hills, Asylum Hill, Clay Arsenal, and North East neighborhoods (One City, One Plan Demographics Report, 2010). People of African descent that are not Hispanic account for approximately 80% of the Upper Albany neighborhood (82.9%); over 70% of Blue Hills (71.3%) and Northeast (72.9%) neighborhoods; and over 40% of the Clay Arsenal (44.1%) and Asylum Hill neighborhoods (47.1%) [U.S Census, 2010]. Both the quantitative surveys and qualitative semi-structured interviews were reliant on a convenient sampling method.

survey. Sample size determination for correlational studies using hierarchical multiple regression to analyze data derived from surveys require a power analysis using four parameters– number of predictors, anticipated effect size, probability level, and power level (Cohen and Cohen, 1983). Because there is very limited statistical information available about the ethnicity of African descent populations in Hartford, this study could not be weighted by ethnicity. An a priori sample size of at least 76 was used to ensure adequate power in detecting a medium effect size of 15% of the variance when alpha = .05. Because of the sensitive nature of the topic studied, the researcher anticipated that there may have been some difficulty in recruiting and

gaining information from women about their HIV risk behaviors. This study, therefore, oversampled for each group of women.

qualitative interviews. The semi-structured interviews were conducted with six African Jamaican women. Creswell (2007) recommends a sample size of *up to 10* people when utilizing phenomenological method. Because the study was primarily quantitative and not a mixed method, only six African Jamaican women were selected to participate in the semi-structured interviews. Qualitative data collection continued until no new topics or perspectives were introduced. Based on this researcher's professional practice knowledge, it was originally thought that it would be difficult to recruit African Jamaican women for this study because of the sensitive nature of the topic. Women's "high interest" in the study was therefore deemed as suitable criterion for recruiting women for the semi-structured interviews beyond their volunteering for the study. The sample of six African Jamaican women was identified during the screening process for the study. If women met the inclusion criteria for the study and verbalized wanting to participate in the semi-structured interviews they were selected. After screening, four African Jamaican women volunteered for the semi-structured interviews. Two women who completed surveys, but did not volunteer for the interviews were asked whether they would like to participate in the semi-structured interviews. Selection of these two women was based on their level of interest in the study before and after being surveyed. These two women engaged the researcher in further questions and conversations about the study. The interviews provided a deeper insight into African Jamaican women's lived experiences around condom use thereby helping to fill a major gap in the literature.

setting. CRT is non-profit anti-poverty agency located in Hartford, providing services to low-income families throughout Connecticut, including the five neighborhoods that have the

highest concentrations of Jamaican immigrants. Of the 60 different human services program provided by CRT, those related to childcare and energy services are the most utilized. Energy related services are delivered through Family Service Centers (FSC), while childcare services are provided through Early Childcare Education Centers (ECE). Currently CRT operates 18 ECE's, of which ten are located in the five neighborhoods in the City of Hartford (Asylum Hill, Blue Hills, and Clay Hill, Northeast, and Upper Albany neighborhoods) , and fourteen FSC's.

Women were recruited for the survey and interviews through two of FSC in Hartford, Connecticut (Albany Avenue and Wethersfield Avenue) and four ECEs'. Three of the ECEs' are located in Hartford (Ritter Early Care Center, Heritage Child Development Center, and Martin Luther King). The fourth ECE was located in Bloomfield, CT (Eric Coleman Center). The agency provided a private office space at each site where data collection was completed.

This researcher is ethnically, African Jamaican and grew up in the Upper Albany neighborhood of Hartford. Therefore to increase participation and help women feel more at ease, she spoke in her native tongue. Although the role of the researcher as a former member of the community may have presented some difficulties during the initial recruiting phase of the study, the use of patois strengthened the interview process. The women were visibly more comfortable expressing themselves during the interview. In qualitative interviews the researcher is deemed to be an instrument (Creswell 2007, Padgett, 2008). Therefore self-awareness is essential. This researcher utilized a bracketing method of suspending her insider's assumptions, beliefs and feelings as well as ongoing debriefing sessions with her main advisor toward better understanding the six African Jamaican women's lived experiences (Padgett, 2008).

Inclusion criterea. There were four inclusion criteria for the study:

1. The women also had to be between ages 18 and 54.

2. Women had to self-identify as either a Jamaican woman of African descent or American women of African descent
3. Receive services through CRT programs
4. Had been sexually active with a main male partner within the past three months.

The age range 18-54 conforms to the most common age range used in previous studies (Wyatt et al., 2000). For the purposes of this study, African Jamaican women were defined as those individuals who were born or have at least one biological parent born on the island of Jamaica. African American women were those individuals who were born or have at least one biological parent born in the U. S. A main partner was defined as someone like a husband or stable boyfriend (Harvey et al., 2006).

recruiting. One African American female MSW research assistant from the University of Connecticut School of Social Work assisted with screening women into the study and administering the EPCUS. The research assistant successfully completed the Basic Course in Social and Behavioral Science with a score of at least 80%. This course was offered through the Collaborative IRB Training Initiative (CITI) program. As suggested by Rubin and Babbie (2014), the research assistant was also trained and supervised to control for measurement bias that might have been introduced into the study due to any discordance between the interviewers. Training included introduction to the study and its purpose, a review of the general guidelines for conducting the survey interviews as well as review of acceptable explanatory and clarifying comments (Rubin and Babbie, 2014). Before conducting and administering surveys on her own, the researcher and research assistant practiced, the research assistant was also observed three times by the researcher (Rubin and Babbie).

Agency staff also assisted the researchers by referring women for the study and initially brainstorming other effective recruiting strategies. Before data collection began, the researcher met with CRT administrative staff located at each site to describe the study. CRT case managers

at each site then were assigned the task of helping with study recruitment. Case managers were trained by the researcher to sensitize them around the necessary steps involved in protecting subjects involved in research studies. This included the importance of not excluding women from services who refused to participate in the study. A second purpose of meeting with case managers was to solicit their expertise and guidance in coming up with the best recruitment strategies. One such strategy offered was later used: secure locked drop boxes were placed in the lobbies of each site along with sign-up slips that way women who were interested in the study could fill out their name and contact information then place in the slot provided on the box. Case managers suggested the use of a drop box because of the sensitive nature of the study and what they believed would be women's apprehension to become involved in the study if approached by a case manager. IRB-approved posters briefly describing the study, reason for the study, potential participants, incentives and the researcher's contact information were also displayed throughout the agency and alongside the secured drop box. Staff also used the research poster and a script prepared by the researcher and approved by the IRB to invite African descent women who considered themselves African American or African Jamaican to participate in the study. The agency provided the researchers with a private setting at each site where women were consented for the study and screened. Researchers also administered surveys and conducted interviews in this private setting.

The researcher presented the study to groups of consumers/clients at the end of several events at the ECE sites. One such event was the parent meeting at the various ECE sites. During these presentations, the consumers/clients were given a short introduction to the study. If interested, the women were brought to the room provided by the agency immediately and were consented and screened. Women, who were referred by staff during times that the researchers were onsite

were consented, screened immediately and, if eligible and willing to participate, asked to complete a survey. The researcher made follow-up appointments with the African Jamaican women who wished to complete the survey but return to complete the semi-structured interview. Researchers sat at a table designated by agency staff in the agency lobby. Some women made inquiries on their own upon seeing the researcher and signage with researchers' names and affiliation.

If the researcher or research assistant were not onsite, staff was asked to record the women's contact information. When contacted by phone or email, a mutually agreeable appointment was made with each woman to meet with the researcher to be consented, screened and if eligible surveyed. African Jamaican women that were eligible for the study that either requested to be a part of the semi-structured interviews or who seemed to enjoy talking were asked to participate in the qualitative interviews as well. After meeting with the women who submitted contact information, their information was immediately destroyed. If after attempting to contact the potential participants three times (without success) their contact information was destroyed. Women, who stated they were no longer interested in being a part of study after being contacted, were thanked graciously for their time and their contact information was also destroyed.

As mentioned before, this researcher grew up in the Upper Albany neighborhood of Hartford. On many occasions community members recognized the researcher. Some who were familiar with the researcher did not request further information about the study. One might speculate that this may have been because of their familiarity with researcher. In this case, these women may not have wanted to share their private information with someone who they had grown up with and knew on personal level. The researcher did not approach any of the women, but allowed the women to approach her to solicit more information about the study.

Data Collection

Informed consents were obtained from each participant before data collection began. Participants were given a consent form that was read out loud to them by the researcher. The consent form included the purpose and nature of the study, the rights of each participant, and all procedures that were utilized to protect confidentiality. Upon reading the consent form, the researcher asked each woman if she had any questions and whether she understood what was being asked of her. A signature was required to affirm consent. Researchers also explained to the participants their right to withdraw from the study at any time.

To establish study eligibility, the researchers administered a specific screening questionnaire (Appendix A). The screening questionnaire consisted of several questions about the women's age, ethnic identity, place of birth, biological parent's place of birth, whether they have had sex with a main male partner in the past three months, and how often condoms were used when engaging in sexual intercourse with that male partner. Only women who reported the use of condoms either sometimes or never during sexual intercourse with their male partner were deemed appropriate for the study. Women received incentives for participating in any of three phases of the study – screening, surveys and semi-structured interviews. If not eligible, each woman received a two dollar ($2) Dunkin Donuts gift card upon completion of the screening. Women who were determined to be eligible for the study and who completed the survey received a ten dollar ($10) Dunkin Donuts gift card. African Jamaican women who participated in the semi-interviews received another ten dollar ($10) Dunkin Donuts gift card.

Measures

Quantitative data were collected through the administration of EPCUS (Appendix B). All surveys were administered by both the researcher and research assistant. The survey consists of

seven different scales that measured ethnic identity, interpersonal and personal power, and condom use self-efficacy, as well as condom use intentions. Variables found in the literature to be related to African descent women's condom use beliefs and patterns were also included as measures on the EPCUS and controlled for in the analyses. These were age, educational attainment, length of time in relationship, religion and acculturation (Maxwell and Boyle, 1995; Wyatt et al, 2000; DiClemente et al, 1998; Hoffman et al, 2008; Gellespie-Johnson, 2008; Locke, 2008; Maxwell and Boyle, 1995; Sormanti and Shibusawa, 2007; Wyatt et al, 2000). A detailed description of the main measures follow.

Socio-economic status. The income guidelines for both CRT programs were utilized as a measure of women's socio-economic status. Both programs had an income threshold of 200% of the federal poverty guidelines. All women surveyed had to meet this poverty guideline measure before receiving CRT services. Therefore all women who received services through ECE and FSC were eligible to participate in this study if they met the additional study inclusion criteria.

age. The measure for women's age was a self-reported birthdate. Women's age was collected on the screening questionnaire. Screening occurred on the same day as the survey interviews.

educational attainment. Women's educational attainment was measured using five categories – eighth grade or less , some high school, graduated high school, some college , a four year college degree, graduate school or above .

length of time in relationship. Women's length of time in their current relationship was a self-report measure. Women were asked how many months they been in their current relationship (Harvey et al. 2006). Women were also asked if "Are you in a relationship now with the male sex partner with which you have had sex with in the 3 month"

religiosity. One item was used to assess women's religiosity. The women were asked

"how religious would you say you are". The item was answered using a four point Likert scale ranging from "not at all religious" to "very religious". This item was taken from a scale adapted by Strayhorn, Weidman, and Larson (1990). Originally created by Kauffman (1979), the scale had 12 items and showed good stability over to administrations "[r=.85, n=91, p<.0005]" (Strayhorn, Weidman, and Larson, 1990, p.39; see also Hardy, 2010).

ethnic identity. The MEIM measures two constructs -- ethnic identity search, and ethnic identity belonging, which comprise two subscales. There are a total of 12 ethnic identity items on the two subscales that were used – ethnic identity exploration or search (5 items) and ethnic identity belonging (7 items). Three additional items were used only for the purpose of identifying and categorizing the women (items 1,2,3) at the beginning of the scale. All MEIM items are rated on a four point Likert scale ranging from strongly disagree (one) to strongly agree (four). In addition to the subscale scores, the MEIM yields a composite EIS. Once the score was established for each group of women, it was possible to evaluate African Jamaican and African American women on how closely they identify with their self-identified ethnic identities. It was therefore possible to assess whether the strength of the women's ethnic identity impacts their personal, interpersonal power, condom use self-efficacy and condom use intentions. When tested among a high school and college sample the reliability scores for the MEIM were .81 and .90 respectively. Currently, the MEIM is the most widely used measure of ethnic identity (Gaines et al, 2010; Worrell, Conyers, Mpofu, Vandiver, 2006).

acculturation. Acculturation is measured using the work of Hoffman et al (2008), who operationalized two variables associated with acculturation (*how long in the U.S* and at *what age upon arrival* upon arrival. *How long in the U.S* has three categories -- five years or less, five to nine years or 10 or more years. *What age upon arrival* has four categories – less than 12 years,

12 to 18 years, 19 to 24 years, or 25 years or older. This was a uni-dimensional measure of acculturation. The operationalization of this variable follows guidelines laid out by Hoffman et al. (2008).

condom use self-efficacy. The women's condom use self-efficacy was assessed using Harvey et al. (2006) adaptation of Bradford and Beck's (1991) original Condom Use Self Efficacy Scale (CUSES). Condom use self-efficacy denotes the women's assurance in their ability to use a condom (Harvey et al., 2006). The CUSES consisted of 28 items, with a reliability score of .91. The Harvey adaptation was used because it conforms best to common standards established in the literature of considering women's limitations of using a male condom.

interpersonal power. The two sub-scales which make up the Sexual Relationship Power Scale (SRPS) was used to assess women's interpersonal power. Gutierrez et al. (2000) define interpersonal power as one's "ability to influence others with social power" (p.586). The SRPS was developed by Pulerwitz, Gortmaker, and DeJong (2000) to measure women's interpersonal power, which includes their relationship control and decision making dominance. The scale consists of 23 items. The instrument has a reliability score of .84.

condom use intentions. The main outcome variable, condom use intentions, was assessed using four items adapted by Harvey et al (2006) from the behavioral intentions for AIDS prevention measure. This is a subscale of the Health and Relationships Survey developed by Miscovich, Fisher and Fisher (1998). The condom use intentions scale has a reliability score of .80. The Harvey adaptation was used because it conforms best to common standards established in the literature in considering women's limitations of using a male condom. Condom use intentions are defined as a woman's intentions to use a condom in the next month (Harvey et

al., 2006). Each item is scored on a five- point Likert scale, ranging from not at all likely (one) to extremely likely (five).

personal power. Three items developed by Gutierrez, et al (2000) were included on the survey to measure women's personal power. Personal power is a woman's experience of herself as potent and capable (Gutierrez, Oh and Gilmore, 2000). Items for this measure are scored on a seven point Likert scale, ranging from strongly disagrees to strongly agree. The items in this subscale were adapted from the empowerment literature (Gutierrez, Oh and Gilmore, 2000) and have a reliability score of .68 representing the overall consistency of the measure.

qualitative interviews. All semi-structured interviews were conducted by the researcher only. The development and administration of the semi-interviews were guided by the phenomenological approach, and through application to develop the interview guide the HBM. Developed by Rosenstock, the HBM has been one of the most widely used theoretical approaches that seek to explain "health-related" behaviors (Rosenstock et al., 1994). There are six core components within the HBM -- perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues and action, and self-efficacy. Five of the six core components were used -– perceived severity, perceived susceptibility, perceived benefits, perceived barriers as well as cues and action.

The semi-structured interviews were conducted in private setting once with each woman in face to face encounters. Interviews were conducted in an empty office in each building away from staff offices to minimize any interruptions and to foster an environment where women would feel more at ease when discussing their sexual experiences. During each of the six interviews the researcher and respondent sat facing each other with only a desk or table between them. The audio recorder was placed on top of the desk or table. Each interview lasted

approximately one hour and was recorded on an audio recording device. Women were asked the guiding questions of interests and were allowed to express themselves freely for each question. The researcher utilized probes to clarify questions and elicit more detailed responses from each woman. Long interviews are critical when utilizing phenomenological approach (Creswel, 2007). Table 2.1 details the variables and corresponding scales as well as reliability scores for each (as reported by the measurement source article).

