HIV/AIDS Prevention Practices among Recent-Immigrant Jamaican Women

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Introduction: The HIV/AIDS pandemic continues to affect people in the United States and around the world at a profound rate, and African Americans are disproportionately affected.

Methods: This exploratory, descriptive, and phenomenological study explored the meaning of HIV/AIDS safer sex practices among 20 single, heterosexual women, 18–30 years old, who emigrated from Jamaica in the last 12 years. The study described the participants' HIV/AIDS prevention knowledge, behaviors, health-beliefs, and social and cultural factors that influenced their behaviors. The Health Belief Model guided the study, and the maximum variation criterion sampling technique was used to select participants. In-depth interviews, journal entries, and field notes were used to collect data. Diekelmann, Allen, and Tanner's seven-stage process of Heideggarian hermeneutics data analysis was used to produce rich descriptions of shared practices and common meanings.

Results: Participants in this study acknowledged that HIV/AIDS was serious, but most women did not perceive themselves as susceptible to the disease. Women in this study did not use condoms. These women expressed lack of condom negotiation skills, fear of losing their relationship, and fear of physical or mental abuse from their significant other as barriers to using condoms.

Discussion: Most women were knowledgeable about HIV/AIDS prevention but have religious beliefs and cultural practices that were deeply embedded in their health practices. Many women were not sure of a mutually monogamous relationship, and talking about sexual issues was viewed as taboo. This research provides the foundation for the development of culturally appropriate interventions to decrease HIV/AIDS and improve health disparities among immigrant women. (*Ethn Dis*. 2008;18[Suppl 2]:S2-175–S2-178)

Key Words: HIV/AIDS, Immigrants, Jamaican Women, Cultural Practices

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Background and Significance

The HIV/AIDS pandemic continues to affect people in the United States and around the world at a profound rate. African Americans and women are affected at a rate 10 times that of White women,[1] and this number continues to increase. Globally, an estimated 39.5 million people are living with HIV/AIDS, 1.4 million in the North American region and 450,000 in the Caribbean at the end of 2006.[2] As of 1999, the Caribbean region was identified as having the largest number of HIV/AIDS cases outside of sub-Saharan Africa.[2]

Globally, 4.3 million people were newly infected with HIV in 2006. Among the 43,000 new HIV infections in the United States in 2006, 48% were African Americans.[2] In addition, an estimated 2.9 million persons worldwide died from AIDS in 2006, of which 50% were women aged 15–44 years.[2] African Americans make up only 12.3% of the US population[4] but accounted for ≈72% of newly reported HIV/AIDS cases,[2] and their infections were acquired mainly through heterosexual contact. In 2005, Florida reported 5621 new HIV infections and 4869 new AIDS cases, and the state ranked third in the cumulative number of AIDS cases and second in AIDS incidence rate in the United States.[3]

Immigrants in the United States

HIV/AIDS is an increasing problem that is compounded by migration. The foreign-born population of the United States was >35 million (12.1% of the US population) as of March 2005. Immigrants possess challenges such as language and cultural barriers, lack of health insurance, low education levels that result in low wages, poverty, and the use of welfare programs. Poverty has disproportionately affected immigrants; ≈25% of immigrants and their minor children live in poverty, compared with 11.7% of native-born Americans.[2]

HIV/AIDS data for various cultural groups, such as Jamaicans, are consistently classified with those of African Americans, in spite of their unique culture, values, and beliefs. The US healthcare system must provide affordable, accessible, culturally congruent care to populations at high risk for diseases exacerbated by behavior or lifestyle. However, doing so is difficult because some immigrant HIV/AIDS data, including data for Jamaicans, are included under the category of African Americans, and thus the exact incidence, prevalence, behaviors, and risk factors among these subgroups are unknown.

Of immigrant-headed households, 29% used at least one major welfare program compared with 18% of native-born Americans, and overall, 33.7% of the immigrants lack insurance compared to 13.3% of natives. Other challenges faced by immigrants include access to healthcare and risk of deportation because of their immigration or their HIV/AIDS status. Moreover, sex practices differ among immigrants based on the recency of their immigration,[5,6] and these differences affect HIV/AIDS risk behavior, such as acceptable male sexual promiscuity.[7]

Purpose

The overall purpose of this study was to explore the meaning of HIV/AIDS safer-sex practices among young, single, heterosexual, recent-immigrant Jamaican women in the Miami–Fort Lauderdale metropolitan areas and to describe their HIV/AIDS-prevention knowledge and behaviors/practices. The specific aim was to describe the

cultural factors, including health beliefs, which influence these women's health practices regarding HIV/AIDS-prevention behaviors.

