Knowledge and Attitudes Toward HIV/AIDS and Risky Sexual Behaviors Among Caribbean African American Female Adolescents

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The incidence of HIV/AIDS among African Americans in culturally blended south Florida constantly challenges the health care community to reconsider prevention efforts. Very few studies examine the Caribbean population. This study was performed to identify and describe knowledge and attitudes toward HIV/AIDS and risky sexual behaviors in Caribbean African American female adolescents. Three focus group sessions were conducted using a sample of 22 adolescents. The questions included, "What do you know about HIV/AIDS?" "How would a friend's diagnosis of HIV affect your friendship?" and "Why do your peers engage in risky sexual behaviors?" Adolescents abstained from sexual activity mainly because of parental fear and church teachings. Some had accurate knowledge of HIV/AIDS, but all expressed reluctance to share space and personal items with an HIV/AIDS-infected friend. Sharing personal items with a close friend is a common Caribbean practice. This unwillingness suggests a need and direction for further inquiry.

Key words: *parental influence, risky behaviors, religion, HIV/AIDS, Caribbean*

The increase in HIV/AIDS in the African American population continues to challenge the health care community. Although risk behaviors may be decreasing in some target populations, groups such as African American adolescents seem to be at ever-increasing risk for being infected with HIV (Centers for Disease Control and Prevention [CDC], 2002). This increased risk is occurring parallel with a greater focus on prevention efforts to reduce the risk of HIV infection (Jemmott, Jemmott, Braverman, & Fong, 2005; Brown & Brown, 2003). The CDC (2002) estimated that the African American population accounts for 54% of all new cases of AIDS, mostly in females between the ages of 13 and 24 years. According to the U.S. Department of Health and Human Services (USDHHS) (2000), cultural differences in the African American community challenge health care leaders to reconsider HIV prevention efforts. Still, multiple studies performed with African Americans reveal a wide range of unique cultural qualities (Brown & Brown, 2003; Smith et al., 2003; Robillard, 2001) with little consideration of subcultural differences. For instance, although the Caribbean African Americans are a unique cultural group, no scientific data regarding the factors that predict risky sexual behaviors in Caribbean African American female adolescents were located. In a recent survey, this group comprised 25% of AIDS cases among Blacks in Miami Dade County (Dade County Health Department, 2003). Hence, there is a legitimate call for a closer comparison of Caribbean African Americans, especially females, who are at greater HIV/AIDS risk (CDC, 2002).

The purpose of this study was to identify and describe knowledge and attitudes toward HIV/AIDS and risky sexual behaviors among Caribbean African

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JOURNAL OF THE ASSOCIATION OF NURSES IN AIDS CARE, Vol. 18, No. 4, July/August 2007, 64-72
doi:10.1016/j.jana.2007.05.004

American female adolescents living in south Florida. This study will contribute to a foundation for the development of a culturally competent community-based intervention for HIV/AIDS prevention for this culturally distinct group of African American adolescents.

Background

The prevention of HIV infection is one of the goals for Healthy People 2010, but access to culturally appropriate intervention approaches could limit progress toward this goal (USDHHS, 2000). Much research has been performed regarding knowledge about HIV/AIDS; however, if efforts to develop culturally sensitive prevention approaches are to be realized, research on culture-specific causative agents for risky behaviors is necessary.

The Caribbean region is experiencing challenges as is the rest of the world, with its incidence of HIV being second to sub-Saharan Africa (World Bank, 2000). The Caribbean population is the second largest immigrant group in south Florida. (Dade County Health Department, 2003). Because African Americans are highly religious and deeply involved in ministries and there is an inverse relationship between religious beliefs and risky lifestyle behaviors (Donnahue, 1995), churches are positioned to assist with the challenge of minimizing risky behaviors. Although the AIDS National Interfaith Network with more 2,000 AIDS ministries makes a major impact on public heath education, the churches' powerful ability to influence desired sexual behavior among young people is underutilized (Jemmott et al., 2005). Religiosity in the African American population plays a significant role in childrearing, and parents, though often silent on teaching their children about sex, play a pivotal role in adolescents' decision regarding the initiation of sexual activity.

