

April 2018

An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother–Daughter Dyads in West Central Florida

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An Exploratory Study of Health Promotion and Disease Prevention Communication among
Haitian Mother–Daughter Dyads in West Central Florida

by

Stacy Eileen Kratz

A dissertation submitted in partial fulfillment
of the requirement for the degree of
Doctor of Philosophy
School of Social Work
College of Behavioral and Community Sciences
University of South Florida

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Date of Approval:
April 2, 2018

Keywords: Sexual Health Communication, Health Disparities, HIV/AIDS, Constructivist
Grounded Theory

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DEDICATION

This dissertation is dedicated to my parents and siblings, what we have called ourselves as The Power of Ten. I have travelled life's road with my eight siblings (Karen, Don, Matt, Tom, Mary Beth, Jay, and Maureen), and my mother and father, Don and Mary Morrissey. My father, may he rest in peace, brought us the power of creativity, especially through jazz, to change people's lives. My mother, possessing a radiant of inner light and sustained strength, my very own Irish *poto mitan*, showed us external achievement is never the end goal in life, that in fact internal struggle and knowing a sense of our own limitations has higher rewards for the self and for humanity. My siblings have taught me life is much bigger than we think, and supported me on every trail I explored, including this dissertation, always waiting for me to return to tell of the journey.

This dissertation is also dedicated to my children, Bridget, Gordon, and Frances, who cheered me on, and brought laughter at every right moment. Their joyful giving, especially of time when I had none, inspired me to keep working. They also remind me every day that those who have a voice for social justice must use it.

It is to my husband Paul Kratz, that I also dedicate my work. His love and support, and the personal sacrifices he made for me in this process, got me through. Paul is a great thinker, who inspires all those he knows to continually examine deeper values that inform our lives. He inspires me to think globally, and to continually work on being ok with not being able to get to all the answers, that we have to live with uncertainty sometimes. As my technology champion, he also has taught me there is no such thing as randomness in IT, unlike in life.

Finally, it is with deep gratitude that I also dedicate this dissertation to the all the Haitian women who believed in this project, who opened their hearts and welcomed me at their kitchen tables and their office desks, so together we might make a difference in the lives of all women.

ACKNOWLEDGMENTS

I would like to give a heart-felt thank you and acknowledgement to my dissertation committee: Dr. Guitele Rahill, Dr. Manisha Joshi, Dr. Nan Park, and Dr. Celia Lescano. Their wisdom, patience, and steadfast support, gave me strength to keep going. They continually encouraged me, both in small and grand ways, by letting me know they believed this work could make a meaningful contribution.

I wish to express deep gratitude to my dissertation committee chair, Dr. Rahill, for her unwavering belief in my capabilities, and this work, as this required sustained commitment to share her time, insight and expertise. She kept me on track, allowing for the reality of work life pressures, and also supporting me when putting this work aside momentarily was necessary, to address real life situations. I could not have asked for a more compassionate chair. In addition, Dr. Rahill graciously shared her personal and professional network within the West Central Florida Haitian community, expanding my knowledge and love of this beautiful culture.

I would like to acknowledge the love and support given to me by my fellow classmates Bina Patel, Rick Glaesser, Jodi Jordan, Kristin Smyth, and Kim Snyder Wollard. In the many-years process of spending time working together on coursework and studying, and encouraging each other in our dissertations, we became great friends too, a gift I will treasure always.

I would like to acknowledge my dear friends Susan Ray and Lori Coleman. Despite all the times during my dissertation years that I was absent in their lives, they unconditionally loved me, and brought me the metaphorical chicken soup when I needed it most.

Finally, I want to acknowledge the University of South Florida, the College of Behavioral and Community Sciences, and the School of Social Work, for their commitment to my success.

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ABSTRACT

This exploratory study examined links between health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads living in West Central Florida, and the risk or protective factors for HIV. Risky sexual behaviors can be reduced with accurate and effective information provided through parent-adolescent communication (Coetzee et al, 2014; Ogle, Glasier & Riley, 2008; Hadley et al., 2009). In Haiti, a country that bears a disproportionate burden of HIV/AIDS, women are the most vulnerable (UNAIDS, 2016a); In the United States (U.S.), foreign-born Haitian women in the state of Florida experience health disparities in many areas and bear a disproportionate burden of HIV/AIDS relative to their non-Haitian peers but little is known about (Florida Department of Health [FLDOH], 2017; U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion [ODPHP], 2017). Indeed, the state of Florida recently reported that newly diagnosed cases of HIV increased for foreign-born Haitian women and in 2016, the latter represented 3.64% of all cases (Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2017a). Recognizing that Haitian mothers traditionally bear the primary responsibility for transmitting traditional norms, values, health beliefs and practices, a concept referred to as *poto mitan*, this qualitative study examined risks and protective factors for HIV that may emerge in health and sexual health communication among Haitian mothers and daughters.

This study comprised a two-phase process in which purposive sampling was first used to recruit and interview a focus group of seven health care providers and Haitian-descendant

community leaders who engage Haitian-descendant clients in West Central Florida, after which findings from the focus group were used to strengthen a semi-structured interview guide that would be used to interview 10 Haitian mother/daughter dyads in the area. This study addressed a gap in the scientific literature related to health and sexual health promotion and disease prevention communication among Haitian immigrant women in the U.S., particularly surrounding HIV risk. Specifically, it sought to discover what constitutes specific methods that Haitian mothers use to communicate health and sexual health and the contents of such conversations, as well as the intention of daughters to transmit information that they received from their mothers, even here in the U.S.

This study applied a constructivist grounded theory approach, in which Symbolic Interactionism (SI) and the Information-Motivation-Behavioral Skills Model (IMB) were triangulated as a framework. ATLAS.ti® 7.0, a software that supports analysis of textual data, was used to analyze transcripts from the focus group and from the interviews.

Findings indicate that (a) Haitian mothers intentionally transmit specific and valued traditional knowledge about health and sexual health to their daughters, specifically in the areas of vaginal health, post-partum rituals, and abstinence as the acceptable mode of HIV prevention; (b) Haitian mothers in the study sample lack adequate and accurate knowledge about HIV/AIDS as well as the time to learn more that they can share with daughters; (c) Haitian mothers in the study sample do engage in direct communication about HIV prevention, taking advantage of teachable moments, using popular music and television programs; (d) there is a strong reliance on religious leaders and school systems to address health and sexual health instruction; (e) Haitian mothers in the sample reported and daughters confirmed that there is extremely limited conversation between the mothers and daughters surrounding sex, HIV risk reduction methods

outside of abstinence. (f) Symbolic Interactionism is a useful framework for understanding the process of communication between Haitian mothers and daughters in this study; (g) IMB is useful to understand that the information being provided by Haitian mothers in this sample is at times insufficient and inaccurate, thereby limiting the ability of daughters to effectively and intentionally engage in conduct that protects their sexual health and reduces HIV risk.

This study has several implications for social work education, research, practice, and policy. First, social work students must be taught to conduct comprehensive assessments of Haitian women in the context of valued Haitian family dynamics, and to engage in life-long learning regarding protective as well as risk factors for Haitian mothers and daughters. Second, Haitian and non-Haitian health providers who serve Haitian clientele could be surveyed regarding knowledge of health beliefs and practices and its potential impact on the health of their Haitian patients. Third, researchers may use this study's findings as a foundation for developing interventions that enhance strategies aimed at establishing rapport with Haitian clients and for assessing potential interactions between hidden health practices and prescribed medications. Fourth, findings suggest the need to develop interventions that empower trusted religious leaders to gain accurate HIV knowledge and to deliver empowering information effectively to their congregants. Fifth, findings suggest a need to develop outreach programs aimed at heightening HIV awareness and increasing HIV testing for Haitian women who are similar to this study's sample. Sixth, social workers engaging Haitian female clients can make intentional efforts to include Haitian mothers in treatment. Seventh, this study's findings underscore a need for social workers to advocate on behalf of Haitian immigrants' efforts to be properly counted in the census, and to be counted as a culturally distinct group in other surveillance data.

Social workers can benefit from understanding the strengths of relationships between Haitian mothers and daughters and to enhance their awareness of the heterogeneity among Haitians in general when working with Haitian clients. To work effectively with Haitian immigrant females overall requires cultural humility to mitigate the likelihood of bias towards them based on known or hidden traditional health beliefs and practices and gender roles.

CHAPTER 1: INTRODUCTION

Recent international research affirms that risky sexual behaviors can be reduced with accurate and effective information provided through parent-adolescent communication (Coetzee et al., 2014; Ogle, Glasier, & Riley, 2014; Hadley et al, 2009). In Haiti, a country that bears a disproportionate burden of HIV/AIDS, women are among the most vulnerable (UNAIDS, 2016a). The Florida Department of Health reports that newly diagnosed HIV cases among Haitian-born women in Florida increased by 27.6 % between 2012 and 2016 (Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2017a). In the present qualitative study, I explored potential links among health/sexual health communication and other constructs affecting health promotion and disease prevention among Haitian mother–daughter dyads in relation to risk or protective factors for the Human Immunodeficiency Virus and the associated Acquired Immune Deficiency Syndrome (HIV/AIDS).

Purpose of the Study

The purpose of the study was to explore links between health communication and other constructs, such as motivation for behavior change or skill attainment, that may affect health promotion and disease prevention communication among Haitian mother-daughter dyads, particularly as they concern risk or protective factors for HIV; the study explored the content of such information, the process by which knowledge about health promotion and disease prevention is transmitted and the accuracy of the knowledge transmitted, as well as the effectiveness of knowledge transmission in impacting daughters' health and sexual health behaviors, including HIV prevention for Haitian women. In the present study, a qualitative

research design (purposive sampling) was used to guide a two-step process to first recruit and interview a focus group of Haitian-descendant health care providers and community leaders who engage Haitian clients in order to obtain information not readily available in the limited literature regarding the health of Haitian women. Findings from the analysis of the focus group transcript strengthened a previously developed semi-structured interview protocol that was then used to interview Haitian mother–daughter dyads (hereafter referred to as “dyads”) who reside in West Central Florida; the interviews of the dyads aimed to elicit retrospective accounts of crucial health and sexual information transmission from mothers to daughters. Constructivist grounded theory, discussed later in this work, was used as an analytic framework.

Definition of Key Concepts

In this study, “Haitian mothers” refers to foreign-born women of Haitian descent who have a daughter aged 18 years or older, and who was available and willing to participate in this study. Similarly, “Haitian daughters” refers to women who were born to foreign-born Haitian mothers, but who themselves were born either in Haiti or in the U.S. This study’s participants were recruited from West Central Florida, an area that has a significant Haitian immigrant population.

Health and sexual health communication.

There are varying definitions of health (Brussow, 2013; Godlee, 2011; Isla-Pera, López-Matheu, & Insa-Soria, 2008; World Health Organization [WHO], 2006). Health, in the medical literature, is defined as the absence of disease, with the allowance that health includes the capability to adapt to changing circumstances, including challenges across life domains (Brussow, 2013; Godlee, 2011; Rice, 2006). Health has also been defined in terms of poor health and reduced health (Brussow, 2013).

The World Health Organization (WHO) (2006) defines sexual health as an “integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication, and love” (p. 4). Rice (2006) distinguishes *somatic sexual health* as behaviors such as regular physical check-ups, gynecological cancer screenings, self-examination of breasts, and usage of various forms of birth control, including condoms; she offers that (a) *emotional sexual health* behaviors may include activities such as avoidance or cessation of uncomfortable sexual activities or relationships, use of assertive communication techniques describing one’s sexual preferences, or personal acceptance of sexual feelings; (b) *intellectual sexual health* includes possession of accurate information, acquisition or hindrance to information, and knowledge of personal and social health risks and vulnerabilities, and (c) social sexual health involves the ability to talk honestly and openly with a partner about feelings regarding various sexual practices, and the capacity to engage in open and honest communication about avoiding sexually transmitted infections (STIs). Rice adds that sexual health also includes individuals utilizing a reciprocal support system from friends and family, so that individuals look for help from their friends and families to support them in healthy relationships, and also that individuals support the healthy relationships of their friends and family members (2006).

Sexual health has been defined as part of reproductive health, and its importance is emphasized in the United Nations’ Sustainable Development Goals (SDGs) (WHO, 2006; United Nations, 2015). The SDGs are measureable targets proposed for improving the lives of the world’s poorest people by 2030. The third SDG goal, “Ensure Healthy Lives and Promote Wellbeing at All Ages”, sets a target of achieving access for all women globally to sexual and reproductive health care services in order to improve maternal health (United Nations, 2015).

Specifically, reproductive health, which includes sexual health, is defined as “a state of complete physical, mental and social well-being ... in all matters relating to the reproductive system and to its functions and processes” (WHO, 2006, p. 4).

Relevant to the present study is research which contributes that parents are influential contributors to their children’s sexual knowledge (AlQuaiz, Kazi, & Muneef, 2013; Cedarbaum, 2011; Hutchinson et al., 2012). The consensus, in the latter body of research has been that parents want to talk to their children about health and sexual health, although the former may have low comfort levels and skills regarding this discussion, and children often resist efforts by their parents to speak with them about issues involving sex (Ogle, Glasier, & Riley, 2008; Schuster et al., 2008). Coffelt (2010) reported that sexual communication does occur between parents and adolescents, but this often occurs in small snippets and not through formal conversations. There is a disparity between parent and adolescent beliefs of whether or not sexual communication has actually transpired and the frequency of its occurrence (Coffelt, 2010; King & Lorusso, 1997; Hadley et al., 2009).

Health/ sexual health communication among Haitians.

Much of the research surrounding the health, sexual health and reproductive health of Haitians addresses health in terms of the presence or prevention of illness or violence (Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006; Faedi, 2008; Gómez Speizer, & Beauvais, 2009; Kobetz et al., 2009; Meade, Menard, Thervil, & Rivera, 2009; Pape et al., 1986; Rahill, 2008; Rahill & Rice, 2010; Rahill, De la Rosa, & Edwards, 2012). As an example, DeSantis, Thomas, and Sinnott (1999) reported that within Haitian parent-adolescent pairs in southern Florida, the parents believed they held most of the responsibility for providing information about reproduction and contraception to their children. As another example, Stephens and Thomas

(2012) reported poor sexual health communication between Haitian-immigrant mothers and daughters in a study that explored acceptance of human papillomavirus (HPV) vaccinations as a health prevention measure for young Haitian females.

The use of semi-structured interviews with open-ended questions permitted me to explore the topics of interest in detail and to draw out attitudes and feelings that would not be attainable through a structured, close-ended survey (Gillman, 2000; Padgett, 1998; Silverman, 2005).

Significance

The present study of health /sexual health communication among Haitian mothers and daughters is important for several reasons.

First, health disparities persist for Haitians, and for Haitian women in particular. Second, Haitian mothers hold a central role in the Haitian family as the individual who is primarily responsible for transmitting values, norms and health information, thus supporting their inclusion in this study, as opposed to Haitian fathers. Third, although HIV/AIDS has historically been politicized in relation to persons of color, there is only one Haitian Creole adaptation of an Evidence-Based HIV intervention in the Centers for Disease Control and Prevention's compendium of Evidence-Based interventions, and it is not widely publicized (Centers for Disease Control and Prevention [CDC], 2017a). Fourth, HIV knowledge is foundational to HIV prevention. Fifth, the state of Florida recently reported that newly diagnosed cases of HIV increased for foreign-born Haitian women and in 2016, the latter represented 3.64% of all cases (Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2017a). Sixth, there is a lack of unambiguous scientific knowledge about Haitians in general, which prevents knowledge of risk for disease and knowledge of health beliefs or practices that may serve as protective factors. Finally, the persistent conflation of Haitians with African Americans

based on color impedes progress in understanding protective and risk factors for Haitians, including Haitian women.

Health disparities among Haitian women in relation to peers.

A growing body of research indicates that Haitian-immigrant women in the U.S. experience health disparities in many areas, including cancer and HIV/AIDS (CDC, 2010; CDC, 2014; Florida Department of Health [FLDOH], 2006, 2010; Florida Department of Health [FLDOH] Prevention Planning Group [PPG], 2012; Meade et al., 2009; Institute of Medicine, 2012; National Association of Social Workers [NASW], 2012; National Cancer Institute, 2005; UNAIDS, 2017d; U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion [ODPHP], 2017). The significance in this study, thus, is in its potential to address factors associated with HIV health disparities in this population.

Central Role of Haitian mothers.

The place of mothers in Haitian families adds to the significance of this study in that Haitian mothers play a central role in the Haitian family and are often referred to as the family's "*poto mitan*." The concept of *poto mitan* identifies Haitian women as the center post of Haitian families and communities, i.e., the mechanism that holds the structure together (Alexander, 2011; Armand, 2013; Bergan, 2009). Armand (2013) confirms the long-standing veneration of mothers as *poto mitan* in Haitian culture and confirmed Haitian mothers as the first teachers in the family. Jeanty and Brown (1996) discussed the central role of mothers in Haitian culture as well, noting as illustration, the prominence of mothers in Haitian proverbs. In general, studies reporting on sexual health communication between caregivers and their adolescent offspring indicate that mothers are the ones who primarily engage in such dialogue (DiIorio, Kelley, & Hockenberry-Eaton, 1999; Hadley et al., 2009; Raffaelli, Bogenschneider, & Flood, 1998). In

fact, mother–daughter communication about sexual risk behaviors led to a decline in unprotected sexual intercourse and sexual intercourse in general (Hutchinson & Wood, 2007; Ogle, Glasier, & Riley, 2008). The fact that Haitian culture is matrifocal (Pierce & Elisme, 2000) informs that eliciting risks and protective factors for HIV that may emerge in health and sexual communication among Haitian mothers and daughters would necessarily involve Haitian mothers as the *poto mitan*, around whom health promotion and disease prevention revolve.

Politicization of HIV/AIDS.

HIV traditionally has been a politicized disease associated primarily with men who have sex with men and intravenous drug users, and interventions geared to women of color of reproductive age have often been underfunded (CDC, 2015b). Therefore, investigating health and sexual health communication among Haitian mothers and daughters, inclusive of the presence or absence of accurate HIV knowledge, is tantamount to a human rights issue, as all persons deserve to be healthy (Halperin et al., 2004, Office of the United Nations High Commissioner for Human Rights [OHCHR], 2017).

Relevance of HIV knowledge in relation to HIV prevention.

The importance of HIV knowledge in relation to the prevention of HIV infection is highlighted repeatedly in the pertinent literature (Cedarbaum, 2011; D’Silva, Hart, & Walker, 2008; UNAIDS Global HIV/AIDS Response Progress Report, 2011). HIV knowledge can lead to HIV testing, and early detection of the virus can lead to early treatment, better prognosis, and potentially reduced transmission of infection and reduced progression to AIDS (Klein, Hurley, Merrill, & Quesenberry, 2003).

Disproportionate impact of HIV/AIDS in certain regions.

Although for the past several years there has been a gradual and region-specific decline in the occurrence of new HIV infections in some populations, the virus has not been eradicated and continues to disproportionately impact certain regions and subgroups (UNAIDS, 2017d). In 2016, more than 1.1 million people died from Acquired Immune Deficiency Syndrome (AIDS), of which one symptom includes weakened immune systems that leave those affected susceptible to opportunistic infections and AIDS-related cancers (Centers for Disease Control and Prevention [CDC], 2017). Some suggest that increased knowledge of the disease, along with other culturally based constructs at the local, regional, national, and international levels can lead to further reduction in HIV/AIDS risk behaviors, and lower transmission rates (D’Silva et al., 2008; UNAIDS, 2014; UNICEF, 2004). The leading cause of death among reproductive age women (15-49 years) globally is HIV-related illnesses (UNAIDS, 2017d). In the U.S., health inequities disfavoring Haitian immigrants contribute to widespread health disparities across multiple medical domains, including issues relating to HIV/AIDS; but little research exists pertaining to Haitian immigrants who have migrated to West Central Florida (CDC, 2014).

Growing number of new HIV cases in the state of Florida.

Adding to the significance of this study is that the state of Florida recently ranked first nationally for the highest estimated number of new HIV diagnoses; Hillsborough County, located within this study’s recruitment area, reports the largest increase, i.e., 63 %, between 2012 and 2014. Pinellas County, part of the West Central Florida recruitment area for the present study, reported a 32 % increase in the same period (FLDOH, 2014b). Although the bulk of HIV/AIDS cases reside in southern Florida counties that include Broward, Miami-Dade, and

Palm Beach, the percentage increases noted in West Central Florida underscore the importance of the present work.

Lack of unambiguous scientific knowledge about Haitians in general.

Population-specific data related to Haitians remain elusive in some areas because race/ethnicity is often reported in terms of Black non-Hispanic (FLDOH Prevention Planning Group [PPG], 2012; FLDOH, 2017b, 2017c). Thus, although available data regarding Haitian born adults living with HIV suggest that the highest number are over the age of 50 (FLDOH, 2015), it remains difficult to disentangle Haitian-descendant persons between the ages of 15-24, the “daughters” in this study, particularly since they are often categorized as African American rather than Haitian (FLDOH, 2014a). Thus, we may be missing an entire generation of Haitian descendant youth with culturally-specific interventions across the HIV treatment cascade. The need to disentangle Haitian health risks from those of their African American counterparts is also in response to culturally-specific behaviors among Haitians that may not be practiced by African Americans, for example, the use of injections that are administered by non-medical professionals (Agyemang, Bhopal & Bruijnzeels, 2005; Pierre, 2012; Rahill, 2008).

If findings from the present study reveal that the content of health and sexual health communication within the targeted dyads includes crucial accurate information concerning how HIV is transmitted or avoided, I would have identified that at-risk Haitian women possess some tools and resources that can potentially reduce their disparate risks for HIV. If, on the other hand, findings from the present study reveal that the content of sexual health communication within these dyads is inaccurate or insufficient to inform how HIV is transmitted or avoided, then I would have identified HIV knowledge as an area to focus on when developing or adapting primary (educational) or behavioral interventions for them. Consonant with UNAIDS’s call for a

“prevention revolution” with respect to eradicating HIV/AIDS, my study will help shape the discourse of evidence-informed HIV/AIDS prevention and intervention options with new, clear, and unambiguous information about the target population by addressing several research questions (UNAIDS, 2010).

As noted earlier, this investigation of health promotion and disease prevention communication among Haitian mother–daughter dyads of West Central Florida began with a focus group of community health providers and other community leaders who serve Haitian women in the study zone, as a first step in developing pertinent culturally endemic and contextual factors that must be considered. This approach is detailed in Chapter 3.

Research Questions

1. What do health care providers or community-level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents?
2. What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?
3. What messages do Haitian daughters in West Central Florida *receive* from their mothers about what constitutes health and sexual health?
 - a. Are the daughters hearing what the mothers are attempting to convey?
 - b. Do Haitian daughters have intention to transmit health and sexual health communication that they receive from their mothers and/ or other sources to their own daughters? If so, how similar or different will such communication be compared to what they have received?

To accomplish the study's objectives of enhancing knowledge regarding health and sexual health communication among Haitian-descendant dyads living in West Central Florida and to obtain data which are pertinent to the above research questions, I triangulated symbolic interactionism (SI), and the information-motivation-behavioral skills model of health behavior change (IMB) as theoretical frameworks, with the analytic approach of constructivist grounded theory; constructivist grounded theory is detailed in Chapter 3. SI and IMB are introduced below, and more fully detailed in Chapter 2.

Introduction of Theoretical Frameworks

Symbolic Interactionism.

Blumer is credited with coining the term *symbolic interactionism* (SI) (Blumer, 1969). SI theorizes that it is through social, contextual interactions, experienced through language and symbols, that knowledge, and what is held as truth, is formed (Anglin, 2002; Blumer, 1969; Charmaz, 2014). SI assumes that social interactions create personal and shared meanings among individuals. The way in which individuals interpret and act upon what they understand their reality to be determines how they behave and how they react to various circumstances and experiences. Specifically, people act according to symbols and symbols are created through interpreting interactions, both between individuals, and the outside world, through language (Blumer, 1969). Strykes (2001) outlined the importance of understanding that “things, ideas, and relationships among things and ideas can all be symbolized,” and these symbols, therefore, define experience as objects (p. 3,096). These objects emerging from social interaction become reality, surfacing from significant symbols of communication and social interaction, and are shared among individuals in their shared social contexts. Strykes also stated that “because significant symbols anticipate future behavior, they entail plans of action: They organize

behavior with reference to what they symbolize” (p. 3,097). Since I utilized retrospective qualitative interviews in this study, I looked for language details that might be expected to include plans of action for sexual health promotion and disease prevention.