Table 2.1 *Main Measures*

Variables	Measures	Cronbach Alpha Scores
EPCUS (Quantitative Data)		
Ethnic Identity Score	MEIM	.81-.91
Personal Power	Gutierrez. et al. (2000)	.68
Interpersonal Power	SRPS	.84
Condom Use Self Efficacy	CUSES	.88 - .91
Condom Use Intentions	Subscale of HRS	.80
Semi-Structured Interviews		
Health Belief Model (Qualitative data)	perceived severity, perceived susceptibility, perceived benefits, perceived barriers as well as cues and action.	---

Data Analysis

quantitative data. Prior to conducting the statistical analyses, preliminary analyses were conducted in SPSS on all major variables to examine the accuracy of data entry, missing values, frequency distributions, multicollinearity, as well as the normality of data.

data re-coding. In accordance with the level of education that has been found in the HIV literature to be related to African descent women's desire for condom use (Wyatt et al, 2000), education was recoded at two levels – women with high school diplomas or above educational attainment and women without high school diplomas. Because data were not collected for African American women on acculturation measures (since these women considered themselves Americans), the acculturation measures were recoded to capture African Americans in order to run the analyses with all available data. For instance, the variable *length of time in the U.S* was recoded into two categories -- in the U.S 10 or more years or less than 10 years. African American women were included in the first category. The variable *what age upon arrival* was recoded using the four original categories but now including African American women in the first category – less than 12 years, 12 to 18 years, 19 to 24 years, 25 years or older.

Importantly, after completing data collection for the study, this researcher realized that the Gutierrez, Oh and Gilmore (2000) personal power scale had been written incorrectly for the Ethnicity Power and Condom Use Survey (EPCUS). There were two problems. First, the measure was designed with a seven point Likert scale (ranging from strongly disagree to strongly agree) for each item but had been reduced to a four point Likert scale (ranging from disagree to strongly agree). The order of the Likert options was also written incorrectly. During the data cleaning process, the personal power Likert scale was recoded and rescaled in SPSS to include seven points in the correct order as originally intended.

missing values. After determining that no patterns existed in relation to missing values found on age, personal power, and condom intentions, ANOVA tests were run to determine if there were significant differences between cases deemed as missing and those not missing. There were no significant differences found and missing values represented less than five percent

(5%) of the cases for each variable. Therefore these cases were not excluded from the analyses (Tabachnick and Fidell, 2007).

frequency distributions. Univariate analyses were conducted among continuous and dichotomous variables to identify outliers. There were no excessive uneven splits, defined as 90 versus 10% of cases or greater, detected among the dichotomous variables (high school diploma and length in the U.S) (Tabachnick and Fidell, 2007). Univariate outliers were detected for some continuous variables (*interpersonal power, personal power, and EIS*). Z-scores for these outlying cases exceeded the conventional limit of 3.3 (Tabachnick and Fidell, 2007). These cases were identified and after data screening procedures, a sensitivity test was included during the regression analyses to compare the results of removing and keeping the outliers. Results were the same in both scenarios; therefore the outliers were not deleted.

multicollinearity. Study variables were examined for multicollinearity using bivariate correlations. Tabachnick and Fidell (2001) have advised against including variables with a bivariate correlation of .70 or more in the analysis. The two acculturation variables (*how long in the U.S* in the United States and at *what age upon arrival* upon arrival) were highly correlated (rho=-.642, p<.0010). The covariate *how long in U.S* was kept in the analyses while *what age upon arrival* was removed completely.

normality. The normality of residuals for the continuous variables (*personal power, interpersonal power, condom use intentions and EIS*) were assessed through scatterplots, histograms and tests of skewness. *Interpersonal power, EIS* and *condom use intentions* had a normal distribution. However, *personal power* was found to be non-normal, with a Z-score = 7.8. Scores were significantly skewed to the left indicating a non-normal distribution. Tabachnick and Fidell (2007), suggest that skewed variables should undergo transformations to ensure the

reliability of results; unless there are other reasons not to do so. Transformation of the personal power variable was therefore undertaken, with a resulting Z-score = 2.8. Table 2.2 details the variables included in the analyses.

Table 2.2

Test Variables Included in the Analyses

Variables		Measurement	Level of Measurement
Covariate	Age	Number of Months	Continuous
Covariate	Religiosity	Not religious at all , Slightly religious, Moderately religious, Very	Ordinal (4)
Covariate	Length of Time in U.S	Less than Ten Years (0) Ten Years or More (1)	Ordinal (2)
Dependent /Main	Personal Power	Scale 1-5	Continuous
Dependent/Main	Interpersonal Power	(1) Scale 1-5 (2) Scale 1-4	Continuous
Main	Ethnic self-Identity	African American (0) African Jamaican (1)	Nominal (2)
Main	EIS	Scale 1-4	Continuous
Dependent	Condom Use Intentions	Scale 1-4	Continuous
Main	INTERAJ	Ethnic Identity x EIS	nominal x Continuous

qualitative data. Six interviews were transcribed by the researcher. These transcripts were a verbatim account of what was said during the interviews with the six African Jamaican women. Before beginning the analysis cleaning and de-identifying of the interviews were conducted. The researcher reviewed each transcript while listening to the audio recording of each corresponding interview to ensure accuracy of the transcripts.

A phenomenological approach (Creswell, 2007) was then utilized to analyze the data. Steps included a thorough review of data, noting significant statements, which included sentences and quotes that helped to provide a deeper understanding of each participant's experiences. The researcher along with her major advisor, who has much experience in coding qualitative data, began by reviewing the transcripts and coming up with six preliminary codes – *barriers for condom use, facilitators for condom use, barriers for condom negotiating, facilitators for condom negotiation, trust and cheating*. These initial codes were then used to code the transcripts by hand. Next the transcripts were loaded into ATLAS.ti version six, a qualitative data analysis software program, into a single hermeneutic unit for coding. The researcher then coded the transcripts using the initial six codes in ATLAS.ti version six. Upon careful review of the quotes associated with the codes by the researcher and major advisor, the codes were refined from six to four. Barriers for condom use and facilitators for condom use were collapsed into one code condom use. Barriers for condom negotiating and facilitators for condom negotiating were collapsed into the single code negotiating condom use.

A list of four final codes were developed that focused on African Jamaican women's *knowledge of HIV/AIDS and safe sex* as well as their perceptions around *condom use*, *condom negotiation*, and *trust/cheating*. Quotes in the coded transcripts were then grouped by code label using ATLAS.ti. The researcher and advisor then reviewed the generated report with the quotes.

A cluster of meaning (Creswell, 2007) was developed into themes using African Jamaican women's significant statements. These themes were then used to write a description of the women's experiences. The results from this study may help to fill the existing gap in research knowledge related to African Jamaican women's ethnicity, empowerment and condom use intentions.

Ethical Considerations

Review and approval of this study was sought through the University of Connecticut Institutional Review Board. The IRB-1 – Protocol Application for Involvement of Human Participants in Research: for Expedited or Full Board Review was completed. All data collected in this study was kept confidential. All data are kept in locked file cabinets and secured computers located at University of Connecticut School of Social Work. Audio recordings were deleted from the audio recorder once they were uploaded to a computer located at University of Connecticut School of Social Work. Upon completion of the study all audio files will be destroyed within seven years as required by law. Hard copies of the surveys will also be destroyed upon study completion. All survey data are reported in an aggregate fashion to protect the identity of participants.

Summary

This chapter provided an overview of the methodology used in this study. A quantitative cross-sectional survey design was employed and qualitative interviews were conducted in order to gain a deeper understanding of any cultural differences which existed among African Jamaican and African American women around their empowerment and condom use. All data collection activities were conducted through CRT early education centers and family service center sites. The EPCUS survey was administered to 50 African Jamaican and 52 African

American women. Semi-structured interviews were conducted with six African Jamaican women. While SPSS was utilized to analyze the quantitative data, Atlas.ti version 6 was used organize and manage the qualitative data derived from the semi-structured interviews.

CHAPTER III

QUANTITATIVE RESULTS

One hundred and twelve (112) women participated in the study. Of this amount, fifty-two (52) women self-identified as African American, 50 women self-identified as African Jamaican and 10 women self-identified as being mixed. Women who considered themselves mixed, had one parent born in Jamaica and the other parent born in the U. S. Because the overall goal of the study was to examine differences between women who either self-identified as African American or African Jamaican, these 10 mixed group women were excluded from the analysis (n= 102).

Correlation

Significant relationships were found between several variables. Overall correlation results show a positive relationship between women's *age* and their *religiosity* (rho=.298, p<.001) as well as the *length of time in current relationship* (rho=.444, p<.001). Older women were more likely to be more religious and to have been in their current relationships longer. Women with higher levels of *EIS* also had higher levels of *interpersonal power* (r=.385, p<.001). There was also a positive relationship between *personal power* and *interpersonal power* (r=.385, p<.0011). Women with higher levels of personal power also tended to have higher levels of interpersonal power. While women's *EIS* was positively related to their *age upon arrival in U.S* (.387, p<.001) and religiosity (rho=.361, p<.05); *EIS* was negatively associated with the *length of time they spent in U.S* (rho= -.205, p<.05). *Age upon arrival in U.S* was also significantly related to *religiosity*. Women with lower ethnic identity scores were more likely to have been in the U.S longer. Alternatively, women who identify with their group more strongly were more likely to have entered into the U.S at younger ages and also more likely to have higher religious

orientations. *Condom self-efficacy* was positively related to women's *interpersonal power* (r=.522, p<.001), *personal power* (r=.424, p<.001) and EIS (r=.305, p<.001). Women with increased levels of empowerment also reported higher levels of condom self-efficacy. Women's condom use intentions were related to levels of acculturation [*how long in U.S* (rho = -.298, p<.001) and *age upon arrival* (rho=.230, p<.05). The longer women were in the U.S, the lower their intentions to use condoms. Women, who came into the U.S at younger ages, were more likely to have higher condom use intentions. Women's *EIS* was positively correlated with *age upon arrival* (rho=.387, p<.001). Women who were older when they arrived in the U.S identified with their group more strongly.

Length in current relationship and *educational attainment* were also removed from the models because they were not significantly related to any of the main variables in the model. While *length in current relationship* was significantly correlated with one covariate age, *educational attainment* had no relationship with any of the covariates. Table 3.1 gives a more detailed account of how each of the continuous main variables used in the analyses were related.

Table 3. 1

Main Variables Correlation Table

	1	2	3	4	5	6	7
1. Age	1	.387**	-.167	.164	.145	-.008	-.004
2. Length of Time in Current Relationship		1	-.045	.171	.017	.045	.005
3. Personal Power			1	.220*	.223*	.093	.424**
4. Interpersonal Power				1	.385**	.000	.522**
5. Ethnic Identity Score					1	.021	.305**
6. Condom Use Intentions						1	.090
7. Condom Use Self Efficacy							1

Note.
* p< .05 , **p<.01,

Descriptive Statistics

Although women's age ranged from 18 – 54 years old, the mean age for African Jamaican and African American women was 36 years. Of this amount, African Jamaican women on average were slightly older than African American women by only a few months (*M*= 36.20, *SD*= 9.96 vs. M=35.96, *SD* = 10.44 respectively). There were no significant differences on age found between both groups of women. Women's *length of time in relationship* ranged from one month to approximately 28 years. The average length of time that participants were in their current relationships was approximately 8 years (7.81). African Jamaican women (*M* = 8.24, *SD* = 7.05) were in relationships longer than African American women (*M* = 7.42, *SD* = 6.39). In

the sample, approximately 76% of women had at least a high school diploma or above education. This was true more so for African Jamaican women (78%) [M = 39] than for African American women (73.1%) [M = 38]. While a majority of African Jamaican women (87. 8%) were at least 12 years of age when they migrated into the U.S, approximately sixty percent (61.2%) reported being in the country 10 or more years. Though non-significant African Jamaican and African American women had similar mean scores for their personal power (M = .75, SD =.28 ; M = .76, SD =.30) , interpersonal power (M = 1.76, SD = .49, p>.05; M = .1.80, SD = .55, p>.05), and condom use self-efficacy (M =3.12 , SD = .85, p>.05 ; M = 3.26 , SD =.79, p>.05). African Jamaican women's ethnic identity mean score was slightly higher (M =2.31, SD = .57, p<.05) than African American women (M = 2.09, SD = .61, p<.05). Though non-significant they varied slightly on their condom use intentions mean score (M = 1.89, SD = 1.38, p>.05; M =1.91, SD = 1.42, p>.05). Table 3.2 presents the overall demographic characteristics of the women sampled for the study.

Table 3.2
Mean Ethnic Characteristics

	African Jamaican Frequency or Mean Percent n=50	African American Frequency or Mean Percent n=52
Age	36.20 (9.96)	35.96 (10.44)
Educational Attainment		
High School Diploma	39 (78.0%)	38 (73.1%)
Length of Time in Relationship	8.24 years (7.05)	7.42 years (6.39)
Religiosity (0-3)	2.14* (0.95)	1.65* (1.15)
Length of Time in U.S		***
Less than 10 years	19 (38.8%)	0
10 or more years	30 (61.2%)	52 (100.0%)
Age Upon Arrival U.S	***	***
Less than 12 y/o	6 (12.2%)	52 (100.0%)
12 -18 y/o	16 (32.7%)	0
19-24 y/o	11 (22.4%)	0
25 or more	16 (32.7%)	0
Ethnic Identity Score	2.31** (.57)	2.09 ** (.61)
Personal Power	.75 (.28)	.76 (.30)
Interpersonal Power	1.76 (.49)	1.80 (.55)
Condom Use Intentions	1.89 (1.30)	1.91 (1.42)
Condom Use Self-Efficacy	3.12 (.85)	3.26 (.79)

Note. . * p< .05 , **p<.01, ***p<.001. ANOVA were used for continuous variables, and chi-square for categorical variables. Standard deviation scores appear below the mean in parentheses.

Group Differences

ANOVA and chi square tests were employed to determine if there were any demographic group differences between African American and African Jamaican women on several categorical (*length of time in relationship, religiosity*, and *educational attainment*) and the main variables of interest (EIS, *interpersonal power, personal power, and condom use intentions*). Chi square statistics were used for categorical variables, while ANOVA was used to test continuous variables. The acculturation measures (*how long in the U.S* in the country and at *what age upon arrival* upon arrival) were not examined for demographic differences as data were not collected for African American women on these variables.

ANOVA. Results show that African Jamaican and African American women differ significantly on one main variable – *EIS*. A one-way ANOVA between –groups analysis of variance was conducted to explore the impact of African descent women's ethnic self-identity (African Jamaican or African American) on their EIS as measured by the Multiple Ethnic Identity Measure (MEIM). There was a statistically significant difference at the $p<.01$ level in EIS scores for both groups ($F(1,100) = 8.12$, $p = .005$). African Jamaican women had a slightly higher mean score than African American women. No significant differences were found between the groups on *interpersonal power, personal power, condom use intentions and condom self-efficacy.* The groups also did not differ on *length of time in current relationship*. See Table 3.3 for a detailed look at differences found between African Jamaican and African American women on the main continuous variables.

Table 3.3
Ethnic Differences on Main Variable Score s

	Ethnicity			
	African Jamaican n=50	African American n=52	*Df*	*F*
Ethnic Identity Score	2.41** (.562)	2.08** (.594)	(1,100)	8.12
Personal Power	.815 (.263)	.753 (.295)	(1,99)	1.26
Interpersonal Power	1.84 (.454)	1.81 (.537)	(1,99)	.121
Condom Negotiation Intentions	2.31 (1.38)	1.88 (1.42)	(1,97)	2.33
Condom Use Self-efficacy	3.26 (.789)	3.14 (.849)	(1,77)	.383
Age	35.9 (10.4)	36.2 (9.96)	(1,92)	.014
Length of Time in Relationship	88.98 (76.6)	98.85 (84.6)	(1,98)	.375

Notes. **p<.01. Standard deviations appear in parentheses below means.
D*f= degrees of freedom*

chi square. While significant differences between the two groups was found on three categorical variables (*age upon arrival, length of time in U.S*, and *religiosity*), no significant intergroup differences were found on *educational attainment* (chi-square (1) = .33, p> .05). However, significant group differences existed on *religiosity* and women's *age upon arrival in U.S* as well as *length of time in U.S.* A chi square test of independence was calculated comparing the African descent women's ethnic self-identity and their *religiosity, age upon arrival in U.S* as well as *length of time in U.S.* A significant interaction was found (chi-square (3) = 8.72, p< .05). African Jamaican women tended to be more religious than African American women. Women's *age upon arrival in U.S* (chi-square (3) = 8.71, p< .001), and *length of time in U.S*

(chi-square (1) = 24835, p< .001) was also significantly different. See Table 3.4 for differences found in women's religiosity.

Table. 3.4
Ethnic Differences on Categorical Variables

		Ethnicity		
	χ^2	African Jamaican	African American	D*f*
				3
Religiosity	8.718*			
Not At All		3 (6%)	13 (25%)	
Slightly		10 (20%)	7 (13.5%)	
Moderately		14 (28%)	17 (32.7%)	
Very		23 (23%)	15 (28.8%)	
Educational attainment	.334			1
High school diploma		39 (78%)	38 (73.1%)	
No High School Diploma		11 (22%)	14 (26.9%)	
Age Upon Arrival	79.464***			3
Less than 12 y/o		6 (12.2%)	52 (100%)	
12-18 y/o		16 (32.2%)	0 (0%)	
19-24 y/o		11 (22.4%)	0 (0%)	
25 or more		16 (32.7%)	0 (0%)	
				1
Length of Time in the U.S	24.835***			
Less than 10 years		19 (38.8%)	0 (0%)	
10 or more years		30 (61.2%)	52 (100%)	

Note. * p< .05, *p<.00 . D*f* = degrees of freedom. Numbers in parentheses indicate column percentages.