In developing countries, HIV/AIDS threatens decades of development because it attacks people in their most productive years, destroys communities, disrupts food production, and a places heavy burden on the already weak health services. AIDS is the leading cause of death among women ages 15 to 44, claiming 27,000 lives in 2005 (UNAIDS/WHO, 2006). Haiti, one of the largest islands of the Caribbean, has more people living with HIV than any other island in the region. The decline in the number of pregnant women in Haiti during 2003 and 2004 was in part because of AIDS-related deaths (UNAIDS/WHO, 2006). The Bahamas and Barbados rank among geographic regions with the highest incidence of HIV/AIDS; Cuba has an estimated 4,800 people living with HIV and 500 dying from AIDS-related illnesses. The islands of Trinidad and Tobago have seen an unprecedented 500% increase in HIV/AIDS, with adolescents at disproportionate levels (Caribbean Epidemiology Research Center [CAREC], 2000). Youth in these countries represent 18% of the population and 48% of reported HIV cases (Trinidad and Tobago HIV/AIDS National Surveillance Unit, 2002). Girls between the ages of 15 and 19 years are six times as likely to be infected with HIV in Trinidad and Tobago (CAREC, 2000). In Guyana, a serious epidemic is under way, and in 2005, AIDS was the leading cause of death in women ages 25 to 44 years. In Jamaica, there are signs of HIV receding as more people are protecting themselves. However, an estimated 25,000 adults and children are living with HIV in Jamaica (UNAIDS/WHO, 2006).

As in most places in the world, in the Caribbean, young people are engaging in sexual behaviors at earlier ages (Eggleston, Jackson, & Hardee, 1999) and with minimal knowledge and much misconception about HIV/AIDS and other sexually transmitted diseases (Smith et al., 2003). Sexual activity during adolescence, especially when it is initiated at a young age, raises concerns about the acquisition of sexually transmitted disease including HIV/AIDS and greater exposure to pregnancy and associated morbidity (Blum et al., 2003).

There is more concern among sexually active adolescents about getting pregnant and their reputation than there is about their risk for HIV/AIDS (McCree, Wingood, DiClemente, Davies, & Harrington, 2003). Adolescents from unstable families are more likely to initiate sexual intercourse earlier, but the likelihood of responsible sexual activity is comparable to most other ethnic groups (McCree et al., 2003).

Adolescents involved in churches tend to have more accurate information regarding the disease and how to practice abstinence and avoid drugs and alcohol, observing the principles of the church (Robillard, 2004; Smith et al., 2003). Despite this knowl-

edge accuracy among church youths, however, they tend to believe that HIV/AIDS is spread mainly by homosexual contact (McCree et al., 2003; Smith et al., 2003).

Compromising health behaviors are quite common in the Caribbean. Sex and reproductive body functioning is not discussed as openly as in the United States. In fact, many adolescents enter into puberty unaware; some girls face traumatic questions at the onset of menstruation and believe they are guilty of committing a major offense. There is also a clear gender-based double standard of expectations with regard to sex, but females have more power than they realize regarding sexual behavior (Smith et al., 2003). Schools are brief on the subject of sex, and children are often shy about asking questions (Robillard, 2001). Initiation of sexual intercourse is not necessarily associated with social deviance and may even be viewed as normative in some areas (Eggleston et al., 1999).

There is also a strong matriarchal dominance in the Caribbean regions. This is especially the case in families of lower socioeconomic status to the extent that it is a major influence on many Caribbean adolescents' decision-making regarding sex (Clarke, 1966). It is the mother's responsibility to teach the children about sex, and she decides if her pregnant unwed teenage daughter will reside at home. Sex is not discussed at home; women do not discuss sex; in schools, women are confused by the dichotomy between the traditional pattern of keeping silent and the need to inform adolescents about sex (Talashek, Peragallo, Norr, & Dancy, 2004). Young people enter into marriage without a word about sex from parents, and girls are given a book to read about puberty (Clarke, 1966).