Rahill (2008) applied an SI framework to her work to investigate the development of health beliefs surrounding Florida Haitian immigrants’ use of *picuristes* (informal injectionists). In that study, SI was triangulated with the Health Belief Model and the Explanatory Model of Illness to shed light on study participants’ development of health-seeking behaviors in relation to traditional health beliefs and explanatory models of illness and treatment. Rahill’s study sets precedence for using SI as part of a framework for studying the content of communication within the targeted dyads. The present study built on previous findings and highlighted the specific content of beliefs about disease prevention and health promotion within a subsample of Haitian immigrants, for example, Haitian mother-daughter dyads, by shedding light on how Haitian-descendant mothers and daughters socially construct the meanings of health and sexual health.

In conjunction with SI, the IMB model was used to help understand how the data collected through the semi-structured interviews helps to explain the process of how health communication occurs, and add to the understanding of predictive behavior properties of health promotion and disease prevention.

Information-motivation-behavioral skills model.

The IMB model was developed to foster understanding of HIV/AIDS risk and prevention (J.D. Fisher & Fisher, 1992). The model espouses three psychosocial determinants of behavior: 1) knowledge of behavior of concern, 2) motivation on a personal and social level, and 3) objective demonstration of desirable health promotion behaviors and abilities, as well as self-efficacy in enacting the behavior correctly. The model emphasizes the importance of moving

beyond knowledge to the inclusion of concepts such as motivation, skills, and other constructs in determining health or disease.

Together, IMB and SI help to deconstruct potential links between health/sexual health communication and other constructs affecting health promotion and disease prevention among Haitian mother–daughter dyads in relation to risk or protective factors for the Human Immunodeficiency Virus (HIV). Constructivist grounded theory provides a useful framework for analysis of the data as it allows for an inductive, systematic inquiry into these constructs (Charmaz, 2000).

Chapter 1 has described the purpose of this study, including an introductory discussion on HIV/AIDS, HIV and Haitian women, and definitions of key concepts of health and sexual health communication. It has also described the relevance and significance of this work, the research questions, and finally the theoretical framework guiding the study. Chapter 2 begins with a summary of the HIV/AIDS pandemic as a context for this present study and factors that may hinder the acquisition and effective use of HIV knowledge among Haitian women. It then presents a discussion of traditional Haitian health beliefs concerning health and sexual health. Next, a review of the influence of transnational ties on U.S. Haitian health beliefs and practices is presented. Finally, the theoretical frameworks for this study, SI and the IMB model, are discussed. Chapter III describes the methodological approach and analytical method used in the present study. Chapter IV presents the findings of this study, followed by Chapter V, a discussion of the findings.

CHAPTER 2: LITERATURE REVIEW

Chapter 2 is organized in four sections: (1) a summary of the HIV/AIDS pandemic as a context for this present study, and factors that may hinder the acquisition and effective use of HIV knowledge among Haitian women, (2) a discussion of traditional Haitian health beliefs concerning health and sexual health, (3) a review of the influence of transnational ties on U.S. Haitian health beliefs and practices, and (4) the theoretical frameworks for this study, SI and the IMB model.

HIV/AIDS

The Centers for Disease Control and Prevention (CDC) describe HIV as “a virus spread through body fluids that affects specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body cannot fight off infections and disease. When this happens, HIV infection leads to AIDS” (CDC, 2015a). Globally, an estimated 36 million people have died from HIV-related complications since the first five cases were reported in California in 1981 (World Health Organization [WHO], 2017). Although a recent report confirms unprecedented positive results in the global fight against HIV/AIDS, there are still approximately 36.7 million people living with HIV/AIDS today (UNAIDS, 2017a). People are living longer for various reasons including enhanced availability and access to antiretroviral therapy, increased HIV testing, and increased HIV knowledge in certain regions (UNAIDS, 2017d).

Whereas the picture of HIV/AIDS may not be as dismal as it was 33 years ago, the disease remains an immense global concern. Of noted concern is that racial and ethnic minorities

are proportionally impacted more by HIV/AIDS than majority populations, and the impact of HIV/AIDS varies across different geographical regions (UNAIDS, 2017b). UNAIDS recently reported that sub-Saharan Africa, the region where roughly 66% of new HIV infections have occurred, has 25.6 million people living with HIV (UNAIDS, 2017d). Today, the Caribbean region remains the most heavily affected region outside of sub-Saharan Africa (UNAIDS, 2017d). These disparities exist despite the millions of dollars that have been invested to combat the disease in those regions (UNAIDS, 2017d). Indeed, new adult HIV infections in the Caribbean rose 9% between 2010 and 2015, reversing progress that had been made in the previous decade, with an estimated 18,000 adults and children newly infected in 2016 (UNAIDS, 2016c). The overall HIV prevalence rate among Caribbean adults aged 15 to 49 is 1.3% (UNAIDS, 2017c). In fact, the prevalence rate in women aged 15 to 49 is estimated to be the same as the overall rate of 1.3%, a higher rate than men of the same age, which is estimated at 1.2% (UNAIDS, 2017c).

Within the Caribbean, as recent as 2014, the island of Hispaniola reported approximately 70% of all regional HIV/AIDS cases (James, 2014; Karabanow, 2018). Since then, UNAIDS data suggest the high percentage remains the same (2017c). Haiti is the most impacted country on Hispaniola, in the Caribbean, and in the Western Hemisphere; it is not immune to the worldwide gender inequality that drives the HIV pandemic. Decades of international research and practice focusing on the transmission and treatment of HIV and on the prevention of AIDS has greatly impacted the disproportionate HIV/AIDS transmission rate in Haiti, such that the overall adult prevalence rate had declined from nearly 12% in 2003 to 2.1% in 2016 (AIDS Healthcare Foundation, 2017). However, Haitian women have still been disproportionately affected not only in Haiti but in the U.S. (UNAIDS, 2017d; Saint-Jean et al., 2011; FLDOH

PPG, 2012). Estimates indicate that HIV prevalence among Haitian females aged 15 to 49 is 2.5%, compared to the aforementioned 2.1% overall rate among Haitian adults. The adult female prevalence rate is nearly double that of females from Jamaica (1.3%), and two and a half times the prevalence rate of women in the Dominican Republic (1.0%) (UNAIDS, 2016a, 2016b, 2016c).

Studies conducted in Haiti indicate that Haitian women lack HIV knowledge and at times hold traditional beliefs about the origin of HIV/AIDS that can inhibit their ability to be proactive in receiving HIV testing or in engaging in risk reduction activities (Devieux et al., 2009; Devieux et al., 2004; Logie, Daniel, Newman, Weaver, & Loutfy, 2014; Martin, Rissmiller, & Beal, 1995). HIV knowledge, particularly knowledge of sexual risk behaviors, and sexual health communication between caregivers and their offspring have been associated with the reduction of HIV risk (Erausquin, 2008; Jones, Cook, Rodriguez, & Waldrop-Valverde, 2012; Velcoff, 2010).

In the U.S., HIV/AIDS disproportionately impacts women of color, including Haitian women (FLDOH, 2017a; FLDOH, 2013; Marcelin, McCoy, & DiClemente, 2006; Saint-Jean et al., 2011). Rahill and colleagues (2012) reported that Haitians are underrepresented in health research, yet continue to experience health disparities in relation to White and Latina women. Further, as mentioned above, HIV rates have increased for Haitian women in the state of Florida.

Little is known about factors contributing to this recent increase in HIV rates for adult Haitian female residents of Florida. Even less is known about HIV knowledge among Haitian-descendant females of any age residing in the U.S.; or about the type of health communication that occurs between Haitian women and their mothers (Marcelin et al., 2006). Although this exploratory study precluded the use of a quantitative scale to assess HIV knowledge in the

targeted population, findings from this study can be foundational to future studies that assess HIV knowledge within the targeted group. Additionally, findings concerning health communication within the dyads can ultimately inform the development/adaption of Evidence-Based behavioral interventions (EBI) or translational studies that enhance protective factors and reduce risk for HIV in Haitian women and their daughters. Indeed, translational research continues to be prioritized by the National Institutes of Health (NIH) for HIV/AIDS mitigation (NIH, 2017).

Factors Hindering Accurate Knowledge of HIV Health Disparities for Haitians in the U.S.

In the U.S., general health data specifically regarding Haitians are rare, as most studies combine various Black ethnicities into one category of African American or Black (Allen et al., 2013). Betty (2007) noted that Haitians may not self-identify as African-American because of a distinction in “identity formation based upon social, linguistic, and cultural factors, not race” (p. 231). Toness (2010) later confirmed that Haitians in America choose to maintain their transnational ties and their ethnic identity and rarely identify solely as African American. As most of the literature on health disparities affecting racial and ethnic minorities is reported in terms of Black/African American, research that disentangles Haitians living in America from Black/African Americans is rare. An exception is the CDC’s report that health inequities experienced by Haitian immigrants result in widespread health disparities in relation to other groups (2011). The lack of distinction of Haitian immigrants in the U.S. from African Americans and other African descendant populations is particularly affronting, given the large presence of Haitians in the U.S. and in light of research findings indicating that their health behaviors and

practices often differ from African Americans born in the U.S. (Agyemang, Bhopai, & Bruijnzeeis, 2005; Pierce & Elisme, 2000).

The Haitian presence in America has nearly doubled in the last three decades, with a recent estimate of 830,000 Haitians in the U.S., of which more than one-third live in Florida (U.S. Census Bureau, 2010). Whereas most of this Florida population resides in the Miami-Dade County area, the presence of Haitian immigrants in the Tampa Bay region, as well as in all of central Florida, is significant. Data from the U.S. Census Bureau's 2007-2011 American Community Survey (ACS) 5-Year Estimates indicated that nearly 36,000 central Florida respondents identified as having first- and second-generation Haitian ancestry. Roughly one-third of this population resides in the Tampa/St. Petersburg/Clearwater metro area (extended to include Lakeland, Brooksville, Gainesville, Pasco County, and Sarasota), and the remainder resides in the Orlando/Orange County metro area (U.S. Census Bureau, 2011).

The disproportionate occurrence of HIV/AIDS among Haitians as compared to the presence of the virus among non-Haitians in Florida is complex; it may be related to lack of knowledge regarding how the virus is transmitted, a lack of clear understanding of personal and social incentives for behavior change, and lack of the necessary skills required for disease prevention and health promotion. Included in the complexity of factors that impact HIV in this population is that roughly 18% of Haitians in the U.S. live in poverty (overall U.S. rate is 12.7%) and nearly 22% do not have health insurance (overall U.S. rate for non-elderly is 12%) (Kaiser Family Foundation [KFF], 2017; Schulz & Batalova, 2017). In general, those with insurance in the U.S. access health care services at greater rates than those uninsured and have better health outcomes (KFF, 2017), but Rahill (2008) found lack of insurance in the Miami-Dade, Florida area did not dictate use of non-traditional health treatment. The Florida Department of Health

reported that “people who have specific knowledge, attitudes, beliefs, and behaviors are more (or less) likely to become infected and more (or less) likely to suffer HIV’s effects” – depending on whether or not the knowledge is accurate, the attitudes and beliefs promote health as opposed to enhancing risk, or the behaviors involve health risk versus health promotion (FLDOH, 2012, p. 37). In the same report, lack of knowledge was ranked among the highest HIV risk factors. Other factors that the Florida Department of Health reported as influencing HIV infection include social, psychological, and economic circumstances.

The United Nations International, Cultural, and Educational Fund (UNICEF) reported that merely 35% of young Haitian women studied in Haiti between 2008 and 2012 had comprehensive and correct knowledge of HIV/AIDS, such that they could correctly identify two methods of avoiding HIV transmission and three common misconceptions about HIV transmission (UNICEF, 2014). HIV knowledge is associated with HIV risk and early education regarding how to prevent HIV can impact comprehensive and correct knowledge.

As this study aimed to assess the transmission of health and sexual health communication among Haitian mothers and their daughters in the West Central Florida region and to discover constructs regarding health promotion and positive health behavior practices, its findings will inform the vision of the national HIV/AIDS strategy that the U.S. has a future free of HIV (CDC, 2017b). Accordingly, among this study’s scientific contribution is in its enhancement of knowledge pertaining the content of health communication in the targeted dyads. The results also can contribute to the UNAIDS 2016–2021 global campaign to eradicate HIV/AIDS (UNAIDS, 2016a).

Traditional Haitian Health Beliefs concerning Health and Sexual Health

Understanding traditional Haitian health beliefs regarding health and sexual health communication, including communication about HIV/AIDS, is an important first step in exploring links between health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads and the risk or protective factors for HIV.

The limited research on traditional Haitian health beliefs suggests that health promotion and disease prevention are indistinguishably connected to culture, that biological sex and gender are important in health seeking and provision (Devieux et al., 2009), and that Haitian mothers, as the traditional *poto mitan*, are a valued and significant social influence in transmission of health information and health practice itself (Alexander, 2011; Bergan, 2009; N’Zengou-Tayo, 1998; Schuller & Bergan, 2009).

Traditional Haitian health perspectives include a belief in both supernatural and natural etiologies of illness, a belief in a hierarchy of resort, such that family members are the first to intervene in managing illness and symptoms (unless it is a severe illness) (Adonis-Rizzo & Jett, 2006), a belief that blood is of great importance and central to good health (Meade et al., 2009), and a belief that home remedies for illness and management of symptoms are preferable (Adonis-Rizzo & Jett, 2006; Allen et al., 2013; Goodman, 2005; Martin, Rissmiller, & Beal, 1995). Among traditional Haitian health beliefs as it relates to both preventing and treating illness, is that what helps in this pursuit is drinking traditional herbal teas, praying, taking vitamins, dressing warmly to avoid chill and drafts, and eating foods considered healthy such as garlic and plantain (Adonis-Rizzo & Jett, 2006).

Menard, Kobetz, Diem, Lifleur, Blanco, & Barton (2010) document that particular emphasis is placed on vaginal cleanliness, freshness, and tightness in Miami-Dade County, Florida, including the use of herbs and other botanical and chemical products to ensure those desired states. Also sex and gender roles were found to contribute to the decision to accept injections from non-medically trained Haitian peers in Florida, for purposes of general and reproductive health (Rahill, 2008).

With respect to traditional Haitian health beliefs and HIV/AIDS, research is sparse. Devieux and colleagues (2009) reported gaps in HIV/AIDS knowledge for Haitians, and surveys that have been conducted on HIV transmission factors have not only been few in number, but also have inconsistent results. In addressing this gap, Devieux and colleagues examined the HIV/AIDS knowledge, attitudes, and behaviors of over 43,000 women attending a health care clinic in Port au Prince, Haiti. Results confirmed that although study participants in general were knowledgeable about the risk of HIV transmission through dirty needles and mother to child transmission, inaccurate information persisted about transmission through supernatural pathways as well as through mosquitoes. In response to these conclusions, Devieux and colleagues underscored the necessity of understanding traditional health beliefs when researching Haitian communication of health promotion and disease prevention and noted “young women should be a particular focus for HIV education” (Deviux et al., 2009, p. 567).

In the U.S., there has long been evidence that transnational ties impact traditional health beliefs and practices of Haitian immigrants, such as my targeted sample of mothers and daughters (Martin, Rissmiller, & Beal, 1995). Health beliefs about HIV are influenced by these traditional health beliefs (Malow, Cassagnol, McMahon, Jennings, & Roatta, 2000).

Influence of transnational ties on U.S. Haitian health beliefs and practices

Historically, U.S.-based Haitians have remained committed to their families back home and demonstrated a continual connection via transnational ties (Brodwin, 2001; DeSantis et al., 1999; Huffman, Vaccaro, Zarini, & Dixon, 2014; Lundy, 2011; Orozco & Burgess, 2011; Rahill, 2008; Schiller et al., 1987; Schiller & Fouron, 1999, 2001). Transnationality describes how immigrants stay actively connected with their countries of origin while fully engaging socially and economically in the country of settlement (Schiller & Fouron, 2001). Transnationalism includes engagement in various activities, the movement of people, the transfer of ideas, and the shifting of financial capital across borders. This process may not only facilitate a continual sharing of traditional ways of living, but may also help in the distribution of new practices and norms (Schiller & Fouron, 2001). The reaction of Haitian immigrants in America to the devastating 2010 earthquake that destroyed their home country, and the unprecedented gathering of resources to send back home, serve as further evidence of transnational ties within the Haitian diaspora (Lundy, 2011).

Meade and colleagues (2009) highlighted the importance of transnational ties for Haitian women in West Central Florida seeking health knowledge and care relative to breast cancer and breast health. Further evidence of transnationalism in the geographic area of interest can be seen in the large number of Haitian churches present, the availability of Haitian restaurants, university-level Haitian student organizations, international mission activities, and other community-level Haitian grassroots efforts that support Haiti-based venues.

In the present study, beliefs that Haitian mothers in this study possess about HIV, how it is transmitted and ways to prevent it would be expected to reflect what the mothers learned in Haiti. The influence of transnational ties might also be expected to emerge if mothers consult

with others in Haiti about their health and sexual health and about the health and sexual health of their daughters, as well as in whether or not they rely on plants and or pharmaceutical products from Haiti in modeling and teaching health promotion and disease prevention. Such findings would support the influence of transnationalism in this study's sample.

Theoretical Framework

Symbolic Interactionism.

SI officially developed and emerged in Chicago, Illinois, in the early decades of the 1900s, although it was influenced by several mid-19th century philosophers in Europe (Blumer, 1969; Denzin, 1992). SI has been used extensively in sociological inquiry. Several research scientists influenced the development of SI (Kuhn, 1964). SI emphasizes that human interaction plays the fundamental role in the creation, maintenance, and transformation of culture, knowledge and behavior (Blumer, 1969).

Blumer classified human interaction in the following ways: (1) the behavior of people is based on how they give meaning to the objects in their environment, (2) people define and interpret each other's acts, (3) the way people socially act is constructed through a process of noticing, interpreting, and assessing the environment people find themselves within, and (4) researchers must observe the process by which social action was constructed to effectively analyze it since social action is a continually moving process (Blumer, 1969). Since I conducted a retrospective study, I did not have opportunity to observe in the moment how the process of health and sexual health communication had developed or were developing within the interviewed dyads; however, I did have opportunity to explore the unfolding of this communication during both the focus group of health care providers and Haitian-descendant community leaders who engage Haitian clients, and in the mother-daughter dyad interviews

through the use of prompts and the open-ended questions which permitted furthering of participants' responses.

SI states that people derive meaning through interaction with others in interaction with those who share their social and environmental contexts. This interaction contributes to how people make sense of and respond to symbols such as language, signs, and cultural artifacts (Blumer, 1969; Charmaz, 2014; Hays & Singh, 2012). The derivation of knowledge and truth are grounded in this social environmental interaction and interpretation of signs and symbols (Blumer, 1969). Blumer's addition of *joint action* and *acting unit* to SI enhances understanding of the interactions that occur in complex institutions as well as those that occur in dyadic interaction. For example, interaction is often perceived as occurring between one or two people; but interaction is also between individuals and the social institutions with which they interact. Thus, interaction becomes a social justice issue, such as when certain racial or socioeconomic groups experience health disparities in relation to others. *Joint action*, as an aspect of SI, when applied to this study, stipulates that when mothers and daughters are communicating with each other about sexual health, that communication takes place in a larger context (West Central Florida) and involves actors beyond the mothers and daughters (health providers who participated in the focus groups). SI's *acting unit* in relation to this study means that separate entities within a particular social dyad or group can act singularly and /or together. Specifically, an individual's actions can influence his or her own social reality as well as that of others who are interpreting their verbal messages and behaviors. Concomitantly, an acting unit's positive health behavior can be influenced by others who share their sociocultural context and their interpretations of symbols and language; in turn, the latter interpretation or interaction can actually negatively impact the health of the individual as well as the health of those who exist

and interact in their social context. From an SI perspective, health and sexual health communication between mothers and their daughters constitutes joint action in that they share context within and beyond their relationship, and the acting unit refers to individual mothers and daughters as separate entities within each dyad.

Kuhn maintained that SI was the only major theory “logically consistent with the basic propositions of the social sciences” that addresses cultural variability, creativity, socializability, and modifiability of man, especially in terms of complex correctives to behavior (Kuhn, 1964). Thus, another application of SI in the present qualitative study is in its assumption that health promotion and disease prevention activities are contingent upon cultural norms learned and transmitted by interaction with others. As a reminder, in the Haitian cultural context, mothers remain the *poto mitan*, the central post, and, thus, a central influence on the family, the community, the homeland, and the Haitian diaspora (Alexander, 2011; Bergan, 2009; N’Zengou-Tayo, 1998; Schuller & Bergan, 2009). Through the lens of language and symbols, meaning is derived on what is useful and what is valuable in terms of health seeking behavior. This perceived meaning is either confirmed or denied based on continual interactions in the shared-language environment through subjective interpretation. This identified meaning leads to the construction or reconstruction of roles and behaviors that come into play in social situations with respect to health promotion and disease prevention (Rahill, 2008; Strykes, 2001).

Consonant with SI, the current study triangulated key concepts from the IMB model to develop a conceptual framework for understanding health communication within Haitian mother-daughter dyads.

Information-motivation-behavioral skills model.

Constructs from IMB are important in this study because the theory suggests that “sexual behavior is a function of the individual's information about sexually transmitted infections, pregnancy-related knowledge, attitude and motivation toward sexual activity, and the subsequent behavioral skills essential to refuse sexual intercourse effectively while minimizing the negative consequences that may come with this refusal” (Fisher et al., as cited in Bazargan, Stein, Bazargan-Hejazi, & Hindman, 2010, p.287). IMB is pertinent to the ability of Haitian-descendant young women to negotiate safer sex and other positive behaviors, such as avoiding multiple partners and implementing consistent use of condoms when they choose to engage in sexual activity.

Understanding protective behavior practices, attitudes, and other factors that promote protective behaviors facilitates effective sexual health interventions (Ajzen & Fishbein, 1980; Boyer et al., 2000; Darroch, Frost, & Singh, 2001; W.A. Fisher et al., 2003; Fullerton, Rye, Meaney, & Loomis, 2013; Lescano, Brown, Puster, & Miller, 2005). J.D. Fisher and Fisher (1992) conceptualized a model that takes into account social and psychological factors for comprehending and promoting health-related behavior within the context of HIV risk and prevention, called the information-motivation-behavioral skills model.

The IMB model links a group of causal relationships among three constructs for the elicitation and maintenance of change in health-related behavior (J. D. Fisher & Fisher, 1992, 2000; W.A. Fisher & Fisher, 1993, 1998; W. A. Fisher et al., 2003; Fullerton et al., 2013). These constructs comprise information, motivation and behavior. *Information*, refers to an individual's relevant knowledge of specific facts regarding performance of health behavior and promotion and relevant the process of how someone learns, discovers, understands, or solves problems (W.

A. Fisher et al., 2003). In this study, *information* would include discovery of information from the mothers regarding knowledge of how HIV is transmitted, specific methods of preventing infection and transmission, and how one decides to engage in health-related actions, such as actively seeking HIV testing (Misovich, Fisher, & Fisher, 1996). Crucial to understanding information as a determinant of health behavior are information deficits, the presence of misinformation, and thought patterns that impede health-seeking behavior. The latter can stem from education programs that provide erroneous or even dangerous health information, whether intentionally or unintentionally (W.A. Fisher & Fisher, 1998). Misinformation, especially among youth, can also occur within the context of interaction with peers, sexual partners and caregivers such as mothers in this study. *Motivation* in the IMB model refers to personal motivation and social motivation, as well as emotional responses to sexual cues. Personal motivation refers to how one would view their own attitudes about health seeking, or avoidant, behaviors as well subjective perceptions regarding the importance of the behavior. Social motivation underscores the presence and relevance of social support/reinforcement for engaging in and maintaining health-promoting behavior in familial and social circles. In the larger community contexts, social motivation includes responding to overall social norms for healthy sexuality (Fisher et al., 2003; Fullerton et al., 2013). In the current study, knowledge about motivation would be reflected in the responses of daughters regarding the application of health and sexual health information obtained from their mothers and external sources. *Behavioral skills*, as the final pathway to risk-reduction behavior, refer to the objective abilities to perform health-behavior activities, such as how to use prophylaxes properly, how to distinguish between consensual and non-consensual sex, and how to negotiate for safer sex. Behavioral skills also include the notion of self-efficacy, i.e., the individual's belief that she possesses the capacity for enacting these skills. The

combination of skills and the belief in their capabilities for enacting these skills determines whether an individual will be able to engage in healthy behaviors effectively (Fisher, 1997; French & Holland, 2013; Kalichman et al., 2006; Malow et al., 2009). In this study, it was important to look for indications of possession of knowledge of health promoting and disease preventing behaviors, and how knowledge impacted resulting behaviors.