Hypotheses Testing

Two-level hierarchical multiple regression analyses were used to test the five hypotheses in answering the three research questions posed in this study. These were: Is there an association between *EIS* and African descent women's perceived sense of power? Is there a difference in the personal and interpersonal power of African Jamaican and African American women receiving services through CRT programs? If there is a difference, does it impact their condom use intentions? An interaction term (*INTERAJ*) was calculated using the two predictor variables *EIS*

and ethnic *self-identification*. This interaction term was used in hypotheses one, two and five to examine whether women's self-identification combined with their *EIS* (strength of their ethnic identity) are significant predictors of the proposed outcome variables in each hypotheses. While *EIS* is a continuous variable, the *ethnic self-identification* variable is a two level categorical variable (African Jamaican, African American). As such, a dummy coded variable with two levels was created: African Jamaican versus African American (1 versus 0). After removing variable during preliminary analyses other analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedasticity for each hypotheses test. The sample size used in each hypotheses tests met the general requirements of no less than 50 participants for regression analyses plus the total number variables included in each analyses (Tabachnick and Fidell, 2007).

In step one, covariates were entered first. These include *age, length of time in U.S* and *religiosity*. All variables of interest were entered in the second step depending on the hypothesis being tested (*personal power, interpersonal power,* ethnic *self-identity*, *EIS,* and *INTERAJ*). The first level of analysis considered the effects of the covariates on outcome variables (personal/interpersonal power or condom negotiation intentions). The second level of analysis considered the effects of main variables (ethnic self-identity, EIS, the interaction term of EIS with ethic self-identification, personal/interpersonal power) on women's outcomes.

mediation test. A mediation test was employed using simple regressions to discern the effectiveness of the mediator variable self-efficacy for inclusion in the model for hypotheses three, four and five. As suggested by Baron and Kenny (1986), a four step approach was utilized. In this process it is recommended that if one of the first three steps is non-significant researchers should conclude that mediation is not likely. After following all steps a significant relationship

was not established. Despite women's *personal* and *interpersonal power* being significant predictors of their *condom self-efficacy*, these variables including *condom* self-efficacy were not significant predictors of women's *condom use intentions*. The variable *condom self-efficacy* was removed from the regression.

hypothesis one. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower perceived personal power compared to women who self-identify as African American. This hypothesis examined the association between the women's *EIS* and their personal power. This hypothesis was not supported. The first model explained 30% of the variance found in women's personal power *R* square change = .09, (F (5, 87) = 1.73, p>.05). With the addition of the *INTERAJ* variable, the second model explained 32% of the variance in women's personal power. After controlling for the *age*, *length time U.S* and *religiosity*, women who self-identified as African Jamaican did not have lower rates of personal power than self-identified African American women, *R* square change = .01, (F change (1, 86) = 1.08, p>.05). There was a statistically significant difference found between women's age and their personal power (beta = -.006, p<.05, beta = -.006, p=.03 respectively, p<.05). In the second step, a one month increase in women's age reflected -.006 decrease in their personal power. R*eligiosity, length of time in U.S,* ethnic *self-identity and EIS* were non-significant. See Table 3.5 for a detailed look at the interaction between women's self-identity/EIS and group differences found on their interpersonal power.

Table 3. 5
Primary Analysis: Ethnic Difference and Personal Power

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.001			
Age		-.01*		-.01*
Religiosity		.03		.03
Length of Time in U.S		.04		.04
Ethnic Identity		.07		.32
EIS		.06		.10
Step 2				
INTERAJ			.01	-.11
Total R^2	.10			
n	93		93	

Note. Note. Reported using Unstandardized beta (β).
*p<.05,

hypothesis two. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower perceived *interpersonal power* compared to women who self-identify as African American. This hypothesis was also not supported. The first model was significant and explained 47% of the variance found in women's interpersonal power, *R* squared change .22, (F(5,87) = 5.00, p<.0001). After controlling for a*ge, religiosity, length of time in U.S* in the second model accounted for 47% of the variance. The addition of *INTERAJ* in the second step did not add any additional explanation of the variance found in women's interpersonal power *R* squared change=.00, F change (1, 86) = .06, p<.05. The results indicate that after controlling for the covariates and main independent variables (*ethnic self-identity and EIS*), women who self-identified as African Jamaican did not have lower rates of *interpersonal power* than self-identified African American women. A significant relationships were found between women's *EIS* and their interpersonal power in both models (beta = .39, p<.0010; beta =.41, p<.001). An increase in women's EIS results in .450 point increase in both groups interpersonal power. See Table 3.6 gives a detailed look at the analysis.

Table 3. 6

Primary Analysis: Ethnic Differences and Interpersonal Power

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.22			
Age		.01		.01
Religiosity		-.06		-.06
Length of Time in U.S		.27		.27
Ethnic Identity		-.01		.09
EIS		.39***		.41***
Step 2				
INTERAJ			.01	-.04
Total R^2	.22			
n	91		91	

Note. Note. Reported using Unstandardized beta (β).
***p<.001

hypothesis three. Women with lower personal power will have lower condom use intentions. This hypothesis was not supported. The first model which included the covariates *religiosity, age, length of time in U.S* was not significant (though marginally significant, p=.051). This model explained 29% of the variance found in women's condom use intentions, *R* square change = .09, (F (5, 86) = 1.74, p>.05). With the addition of the personal power variable there was a slight improvement. After controlling for the covariates, this model explained 30% of the variance found in women's condom use intentions. *R* square change = .01, (F change (1, 85) = 1.06, p>.05). These results indicate that there was no significant relationship between women's personal power and their condom use intentions. However there was a significant relationship between their l*ength of time in U.S* and condom use intentions in both models (beta = -1.06, p<.05; beta = -1.09, p<.05). An increase in women's length of time in the U.S reflects a decrease in their condom use intentions. Table 3.7 gives further details on the analysis performed.

Table 3. 7
Primary Analysis: Women's Personal Power and Condom Use Intentions

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.92			
Age		-.00		-.00
Religiosity		.17		.15
Length of Time in U.S		-1.06*		-1.09*
Step 2				
Personal Power			.11	.56
Total R^2	.32			
n	92		92	

Note. Note. Reported using Unstandardized beta (β).
*p<.05

A secondary analysis was conducted using only the covariate *length of time in U.S*. This model was supported. It explained 29.5% of the variance found in women's condom use intentions *R* square change = .09 (F (1, 96) = 9.15, p <.05). With the addition of the personal power variable, the explanation improved slightly. The second model explained 31.4% of the variance in women's condom use intentions. After controlling for the *length of time in relationship*, *R* square change = .10, (F change (1, 95) = 1.20, p>.05). These results indicate that after controlling for the covariates *length of time in relationship*, there was no significant relationship between the women's personal power and women's condom use intentions. There was, however, a significant relationship between women's length *of time in U.S* and their condom use intentions in both models (beta = -1.08, p<.01; beta = -1.08, p<.01). A ten year or more increase in women's *length of time in the U.S* reflected - 1.083 points of decrease in their condom use intentions. See Table 3.8 for a more in depth view of the analyses.

Table 3. 8
Secondary Analysis: Women's Personal Power and Condom Use Intentions

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.09			
Length of Time in U.S		-1.08**		-1.08**
Step 2				
Personal Power			.01	.10
Total R^2	.31			
n	97		97	

Note. Note. Reported using Unstandardized beta (β).
**p<.01

hypothesis four. Women with lower interpersonal power will have lower condom use intentions. This hypothesis was not supported. Women's interpersonal power was not significantly related to their condom use intentions (F (4, 86) = 1.40, p>.05). This model accounted for 28% of the variance found in women's condom use intentions. With the addition of the interpersonal power variable in the second step, the second model accounted for 29% of the variance found in women's condom use intentions, *R* square change = .00, (F change (1,86) = .219, p>.05). In the first and second steps, only *length of time in U.S* was significantly related to women's condom use intentions (beta = -1.00, p<.05; beta = -1.10, p<.05 respectively). A ten year or more increase in women's *length of time in the U.S* reflected 1.096 points of decrease in women's condom use intentions in the second model. Table 3.9 provides a more detailed look at the primary analysis.

Table 3. 9
Primary Analysis: Women's Interpersonal Power and Condom Use Intentions

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.08			
Age		-.00		-.01
Religiosity		.15		.17
Length of Time in U.S		-1.00*		-1.10*
Step 2				
Interpersonal Power			.09	.30
Total R^2	.29			
n	91		91	

Note. Note. Reported using Unstandardized beta (β).
*p<.05

A secondary analysis was conducted using only the covariate shown to be a significant predictor of *condom intentions*, *length of time in the U.S.* This model was supported. A significant relationship was found between women's *length of time in the U.S* and their *condom intentions* (F (1, 95) = 7.67, p<.01). This model explained 27.3% of the variance in women's condom use intentions. With the addition of the interpersonal power variable in the second step, the second model accounted for 27.6% of the variance found in women's condom use intentions, *R* square change = .01, (F change (1, 94) = .161, p>.05). In the first and second steps, only *length of time in U.S* was significantly related to women's condom use intentions (beta= -1.02, p<.01; beta = -1.04, p<.01 respectively). Women's length of time in the U.S was statistically significant in both models. A ten or more increase in women's length of time in the U.S reflected -.1.041 points of decrease in their condom use intentions. See Table 3.10 for more details.

Table 3. 10
Secondary Analysis: Women's Interpersonal Power and Condom Use Intentions

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.06			
Length of Time in U.S		-1.02*		-1.04*
Step 2				
Interpersonal Power			.06	.11
Total R^2	..25			
n	97		97	

Note. Note. Reported using Unstandardized beta (β).
*p<.05

hypothesis five. As the women's *EIS* rise, women who self-identify as African Jamaican will report lower *condom use intentions* compared to women who self-identify as African American. This hypothesis was not supported. The covariates (*age, religiosity, length of time in U.S)* and main variables (*ethnic self-identity and EIS*) were entered at step one. The first model was not significant F (5,86) = 1.74, p>.05). This first model accounted for 9.2% of the variance found in women's condom use intentions. The interaction term (*INTERAJ*) entered in the second step was not significant (though marginally significant, p=.058), therefore the results indicate that after controlling for the covariates (*age, religiosity, length of time in U.S*) and main independent variables, women who self-identified as African Jamaican did not have lower rates of *interpersonal power* than self-identified African American women, *R* squared change = .039, (F change (1, 85) = 3.828, p>05). With the addition of *INTERAJ,* the second model accounted for 13.1% of the variance found in women's interpersonal power. In both model's women's *length of time in U.S* was significantly related to their *condom use intentions* (beta = -1.064, p<.05; beta = -1.119, p<.05 respectively). A ten or more year increase in women's length of time in the country yielded a -1.119 point decrease in their condom use intentions in the second model. The Table 3.11 gives a fuller description of the analysis employed.

Table 3. 11
Secondary Analysis: Ethnic Differences and Interpersonal Power

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.09			
Age		-.005		-.007
Religiosity		.169		.175
Length of Time in U.S		-1.06*		-1.12*
Ethnic Identity		-.047		2.308
EIS		-.213		.169
Step 2				
INTERAJ			.03	-.043
Total R^2	.13			
n	92		92	

Note. Note. Reported using Unstandardized beta (β).
*p<.05 +p<.10

A secondary analysis was conducted using only the covariate shown to be significantly correlated with condom intentions*, length of time in the U.S al*ong with main independent variables *(ethnic self-identity and EIS)*. This model was supported, power R squared change = .09, (F (3, 94) – 3.00, p<.05). This model explained 29% of the variance in women's condom use intentions. With the addition of the interpersonal power variable in the second step the model was not significant. It accounted for 32% of the variance found in women's interpersonal power R squared change = .02, (F change (1, 93) = 1.72, p>.05). Results indicate that after controlling for women's *ethnic self-identity, EIS, length of time in relationship*, women who self-identified as African Jamaican did not have lower rates of *interpersonal power* than self-identified African American women. A significant relationship remained between women's *condom intentions* and *length of time in the U.S* in both models (beta= -1.10, p<.01; beta = -1.12, p<.01). An increase in women's *length of time in the U.S* reflected -.1.120 point decrease in their condom use intentions in the second model. Table 3.13 provides more details.

Table 3. 12
Secondary Analysis: Ethnic Differences and Interpersonal Power

	Model 1		Model 2	
Predictor	Δ R^2	β	Δ R^2	β
Step 1	.09			
Length of Time in U.S		-1.10**		-1.12*
Ethnic Identity		.01		2.31
EIS		-.05		.16
Step 2				
INTERAJ			.03	.11
Total R^2	.13			
n	98		98	

Note. Note. Reported using Unstandardized beta (β).
*p<.05 . **p<.01

Summary

This chapter provided the results from the EPCUS, which was used to .investigate whether there were cultural difference in the personal and interpersonal power of African Jamaican and African American women utilizing services at CRT and whether differences found impacted both groups' condom use intentions. Preliminary analyses provided a wealth of information about group differences and similarities that exist among these women. While, none of the five proposed hypotheses were supported, other major findings support the overall premise of the study that critical cultural differences do exist between African Jamaican and African American women which impact their condom use intentions. Themes from the qualitative interviews provided additional insight into African Jamaican women's experiences and perceptions around condom use and the negotiation of condoms in their sexual relationships.

CHAPTER IV

QUALTITATIVE RESULTS

The six African Jamaican women who participated in the interviews were deemed appropriate for the interview process if they requested to be a part of the interview after being screened into the study or if they were expressed additional interests in the study and agreed to participate in the interviews upon request. These six women also completed surveys. However, their surveys were not linked with their interviews during the data collection process. As such, an analysis of their interviews cannot be done in conjunction with their particular surveys. The following is a discussion of major themes along with smaller sub-themes that were developed from the six interviews. Five major themes were identified -- *women's basic HIV prevention knowledge; women's perception of risk in their relationship, condom use and relationships, condom use negotiation and negative meanings/consequences, successful condom use negotiation and intentions.* These themes capture women's experiences and perceptions of condom use and condom negotiation within their heterosexual steady sexual/intimate relationships.

Although it was the intention of the researcher to conduct the interview in English, many of the women felt more comfortable conversing in their native tongue – English patois. This was especially the case since they knew that the researcher was an African Jamaican woman as noted earlier. The women were more likely to use patois when they became animated about a particular topic such as infidelity or when they wanted to emphasize a particular point. Some translations have been integrated in with the following results to help the reader better understand the women's experiences.

Women's Basic HIV Prevention Knowledge

Overall women's knowledge of HIV/AIDS was consistently adequate in three areas – seriousness of the disease, overall risk of transmission as well as prevention methods. However, women's knowledge of testing protocols used for HIV prevention was inadequate.

seriousness of disease. All participants agreed that HIV/AIDS was a serious disease which requires their concern. Three women reported being personally affected by the disease. Four of six women reported,

> …[it's] a disease that you can get sexually make you either very sick or in some instances end up in death.
>
> It means you're dead and there is no return. I would leave my three beautiful children behind.
>
> When I heard about AIDS it let me know that when a person catches it they are doomed for life. HIV/AIDS is a very serious disease that has no cure but it is treatable these days. It's no longer so much of a death sentence but it's pretty scary. It's like cancer you know, I put it in very similar categories.
>
> To me it's a disease that cannot be cured, so I think it's incurable and with medical advancement I know you can live a productive life somewhat. But it's not like it's gonna eliminate the disease at all so to me it's detrimental to health if you ask me…Yes, because of medical advancement. There's medicine. I think there's more accessibility to it too. So maybe more money you have, I guess you better to get the top line medications. Magic Johnson look at him. You have the best doctors if you have the money to get that taken care of. But at least it's not frightening as it was at first. The fact that there was medicine for it.

In a two cases some women reported being personally affected by the disease. Two of which state,

> I know two somebody [patois- *somebody* -- people] in Jamaica, one when I was in Jamaica and when I was here the other died and their two children.
>
> Yes I know people with HIV, who are HIV positive. People I've worked with, some have died. Some are living with the disease. I have close friends who are like family who are HIV positive. So it's hit close to home.

overall risk of transmission. Along with the reported seriousness of the disease by all women, five of the six women interviewed reported that there was a possibility of them contracting the HIV/AIDS because of risky behaviors such as being unaware of partner's behaviors, being involved in high risk sexual networks as well as drinking and becoming impaired.

Five women's stated,

> It is very likely; I would say it's very likely. The person you control is yourself. I don't know what my husband doing when I turn my back. So yeah, it is very likely.