Migrants are especially vulnerable to HIV because of their isolation, insecure jobs and living situations, fear of government services, and lack of access to sexual and reproductive health care (UNAIDS/WHO 2006). This scenario is further compounded for undocumented immigrants who are more likely to be exposed to abuse because of the lack of legal protection. Multiple sex partners, inconsistent condom use, lack of knowledge, and unsupervised free time are a few of the factors that put adolescents at risk for HIV infection (Kotchick, Shaffer, Miller, & Forehand, 2001). If culturally sensitive prevention approaches are to be implemented, Caribbean African adolescents' way of life must be considered.

Methodology

Design

A qualitative descriptive design using focus groups was used. Focus groups are convened in an effort to understand "poorly understood people and topics" (Morgan, 1998, p. 12). The following questions guided the sessions: (a) What do you know about HIV/AIDS? (b) How would a diagnosis of HIV/AIDS in your best friend affect your relationship? and (c) Why do young people in your age group become involved in risky sexual behaviors? This set of questions was framed based on the results of published studies, from consultation with L.S. Jemmott (personal communication, March 31, 2006), and as guided by the writings of Krueger (1998). These questions were used during the first focus group discussion. Then, questions for the next focus groups evolved as a combination of this set and what was learned from the adolescents during the first focus group. The questions for the third focus group evolved in a similar way.

Procedure

Upon receiving permission from the institutional review committee, the researcher started recruiting participants. The adolescents and their parents or guardians were recruited from a Caribbean African American community church in a three-step process. This church was located in a predominantly Caribbean populated area of south Florida and was selected because of the potential to obtain a representative sample for the study.

The investigator arranged a meeting with the youth leaders of the church to introduce them to the study and to schedule attendance at a regularly scheduled youth meeting with parents or guardians and their adolescent daughters. It is a common practice in this culture to separate the sexes when sensitive issues such as sexuality are discussed. At this meeting with parents or guardians and female adolescents, the investigator introduced the research

team including the focus group facilitator, who is a skilled counselor of Caribbean background and has years of experience in conducting adolescent focus groups. The investigator also gave details of how the study would be conducted. A light snack was provided to the group in keeping with cultural traditions and church practice.

Participation in focus group discussions occurred after parental/guardian and participant consents were obtained. All focus group sessions were held in a private room at the church. Before each discussion, a demographic and sexual activity instrument was completed by participants. Information such as age, grade in school, place of birth, and sexual activities was collected. Sexual activities questions included (a) Are you sexually active? (b) If yes, do you use condom? (c) Have you ever been pressured into having sex? (d) If you answered "yes," did you give in? (e) If you answered "no," what prevented you? No identifying characteristics were on the demographic questionnaire. The facilitator discussed with the adolescents the elements of the consent in addition to the confidential nature of the discussion and the right to withdraw or not answer questions. The key questions were posed, and the young people were encouraged to speak at length. Information shared in each focus group was used to refine the query for the subsequent focus group.

Each focus group session lasted 45 to 60 minutes. The sessions were audiotaped, and field notes about the context of the discussion were taken. At the end of each discussion, the facilitator expressed appreciation and presented a gift certificate to each participant. Stewart and Shamdasani (1990) advocate incentives as an additional means of compensation beyond a lively discussion of researchers' interests.

Results

Sample

Twenty-two female adolescents of Caribbean background volunteered to participate in three focus group discussions. The islands represented in the sample included Antigua, Bahamas, Jamaica, and St. Thomas. Ages ranged from 14 to 18 years. A total of 50% were American-born citizens of Caribbean parentage, and 50% were naturalized citizens or had U.S. residency status. Participants with U.S. residency status lived in the United States for more than 5 years and thereby were eligible for citizenship. All were involved in their church youth ministry. A total of 64% of the sample lived with parents or legal guardians, and 14% ($n = 3$) of those parents or legal guardians held professional employment. A total of 81% ($n = 18$) reported respecting their parents' opinion the most, but only 36% ($n = 8$) said they would share secrets with their parents. With the exception of 2, all participants were regularly attending school or college. None of the adolescents had to drop out to work to support families or siblings, so there were no gaps in their education. A total of 18% ($n = 4$) of the adolescents reported being sexually active; 63% ($n = 14$) reported experiencing peer pressure about having sex, but less than 1% of those who were pressured reported acquiescence.