Empirical support for the IMB approach has demonstrated its relevance for positive behavior change across populations. (J. Fisher & Fisher, 1992; Fisher, Fisher & Harman, 2003; Fisher, Fisher, Williams, & Malloy, 1994). The triangulation of SI and IMB in this study was utilized to heighten understanding of what information is possessed by mothers relative to health and sexual health; how that information is conveyed to their daughters; what, if any, motivation exists to benefit from the information transmitted from mothers to daughters; and if the information results in behavior change that impacts disease prevention and health promotion in the daughters.

Chapter 2 provided a summary of the HIV/AIDS pandemic as a context for this present study, and factors hindering the acquisition and effective use of HIV knowledge among Haitian women. Next, a discussion of traditional Haitian health beliefs concerning health and sexual health was presented, followed by a review of the influence of transnational ties on U.S. Haitian health beliefs and practices. The chapter concluded with a review of the theoretical framework used for this study, i.e., SI and the IMB model, and how they related to the aims of this research. Chapter 3 discusses the methodology of this study.

CHAPTER 3: METHODOLOGY

This chapter summarizes the study methods including (1) an overview of the study, (2) the analytic approach, i.e., constructivist grounded theory, (3) the usefulness of constructivist grounded theory in this study, (4) the research questions, (5) the sampling and recruitment procedures, (6), participant eligibility, (7) steps taken to ensure human subjects protection, (8) data collection instruments, (9) study procedures, (10) the data analysis process, and (11) steps taken to maximize trustworthiness of findings.

Overview of the Study

As a reminder, the goal of the present study was to enhance knowledge and address gaps in the literature on health communication and HIV risk among mothers and daughters. Specifically, I investigated how Haitian-descendant mothers in West Central Florida communicate what constitutes health and sexual health to their daughters, including messages of health promotion and disease prevention. To accomplish this, I engaged in a two-phase process in which I first conducted a focus group interview consisting of health care providers and Haitian-descendant community leaders who engage Haitian- descendant clients in the region as key informants. Key informants are people who know and can talk about a community, and provide details about the community, and act as experts (Fetterman, 2008; Stacey et al., 2004). As indicated earlier, findings from the analysis of the focus group transcript contributed to the refinement of a previously developed semi-structured interview protocol that was used to interview Haitian mother–daughter dyads in the area; this process is supported in qualitative literature (Krueger and Casey, 2015).

Of particular interest in this study was identifying how HIV/AIDS prevention knowledge is transmitted between Haitian mothers and their daughters, since Haitians in Haiti and in the U.S. diaspora bear a disproportionate burden of HIV/AIDS diagnoses (UNAIDS, 2017d). I was further interested in discovering the extent to which social context and transnational ties contribute to this discourse among Haitian mother–daughter pairs.

Approach

An exploratory sequential qualitative approach was used in this study because it afforded two distinct but socially connected sources of data about the topic of interest (i.e., focus groups of Haitian community leaders and interviews of mother-daughter pairs) and provided flexibility in probing participant responses on this potentially sensitive subject (Hays & Singh, 2012; Charmaz, 2014; Creswell, 2007). Lincoln and Guba (1985) submitted that the process of qualitative research involves the development of explanations of social phenomena, with minimal a priori expectations. Similarly, Denzin and Lincoln (2005) described qualitative research as “a situated activity that locates the observer in the world” (p.4), and maintain that qualitative research design as a research method allows the researcher “to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 2005, p.3). Based on these assertions, this study’s objectives of exploring and describing beliefs, attitudes, perspectives, and experiences of Haitian mothers and their daughters was best achieved using a qualitative method that first yielded knowledge of common health beliefs shared by members of social networks. A quantitative approach would not have enabled the procurement of complex textual descriptions of how Haitian mother–daughter dyads experience health-promotion and disease-prevention communication or contributed to understanding these phenomena in as detailed or rich a fashion as did the selected qualitative design.

Previous studies exploring Haitian health beliefs have not focused on mother–daughter sexual health communication, nor have they drawn attention to important dynamics within these pairs of individuals (Allen et al, 2013; DeSantis et al, 1999; Gomez et al, 2009). Incorporating a qualitative design to this study allowed for sufficient attention to be given to health and sexual health within and across the dyads with the hope that it may influence disease-prevention and health-promotion interventions for this population of concern. In the present case, because the HIV/AIDS pandemic is in part a reproductive health issue, prompts developed from analysis of the focus group transcript were used during the interviews of mothers and daughters in order to evoke what the Haitian mothers told their daughters about sexual and reproductive health, including intimate hygiene practices, the onset and management of menses, other health practices and STIs (Cohen, Bukusi, Rees, & Blanchard, 2013; Schiller & Fouron, 2001; Stevens, 2008).

Table 3.1 briefly outlines some other differences between quantitative and qualitative research designs that justify this study’s approach.

Table 3.1

Comparison of Quantitative & Qualitative Research Approaches Applications to present study

Structure/ Format	Quantitative	Qualitative	Application to Present Study
General framework	Seek to confirm hypothesis about phenomena*	Seek to explore phenomena about which there is little available scientific knowledge*	Exploration of HIV knowledge and health/sexual health communication of Haitian mothers and daughters
	Instruments use more rigid style of eliciting and categorizing response to questions*	Instruments use more flexible, iterative style of eliciting and categorizing responses to questions*	Use of semi-structured interview protocol to allow researcher flexibility and to encourage authentic participant responses
	Use highly structured methods such as questionnaires, surveys, and structured observations*	Use semi-structured methods such as in-depth interviews, focus groups, and participant observation*	Use of semi-structured focus group guide and semi-structured interviews of mother–daughter permitted procurement of knowledge not previously documented in available literature
Analytical objectives	To quantify variation*	To describe variation*	Identification of potential differences between mother and daughter perspectives and knowledge
	To predict causal relationships*	To describe and explain relationships*	Analysis of content of mother–daughter interviews used to describe relationships between what knowledge was offered by mothers, and daughters’ understanding of the information
	To describe characteristics of a population*	To describe individual experiences*	Mother–daughter interviews to describe individual experiences even within the dyads
		To describe group norms*	Focus groups and mother–daughter interviews both describe group norms
Question format	Close-ended*	Open-ended*	Open-ended, permitted use of prompting and development of responses
Data format	Numerical (obtained by assigning numerical values to responses)*	Textual (obtained from audiotapes, videotapes, and field notes) *	Textual-audio tapes and field notes contributed to the data analysis and interpretation
Flexibility of Study design	Study design is stable from beginning to end*	Some aspects of the study are flexible (for example, the addition, exclusion, or wording of particular interview questions) *	Data obtained from focus groups informed the modification of semi-structured interview protocols and informed determination of saturation;

Table 3.1

Comparison of Quantitative & Qualitative Research Approaches Applications to present study

Structure/ Format	Quantitative	Qualitative	Application to Present Study
	Participant responses do not influence or determine which questions the researchers ask next and how*	Particular responses affect which questions the researchers ask next and how*	Particular responses in both focus groups and mother–daughter interviews affected which questions were asked next and the appropriate use of prompts
	Study design is subject to statistical assumptions and conditions*	Study design is iterative, that is, data collection and research questions are adjusted according to what is learned*	Iterative study design permitted modification of study questions so that as new knowledge emerged, subsequent participants were asked additional questions

Note. Adapted from “Qualitative Research Methods Overview” by N. Mack, C. Woodsong, K.M. MacQueen, G. Guest, and E. Namey, 2005, *Qualitative Research Methods: A Data Collector’s Field Guide*, p. 3. (*denotes quotation from Mack et al., original table cited)

Grounded Theory

The use of grounded theory in qualitative research has been cited as one of the most popular methods (Charmaz, 2014; McCallin, 2009; Parahoo, 2009). Patton (2002) describes grounded theory as the most influential tradition in all of social science research.

Grounded theory refers to both a qualitative research method, as well as the product of that inquiry (the theory) (McCallin, 2009). Glaser and Strauss (1967) developed this qualitative research method as a way to develop theory from the “ground” up (from collected data). This approach was in contrast to what had been the traditional method of starting with hypotheses that would be rejected or accepted. Glaser and Strauss (1967) maintained the researcher must keep an open mind so that discovery of new phenomena in the data was feasible. They maintained the researcher must take an inductive approach by developing codes, and then categories of codes, directly from the data, which would lead to theory building from the categories; this was in contrast to the traditional “testing” of hypotheses. When there is scant information about a

research topic of interest, and the development of a theory is desired, grounded theory is particularly useful (Gibbs, 2012). Such was the case in this exploratory study. Grounded theory, with its inductive, emergent process, has the goal of constructing “a picture that draws from, reassembles, and renders subjects’ lives” (Charmaz, 2003, p. 270). The final product of a grounded theory study is to deliver an integrated and comprehensive theory that explains a process (Connelly, 2013).

Constructivist Grounded theory was selected because the intent of the present study was to discover a theory directly from the data. Creswell (2007) states the intention of grounded theory is to generate a theory, “an abstract analytic schema of a process” (p. 63). The present study incorporated a constructivist grounded theory design, a method that evolved from Glaser and Strauss’ classical grounded theory (1967). Prior to detailing key concepts in constructivist grounded theory, a description of the development of grounded theory is presented.

History and development of grounded theory.

The development of grounded theory methodology has occurred over the last 50 years (Morse, Stern, Corbin, Bower, Charmaz, & Clarke, 2009). Figure 3.1 illustrates a comparison of the three major prevailing developments: Classical, Straussian, and Constructivist grounded theory.

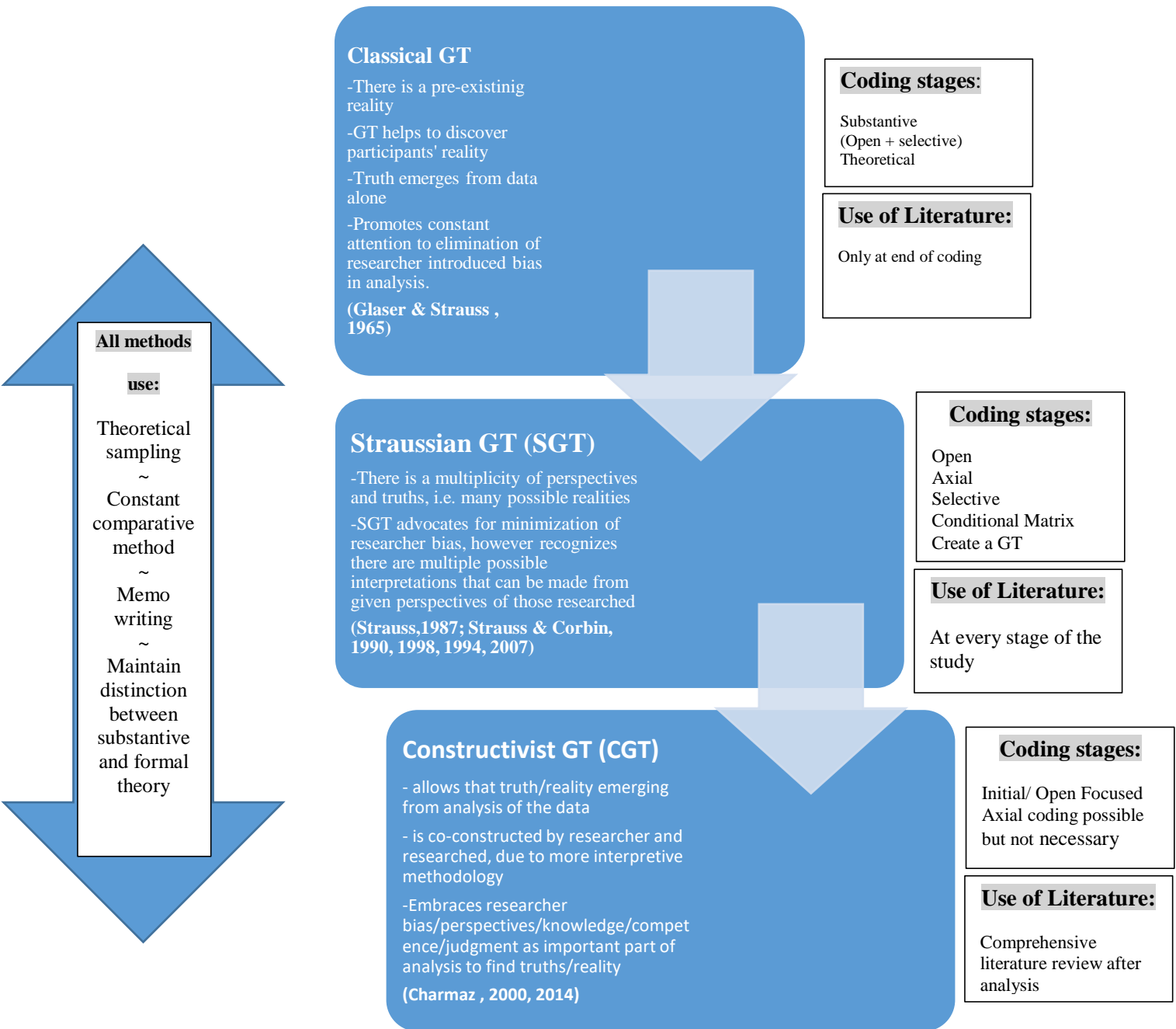


Figure 3.1. Comparison of Classical, Straussian, and Constructivist Grounded Theory.

Constructivist grounded theory as an analytic framework.

Related to grounded theory, constructivist grounded theory is suitable when the researcher has an aim of understanding the process of how people construct meaning from their intersubjective experience, i.e., how one's subjective interpretation of events is influenced by those of others in their environment (Charmaz, 2014; Creswell, 2007; Suddaby, 2006). The constructivist view provides a systematic and intentional approach to inquiry that includes integration of subjective experience with social contexts in the analysis (Charmaz, 2005). In constructivist grounded theory, researchers necessarily work through a process of intentionally examining their frames of reference, consciously determining their potential biases and influence on the study, and purposely asking themselves questions that challenge the findings as they emerge from the analysis of the data (Charmaz, 2014). Thus, constructivist grounded theory adheres to the underlying assumptions of classic grounded theory, but permits a reflexive stance on ways of reporting what is studied; it stipulates that the researcher's own perspectives and influence cannot be disentangled from the research being conducted or from the analysis and findings. Such a process facilitates interpretation of complex phenomena and allow for emergence of theory without *a priori* assumptions. Despite the relevance of the researcher in constructivist grounded theory data analysis, the data are re-examined constantly to ensure that researchers "do not apply an analytic frame to the data" during re-examination –thus minimizing bias (Charmaz, 2014, p. 149).

The application of constructivist grounded theory in this study was to generate a substantive knowledge base that was grounded in the dyads' personal experiences and histories, detailing their unique perspectives regarding health sexual communication, including HIV prevention. In this study, constructivist grounded theory contributed to interpretation of health

and sexual health communication that occurs within the targeted dyads, incorporating the researcher's knowledge, skills, and judgment in the analytic process. Specifically, constructivist grounded theory in the present study acknowledges that the researcher brings an interpretive frame of reference to the study and welcomes the researcher's sharing in the construction of knowledge as it stems from the data. Hence, conceptual categories of understanding the phenomena of interest arise through interpretation *of* data rather than deriving *from* them.

Of importance in a constructivist grounded theory approach to data analysis are the concepts of *implicit language, explicit and implicit meanings and actions and constant comparative analysis*. *Implicit* meaning is that which is hidden, implied and not plainly expressed. *Implicit language* is that dimension of language that has the "capacity to evoke affective experience" and that which "uncovers subjective meaning ...and affective experiences" (McVey, Lees, & Nolan, 2016). *Explicit meaning and actions* are those that are specifically stated, clearly detailed, understandable and relatively straight-forward. In the present study, these concepts from constructivist grounded theory enabled the interpretation, for example, of the implicit message that a Haitian mother was attempting to communicate to her daughter when she reported insisting that the daughter go to church and be a good girl as part of sexual health communication. That interpretation is consistent with Charmaz's (2017) explanation that the analytic process requires the constructivist grounded theory researcher to "move back and forth" between theorizing and collecting data (p. 41). This process is the technique that she and other grounded theorists refer to as the *constant comparative method* (Charmaz, 2014).

Also of importance in constructivist grounded theory are the concepts of initial and focused coding.

Initial coding.

The initial phase of coding in constructivist grounded theory involves putting a name to each word, each line, or each segment. Constructivist grounded theory demands that careful attention is paid to acknowledge that researchers hold bias, prior ideas and skills, and as such must try to remain open to seeing what can be learned from the data. Researchers must make an effort to learn and understand how these biases influence the current view of the data (Charmaz, 2014; Charmaz, 2017). Grounded theory states initial codes best use words that denote actions, called gerunds, which “not only give the reader a sense of people’s intentions and concerns, but they also specify and anchor the analysis” (Charmaz, 2008, p. 406). A gerund is a verb form functioning as a noun (Quirk, Greenbaum, Leech, & Svartvik, 1985). An example of the use of a gerund is *speaking did not come easily*. As the use of gerunds allows the researcher to code for action and process, the use of gerunds reduces the tendency to code for types of people, focusing the data to the individual level. If types of individuals are coded, rather than actions, the risk of minimizing variation may occur (Charmaz, 2014). Charmaz further reminds constructivist grounded theorists that the “aim is to code for possibilities rather than ensuring complete accuracy of the data” (p. 120). The coding process of grounded theory dictates that researchers “remain open, stay close to the data, keep codes simple and precise, construct short codes, preserve actions, compare data with data, and move quickly” (Charmaz, 2014, p. 120).

Focused coding.

Focused coding is the next phase in Constructivist grounded theory. Studying and assessing initial codes, determining what they say, and comparing the codes between each other, defines the focused-coding phase. Grounded theorists are concerned with how the initial codes compare with the data and what patterns are revealed. When initial codes are identified that best

account for the data, they are raised to the level of focused codes and may, in fact, reveal gaps in the data (Charmaz, 2014). Focused coding is the significant step for managing the emerging analysis. Focused codes fit tightly with the data and are more concerned with accuracy than initial codes (Thornberg & Charmaz, 2012). In constructivist grounded theory, focused coding and categorizing are crucial steps in data analysis and detailing of findings (Charmaz, 2014).

Figure 3.2 illustrates the process of constructing grounded theory from the constructivist perspective used in the present study. Following the figure is a list of the research questions posed in the present study.

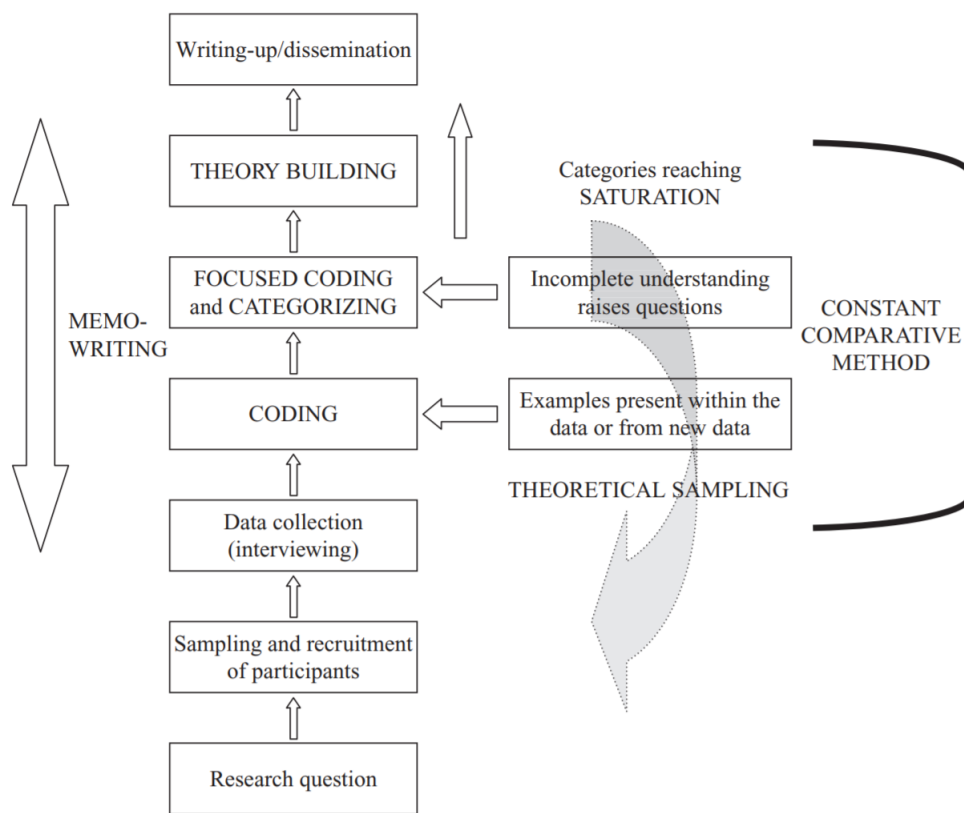


Figure 3.2. Visual representation of a grounded theory. Original figure appeared in Tweed and Charmaz (2012, p.133). Copyright permission granted from Wiley & Sons, Inc.

Research Questions

As previously stated, the following three research questions were addressed in this qualitative exploratory study:

1. What do health care providers or community-level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents?
2. What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?
3. What messages do Haitian daughters in West Central Florida *receive* from their mothers about what constitutes health and sexual health?
 - a. Are the daughters hearing what the mothers are attempting to convey?
 - b. Do Haitian daughters have intention to transmit health and sexual health communication to their own daughters? If so, how similar or different will such communication be compared to what they have received from their own mothers?

Sampling and Recruitment

Consistent with a qualitative research design and with this study's objectives, I utilized venue-based and purposive sampling as a strategy to first recruit a purposive, targeted sample of focus group participants consisting of health care providers and Haitian-descendant community leaders as key informants who engage Haitian-descendant clients in their West Central Florida venues. I then used the same methods to recruit Haitian women and their adult daughters (over 18years) who reside in West Central Florida. Snowball sampling was employed as some participants referred others who were eligible, interested and available.

The initial targeted focus group sample size was seven participants, which is within the recommended optimal size for focus-groups in research; a sample size of 6-10 participants is considered manageable and offers the opportunity for comprehensive and useful discussion among participants (Gaizauskaite, 2012; Krueger & Casey, 2015; Linhorst, 2002). Specifically, “the group must be small enough for everyone to have an opportunity to share insights and yet large enough to provide diversity of perceptions” (Krueger & Casey, 2015, p. 10). The final sample size of the focus group was seven participants. The targeted sample size for mother–daughter dyads was 10 pairs. However, saturation was achieved after interviews with eight pairs. This final sample size is well within the range prescribed throughout qualitative methods research literature as an appropriate number for gathering enough information to fully inform grounded theory research (Charmaz, 2014; Creswell, 2007). In accordance with the recommendations for grounded theory, the sample size would have increased if more information was necessary to obtain saturated categories, or a level of detail to support a substantive theory (Charmaz, 2014, Creswell, 2007; Dworkin, 2012; O’Reilly & Parker, 2012). Creswell (2007) described reaching saturation in the data analysis phase of grounded theory research when after gathering additional data, the new information does not deepen understanding, when in fact nothing more is added to the analysis. As such, categories in this study were considered saturated when the sampling and the data collection process failed to offer any data that provided additional information, which happened at 16 individual interviews (Charmaz, 2014).

To recruit the purposive sample of focus group participants and mother daughter dyads, assistance was sought from the targeted area’s Haitian community, both from area leaders and employees at Haitian-serving organizations who have a history and experience serving Haitian

immigrants in West Central Florida. I had been working in this community for nearly 15 years and enjoyed lengthy relationships with Haitian service organizations, faith-based organizations with Haitian members, health centers that Haitians frequent, and immigrant and refugee service providers. I extended verbal invitations to potential participants, and the University of South Florida Institutional Review Board (IRB) approved an informational flyer that was distributed at the aforementioned organizations. The recruitment flyer is attached as Appendix A of this proposal.