Another stated,

> …I think I just feel blessed. Because of putting everything together my carelessness, now reaches up closer to a seven. [scale of 1 - 10]. Not meaning that I was promiscuous, but the few that I did [sexual partners], I still should have taken precaution.

Others stated,

> …50/50% chance meaning that you as a person know that you're protected but sometimes your partners that you might think that is not doing anything and you can't swear for them might, you understand, you are protected 50% but your partner is the other 50% of you. So if they do something then they're exposed to it.

> …Because, alright, not that you couldn't have one person and get it from that one person, even for that one time. That's a possibility but to me the more players involved, the more likelihood I would say. See what I mean?

> Not practicing in risky behavior. Because a lot a times people are not themselves. They drink and go out and they do things that they would not do normally do. So even though you have one partner, whatever, your drunk and somebody rapes you or somebody else say you have consensual sex with them that would not necessarily happen if you were not living that lifestyle…

prevention methods. Not only were the women knowledgeable about behaviors that may heighten their risk, they were also aware of the effectiveness of male condoms in preventing disease.

Five of the six participants stated,

> Well to me safe sex should be, hmm, when you have your male partner using some sort of protection, condoms. As the doctor would say, commercials tell you. But to be honest the safe sex that I have been following is just having the one partner and not being promiscuous and feeling safe with that.
>
> Using a condom. I think that more than anything else. Double up if you have to, you know…Put on two (laughter). I'm just kidding, I'm just saying condom, condom, condom. You know what I mean, I would say that it's the safest. And the next thing having one partner just that one person. Don't be hop, skipping and jumping all over the place.
>
> I would say condom use in this day and age is very essential to our lifestyles because there is so many other types of diseases out there not only AIDS but there are other types of diseases that you can contract through sexual contact. Not only from vaginal use but also from your mouth. So I mean condom use…. It only can protect, if a person have an outbreak especially on their mouth.
>
> Well, I feel like using a condom will, nothing is 100%, help at least but I feel protect me from contracting any type of venereal disease, whether HIV or STD diseases. Help prevent pregnancy and for me give me a chance when I just meet a guy, just make sure that ummmhh until I get to know him everything is of health wise.

One participant stated,

> [Safer sex means] wearing a condom all the time.

testing. Even though women's knowledge of the effectiveness of condom use was adequate, they were unaware of the correct protocol necessary when getting tested to determine if they were HIV positive. Three women detailed various testing methods that they have used in the past as alternative methods of prevention. One woman stated,

> Safe sex practices every three month you do your annual, you do your uhmm your annual test. Well that's when me and him started , before everything, you understand. Before him do all of him tests and I got back all his results. I would go do and do a test every three to six months just to make certain there is nothing there. But since me and him are both clear…

CDC protocol requires that women get tested annually, refrain from having unprotected sex and then go back three months later to be re-tested. This process should happen every year. Despite

the CDC recommendations of ongoing annual testing, the above respondent did not return for annual HIV testing once she perceived both her and her partner were clear. She stated further,

> there was no excuse for not having on a condom [before] like I said when we both went and took our test and everything come back clear then we went on…

The other two respondents stated,

> Right. Safe sex for me in my relationship? Let me see now. Safe sex for me I still go and do all my pap smear and still do everything. So I mean do all my checks to make sure me myself is not carrying anything that I can give to my partner and make sure my partner hasn't contracted anything which he can give to me. So safe sex to me is protecting myself the best way I know how, which is like I said following with the doctor or so forth because we don't use condoms.

> Me and him don't have any problems, we go to all of our doctor's appointments together, we go, have the same doctors together. So I mean, health wise there is no health issues but like I said there is no issue. The only thing this [condoms] is for birth [pause] prevention of birth.

African Jamaican women have been shown previously to have low levels of knowledge around HIV/AIDS and prevention strategies (Wyatt, 1999). For instance, Wyatt et al. (1999) found that young women in Jamaica had little information about their bodies, pregnancy, contraception, and STDs. Contrary to these earlier studies; the six African Jamaican women, interviewed in this study, were knowledgeable about HIV/AIDS, safe sex and the effectiveness of condoms. These findings are consistent with recent national studies conducted in Jamaica. The JRHE national survey that was conducted in Jamaica in 2010 showed that the majority of women are not only knowledgeable about HIV/AIDS and prevention strategies but also perceive condom use as an effective method of HIV prevention (UNAIDS, 2010). Therefore the six African Jamaican women's view of the seriousness of the disease, overall knowledge of transmission and prevention methods may reflect not only the widespread impact of HIV/AIDS, but also an overall increase in the awareness of HIV/AIDS among populations globally. This increase may be related to the concerted global response to and the massive proliferation of

education/resources as well as prevention efforts over past 30 years of the HIV/AIDS epidemic (UNAIDS, 2012). The UNAIDS (2012) global report: *AIDS at 30: Nations at the Crossroads* states, "HIV-related knowledge increased and more people adopted safer sexual behaviors during the third decade of the epidemic, reflecting the impact of scaled-up prevention and awareness efforts (p.53)." Despite the adequate fundamental knowledge of the six women interviewed, some women were still unclear of the specific protocols related to the use of HIV testing as a prevention method. This was the case for two of the African Jamaican during the interviews; these women had incorrect knowledge about the appropriate HIV testing protocol used for prevention. The other four women made no mention of HIV testing as an appropriate preventative method. Although accurate knowledge is an important first step in preventing HIV/AIDS, the sustaining impact of the disease on African descent populations clearly requires a more nuanced approach to prevention that moves beyond what was initially unknown among this population.

Women's Perception of Risk in Their Relationship

In spite of women's knowledge of HIV/AIDS and behaviors which may heighten their risk, need for safer sex and effectiveness of condoms, many women believed their risk of contracting HIV/AIDS in their current relationship was low because they trusted their partners and believed they were in committed relationships. When asked to rate their risk in their current relationship five out of six stated their risk was very low. African Jamaican women's perception of being committed /monogamous relationship may have impacted their perceptions of low risk in their relationship.

The respondent that rated her risk high stated,

> [Ten being not] …Definitely not contracting anything, I'll say around a … say around an eight because I don't think I will, but in the back of my mind I'm still within doubt of this guy..

These five women who reported low risk responded by stating,

> I would say a three, my chances slim. I don't think he cheating.
>
> Ten being the worst you say?...I would say (laughter). I would say maybe a four and that is because you don't know what the next person is doing. You know what I mean. I can vouch for me, I can't you know what I am saying…
>
> You know, we, I worry about it at times. But when you have someone who is your partner and you trust. I will admit that I don't think about it as much. You know you always feel that it won't happen to you so you probably don't take as much precaution to it, but I worry about it at times.
>
> [10 being worst] Ahhh.. with my behavior now of being unprotected, I say maybe, I put myself maybe a two, because once, I'm like most feeling like it won't happen to me.
>
> There are no benefits because I trust him. I'm pretty sure he is not doing what he's not supposed to do.
>
> …I say probably three years into the relationship then we became committed to the point where we didn't need to use any protection.

She goes on to say,

> Probably a two [10 being the worst], because even though when I try every now and then. Like I said the conflict after a while, you just, your head just don't want to be bothered with it.

Three women described why they thought their risk was low.

> …Safe for me is that I have one partner, and that's basically what I use in my relationship in terms of remaining safe. Might not be the safest but at this stage of the game I'm not quite comfortable in introducing condoms on a regular basis with somebody I have promised to be faithful with. Because he's faithful and I am faithful, it's unlikely that we would have that problem.
>
> Mine are minimal. Although I'm in close proximity with people who are HIV positive. Based on how the disease is passed on, its very unlikely. Because I drink from them [share the same glass/cup], because based on the knowledge I have I know that's no problem. I know, you know, what to do in the case someone gets cut [practicing universal

> precaution]. I have one partner and I think he's faithful. So I think my chances are minimal. I've never been promiscuous or anything like that even before getting married.

Women's perception of low risk in relationships has been found to be negatively associated with their self-protective behaviors (Wyatt et al., 2000). Ellen, Bolan and Padian (1998) conducted a study among 100 women and their main heterosexual partners of unknown race and ethnicity. Twenty percent (20%) of the women reported that their partners had not had extra affairs, 85.7% of the women reported that their partners had never had sex with a man, 38.9% reported partners had not used crack and 25% reported no injection drug use among their partners in the past were all incorrect. These women's perception of their partner's behaviors was incongruent with their partner's self-report. Women's perception of low risk may or may not be correct. For instance, Smith and Watkins (2005) administered a longitudinal survey in 1998 and 2001 in Malawi. Both men and women in the study worried less about contracting AIDS overtime. The researchers conclude a decline in women's perceived risk reflected an actual decline in risk behaviors in Malawi. In these studies, women's cognitive appraisal of their personal risk in relationships involved an evaluation of several variables rather than just their fundamental knowledge of HIV/AIDS (Sobo, 1993; Wulfret and Wan, 1993). These previous findings, as well as the qualitative findings from this study, highlight the need for a clearer evaluation of women's risk to include their partner's knowledge and behavior as well as the time and social context. Sobo (1993) notes depending on the social situation in which the choice is made perceived benefits may outweigh the perceived risk. The five African Jamaican women interviewed attributed their low risk and resulting lack of desire for condom use in their current relationship to their perceived high commitment and perceptions of monogamy in their relationship (Harvey et al., 2006).

Condom Use and Relationship

The five women who had a low perception of their risk in their relationship and the respondent that perceived her risk being high used condoms either not at all or inconsistently. Overwhelmingly, women reported that lack of desire for and/or lack of condom use during sexual intercourse was influenced by *men's desire to not* wear condoms. Women stated that men did not want to wear condoms because of they did not like them, because it limited men's or their sexual pleasure and/or comfort.

he does not like. The majority of women felt men did not like condoms because it limited their [the men's] experiences rather than their own. In this way they expressed condom use was more of a problem for men than it was for them. This was expressed directly by four respondents.

> cause you know most men don't want to use condoms…
>
> Yeah. Because he's busy convincing, talking about it doesn't feel the same… So eventually you convince yourself that he's enjoying you much better without it. She goes on to say, cause you know most men don't want to use the condoms…
>
> Well remember I tell you that it doesn't feel the same. They feel like it's blocking or don't feel the sensation the way they would want to.
>
> ... They [men] also say that the feel of it, so then you don't want them to not enjoy you because they said the condoms feels, you know, you can't get much feeling from it. So that also puts a play in making them get away with not using it too. Because you want to be pleasurable to them or they may go to somebody else.

Women were asked about barriers for using condoms. Three stated,

> I wouldn't so much say it's the barriers. It's for the fact that he don't like it so he complains. So that's where it is. To me it don't make a difference. He said it make a difference to him. Like you know he not feeling me or something because of course that is between us. So I would say him, him not liking it and complain. So it's him, that has absolutely nothing to do with me, for me it doesn't make a difference. .. No, no his apprehension is not to wear it. He saying he don't want to wear it.
>
> his negative is not really a negative. His negative is it don't feel the same. To him it's

> like, what I would say now, he pulls on the experience. For me I don't see any difference. I don't think there's a negative on my part. As a matter of fact I feel better using it after than not using it. When you use it you know that was a safe experience and I feel freeing. … To me I feel like I have a better feeling afterwards using it.
>
> Well probably for him what me [patois *me* – meaning "I"] can think of is him not feeling it the way him suppose to feel it. Sensation.

When asked if sensation was an issue for her the previous respondent stated,

> Not at all.
>
> She went on to explain that condoms rather than limiting pleasure can enhance pleasure.
>
> She stated,
>
> Yes, if his penis is not like very big and you wear a condom, it kinda help, I think with stimulation. Or if you're too wet, there's a certain times, certain times of the month that you're just quite sure. But there's times of the month that you're just so wet. But it's just too wet, you know, wet. So with the condom it helps.

But some women gave reasons as to why they did not like condom use.

she does not like. While two women discussed the discomfort and limited pleasure of condom use, one reported that it just felt different.

> So besides them not wanting to use it, I'm going to admit sometimes it gets uncomfortable for me too. It dries me up or I might end up itching from the latex of it. So it's not just not on their part of them convincing you [not to use]. So its like I use that as an excuse as well for me not to because it does give me a different feel from the actual sex… I've tried a couple of different [condoms]. I tried the lamb skin that's suppose to be more natural. But that doesn't protect you against the venereal diseases. You know, then you have the other one. But for some reason I don't know the feel of it is just a little different. I don't know if I'm a little bit more sensitive, but I can definitely feel a difference to it.
>
> Mmmhmmm (gestures no), not really. Sometimes you want little changes…Well when I say changes, you use to doing it without, so now you take up doing it with it. So you want to go back to feel how it feel without it again.

In this study four of the African Jamaican women's desire for condom use reflected and incorporation of their partner's feelings about condom use. Similar findings have been found

among women, living in Jamaica. For instance, in a national survey conducted by Hope Enterprises (2000) in Jamaica, it was found that women's consideration of their male partner's sexual desire plays a critical role in the non-use or inconsistent use of condoms. Three reasons were found to be related women's inconsistent and non-use of condoms were men's dislike and objection of condoms as well as women's perceived familiarity with their partner.

Three African Jamaican women expressed either not liking; feeling discomfort from or condoms just feeling different. These women's feelings about condom use were independent of their partner's views. Their vulnerability was not a necessarily product a product of gender inequalities, which thwarted their empowerment. These qualitative findings support the quantitative results. Women's empowerment did not necessarily align with their condom negotiation intentions or behaviors. Interestingly, the two women who had no desire for condom use verbalized feeling powerful in their relationship around condom use decision-making. They clearly stated that if they desired condom use, it would happen. In the quantitative results women's empowerment was not related to their condom use intentions. These findings contradict what has been a popular understanding of women's condom use intentions in the literature. This understanding reflects the major assumptions of the vulnerability model, which is embedded in a traditional feminist approach of understanding women's HIV risk (Higgins, Hoffman, Dworkin, 2010; Edstrom, 2010; Gupta, Ogden and Warner, 2011). In this view women are seen only as victims who always want to protect themselves from male perpetrators (or cheaters) but are frustrated towards this endeavor due to the lack of power (personal and interpersonal). African Jamaican women condom negotiation intentions and overall desire for condom use patterns were influenced by their condom use meanings and experiences inside their relationships.

Condom Use Negotiation and Negative Meanings/Challenges

Three of five women who believed that condoms were more of an issue for men rather than themselves, were very clear that despite their lack of apprehension toward condom use; their negotiation for the use of condoms may convey *negative meanings* to their partners. These meanings may include a possibility of infidelity on their part and a lack of trust for their partner which could be taken as an insult by their partners. In this way, women feared that condom use negotiation may undermine the stability of their relationship. Many of the women also shared challenges that they have experienced which influence their inability to negotiate condom use successfully. These include condoms breaking during arousal, men's insistence that they can be trusted, allergies to condoms, fear of men's reaction, and men persistent complaining during negotiation. Only two women, who were in non-condom using relationships, stated that they did not want to negotiate condom use with their partner. These two women felt they had the ability to do so but had no desire unless it was being used for pregnancy prevention.

challenges. The majority of women detailed challenges that occurred during condom use negotiation with partners. Some expressed difficulty negotiating when in a state of arousal but having no condoms readily available. Others discussed the difficulty of being pressured to engage without condom use by their partner during negotiation. One woman expressed that overtime no condom use was a compliment. It meant that her partner wanted to feel her or be closer to her. Five women stated,

> What is wrong if we go without, so you don't want to stop in, you know, the middle of hmmm… I guess that's the best way excitement or you don't want anything be turned off or you your partner being turned off. .. In this instance that's what I'm talking about telling them to put maybe we should wear one and being that you're in the middle of the excitement he's telling me, why, you know . Like I said we're in the middle of excitement right now we shouldn't what's the problem, you know, you don't trust me, you know.

She stated further,

> Ah, yes. One occasion we end up using one but it breaks and we don't go put another one on…Once again when that happens you don't bother using anymore…I feel comfortable, it's just that ahhh he still would come out with his different excuses of why we don't have to, why we have to now put it on we been together for a while don't you trust me , or it doesn't feel the same, you know. And then right back to the same old, yeah and if you continue to try to let them [condom use] , well we should, then they go to the other extreme well why is it because you seeing someone else [laughter], we're hurting their feelings now. Their being suspicious now and of course sometimes it causes you to come back down.
>
> Sometimes no condom is around and sometimes I say let's try it without a condom.
>
> Maybe availability when you feel for it may not be the time when it is there. So you have to get it. Cause remember once and this was not even…. I don't necessarily think that this was for AIDS prevention but for pregnancy prevention… If you know your not with somebody you don't want to carry or you don't want him to feel like you're carrying. Ability I think might be an issue, because you have to go buy it where you go you don't have condoms at that time.
>
> I didn't know how to go about telling him that he had to use the condom. I was scared I didn't know what I was gonna say or how he was gonna react.
>
> I don't know, I don't know, is just, if I say wear he would say why, why, why. So I don't know what his why is. It's hard for me to think from his perspective. He just says "why baby" And that's where it stops….