METHODS

Study Design

Heidegger's hermeneutic (interpretive) phenomenology design[8] was used for this exploratory, descriptive study and focused on the interpretation of the meanings.[9] Although we did not test a theory, the Health Belief Model[10] was used as an overall guiding framework from which question were conceptualized. This model examines how beliefs influence health behavior[11] and asserts that people will engage in preventive behavior if they feel susceptible to a health condition, if they believe the condition is serious, and if they feel the benefits of engaging in the preventive behavior outweigh the cost. These actions must be perceived by an individual as reducing their susceptibility to or the severity of the condition, and they are motivated by external triggers. To perform preventive behavior, an individual must feel that he or she is competent to perform the behavior and to overcome the barriers to action.

Sample and Study Setting

Twenty in-depth interviews were conducted with young, single, heterosexual, Jamaican women aged 18–30 years who immigrated to the United States <12 years ago and lived in the Miami–Fort Lauderdale metropolitan area. All women self-reported being sexually active with a man within the previous six months. The mean age of the participants was 24 years, and participants were recruited from predominantly Jamaican-owned or operated hairdressing parlors or salons, barbershops, grocery stores, and a predominantly African American healthcare training center.

In this study, purposeful sampling that used the maximum variation criterion was used to select the participants. This technique allowed us to deliberately select a heterogeneous sample and observe commonalities in experiences; it provides high-quality case descriptions, uniqueness, and commonalities across participants.[12,13]

Recruitment of Participants

Before active recruitment began, institutional review board approval was obtained, and two meetings were held with community gatekeepers. These were prominent residents of their communities, chief executive officers of target businesses, and business owners or operators within the Miami–Fort Lauderdale metropolitan areas. The study was explained in detail, and questions and issues concerning the project were answered and discussed. Gatekeepers assisted the researcher in identifying potential recruitment sites and displaying flyers that contained the details of the study and researcher contact information in their own businesses. Potential participants were directed to the researcher.

Procedure

Interested participants were prescreened by using a nine-item, self-reported, researcher-administered questionnaire. All participants signed informed consent forms that described the purpose of the study, the potential risks and benefits, confidentiality, and the right to refuse or withdraw at any time without negative consequences. Next, an in-depth, semistructured, audiotaped interview that lasted an hour was conducted. Interviews were conducted in a private room, and participants were asked one global question for each research question and for each of the six constructs of the Health Belief Model. On the basis of the participants' responses, probes were used to rephrase the question, clarify meanings, or provide further explanation.

Field notes, detailed recordings, and descriptive notes on the study setting, interactions, problems, or critical events were made by the researcher immediately after completion of each interview. Other data, such as participant observations and the researcher's ongoing thought process, feelings, and emotional reflections, were also recorded as part of the data analysis. These data sources were used in conjunction with the interview transcript and provided the basis for establishing the credibility of the data interpretation.[14,15] At the end of each interview, the demographic questionnaire was administered to each participant and was used as part of the descriptive data analysis.

Data Analysis

All data (interviews, journal entries, and field notes) were collected, transcribed, verified, coded, and then saved to a password-protected file by the researcher. After all the data had been transcribed and coded, data were analyzed for patterns and meanings in context by using Diekelmann, Allen, and Tanner's[16] seven-stage process of Heideggarian hermeneutics. All interviews were read for an overall understanding, and then interpretive summaries were written and coded for possible themes. Selected interviews were then analyzed to identify potential themes, and any disagreements were resolved by going back to the initial interviews. Common meanings and shared practices were then compared and contrasted.

Emergent relationships among themes were identified, and final themes, with exemplars from interviews, were determined. Themes were verified by two independent peer debriefers and an external reviewer. This process produced rich descriptions of shared practices and common meanings and confirmed the study's credibility, dependability, consistency, confirmability, and transferability.

RESULTS

Findings showed that most women were knowledgeable about HIV/AIDS prevention but had religious beliefs and cultural practices that prevented them from practicing protective behaviors. Participants may practice herbal or bush medicine before seeking Western medical care, and some people still believe and practice voodoo to some extent and will do this before seeking, or in conjunction with, medical care. One participant in response to her health belief stated that:

> "I believe that sickness and disease is a punishment from God. If you obey all commandments of God, there would be no sickness, and if you have any disease or sickness, it is just to test your faith like Job. So he [God] will eventually cure you or take you home [allow you to die] when he thinks you ready. It's because of man's disobedience to God and his selfish desire why all these kind of sickness come upon us."