Participant Eligibility

Inclusion criteria for focus group participants were individuals aged 18 years or older whose agencies, community-based organizations or clinics serve Haitian-descendant clients who reside in the targeted Haitian community. Inclusion criteria for interviewees in the mother–daughter dyads included: (1) Haitian mothers who were born in Haiti, and (2) adult daughters aged 18 or older who were born either in Haiti or in the United States. Both members of each dyad had to live in the geographical area of West Central Florida, including the various geographical enclaves of Tampa, St. Petersburg, Clearwater, Orlando, and other small towns nearby. The mothers and daughters did not have to reside together; however, both mother and daughter had to consent to participation for their dyad to be eligible. Due to the fact that I do not speak Haitian Kreyòl, all focus group and mother–daughter dyad interviews had to be conducted in English, so all participants needed to meet the additional criteria of fluency in English. Hence, a limitation of this study was that it did not include participants who do not speak English, and who might be considered to have less information about sexual and reproductive health typically available in schools and clinics in the U.S.; such individuals would likely be less acculturated to

U.S. norms and values and would likely have less access to information that is available only in the English language (Rahill, 2008).

Human Subjects Protection

Human subjects protection in the present study involved (1) procuring IRB approval from USF; (2) taking specific measures to insure confidentiality and protection of privacy, and (3) minimizing harm, i.e., insuring informed consent. These safeguards are required in the IRB application process and are summarized below.

Informed consent.

Informed consent ensures clear communication to the study participant of the intent of the research and seeks permission to collect data from them (DiCicco-Bloom & Crabtree, 2006; Hays & Singh, 2012; Locke, Spirduso, & Silverman, 2014). The National Association of Social Workers (2017) remind social workers that the absence of informed consent procedures in the type of research design is a breach of the field's *Code of Ethics*. The following procedures were approved by the USF IRB and constituted steps to insure an informed-consent process.

Interviews began with a statement that the entire process was voluntary and confidential. Participants were instructed of their role in terms of time and effort and informed they may stop at any time without compromising their membership in or services they receive from the referring organization. Lincoln and Guba (2013) also recommended that if a participant chooses to withdraw from the inquiry, he or she would receive all relevant data back in his or her possession; this study was prepared to followed this recommendation, however, no participant chose to withdraw at any time. Verbiage in the informed consent elucidated that the applicant must be permitted to take as much time as needed to review the materials. I read aloud the IRB-approved informed consent form exactly as written to each participant, and provided an

opportunity for participants to ask questions. I obtained signed consent before conducting the interviews and provided copies to participants.

Copies of the informed consent forms provided for each participant category (mother, daughter, or focus group participant) are attached as Appendix B, C, and D, respectfully.

Confidentiality and protecting privacy.

Assurance of confidentiality and privacy of the interviewee and of the information they share are ethical issues that must be addressed in any research with human subjects (DiCicco-Bloom & Crabtree, 2006; Hays & Singh, 2012). In the present study, confidentiality was maintained and the anonymity of participants insured in the following manner: an anonymous identification number was assigned to each participant (Ruel, Wagner, & Gillespie, 2016). No personal information led back to the participants. Participants were informed of the measures taken to ensure confidentiality and privacy. As detailed in the informed consent form, audio recordings, transcripts, and any other identifying information of participants was not shared with anyone other than members of my dissertation committee. All study materials were kept in locked file cabinets within my locked office. Electronic data were password-protected and the computer was locked in my office. The data will be kept for five years after the report has been submitted, in keeping with University of South Florida (USF) IRB guidelines (2016).

Minimizing harm.

An ethical responsibility of human subject research is minimizing harm, especially in research that involves vulnerable populations such as underrepresented or marginalized groups (Creswell, 2007; Hays & Singh, 2012). The first step in guarding against participant harm was obtaining University of South Florida IRB approval for the study, which dictates adherence to confidentiality and privacy protections.

As stated in the USF IRB (2016) informed consent form, the research was considered to be at minimal risk, meaning the risks associated with participation in the study were not greater than those faced by participants in their daily lives.

As stated in the USF IRB *Policy and Procedure Manual* (2016) it is unlawful in the state of Florida for any health care provider to “offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash, or in kind, for referring or soliciting patients,” and I respected this mandate (p.102). However, participants of the mother–daughter dyads were compensated for their time with a \$25 Wal-Mart gift card. The gift card was presented to the participant when the interview ended, regardless of when the participant decided to conclude. Participants were aware of this, as it was outlined in the informed consent. Focus group participants did not receive compensation and no costs were incurred by any participants. The monetary incentives in this study were provided by the USF College of Behavioral and Community Sciences.

There were no additional known benefits for this study’s participants, but benefits to society include an increase in knowledge related to better understanding health promotion and disease prevention for Haitian women. Benefits for focus group participants included opportunities for professional network building.

Data Collection Instruments

Consistent with constructivist grounded theory detailed above, data collection instruments for this study included participant-specific (focus group members, mothers, and daughters) semi-structured interview guides (Charmaz, 2014; Charmaz, 2017; Creswell, 2007). Semi-structured interview guides are useful when a researcher wishes to explore a topic in detail and explore attitudes and feelings about specific areas, without constraining participants’

responses (Padgett, 1998). The semi-structured interview guides comprised open-ended questions and prompts that ensured a minimum number of domains pertinent to the study's objectives were addressed, such as what participants considered important life messages and what important messages had mothers given and daughters learned while communicating with each other about health, sex, and sexual reproductive health. Whereas the interview schedule relied on this preset list of questions, in keeping with constructivist grounded theory, throughout the interview, new areas of concern and topics of interest were explored and incorporated into the interview if they arose (Charmaz, 2014; Charmaz 2017).

Appendix F contains the complete semi-structured interview guide for the focus group and Appendices G and H contain the semi-structured interview guides for Haitian daughters and mothers consecutively, which had been informed by the interview data of the focus group.

The use of an Olympus model WS823 digital audio recorder guaranteed quality audio taping for accurate transcription and analysis. Audio equipment did not fail in this study at any time. Copies of the data collection instruments are attached in Appendices E, F, and G.

Study Procedures

Recruitment.

Recruitment flyers were broadly distributed to the aforementioned faith-based and community-based organizations. This broad distribution included the added benefits of increasing the range of respondents, ensuring diversity of response, and ensuring the variability of participants recruited.

Simultaneous data collection and analysis.

Because qualitative inquiry is an emergent design, research questions and data sources can change as the research progresses (Charmaz, 2014; Glaser & Strauss, 1967; Strauss &

Corbin, 1998). Thus, researchers conducting grounded theory typically collect and analyze data simultaneously (Hays & Singh, 2012). This process of concurrent data collection and analysis maximizes the extent to which the researcher can obtain clarification on the process of data collection and analysis, thus maximizing trustworthiness. In the present study, data collection and analysis was concurrent, beginning with the focus group, and with each individual interview. All interviews were analyzed as they were completed, which also allowed for further exploration of emerging themes.

Audio recording of focus groups and interviews.

The study procedures also comprised audio-recorded, semi-structured, in-depth, qualitative interviews of targeted key informants in a focus group and mother–daughter dyad interviews analyzing particular responses within, between, and across interviews and the focus group. Separate interviews were conducted because I wanted to explore information retention and what made sense at the time of health information transmission. The focus group took 75 minutes and interviews of individual mothers and daughters lasted an average of 30–45 minutes. The focus group was conducted in a conference room at the University of South Florida School of Social Work. The interviews of individuals in the mother–daughter dyads were conducted either at the participants’ homes or at a participant- chosen community venue that they determined was safe, private, and convenient.

Transcription of audio-recorded data.

I transcribed the focus group interview and individual recorded interviews into a Word document, and each transcription took approximately five hours to complete. The transcriptions were then uploaded to ATLAS.ti® and saved as a primary document. From there, data analysis began.

Data Analysis

The use of constructivist grounded theory as an analytic approach was to discover knowledge that adds to my understanding of the process by which Haitian mothers and people construct meaning from their intersubjective experience, i.e., how one's subjective interpretation of events is influenced by those of others in their environment (SI). Specifically, I was interested in learning how Haitian women and their daughters construct health and sexual/ reproductive health. Charmaz (2006) recommends a systematic but flexible process in coding data (in this case, transcripts of the focus group and of the dyads' interviews). In addition, Straussian grounded theory, described above and which is one of the foundations of Constructivist grounded theory (Strauss & Corbin, 1998) summarizes the goals of grounded theory data analysis as testing theory, effectively handling masses of raw data, considering alternative meanings to phenomena, being simultaneously systematic and creative, and finally, identifying, and finally developing codes that lead to categories, which in turn reveal the emerging theory.

ATLAS.ti®

ATLAS.ti®, a computer based software that supports analysis of textual, graphical and audio data, provided a useful hermeneutic /interpretive framework that enabled systematic viewing of all the transcribed data in one corpus. ATLAS.ti®, facilitated my ability to be flexible and creative, while insuring that my knowledge, skills and judgment were not omitted from the data analysis and interpretation of findings.

ATLAS.ti® has methodological roots in grounded theory (Friese, 2011) and been used successfully in similar exploratory studies investigating health communication (Rahill, 2008; Rosenberg, Leanza, & Seller, 2007; Woods, Paulus, & Adkins, 2015).

Coding using ATLAS.ti®.

Coding refers to a set of techniques that allows the researcher to formulate distinct categories closely related to the data (in this case the content of the focus group and dyadic interviews) and to other categories from the literature about the researched population (Gibson & Hartman, 2014); it is a process that is a first step in the analytic process and the ultimate interpretation of the gathered data (Charmaz, 2014; Gibson & Hartman, 2014). Coding is used to outline what the data are actually telling the researcher.

In constructivist grounded theory, coding refers to “categorizing segments of data that simultaneously summarize and account for each piece of data” (Charmaz, 2014, p. 111). Codes are created to break down the data and conceptualize segments and components that explicate how people enact or respond to events, what meanings they hold, and why these actions and meanings evolved, providing the link to emergent data to develop a theory to explain them. In constructivist grounded theory, researchers work to preserve a stance that they will be open and close to the data, meaning they will seek the emergent codes directly from what is in the data, and they will do this by using codes that are short and precisely related to the data (Charmaz, 2014). As indicated in Figure 3.2 above, constructivist grounded theory consists of two phases of coding: initial and focused coding, followed by theory building. Constant comparative analysis allows the researcher to return to coding if saturation of coding is not achieved.

Consistent with Constructivist grounded theory, I employed a flexible coding approach utilizing *initial and focused* coding. ATLAS.ti® enabled me to view and code simultaneously the primary documents (transcribed focus group or interview data), to label segments of text line-by-line, as recommended to researchers using constructivist grounded theory (initial coding), to create a list of each individual code, to create links between the codes that illustrate relationships

among them (focused coding), and to recognize and build a theory about health sexual communication between the dyads. It also allowed me flexibility in renaming codes or categories as the analytic process proceeded and new data emerge that clarified initial codes and that elucidated relationships between codes and the categories that emerged during focus coding. It allowed me to ascertain the relevance of initial codes in that it enable me to obtain the report of how grounded codes were (number of quotations attached to a particular code), and how dense codes were (number of other codes to which a particular code is linked). In theory building, the sixth phase of the constructivist grounded theory model, ATLAS.ti® provided a structured and easily managed framework for viewing categories and codes and for retrieving quotations, thus facilitating the development of theory about health promotion and disease prevention in the targeted sample. Following is a description of how to maximize trustworthiness in qualitative inquiry, followed by how ATLAS.ti® facilitated that process.

Maximizing Trustworthiness

Ensuring trustworthiness of a research project and its results leads to confidence that the findings are reliable and can be trusted (Hays & Singh, 2012). Part of enhancing trustworthiness in a qualitative study such as this one is providing vividness or a thick description (Whittemore, Chase, & Handle, 2001). A thick description refers to the detailed account of the research process and resulting new knowledge, allowing a thorough and exhaustive description of as much information as possible, resisting attempts to write “thinly”, meaning lacking detail (Hays & Singh, 2012, p. 212). Thick descriptions may include components such as (1) the research tradition and why it was chosen, (2), listed research questions and the purpose statement, (3) data analysis steps, (4) coding challenges and how coding developed, (5) participant verbatim quotes,

(6) researcher notes, (7) professional, ethical, and cultural implications of the findings, and (8) use of trustworthiness strategies (Creswell & Miller, 2000). These are all provided herein.

In qualitative inquiry, trustworthiness is often compared with reliability and validity of quantitative methods. Lincoln and Guba (1985) detailed four general criteria for insuring trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability. Following is a description of these four strategies and their application in the present study as well as a summary of terminology used by researchers using constructivist grounded theory as an analytic framework to denote criteria for insuring trustworthiness.

Credibility.

Lincoln and Guba (1985) compared credibility to internal validity in quantitative studies. Credibility, in the context of qualitative inquiry, refers to the accuracy and representativeness of the study data, and demonstrates strong logical links exist between the data collected and the analysis (Charmaz, 2006; Lincoln & Guba, 1985). Demonstrating credibility indicates that the researcher's work reflects a deep familiarity with the setting and topic as well as proof in the work that the range, number, and depth of the data are sufficient to merit the research claims.

As previously mentioned, transferability is another measure of rigor and trustworthiness in qualitative research.

Transferability.

Transferability, equivalent to external validity in quantitative methods, refers to the extent to which findings from a qualitative study can be generalized (Lincoln & Guba, 1985, 2013). Transferability is possible when sufficient descriptive data exist so future researchers can assess contextual similarity. Transferability, from a constructivist grounded theory approach refers to the *usefulness* of the particular research contribution in knowledge building and in

making a better world (Charmaz, 2006). In addition to credibility and transferability, dependability is a concept that is central to sound qualitative research.

Dependability.

Dependability in qualitative research refers to the consistency of a researcher's methods (Jensen, 2008; Lincoln & Guba, 1985). The concept is equivalent to reliability in quantitative research (Lincoln & Guba, 1985). Charmaz (2006) utilizes the term *originality*. Charmaz's originality expanded the concept of dependability to include asking whether the research offers new insights, whether the analysis provides a new conceptual rendering of the data, the extent to which the work is significant, and whether the results of the study "challenge, extends, or refines current ideas, concepts, and practices" (p.182). The final criterion for maximizing trustworthiness in qualitative inquiry is confirmability.

Confirmability.

Confirmability entails the degree to which categories portray the fullness of the studied experience (Lincoln & Guba, 1985). Rather than using the term confirmability, Charmaz (2006) uses the term *resonance*, and states a study has resonance if data and findings strongly reflect the participants' perceptions. Biases, motivations, and interests of the researcher are minimized, but are not completely absent (Charmaz, 2006). Constructivist grounded theory indicates an inherent joining of the researcher with the researched to achieve resonance. Resonance of a study asks whether the grounded theory makes sense to the participants, and that it also makes sense to people with similar conditions, and if the study offers deeper insights of their lives and world (Charmaz, 2006). In this study I had two community leaders who also participated in the focus group with whom I confirmed results, i.e. as the analysis proceeded, i.e. that the results resonated with their views, knowledge, and experiences as Haitian women. I also reviewed the results of

the individual interview analyses in conjunction with findings from the focus group and with each other.

A feature in ATLAS.ti® that permitted me to maximize trustworthiness as well as provide an audit trail of the process by which I can claim credibility, transferability, dependability, and confirmability is the code manager. For example, the code *disease prevention* obtained during focused coding was applied to 24 quotations from focus group members, from mothers, and from daughters. One of the codes to which it was linked, *avoiding sex for disease prevention* had 16 quotations attached, illustrating the depth of groundedness and density, whereas *condom use for disease prevention*, also linked to disease prevention, had seven quotations associated with it. Understanding condom use for disease prevention, another code linked to disease prevention during focused coding, had 11 associated quotes. The focused code disease prevention was additionally linked to one other code developed during focused coding, *health promotion*. The number of quotations linked to *disease prevention* and the relevance to the codes to which it was linked, illustrated code groundedness and density for ATLAS.ti® and supported credibility and density as described above. Within the entire corpus of data, including the focus groups, transferability was evident in that sufficient descriptive data from the participant quotes was supported by assertions across the participant groups and substantiated via the member checking process. Described below. So code groundedness and code density in ATLAS.ti® enabled me to demonstrate credibility of my findings, described above as strong logic links between data collected in analysis and illustration that the depth of the data is sufficient to merit claims of trustworthiness. Figure 3.3 provides a network view of the categories DISEASE PREVENTION and HEALTH PROMOTION, followed by strategies for maximizing trustworthiness.

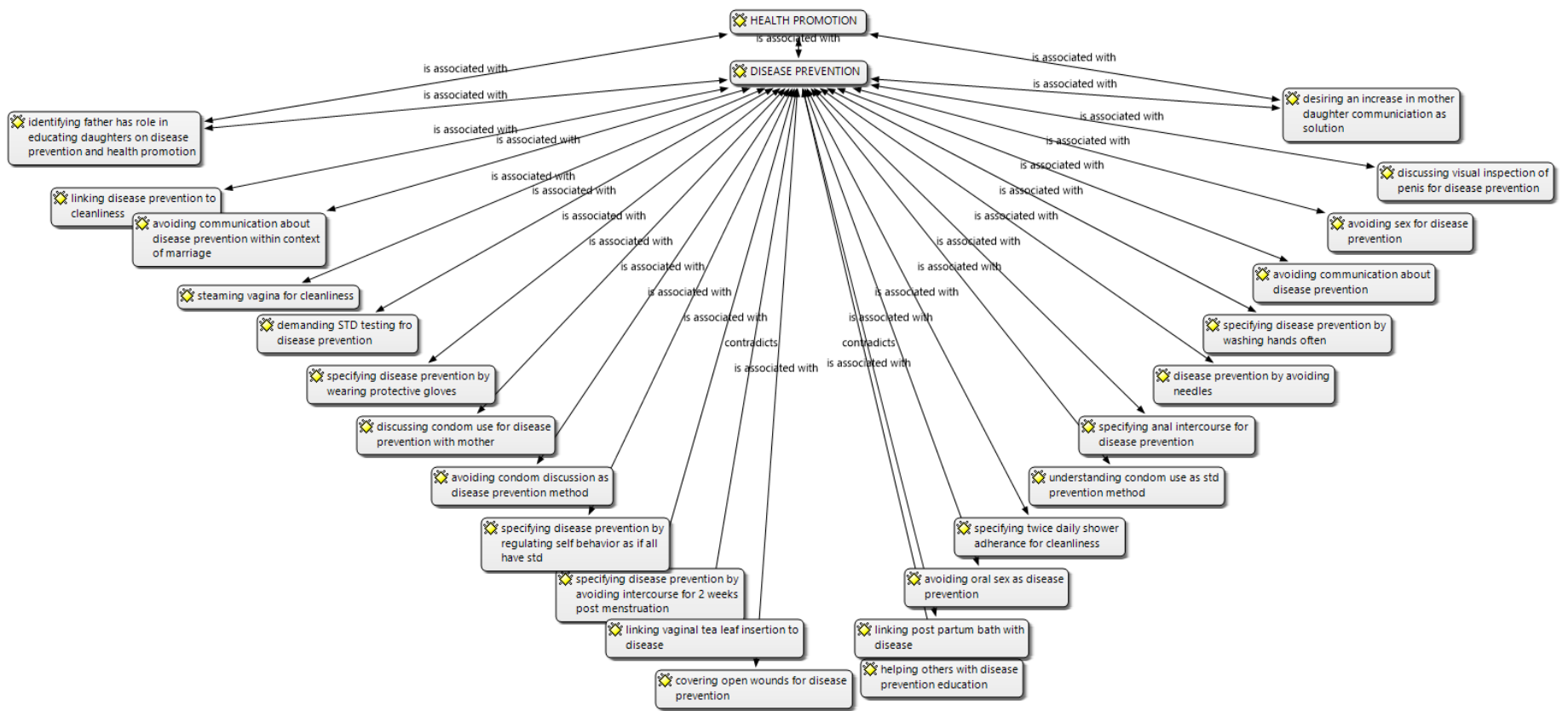


Figure 3.3 Network view sample of the codes DISEASE PREVENTION and HEALTH PROMOTION.

Additional Strategies for Maximizing Trustworthiness

Additional strategies are available for enhancing trustworthiness in qualitative research, including reflexivity of the researcher, member checking, peer debriefing, simultaneous data collection and analysis, and use of an audit trail; these are consistent with constructivist grounded theory itself and with use of the theory as an analytic approach.

Reflexivity of the researcher.

Reflexivity pertains to “the researcher’s scrutiny of the research experience, decisions and interpretations in ways that bring him or her into the process” (Charmaz, p. 344). To maximize researcher reflexivity, I used a reflexive journal that included details of how the study was being conducted, how it related to the participants, and how the participants were portrayed in the writings of the research. The journal also incorporated emergent modification needs for the study, a major aspect of reflexivity (Charmaz, 2014; Morse et al., 2009). The journal enabled me to keep a record of the changes that were occurring both about the research and about the process, and to increase my awareness of unknown preconceptions and bias. Tracking the changes and preconceptions led me to review recordings and previously coded segments in a constant comparative manner. On one occasion, I sensed I was leading the interviewee because I assumed that she possessed this skill, and when I went back to check the recording, I could see how this may have happened.

Member checking.

Lincoln and Guba (1985) stated member checking is a fundamental tactic for establishing trustworthiness. Member checking occurs when researchers consult with participants for “goodness of fit” of the evolving findings with their perspectives or stated understanding of the phenomena of interest (Hays & Singh, 2012, p. 206). In the present study, in addition to constant

consultation regarding evolving findings with my committee Chair, select participants were consulted about emerging findings, checking to make sure the findings “rang true”, and inquiring if I was missing anything, as described in the section above related to confirmability.

Peer debriefing.

Peer debriefing describes the collaboration of the research with other researchers to obtain feedback that enhances credibility (Charmaz, 2014; Creswell, 2007; Hays & Singh, 2012). The process brings in an external reviewer of the study method and processes and provides a critique of methods or process and/or provides an opportunity to reach consensus (Lincoln & Guba, 1985). Adding to iteration and reflexivity, peer debriefing in the current study occurred throughout the study in collaboration with another doctoral candidate and with the dissertation Chair.

The use of an audit trail was also employed in the present study as a strategy to maximize trustworthiness.

Use of an audit trail.

Providing physical evidence of systematic data collection and analysis procedures is not only a necessity of qualitative research because of the complexity and, at times, ambiguity of the data, but is also an asset and a tool that maximizes trustworthiness (Charmaz & Bryant, 2008; Creswell & Miller, 2000). Audit trails, much like client notes in clinical practice, provide a means for significant others to review our work, an ethical responsibility of the researcher (Hays and Singh, 2012). Contents of an audit trail used in this current study include a timeline of research activities, participant contact records, informed consent forms, interview protocols, field notes, memos, and a reflexive journal, as well as dissertation chair and committee meeting notes, transcriptions, and audio recordings. For the present study, the audit trail process included

constant feedback from my dissertation chair throughout the data collection, analysis and interpretation of the data. Also, feedback on the study was provided by my full committee at four different stages in my dissertation process: 1) pre-defense of the proposal, 2) post-proposal defense, 3) pre-dissertation defense, and 4) post-dissertation defense. In this manner, my committee and chair provided feedback addressing whether findings were grounded in data, logic was applied to inferences, methodology was justifiable and appropriate, data was influenced by researcher bias and the extent thereof, and verification strategies were put in place to enhance the trustworthiness of the study (Creswell & Miller, 2000). These collated documents are available upon request.

As discussed above, ATLAS.ti® software program supported analysis of the data and enhanced trustworthiness of the findings. With reference to the statistical analysis of the demographic details of the participant groups, the sample sizes for each group were small enough that it did not necessitate the use of a statistical software program. Tabulations were simply calculated using basic statistics, such as means and proportions.

Chapter III has described an overview of this study and the employed analytic approach. Next, a discussion of grounded theory was presented, including its history and development, as well as a detailed account of constructivist grounded theory and its coding procedures, utilized in this study. Research questions were then presented, along with sampling and recruitment methods, and participant eligibility. Next, human subjects protection related to ethical considerations was reviewed. Next, data collection instruments were reviewed, followed by the study procedures. A discussion of data analysis using ATLAS.ti® software followed. Finally, strategies employed to maximize trustworthiness of the study were then described (following Lincoln and Guba's (1985) four criteria of credibility, transferability, dependability, and

confirmability), along with a discussion of the additional strategies employed to maximize trustworthiness of the study (reflexivity of the researcher, member checking, peer debriefing, and the use of an audit trail). Chapter IV, the Results section, discusses the findings that emerged from this study. Chapter V, the final chapter of this writing, provides a discussion reviewing the purpose and objectives of the study and the relevance of the theoretical frameworks chosen.