When this respondent was asked why she gave in, she stated,

> maybe because I don't want to hear the complaining.

One woman stated that her partner's desire not to use condoms became compliment overtime.

> And then another thing too after a while you start convincing your own self that its some kind of uhhm, compliment because he wants to feel you (laughter), you know, natural.

threats to the relationship. When asked about barriers to getting their partners to wear a condom every time they had sex. Women expressed why they had given up on negotiating condom use with their partners. Two women stated,

> They think you gonna, you be cheating or they think you gonna cheat so that's why you want them to use a condom…. Yeah cause you know sometimes they say why you want to use condoms all of a sudden? You cheating. Or some of them would say I'm not using

> any condoms so it [patois *it* –meaning it's] better you find somebody that will use it (laughter).
>
> My partner feeling that I am messing around with someone else is that's why I want him to wear it. He gonna think I'm cheating and maybe don't sure if the person that I'm cheating with have any form of disease or whatever.

As a follow up question respondent were asked, so do you think that he would probably want to leave the relationship if you tried to negotiate condom use? While women affirmed. She simply stated,

> Yes, yes.

The second woman stated,

> Yeah because of the same fears of can you catch something. You definitely don't want HIV or any other venereal disease. At the same time you trusting that this someone that I care about and I don't want to be insulting them, you know, hmmm if you bring them up [condoms] or they're feeling like you don't trust them. So you start out wanting to do the right thing then they talk you out of it you know.

She further explained,

> You just don't want to hmmm, you just want to keep your relationship as comfortable and as healthy as possible and if he starts thinking that sometimes then that sometimes that will create, you know, arguments. Or as a woman sometimes if he thinks that of you then he might step out and do the same thing.

Two additional patterns emerged from the qualitative results that provided further insight into specific reasons associated with African Jamaican women's condom negotiation intentions and overall desire for condom use. These were (1) a lack of condom negotiation strategies which was common among most women, (2) as well as an underlying belief that the use of condoms implied unfaithfulness by either partner. These factors interfered with African Jamaican women's desire for or ability to negotiate consistent condom use despite their initial confidence.

The majority of women lacked the specialized strategies that were vital to the successful negotiation of condom use especially during arousal. These findings reinforced the quantitative

results. In the quantitative analysis; not only, were women's empowerment (personal and interpersonal power) significantly unrelated to their condom negotiation intentions; but their self-efficacy was as well. Despite, self-efficacy being cited as an important mediating variable between personal/interpersonal power and women's condom negation intentions and desires in previous studies (Harvey et al., 2006; Pearson, 2006; Robillard, 2001; Wulfret and Wan, 1993), in this study, women's possession of the knowledge, ability and confidence to communicate and negotiate condom use may not necessarily translate into their desire to do so or their overall desire for condom use with their partners. French and Holland (2011) found that women's condom influence strategies (CIS) completely mediated the relationship between their condom use self-efficacy and the actual use of condoms in their relationships. These skills may act as mediator between women's confidence in their ability and their actual intentions (Bowleg, Belgrave and Reisen, 2000; Choi, Wojcicki and Valencia-Garcia, 2004; French and Holland, 2011; Noar, Morokoff, and Harlow, 2002). The qualitative interviews provided further insight into the importance of women's possession of condom influence skills as an important mediator between their condom use self-efficacy and their condom use intentions.

Many women reported that condom use was an intrusion and/or a threat to the health of their relationship. Chimbiri (2007) found that condom use is more likely outside of committed relationships like marriages rather than within. Three findings from the Chimbiri (2007) studyare important in relation to this study, (1) condom use is a negligible factor within marriages, (2) discussion of condom use are done within the context of extramarital affairs, (3) discussion of condom use therefore poses a problem for relationship. Researchers also suggest that women's commitment, emotional closeness and intimacy in relationships are barriers for condom use (Gorbach and Holmes, 2003; Harvey et al., 2006; Umphrey and Sherblam, 2007;

Woolf and Maisto, 2008). African Jamaican women's perception of no or low risk can greatly impact their HIV risk reduction desire, regardless of their knowledge, confidence in their ability and possession of influence skills (Bowleg, Belgrave and Reisen, 2000). In this study, the qualitative finding suggests that the maintenance of healthy relationship is a high priority for African Jamaican women. Women's condom use desires and negotiation intentions are evaluated with this goal in mind.

Successful Condom Negotiation and Intentions Use

Women's ability to negotiate condom use successfully in their relationship was dependent upon whether it was the *beginning of a new relationship* where commitment was not yet affirmed and if they did not wish to become pregnant. Their intentions to negotiate condom use were strengthened by any possibility that their partners may be cheating.

> **beginning of relationship**. Yes, when you start out with, when I first meet my partner then I would suggest the condom, you know, that very first cause I don't really know you… You know you getting to know as far as sexually. So their trying to make me as comfortable with not too much, you know, disagreeing because they want to get to the goal of having sex. So in the moment there is not too much of fuuss and so I'm usually successful with the beginning of relationship when we first meet.
>
> Well it just happen like a vibes thing and when we just chilling and me [patois *me* –"I"] know say that wasn't a boyfriend and girlfriend thing. It was just we got up as friends and so therefore both of us know say that we just have to protect ourselves. Cause it wasn't, we weren't really in a committed relationship at the point when we started …
>
> …Right because I know that my partner and I are both clear but say I'm introduced to a new relationship where I don't know about the person status that is[condom use] always a must.
>
> **pregnancy prevention**. Two participants stated that they only negotiated condom use as a means of preventing pregnancy.
>
> So right now I'm on birth control and sometime I don't feel like having the ring [type of birth control] inside so I would pull it out and say alright for this month me [patois *me* – "I"] no want no birth control. So we just use condoms for this month; that way me get a break and you understand, there still vibes in between where we still enjoy we self [patois

> – *we self* – "ourselves] without the risk of me getting pregnant…He has no problem.. No him better no have no difficulties because me will chop him up [laughter] So him have to accept it same way [laughter].

She goes on to state,

> The benefit is me not going to breed [patois – breed "get pregnant"] again that is one benefit… Second benefit is uhhhmm. Health wise I'm not always having any birth control. It's a second type of birth control for me
>
> But I wasn't trying to get pregnant anyways so it was more that reason… Not now because now I can't have any more children, I did an operation.

.

infidelity. When respondents were asked what would motivate them to protect themselves from HIV/AIDS. Overwhelming all participants agreed that they would negotiate condom use if there were suspicions of infidelity in their relationship. This included women who stated they did not desire condom use. They stated,

> If I think he's out there cheating [pause] maybe I'll suspect him if I see spots in his clothes, or different body odor, or he's not eating at home no more.
>
> If I have any feeling that he is not faithful to me. So if I have any feeling in the back of my mind, any intuition or anything that suggest that he might be unfaithful or it's headed in that way then yes.
>
> What would some of things be? Maybe if I noticed anything funny…Yeah, I been trying to think when I say funny what I'm saying. Ah, if something is unusual. Because you know the person you been with them so long, so suppose he's avoiding you.
>
> If have reason to feel that he is not faithful, he cannot tell me that I cannot protect myself. Unless he makes it cler that there is no such reason for me to be worried. You what I am saying… So my big stick is that if you give me reason to doubt you. You got to fix it and if you don't fix it this what I'm gonna do to protect …

She went on to detail grounds for deciding whether her partner is cheating. She stated,

> Well if I see things like I can't see him when I usually see him… He's getting phone calls and cannot tell me who is calling. Somebody tells me something that he was not supposed to be. Or somebody saw him with somebody. If things just change, something that you know, something doesn't seem to be going the way it use to …

Two other respondents stated,

> If me [patois *me* – "I"] see a sign of something then it mean say me a share something that don't belong to me you know my girl [patois – if I caught her man cheating]. So once me have a sight of something it not going to really continue. So motivation would be for my health.
>
> Yes if I found out that my partner had extra affairs with other women, or is involved in other risky health situations like needles, because you can get AIDS from doing drugs not necessarily from having sex with someone else. Then I would be a little bit more worried and say well you know you're doing risky things with your life and not considering me now, and so now we're in a place where you're making it more dangerous for me. So since you're not looking out for me in that because I've trusted you, for my health and my life in your hands, you know. And you've disappointed me in that way, so now I have to…I have to take charge and protect myself by using a condom. So your choice of us not using a condom is no longer a valid choice.

In spite of her remarks she went on to say,

> And to b honest, he'd probably have to mess up more than one time (laughter), because we tend to be forgiving. You have to be truthful about that. We tend to be forgiving. And uh, I would never do it again [in male voice]. So it would probably have to be more than one time.

This participant then detailed specific strategies she uses to determine whether her partner is cheating. She states,

> Some sign would be if somebody a call the phone and him can't answer in front of me, why him can't answer in front of me. Why him can't answer him phone. Another sign would be if him have to go out on the road for something and I don't know what him going for. Why you have to go out on the road? [laughter]. If him body odor change. Him, him don't want me to wash certain things for him or do certain things for him. Well me know say there is something else going on with my husband if I'm calling his phone and not getting him. He have to call me back within a certain period of time.

This participant goes on to say if she noticed infidelity she would just end the relationship would not consider condom use negotiation.

Wyatt et al. (2000) and Gomez and Marin (1996), found that African descent and Latina women who were declared non-condom users, only desired condom use as a method of birth control and not as method of disease prevention. The two women who were verbalized only desiring condom use as a method birth control, in this study, were non-condom users. The

majority of African Jamaican women interviewed reported that their only successful negotiation of condom use with their partner was at the beginning of relationships. Women concluded condom negotiation once they thought they were in a monogamous or committed relationship. These beliefs align closely with findings from Gorbach and Holmes (2003) study, they stated that condom use is more likely when a partner is subjectively viewed as a *new* partner. In their study they found that people with increased feelings of commitment were less likely to request condom use than those with limited feelings commitment. Unfortunately, these women were not questioned about the length of time in their relationship.

None of the women who participated in the qualitative interviews described any other strategy that could help them protect themselves from HIV/AIDS outside of refusing to engage in sexual activity with their partner *if* infidelity was suspected. Gillespie-Johnson's (2008) findings were very similar. She conducted 20 in-depth interviews with young heterosexual, Jamaican women between 18-30 years old who had been in the U.S less than 12 years. Although the participants recognized the seriousness of HIV/AIDS, they believed their risk of contracting HIV/AIDS in their current relationship was low. These women also lacked negotiation skills and feared a loss of relationship. Interestingly, despite lacking condom influence strategies, all African Jamaican women interviewed had developed strategies (effective or not) by which they thought they could detect their partner's unfaithfulness.

Summary

A wealth of information was provided by six African Jamaican women. The themes and sub-themes developed gave additional insight into African Jamaican women's perception and experiences around the issue of condom use in their relationships. Overall, the women had adequate knowledge of HIV/AIDS and the effectiveness of male condoms. But several

challenges prevented women for negotiating condom use with their partners, such as women's lack of desire for condom use, feeling of being in committed relationships and their overall lack of specialized strategies and skills necessary for negotiating condom use with unwilling partners. The results from the quantitative surveys and semi-structured interviews are discussed in the following section.

CHAPTER V

DISCUSSION

This chapter provides an interpretation of the quantitative and qualitative findings related to the goal of this study, which was to determine whether there are important cultural differences in the empowerment of African Jamaican and African American women utilizing services at CRT which may impact their condom use intentions. The three research questions associated with this goal are as follows: 1) whether there is an association between African descent women's ethnic identity score and their perceived sense of power 2) whether there were differences in the personal and interpersonal power of African Jamaican and African American women and 3) whether differences found significantly impact African Jamaican and African American women's condom use intentions

A cross-sectional survey research design was utilized to compare differences between the strength of both group's ethnic identification and its impact on their empowerment (personal and interpersonal power) and condom use intentions. The Ethnicity Power Condom Use Scale was used to collect the quantitative data from both groups of women. Because so little is known about African Jamaican women and their experiences around male condom use, semi-structured interviews were also conducted with African Jamaican women. The phenomenological approach was used to explore African Jamaican women's lived experiences and beliefs around male condom use. The development of the qualitative questions used in the interviews was guided by the Health Belief Model. In many instances, information gained through the qualitative interviews supported the quantitative results. Lack of support for the five hypotheses may indicate that there truly are no cultural differences to be found between African American and African Jamaican women along their empowerment and condom intentions and desires.

However, in spite of the unsupported hypotheses, additional findings point to the overall importance of the study and the necessity of continuing to examine whether intragroup differences exist among African descent populations around their condom use desires and condom negotiation. A discussion and interpretation of the findings will unfold in relation to three research questions posed in the study. Whenever possible and appropriate an integration of the qualitative and quantitative results along with relevant research literature will be used to inform this discussion. This chapter will conclude with an outline of the limitations associated with this study.

Research Question One: Is there an association between African descent women's ethnic identity score and their perceived sense of power?

Although, women's ethnic identity score (EIS) was positively correlated with all women's personal and interpersonal power; it was not a significant predictor of any cultural differences around how powerful women felt within themselves or in their current relationships A women's EIS is largely a measure of self-concept or self-esteem in relation to their self-identified group. Ethnic identity theory, an extension of Tajfel's social identity theory, postulates that one's membership within a given group has a profound impact on one's self-image or self-esteem (Tajfel, 1982). In many research studies, self-esteem has been found to be positively related to a strong identification with one's social group (Bracey, Bamaca, and Umana-Tylor, 2004; Greig, 2003, Lorenzo-Henandez and Oullette, 1998; Phinney et al., 1997). People who identify strongly with their social group tend to have higher self-esteem and vice versa. As operationalized in this study women's interpersonal power reflects an overall *self-confidence* in their ability to complete decision-making tasks in relationships. Women's EIS was significantly predictive of all women's interpersonal power in this study. Likewise women's with higher sense of individual strength

(personal power) equally had and more intact self-concept. This suggests that there may be a connection between women's self-confidence, inner strength and their self-concept or self-esteem related to their group membership. These results indicate that women with stronger connections with their group also may a healthier self-concept/self-esteem in relation to other groups around them. While a stronger connection with their group is associated with feeling a stronger sense of power it actually predicts women's confidence in relationships. Women who were more acculturated experience a sense of power in themselves and in relationships. These findings warrant further investigation.

Research Question Two: Are there differences in the personal and interpersonal power of African Jamaican and African American women?

Despite its connection to women's sense of power in relationships, the Multiple Ethnic Identity Measure, which measured strength of women's ethnic identity, may not have been an appropriate stand-alone measure of women's culture in relation to the study goal. An understanding of women's broader cultural experience requires an identification of specific experiences that can be compared and contrasted to a referent group. In this case, the subjective cultural experiences of African Jamaican women around issues of empowerment along with those of African American women should be identified and compared when studying differences in women's culture. As mentioned before, "Culture is the beliefs, systems of knowledge and patterns of behavior shared by a group of people" (Thompson-Robinson et al., 2007, p.157). Ethnic identity was used as a proxy for exploring women's cultural experience and its connection to their empowerment in this study. The ethnic identity variable was operationalized as a combination of women's self-identified ethnic identity and EIS [as measured by Phinney's MEIM scale]. Although an aspect of culture, the operationalization of women's culture to include only their self-identified status and the strength of that identification did not sufficiently

capture what was originally advanced as a conceptual definition of culture. Suggestions for a appropriate measures of women's culture will follow.

Researchers bemoan the complexity involved in defining and measuring culture (Cokley, 2007; Hruschka, 2009; Khort, Hadley, Hruschka , 2009; Phinney, Horenczyk, Liebkind, and Vedder, 2001). Because ethnicity, like race is a social construct, it can take on different meanings. Depending on the time or social context, a woman's choice of label or ethnic self-identification (African Jamaican or African American) may not necessarily reflect or align with her actual system of knowledge, belief or behavior patterns (culture) [Phinney, 1992]. Phinney (1996) notes, self- identification alone cannot explain or predict behavior (Lam and Smith, 2009; Phinney, 1996). African Jamaican or African American women can feel a strong sense of commitment and connection to their self-identified group and a higher sense of power within themselves or within their relationships but depending on the groups they are in contact with and how long they are in contact with them, these women can experience a shift in their learned cultural patterns and beliefs (acculturation) which may or may not be reflected in their choice of label. With this in mind the non-significant findings related to the proposed difference between both groups interpersonal and personal power is not unsettling.