Each interview ended with allowing the women to talk freely about HIV/AIDS. Most of the women appeared to have some self-reflective thoughts and wanted to know more about condoms, types, and uses. In some cases, the interviewer was asked to show them the female condom and to illustrate how to use it. When participants were given factual information on HIV/AIDS, ≈50% of them expressed interest in learning ways to safely introduce the concept of mutual monogamy and condom use with their partners, to prevent HIV/AIDS transmission. Some women stated that they never thought about HIV/AIDS or their risk status before, and now that they realized that they might be at risk, they did not know how to appropriately approach their partner. One woman stated that her sister was "boxed in her face and throw out in the street because she told her boyfriend to use rubbers [condoms]." On further probing, this young woman recounted her experience:

> "Mi [*sic*] sister know that him have other woman [*slow but animated*]. She knew he had other women, and I don't know why she still stay with him. Him come in so late at night that him don't eat there, him don't want sex when him come in, and always finding fault with her. One day him come home smelling like some kind of a woman's perfume and a type of soap that my sister don't use. So in the night him want sex and she tell him to use rubbers. And it is so the fight start! When she go to the clinic in the morning… the nurse them say she wrong. [*Silence.*] Them say she should never say anything to him. Them say other people in the community say that she could stay in the house because the woman them not troubling her, and now she is like a pillow to post [keeps moving from place to place], have no food or nowhere to go or no means of supporting herself. At least with him she had a roof over her head and some food to eat."

This sentiment was consistent with the two groups of women who were interviewed but were not participants in the study (modified member checking). The women stated that their fear of domestic violence was less than if they were living in Jamaica, because they believed that laws in the United States would protect them from such abuse.

When asked by the interviewer, "What would be the best way to reach this population to educate them on HIV/AIDS issues?" the women agreed that one-on-one intervention is the best method; however, they thought some group intervention might also be beneficial. When asked if they would discuss these same issues in a group, several participants did not think women would open up in a group. Nonetheless, upon further probing, the women stated that they would participate in a group where other individuals openly discussed their own issues. One participant recommended advertising a fundraiser or a get-together with beauty supply incentives.

DISCUSSION

Women in the study accepted male sexual promiscuity as unavoidable, and the power imbalance between men and women can make it impossible for women to refuse unwanted or unprotected sex, to negotiate condom use, or to use contraception against a husband's or partner's wishes. Some working women stated that even though they work, the cost of health insurance is high and prohibitive, so seeking medical care is not a common practice. Free clinics are for the poor, and healthcare providers "treat you like dogs so I don't go there," as one woman commented, regarding accessing health care for HIV/AIDS testing.

In addition to response to the intended research questions, other findings evolved from the study. Participants realized that they were at risk and were eager to get more information. They understood the need to be empowered but yet did not know how or where to get this information. Their inability or difficulty in initiating and enforcing condom use, a lack of access to health care, a fear of losing a relationship, and lack of knowledge and behavior skills regarding condom use are serious implications. Participants in this study were not sure how they could individually practice HIV/AIDS-preventive behavior, and HIV/AIDS is perceived as being distant from them individually and as a group. Empowering Jamaican women through the church, blending cultural practices and religious beliefs with some modified interventions such as role playing that include men, may reduce risk-taking behavior among this population.

Implications for Improving Health Disparities

Despite the increased number of immigrants living in the United States, the disparity in healthcare access, and the rise of HIV/AIDS globally, little research has been conducted among this group to determine the effect of culture, migration, lack of health care, and high-risk behavior for HIV/AIDS. As recent immigrants with transferable cultural beliefs and practices are exposed to the challenges of poverty, financial instability, low levels of HIV/AIDS knowledge, prolonged unemployment, the widespread availability of drugs, discrimination, acculturation stresses, and the fragmentation of extended families and relationships, this group needs to be targeted to curtail the spread of HIV/AIDS infection.

Since health beliefs among this group are embedded in their rich religious heritage, which in turn influences their preventive health behaviors/practices, having a cultural sensitive intervention that address health and religious beliefs may not only prevent HIV/AIDS transmission among this group but it will eventually improve health disparities among African Americans as a whole and among other ethnic groups, in accordance with the goals of Healthy People 2010.[17]

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