CHAPTER 4: RESULTS

Chapter 4 provides results from the qualitative analysis that emerged from the interviews in relation to each research question introduced in Chapter 1. It begins with demographics of both the focus group, and of the individual mother/daughter dyads. The chapter continues with a discussion of the findings with respect to each of the three research questions, supported by illustrative quotes in the study participants own words, followed by a discussion of how the study's findings relate to the theoretical framework utilized in this study.

Participant Demographics

As a reminder, the study comprised a focus group of seven Haitian-descendant health care providers and community leaders as key informants who engage Haitian-descendant clients in the study region. It also comprised individual interviews with ten mother/daughter dyads, equaling 20 participants in total. Saturation was met with eight mother/daughter dyads, and as such, 16 individual dyads were analyzed.

Demographic characteristics of focus group participants.

All seven of the focus group participants were female. Table 4.1 summarizes demographic characteristics of the focus group sample.

Table 4.1

Characteristics of Focus Group Participants (n=7)

I	Age	Country of Birth	Years in U.S.	Years in Florida	Current Residence	Predominance of Male or Female Clients	Whether majority of clients are over 18 years
F01	37	Haiti	25	25	Lutz	female	no
F02	74	Haiti	57	42	Tampa	equal	yes
F03	27	U.S.	27	24	Tampa	male	yes
F04	22	Haiti	15	15	Tampa	female	yes
F05	26	U.S.	26	26	Tampa	equal	yes
F06	52	Haiti	23	23	Tampa	female	yes
F07	abstain	Haiti	35	5	Tampa	equal	yes

The focus group participants ranged in age from 22 to 74 years, with a mean age of 40. One participant abstained from providing her age, stating she prefers to refrain from telling anyone her age. There were five Haitian-born participants (71%), and two participants that were U.S.-born of Haitian descent (29%). The two U.S.-born participants had spent their entire lives residing in the U.S. The average length of time residing in the U.S. for the five Haitian-born participants was 31 years, representing a range of length of time in the U.S. from 15-57 years. All but one of this sample was currently residing in Tampa, Florida (86%). The one focus group member not living in Tampa (representing 14% of the sample), resided in Lutz, Florida, an adjacent town just north of Tampa. Of the participants, four were health care providers (57%), and three were community-level leaders (43%). All of the participants stated they serve both

male and female Haitians, but six of the seven interviewees (86%) claimed at least 50% of their clients were female. Six of the seven participants also claimed that most of their clients were over the age of 18.

Demographic characteristics of mothers.

The sample of interviewed mothers in this study (n=10) were all born in Haiti. Table 4.2 summarizes characteristics of the individual mothers in this study.

Table 4.2

Demographic Characteristics of Participant Mothers (n=10)

Participant Code	Age	Country of Birth	Years in U.S.	Years in Florida	Current Residence	Religion
M1	52	Haiti	22	22	Tampa	Christian
M2	60	Haiti	30	30	Lutz	Baptist
M3	47	Haiti	7	7	Tampa	Evangelical Christian
M4	52	Haiti	28	28	Tampa	Pentecostal
M5	54	Haiti	23	15	Winter Haven	Pentecostal
M6	44	Haiti	4	4	Tampa	Baptist
M7	abstain	Haiti	30	6	Tampa	Catholic
M8	71	Haiti	46	12	Valrico	Jehovah's Witness
M9	41	Haiti	24	24	Tampa	Baptist
M10	47	Haiti	15	15	Bradenton	Baptist

The mean age of the mothers was 52 years old, ranging from age 41 to 71 years. One mother abstained from providing her age. On average, these mothers had been residing in the U.S. for 22.9 years, with a range of U.S. residency from 4 to 46 years. The participants were more spread across West Central Florida than the focus group participants, with 60% (six subjects) living in Tampa, one participant living in Lutz, one in Winter Haven, one Valrico, and

one in Bradenton. They have on average spent most of their years in the U.S. as residents in Florida, averaging 16.3 years living in Florida. Religious affiliation was also captured in the demographic collection, with eight (8) religious affiliations reported: Christian (10%), Baptist (40%), Evangelical Christian (10%), Pentecostal (20%), Catholic (10%), and Jehovah’s Witness (10%).

Demographic characteristics of daughters.

The sample for the interviewed daughters in the mother/daughter dyads (n=10) was the same as the number of mother participants. Table 4.3 summarizes demographic characteristics of the daughter participants.

Table 4.3

Demographic Characteristics of Participant Daughters (n=10)

Participant Code	Age	Country of Birth	Years in U.S.	Years in Florida	Current Residence	Religion
D1	24	U.S.	20	20	Tampa	Christian
D2	37	Haiti	26	26	Lutz	Baptist
D3	20	Haiti	6	6	Tampa	Pentecostal
D4	19	U.S.	19	19	Tampa	Christian
D5	28	Haiti	23	15	Riverview	Atheist
D6	19	Haiti	2	2	Tampa	Baptist
D7	23	U.S.	23	6	Tampa	None
D8	36	U.S.	36	10	Plant City	Jehovah’s Witness
D9	19	U.S.	19	19	Tampa	Baptist
D10	26	Haiti	16	16	Tampa	Christian

In consideration of place of birth, 50% of the daughters (n=5) were born in Haiti, and the remaining 50% (n=5) were born in the U.S. The mean age of the daughters was 25.1 years old, ranging from age 19 to 37 years. Of the five Haitian- born daughters, on average, they had been

residing in the U.S. for 14.6 years, with a range of U.S residency from 2-26 years. The daughter participants were less spread over West Central Florida than the mothers, with 70% (n=7) living in Tampa, one participant living in Lutz, one in Riverview, and one Plant City. They have on average spent most of their years in the U.S. as residents in Florida, averaging 13.9 years living in the state. Self-identified religious affiliation was also captured in the demographic collection, with four religious affiliations reported: Christian (30%), Baptist (30%), Pentecostal (10%), and Jehovah's Witness (10%). One participant stated she does not follow any religion, and one stated she was atheist.

Results of Initial Coding Process

The initial coding process resulted in 433 codes.

Figure 4.1 illustrates the complexity of initial coding and the usefulness of ATLAS.ti® in viewing the initial codes as a network view; it illustrates how unmanageable those 433 codes would be, if the attempt were made to move directly from the initial coding phase to constructing theory about the topic of interest, i.e., health promotion and disease prevention communication in our sample(s).

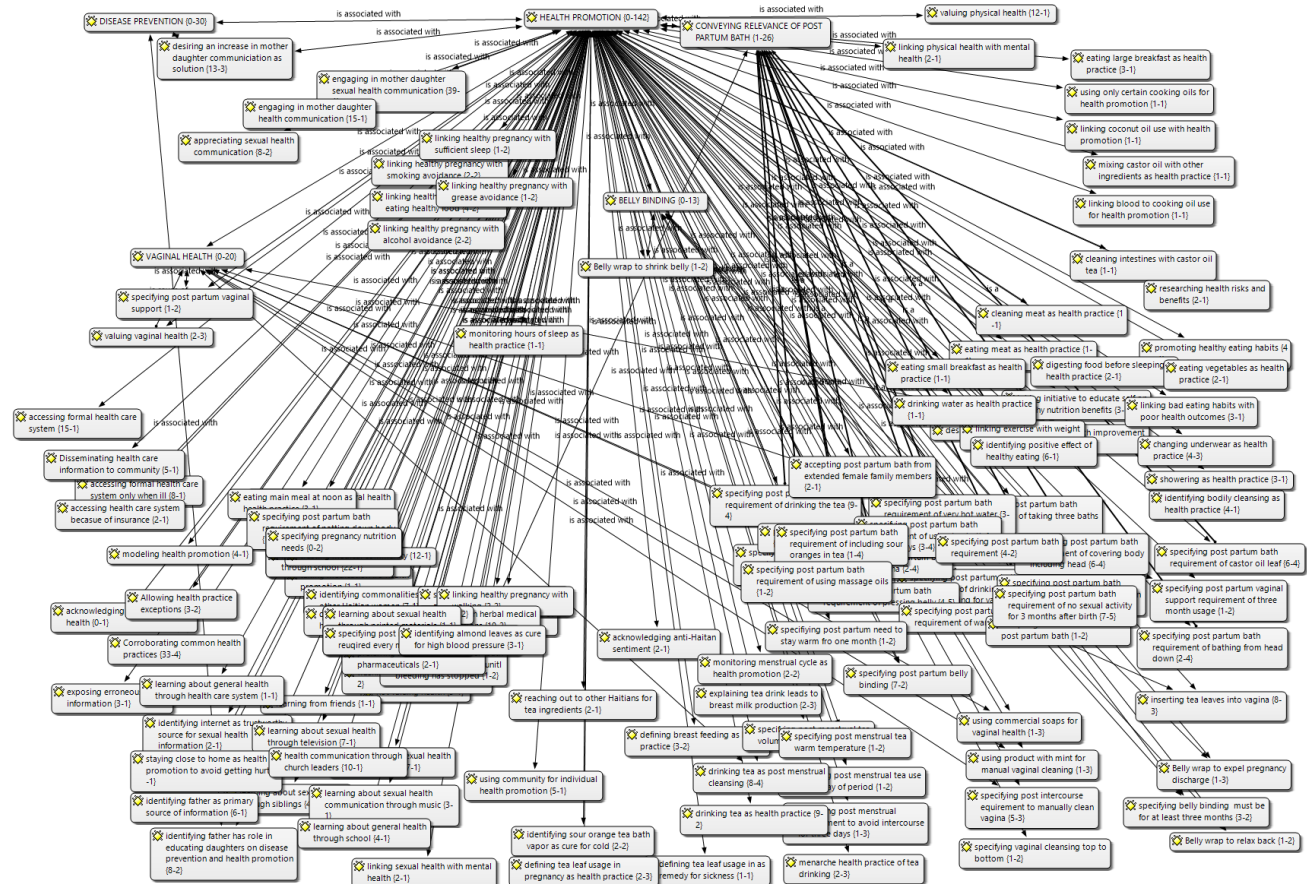


Figure 4.1. Result of Initial Coding Process.

ATLAS.ti® was useful in reducing this large amount of codes into categories via the focused coding process. Figure 4.2 illustrates the usefulness of ATLAS.ti® in reduction of codes and contributing specifically to theory development. Figure 4.3 further illustrates further reduction of codes.

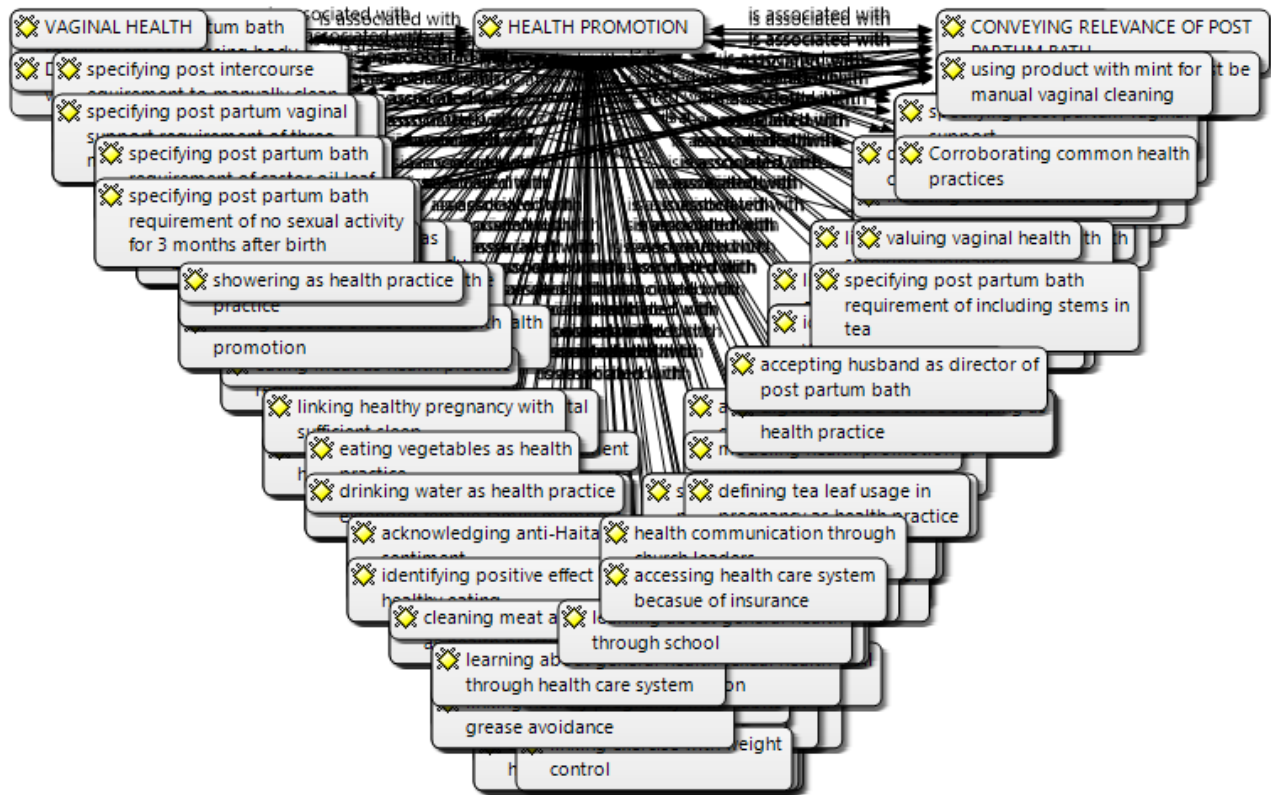


Figure 4.2. Justification for systematic process of constructivist grounded theory in this study.

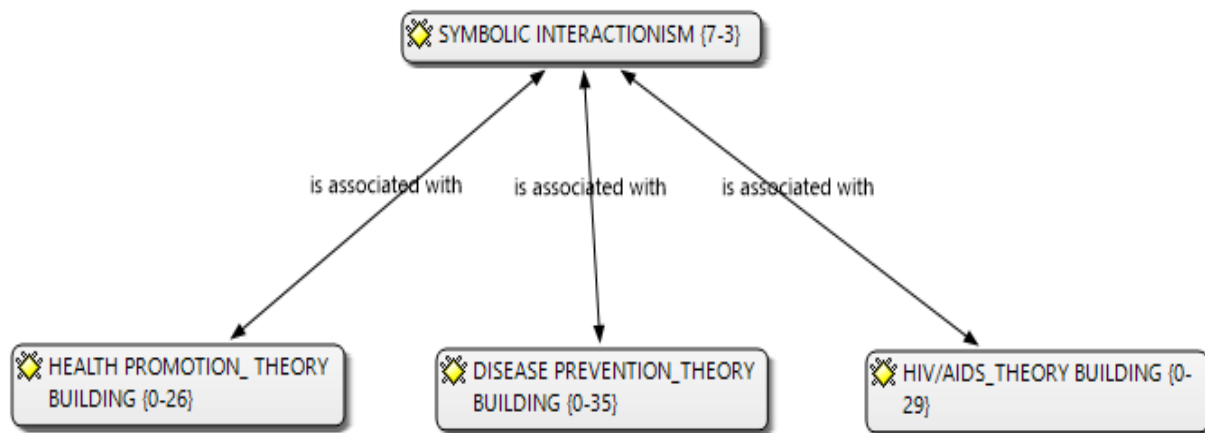


Figure 4.3 Sample contribution of ATLAS.ti® in reduction of codes to categories in focused coding.

Findings Development of Categories based on Research Questions

I engaged in a two-phase process in which the first phase was to conduct a focus group consisting of health care providers and Haitian-descendant community leaders who engage Haitian-descendant clients in the region as key informants. The first research question was, *What do health care providers or community-level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents?*

Nine major categories emerged from analysis of the focus group interview: CONFIRMING POTO MITAN, EMPHASIZING ATTENTION TO VAGINAL HEALTH, INTRODUCING RELEVANCE OF POST-PARTUM BATH, IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN HEALTH INSTRUCTION, IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN SEXUAL HEALTH COMMUNICATION, VALUING CULTURAL DISTINCTIVENESS AND PRIDE, CLARIFYING ATTITUDES TOWARD FORMAL HEALTH CARE SYSTEM, CONVEYING SEXUAL ASSAULT VULNERABILITY, and DEMANDING ACCURATE CENSUS REPRESENTATION. Figure 4.4 illustrates these nine categories.

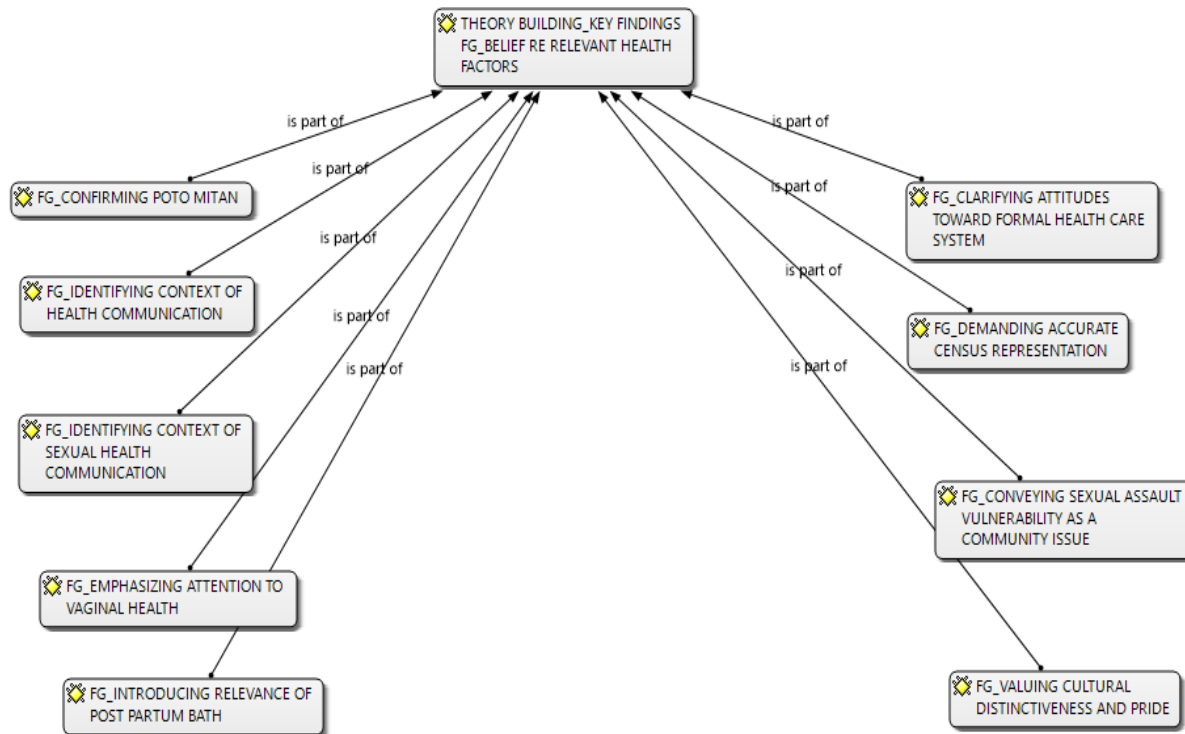


Figure 4.4 Nine major categories from focused coding phase of focus group transcripts.

Confirming poto mitan.

CONFIRMING POTO MITAN emerged as a category, following the initial and focused coding stages of the focus group transcripts. Following is a compiled illustrative quote for CONFIRMING POTO MITAN.

...Haitian moms are very powerful, and they are the ones who take control...The mom being the poto mitan...I am an adult, I am 27 years old, but when I am home, I am still a child...it's hard to address the conversation of health between mothers and daughters without addressing power dynamics in the family, the hierarchy of the mother...I follow it, my mom tells me to follow the rule, and you hear her...So here it is, in terms of health, an example, we are even in the new generation, under our mothers always, no matter what...So you do what she says...And even when we're adults, our mothers take ownership of us and I can tell you, that it doesn't change regardless of how long the mom has been here...and I don't think that moms are just the poto mitan! No, they're God too...and to deny her of that part is very unusual...Oh, to refute that is VERY unusual...no denying that in the Haitian culture...

The quote supports the relevance of Symbolic Interactionism in identifying mothers as the *poto mitan*, in that individuals interpret and act based on what they understand their reality to be. The belief that Haitian mothers are the *poto mitan* would necessarily then influence how daughters react to circumstances and experiences (Charmaz, 2008).

The importance of vaginal health was also included in focus group participants' perspectives of relevant health information for Haitian women.

Emphasizing attention to vaginal health.

EMPHASIZING ATTENTION TO VAGINAL HEALTH emerged as another key finding in identifying influential factors for Haitian women's health and well-being. Focus group members stated Haitian women place great importance on vaginal cleanliness and health. Participants reported the practice of "inserting tea leaves into your vagina, and you sleep with it", as well as linking post-partum vaginal cleaning practices with vaginal health through the use of "herbal medicines to bring your vagina back" and "protecting themselves ...by treating themselves with plants, because if they don't care for themselves, then infection can occur".

More about EMPHASIZING ATTENTION TO VAGINAL HEALTH will be discussed in the section summarizing findings from the interviews with mothers and daughters. Relatedly, the relevance of post-partum baths emerged as a key finding.

Introducing relevance of post-partum bath.

A total of 85.7% of the seven focus group participants (all but one) emphasized the relevance of post-partum baths to the health and well-being of Haitian women, suggesting it might emerge or need to be prompted during interviews with mothers and daughters. However, one participant stated she had never heard of the post-partum bath before the focus group. Initial

codes in this category included *accepting the mother as director of post-partum bath*, *linking post-partum bath with disease*, and *outlining post-partum bath vaginal practice*.

Accepting mother as director of post-partum bath appeared 10 times in the interviews of focus group members. Following is an illustrative quote from a 37-year old daughter in the study sample; her quote supports the role of mothers as the director of post-partum baths is tightly linked to SI as a theoretical framework.

...They bathe you...With mothers it's something that has been passed down for generations... My mom gave her the bath each time after she had her children... When she tells you she does it, you allow it...

Linking post-partum bath with disease appeared as an initial code in the analysis of the focus group transcripts that was linked to the category INTRODUCING RELEVANCE OF POST-PARTUM BATHS. The code *Linking post-partum bath with disease* illustrated that focus group participants were not in agreement about the value and usefulness of the post-partum baths. Following is an illustrative quote for *Linking post-partum bath with disease*.

...Post-partum bath can also be linked to disease... Which other studies have shown that can be linked to having cancer... You shouldn't be having the bath, it can cause infection, and more, serious illness...

Outlining post-partum vaginal practice appeared as well in the initial coding phase of the analysis of the focus group transcripts; it was also linked with the category INTRODUCING RELEVANCE OF POST-PARTUM BATHS during focused coding. Following is an illustrative quote detailing part of the post-partum bath procedures that focus group members informed would be part of their constituents' health practices.

...[Haitian women] put herbs in the vagina to bring the vagina back... she [mothers] says you need to do this to tighten the walls of your vagina... You just gave birth and you want your vagina back [to pre-birth state]...

The category INTRODUCING RELEVANCE OF POST-PARTUM BATHS reveals that focus group participants believe post-partum baths as a health practice is an important influence to the health and well-being of Haitian women. Of interest in this category is the confirmation of *poto mitan* within the post-partum bath experience, as the mother plays a central figure in this practice.

Another key finding emerging from the focus group interviews illustrated the relevance of religious leaders in health instruction of Haitian women.

Identifying relevance of religious leaders in health instruction.

IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN HEALTH

INSTRUCTION emerged as a category in the data analysis of the focus group interviews. Focus group participants stated health communication is often initiated by and relegated to church leaders, emphasizing this incorporation of religious leaders as purveyors of health and sexual health communication seven times in the interview. One participant stated, “We have had to go through the pastors and the priests, to get to the Haitian women; it was like we were asking [the religious leaders] for permission”. When this was stated in the interview, all participants nodded in agreement, with one reiterating, “We had to go through the pastors to get to the women, to get access”. Relatedly, religious leaders were also identified as relevant to sexual health communication of Haitian women.