Although age was found to be a significant predictor of women's personal power, in this study, there were no cultural differences found between African Jamaican and African American women's personal power. The relationship found between women's age and personal power aligns well with most of the HIV/AIDS literature in this area (Maxwell and Boyle, 1995; Sormanti and Shibusawa, 2007). In their study Maxwell and Boyle (2007) conducted qualitative interviews with 23 older women over the age of 30. They found that the imbalance of power between women and men in relationships in favor of men continues in later adulthood (Maxwell

and Boyle, 2007). This imbalance can affect older African descent women's decision-making in relationships. One can speculate that women who are older may perceive their choices of partnership as being even more limited than those of younger women. Therefore, a threat of a loss of relationship may be of even greater consequence to older women than younger women of any ethnicity. In light of the sex ratio imbalance found among African descent women and men, one can speculate that African descent women's age may further limit their ability to partner in low-income communities thereby impacting their desires and decisions around condom use. As noted earlier, African descent women with limited choices in mate selection may opt to engage in unprotected sex rather than risking a loss of mate (Wyatt, 1998; Newsome and Airhihenbuwa, 2013). Researchers also note that the risk of no condom use among older women and their partners becomes normalized over time in relationships (Sormanti and Shibusawa, 2007).

Research Question Three: Do differences found in women's empowerment significantly impact African Jamaican and African American women's condom use intentions?

Research routinely suggests that women's positive condom negotiation intentions and desires are predicated on their having a strong sense for keeping themselves safe (personal power) as well as an ability to influence condom use decision making when engaging in sexual intercourse with a male partner (interpersonal power) [Geilen, McDonnell Gutierrez, Oh and Gilmore, 2000; Cox, Posner, Sangi-Haghpeykar; Harvey, Thornburn-Bird, Galavotti, Duncan, Greenberg, 2002, 2010; Pulerwitz, Amaro, De Jong, Gortmaker and Rudd, 2002; Sherman, 2000], However, in this study, not only, were both group of women's empowerment (personal and interpersonal power) significantly unrelated to their condom negotiation intentions; but their self-efficacy which has been proposed to act as a mediator between women's empowerment and condom negotiation in the literature was unrelated as well. Self-efficacy has often been cited as an important mediating variable between personal/interpersonal power and women's condom

negotiation intentions and desires in previous studies (Harvey et al., 2006; Pearson, 2006; Robillard, 2001; Wulfret and Wan, 1993). Women's condom use self-efficacy was operationalized as women's confidence in their ability to negotiate condom use in relationships. Wan and Wulfret (1993) suggests that an individuals' cognitive appraisals involved in decision-making initially relies on his/her knowledge and skills.

However, as shown in the quantitative and qualitative portions of this study, women's possession of the knowledge, ability and confidence to communicate and negotiate condom use may not necessarily translate into their desire to do so or their overall ability to negotiate condom use with their partners. In the past, many researchers have suggested that African descent women's low level of educational attainment may directly limit their access to knowledge and strategies around HIV prevention (Blankenship, Bray, du Guerny and Sjoberg, 1993; Merson, 2000; Wingood and DiClimente, 1998; Wyatt et al., 2000). Despite past significance this variable was unimportant in this study. As noted earlier women's knowledge deficits around HIV/AIDS may have shifted over the past 30 years of virus. With the passing of time women's needs in relation to HIV/AIDS knowledge like the disease must become more nuanced beyond the basic information that was previously viewed as necessary during the first ten or 20 years of the virus. Although African Jamaican women interviewed were knowledgeable about the seriousness of HIV/AIDS, safe sex and sexual transmission, two women interviewed had considerable knowledge deficits around testing. It was also noted that most African Jamaican women were more concerned about sexual transmission during the administration of the surveys rather than transmission due to drug use. This obvious prejudice may point to a neglected need in African Jamaican women's prevention knowledge.

Another area of knowledge deficit identified was African Jamaican women's negotiation strategies. In their study, French and Holland (2011) found that women's condom influence strategies (CIS) completely mediate the relationship between women's condom use self-efficacy and the actual use of condoms in relationships. These skills may likely act as mediator between women's confidence in their ability and their actual intentions (Bowleg, Belgrave and Reisen, 2000; French and Holland, 2011; Noar, Morokoff, and Harlow, 2002). The qualitative interviews provided further insight into the importance of women's possession of condom influence skills. As mentioned before, the two African Jamaican women who appeared to be the most empowered during the qualitative interviews were also self-declared non-condom users. The majority of African Jamaican women interviewed who desired condom use and tried to negotiate the use of condoms with their partners, despite their confidence in their ability, felt ill-equipped in confronting their partners barrage of pressure towards no condoms use in that moment. Women's use of CIS may effectively help them manage during these stressful situations.

In the quantitative findings, women's EIS (used as a proxy for culture) was also unrelated to African descent women's condom use intentions. There were no differences found between African Jamaican and African American women's condom use intentions. As noted, women's self-concept is only a small part of their cultural experience. What emerged as a significant predictor of women's condom use intentions was their level of acculturation in three of the five hypotheses tested. These findings suggest that understanding the acculturation process among African descent groups who have been in contact with each other for a number of years is critical in developing a fuller understanding of different cultural shifts which may occur between African Jamaicans and African Americans.

Acculturation refers to a process of cultural and psychological exchange that follows intercultural contact (Berry, 1997). African Jamaican women's traditional belief and behavior patterns around gender roles and rules may have been adapted towards the beliefs of African American women, despite their choice of ethnic label. Quantitative findings show that women's acculturation was inversely related to their ethnic identification. This study highlights an important difference between the two measures used to approximate culture within this study – acculturation and ethnic identity. Phinney, Horenczyk, Liebkind, and Vedder (2001), leading scholars consider ethnic identity as part of a broader acculturation process and experience.

In this study women's acculturation was operationalized as the number of years spent in the United States of America. Over 60% of African Jamaican women interviewed had been in the U.S 12 or more years. Women who had been in the U.S longer were not only less likely to identify with their self-identified group and more likely to have increased personal power and condom use self-efficacy, but significantly more likely to have lower condom use intentions. With an increase in the amount of time African Jamaican women spent in the U.S, their condom use intentions decreased. Similar results have been found among Latino groups.

As mentioned earlier, women's gender socialization can influence their gender norms, sexual scripts, as well as their desire and intentions to negotiate condom use (Azjen and Fisbein, 1980). For instance, in a focus group conducted among 15 to 18 year olds in Jamaica, analyses revealed different sexual scripts among males and females. While abstinence was not desired among males, females were shown to be culturally restrained around sex. These beliefs may change overtime and within a different social context. Also important is although previous studies have found African Jamaicans religiosity to be related to their socialization experience and the way in which they conceptualize health and illness, specifically HIV/AIDS; women's religiosity in this

study though significantly different among both groups of women, was unrelated to their empowerment and condom use intentions (Gillespie, 2005; Robillard, 2001) . Berry (1997) notes, acculturation tends to induce more change in the immigrant group. African Jamaican women's traditional belief and behavior patterns around gender roles and rules may have been adapted towards the beliefs of African American women, despite their choice of ethnic label. Preliminary analyses from this study showed an inverse relationship between women's acculturation and their ethnic identification. Women who were in the U.S ten or more years were more likely to identify less with their self-identified group. As suggested by Hoffman et al (2013), African Jamaican women's restrained and *disempowered* gender socialization may actually serve as a *protective factor* upon arrival in the U.S. Findings from their study suggest that the longer African Jamaican women were in the U.S and the more acculturated they became, the more likely they were to participate in high risk behaviors.

Similar results around acculturation and HIV risk taking behaviors have been identified among Latinas in the U.S. For instance, Newcomb et al. (1998) found that the acculturation of Latinas' was directly related to their risk-taking behaviors. Kaplan, Erickson and Jaurez-Reyes (2002) found that less acculturation was associated with lower rates of HIV risk behaviors. Findings from this study may be associated with less rigid gender roles as well as the reduced stigmatization of HIV/AIDS found in the U.S in comparison to those found in Jamaica (Gupta, 2000; Hoffman et al. 2013; Gellespie, 2005; Gellespie-Johnson, 2008). These factors may reduce women's perception of risk and/or lessen the social consequences/sanctions associated with engaging in high risk behaviors such as unprotected sex.

Data derived from the qualitative interviews indicate that African Jamaican women's partnership type/relationship status also is related to their condom use in relationships. The

variable length of time in relationship is often used to evaluate women's partnership type or relationship status in determining their desire for condom use and power in relationship. Quantitative results show that women's length of time in relationship, although significantly correlated their age, was not a significant predictor of women's personal and interpersonal power or condom use intentions. While some researchers have operationalized serious partnership type in relation to the time women spend in relationships and/or marital status, others have measured this in relation to how committed or close women are to their partner (Conley and Collins, 2005). Umphrey and Sherblam (2007) state, "Commitment refers to an individual's psychological state and emotional feelings of attachment to a partner (p.62). In essence, researchers in the latter cohort suggest that women's commitment, emotional closeness and intimacy in relationships are barriers for condom use (Gorbach and Holmes, 2003; Umphrey and Sherblam, 2007; Woolf and Maisto, 2008). Findings from the qualitative interview support the latter group's findings. These findings suggest that women's relationship status is better understood by looking at women's perceived level of commitment in relationships, rather than length of time. Though not asked about the length of time they had been in their relationship, all African Jamaican women interviewed reported feeling committed in their relationships. Results show that African Jamaican women may place a high value on being in lasting relationships, which may also shape their desire for condom use and condom negotiating. These women also identified condom use as a threat to the health of their relationship in the qualitative interviews. Women's condom use decision-making, rests not on their knowledge of HIV/AIDS, but additional factors such as the value of their relationship (Sobo, 1993). Whether the identified value around commitment in relationships among low-income African Jamaican women differ from low-income African American women's value remains unanswered in this study because qualitative interviews were

not conducted with African American women. The ability to study women's culturally bound experiences and its impact on their health attitudes and behaviors is for more complex and calls far more rigorous methods of research (Hruschka, 2009).

Limitations

Four limitations connected with this study are identified. These were the sampling method used select the sample, the exclusion of African American women from semi-structured interviews, the use of the personal power measure and the majority (over 60%) of African Jamaican women were very acculturated . Because a nonprobability convenience sampling procedure was used to recruit women for the study, findings are limited in its generalizability beyond the 102 women recruited from CRT. This sampling procedure relied on the available women. The women recruited may not represent the population of women that receive services through the ECE or FSC at CRT. Additionally, because the surveys were administered by the researchers and the personal nature of the questions, women's responses may have been biased during the survey interviews and the semi-structured interviews. Women may have felt a need to appear socially desirable (Rubin and Babbie, 2014). To this point, on many occasions during times researcher administered, the survey felt as though it was an intervention. Women seemed self-reflective in many instances, and some occasions paused to ask this research questions regarding the transmission of HIV/AIDS. This may have impacted the women's response. Some women verbalized having to change their behavior because of their contact with the study. In these instances, women were provided with additional resources for HIV testing and counseling.

The study could also have been strengthened if African American women were included as well as African Jamaican in the semi-structured interviews. In developing and confirming women's cultural experience it is necessary to have a comparison group. However, the necessity

of including both groups of women is in hindsight. The inclusion of African American women in the qualitative interviews could have provided a better context for identifying and evaluating cultural differences between both groups of women. Qualitative data received from African American women could have strengthened the quantitative results and overall purpose of this study. Although the inclusion criteria for the study required that women use condoms either not at all or inconsistently, the interviews did not include a balance amount of women in these two categories. A more balanced sample could possibly have allowed a clearer view of differences on condom use patterns and beliefs.

Another major limitation in this study may be the use of the personal power scale developed by Gutierrez, Oh and Gillmore (2000). Rubin and Babbie (2014), note that scales have a good to excellent internal consistency if they produce alpha scores of .80 and above. The personal power scale used only had an internal consistency score of .68. Also problematic was validity of the scale. According to Rubin and Babbie (2014), the incorrect operationalization of variables can impact the overall results of a study. Although items on the scale questioned women about how powerful they felt in general, it did not ask questions about how powerful women may they feel around negotiating condom use. This scale's ability in predicting women's knowledge, understanding, and abilities to execute different skills, for keeping themselves safe when engaging in sexual intercourse with a male partner is therefore questionable at best.

Over 60% of the African Jamaican women involved in the study were in the country over ten or more years. This may have been another limitation in the study. African Jamaican and African American women had very similar mean scores on most of the variables entered in the analyses. This similarity may have been due to extended contact between these two groups of

women over many years. Future studies should include an even balance of African Jamaican women who have been in the country varying years.

CHAPTER VI

IMPLICATIONS

This study sought to examine whether there are critical cultural differences in the empowerment of African Jamaican and African American women which may impact their condom use intentions. The purpose of the study is consistent with the profession's goal of developing and advancing relevant evidence informed practice models as well as research that addresses the needs of diverse and vulnerable populations. In light of the impact that the HIV pandemic has had on African descent women in the U.S, the need for culturally competent approaches are vital. According to Davis and Donald (1997) culturally competent practice reflects, "…the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes" (NASW, 2001, p.11). Cultural competence is the hallmark of "good" social work practice. Not only is it a gold standard for practicing and conducting research, social workers are ethically bound to practice in ways that affirm the human rights of all populations. The implications for social work research, practice and education are advanced along with recommended HIV/AIDS prevention approaches in working with African descent women who live in Hartford.

Implications for Social Work Education

Since its inception, the profession of social work has struggled with developing the best practice approaches in fulfilling its commitment towards vulnerable an oppressed groups (Giitterman and Germain, 2008). The history of social work details a long and persistent movement toward developing practice models that can successfully integrate the profession's attention to both people helping and society changing [generalist practice] (Goldstein, 1995). In

the absence of a cure for HIV/AIDS, the need for effective social work practice models has never been more crucial. Despite the advances in critical technology and medication that has helped to curb the trajectory of the disease among most populations in the U.S, low-income African descent populations continue to have the highest prevalence, incidence as well as mortality rates. In the wealthiest nation in the world it is simply unacceptable and shameful that a small minority of its population continues to disproportionately die and suffer from this disease in silence. The state and fate of "Black America" specifically low-income African descent communities in relation to this disease has been compared to some of the poorest regions in the world (NASTAD, 2008).

Although the virus has long-since slowed in its impact among European descent homosexuals, in the absence of public outrage and organized efforts, low-income African descent communities that endure multiple oppressions remain voiceless. Who will speak and lend their voice to this group? If not social workers then who, if not now then when? As social change agents with an overarching mission of serving and facilitating the empowerment of oppressed groups, social worker are especially poised to answer this call to action. In answering this call, social workers must equip themselves with an appropriate and acceptable amount of knowledge around HIV/AIDS. Social workers must also develop and advance approaches which affirm the diversity as well as the humanity and dignity of members of African descent communities that they partner with in this effort.

Empowerment Practice. The empowerment practice model which evolved during the early years of the profession is widely used in the field of HIVI/AIDS. Despite its relevance in past periods, the empowerment models' utility in addressing the pandemic of HIV/AIDS among African descent women in the U.S is being challenged. Kuhn (1970) notes, when a dominant

paradigm is no longer able to evade anomalies or explain crises, competing paradigms will appear or re-appear. As noted by Bertha Reynolds (1934), in the midst of great crises, there is great opportunity. Two recommendations for social work education are advanced here to help develop future social workers in answering this call to action – (1) future professionals need to re-evaluate and re-conceptualize the usefulness of the major assumptions found within the empowerment practice model (2) social work education must integrate specific curriculum into its education structures to address the importance of understanding the plight of low-income African descent women.

Empowerment practice incorporates a critical feminist perspective in analyzing women's behavior in relation to HIV/AIDS. Empowerment theory is a major theoretical underpinning of the vulnerability paradigm. Assumptions found within this framework places both men and women in fixed and one dimensional roles, women are assumed to be victims who helplessly contract HIV from male perpetrators/fiends. This assumption not only objectifies both men and women, it also perpetuates the myth that heterosexual women's gender socialization and resulting sexuality only allows for a lack of power in all cases (Correa, 2010; Edstrom, 2010; Gupta, Ogden and Warner, 2011 Higgins, Hoffman, Dworkin, 2010). Results from this study as well as other studies suggest that women's sense of power and/or limited socialization may have very little to do with their exercise of self-protective behaviors. As mentioned before, an appraisal of many factors is related to women's condom use desire and decision-making. The classroom should be used as active laboratory in keeping the profession moving forward. Social work students should be encouraged to think critically and challenge these paradigmatic assumptions towards the development of "new" knowledge/understandings that can lead to the development of better approaches in their time and social context.

Also critical is the necessity to shift the profession's gaze from a critical examination of African descent women's individual behavior to include an examination of structural issues that are found to be impacting the trajectory of HIV/AIDS among this population. This gaze is a deficit-only approach to examining women's behavior that (in the absence of solutions) encourages victim-blaming. In that, it does not allow for a fuller examination of structural forces that plague low-income African descent communities and exacerbates the spread of HIV. As mentioned earlier, African descent women's heightened vulnerability to HIV/AIDS is overwhelming a product of inequalities that are embedded within their social environment (Airhihenbuwa et al., 2002; McNair and Prather, 2004; Sormanti, et al., 2004). Therefore, teaching and understanding the impact of the mass incarceration of African descent men or high incidents of de-facto segregation and racial isolation on women's partnering options and behavior are critical to developing a more balanced reaction to the HIV/AIDS pandemic among this population.