Data Analysis

The taped sessions were transcribed, but no names were included on the transcripts. Data analysis for the focus groups was transcript-based and used a pragmatic content analysis method. According to Stewart and Shamdasani (1990), "This method may be employed when trying to understand . . . beliefs of a group of teenagers concerning the transmission of AIDS" (p. 107). Krueger (1998) describes the transcript-based approach as the most time-intensive and the most rigorous approach to focus group analysis. To assure trustworthiness of the data, the investigator and focus group facilitator independently reviewed the transcripts against tapes for completeness and accuracy. Field notes served as contextual supplements to the transcripts for each group. The investigator and facilitator independently classified the information and arrived at similar conclusions, which provided consistency and credibility.

Question 1: What do you know about HIV/AIDS?

The adolescents' responses to this question revealed bits of accurate information interspersed with inaccuracy and confusion. "People with HIV don't usually look any way different, except when

they are ready to roll over and die," and "I know people get AIDS from sleeping around." They could readily identify what HIV is and that it is potentially a fatal sexually transmitted disease that can be transmitted through body fluids. Their knowledge was evident as they spoke of a woman who died of AIDS: "She didn't have any husband, and we don't remember hearing that she got any blood transfusion or anything like that. So she must have been fooling around. I wonder with whom?" (everyone laughed).

Other evidence of knowledge and concern about HIV/AIDS was observed in statements such as, "I used to think it was a gay disease, but not any more." Narratives of anxiety include, "It used to be gays and White folks who had this disease; now . . . it's the Africans and Haitians," and "It's an 'everybody' disease now." The adolescents were also quite aware of the mother-baby transmission; "Babies can get it through breastfeeding too." Some of the participants who knew of HIV and AIDS could not differentiate between the two.

These teens were feeling shortchanged on the knowledge they received from school and offered helpful suggestions to educate the community. "Our parents don't know, so they can't teach us. Most of what we know, at least for me, I hear it at school from my friends." They talked about the brief overview of HIV/AIDS they received in school but that the details were not explicit enough to elicit any positive changes in adolescents' risky behaviors. "They tell us a little something but not enough to make you always remember." "They need to show pictures of regular people or movies or get people who have it to come and talk to us so people will see what will happen if they keep on having sex" (14-year-old middle school girl). "They could have some classes at the church on the nights when they don't have church [services]." "Yes, they could have it at church one evening for young people and one evening for the old people." They all agreed to not wanting to talk about sex with adults or with their parents.

In the midst of verbalizing some accurate knowledge about HIV/AIDS, the teens still had areas of inaccuracy and confusion. When asked about their risk for HIV/AIDS, most participants agreed that they were not promiscuous; hence, according to their understanding, they were safe: "I am not at risk, for I am not having sex." Statements of inaccuracy included, "It's the older people who get this stuff; not people in our age group." Some thought that the incidence of HIV/AIDS among young people of their age group was congenitally acquired; "Babies get it from their mothers." Others thought antibiotics could put the disease in remission, because they mentioned a national celebrity living with HIV, "He knows he has it, but it doesn't bother him; he is living a normal, healthy life." The discussion of this national figure stirred discussion regarding medication affordability. Such statements of affordability included, "He will never get AIDS; he can afford any treatment he wants," and "You have to be rich to afford medication in America," and "My grandmother goes home [to the island] to buy her medications; we cannot afford it here. For it is cheaper there when you convert it." Other statements included, "I know they have free clinics here, but you have to spend almost the whole day to get anything." "When poor people have anything, they die much sooner than people with money, for they don't have the money to go to the doctor, and they cannot take off a day to go to the free clinic."