Identifying relevance of religious leaders in sexual health communication.

IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN SEXUAL HEALTH

COMMUNICATION emerged as a separate, but related category linked to the category *identifying relevance of religious leaders in health instruction*. Focus group participants stated sexual health communication also occurs under the leadership of religious leaders, with one

participant stating “We first have to convince him why we have all these questions, then he will open the door for us.” One other participant noted “the pastors kinda have the pulpit,” meaning communication of anything important comes from these leaders.

The role of religious leaders as gatekeepers and as instructors who transmit health and sexual health communication to Haitian women is an important finding that adds to knowledge of who to include in potential health promotion and disease prevention interventions for Haitian women. Additionally, valuing cultural distinctiveness and pride emerged as an analytic category.

Valuing cultural distinctiveness and pride.

VALUING CULTURAL DISTINCTIVENESS AND PRIDE also emerged as a key category under research question 1; *What do health care providers or community level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents?* This category centered on a belief that Haitian women feel proud of their communities and their culture. Focus group participants noted this category is a key factor that influences health and well-being among Haitian women. Following is an illustrative quote for VALUING CULTURAL DISTINCTIVENESS AND PRIDE

...We are really knowledgeable about everything in the community...We are building strong leaders...We are building a strong youth community... We have resilient families...We do not want to lose our culture...Our culture is very proud...

In association with the category *valuing cultural distinctiveness and pride*, participants in the focus group believed that clarifying attitudes toward the formal health care is a key factor in influencing the health and well-being of their constituents.

Clarifying attitudes toward formal health care system.

CLARIFYING ATTITUDES TOWARD FORMAL HEALTH CARE SYSTEM emerged as an important category from the focus group interview data. Six focused codes led to this

category: (1) believing in efficacy of herbal medication interventions, (2) distrusting the formal health care system, (3) criticizing medical professionals' interactions with the Haitian community, (4) expressing anger with Western medical professionals, (5) rejecting the formal health care system, and (6), desiring recognition of efficacy of Haitian health practices. The two most frequently occurring initial codes under CLARIFYING ATTITUDES TOWARD FORMAL HEALTH CARE SYSTEM were *believing in efficacy of herbal medication interventions* (17 times), and *distrusting the health care system* (5 times). Following is an illustrative quote from the focus group detailing that *believing in efficacy of herbal medication interventions* was a factor that influences health and well-being of their constituents, and that, therefore might emerge in interviews of mothers and daughters. The quote also supports the relevance of SI in this study, as the daughters are learning from mothers and others who share their sociocultural context about the meaning and relevance of herbal medicines:

...So I have in my mind, that herbal things are really *really* good...it does do all sorts of things for your body... We have knowledge about herbs, and then with Western medicine, we come to a common ground...And my Mom, she gives me her herbal concoctions and it works...It's the way you live. She has everything in her yard... She got her leaves ...and they do work...

Following is an illustrative quote for *distrusting the health care system*.

...Oh they are just trying to take your money in America... there is a risk in going to a Western doctor... ...Haitians, we're not a big fan of going to the doctor because [she] can't get help there... They don't like the health system, it's not good for her or even helps her...Guess our healthcare system sometimes can be a scam...

The latter quote also is pertinent to SI, in that the reference is made to "Haitians", in general not liking western medicine for the stated reasons, suggesting it is a common perception adopted through interactions with other group members through language and symbols that are interpreted in context.

Focus group participants also identified sexual assault vulnerability as a key factor in influencing the health and well-being of their constituents.

Conveying sexual assault vulnerability as an issue in the community.

Focus group participants stated that Haitian women are experiencing sexual assault, and offered their perspectives on sexual assault vulnerability of Haitian women in West Central Florida. One participant stated, “sexual assault is what I hear about, and what I see”. All focus group members nodded in agreement when they heard this statement, and one participant linked sexual assault to immigration status, stating “We’re dealing with [serving] people [in our agencies] who may be dealing with immigration status issues and maybe [with] the power of who has the green cards”. While sexual violence against women is an issue of public health significance around the globe, the focus group participants seem to indicate that not having legal permanent residence in the U.S. poses an added layer of vulnerability for Haitian women whose immigration status may preclude their ability to combat or to report sexual assaults for fear of being deported.

In association with the category *conveying sexual assault vulnerability*, participants in the focus group clamored for accurate representation in the 2020 census, because they are interested in correct representation of their constituents and in insuring that their numbers and distinct needs are taken into account in funding decisions.

Demanding accurate census representation.

DEMANDING ACCURATE CENSUS REPRESENTATION is, in fact, a key finding from analysis of the focus group transcript. Focus group participants stated they did not believe the census count accurately reflected the number of Haitians in West Central Florida, noting census counts can determine levels of funding for some social programs, including health-related

programs. Thus, an inaccurate census count can influence constituent health and well-being. One participant noted the “low census number is my pet peeve right now”. Another member noted, “...We really, *really* have to work on that number...it is not correct”. All participants in the interview nodded in agreement with that speaker, with one further participant adding “Uhhh, that’s *way* low”.

These previous nine categories were deemed important in influencing the health and well-being of focus group participants’ constituents. Focus group participants expected these categories to come up in the mother and daughter interviews. Research question 2 follows.

Research question 2.

The second research question was, *What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?*

Individual interviews were conducted with eight Haitian mothers, via the open-ended semi-structured interview protocol described above. Four major categories emerged from 15 initial codes related to specific methods that Haitian mothers use to communicate what constitutes health and sexual health to their daughters. Figure 4.5 illustrates these four key categories.

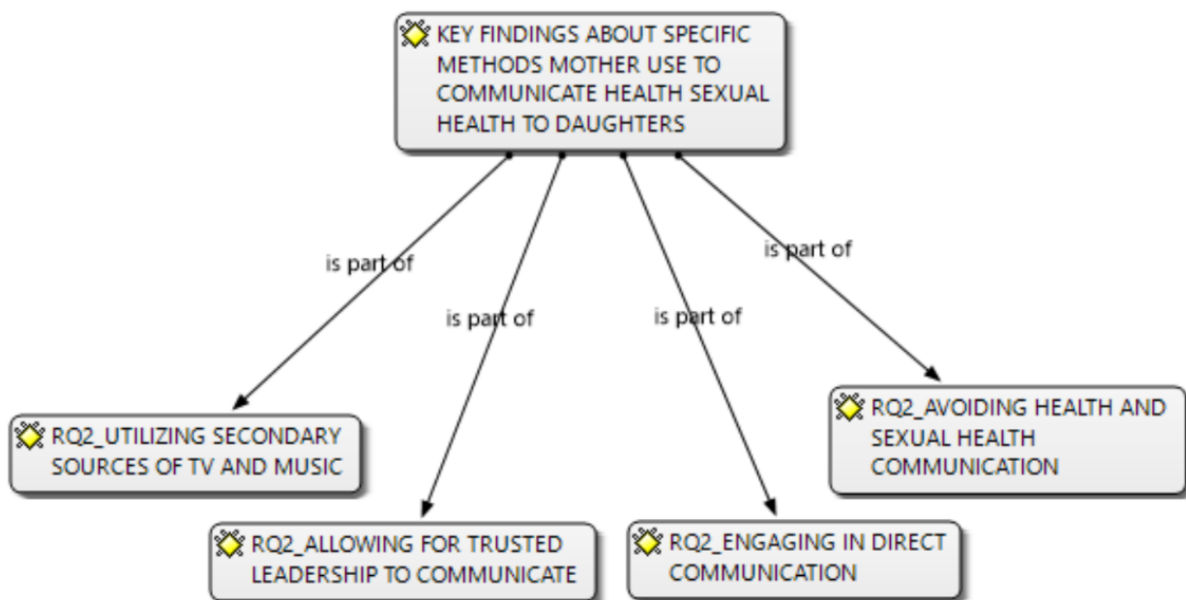


Figure 4.5 Specific methods used by Haitian mothers to communicate health/sexual health information to daughters.

Utilizing secondary sources of TV and music.

UTILIZING SECONDARY SOURCES OF TV AND MUSIC emerged as the first category in the focused coding phase of the transcripts of mothers’ interviews, in response to the question, *What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?*

This code appeared four times in interviews with the eight mothers, and each time, the mothers seemed to use either examples of musicians dying from AIDS or used an image on TV to foster discussion about HIV/AIDS. One mother indicated:

...they used to watch TV, and there were like two people kissing. One day, I came in, and the same thing was on, and they were like, ‘why mommy?’ ...and I said let’s talk about it...Instead of just turning it off and not talking about it ... We turn it on, turn it on....and then we talk about it all...

Another mother indicated:

...the guy was singing about his fiancée who has HIV. So, he brings this song to show that he was about to die; that he had everything...but he makes the song to say what's going to happen, that he's going to die; so I talked to her- that's the only way- through the music- the only way that you can have HIV is through sexual contact and probably (she motions to her arms)...so I talk to her, that's the only two ways you can have HIV...and probably kissing...

These quotes indicate that for some mothers, although they do not initiate all health and sexual health communication, they do take advantage of teaching moments from the content on television and from popular music. However, the mother's assertions suggest that the HIV knowledge being transmitted is incomplete and inaccurate.

In addition to using media such as television and music to facilitate health and sexual health communication with their daughters, Haitian mothers in the present study indicated that they are in fact engaging in direct communication with their daughters about health and sexual health.

Engaging in direct communication.

ENGAGING IN DIRECT COMMUNICATION is a category that was developed from focused coding in the analysis of the transcripts of mothers' interviews. This category emerged from three initial codes, to which 36 quotes were attached, indicating a high level of groundedness in this study of the initial codes, and moderate code density in the focused codes. The level of groundedness supported the creation of the category ENGAGING IN DIRECT COMMUNICATION to describe one aspect of health and sexual health communication between mothers and daughters in the present study (in addition to indirect communication). Following is an illustrative quote confirming this mother/daughter direct communication; it indicates some direct communication about sexual health, but relative to protecting one's self from others who might have a sexually transmitted disease. However, it does not suggest direct knowledge is transmitted to the daughters about *how* to protect themselves.

...Yes, you have to communicate with the kids because you are their mother. You have to protect them no matter what...I want to protect them from STDs...I say, you can be around people with AIDs, STDs, but make sure you protect yourself. Don't deal with the needle they're using, protect yourself if you are having sex...' But to protect your kids you must communicate with them...if you don't talk to them about sex, about AIDs, STDs, how can they protect themselves?...

Conversely, avoiding health and sexual health communication appeared in the analysis of the transcripts of mothers' interviews.

Avoiding health and sexual health communication.

AVOIDING HEALTH AND SEXUAL HEALTH COMMUNICATION is a category that was developed from focused coding in the analysis of the transcripts of mothers' interviews. This category emerged from six initial codes, to which 36 quotes were attached, indicating a high level of groundedness for those codes. This level of groundedness supports the claim that mothers, although engaging in some direct communication about health and sexual health, are avoiding direct health and sexual health communication with their daughters, and are possibly missing opportunities to transmit concrete and accurate information that would enable daughters to make wise decisions about their sexual health. Following is an illustrative quote confirming this avoidance.

...So it's something that practically we don't discuss...We don't discuss sex... We don't discuss sex, with family...We learn it by ourselves our own way... We never discuss it practically...We discuss love but not sex...Because we say that's a private thing...For my daughter, we never discussed it, sex...

Of note, one daughter specified:

...as far as sexual health, my mom didn't have the sex talk with me. When we were younger, we were told that if someone touches your private parts, you tell mom – and you tell daddy that. But when I got older, the conversation I had with my mom was 'Don't have sex before you're married. And don't let anyone make you do anything you do not want to do...nothing was talked about all those other deep things. We don't talk about that. There is no other conversation about that...

The latter two illustrative quotes support the relevance of SI in this study, in that daughters are indeed learning from their mothers, but they suggest that the health and sexual health communication which takes place within the dyads is framed in avoidance. In other words, the direct communication includes that they have to avoid disease; but there is, at the same time, intentional avoidance of individual sexuality and of messages geared towards how a daughter's sexual decision making translates into how to avoid disease. In other words, not communicating specifically about personal sexual behavior in relation to HIV risk is still part of SI. The use of SI as a theoretical framework in this study indicates daughters would obtain knowledge from their mothers about what constitutes safe and healthy sexual behavior and what constitutes risky sexual behavior in the context of disease prevention, through the interpretation of language and symbols.

In addition to avoiding health and sexual health communication with their daughters, Haitian mothers in the present study indicated that they look to trusted community leaders such as school and church personnel to intervene in providing health and sexual health knowledge to their daughters.

Allowing for trusted leadership to communicate what constitutes health and sexual health to their daughters.

ALLOWING FOR TRUSTED LEADERSHIP TO COMMUNICATE WHAT CONSTITUTES HEALTH AND SEXUAL HEALTH TO THEIR DAUGHTERS is the final category from the focused coding of the analysis of mothers' interviews. The trusted leaders were identified as school teachers/ interpreters and religious leaders. Below is an illustrative quote from a mother interviewed in this study, supporting allowance of health and sexual health communication transmission through these leaders.

...At school some teachers give some kids protection a condom...teachers give them to the students...But I *think* she knows [about condoms] ...And I know in school they talk about sex and condoms and HIV ...I *think* they give them condoms at school and they are free...

The latter quote relates to the theoretical framework of symbolic interactionism (SI) utilized in this study, signifying that mothers have expanded their social network to include not just those with whom they share a sociocultural context in Haiti but with those who traditionally have not been part of their social networks. It is also pertinent to the information-motivation-behavioral skills model (IMB), in that the mother indicates her daughter “knows” about condom use, suggesting the daughter possesses information of a sexual health behavior. Research question 3 follows.

Research question 3.

As a reminder, the third research question was, *What messages do Haitian daughters in West Central Florida receive from their mothers about what constitutes health and sexual health?* The latter question is important in that when mothers actually do communicate important health promotion and disease prevention knowledge to their daughters, assessment of whether or not the daughters actually gain knowledge from this SI process is important.

The Haitian daughters were interviewed individually, again using an open-ended semi-structured interview protocol. Four key categories emerged from the focused coding phase of the analysis of the Haitian daughters. Figure 4.5 illustrates these key findings regarding messages Haitian daughters receive from their mothers about what constitutes health and sexual health: ACCENTUATING HERBAL MEDICINAL BENEFITS, PARTICIPATING IN POST-PARTUM BATHS, CONTEXTUALIZING SEX IN MARRIAGE, and MAINTAINING PHYSICAL HEALTH.

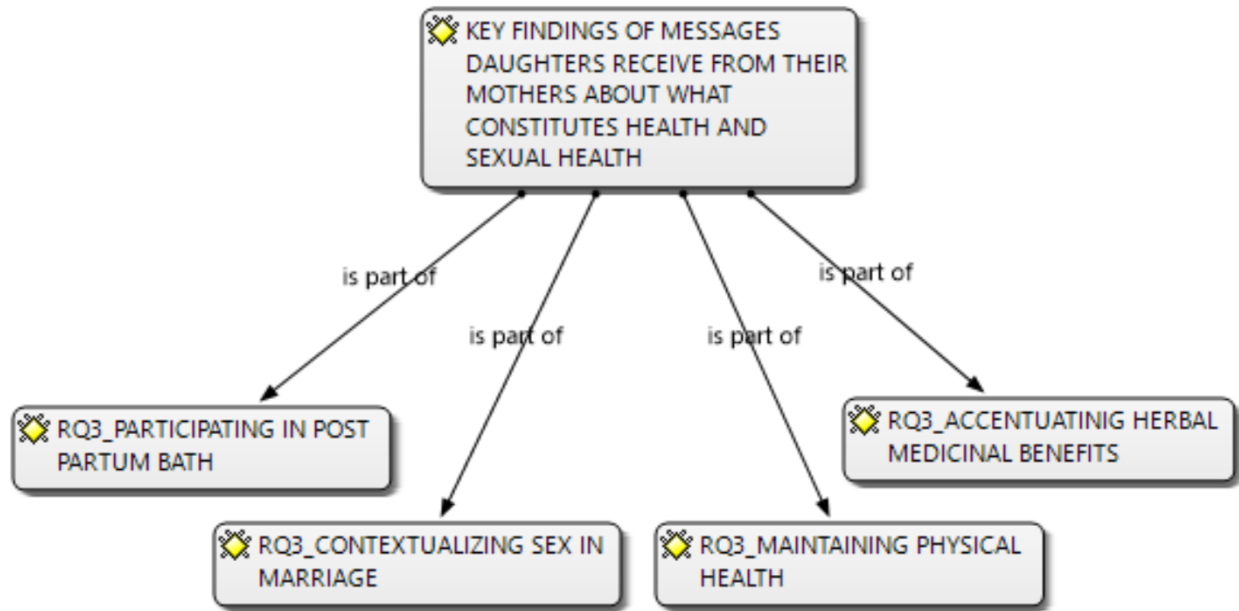


Figure 4.6 Messages Haitian daughters receive from their mothers about what constitutes health and sexual health.

Accentuating herbal medicinal benefits.

ACCENTUATING HERBAL MEDICINAL BENEFITS emerged in the focused coding phase of the analysis of daughters' interview transcripts, in response to the research question, *What messages do Haitian daughters receive from their mothers about what constitutes health and sexual health?* Following is an illustrative quote for ACCENTUATING HERBAL MEDICINAL BENEFITS.

...But my mom told me to drink it [herbal tea] because it cleans the body, cleans the colon, all of your system... Then we have a shower, and we use [tea] leaves... a lot of boiled leaves... to relax your body, we drink tea... We believe in that... She has a fever, so we showered her [in tea leaves] so that all the fever would go out... In the Haitian culture you'll hear -oh it's gas, everything is gas, you have gas... have tea, drink some tea, have some clove tea, and the skin of garlic, and the gas will go away... He had a kind of tea he gave us and the fever would go away... when I have a headache or something or I have a stomach ache or I have a cramp or something, my parents are just like go get this plant outside and boil it on the stove and it's going to help you...

Of note, focus group participants indicated herbal medicinal practices to be a factor in influencing the health and well-being of their constituents, and that this category was likely to surface in individual mother/daughter interviews. Closely related, the category of *participating in post-partum bath* emerged from the interviews with the daughters in this study.

Participating in post-partum bath.

PARTICIPATING IN POST-PARTUM BATH is the second category that emerged from the focused coding phase of the analysis of daughters' interviews. This category emerged from eight initial codes, to which 12 quotes were attached, indicating a high level of groundedness in this study. Daughters receive the message from their mothers that participating in the post-partum bath constitutes health and sexual health and they buy into that. One daughter stated,

...But I know the bath is important to me, to me...It is because, the reason why I say that its important, whatever is coming out of your vagina, it smells bad and the bath is actually pushing it out... We have the bath, that is what will help the woman get back to normal and to help her get rid of all the blood and all the other pieces that might stay in [her]...With the bath, you give up having sex for 3 months after giving birth...

Additionally, contextualizing sex in marriage is the third category from the focused coding of the analysis of the daughters' interview transcripts, about what constitutes health and sexual health.

Contextualizing sex in marriage.

CONTEXTUALIZING SEX IN MARRIAGE, emerged as a key category from analysis of the daughters' interview transcripts. Daughters stated this is a clear message they receive from their mothers about what constitutes health and sexual health. The following quote illustrates this message.

...Haitians don't have sex until you get married... they don't want to get pregnant... [we do not believe in sex before marriage] because of faith... Complete abstinence, until marriage of course, cause I'm Christian; so, just don't do it at all... so, you can't, you

know, live with a guy before you get married, you can't, you know, have sex before marriage...

The category CONTEXTUALIZING SEX IN MARRIAGE directly supports the relevance to SI in this study, i.e., that daughters are learning from their mothers what the cultural expectation is with regard to premarital sexual activity. Finally, *maintaining physical health* is the fourth category to emerge from the focused coding of the analysis of the daughters' interview transcripts, about what constitutes health and sexual health.

Maintaining physical health.

MAINTAINING PHYSICAL HEALTH, as a finding in this study, referred to exercising regularly for weight control, avoiding unhealthy food, and taking initiative to self-educate on healthy nutrition. Below is an illustrative quote from the daughters interviewed in this study, supporting *maintaining physical health*.

...[I'm] paying attention to what we eat...what you put in your body, and exercising, for sure...What she passed down to me, she tells me I need to exercise more... do some exercise, don't let that food grow in you because we Haitians, like after we eat, I put on music, I shake my body; and then after that, you realize you feel better...

Research question 3 also included the sub-question, *Are daughters receiving what mothers are attempting to convey?* As can be determined by the illustrative quotes above, daughters are hearing these messages from their mothers, and what they are trying to convey. Daughters report herbal medicinal usage and benefits, especially with tea drinking, participation in post-partum-baths, receiving a message maintaining physical health, and the message of reserving sexual activity in marriage. Nevertheless, five of the interviewed daughters noted they

desired an increase in mother daughter communication, and that this increase may help provide solutions to health disparities.

Another sub-question to Question 3, *What messages do Haitian daughters in West Central Florida receive from their mothers about what constitutes health and sexual health, was, Do Haitian daughters have intention to transmit health and sexual health communication to their own daughters? If so, how similar or different will such communication be compared to what they have received from their own mothers?*

Intention of daughters to transmit health practices to next generation.

Some daughters in the present study maintained that they would not continue the practice of post-partum bathing, especially since they had become aware of scientific studies indicating that such practices studied in different culture were ultimately unsafe. For example:

...because of course education plays a role. Cause I was looking at different studies...not everything should be used; it's also a safety issue- like the things she said to put into my vagina. I didn't. don't tell her I said that. I was thinking 'Really? You're making me put leaves inserted?! That's a very sensitive area...but what about cancer? Ovarian cancer? We don't know if it's the cause of it. there's really nothing wrong with these leaves; but not all leaves are healthy...So that's what I'm talking about...If my mom is around when my daughter has a baby, she'll want to bathe her; and I doubt if I'll stop her. But if she's not around, I will not bathe her [post-partum bath]. I will not put anything into her vagina; but my mom is going to want to do the whole shebang...

This same young woman asserted firmly:

...If my mom is not around [when my daughter has a baby], I won't bathe [her]... It's a safety issue so, like I said, the things she said to put into my vagina, I didn't; don't tell her I said that...

The latter quotes illustrate the strength of the mothers as POTO MITAN, to the point where daughters are willing to engage in health practices that not only risk their own lives but the lives of their daughters, just to comply with the cultural mandate of mother as POTO MITAN.

From the above discussion, it is clear that much health and sexual health communication is occurring between mothers and daughters, and that some content areas are addressed more comprehensively and accurately than others. This is evident in the above noted report that five of the daughters in this study expressed a desire to have more in-depth conversations with mothers regarding sexual health in particular. This leads to a discussion of health promotion and disease prevention in this sample.

Following is a network view (Figure 4.7) created from ATLAS.ti® which illustrates the linkage of the categories HEALTH PROMOTION and DISEASE PREVENTION to the pertinent initial codes.