As suggested by the Life Model, the social work professionals' function is to improve the level of fit between people and their environment. This integrated helping paradigm calls for and extensive examination of not only individual behavior but also the structure and quality of people's environment. Empowerment practice advances three dimensions – personal, interpersonal and political. Although the first two which examine micro-level issues have been conceptualized well in the literature, political power which addresses macro issues has not been evenly advanced as an appropriate intervention. Further development in this area could deepen future social worker's understanding of the HIV related experiences and prevention needs of African descent communities.

A third and important point to keep in mind when evaluating empowerment practice is that empowerment is a rigidly defined outsider's concept that is being used as a measuring stick

against all cultures void of an insider's view of their own experiences. This perspective does not give careful consideration of different women's own subjective cultural lenses. Social work students should be taught to arrest their own cultural assumptions in evaluating African descent women's experience of power in relationships. Thereby allowing women to own and speak their own truth. In this study, it was found that less acculturated women had more condom use intentions.

Implications for Social Work Research

The development and use of appropriate measures is critical in understanding the etiology of HIV/AIDS among different cultural groups of African descent women. Researchers note the difficulties in operationalizing and measuring culture and call for better measures, more rigorous methods for examining culture, as well as an examination of alternative hypotheses (Hruschka, 2009; Khort, Hadley, Hruuschka, 2009; Phinney, 1996; Malanbarche and Wyatt, 2013). They note, this effort among researchers require careful, lengthy and in depth study of the social setting in which each group is embedded. Three suggestions are as follows – researchers should (1) use multi-dimensional measures of acculturation when conducting within-group studies with African descent populations (2) integrate qualitative method when designing researches in this area (3) integrate scales into surveys that measure women's condom negotiation strategies when examining women's condom use behaviors and intentions.

Acculturation Measures. In this study, more acculturated African descent women were not only less likely to identify with their group but more likely to have increased personal power and condom use self-efficacy. Acculturation refers to a process of cultural and psychological exchange that follows intercultural contact. In this study a acculturation was operationalized as a unidimensional construct, a measure of the length of time women were in the U.S. Researchers

agree that the use of a unidimensional construct evokes a limited and linear understanding of individuals who are constantly shaping and are being shaped by their social environment. Obasi (2005) state that more differences can be found within groups rather than between. Studies have identified regional differences on women's perceptions of gender roles among African Jamaicans who live in rural versus those that are from urban areas Jamaica (Gillespie, 2005; Smith et al.). A more in depth analyses of these differences can be attained with the use of multidimensional scales. Despite the appropriateness of multidimensional scales, those commonly available are developed to examine differences between groups (intergroup) rather than within groups (intragroup). These measures routinely compare all groups' cultural change in relation to "mainstream" or European descent culture. This obscures the obvious diversity of host groups and communities (Obasi, 2008; Phinney, 1992). Therefore, there is a gap of knowledge in the literature regarding within group cultural variations that may exist among African descent populations in the U.S, who have ongoing interactions (Obasi, 2005; 2009). During this researcher's literature search only one such scale was identified --Measurement of Acculturation Strategies for People of African Descent. As such, the use and development of more scales in this area is necessary (Obasi, 2005).

Qualitative Methods. In depth levels of analyses which can evaluate whether women's acculturation strategies and/or their unique social setting may be influencing their intentions or behaviors are also necessary. Although, the hypotheses were not supported in this research, this study elicits many questions for future research. For instance, are African Jamaican women who are more traditionalists or assimilationist in their cultural beliefs and behaviors dating exclusively within their ethnic group? Are these women different? Do African Jamaican me face similar plight like African American men which remove them from women's dating pool? Do

African Jamaican women despite their acculturation status perceive that there is a constrained supply of African Jamaican men? If so, is this perception a better predictor of their behavior than their acculturation? As mentioned before, in light of the sex ratio imbalance among African men and women, dating exclusively within one's ethnicity may further limit their dating options. An even more limited dating pool cannot only influence women's perceptions and behaviors but also create "risk situations" (Newsome and Airhihenbuwa, 2013). Research designs which incorporate qualitative and quantitative measures can potentially be more meaningful in understanding and comparing African Jamaican and African American women's cultural values and beliefs associated with their condom negotiation intentions and behaviors.

Condom Strategy Scales. The incorporation of a scale that measures African descent women's condom communication and negotiation skills and strategies, such the CIS, is also necessary when conducting research in this area. According to French and Holland (2013), women's condom negotiation strategies can include withholding sex, direct request of condom use, seduction (eroticizing), relationship conceptualizing, sharing risk information and deception. While women may feel confident within themselves and within relationships in communicating and negotiating condom use the possession of the actual skills necessary to do so may be absent, as was the case among the African Jamaican women interviewed in this study.

In light of the heavy infection rates and death toll caused by the epidemic of HIV/AIDS among low- income African descent populations in the U.S, an integrated response to practice which evaluates women's individuals as well as their environment becomes all the more important. This approach requires that social workers help their clients or client groups not only acquire the necessary skills in keeping themselves safe in relationships. African Jamaican women in this study place a high value on relationships. Helping these women to lower their risk

in while relationship require identifying barriers to and teaching the specific strategies necessary in communicating and negotiating condoms during high stress situations.

Implications for Social Work Practice

Social workers' knowledge of women's culturally bound experiences should shape the way they engage specific populations for research. During the recruitment and data collection phases of the study, there were several insights that manifested which may help to inform social workers' future engagement with African Jamaican and African American women.

The first of which was that this researcher became very aware of the power differentials between her and potential participants despite growing up in the same neighborhood. Also evident are ways in which this imbalance in power may have presented difficulties early on in recruiting women into the study. At the beginning of the study women would avoid the researcher if not introduced to her by a staff person. In some instances, women who knew the researcher, through personal encounters avoided her even more after finding out the topic of the research. Women also made no direct inquiry about the study to the researcher when onsite, even though the researcher was very visible.

To increase interest in the study, this researcher had to make time to present her study at several different events or conduct on- the- spot recruiting with staff assistance. The researcher also had to spend time at each site on a regular basis before recruitment improved. Besides women developing a sense of trust, women's hectic life may have presented a challenge to their wanting to become involved in the study. Ultimately, women who participated had to be willing to not only sacrifice time out of their hectic schedules, but also share very personal information. This highlighted the importance of staff assistance during recruitment in getting "buy in" from most participants at the various sites.

African Jamaican women were even more difficult to recruit than African American women. Despite the aforementioned recruitment tactics, African Jamaican women were less likely to want to be a part of the study than African American women. These women were more inclined to listen and participate in the study if the researcher or another African Jamaican CRT staff spoke patois during recruitment, and if other African Jamaican women were seen participating. Implications are that social work researchers should partner more with staff during the recruitment phase of studies when working with low-income African descent women. Social work researchers interested in conducting research with African Jamaican women should hire research assistants that are not only of African descent but also ethnically African Jamaican and can speak/understand patois fluently.

Another observation was that women who were interested in and self-identified as Jamaican but were screened out of the study because were not born in Jamaica were often upset. Despite not being first generation Jamaican immigrants, these women self-identified as Jamaican women. These women lived in communities that were predominantly Jamaican, had one or both parents who were Jamaican and also grew up in households where the use of patois and practice of relevant customs were the norm. Social work researchers should be aware of the possible distress women may feel in being left out of a study. All efforts should be made to provide women with appropriate information and resources before and after screening to alleviate any distress they may feel. Criteria for participating in interventions that target African Jamaican women should be left broad so as to include all women who may self-identify as African Jamaican. In spite of these broad inclusion criteria, specific materials should cover all areas identified by research as being salient to African Jamaican women's condom use intentions including acculturation.

Also interesting was that African-Jamaican women were more likely to refuse to answer an item on the condom self-efficacy scale which asked about substance abuse. The exact wording of the question is, "How confident are you in your ability to use a condom with your male partner if you or your partner were high?" While some African Jamaican women showed great disdain for the question, all of the African American women answered and showed no signs of sensitivity around the item. African Jamaican women who elaborated on their dislike for the question and requested further clarification either verbalized being very religious, wanting to know what type of drugs were implied, or specifically asked if the question included marijuana or alcohol. This researcher felt that the women wanted to distance themselves from being thought of as a substance abuser altogether or wanted to make a clear distinction between what they thought were stigmatized drugs in their community. Further research in these important areas would be helpful.

Prevention and African Jamaican Women

The African Jamaican community in Hartford, Connecticut is one of the largest in the nation (Kent, 2007). Services offered to this community should be developed in a culturally appropriate way. To this end, five recommendations follow. First, since quantitative findings suggest that it is important to consider women's acculturation in examining their condom negotiation intentions and behaviors, developing prevention programs that target African Jamaican women who are new arrivals and over time may have reduced condom use intentions is essential. Second, integrating culturally appropriate prevention messages into public announcements and in curricula aimed at communities with large populations of African Jamaican is also necessary. Although African Jamaican women's knowledge around HIV/AIDS and the effectiveness of condoms were appropriate in this study; their knowledge of the appropriate testing protocol

recommended by the CDC was inadequate. Third, prevention programs should develop a more nuanced approach to improving women's knowledge which reflect changes in epidemiology of the disease over the past 30 years, in women's behaviors, the general view of HIV/AIDS in society where HIV/AIDS is no longer a death sentence and in access to technology that have occurred over the past 30 years of the disease. For instance, since HIV/AIDS is no longer a death sentence, how does this impact women's perception and behaviors. Fourth, since African Jamaican women may place a high value on being in relationships, prevention programs should also include their male partners. Along with their partners, African Jamaican women can explore feelings of commitment in their relationship and how this may be impacting both parties desire for condom use. In targeting dyads, these programs will break from the inappropriate tradition of saddling women with the responsibility of managing a male technology (male condoms). Fifth, prevention programs should also teach specific condom influence strategies/skills and allow African Jamaican women to practice them so that they can build their self-efficacy around this task.

Conclusion

Social scientists have detailed the path of the HIV/AIDS pandemic on low-income African descent women in the U.S. The impact of the disease calls for swift, innovative and broad based responses. The ability to interrupt the path of pandemic is contingent on a detailed understanding of the disease and the population it is impacting. While social scientists have shed light on many factors which heighten African descent women's risk, very few have looked at the cultural diversity found within the racial category African America/black. Effective strategies for curbing the plight of the disease cannot be developed outside of a detailed understanding of the population being impacted. Low-income African descent women's risk of contracting

HIV/AIDS must be examined along a multiplicity of potential causes, including culture. The impact of the disease demands a myriad of approaches not just those designed to change individual behavior. Low-income African descent women's vulnerability to HIV/AIDS is heightened by their diminished social standing and life chances in the U.S. The lack of passionate response to match the severity of the disease among African descent communities in the U.S highlights an enduring disregard for the lives of millions who continue to become infected and affected by HIV/AIDS, even in a time when the disease is no longer a death sentence. The social work professions' role and activism in this context is urgent.

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List of Appendices

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Appendix A: Screening Questionnaire

Introduction:

Hi my name is _____ and I am a researcher/assistant researcher with University of Connecticut. We have designed a study to learn more about different groups of black/African descent women, their health and concerns they may have about their relationship.

We would like to know if you would be willing to answer a few questions to determine whether you qualify for this study.

Would you like to hear more about the study?

Thanks for taking the time to learn more. I'll give you some more information about the study and then I would like to ask you a few questions. These questions will tell me whether this study is right for you. If qualify, then you can decide If you would like to participate or not. There is no obligation for you to do anything: I will ask some questions and give you a $2 CVS gift card for your time. Some of the questions are personal, but everything you say will be kept confidential. You do not have to report your real name. There is no right or wrong answers; we are just interested in your own experiences.

Are you ready?

I would like to begin by asking you a few questions about yourself.

1. What is your date of birth?
2. Where were you born?
3. Where was your mother born?
4. Where was your father born?
5. Which racial/ethnic group best describes you?
    a. black/Jamaican or African Jamaican
    b. black/African-American

c. Other

The next few questions are about your relationship with men only

6. Is there someone in your life like a husband or boyfriend, or lover that you consider your main sexual partner?
7. Have you had sex –where a man puts his penis into your vagina or anus (butt) - with your main male partner in the past 3 months?
8. How often during the past 3 months, was a condom used when having sex with your main male partner?
    a. Sometimes
    b. Always
    c. Never

Appendix B: Script for CRT Staff Referring Women to Study

Since you will be here today, maybe you would like to fill out a survey and/or complete an interview with a researcher from the University of Connecticut. They are asking people about their health and concerns they may have about their relationship. It will only take a few minutes. If you are interested, the researcher is at [location] today. She can tell you all about the survey and interview. If you are interested, but cannot complete it today, I can take your contact information and ask the researchers to contact you to set up a more convenient time for you to meet with them.

Appendix C: Recruiting Poster

Jamaican women and African American women
18 – 54 years old who are in a relationship with a man,
and receive energy or childcare services from CRT.

To participate in a HIV/AIDS Prevention Study
*****Will take about an hour of your time*****

To determine beliefs and practices of condom use among heterosexual African American and Jamaican women 18-54 years old in a relationship with a man

CONTACT:

YVONNE PATTERSON

(860) 548-0155

YVONNE.PATTERSON@UCONN.EDU

YOU WILL RECEIVE A CVS GIFT CARD as a Token of Appreciation

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Invitation to Participate and Description of Study: Women of African descent are more likely to contract HIV/AIDS than any other group of women in the United States. More information is needed to determine whether women's cultural beliefs and attitudes may put them at higher risk for contracting HIV to help develop more appropriate strategies for preventing HIV. You are being invited to participate in a study that seeks to improve the delivery of HIV prevention strategies. We are asking you because you are an African Jamaican or African American woman in a relationship with a male partner using condoms inconsistently and receiving services from CRT. Your participation is completely VOLUNTARY. If you decide to participate in this study, you are free to withdraw your consent and stop participation at any time without any penalty. Your participation will not affect the services you receive from CRT. Before agreeing to be a part of this study, please read and/or listens to the following information carefully.

Description of Procedures: This study involves three activities. If you decide to participate, and depending on your ethnic identification, you may be asked to participate in one or more of the activities listed below. You can participate in any portion of the study and decline any other portion of this study. **First**, if you identify as a Jamaican women of African descent you will be asked to participate in a pilot study. We are recruiting six to ten African Jamaican women to participate in the pilot study. The pilot study has three purposes (**a)**determine the most appropriate ethnic label to include in the screening and survey for African Jamaican women, (**b**) determine how willing African Jamaican women will be in sharing information about their sexual behaviors, (**c**) determine whether the survey can be self-administered or best administered as an interview by the researchers. **Second**, we will ask women who have not participated in the pilot study to fill out a brief survey about how strongly you identify with your ethnic group, your condom use skills, how powerful you feel in general and in a relationship with your male partner. We are recruiting 50 African American and 50 African American women for this portion of the study. **Third**, we are recruiting approximately 16 women to participate in an interview that about beliefs and attitudes around HIV /AIDS and condom use. To keep the interview time short we would like to do an audio recording of this interview so that we can make sure that we accurately understand the information you provide. The information will only be available to researchers working on the study and will be deleted following the transcription of your interview. Your name will not be linked with the written transcript. If you prefer not to be tape recorded, this will not affect your participation in the overall study.

Risks and Inconveniences: There is a possibility that some of the questions in the survey and interview may make you feel uncomfortable. If this happens, we can do any of the following: You can choose not to answer any question. You can take a break and continue later. You can choose to stop the survey or interview at any time. You may also be slightly inconvenienced by filling out the survey and/or participating in the interview. Also, if someone on the research team broke confidentiality and shared your materials and/or responses with others in the agency, you might be embarrassed. However we take every precaution to maintain your confidentiality. All researchers are instructed that failure to maintain confidentiality constitutes grounds for immediate dismissal.

Benefits: You will receive no direct benefits for participation in this study. However, knowledge gained from this study may be used to improve prevention services among African American and Jamaican women.

Economic Considerations: You will receive no payment or incur any cost because of your participation in this study. However, at the end of each phase of the study that you participate in you will receive a CVS gift card as a token of appreciation. You will also receive a prevention brochure on HIV/AIDS and how to protect yourself.

Confidentiality: The confidentiality of the information collected will be protected at all times. All data reported in the dissertation will be in aggregate form. This means that the data will be combined and reported in such a way that no individuals can be identified. Data will be kept in locked files at the CRT's office. The researchers will keep any information you give us confidential, and will not share it with anyone outside, including your agency directors or other agency staff.

Voluntary Participation: You participation in this study is completely voluntary. Refusal to participate will not affect you're the services you receive from CRT. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions on the surveys or in the interview that you don't want to answer, and still remain in the study.