The teens knew that knowledge of HIV/AIDS transmission did not change behavior. "They know that diseases are out there, but they just think it will not happen to them, and it does not matter what anyone says." Other statements describing the naivete often reported among young people included, "Some are stupid enough to believe a guy who says he is a virgin," or "I have been with him long enough, so we'll be OK."

Question 2: How would your relationship change with your best friend if she were diagnosed with HIV/AIDS?

This question sought to find out more about teens' attitudes and was a follow-up from a previous question, "Would your relationship change if your best friend had HIV/AIDS?" This question emerged from the first focus group. A subgroup of about half of the participants believed that a diagnosis of HIV/AIDS in a friend would not change their relationship. According to that subgroup, adherence to church teachings did not guarantee protection from sickness; rather, they believed that the sickness was there to

strengthen the individual's faith. These young people concurred that any misfortune experienced by a believer was part of the testing from God. This was evident in statements like, "God is just testing you," and "He tests you in so many ways." Specific reference was made to Job, a biblical hero of suffering: "Job was a Christian, and look at what happened to him; he had diseases; people scorned him, and he lost everything he had."

Their loyalty to friendship was clear: "I love my friends, regardless of what happens to them. To me that is what friendship is all about," and "They will be my friends in good times and in bad times." Some took offense at the comments from their peers who shared a different perspective on this question: "Some people just get caught. That does not mean others are not doing it, regardless of how holy some of us want to sound." And, "God loves us in spite of what we do." Also, "We cannot judge everyone, for the Bible says we shouldn't."

Similarly, the feelings of those who believed that their friendship would change were equally charged. Although these church-going adolescents did not view victims of HIV/AIDS necessarily as sinners, most of them concurred that if people adhered to the teachings of the church, they would not be at risk for HIV. "If they don't listen and do what the church says, and then go and do whatever, it is their problem, not mine. They choose to do it." In speaking of those who acquired HIV because of sexual activity, they reported: "I don't need people like that in my life right now, for their behavior might pressure me into doing something that I am not ready for." Also, "It's hard for anyone to be best friends with someone who has different lifestyle from yours. Someone is going to convert, and I don't want to be in that situation." "I am not saying that I would just drop them like a hot potato, I would kind of let them down easy, because it is hard for me too." There were other statements about friendship like, "I'll still love them and give them anything I have that they need." However, all participants in this sample were resolute that such a friend would not be invited to their home for the weekend. Whereas the group was split based on this question and they all knew how the disease is spread, all had issues with their would-be HIV-infected friend sharing bathroom facilities, eating food prepared by that friend, or using personal items such as hairbrush—a common practice among the Caribbean population.

Question 3: Why do your peers engage in risky sexual behaviors?

This was a follow-up question by which teens shared knowledge about their schoolmates' sexual activity. The common refrain was, "They have sex at school everywhere from in the bathroom, behind the portables, and even on the roof." Others chimed in, "They are not using condoms, for they don't have time for that," and "They don't think anything will happen to them." Some believed that they were of age, whereas others believed that their relationship was safe. "We've been together long enough now, so it is safe." Some believed, as follows, that their parents kept changing the standard:

We were always told, "Finish school first before you think about man." When we finished school, they say, "Try to get something in your brain before you take up man." In the meanwhile, to prevent their existing relationship from becoming sour, they enter into risky sexual activity . . . so that the guy would stay with them.

Others talked about the peer pressure that came with being labeled as gay because they were not promiscuous. "I know most Americans don't care what other people think about them, but for us it matters. My parents go back home a lot, and I can see a rumor like that going back home where everybody knows everybody." This group also continued to explain that some did not have enough adult supervision because their parents were working multiple jobs. Another concern they expressed related to American residency status: "Some will do it if the guy promises to sponsor them. They are not thinking of disease . . . that is the only way they can become legal here."