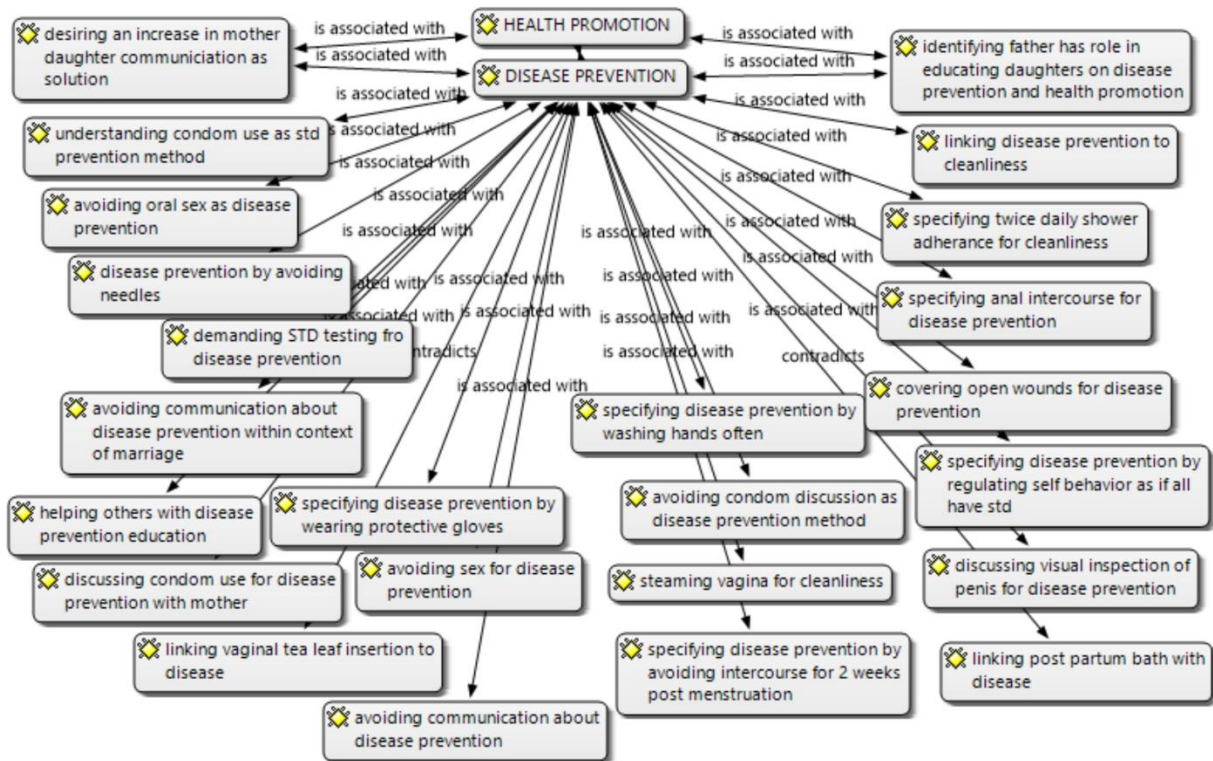


Figure 4.7 Network view illustrating HEALTH PROMOTION and DISEASE PREVENTION links to pertinent initial codes.

Findings Theory building HEALTH PROMOTION

The following figure, Figure 4.8, depicts HEALTH PROMOTION and DISEASE PREVENTION in relation to other categories in the focused coding phase.

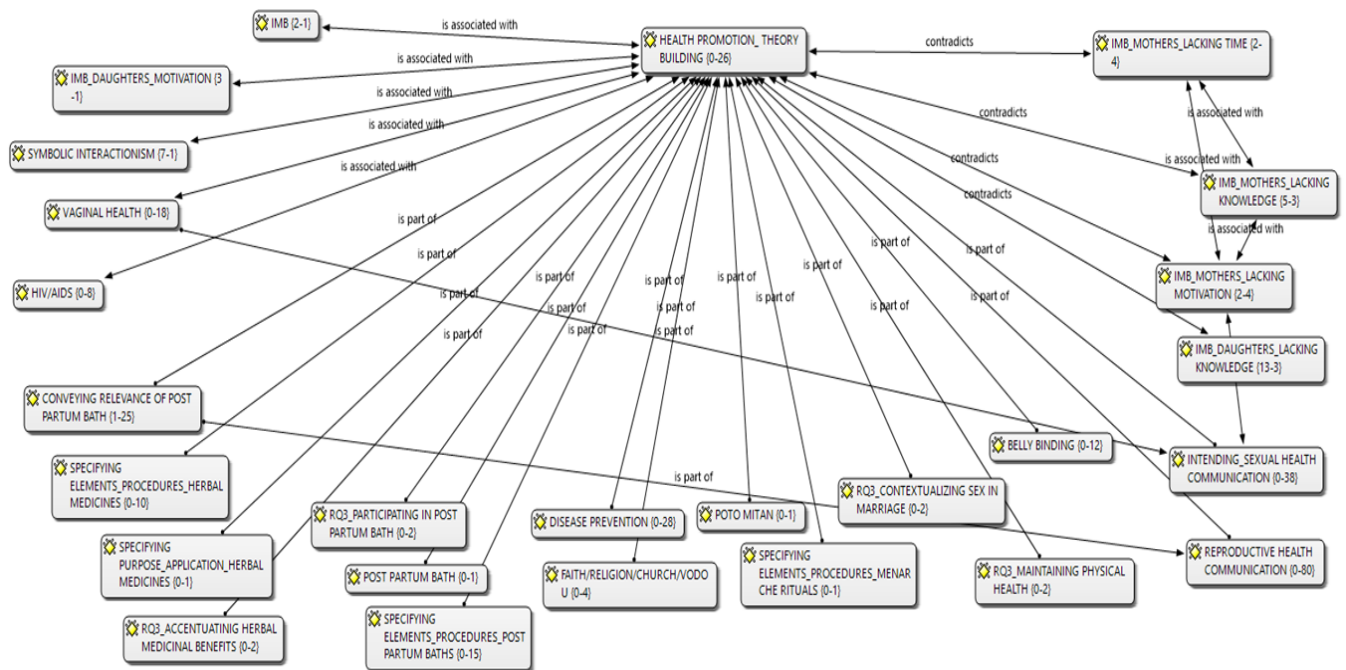


Figure 4.8 HEALTH PROMOTION and DISEASE PREVENTION in relation to other categories from the focused coding phase

Findings Theory building DISEASE PREVENTION in relation to HEALTH PROMOTION

The following figure, Figure 4.9, comprises a network view of DISEASE PREVENTION in relation to HEALTH PROMOTION as part of the theory building phase of constructivist grounded theory.

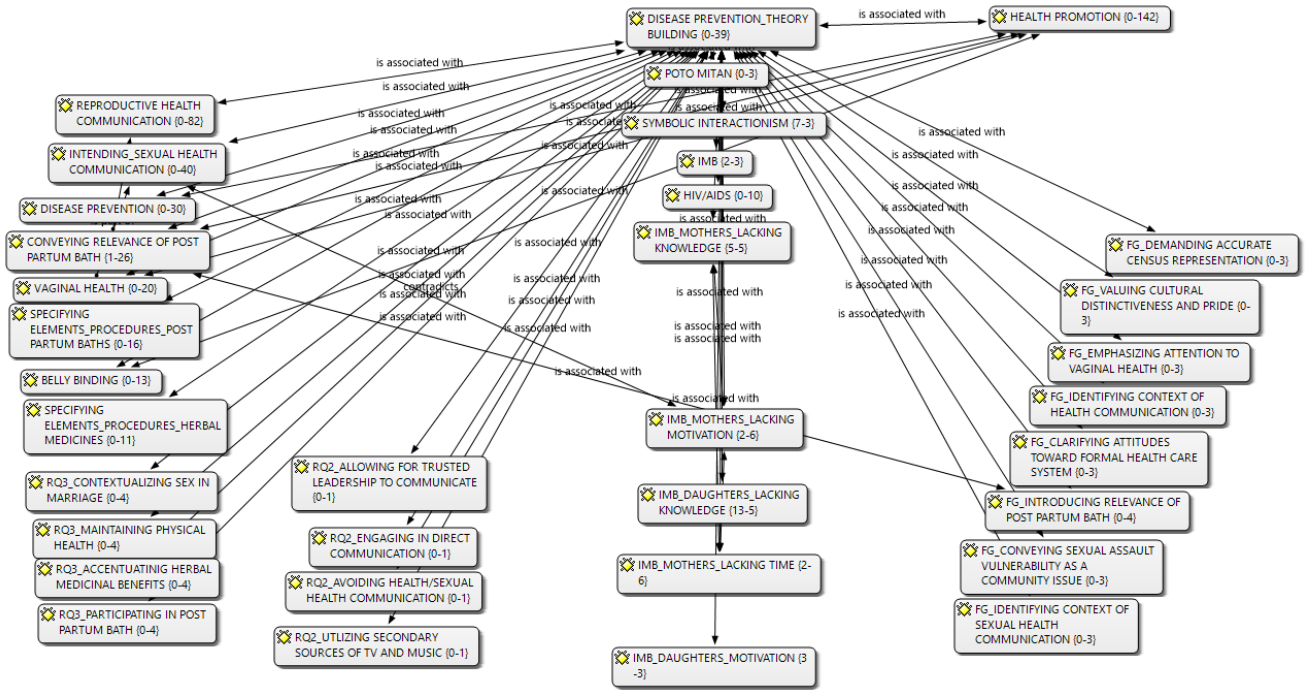


Figure 4.9 DISEASE PREVENTION in relation to HEALTH PROMOTION as part of the theory building phase of constructivist grounded theory.

Findings Theory building Communication about HIV/AIDS

The following figure, Figure 4.10, is a network view depicting findings from the theory building phase specific to HIV/AIDS communication. It is followed by a discussion of the relevance of IMB in the present study.

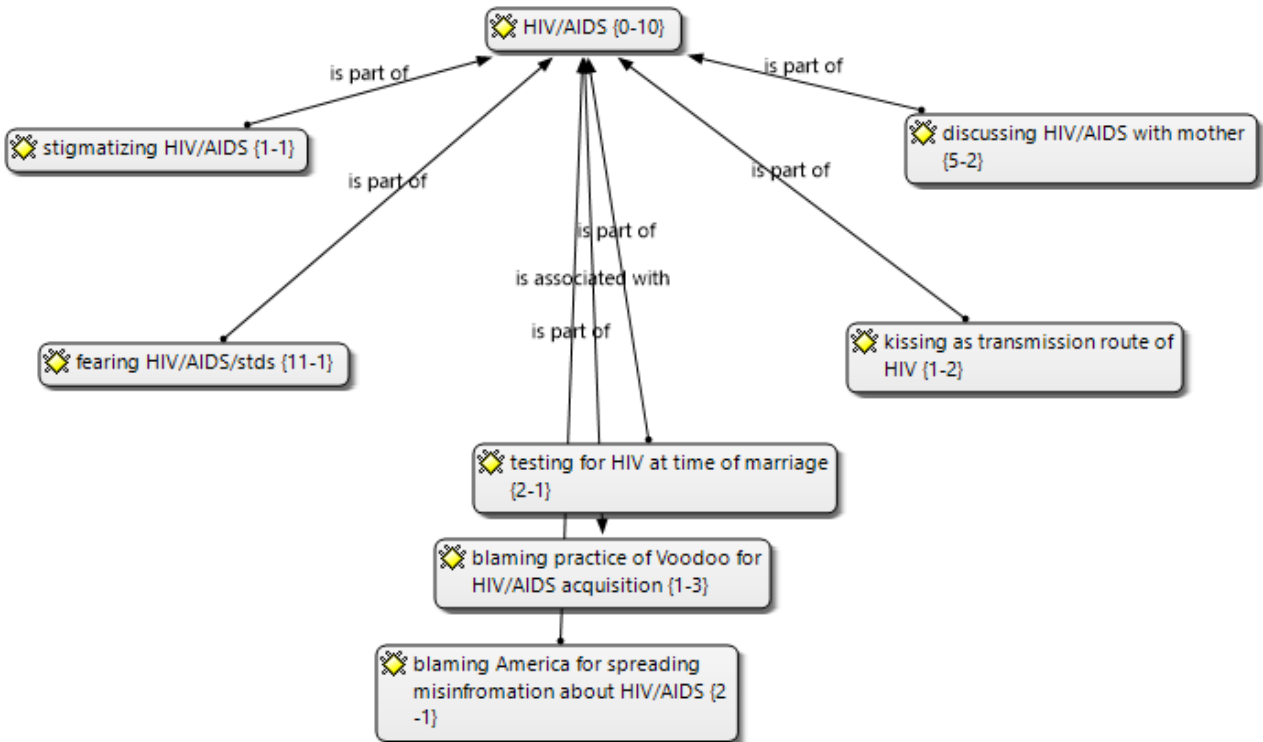


Figure 4.10 Network view of theory building phase specific to HIV/AIDS

communication.

Findings Theory building IMB

The health promotion and disease prevention information transmitted by mothers through SI typically is valued and applied with some exceptions. When the daughters are exposed to scientific information in the U.S. context, they appear inclined to either modify the application of information received or to reject it totally.

...I wish there was more conversation and more knowledge sharing...because that's not something she learned but it's something she taught me...But it's more about the clinical aspects of disease, not just prevention but what it really is, because that's something that I'm learning as well...because I took the initiative to learn that and for us Haitians in general that's just not how it works. I feel like clinically, the medical part, that's not something that people get too...probably avoiding this information...because as long as it's a mystery disease, it's still going to be a lot of stigma attached to HIV and AIDS on an interpersonal level... You're going to cover your bases still with the medical info, but as far as socially, the reason it got destigmatized for me was because I took a little more time to learn, and not just going off what my mother said...It was so helpful, I still knew what my mom said...But I don't know, it would still be stronger knowledge if

there was more info not attached to people, to actual human beings who do have HIV and HIV/AIDS...more medical knowledge, I think that would be good, I think that's a general thing that Haitian mothers don't really get into too much...

Moreover, mothers, while they value traditional health information, when they receive new information the U.S., they also refrain from transmitting traditional health practices to their daughters. One mother stated:

...The bath you start, and then you're clean. If you want, if you want your stomach to be flat, you wear the band for two to three months. If you're like me, my mother made me wear the band for more than three months. Because they want you to be flat, even if you are big. Remember, the blood and bleeding has to be completely done, and then the band...

Interviewer: So there's the band, and there's [pressing on the stomach], is there anything else? ... I've heard before there is something put into the vagina.

Mother: No. They used to do that but we stopped doing that because that gave a little discharge after that. But no, we don't put anything into the vagina because, I used to do that... put the leaves [in] to clean inside the vagina, and leave it inside, but I stopped doing that because [my daughter] read something, I don't remember exactly... know how sometimes you've been doing something for good, and after a study, science, and then [no more]...I used to do it but not anymore, and I am not going to tell anybody else to do it...it might do harm to the body...just outside, not inside...

Chapter 4 provides results for the qualitative analysis that emerged from the interviews to each research question. Research question 1 asked focus group participants *What they believe to be factors that influence the health and well-being of their constituents?* Analysis of the focus group interview transcript revealed nine key categories that influence constituent health and well-being: CONFIRMING POTO MITAN; EMPHASIZING ATTENTION TO VAGINAL HEALTH; INTRODUCING RELEVANCE OF POST-PARTUM BATH; IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN HEALTH INSTRUCTION; IDENTIFYING RELEVANCE OF RELIGIOUS LEADERS IN SEXUAL HEALTH COMMUNICATION; VALUING CULTURAL DISTINCTIVENESS AND PRIDE; CLARIFYING ATTITUDES

TOWARD FORMAL HEALTH CARE SYSTEM; CONVEYING SEXUAL ASSAULT VULNERABILITY; and DEMANDING ACCURATE CENSUS REPRESENTATION.

Research question 2 asked *What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?* Analysis of the mother participant interviews resulted in four key categories: UTILIZING SECONDARY SOURCES OF TV AND MUSIC; ENGAGING IN DIRECT COMMUNICATION; AVOIDING HEALTH AND SEXUAL HEALTH COMMUNICATION; and ALLOWING FOR TRUSTED LEADERSHIP TO COMMUNICATE WHAT CONSTITUTES HEALTH AND SEXUAL HEALTH TO THEIR DAUGHTERS.

Research question 3 asked *What messages do Haitian daughters in West Central Florida receive from their mothers about what constitutes health and sexual health?* Analysis of the daughter participant interviews resulted in four key categories: ACCENTUATING HERBAL MEDICINAL BENEFITS; PARTICIPATING IN POST-PARTUM BATH; CONTEXTUALIZING SEX IN MARRIAGE; and MAINTAINING PHYSICAL HEALTH.

Supportive quotes were provided for each of the research questions, and discussion of how some of the findings related specifically to the frameworks of this study. Chapter 5 follows with a discussion of these results.

CHAPTER 5: DISCUSSION

As mentioned in Chapter 1, the primary purpose of this study was to explore links between health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads and the risk or protective factors for HIV. The study explored the content of such information, the process by which knowledge about health promotion and disease prevention are transmitted, as well as the effectiveness of knowledge transmission in impacting daughters' health and sexual health behaviors, including HIV prevention for Haitian women.

A qualitative research design and a purposive sampling method were used to guide a two-step process that first recruited and interviewed a focus group consisting of seven health care providers and Haitian-descendant community leaders who engage Haitian clients. The findings from the analysis of the focus group interviews then guided the development of a semi-structured interview protocol used to interview eight Haitian mother–daughter dyads who reside in West Central Florida. The following three research questions were addressed; (1) What do health care providers or community level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents? (2) What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters? (3) What messages do Haitian daughters in West Central Florida *receive* from their mothers about what constitutes health and sexual health?

Two follow-up questions were added to research question 3: Are the daughters receiving what the mothers are attempting to convey? Do daughters have intention to transmit health and

sexual health communication that they receive from their mothers and/ or other sources to their own daughters? If so, how similar or different will such communication be compared to what they have received from their own mothers?

This dissertation utilized constructivist grounded theory as the analytic approach, and triangulated symbolic interactionism (SI), and the information-motivation-behavioral skills model (IMB) as a theoretical framework.

This chapter begins with a summary of the findings from this qualitative analysis, then describes how the research findings contribute to the field. Subsequently, the chapter offers implications for social work education, research, policy, and practice, and limitations and strengths of this dissertation study.

Discussion of Research Question 1

This dissertation study was conducted in a two-phase process in which the first phase was to conduct a focus group consisting of health care providers and Haitian-descendant community leaders who engage Haitian- descendant clients in the region as key informants. Research question 1 specifically is addressed to this focus group: *What do health care providers or community-level leaders serving Haitian women in West Central Florida believe to be factors that influence the health and well-being of their constituents?*

The focus group participants contributed that poto mitan is central to health and sexual health communication between mothers and daughters and that attention to vaginal health and relevance of post-partum baths are as well. They also identified that there are different contexts in which health and sexual health communication occur including by religious leaders and by school personnel. They emphasized the importance of cultural distinctiveness and pride. They further reported that immigration status often increases the vulnerability of their constituents to

sexual assault, suggesting a need for human rights and social advocacy for undocumented Haitian women. Moreover, they confirmed previous literature about distrust of formal health care system and persistence of traditional health practices in the U.S. These findings from the focus group have several implications.

The key finding that *poto mitan* is central to health and sexual health communication between mothers and daughters, is consistent with the literature. N'Zengou-Tayo (1998) provided detailed examples dating as far back as the early 1800s denoting how Haitian women have been revered as the center post in their society, even as they have struggled to have their voices heard politically. The celebrated female Haitian author Edwidge Danticat, author of award winning writings such as *Krik? Krak!*, (1991) and *Breath, Eyes, Memory* (1994), details the central role of women both in Haiti, and as immigrants in Florida.

The findings stemming from the present study confirm the continued position and influence of Haitian women as the *poto mitan* provide even in Florida immigrant enclaves, corroborating the relevance of transnational ties in this study. The relevance of transnational ties is further supported by this study participants' assertions regarding the persistence of the Haitian mother as central to the health of Haitian women in the U.S. and by the identification of religious leaders as conveyors of health and sexual health communication. Thus, findings from this study contribute in defining key gatekeepers in the local Haitian immigrant enclave whose presence, knowledge and influence must be considered in the development of interventions for Haitian women. Accordingly, any intervention intended to increase health knowledge for young Haitian women would necessitate partnership with mothers and religious leaders as revered gatekeepers.

Findings from this study further revealed that even educated Haitian daughters reported an intent to assume health risks for themselves and their daughters in order to adhere to mothers'

instructions and to perpetuate traditional norms and roles. The assumption of intentional risks in preservation of valued traditional norms was indicated in Rahill's study of informal injectionists in Florida (2008). In that study, having known someone in Haiti and being referred by a trusted other served as sufficient rationale for obtaining an injection from untrained persons.

The allusion to cultural distinctiveness and pride corroborates the need to highlight the unique and valued traditions in Haitian culture as a health promotion aspect of interventions, while engaging in harm reduction to prevent adverse health outcomes; this is important because focus group participants emphasized the cultural distinctiveness of their Haitian clients, and advocated for being counted as distinct in census efforts. Culturally distinguishing Haitian immigrants from other Blacks/African Americans would increase Haitian immigrants' access to funding that addresses the health promotion and disease prevention needs of their constituents. Also, in regard to health promotion, culturally distinguishing Haitian immigrant clients while insuring respect of traditional norms and hidden health practices such as those that recommend insertion of hot leaves in the vagina post-partum, would permit health providers to treat their clients from a holistic perspective; it would also permit health providers to identify potential risk factors that they would otherwise not know. Concomitantly, knowledge of hidden health practices would equip health providers with previously hidden protective factors (drinking of teas, maintaining vaginal cleanliness) that can be employed to strengthen the health of their clients.

The post-partum bath was introduced by focus group participants as a practice that is important to the health of their constituents. In spite of some risk factors that might be associated with the ingredients used in and the procedures employed in the post-partum baths (Kobetz, et al., 2013), certain associated benefits still need to be explored. Focus group participants

confirmed the practice of post-partum baths in West Central Florida. However, focus group participants were not in consensus that the benefits of such baths outweighed the health risks and one participant had not heard of the practice before the focus group. Nevertheless, post-partum baths are not unique to Haitian culture. Allen (2002) wrote of this enduring practice in West Central Tanzania, stating women in her study utilized this practice to ensure post-partum health by ridding the body of postpartum blood, relieving post-partum pain, and stimulating healing, energy, and strength. In Asia, Nasar (2015) confirms post-partum bath ritual participation for health promotion and disease prevention. In the context of all three of these locales, the fact that post-partum baths are valued indicates that it will likely persist. Therefore, acknowledgement of this practice in the U.S. is an important aspect of Haitian health that must be conveyed to medical personnel.

Brodwin (2001) wrote of the enduring belief of cultural distinctiveness among members of the Haitian diaspora residing in the French West Indies, indicating that Haitian immigrants there do not intentionally seek assimilation but preserve cherished health practices that positively impact their well-being. In fact, in the U.S., Prou (2005) found that preserving cultural distinctiveness for many Haitians in the U.S. means increasing the likelihood of raising one's social status.

Discussion of Research Question 2

What specific methods (if any) do Haitian mothers use to communicate what constitutes health and sexual health to their daughters?

Four major categories emerged from analysis of the interviews with the mothers in this study. With respect to UTILIZING SECONDARY SOURCES OF TV AND MUSIC, it is heartening that mothers are taking advantage of music and television programs that interest their

daughters as a resource to engage in health and sexual health communication. Barz and Cohen (2011) wrote of the use of music in spreading hope and a message of the possibility of healing within the context of AIDS in Africa. Included in their discussion, which also incorporated other art forms such as performance art and photography, was the use of these medium as avenues for health education and social change. In fact, they also wrote of the utilization of TV and radio to accomplish similar goals, calling this practice *edutainment*. Pellettieri (2004) outlined in the U.S. context the importance of incorporating television geared at youth to spread important sexual health information. Stating youth already are relying on TV and the internet for sexual health communication, Pellettieri's recommendation was to increase the quality of these sources so as to have greater positive health outcomes for youth. With this in mind, it would be useful to connect with popular musicians as partners in developing interventions. Also, the use of videos and other visual resources are popular media to develop evidence-based interventions for African Americans (CDC, 2017a); these could be adapted contextually and linguistically for Haitian women, in partnership with mothers, educated daughters and religious leaders. This would insure feasibility and acceptability of such interventions in Haitian communities.

The category, ALLOWING FOR TRUSTED LEADERSHIP TO COMMUNICATE HEALTH AND SEXUAL HEALTH WITH DAUGHTERS, suggests a natural foundation on which to build accurate and comprehensive health and sexual health interventions for young Haitian women. This also can strengthen mothers' capacity to engage in direct communication, and to feel more confident and supported, thus reducing the likelihood that they would avoid health and sexual health communication with daughters.

Discussion of Research Question 3

Question 3 had several facets: *What messages do Haitian daughters in West Central Florida receive from their mothers about what constitutes health and sexual health? Are the daughters hearing what the mothers are attempting to convey? Do Haitian daughters have intention to transmit health and sexual health communication to their own daughters? if so, how similar or different will such communication be compared to what they have received from their own mothers?*

The daughters conveyed that they are receiving information from their mothers about what constitutes health and sexual health. These include the beneficial use of natural (herbal) medicinal products, participation in the post-partum bath ritual, the importance of maintaining physical health, and contextualizing sex in marriage. The use of teas and other herbs are not unique to Haitian culture and in fact are increasingly valued by non-Haitians in the U.S. Nevertheless, the use of herbs and teas, outside of supervision by a health caregiver who is cognizant of the relative benefits, risks, drug interactions, and side effects is cause for some concern; this is especially relevant for mothers and or daughters who are on prescribed medications. Incorporating the wisdom of natural traditional Haitian medication would be a strength of any proposed health intervention for those women. The latter statement also pertains to elements used in post-partum baths as well as the process and time frame for such baths.