Identification of Investigator: If you have any questions or concerns about this study, feel free to contact Dr. Nancy Humphreys, the head of this study at the University of Connecticut. She can be reached at the UConn School of Social Work, 1789 Asylum Avenue, West Hartford, CT ; 860-570-9166; email at nancy.humphreys@uconn.edu

Questions: Please feel free to ask any questions about anything that seems unclear to you and to consider this research and consent form carefully before you sign it.

Rights of Subjects: By signing this consent form you acknowledge that you have heard or read the information about this study, your questions have been answered to your satisfaction and that you agree to voluntarily agree to participate in this study. You will be given a copy of this signed form for your records.

Even after you have signed this form, you may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claim, rights, or remedies because of your participation in this study. You are not giving up any of your rights by signing this form.

If you have questions regarding your rights as a subject, or if you feel you have been treated unfairly in any way relating to this study, contact Andrea Routh, the Chair of the University of Connecticut Institutional Review Board at 860-418-6836 or 1-800-446-7348.

AUTHORIZATION

Please read the following statement: I have read or listened to the information on this consent form, and I understand what is being asked of me. I understand that I will be asked to talk about things like my sexual behaviors with my male partner. I further understand that if I refuse to grant consent, or if I decide to drop out, I still have the same rights as a CRT consumer that I always had and the same rights to privileges and services as I always had.

I have decided that I will be in this study. My signature below also indicates that I have received a copy of this consent form.

Signature _____

Name (please print) _____ Date _____

Signature of person obtaining consent _____

Name (please print) _____ Date _____

Appendix E: Ethnicity, Power and Condom Use Survey

Please tell us a little about yourself.

1. What is the highest grade of schooling you have completed? Please mark an ***X***on the appropriate line.

☐ 8th grade or less _____

☐ Some high school _____

Graduated high School _____

Some college _____

A four year college degree _____

☐ Graduate school or above _____

2. Are you in a relationship now with the male sex partner with which you have had sex with in the 3 months?

Yes _____

No _____

3. How long have you been in this relationship? Please indicate by including the number of year (s) and month (s) in spaces provided below.

Years _____ Months _____

4. How religious would you say you are (Choose One)?

_____ Not religious at all

_____ Slightly religious

_____ Moderately religious

_____ Very

Ethnicity

Using the following groupings

- My ethnicity is

(1) African Jamaican

(2) African American

(3) Mixed; Parents are from two different groups

4) Other (write in): _____

1. Using numbers above: I consider myself a part of the _____ ethnic group.

2. My father's ethnicity is (use numbers above) _____

3. My mother's ethnicity is (use numbers above) _____

Please indicate how much you agree or disagree with each statement by putting an X under your choice

Statements	(4) Strongly Agree	(3) Agree	(2) Strongly Disagree	(1) Disagree
4.I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.				
5.- I am active in organizations or social groups that include mostly members of my own ethnic group .				
6-I have a clear sense of my ethnic background and what it means for me.				
7- I think a lot about how my life is affected by my ethnic group membership.				
8- I am happy that I am a member of the group I belong to.				
9- I have a strong sense of belonging to my own ethnic group.				
10- I understand pretty well what my ethnic group membership means to me.				
11- In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.				
12- I have a lot of pride in my ethnic group.				
13- I participate in cultural practices of my own group, such as special food, music, or custom				
14- I feel a strong attachment towards my own ethnic group.				
15- I feel good about my cultural or ethnic background.				

Now I would like to ask you some questions about the use of condoms when having sex with your male partner – where a man puts his penis into your vagina or anus (butt).

Please indicate how confident you are about each question marking an X under yourchoice.

Questions	(1) Not all Confident	(2) Somewhat Confident	(3) Undecided	(4) Confident	(5) Extremely confident
1. How confident are you that you could suggest using a condom, even if you were afraid that your sexual partner would reject you?					
2. How confident are you that you could suggest using a condom, even if you wereunsure of how your sexual partner felt about using condoms?					
3. How confident are you that you could suggest using a condom, even if you were afraid that your sexual partner would think that you have had sex with another man before?					
4.How confident are you that you could suggest using a condom, even if you were afraid that [your sexual partner would think you have a sexually transmitted disease?					
5. How confident do you feel in your ability to discuss using condoms with your sexual partner?					
6. How confident do you feel in your ability to discuss using condoms with your sexual partner?					
7. How confident do you feel in					

your ability to suggest using condoms with your sexual partner?				
8. How confident do you feel in your ability to put a condom on your sexual partner correctly?				
9. How confident do you feel in your ability to use a condom correctly with your sexual partner?				
10.How confident do you feel in your ability to put a condom on without breaking the sexual mood with your sexual partner?				
11.How confident are you in your ability to use a condom with your male partner if you or your partner were high?				
12. How confident do you feel in your ability to buy condoms without feeling embarrassed?				
13. How confident are you that you could remember to carry a condom with you in case you Need one?				
14.How confident do you feel in your ability to use a condom with your sexual partner even after you have been drinking?				
15.How confident do you feel in your ability to use a condom with your sexual partner even if you were sexually excited?				

Please indicate how much you agree with each statement by marking an X under your choice.

Questions	**(1) Strongly Agree**	**(2) Agree**	**(3) Disagree**	**(4) Strongly Disagree**

1. If I asked my partner to use a condom he would get violent.				
2. If I asked my partner to use a condom he would get angry.				
3. Most of the time, we would do what my partner wanted to do.				
4. My partner won't let me wear certain things.				
5. My partner won't let me do certain things				
6. When my partner and I together , I am pretty quiet.				
7. My partner has more to say I do about important decisions.				
8. If I asked my partner to use a condom, he would think I'm having sex with other people.				
9. I feel trapped or stuck in our relationship.				
10. My partner does what he wants, even if I don't want him to.				
11. I am more committed to our relationship than my partner is.				
12. When my partner and I disagree he gets his way most of the time.				
13. My partner gets more out of the relationship than I do.				
14. My partner always wants to know where I am.				
15. My partner might be having sex with someone else.				

Please indicate who has more about each statement by marking a question is by marking an X under each statement.

Questions	(1) Your Partner	(2) Both of You Equally	(3) You
16. Who usually has more say about whose friends to go out with?			
17. Who usually has more say about whether you have sex?			
18. Who usually has more say about what you do together?			
19. Who usually has more say about how often you see one another?			
20. Who has more say about when you talk about serious things?			
21. In general, who do you think has more power in your relationship?			
22. Who usually has more say about whether you use condoms?			
23. Who usually has more say about what type of sexual act you do?			

Please indicate how likely or unlikely you are to accomplish each task by marking an X under your choice.

Statements	(1) Not at all likely	(2) Somewhat likely	(3) Undecided	(4) Likely	(5) Extremely likely

1. During the next month, you intend to try to persuade your sexual partner to use condoms every time you have sex. **.**				
2. You intend to get condoms during the next month				
3. You intend to always have condoms handy during the next month.				
4. You intend to negotiate condoms use every time you have sex with your sexual partner during the next month?				

Finally, can you please tell us how you feel about yourself.

Please indicate how much you agree or disagree with each statement by marking an X under your choice.

Statements	(4) Strongly Agree	(3) Agree	(2) Strongly Disagree	(1) Disagree
1.I have a realistic chance of accomplishing my personal goals				
2. I can live according to my personal values would be				
3. I feel strong as a person				

Appendix F: Interview Guide

1. Perceived Susceptibility: How likely do you feel it is for you to get HIV/AIDS?
    a. On a scale of 1-10, ten being the most likely, how would you describe your risk of getting HIV?
    b. Based on your current/past sexual practices/behaviors, what do you feel/believe are your chances of getting HIV/AIDS?
    c. How would you describe safe sex practices?
    d. Think of a time when you negotiated condom use during a sexual encounter and tell me about it. What influenced the decision to negotiate condom use?
2. Perceived Susceptibility: How capable do you feel in communicating and negotiating condom use to prevent the spread of HIV/AIDS to and from your partner?
    a. Are you able to discuss safe sex with you partner? Tell me about that experience.
    b. Are you able to discuss condom use with your partner? Tell me about an experience.
    c. How do you protect yourself and your partner from HIV/AIDS?
3. Perceived Severity: What does HIV/AIDS mean to you?
    a. What is significance of HIV/AIDS to you?
    b. What has been your experience with HIV/AIDS?
4. Perceived Barriers: Based on your own experiences what are some of the barriers for getting your main male partner to wear a condom every time you have sex?
    a. How did you learn about condom use? Any training?
    b. What are some of the things that have prevented the use of a condom during sexual intercourse with your partner?
    c. Think of time when a condom was used, were you involved in making that decision?
    d. Under what conditions were safer sex practices used?
5. Perceived Cues to Action: What are some of things that will motivate you to protect yourself from HIV/AIDS?
    a. What are some things that can help you to remember to communicate and negotiate condom use with your partner?
6. Perceived expectations (cost and benefit): What are some of the expectations you have for condom use during sexual intercourse with your partner?
    a. What do you expect some of the benefits are of communicating and negotiating condom use with your partner?
    b. What are good things that come from communicating and negotiating condom use with your partner?
    c. What do you expect some of the costs are of communicating and negotiating condom use with your partner?
    d. What are bad things that come from communicating and negotiating condom use with your partner?

Curriculum Vitae

YVONNE PATTERSON

860-548-0155 **pordow@yahoo.com**

EDUCATION

UNIVERSITY OF CONNECTICUT
School of Social Work, West Hartford, Connecticut
PhD in Social Work, 2013
~ Recipient *Vicki and Michael Konover Graduate Fellowship, 2007-2008*

UNIVERSITY OF CONNECTICUT
School of Social Work, West Hartford, Connecticut
Master in Social Work, 2003
~ Major Method: Community Organization; Minor Method: Policy & Planning; Substantive Area: International Studies;
~ Recipient *Frank V. Carolla*Scholarship, 2002

UNIVERSITY OF CONNECTICUT
Storrs, Connecticut
Bachelor of Arts in Political Science, 2000
~ Cum Laude Graduate
~ Member of Golden Keys Honor Society, 1999
~ Member Phi Beta History Honors Society, 2000

TEACHING

Sociology of the Family
Contemporary Social Issues
Human Oppression
Research Methods

CAREERACCOMPLISHMENTS

Community Renewal Team, Inc. (2005-2008)

- Conduct and analyze three neighborhood assessments
- Develop all agency HIV recruitment strategies and work plan
- Implement and oversee all Agency HIV Prevention Interventions
- Function as advisor on HIV/AIDS proposal search and development for the Community Renewal Team, Inc.
- Member of the Community Renewal Team's Wellness Committee
- Member of the Community Renewal Team's Strategic Planning Committee

Additional Service

- Provide Support on HIV/AIDS Community Promise Intervention for the Department of Public Health.

- Provide HIV/AIDS educational support and training to The Boys and Girls Club of Hartford.
- Provide HIV/AIDS educational support and training to Community Renewal Team's Early Child Care Centers parents
- Provide HIV/AIDS educational support to SISTA SISTA Group at Weaver High School
- Provide professional support to Martin Luther King Junior Soccer League with grant writing and organization assessment and planning

PROFESSIONAL EXPERIENCE

CAPITAL COMMUNITY COLLEGE, Hartford, Connecticut 2010 – Present
Adjunct Professor
- Instruct Students in course material

UNIVERSITY OF CONNECTICUT, West Hartford, Connecticut 2009 – Present
Graduate Research Assistant
- Assist in the design of studies
- Prepare IRB applications, continuing reviews, and reports, and ensure that all study activities conform to approved protocols
- Participate in data collection
- Meet with program sites on a regular basis
- Keep Principal investigator informed on the progress of the study
- Enter data in Assist database
- Conduct data analysis using SPSS

UNIVERSITY OF CONNECTICUT, West Hartford, Connecticut 2008 – 2010
Adjunct Professor
- Instruct Students in course material

UNIVERSITY OF CONNECTICUT, West Hartford, Connecticut 2007 – 2009
Faculty Advisor
- Assist students with the field education experience
- Serve as educational resource to the field instructor and student
- Ensure that the School's standard for field education are met by the field instructor and student
- Mediate between agency, field instructor, school and student
- Problem solve
- Ensure that ethical and professional standards are met in field education

COMMUNITY RENEWAL TEAM INC., Hartford, Connecticut 2005 – 2008
HIV/AIDS Program Coordinator / Lead Facilitator and Trainer
- Implement and manage all agency HIV Prevention Interventions
- Conduct community assessments and ensure the effective delivery of agency community-wide HIV Prevention Intervention at three sites in Hartford
- Ensure appropriate care for HIV patients is being met through thorough review of records; create and maintain statistical database to track patient medical care.

- Use Statistical Program for Social Sciences (SPSS), analyze data for the development of recruitment methods and messages
- Establish and foster partnerships with other city & state HIV/AIDS service agencies; for the effective delivery of HIV Prevention services.
- Deliver HIV prevention curricula to target populations through multi-session group facilitation .
- Conduct staff trainings on HIV/AIDS
- Conduct Focus groups
- Recruit community members to participate in the fight against HIV/AIDS.
- Train and supervise four HIV outreach staff and agency interns

.

CITIZENS FOR QUALITY SICKLE CELL CARE INC. 2004 – 2005
Program Director
- Oversee daily operations, including assisting in agency strategic planning
- Write, develop and manage agency grant proposal programs.
- Advocate for rights of groups and individuals infected and affected by sickle cell disease

.

DEPARTMENT FOR CHILDREN AND FAMILIES, Manchester, Connecticut 20004
Social Worker
- Facilitated communications and services with clients, families, and service providers .
- Provide skilled counseling services to assigned clients
- Professionally evaluate and interpret results of evaluations.

DEPARTMENT FOR CHILDREN AND FAMILIES, Middletown, Connecticut 2000-2004
Child Service Worker
- Assisted clients in crisis, performing daily supervision and help with resident ADLs.
- Designed implemented treatment strategies in conjunction with counseling.

VISITING NURSES ASSOCIATION 1996 – 1998
Service Coordinator
- Designed and implemented treatment strategies that included group & individual counseling.
- Oversaw medication disbursement; liaised with client network resources; assisted clients in daily living.

URBAN LEAGUE OF HARTFORD 1991
Peer Educator
- Develop and Implemented Peer Education teaching strategies on HIV/AIDS
- Consult on curriculum revisions to address current issues, trends, and concerning facing young adults

Additional experience as a Graduate Student Intern for Nancy Humphreys Institute for Political Social Work at the University of Connecticut School of Social Work, Intern with The International Federation of Social Worker (IFSW) at The United Nations in New York City as well as for the Village for Children's and Family Clark School Family Resource Center. I have also interned with Urban Semesters lead by Dr. Louise Simmons at, a community based organization, O.N.E/C.H.A.N.E in Hartford

PROFESSIONAL AFFILIATIONS

National Association of Social Workers; National Association of Black Social Workers;
African American and Caribbean HIV/AIDS Care Team, Network of Women of African Descent Advocates

PROFESSIONAL CERTIFICATIONS

- Certified Completion of Betty Gallows and Associates Lobby Training (2002)
- Certified Completion of Grantsmanship Training (2004)
- Certified Completion of Community Promise HIV/AIDS Prevention Intervention Training (2005)
- Certified Completion of Sisters Informing Sisters on Topics of AIDS Intervention Training (2005)
- Certified Completion of Healthy Relationships Intervention Training(2006)
- Certified Completion of Ryan White Training (2006)
- Certified Completion of Department of Health Recruitment and Retention Training (2006)
- Certified Completion of Department of Public Health Group Facilitation Training (2006)
- Certified Completion of Department of Public Health HIV/AIDS Educators Training (2006)
- Certified Completion of Risky Relationships Intervention Training (2010)

CONFERENCES: Ryan White CARE-Grantee Conference- New York City, International AIDS Conference –*Time to Deliver*- Toronto, Canada; National Association of Black Social Workers Conference; – Washington, D.C,

YvonnePATTERSON

112 Adams Street ~ Hartford, Connecticut 06112

860-548-0155 **pordow@yahoo.com**

REFERENCES

Dr. Nancy A Humphreys
Professor and Director of Nancy Humphreys Institute for Political Social Work Practice
University of Connecticut School of Social Work
1798 Asylum Avenue
Hartford, Connecticut 06117
860-570-9166

Dr. Irene Glasser
Adjunct Professor in Anthropology, Roger Williams University
Research Associate, Center for Alcohol and Addiction Studies, Brown University
Professor Emeritus in Anthropology, Eastern Connecticut State University
860-377-5455
iglasser@rwu.edu

Jose Vega
Assistant Director of Supportive Housing
Community Renewal Team Inc.
8 Stonington Street
Hartford, Connecticut 06106
Vegaj@crtct.org

Dr. Linda K. Frisman
Research Professor, Uconn School of Social Work
Research Division, CT Department of Mental Health & Addiction Services
MS# 14 RSD, 410 Capitol Avenue,
Hartford, Connecticut 06134
860-418-6788