Whereas the majority of participants were committed workers in the church ministry where abstinence is preached, when asked what prevented them from joining their friends in risky behaviors their responses were related to parental reaction, as one of intense parental displeasure: "My parents would whip my butt. They don't care that we live in America. Then they will give me the HRS [Human Resource Services] number and tell me to call," and

"I know they are not playing, for my stepdad told my sister [his child] she had to go . . . she came back after a while, but what she went through . . . ." Another stated the following:

My mom doesn't tell me anything about sex or anything like that, but I just know what will happen if I ever have sex. She will start talking that island talk, then the belt comes. "You think you going to turn cruff [unmotivated] in this house? "She does not care that I am 16 years old."

Everyone agreed, "Yes, mine too . . . ."

A few isolated comments supported the church teaching as a reason for practicing sexual abstinence. "I think the Bible say you should not have sex before you married—I think." "We should be doing what the church teaches us, and we'll be OK." And others commented on the double standard of promiscuity among many church members: "I don't know how people can be wasting their time . . . going to church . . . still be doing it, and it does not bother them." Some made statements affirming that "a few 'good girls' are still left." Good girls were defined by the group as those who go to church, focus on schoolwork, do chores around the house, don't have sex, and have manners and respect. Other reasons for abstinence included, "I am afraid of getting disease, for although they say use a condom . . . I don't want nothing from nobody."

Discussion/Implications

The study identified the knowledge and attitudes toward HIV/AIDS and risky sexual behaviors among Caribbean African American female adolescents. The demographic of this Caribbean sample as half American-born and half Caribbean-born truly represents the population of south Florida. This study provided culture-specific results and some results consistent with other ethnic adolescent populations.

Knowledge and Religious Beliefs

The accurate knowledge regarding HIV/AIDS evident in this study and even the areas of confusion concur with earlier studies by Robillard (2001), Holschneider and Alexander (2003), McCree et al., (2003), and Jemmott, Maula, and Bush (1999). Much teen knowledge is gained from the briefings they get in school or what they learn from friends, because the parental silence on sex education is deafening in the West Indian culture. Clarke (1966) pointed out, however, that although overcrowding and sleeping with both sexes, which is common in third world countries, invariably teaches many at an early age about sex, there is a salient understanding of expectations regarding sexual behaviors among adolescents.

Despite the areas of faulty knowledge of HIV/AIDS and the risk behaviors, self-control was quite evident. The strong religious beliefs and heavy involvement in religious activities might account for the small percentage of engagement in risky sexual behaviors in this sample. These adolescents believed that HIV/AIDS "is an old people's disease." This result is divergent from Rose's (2004) study in which older adults said that HIV/AIDS was "a young people disease" (p. 35). Studies show that when distinct groups receive AIDS information that is specifically framed in a more cultural context, it is more likely to be taken as a personal threat than simply viewing public standardized ads (Jemmott et al., 1999; Kalichman, Kelly, Hunter, Murphy, & Tyler, 1993). It would be useful if AIDS education incorporated case studies of young people under age 20 years who have a diagnosis of HIV/AIDS, including them in the literature, pictures, videos, and other learning tools. This adjustment might serve as a more meaningful reminder of the risks for these adolescents.

Parental Influence on Risk Behavior

Religious teachings seemed to have some influence on the participants' views and attitudes; however, fear of maternal reaction contributed to their abstinence. This is different from other studies that identify parental influence as a predictor for behavior change. The result of fear of maternal reaction is quite unique to this study. Although one cannot attribute a single factor to a multifaceted issue, adolescents' matriarchal fear has its roots in slavery and is especially evident in the lower socioeconomic stratum of the West Indian society. The children of slaves who were the result of sexual exploitation by the slaveholders were not connected biologically to the male slaves (because many did not have conjugal contact), nor were the "mulatto" children allowed

into White society. They were allowed to be raised by the mother although owned by the mother's master. These biracial children adopted their fathers' European manners, weakening the paternal role and setting the stage for matriarchal rule in the culture (Clarke, 1966). Clarke also added that when a girl becomes pregnant, the news is accompanied by noisy upheaval and severe beatings, and often the girl is expelled from the house.