The finding pertaining to the maintenance of the physical body is a protective factor that emerged in this study. The daughters are receiving those positive messages and complying with them. It is heartening that daughters are also beginning to resist (at least covertly) potentially risky practices such as insertion of leaves in vagina. However, health promotion and disease prevention interventions for Haitian women should include discussions of expected

consequences of such practices without minimizing the role of the mother or devaluing the practice itself.

The contextualizing of sex in marriage is not different from other U.S. groups who propose abstinence to their daughters. In fact, abstinence is the only surefire way to prevent sexually transmitted diseases, including HIV. However, daughters, although receiving those messages are not consistently adhering to them. Like the post-partum baths, they adhere when the mother is present or involved and depart from the norms when the mother is absent or not expected to know. This was evident in some daughters saying, “Don’t tell her [mother] I said that.” So, any interventions that would be developed to promote the well-being of Haitian women has to recognize that the message of abstinence is commonly promoted but not adhered to, and, therefore, must be ground in the reality that daughters may, in fact, be having sex outside of marriage. So interventions must include disease risk reduction messages as well as abstinence.

Daughters in this study were not inclined to blindly transmit health messages received from mothers to their daughters, but maintained that they were relying on scientific evidence and other sources of health information in addition to what their mothers taught them. This finding relates to SI, indicating an expanded network of health information for daughters.

Discussion of Theories derived from the Study

The figures in Chapter 4 clearly outline that communication that is occurring between Haitian mothers and daughters contains information about how to promote health and avoid disease. Within those conversations, there are clearly delineated roles of mothers and religious leaders as purveyors of knowledge and as trusted gatekeepers. There are many complex aspects of health promotion in those conversations, including belly binding, post-partum baths, and maintaining vaginal cleanliness to avoid infections. How particular aspects of health promotion

are interpreted is all within the context of SI. Moreover, there are also specific elements to each practice aimed at health promotion, as well as specific time frames for engaging in those practices. As further examples, there are specific ingredients that must be used, all learned within the context of SI. IMB is featured in that there is a great deal of information being transmitted and a strong motivation to learn and adopt the necessary health behaviors/ skills, that is being modified by mothers' and daughters' exposure to new and often different health information in the U.S. there is little communication about HIV between mothers and daughters, beyond warning daughters about other groups who are infected with the virus and to promote abstinence in order to avoid infection. It is evident that abstinence alone is not sufficient to prevent HIV. The challenge is how to engage mothers, daughters and religious leaders to have courageous and earnest conversations about sexual thoughts, activities and consequences without fear of being socially or morally ostracized/ stigmatized/ devalued.

Disease prevention is closely related to health promotion in this study. For example, contextualizing sex in marriage is associated with health promotion and with disease prevention in Figure 4.8, as is belly binding and vaginal health, both of which involve the use of herbal concoctions to either maintain health or avoid disease.

Implications of the Study

As indicated in Chapter 2, Haitian-immigrant women in the U.S. experience health disparities in many areas, including cancer and HIV/AIDS. There are many remaining questions on how best social workers can help to improve these disparities. In fact, the 12 Grand Challenges for Social Work, under the direction of the American Academy for Social Work and Social Welfare (AASWSW), has named *Close the Health Gap* as one of these top-priority plans for the profession. Therefore, many further opportunities are available for social workers to

influence social work education, practice, research, and policy affecting the lives of Haitian women in the studied region of Florida (which will also attend to the aforementioned Grand Challenge).

Implications for social work education.

Implications of this dissertation research reveal opportunities in social work education. There is a need to educate social work students to conduct comprehensive assessments of Haitian women in the context of valued Haitian family dynamics. Social work students must also be educated in life-long learning regarding protective as well as risk factors for Haitian mothers and their daughters.

Implications for social work research.

Given the lack of comprehensiveness and inaccuracy of HIV knowledge reported in this study, and in the context of the 2017 Florida Department of Health State of the HIV Epidemic in Florida report of increased incidence of HIV among Haitian women in Florida, research is needed to assess HIV knowledge in young Haitian women from early adolescence through emergent adulthood. Other researchers have discussed the need for research “that investigates how traditional Haitian beliefs [and practices] develop, the cultural distinctions that are unique to them, and how these translate into health-seeking behaviors and health outcomes” (Devieux, et al., 2004; Rahill, 2008, p. 21). This first step in exploring health and sexual health communication among Haitian mothers and daughters also revealed a need to survey both Haitian and non-Haitian health care providers in the targeted area regarding their knowledge of health beliefs and practices of their Haitian women patients. Findings from this survey can be used to develop interventions that equip them with strategies to establish rapport with Haitian patients and to assess potential interactions between their hidden health practices and prescribed

medications. Additionally, interventions may be developed that empower trusted religious leaders to gain accurate HIV knowledge and how to deliver that knowledge effectively to their congregants. Implications for research also include a need for development of outreach programs that result in heightened awareness of HIV, a reduction of HIV stigma, and increased HIV testing for Haitian women who are similar to this study's sample. This study has also revealed implications for practice.

Implications for social work practice.

Clinicians and case managers who engage Haitian immigrants in the U.S. encounter resistance stemming from historical and cultural experiences that impede engagement and retention of these clientele (Kobetz et al., 2013; Menard, 2008; Menard, Kobetz, Maldonado, Barton, Blanco, & Diem, 2010; Rahill, 2008). The present study adds knowledge that can inform clinicians and case managers how to convey respect for their valued traditions, which can potentially minimize the fear that may characterize Haitian-immigrant populations engaged in health-seeking behaviors (Desrosiers & St. Fleurose, 2002). Clinicians who engage Haitian women as clients in the U.S. not only need to be aware of the heterogeneity among Haitians in general, but also need to be aware of the cultural strengths and potential health risks that emerged in this study. Therefore, and in light of the cultural strengths highlighted in this study, a strengths-based perspective is a useful lens for clinicians and researchers engaged in considering the content, process and transmission of information between Haitian mothers and daughters, especially in terms of the mother as the central figure of the family, the *poto mitan*.

Implications for policy.

Of particular note to social workers, the National Association of Social Workers (NASW) Code of Ethics (2017), reminds all social workers they are called to be policy advocates, fighting

for policy that reflects not only decreasing health disparities, but policy that reflects social justice as well. Immigration policies are an important consideration in this troubled time of our nation, especially given the relative vulnerability of the undocumented women as described by focus group participants. Immigration status was not queried in the present study; however, there is concern that undocumented women may become an even more hidden population as the U.S. government moves toward non-renewal of temporary protected status for Haitians. Needed is political advocacy at the regional, state and national levels. Specific advocacy efforts can work for immigration reform efforts that reflect social equality. Additionally, there is a need to support the Haitian community's efforts to participate in the census, as well as advocating for Haitians as a distinct group in the census and surveillance data. Another specific policy advocacy goal can be to include Haitian mothers and their daughters in the development and implementation of future policy, so their voices can continue to be heard, and can be reflective of the results of this study, for example, collaborating with U.S. healthcare organizations and agencies to improve understanding of Haitian health beliefs. Finally, policy implications include the need for advocacy for policy dictating development of Evidence-based Haitian-specific HIV prevention and intervention programming.

Limitations

There were two limitations to this study. First, I collected all data in English, so this study did not include focus group participants or Haitian mothers and daughters living in West Central Florida who do not speak English. This limitation hindered my ability to obtain the perspectives of individuals for whom length of time in the U.S., or an ability to speak English might have served as acculturation proxies, or limited the study to interviewing those who are ostensibly more acculturated. Additionally, the small sample size drew from a relatively small geographic

area of West Central Florida, and utilized a nonprobability purposive sampling method, thus limiting the generalizability of findings. Despite these limitations, this study has several strengths.

Strengths

To my knowledge, it is the first study in the U.S. to seek perspectives of Haitian mother-daughter dyads on health and sexual health communication, particularly in relation to HIV/AIDS. Findings from this study add to scientific knowledge on the health and sexual health of Haitian women in the U.S., denoting key gatekeepers and potential collaborators. Findings from this study comprise an additional step in understanding the influence of traditional beliefs and norms on health outcomes.

Conclusion

Qualitative research reinforces the idea that social and cultural influences impact how people make sense of their lives (Jakubec & Astle, 2017). A clear strength of this study is that this inductive approach for knowledge development fits the main purpose of this study, which was to explore the links between health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads and the risk or protective factors for HIV. Utilizing the constructivist grounded theory approach in conducting this research allowed me to develop a theoretical understanding from the data itself, by analyzing action and processes that Haitian mother-daughter dyads experience in health communication. This was not a linear process, and in utilizing this approach, I had the great benefit of being able to follow leads as they presented in the interview and in the analysis, what Charmaz (2014) states is “similar to a camera with many lenses” (p.25). What emerged in this study was a telling of the participants’ experience, from their own perspective. Providing this avenue for Haitian women to

speak about their lives, which resulted in this written report of their perspectives, is in keeping with the values and mission of the social work profession (NASW, 2017).

As a social work practitioner, this study also impacts my future work. Upon completion of this study I will be able to inform not only my work but the work of my colleagues and other professionals as we improve prevention and intervention strategies and work for a more just society. Although findings from an exploratory study such as this are not generalizable to Haitians in general or even to Haitian immigrants in the U.S., as an educator, and policy maker, findings from this study will be a first step in further professional development for me, my students and colleagues.

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APPENDIX A: RECRUITMENT FLYER



Haitian Mothers and Daughters

You are invited!

- **Would you like to participate in a research study looking at how Haitian mothers and daughters talk about health with each other?**
- **We are looking for Haitian mothers and their adult daughters to participate in a one-time 45-minute interview centered around health communication.**
- **To be included you must: Reside in West-Central Florida, be of Haitian descent and speak English. Daughters must be at least 18 years old.**

**A \$25 WalMart gift card
will be provided in appreciation for your participation**

Call research leader Stacy Kratz to sign up or if you have any questions: 813-380-2375

This Study is being conducted at the University of South Florida, Investigator Stacy E Kratz, MSW, LCSW IRB#16140



College of Community and Behavioral and Sciences School of Social Work 13301 Bruce B Downs Blvd., MHC 1400 Tampa FL 33612



APPENDIX B: INFORMED CONSENT ADULT DAUGHTER



Informed Consent to Participate in Research Information to Consider Before Taking Part in this Research Study

IRB Study # Pro00016140

CONSENT FORM FOR ADULT DAUGHTER IN STUDY

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:

An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother Daughter Dyads in West Central Florida

The person who is in charge of this research study is **Stacy E. Kratz**. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by **Dr. Guitele J. Rahill**.

The research will be conducted at the participant's home or other community setting as requested by the participant.

Purpose of the study

The purpose of this study is to:

- Investigate health and sexual health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads who reside in West-Central Florida. You are being asked to participate because of your ability to share your knowledge of this topic.
-

IRB Number: _____
IC Adult Minimal Risk - SB Rev:9-3-2010

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- This study is being conducted for a dissertation by the principal investigator Stacy E. Kratz. She is a student in the School of Social Work at the University of South Florida

Study Procedures

If you take part in this study, you will be asked to:

- Meet with individually with interviewer Stacy E. Kratz, once for up to 90-minutes, at either the participant's home or another place that the participant requests in the community.
- You will be asked for permission to audio record the interview, and if you agree, the interview will be audio recorded. The audio recorded interviews will be transported in a secure box to the professional office of Principal Investigator Stacy E Kratz, where they will be placed in a locked file cabinet, which only she will have access.
- The recordings will be kept on file for five years, after which time they will be destroyed.

Total Number of Participants

About 20 mother/daughter teams, which will total about 40 individuals, will take part in this study at USF. Both mother and daughter must consent individually in order for the pair to participate.

Alternatives

You do not have to participate in this research study.

Benefits

There are no known benefits to you for participating in this study.

Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation

You will be paid *\$25 in the form of a Wal-Mart gift card* if you agree to participate in this study. Both the mother and daughter in each team will each be paid their own \$25 Wal-Mart gift Card. If at any time you wish to stop the interview you still will be compensated in full.

Privacy and Confidentiality

We will keep your study records private and confidential. Certain people may need to see your study

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records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator. Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an adverse event or unanticipated problem, call Stacy E. Kratz at 813-380-2375.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

Signature of Person Taking Part in Study

Date

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/she understands:

- What the study is about;
- What procedures will be used;
- What the potential benefits might be; and
- What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give informed consent.

Signature of Person Obtaining Informed Consent

Date

Printed Name of Person Obtaining Informed Consent

IRB Number: _____
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IRB Consent Rev. Date: _____
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APPENDIX C: INFORMED CONSENT ADULT MOTHER



Informed Consent to Participate in Research Information to Consider Before Taking Part in this Research Study

IRB Study # **Pro00016140**

CONSENT FORM FOR ADULT MOTHER IN STUDY

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:

An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother Daughter Dyads in West Central Florida

The person who is in charge of this research study is **Stacy E. Kratz**. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by **Dr. Guitele J. Rahill**.

The research will be conducted at the participant's home or other community setting as requested by the participant.

Purpose of the study

The purpose of this study is to:

- Investigate health and sexual health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads who reside in West-Central Florida. You are being asked to participate because of your ability to share your knowledge of this topic.

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- This study is being conducted for a dissertation by the principal investigator Stacy E. Kratz. She is a student in the School of Social Work at the University of South Florida

Study Procedures

If you take part in this study, you will be asked to:

- Meet individually with interviewer Stacy E. Kratz, once for up to 90-minutes, at either the participant's home or another place that the participant requests in the community.
- You will be asked for permission to audio record the interview, and if you agree, the interview will be audio recorded. The audio recorded interviews will be transported in a secure box to the professional office of Principal Investigator Stacy E Kratz, where they will be placed in a locked file cabinet, which only she will have access.
- The recordings will be kept on file for five years, after which time they will be destroyed.

Total Number of Participants

About 20 mother/daughter teams, which will total about 40 individuals, will take part in this study at USF. Both mother and daughter must consent individually in order for the pair to participate.

Alternatives

You do not have to participate in this research study.

Benefits

There are no known benefits to you for participating in this study.

Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation

You will be paid *\$25 in the form of a Wal-Mart gift card* if you agree to participate in this study. Both the mother and daughter in each team will each be paid their own \$25 Wal-Mart gift Card. If at any time you wish to stop the interview you still will be compensated in full.

Privacy and Confidentiality

We will keep your study records private and confidential. Certain people may need to see your study

IRB Number: _____
IC Adult Minimal Risk - SB Rev:9-3-2010

IRB Consent Rev. Date: _____
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records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator. Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an adverse event or unanticipated problem, call Stacy E. Kratz at 813-380-2375.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

Signature of Person Taking Part in Study

Date

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/she understands:

- What the study is about;
- What procedures will be used;
- What the potential benefits might be; and
- What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give informed consent.

Signature of Person Obtaining Informed Consent

Date

Printed Name of Person Obtaining Informed Consent

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IRB Consent Rev. Date: _____
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APPENDIX D: INFORMED CONSENT FOCUS GROUP ADULT



Informed Consent to Participate in Research Information to Consider Before Taking Part in this Research Study

IRB Study # **Pro00016140**

INFORMED CONSENT FOR FOCUS GROUP PARTICIPANT

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:

An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother Daughter Dyads in West Central Florida

The person who is in charge of this research study is **Stacy E. Kratz**. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by **Dr. Guitele J. Rahill**.

The research will be conducted at the office of Dr Guitele J Rahill, at the University of South Florida School of Social Work, Tampa, Fl.

Purpose of the study

The purpose of this study is to:

- Investigate health and sexual health communication and other constructs affecting health promotion and disease prevention among Haitian mother-daughter dyads who reside in West-Central Florida. You are being asked to participate because of your ability to share your knowledge of this topic.

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- This study is being conducted for a dissertation by the principal investigator Stacy E. Kratz. She is a student in the School of Social Work at the University of South Florida

Study Procedures

If you take part in this study, you will be asked to:

- Meet in a focus group with interviewer Stacy E. Kratz, once for up to 90 minutes at the office of Guitele J. Rahill, located at the University of South Florida, School Of Social Work, Tampa Campus.
- You will be asked for permission to be audio recorded, and if permission is granted, the focus group interview will be audio recorded. The audio recorded interviews will be stored in a secure box in the professional office of Principal Investigator Stacy E Kratz, where they will be placed in a locked file cabinet, which only she will have access.
- The recordings will be kept on file for five years, after which time they will be destroyed.

Total Number of Participants

About 5 individuals will take part in this study at USF.

Alternatives

You do not have to participate in this research study.

Benefits

There are no known benefits to you for participating in this study. However, you will have the opportunity to meet other persons who are engaged in providing services to Haitian-descendant residents of West Central Florida, potentially increasing your network capacity.

Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation

You will receive no payment or other compensation for taking part in this study.

Privacy and Confidentiality

We will keep your study records private and confidential. Certain people may need to see your study

IRB Number: _____
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IRB Consent Rev. Date: _____
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records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator. Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an adverse event or unanticipated problem, call Stacy E. Kratz at 813-380-2375.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

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Signature of Person Obtaining Informed Consent

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APPENDIX E: IRB APPROVAL LETTER



RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC033 • Tampa, FL 33612-4799
813/974-5638 • FAX:813/974-0391

May 8, 2014

Stacy Kratz, LCSW
School of Social Work
Tampa, FL 33612

RE: Expedited Approval for Initial Review

IRB#: Pro00016140

**Title: An Exploratory Study of Health Promotion and Disease Prevention Communication
Among Haitian Mother Daughter Dyads in West Central Florida**

Study Approval Period: 5/7/2014 to 5/7/2015

Dear Ms. Kratz:

On 5/7/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):

Protocol Document(s):

[KRATZ Study Protocol Health Promotion and Disease Prevention.docx](#)

Consent/Assent Document(s)*:

[KRATZ IRB 16140 Adult Daughter Informed Consent minimal risk.docx.pdf](#)

[KRATZ IRB 16140 Adult Mother Informed Consent minimal risk.docx.pdf](#)

[KRATZ IRB 16140 Focus Groups Adult Informed Consent minimal risk.docx.pdf](#)

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR

APPENDIX F: SEMI-STRUCTURED INTERVIEW GUIDE FOR FOCUS GROUPS

Stacy E Kratz, MSW, LCSW

Semi-structured focus Group Guide for West-central Florida Health care providers and Haitian-descendant community leaders

1. As a person who provides health care or community-level leadership to Haitian women, please discuss factors relevant to the health and well-being of your constituents.

Prompts

- a. What are some obstacles you encounter in serving Haitian-women and their daughters?
- b. How do culturally-embedded factors appear to affect awareness and access of available health services among Haitian women and their daughters?
 - i. Health beliefs
 - ii. Vodou as a framework
- c. What factors have you perceived contribute to the health practices of Haitian women in your community?
 - i. Faith-based issues
 - ii. Economics?
 - iii. Stigma related to being Haitian or associated with disease transmission?
 - iv. Immigration context and other influences?
 - v. Transnational ties to Haiti and other Haitian enclaves?
 - vi. Local U.S. norms
- d. Have you noticed any difference in the length of time that a Haitian-descendant woman is in the United States and their health beliefs or practices?
 - i. Language?
 - ii. Length of time in U.S.
- b. How do you reach and retain Haitian-descendant women as clients?
- c. What knowledge or resource do you lack in increasing your capacity to be most effective with Haitian-descendant women and their daughters?

APPENDIX G: SEMI-STRUCTURED INTERVIEW GUIDE HAITIAN DAUGHTERS

Stacy E Kratz, MSW, LCSW

Semi-Structured Interview Protocol: An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother Daughter Dyads in West Central Florida

- 1) What messages do Haitian daughters in West-Central Florida receive from their mothers about what constitutes health and sexual health to their daughters?
 - a) What do Haitian women say to their daughters that they consider are important life messages?
 - b) As a woman of Haitian descent how valuable is health to you? To Haitian women in general?
 - c) What do Haitian women say to their daughters about health?
 - d) As a woman of Haitian descent, what are some of the most important things that you have learned from your mother regarding health?
 - e) What do Haitian mothers say to their daughters about sex?
 - f) What have you learned from your mother regarding about sex?
 - g) What do Haitian mothers say to their daughters that can help promote their sexual and reproductive health?
 - h) What have learned from your mother regarding how to achieve sexual and reproductive health?
 - i) What do Haitian women say to their daughters than can equip the daughters to protect themselves from risk factors for sexually transmitted diseases, including HIV/AIDS?
 - j) What have you learned from your mother regarding how to protect yourself from risk factors for sexually transmitted diseases, including HIV/AIDS?
 - k) What do Haitian women say to their daughters about pregnancy?
 - l) What have you learned from your mother regarding pregnancy?
 - m) What do Haitian women say to their daughters about sexually transmitted infections and HIV?
 - n) What have you learned from your mother regarding sexually transmitted infections and HIV?

APPENDIX H: SEMI-STRUCTURED INTERVIEW GUIDE HAITIAN MOTHERS

Stacy E Kratz, MSW, LCSW

Semi-Structured Interview Protocol: An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother Daughter Dyads in West Central Florida

- 1) How do Haitian mothers in West-Central Florida communicate what constitutes health and sexual health to their daughters?
 - a) What do Haitian women say to their daughters that they consider are important life messages?
 - b) As a woman of Haitian descent how valuable is health to you? To Haitian women in general?
 - c) What do Haitian women say to their daughters about health?
 - d) As a woman of Haitian descent, what are some of the most important things that you have said to your daughter regarding health?
 - e) What do Haitian mothers say to their daughters about sex?
 - f) What have you said to your daughter (s) about sex?
 - g) What do Haitian mothers say to their daughters that can help promote their sexual and reproductive health?
 - h) What have you said to your daughter(s) that can help promote their sexual and reproductive health?
 - i) What do Haitian women say to their daughters than can equip the daughters to protect themselves from risk factors for sexually transmitted diseases, including HIV/AIDS?
 - j) What have you said to your daughter(s) that can equip them to protect themselves from risk factors for sexually transmitted diseases, including HIV/AIDS?
 - k) What do Haitian women say to their daughters about pregnancy?
 - l) What have you said to your daughters about pregnancy?
 - m) What do Haitian women say to their daughters about sexually transmitted infections and HIV?
 - n) What have you said to your daughters about sexually transmitted infections and HIV?

APPENDIX I: PERMISSIONS

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Original Wiley figure/table number(s)	Figure 10.1 , page 133
Will you be translating?	No
Title of your thesis / dissertation	An Exploratory Study of Health Promotion and Disease Prevention Communication among Haitian Mother-Daughter Dyads in West Central Florida
Expected completion date	May 2018
Expected size (number of pages)	160
Attachment	
Requestor Location	Stacy E Kratz 3108 Taragrove Dr TAMPA, FL 33618 United States Attn: Stacy E Kratz
Publisher Tax ID	EU826007151
Total	0.00 USD

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ABOUT THE AUTHOR

Originally from Chicago, Illinois, USA, Stacy Kratz received a Bachelor of Arts in French Language and Literature from Southern Illinois University. She then earned a Bachelor of Social Work, a Master of Social Work, and a Ph.D. in Social Work all from the University of South Florida.

Dr. Kratz started her social work career at MacDill Air Force Base, in Tampa, Florida, as a family advocate and clinical therapist intern. She then spent a decade in direct practice and management for child welfare and juvenile diversion systems. In 2011, Kratz joined the faculty of the University of Southern California (USC) Suzanne Dworak-Peck School of Social Work in the Department of Social Change and Innovation. Her research involves health disparities related to immigrant and refugee populations, improvement of culturally competent service delivery by majority non-ethnic therapists, policy options for improved children's mental health outcomes, and faculty development in the virtual environment honoring diversity, inclusion, and equity.

Dr. Kratz has been awarded numerous community-impact awards by organizations across disciplines. Some of these awards include the National Association of Social Workers Tampa Bay Social Worker of the Year, University of South Florida Public Health Community Partner of the Year, Tampa Bay Business Journal Non-Profit of the Year, Conn Family Foundation Social Work Scholar, Florida Department of Children and Families Refugee Task Force of Tampa Bay Welcomer Award, and the Human Rights Award of the Tampa Bay Human Rights Council. In 2016, Kratz was honored with the Jane Addams Faculty of the Year Award at the University of Southern California Suzanne Dworak-Peck School of Social Work.