Parents' frequent reference to HRS (the Florida Department of Children and Families, which deals with removal of children from abusive situations) is made to remind adolescents of the privileges they enjoy at home, providing them the option of either adhering to the rules at home or being placed in foster care. Parents' frequent use of the term *man* with regard to sex shows strong disagreement about a daughter having a sexual relationship. This may be because the daughter is not mature enough for a relationship or because the partner is not a socioeconomic or educational match (Clarke, 1966). *Cruff* is Caribbean slang, which, according to Dr. W. Thompson (personal communication, April 21, 2006), refers to individuals who, regardless of support, "have limited motivation for self improvement." The term is humorous in the way it is pronounced in the Caribbean culture; the pronunciation assists in conveying the meaning.

Attitude and Religion

The teens' perspective on persons with HIV/AIDS is similar to that with any other illness, a test of one's allegiance to God. This attitude is grounded in church teachings. Church members often find answers to their predicament in the scriptures, which also provide hope for the sufferer, guaranteeing a better life in the hereafter. This is a very common belief in many faiths without regard to Caribbean culture. However, acculturation might have contributed to adolescents' open view about people with a communicable disease, because this perspective is not common throughout the population. The responses might be based on expectation, because the entire sample in this study was emphatic about not sharing space or personal belongings with individuals with HIV/AIDS. This result is culture-specific and might reveal unspoken uncertainty regarding the disease.

The need to avoid peer pressure from their sexually active friends and willingness to relinquish friendships show the level of control among this group. Wong (1999) agrees that adolescents' association with peers who are involved in appropriate or deviant behaviors increases the likelihood of change.

Conclusion, Limitations, and Recommendations

The results of this study do not necessarily reflect the knowledge and attitudes of the entire Caribbean parental heritage population. However, the views and perspectives of these young people can provide valuable insights regarding potential intervention strategies. This study provides some understanding of the Caribbean culture for the purpose of providing culturally competent care. As one becomes culturally sensitive to the Caribbean African American values, one is able to listen and understand the stories of patients from the Caribbean in a nonjudgmental manner. If caring is to take place, the nurse's authentic presence is necessary, because only then will the nurse be able to truly come to know the person. Once nurses set aside preconceptions, they can directly or indirectly enter the world of the patient and understand and anticipate special needs. In this way, nurses can secure the necessary resources to nurture patients as they live and grow in caring (Boykin & Schoenhofer, 2001).

This study extends knowledge by describing an association between religious involvement, parental influence, and behavior in this cultural group of adolescents. It also raises some clinical concerns and suggests approaches for intervention. Kalichman et al. (1993) agreed that "the use of fear induction and sensitization alone are likely to be insufficient for risk reduction unless accompanied by specific strategies to change the high-risk behavior" (p. 294). Intervention strategies should include coordinated efforts of parents and the church in HIV/AIDS education. This should be preferably in an open discussion forum so that information does not get twisted.

The study has several limitations. First, the design and sample size do not allow for generalization. Therefore, assumptions about associations between religious involvement and risky behaviors or parental influences in this study outcome cannot be determined. Only four Caribbean islands were represented in the sample; therefore, generalizations to the Carib-

bean culture cannot be made. The study sample was all female adolescents, and all participants were members of the same denomination. Participants knew each other, and this could serve as powerful grounds for understatements, exaggerations, or socially correct responses.

Additional studies are needed to gain a better understanding of the variables affecting this cultural group; parental silence about sex needs further exploration. It is recommended that further studies be performed to prioritize maternal influence, fear of pregnancy and disease, and church teachings as determinants for abstinence. Follow-up studies of this group are also recommended to corroborate or challenge existing ages of premarital sexual encounter among this group. In addition, inquiry is needed regarding willingness to compromise health for the potential to obtain legal American residency. The aim in any future intervention should be to deliver a socially differentiated HIV/AIDS intervention strategy specific to this culture.

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